REPORT ON PROCEEDINGS BEFORE

PUBLIC ACCOUNTS COMMITTEE (PAC)

INQUIRY INTO THE MANAGEMENT OF HEALTH CARE DELIVERY IN NSW

At Macquarie Room, Parliament House, Sydney,
on Monday 30 October 2017

The Committee met at 9.30 a.m.

PRESENT

Mr Bruce Notley-Smith (Chair)

Mr Lee Evans
Mr Ryan Park
Mr Greg Piper
Mr Mark Taylor

SUSAN PEARCE, Deputy Secretary Systems Purchasing and Performance Division, NSW Ministry of Health, sworn and examined

NIGEL LYONS, Deputy Secretary Strategy and Resources, NSW Ministry of Health, sworn and examined

The CHAIR: I declare open today's Public Accounts Committee public hearing into the management of healthcare delivery in New South Wales. The Committee has just returned from a visit to Lismore where we conducted discussions with the local community, health executives and service providers about health service delivery in the area. This gave the Committee a better appreciation of the issues being dealt with in the inquiry. In the next two days, the Committee will be taking evidence from major agencies and organisations with responsibilities for making policy and delivering health services, including NSW Health, which is appearing first. Today's hearing will focus on the delivery of health care generally, and tomorrow's will focus more closely on mental health services.

Before the proceedings commence, I remind everybody to switch off their mobile phones as they can interfere with the Hansard recording equipment. If your phone is on silent, please switch it off completely. For the benefit of the gallery, I note that the Committee has resolved to authorise the media to broadcast sound and video excerpts of public proceedings. Copies of the guidelines governing coverage of proceedings are available. I welcome Dr Lyons and Ms Pearce from NSW Health and thank them for appearing before the Committee today to give evidence. Before we proceed, do you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Dr LYONS: No, I do not.

Ms PEARCE: No.

The CHAIR: Would you like to make an opening statement before the commencement of questions?

Ms PEARCE: NSW Health is the largest public health system in Australia, accounting for nearly one-third of the New South Wales Government's budget. Responsible stewardship of this $23 billion system with rising demand and consumer expectations has meant the effective and efficient management of health services are a central feature of NSW Health's activities. The Ministry of Health is leading the New South Wales health system to become increasingly focused on quality and safety of care by delivering outcomes that are most valuable to patients, carers and communities. Our approach incorporates transparent monitoring and reporting of the critical health system performance domains, efficiency and effectiveness, as well as safety, patient-centred culture, accessibility, timeliness, appropriateness and equity.

The Ministry of Health has established five strategic priorities to drive improvement in healthcare delivery in New South Wales. These are: patient safety first; leading better value care; systems integration; digital health and data analytics; and strengthening governance and accountability. NSW Health takes a rigorous and businesslike approach to ensure that all healthcare organisations deliver on these priorities. This is reflected in the annual service agreements with our sector partners as well as in the NSW Health performance and purchasing frameworks. These processes continue to mature year on year, adding to and refining them to improve the experience in outcomes and care of patients.

As a system we support transparent reporting of performance. The Bureau of Health Information publishes independent reports on the performance of the New South Wales health system, which are publicly available. The bureau also reports annually to the Minister and Parliament on the performance of the system. In the most recent Healthcare in Focus 2016 report, the Bureau of Health Information found that no comparator country spent less per person and had better outcomes than New South Wales. This is a strong reflection of the efficiency and performance of the system as a whole. New South Wales has the best elective surgery performance in Australia, with 97 per cent of patients receiving their surgery on time. We have the highest proportion in the country of people moving through emergency departments within four hours. This is strong reflection of the performance and hard work of our clinicians and system as a whole.

Australia enjoys a high-quality healthcare system delivering some of the best health outcomes in the world. Against a range of health indicators Australia compares favourably with other developed countries. NSW Health considers quality, effectiveness and value as crucial when measuring excellence in healthcare delivery. Compared with other jurisdictions New South Wales has fewer hospital admissions resulting in a complication for our patients than the national average, and the rate of people returning to hospital after discharge is also below average compared to other jurisdictions. These results demonstrate a high level of quality of care across NSW Health; however, as a system we remain cognisant that there are areas for improvement. The rate of falls, for example, in New South Wales public hospitals is above the national average, and this is an area we are actively working on improving.

The Clinical Excellence Commission was established in 2004 as one of the five key pillars of the public health system. The commission monitors NSW Health processes and performance to provide assurance of clinical quality and safety improvements at a system-wide level. The recently launched safety and quality framework is an enhancement of the supporting structure of NSW Health that guides for design, purchasing and performance management of health services. Over time the framework will help to shape services that are safe, high quality and high care for our patients. It will target unwarranted clinical variation, a better culture of continuous learning and improvement, and enhance the availability of transparent, timely, valid, reliable and attributable data.

The focus of healthcare funding is shifting from volume to value. As a key enabler of value-based health care, patient-reported outcomes have emerged over the past five years as a rapidly developing area of health service research and policy development in Australia and internationally. Since July 2015 the New South Wales Agency for Clinical Innovation has conducted a patient-reported measures program across 11 proof-of-concept sites, and the program is now planned for a wider rollout using an integrated information technology [IT] platform for hospital primary and community services as part of the New South Wales health strategy to deliver better value care. Leading better value care is an initiative that is designing healthcare delivery to derive better patient outcomes, encourage a more collaborative whole-of-system approach and deliver better value health care to our patients.

The targeted models of care have been designed by clinicians, consumers and managers and have been extensively evaluated using the Institute of Healthcare Improvement's quadruple aim methodology of delivering better patient outcomes, better patient experience, better provider experience and improved efficiency. There is strong governance in place across NSW Health to ensure that patients and their carers are at the centre of all decisions. Leading better value care will systematise and further strengthen this governance, leveraging new technology, evidence-based practice and approaches to uncovering and addressing unwarranted clinical variation.

Dr LYONS: I take the opportunity to acknowledge the heartfelt and deeply personal submissions to the Committee from the family and carers of those who have experienced mental illness. Across Australia the prevalence of mental health problems is widespread. Mental illnesses are the single largest cause of disability in Australia and account for 24 per cent of the total non-fatal disease burden. Around one in five adults in Australia will experience a mental disorder each year, and for younger people aged 16 to 24 the rate is one in four. Severe disorders such as schizophrenia, severe depression and severe anxiety disorders account for around 80 per cent of mental health expenditure in Australia. They require intensive, specialist care and support, and both may be episodic and enduring.

For the great majority of people with a mental illness treatment is most appropriately provided in the community. For those whose problems are more severe and complex, treatment in a hospital inpatient unit may be indicated for a limited period of time. Core specialist clinical services provided by NSW Health include assessment and treatment services and continuing care and rehabilitation services, all of which are provided both in hospital and community settings. There are also specialist clinical services, inpatient and community settings for children and young people, older people and forensic patients.

"Living Well: A Strategic Plan for Mental Health in NSW 2014-2024" is an important strategy document for mental health care delivery in New South Wales. It outlines a vision for a mental health system focused on community-based mental health support. Promoting the vision of Living Well, the New South Wales Government has committed to undertaking a decade-long whole-of-government enhancement to mental health care. To strengthen mental health care in New South Wales, healthcare delivery focuses on five strategic directions. The first is a greater focus on community-based care. Second, strengthening prevention and early intervention. Third, developing a more responsive system. Fourth, working together to deliver person-centred care and, fifth, building a better overall system.

To drive improvements in key aspects of mental health service delivery, the Ministry of Health resources evidence-based training for senior clinical staff about reducing seclusion and restraint practices. The Ministry has implemented the six core strategies for the reduction of seclusion and restraint in our Local Health District Services since 2011. The Ministry is also currently undertaking a review of seclusion, restraint and observation of mental health consumers in NSW Health facilities and services. This review is being carried out by an independent expert panel, supported by the NSW Chief Psychiatrist. The review will report to the Minister for Mental Health and the Minister for Health by 8 December 2017. NSW Health is ready to respond to any recommendations made following the review.

In conclusion, NSW Health is consciously driving improved safety, quality and value through its five strategic priorities to improve patient-centred care delivery that responds to the outcomes that matter most to patients. Our embedded business processes and frameworks to monitoring improved performance across the system are delivering benefits. We are confident that as we continue to focus on quality, effectiveness and value we will further mature in our measurement and reporting on system performance to drive improved management of healthcare delivery in New South Wales in a way that is meaningful to patients, providers and the system at large.

The CHAIR: The Committee has a number of questions which have come out of your submission. How does the Ministry of Health ensure that the quality of care is not sacrificed when attempting to achieve various performance indicators such as those regarding how many patients are seen?

Ms PEARCE: I am happy to start to answer that question. Safety and quality is something that underpins all of the work that we do in our performance framework, and I am happy to go into more detail around some of the particular measures that go directly to the issue of safety and quality. We are very conscious—both myself and Dr Lyons have a clinical background in the health system—and acutely aware that health professionals do sometimes view key performance indicators [KPIs] with a level of scepticism as to their existence. The reality of it is that behind every data point there is a person, and the message that we continue to send to our health system is that it is not just about a target or a number; it is about what is in the best interests of our patients.

NSW Health has had a strong background in delivering safe and quality services, although we do recognise that there is always room for improvement. To that end, we have recently revised our safety and quality framework introducing new measures, and also asking our local health districts to establish a safety and quality account for the first time, which is due to be delivered from each service very shortly. We are asking our districts and services to identify the parts of their system—in addition to the performance framework and the various KPIs that exist—that are important to their service, to their local communities and to their patients.

Dr LYONS: I am happy to add further. In addition to what Ms Pearce has provided, the service agreements have a range of measures in them which include the sorts of things you have talked about—targets for activity, access, waiting times for care and those sorts of things—but the safety and quality indicators that are in the service agreements have equal weight to those other measures. The way the local health districts and speciality health networks are judged in relation to their performance is by looking at the suite of performance indicators, including quality and safety indicators. So we have a performance framework and if services are performing well they are level zero, and if there are concerns about performance, they may be elevated to levels one, two, three and so forth. The safety and quality indicators are just as material to considerations of the level of performance of the local health district or speciality health network than any of the other indicators that you have outlined.

The CHAIR: How extensive is the monitoring of achievements of performance markers? Several submissions noted that while effective policies and procedures are in place in healthcare facilities, they are not consistently complied with.

Ms PEARCE: NSW Health, as we have touched on already, is a very large health system. We deliver around 2.8 million emergency department presentations a year, hundreds of thousands of elective surgeries and emergency surgeries. It is a large system and one in which we do need strong measures to be able to ensure that we are delivering continually good service to our patients. So we have the performance framework that has been outlined in our submission. As part of that performance framework we have a quarterly meeting with each entity, each chief executive and their team to go through the range of indicators that exist in their service agreement. Dr Lyons has touched on the escalation associated with performance.

In the event that a district or a service is escalated within the performance framework the frequency of those meetings increases to monthly, or perhaps more frequently, depending on the nature of the issue. That is not to say that we wait, for example, for a quarter to come about for a meeting to address something if we start to see, within our data set, a deterioration in performance. We have a very large amount of information that comes through to the health system. One of the things that we have identified that we are now investing in is how we can be more predictive about areas that may be of concern associated with safety and quality in particular. These things are often evidenced by staff dissatisfaction, more patient experience and perhaps a lower rate of incidents at a lower level, rather than serious incidents, but the story is starting to tell you something.

We are currently working on developing a more rigorous approach to being more predictive as opposed to dealing with issues once they have arisen. There are a range of ways that we view our system. In day-to-day terms, for example, we have very close monitoring—and it has worked very effectively with our system—in regard to how we make sure our ambulance vehicles are able to be offloaded in a timely fashion. We work with the system. We help them when particular are sites are under pressure, and that type of monitoring is literally available to us 24/7, seven days a week.

The reason for that is not because of the target but, as I have mentioned earlier, because behind every data point there is a patient. So we need to make sure that people are not unduly waiting to be offloaded into our emergency departments and nor are they waiting for lengthy periods in a community when they call 000, for example. A lot of work has gone into that and, despite the winter that we have just experienced in 2017, which was quite exceptional from a presentation perspective, in August, for example, we were able to perform that offload function 8 per cent better than we did in August 2015 despite the volume that we were experiencing. All of those issues go to the safety and quality of our patients who are first and foremost.

Mr MARK TAYLOR: What about using the overall general health of the local community as a performance measure? Do you see that as an option?

Ms PEARCE: One of the things that we do each year when we are negotiating with the local health districts and speciality health networks for their service agreement is look at the health of the population. We have an equity adjuster and a population adjuster in that model so that it gives us the ability not to just bluntly allocate resources to these entities but rather to also look at the health of the community so that we are taking account of issues that may be arising. There are parts of the system that require services more than others. I am not saying that the model is perfect, and year by year there is a maturation of the service agreement model, but over recent years we have been able to have a closer look at the health of the community to try to invest more in the services that those particular communities need. We talk very closely with our teams in population health and public health at the ministry as well, who are experts in this regard, in doing so.

Dr LYONS: In addition to that, the local health districts and speciality health networks look at those reports on the disease burden of their local communities and look at their rates of mortality for certain conditions. They assess whether they need to do more in terms of focusing their attention on particular types of care or redistributing resources to support appropriate care for areas that may not be performing as well as comparator districts or national benchmarks. The Chief Health Officer provides a report at the system level each year which highlights how we are trending over time in relation to the disease burden, in particular mortality rates for certain conditions and those areas, and highlights where there might be discrepancies across the State as well. That is so we can support appropriate attention being provided to improve care where that is required or to improve outcomes for certain patients or communities.

Mr RYAN PARK: Are staffing levels subject to performance indicators?

Ms PEARCE: No. We do not have a performance indicator around staffing levels.

Mr RYAN PARK: Why is that?

Ms PEARCE: In terms of the key performance indicators within the sorts of things that we might take note of it would be things more like sick leave. There are also some measures around managing excess leave to ensure that our staff are having annual leave and being able to refresh and so on. We have industrial instruments that set out staffing arrangements across the health system for our staff that are adhered to, and the expectation is that those industrial instruments and the staffing arrangements set out within are adhered to. In addition to that, over the last number of years just from memory we have also had government election commitments that are measured and monitored to ensure that those commitments are being met and they have included staffing enhancements as well.

Mr RYAN PARK: Are you aware of significant concerns at the Illawarra Shoalhaven Local Health District about staffing levels at the Wollongong Hospital maternity service?

Ms PEARCE: In terms of those types of issues that arise, yes, I am aware that there have been some concerns raised in Wollongong recently and at some other sites as well. I am a registered nurse myself and I have been involved with the profession for quite a while. One of the things that we experience in nursing midwifery in particular are peaks and troughs in availability of nursing and midwifery staff from time to time. I was formerly the Chief Nursing and Midwifery Officer of New South Wales and we put a number of strategies in place, for example, to be able to employ as many newly graduating registered nurses and midwives as possible. I think at present there is no shortage of attempts to recruit staff. It is not a matter of holding up recruitment but rather there have been some areas that have struggled to recruit appropriately qualified staff to their services.

There are other things that we have done over the last number of years. For example, by increasing the number of clinical nurse or clinical midwifery educators in units and particularly in rural areas you are then able to take less experienced staff into the service so long as they have proper supervision and support around them.

They are some of the strategies that we have employed. From a workforce perspective there has been a very significant increase in the number of nurses and midwives employed in NSW Health in recent years, well into the thousands. It remains a challenge for us to continue to make sure that we have those recruitment efforts well under way.

Mr RYAN PARK: You are confident that at the Wollongong site it is not a matter of slow recruitment, it is just a matter of getting the nurses and midwives?

Ms PEARCE: I will say that my most recent conversation with the team down there was on the back of the winter period. Winter was extremely difficult and, as has been well documented, we certainly experienced a very significant number of emergency department presentations in particular. What was probably less obvious was that we also experienced quite a significant amount of staff sick leave and staff were certainly impacted. Their children, for example, may have been impacted, requiring them to take time off work. That probably has contributed to exacerbating in some areas some issues around staffing. Again I will say that from a Ministry of Health perspective the very clear expectation is that vacancies are recruited to in a timely fashion. It is counterproductive, frankly, to not do that because you end up requiring premium labour and overtime, et cetera. There is no question that recruiting to frontline clinical vacancies should be dealt with as a matter of priority.

Mr RYAN PARK: Mental health service provision has always interested me. I know this inquiry has received submissions from providers. Obviously, a growing number of people are living in the community with mental illnesses and presenting at hospitals. What advice are you providing government at the moment about service provision for this area of health, given that we are likely to see a big increase in presentations both at an acute level, at a hospital level, and within the community? This is like obesity when it started to emerge 10 or 15 years ago. We now know that more and more people are facing mental health challenges. What contemporary advice are you providing government about the way in which we can allocate taxpayers' money to better deal with this both within the community and at a presentation level within a hospital?

Dr LYONS: The first thing is to say that the mental health budget for this year in NSW Health is some $1.9 billion. That has been increasing over the last number of years and we will continue to maintain a focus on enhancing that budget to ensure that we can meet the needs of people in the community. The focus is about reforming the system as I outlined in the strategic plan, Living Well. The focus in that strategic plan is to increase investment but to start to shift the investment to provide more care in the community setting as opposed to acute hospital settings. But we are very conscious of the fact that this shift takes time, so we are still investing in acute hospital care as well as increasingly in the community setting. To give an example of that in practice, this year when we negotiated the increases in activity for mental health care there was a 1 per cent increase in acute hospital activity but a 2.4 per cent increase in the community setting. It is shifting the focus with more care being provided in the community. The other factor is that we are starting to focus on prevention and early intervention strategies so that we can start to intervene earlier before people get to the point where they require admission to hospital, so we can provide more care in a community setting. Those programs are a continuing investment as part of the reform process.

The other components are to move away from institutional care. In New South Wales we have had, over many years, a number of people who have been in our hospitals as long-stay patients and we have made a significant investment in Pathways to Community Living. That is starting to identify alternative ways to provide residential care for those people and to shift them out of hospitals, to move them appropriately to residential settings and with appropriate support to ensure that they can live outside a hospital environment. That program is underway and is in process. We make assessments of the individual patients and then find appropriate settings for them to be cared for.

There is also, I think, a continuing investment in the Housing and Accommodation Support Initiative [HASI] program, the housing assistance program, which is a very successful program which is providing psychosocial support for people living with mental illness who can then be supported to live in residential environments, and that is an increasing focus as well—we are providing more resources into that area and also more intensive. There is now a HASI Plus program, which is providing more hours of support for people who have complex care needs.

So those are the sorts of directions. We are very conscious of the need to continue in that vein and also to ensure that we are working with other government agencies, with non-government organisations, who play an active part in providing care for people, and with private sector services. They are the focuses of our endeavours over the coming years and they will continue to be a part of our strategic reform.

The CHAIR: Just on that, Ms Pearce, the Bureau of Health Information [BHI] report says New South Wales has the lowest number of nurses per capita of any State in Australia. This is in Healthcare in Focus 2016, and it puts New South Wales at 1,138 nurses per 100,000 population, which is below every other State.

Ms PEARCE: I will have to take that on notice if you wish me to come back to the Committee with some specifics in regard to that issue. What I can tell you is that there has been a concerted effort in regard to increasing the nursing and midwifery workforce. For example, from June 2012 until June 2017 we employed an additional 5,086 nurses and midwives—that is a 12.1 per cent increase in terms of those staffing numbers over that period. So there has been a significant investment in the recruitment in particular. We have been a very strong recruiter here in New South Wales in regard to the recruitment of graduate registered nurses and some models around student midwives and graduating midwives as well.

I have not looked at it in recent times because I have moved out of the chief nursing/midwifery officer role, but certainly during these recent years, New South Wales was the biggest employer by quite a considerable amount of newly graduating nurses and midwives. I am happy to take any more specifics that you might require on notice and come back to the Committee if you wish.

The CHAIR: Would you have an idea of what the full-time equivalent number of positions for nurses is across New South Wales?

Ms PEARCE: Yes. At June 2017 it was 47,282 FTE.

The CHAIR: How many have we got employed at this point?

Ms PEARCE: Again, I would have to take that one on notice. That was June; it is unlikely to have changed considerably. Obviously the head count would be much higher than that, and I know that the head count is over 50,000 nurses and midwives here in New South Wales. There are also different models that exist in New South Wales in terms of our staffing arrangements compared to other States in terms of what is included in those numbers, which is often an issue when you are comparing jurisdictions. But certainly I would be happy to provide more information to you.

The CHAIR: That would be helpful. If you could perhaps have a look at the criteria they have been using and pull it apart for us?

Ms PEARCE: I am very happy to.

The CHAIR: Obviously a campaign has been going for quite some time now and the nurses union will be appearing before the Committee talking about nurse/patient ratios, whereas New South Wales is landed with nurse/patient hours. Could you explain to the Committee why that decision was made?

Ms PEARCE: That arrangement has been in place now for some years in the public hospital Nurses and Midwives Award. It was an agreement that was negotiated between the Nurses and Midwives' Association and the government of the day and, as I said, has been in place now for some considerable period of time. The position that we have taken here in New South Wales is that nursing hours per patient day gives employers a greater degree of flexibility in terms of how staffing arrangements are made. It is worth noting to the Committee, however, that the numbers contained in the reasonable workloads clause in the award are a minimum—they are not designed to be the ceiling—and clinical decisions can be and are made at the local level in terms of what that staffing should look like, dependent particularly on patient acuity or complexity of the patients.

The view has been historically here—and I am not involved in the industrial arrangements, and I was not as a chief nurse either—the view around ratios generally has been that they are very blunt, and in other jurisdictions where they have existed there are issues associated with a blunt application of ratios arrangements versus a more flexible arrangement that we believe is contained currently in the agreed arrangements in the award.

The CHAIR: What does that bluntness result in?

Ms PEARCE: I do not seek to speculate, but the issue around a number, you could argue that a management team would then say, "That's the number, we are not going above it." That is the ratio that is set out in the instrument and, consequently, that is it. As I said, the nursing hours a patient day, which has been in place now for—I cannot remember how long it has been; it has been quite a while—has quite a degree of complexity about how those arrangements are set out, and it also is tailored to different parts of the hospital depending on the needs of the particular wards and units as well. I do not want to speak about something in great detail that I am not an expert in, but the blunt arrangements associated with ratios have certainly been the least favoured option, and the nursing hours per patient day is the current arrangement.

The CHAIR: So the hours per patient day, when they are set out, are the minimum?

Ms PEARCE: Yes.

The CHAIR: It is not what is actually being allocated. It is the minimum allocated, but where is the flexibility to increase that?

Ms PEARCE: The award is quite clear in its provisions, as is any discussion that is held with NSW Health. The award is quite clear, I believe, in regard to those arrangements, and that is that if more nursing hours are required, given the complexity of the patients, there is the ability within the award, but, frankly, common sense dictates that if you have more complexity and sicker patients and you need to increase numbers, dependent on that you are able to do that. There are also shifts, of course, where that complexity is reduced or patient numbers might be reduced that also allows some differing arrangements from time to time. Because the hours are viewed across the week and in terms of the monitoring of those hours, they can be adjusted accordingly across the week. And there are all sorts of exclusions in terms of what is in and what is out of those numbers.

The CHAIR: Do they vary from district to district?

Ms PEARCE: No, they do not vary from district to district as such, except to say that in large high-complexity hospitals the wards within those hospitals will have a higher nursing hours per patient day arrangement depending on their peer group. Again—and this is part of the complexity of the instrument—this is based on the complexity of the patients within that facility. There is no distinguishing between the city and rural; it depends on what the make-up of the facility is, no matter where it is.

Mr GREG PIPER: This question is probably for Dr Lyons. I return to mental health issues and smoking, a matter raised during the hearing in Lismore and one I have heard of anecdotally for a long time. The results of longstanding campaigns to reduce numbers of smokers in Australia have been excellent, and New South Wales has played a big part in that. It is a great outcome for those individuals and also for our health budget. I acknowledge and applaud that, but it is still my understanding that there are certain cohorts in which smoking is extremely high and one of those is mental health patients. Mental health patients have a higher than average participation in smoking. I have not done the statistics for a long time, but is that still correct?

Dr LYONS: That is correct, yes.

Mr GREG PIPER: They also have a high consumption of other substances—not necessarily illegal substances but a very high consumption of soda drinks such as Coca-Cola is common in some mental health cohorts. It has been raised with me a number of times and it was raised with the Committee in Lismore that, for people presenting with acute mental health problems and associated behaviours such as, often, aggression and anxiety, one of the major presenting problems or a new presenting problem is that, as soon as they become an inpatient of a facility, they are no longer able to smoke. Is there no contingency for that?

Dr LYONS: That is my understanding, yes.

Mr GREG PIPER: It was not discussed in great detail but a member of the Committee felt that that was acceptable, while most people understood that it could be an exacerbating feature of an admission for someone who is a smoker, although they are presented with options such as nicotine patches. Are any statistics kept on problems that manifest, such as injuries, assaults, seclusion or restraint, that could be attributed in part to the immediate implementation of a smoking ban on a person who presents and has been a long-term smoker?

Dr LYONS: I start by indicating that, yes, we do have a smoke-free healthcare policy and that is right across all of NSW Health. That does ban the use of cigarettes, other smoking products and e-cigarettes in NSW Health buildings, grounds and vehicles. This was established some time back and the policy is really to reduce the number of patients, staff and visitors who are exposed to environmental tobacco smoke when they are in contact with our facilities. We recognise that there are particular challenges for certain patients and it is not just people in our mental health facilities. People in our emergency departments are often presenting in very stressful situations. It is a requirement of our staff to consider that when they are caring for patients and to think about how they can support their anxiety or stress in other ways, but that is a challenge, particularly when people are admitted for an extended period of time and in particular when they are admitted involuntarily to our services.

It is a policy that we are complying with. We recognise the challenges for some patients, particularly in our mental health facilities, in not being able to have access to cigarettes, but it is difficult for us to create exemptions and not then achieve the goals that we are seeking to achieve, which is why there is a strong focus on supporting consumers or patients in our services with strategies to quit smoking while they are in our facilities. That is the focus of the policy at the moment: looking for alternatives to cigarette smoking while they are in inpatient care and hopefully supporting them to a healthier lifestyle when they are outside our care as well. As to your specific question about statistics, there are no statistics kept around the causes or relationship of seclusion restraint or aggressive episodes linked to patients not being able to access cigarettes. I am not aware of any statistics in that regard, but I am happy to take that on notice.

Mr GREG PIPER: I would like a response if possible. It seems to me a logical conclusion that somebody is acting out because they feel the need for a cigarette. I cannot believe that it has not happened that these things have not escalated to require some kind of restraint or seclusion. Regardless, I am not here to advocate for smoking. It is excellent that mental health services are being directed more towards community-based interventions and support. Are there any targeted or ongoing programs specifically to engage with people with mental health issues to reduce their level of smoking, given that it is clear that that cohort has a higher than average level of smokers in the community? It seems to me that the most targeted intervention is when they present as an inpatient. That is for a number of reasons and you have stated that it is not just for the patient but for other people who receive that smoke passively, such as other patients and workers. That would seem to be a worthwhile program to assist people with mental health issues in the community to move away from smoking.

Dr LYONS: I do not have any specifics about programs, so I will take that on notice and provide you with some detail after the hearing.

The CHAIR: Dr Lyons, you said the issue creates all sorts of challenges for institutions to provide exemptions if you are going to achieve that policy goal. Is it a good policy goal to have?

Dr LYONS: From our point of view, it is an important policy goal. The detrimental effects of smoking have been very clear for decades and it is not just the person themselves who is at risk but also staff, visitors and other patients around them, from passive smoking. We feel it is very important from a health perspective to show leadership in that regard. In fact, we were one of the first organisations to ban smoking inside our facilities and then go completely smoke-free on grounds. That is about illustrating leadership and highlighting the detrimental effects of smoking on people. There is a whole series of programs that we offer to support people to quit smoking, from the Quitline to nicotine replacement therapy, hospitals and ongoing support for people to have a healthier lifestyle. It is important leadership and the health system needs to be able to demonstrate that, we believe.

The CHAIR: If a patient is admitted with, for example, an acute psychotic episode, is giving up smoking a goal for them at that particular time?

Dr LYONS: I think the issue here is about the fact that we are being consistent in all of our health service environments. It is not just about the individual, it is also around other patients, visitors and staff being exposed to the passive smoking effects. It is a work health and safety issue as well. It is clearly demonstrated that there are adverse health impacts by being exposed to cigarette smoke in those environments. We recognise the challenge that might create for some patients at some times but it is very important that we maintain a consistent position for all patients, otherwise exemptions will start to creep in for all sorts of patients in all sorts of settings because we have many stressed patients, families and carers: As you can imagine, acute service providers such as emergency departments, people who are acutely traumatised. That is why we have held a firm position that it is a consistent policy across all our services, notwithstanding some of the challenges that creates for our staff in supporting individuals at stressful times.

The CHAIR: What happens if a patient wanders out of the ward into an open area of the hospital, IV drip in tow, in their gown?

Mr GREG PIPER: And their oxygen attached.

The CHAIR: Perhaps. And lights up.

Dr LYONS: We have a policy that any patients who are observed—in fact, not only patients—any person who is observed smoking on our grounds, the staff are to encourage that person to move off the site completely—if they are a patient they cannot do that, but to cease that activity. That is not without its challenges, in terms of supporting our staff and patients to appropriately and respectfully carry that out, but that is our policy position. We are doing a lot across our health system to support awareness, increasingly encouraging our staff to take positive action appropriately, respectfully and at the end if those things do not occur there are security personnel on the site to support the staff in encouraging the patient to stop that activity.

The CHAIR: I have large hospitals in my electorate and I know that that the policy has caused staff lots of problems. What is the security guard going to do if the person refuses to stop smoking? Your first obligation is to the care of the patient and attending to their illness. You cannot chuck them off the site. This has been the reality of that policy; people are standing out the front of hospitals in their gowns smoking or having to go out onto the street and getting into conflict with security guards.

Dr LYONS: We endeavour to minimise conflict wherever we can. We recognise that the policy position creates some of these challenges. We are committed to maintaining that leadership role and demonstrating that it is a detriment to their health. Ongoing smoking will be causing ongoing damage to an individual's health. Our position is to encourage nicotine replacement therapy, quit smoking lines and all of the initiatives that I outlined before. It is a really important leadership role that we have committed to to maintain that position.

Mr GREG PIPER: Dr Lyons, following on from that, you have spoken about the things that are excluded or banned and e-cigarettes are included.

Dr LYONS: Yes.

Mr GREG PIPER: Is there an ongoing observation of the debate around that, or has Health drawn the line on that? My understanding is that there are still some practitioners arguing that e-cigarettes are a safer option and may attend to some of the other issues that we have here, which you do not have statistics for, which is aggression that comes with the sudden withdrawal of cigarettes. Is Health open to examining the possibility of e-cigarettes along with the use of patches, or is it a closed discussion with Health?

Dr LYONS: It is not a closed discussion, but I know the Chief Health Officer is very acutely aware of the debate occurring in the community and is keeping a close eye on the evidence around e-cigarettes and whether or not they cause harm, recognising that nicotine itself is a noxious substance which causes problems in its own right. The Chief Health Officer is keeping a close eye on this issue and ensuring we are taking appropriate action in relation to e-cigarettes for the community as a whole as well as for patients in our facilities.

Mr LEE EVANS: Is there a standard ratio for mental health beds in local area health?

Dr LYONS: The provision of services and what services are configured to provide the care is a matter which takes a lot of planning. If I talk about the factors that are contributing to decisions about how beds or other types of care are provided, the first is to look at the needs of the community and the population being served, and what models of care are being provided. What is the focus on inpatient care versus community care? There are acute care beds and subacute care beds. Some of those beds will be for acute inpatient care and then step down care might be another component. So, how those resources are distributed across community, acute and subacute are all factors to be thought about in the context of the population and the models of care.

The other factor is how services are linked. Across New South Wales we do not operate in isolation. Each service is networked and there are linkages to other services to provide either steps up in terms of care—if that service cannot be provided at that site but is required, the patient will be transferred to the care that is required. Some of our services are highly specialised, so they are not provided in every setting. Things such as child and adolescent mental health services are highly specialised so they are not provided in every acute psychiatry service. They are in certain parts of the State and there are linkages to provide access to those services as required on the basis of the assessment by the clinicians who are providing care, wherever that care is being received.

It is not a simple matter of ratios. It is about planning and there are planning parameters that people look at in terms of the types of care that might be required and that is always looked at in the context of not only our State figures but what are national benchmarks and international benchmarks. We are always looking for ways to provide contemporary care. As I talked about in relation to mental health care reform, we are increasingly focusing on prevention and early intervention and providing as much care outside acute settings as we possibly can. The investment is about putting more care in the community with the aim that hopefully we can reduce the reliance on acute inpatient beds so that over time the shift will occur.

These things are not static, they are looked at, models of care change, practices change, the requirements for the community change, so we are continually monitoring how we have our services configured, what is the appropriate distribution of resources across the different ways of providing care and making sure we are networking services appropriately so people can get access when they need that care.

Mr LEE EVANS: One of the conversations I had in Lismore regarding mental health was staff saying, "We need more beds." I said, "Well, how many more beds do you need?" They said, "How many can we get?" I said, "If you had 100, would you be able to fill them?" And they said, "Yes". In Lismore, as an example, obviously this is from the mental health nursing staff, they are saying they do not have enough beds for the people. Through the local health area they have the beds available, but are they being utilised or over-utilised and hence people are not receiving the care they require?

Dr LYONS: Certainly we want to have a focus on minimising inpatient care. In fact, when you talk to people in our community, they do not want to be in hospital—whether in a general hospital or one of our mental health facilities. We are encouraging models of care and supporting investments to ensure that we can provide appropriate care in settings outside our hospitals. That is not to say that we will not have a reliance on beds but we do have an issue around changing the focus of some of our clinicians, particularly if they have worked in a hospital setting all their lives and have not worked in a community setting, because they think the solution is more beds in the setting in which they provide care. In fact, if we look at things holistically, the investment might be better in another part of the system to provide better care.

The other thing is that many of our staff who have worked in the public health system know what we do really well but there are so many other providers supporting healthcare delivery—whether that is in mental health or other types of health care—non-government organisations, the private sector and general practitioners have a very important role to play in primary care. It is not only how we link up with those other providers to provide appropriate support for what we do but also making sure that our patients are able to access care in different settings as they move through the phases of their illness, hopefully to minimise the amount of time they are in the acute phase where they are really needing intensive care and they can be provided with early intervention and supports for maintaining their health and wellness in a community setting.

Mr LEE EVANS: Recently some constituents spoke to me about an issue they were having with their young son who needed psychiatric help. The closest youth bed they could get for him was at Shellharbour—120 kilometres from where they lived in the Sutherland shire. Now the facility at Shellharbour is excellent but having to travel 120 kilometres every day to visit their son put a huge stress on the family and the patient. Obviously they could not just drop in at every visiting hour. But once that young boy finished the intensive part of his treatment there was not any real community help in their local health area. Consequently, they had to return to Shellharbour for daily or weekly checks to make sure that everything was going smoothly. In rural areas a 120-kilometre drive is probably not over the odds but in areas like Sydney, Newcastle and Wollongong it is.

Dr LYONS: That is why we are continuing to invest in those community services. Some of those services will need further investment and resourcing to enable appropriate care and transition from acute environments to maintain people in a community setting. The other thing we need to do is to recognise that support needs to be provided to our clinicians in whatever setting they are providing care in, particularly in rural and regional areas. That may mean that we need to have specialist outreach—our specialists who might be providing services in a metropolitan setting, supporting colleagues who are providing care in rural and regional areas—and also using technology like telehealth, which is increasingly being used to provide support on an outreach basis to local clinicians with the backup of the specialists in those other settings to support people appropriately. Those are directions that we will need to continue to invest in because that is what we want to see as well—not needing to travel so much and being able to be supported where people live.

Mr RYAN PARK: As the shadow Treasurer I am always interested in money and NSW Health takes up, as it should, a large amount of taxpayers' money. What advice have you broadly provided to the Government about saving measures in the health system where you believe things can be done better? In your opening statement you talked about value. That interested me. What advice have you provided the Government about how to better provide that value? We are tracking towards health becoming a challenging part of the overall percentage of the budget, regardless of which party is in office. What measures are you looking at to enhance value and, if things are not working, to reduce those expenses?

Dr LYONS: A range of initiatives. Ms Pearce outlined leading better value care. Systems integration is another component, and the focus on quality and safety. We know that if we improve quality and safety we reduce cost by reducing adverse events to patients. If I could just go into a bit more detail about some of those other areas. We have efficiency targets that Treasury sets us, and we continue to achieve those targets. In addition, we are looking at how we can bend the cost curve going into the future, which, as you talked about, is the growth in demand and the resources required to support health care. We have already demonstrated that delivering more efficient care. Over the past five years the national weighted activity unit [NWAU], which is what health is measured on now, a national unit, New South Wales is under the national efficient price, and it has stayed consistently under that. In fact, in terms of growth of the State price, which is what we use to fund our services within New South Wales, we have been managing to reduce the growth in the State price over the past five years as well. That is because we have been delivering care more efficiently and more effectively. That is looking at things like the length of stay for certain activities and providing sufficient care to make sure that we are appropriately delivering services and meeting demands, improving and all the performance measures that Ms Pearce outlined that we are performing very well on.

However, we need to move beyond that. We need to think about our place as the public health care system in the context of the overall health system. What we have not done effectively over time, particularly with the emergence of chronic diseases, is to start to link the system. The systems integration work we are doing needless to say is not just about admissions to hospital but also what care can we link up, particularly for those people who have chronic conditions—diabetes, congestive heart failure, chronic pulmonary disease and mental health needs, which are often chronic conditions as well. How do we ensure that we link the community providers, the general practitioners, the specialists who are out working in community settings, to provide as much care as they possibly can and what evidence tells us will minimise the need for admission to hospital ultimately? How do we incentivise that care to be provided in a way that enables the care to be done in the right place so that we do not drive people into hospitals because they get resources for doing that?

We are thinking about how we can support that shift occurring, how we can make the appropriate connections and how we can incentivise through financing that shift in activity. A key part of it is communication between healthcare providers and having the appropriate information available in those care settings to enable the best care to be provided in those settings. That is why the investment in digital health is so important—having digital health and connections between providers. That is a focus on the systems integration side.

On the leading better value care side we are saying that value is about the outcomes you receive for the investment you make. What we have done historically in health is not measure outcomes very well. We look at process things—admissions to hospital emergency departments and the number of surgeries undertaken. Are they the appropriate surgeries or activities for the care of the patient? Are they delivering the outcomes we want? Is that an appropriate investment in resources? That is where as a system we have not historically looked at those things, measured them adequately and fed back to clinical teams how they are performing, benchmarking their performance against what is happening nationally and internationally. That is the aim of better value care. What does the evidence say we should be doing? What is best practice? What is going to deliver the optimal outcomes for that group of patients? Making sure that we are doing all of those things and measuring the outcomes so that we can demonstrate to our staff, to government and to the community that we are making the appropriate investment to get the optimal return for the resources that we put into healthcare delivery. That is where we are headed with better value care.

Mr RYAN PARK: What evidence was there for the construction of a private hospital at Shellharbour versus the construction of a public hospital at Shellharbour?

Dr LYONS: I was not directly involved in that assessment process so I cannot give you the detail around that, I am sorry. Maybe we can take the question on notice and provide you with some detail around the assessment process.

Mr RYAN PARK: That would be good. I am assuming the same for Maitland hospital?

Dr LYONS: The assessment process for Maitland hospital is still underway.

Mr RYAN PARK: Does that mean that there would be evidence?

Dr LYONS: Not at this point in time, because we are only partway through the process.

Mr RYAN PARK: Is the Government reviewing evidence?

Dr LYONS: Looking at what services are required, and the next phase will be going out to market for expressions of interest from the operators to look at what they can provide and how much that would cost government; that is the next phase occurring over the next few months.

Mr RYAN PARK: Would we not already have evidence of what can be provided and cost per unit?

Dr LYONS: We know what it costs us to provide those services; we have not yet asked the market what they believe they would need to provide those services. That is the next phase.

Mr RYAN PARK: What evidence was there to make the Government change its decision for Wyong, Goulburn et cetera as announced by the Minister for Health in Parliament?

Dr LYONS: My understanding of the Minister's decision around limiting it to not-for-profit providers and limiting the number of sites was based on the level of interest from the industry for those facilities that were under consideration.

Mr RYAN PARK: Did the Minister at the time, Minister Skinner, pick the wrong sites?

Dr LYONS: I cannot offer any opinion about that because I was not involved in those decisions; I was not part of the decision-making process.

Mr RYAN PARK: Have you provided any advice to government on a sugar tax? Does NSW Health have an opinion on a sugar tax?

Dr LYONS: We will have to take that on notice. I am not sure that we have provided any advice, but we will take it on notice. That would be something the Chief Health Officer would do.

Mr RYAN PARK: Recently a remarkable report from Britain came across my desk—and I do not have any opinion on this. I understand that Britain is thinking of banning smoking when children born at a certain time reach a certain age. I do not know the age group but, say, when a child born this year reaches a certain age—say, 18—smoking will be banned. Are you aware of this report? Has such a plan been considered here?

Dr LYONS: I am not aware that it has been considered. We will have to take that on notice.

Mr MARK TAYLOR: How do you support underperforming local health districts or health districts that need support?

Ms PEARCE: I am happy to address that question. NSW Health has, if I might say so, quite a different view from some of our counterparts in other States. In fact, we have a range of support functions. It is not just a matter of purchasing activity and improving the value of the services and the quality of the services that we are delivering and then monitoring that; it is what we do when there is a requirement to offer some support to a local health district, no matter the cause. We have the Clinical Excellence Commission, which has a range of different programs that are very well established in our system and have been in place for some period of time. The Agency for Clinical Innovation is another entity within NSW Health that offers a range of different support functions including redesign of services, evaluation of services that have been provided, clinical networks made up of clinicians so that you get clinical input into different models of care and so on.

At a ministry level we have a program called the Whole of Health Program, which is quite specifically designed to assist local entities when they require some support in regard to how patients are flowing through our hospitals. We have already described the size of our health service delivery system—it is a very large system full of complexities and sometimes it seems everybody has a different view. However, we know that we have fantastic practices that are occurring in various sites. Our job centrally is to make sure that those types of practices are shared across the broader health community. It is not about a one size fits all; things do need to be tailored to local environments—rural areas, more remote areas, metropolitan areas and so on. Those supports certainly exist. When things become more difficult in terms of an escalation in the performance framework, we have in the past made up teams of people with the right expertise to physically go into the health service and work with the chief executives and their executive teams to look at what is happening. Depending on what the issues are, the teams work through a diagnostic-type approach and then design some improvement strategies around that. It is something that we take very seriously.

We have not covered in great detail the issue of culture. Culture in our health services is critically important to health service and healthcare delivery. There are a range of different strategies in place. I do not suggest to the Committee that we have a perfect system or that there is not more work to do. There is always more work to do; however, we do have a number of things geared at improving the culture of our organisation. It is not just in regard to how staff deal with each other but also the care of our patients, which is fundamental going forward, in particular in relation to ensuring that we provide care in a safe way.

The CHAIR: We have touched on primary care and community care as well as integration of data collection. Could you give us a picture of what that perfect model would look like?

Dr LYONS: Nirvana.

Ms PEARCE: Without overemphasising things, given the winter that we have just lived through in 2017—obviously, New South Wales did not have a monopoly on the winter of 2017, which affected Australia generally—it brought home to us in a stark way the close relationships that we must continue to have with services outside the hospital environment. For most people an episode in hospital is a relatively small proportion of their overall health arrangements. From our perspective, we would look at what was happening pre-admission, what happened during the admission and what happened post the admission, including mental health because this does not apply just to other parts of our system. We need to get it right at every stage, which requires strong partnerships. Our integrated care strategies are designed at improving those levels of connectivity. Improving the flow of data is a really important thing, and I do not say that blithely. The reality is that we need to improve the information that we send to general practitioners once a patient has had an episode in hospital, for example. We must also ensure that the right community supports are in place, which is important to allow timely discharge.

We are working on a range of things, and the data piece and those linkages between our systems have definitely improved. We are currently seeing a reduction in the lower triage categories—for example, coming into our hospitals. This phenomenon is being experienced in other quarters, because there are similar strategies going on in other jurisdictions. We are seeing a higher proportion of more acutely unwell people, and we need to make sure that when people need to be in hospital, they know about that too. That is my bit of the picture.

Dr LYONS: I am happy to add to it. I think we would love to see a shift which we are investing in accelerated. The sorts of things that we want to see more of is patients, families and carers having information about the sorts of care they can receive and being a part of decision-making about what they want to have and where they want to have it and giving more control to individuals and their families around how they get appropriate support to meet their healthcare needs and maintain their health rather than being unwell. Particularly with chronic conditions, that means having information available. We are moving towards patient-reported measures which is a process where we actually document what a patient wants to see as the outcome of the care they are accessing, having the clinicians support what is an appropriate response to that, and what is an appropriate referral.

We need to have better integration of the services that we offer with all of the other services that exist. Ultimately we want to do that electronically so the information that is available in one setting is visible in another setting, so the patients do not need to give information more than once; where we do not need to duplicate investigations; where people can have clear understanding of what has gone on before and then what needs to happen now; and that we have got a system that is joined up to enable the minimum amount of imposition on a patient, family and carers so that they can be back at home as much as possible and have technology to support them being in that environment.

But that relies on a whole lot of things being joined up that are not currently joined up and that is having information that is available at the right place to ensure that that can be done in a way that is tailored to the needs of the individual. That is where we want to ultimately go, and where we want to work with the Commonwealth to make sure we can get that joined-up approach, and where we can get information available and where we can make investments in providing care in settings, as much as possible, outside hospitals.

The CHAIR: You say you would like the shift to be accelerated. How fast or slow is it happening at the moment?

Dr LYONS: It is happening, and we are working very hard to achieve some of those things. Some of the constraints that are occurring—there was not just the level of investment that can be made, and we are making a significant investment, particularly in digital health—but part of it is about decisions that have been made in the past around what is going on outside our services. So the GP systems, for instance, whether they can link with our systems and communicate. The investment that is being made in the My Health Record which is a Commonwealth initiative for patient information to be held by the patient, and have all of the healthcare providers put information into that record. That roll-out is occurring but it is occurring relatively slowly, but there are a whole lot of issues around that from the Commonwealth and the State perspective, but New South Wales has indicated that it wants to be the first State to implement the My Health Record for all of our communities.

We are ambitious but very cautiously advancing these initiatives to ensure that we maintain safety in the process, but we need to bring patients, staff and other providers along with us. The complexity of the healthcare system, as you would have observed, means that there are many players that all need to be involved in how those changes occur, and it is not just people in NSW Health. We are only about half of the healthcare system and the other half is provided by private practitioners, general practitioners and non-government organisations. So it is about how we can create all of those connections, increase the relationships, demonstrate that we are working together to make those changes, and that is those improvements for our patients in our communities.

The CHAIR: What impact has the National Disability Insurance Scheme [NDIS] had on this nirvana?

Dr LYONS: It is early days yet but we are very keen to ensure that the NDIS delivers the benefits that we hope it will. It is creating some challenges for us in the implementation phase because there are a number of services that have been provided by the State that other government agencies might have been funding for Health to provide. Some of that now is becoming starker in its distinction between health as a responsibility and disability care. We have got some information that we will need to work through before we get to the benefits, I believe, but we need to work through those very carefully with the Commonwealth, the other providers and other government agencies and make sure that we do get appropriate support for people and they do not then come back to Health because they are not getting the disability care that can support them to maintain a healthy life outside the healthcare system.

The big issue for us is going to be in psycho-social care, we believe, where the intersection with mental health is a big issue to work through, and that is just starting to emerge as an issue, so we need to be very conscious of how that ends up being implemented but we are at the stage now where it is starting to be implemented. We are at the second, third year of implementation in New South Wales but we are not at the full scheme yet, we are still in transition. So some of those things are yet to play out.

Mr GREG PIPER: Dr Lyons, this is a really complex area and a paradigm shift nationally. How are you keeping a focus on that? Who is doing it? Do you have an over-arching committee? It covers an area of your responsibility but how do you keep in touch with the people who are interfaced with NDIS providers or clients of the National Disability Insurance Scheme?

Dr LYONS: It is a challenge, as you say, as it is a massive change at a whole range of different levels, not just for government but for providers, clients and patients and the market is not yet mature either. It is a changing landscape and environment out there at the moment. From our point of view there is a whole-of-government, an NDIS board and a steering group which has got all of the government agencies involved working together to ensure that we work through the issues as they emerge in the transition. And then our linkages are also with the local health districts. We are staying in close contact with the districts about their experience with patients and clients, and getting feedback about things as they emerge and making sure we feed those into the policy and governance process but also address issues on the ground to support appropriate change for those individual patients and clients at the local level.

One of the big issues for our health services is whether or not they become a registered provider. In some of our metropolitan districts they have decided not to and will leave it to the market. In some of our rural and regional services they are often the only professionals in those environments and so they are going to become registered providers under the NDIS. It is variable and it needs to be contextualised to what other services are available and what is the appropriate way to provide the best access to care and support in those different communities.

Mr LEE EVANS: Recently when the Committee went to Lismore it was suggested that there might be over-servicing for some patients which adds to the cost of health in that the area. An example was given of a 93-or 94-year-old who had a pacemaker procedure for the first time—it was not a replacement pacemaker.

Mr GREG PIPER: There were a couple of examples given of people of an extreme age.

Mr LEE EVANS: Obviously it is great for that particular patient but the length of time in a hospital for a 93-year-old is extended because of that procedure. I understand that doctors want to keep their patients as healthy as they can. Is there a cut-off point at some stage where they will deal with a patient with medications rather than an intervention of that nature?

Dr LYONS: I might offer some comments. It comes back to the points we were talking about before which is around better value care. Part of the whole concept of better value is to get agreement about what is appropriate care. What does the evidence say is appropriate? That has to be contextualised to the individual patient but the important thing is to say: What does the evidence in the literature say we should be doing for this type of patient in this circumstance? We have to ensure that we are providing appropriate, effective care but are not over-servicing. Part of that is linking what we do with the outcomes for the patient as well. The other component is having the patients and families involved in the decision-making as well and this becomes a big issue as we come towards the end of life. In health care there are lots of things we can do, because we have the technology to do them. The question is whether we should always do them and in what circumstances we should not do them. That becomes a very important decision for the individual and their families. It is not just the provider; it is the individuals and their families. That is where this whole concept of having patients and families much more actively involved in decisions is really important. It is about giving full information about the benefits and downsides of the treatment options that are available and having people involved in those decisions rather than us as providers saying, "We can do it so we will", which is historically I would tend to say how we have operated more often than not.

The other issue is being very clear about in what circumstances we will or will not do things. If there is good evidence that we should not be doing things then we should stop them happening. There are examples now of certain types of procedures where the evidence says they are of no benefit. We should not fund those and we should not continue to provide them if they provide no benefit or outcome to the patient. That is where this link between what we do and the outcomes is so important. What we have been missing in the past is outcome measures. That is where we are very actively starting to invest to collect those and get agreement about where the outcome measures should be and start to collect those so we can make the connection

The CHAIR: Thank you for appearing before the Committee today. We have a number of questions that we have not got to and some have arisen on notice. The Committee may wish to send you these, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions within 14 days of receipt?

Dr LYONS: We would.

Ms PEARCE: If I could make one last comment, Dr Lyons and I certainly read very carefully the submissions that have been provided to this hearing and to the Committee. We acknowledge that there are times when it is obvious that our system has let people down. I think that it is very important that we reassure the Committee and those that are either in the room or outside the room today that those issues are dealt with with the utmost seriousness. We learn from our mistakes and we never stop trying to improve the quality of the care that we are providing in NSW Health. I think that the community should be reassured of that.

The CHAIR: If you would care to answer any of the assertions made in other submissions we would be very happy to receive that. Thank you.

(The witnesses withdrew)

(Short adjournment)

LENA LOW, Executive Director, Corporate and Surveyor Workforce, Australian Council on Healthcare Standards, affirmed and examined

LINDA O'CONNOR, Executive Director, Customer Services and Development, Australian Council on Healthcare Standards, affirmed and examined

The CHAIR: I welcome Ms Low and Ms O'Connor from Australian Council on Healthcare Standards and thank you for appearing before the Committee today to give evidence. Before we proceed do either of you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Dr LOW: No.

The CHAIR: Would either of you like to make an opening statement before the commencement of questions?

Dr LOW: Thank you for inviting the Australian Council on Healthcare Standards [ACHS] to appear before the Public Accounts Committee public hearing today. Unfortunately, our chief executive, Dr Christine Dennis, who made the original submission, is currently working overseas and has asked us to express her apologies to the Committee for not being here today. As a consequence, my colleague Ms O'Connor and I are attending the public hearing today on her behalf. Ms O'Connor and I will endeavour to answer your questions to the best of our ability. We may need to take some questions on notice and provide a written answer or additional material to the Committee later.

With regard to an overview of ACHS, we are based in Sydney and we are the largest healthcare accreditation agency in Australia, supporting both the national healthcare accreditation scheme as well as delivering and expanding our own products for both the domestic and international markets. ACHS is also the third-largest healthcare accreditation agency in the world. We were established in 1974 as an independent not-for-profit organisation and for more than 40 years we have been dedicated to improving the quality of health care in Australia and overseas through continual review of performance assessment and accreditation using a peer review model. ACHS works with healthcare professionals, consumers, governments and industry stakeholders to develop and continually review health standards. There is wide representation from Australian healthcare organisations and jurisdictions on the ACHS Council, which is representing 30 peak health organisations from where it elects 11 Board members and office holders.

The ACHS endeavours to provide health services with an evaluation of their performance against mandated standards. For most of our 40-year history such assessments have been in an environment of volunteerism. Organisations have through predominantly intrinsic motivation presented themselves for external evaluation and recognised the value of feedback to improve. ACHS accredits approximately 80 per cent of public hospitals in New South Wales. Thank you.

The CHAIR: I commend you for your submission; it is very well written and easy to read. How effective do you believe the current New South Wales health performance frameworks are in driving improvements within the sector?

Dr LOW: Are you asking about ACHS in relation to how it uses the data from our accreditation business, or in the delivery of health care in general?

The CHAIR: Health care in general.

Dr LOW: From the organisation's perspective, we are one of nine approved accreditation agencies to accredit the healthcare organisations Australia-wide. With the accreditation of the New South Wales hospitals and other types of healthcare organisations, the memberships are not by individual hospitals usually, they are in quite large local health districts, and our model is when we go in for accreditation we are looking in the broad sense of looking at reviewing their systems and processes and their policies as well. So from that perspective, when we have the peer review surveyors go in, they are surveyors in relation to a peer review model, it is that they are volunteers or honorary surveyors that have health service backgrounds when they go into these hospitals, and they have to follow the requirements of the national standards requirements—and those are quite prescriptive in certain areas—and their scope is to look at what is required within the standards.

From the ACHS's point of view, when we look at going to do the ratings, the healthcare organisations have been accredited and if there are any high-risk issues they are given an extra 90 days to address those issues and any continuing issues have to be reported back to the commission and also to the jurisdiction.

The CHAIR: Whenever inspections take place it is sort of like the Queen—she only ever sees newly painted buildings—so everybody gets their house in order for the inspection and they perhaps do not reflect what is truly happening. Could you speak to that?

Ms O'CONNOR: Accreditation is part of a quality system and is a valuable mechanism for assessing the health systems, but it cannot prevent all incidents from occurring. We do have annual on-site assessments, and that is according to a series of particular standards. We do find that there are a number of areas that require follow-up. So there is definitely value there. There are a number of organisations that have to undergo an advanced completion survey, which means that certainly there is tremendous value in conducting the assessments, identifying the not-met areas and then following up. Having said that, it is just part of a quality system and review and it does not replace the governance that occurs within an organisation.

Mr RYAN PARK: I refer to your submission, particularly on page 3 firstly and then on page 4. On page 3 you say in a paragraph that "there are excellent examples of data being used to drive improvements as above", and you talk about some of those things above, "but there are equally disturbing examples of data that is collected but not interrogated or analysed or not actioned when there are clear indications of poor performance and poor outcomes". It is about the second paragraph from the top. I am interested in that second component where you say that there are "disturbing examples" of data that is collected but not interrogated or analysed or not actioned. What examples of that are there in the New South Wales health system?

Dr LOW: Are you referring to the Clinical Indicator Program that it refers to in the second paragraph?

Mr RYAN PARK: Yes. Your submission on page 3 and it starts with "The ACHS". You talk about excellent examples of data being collected to drive improvements but "there are equally disturbing examples".

Ms O'CONNOR: I think what we could speak to there is data from the Clinical Indicator Program. The ACHS's Clinical Indicator Program was introduced in 1993 and there was one set of standards at that point in time, but now we have approximately 24 years' worth of clinical data available in the program, and that includes a total of 20 clinical indicator sets. The report is publicly available and it does show that in the majority of the sets we have an increase in quality improvement, but there are some areas where deteriorations still occur. The data is available, it is fed to the organisations, but it is up to the organisations to focus on working on those areas of deterioration.

Mr RYAN PARK: What are they in New South Wales? You use the term "disturbing examples". What are the "disturbing examples"?

Ms O'CONNOR: I would take that on notice about identifying specific areas and we could provide a report.

Mr RYAN PARK: It is just a concern because you are talking about a Clinical Indicator Program, and obviously some of those things are working well, but you then say in your submission that "there are disturbing examples where it is not interrogated or analysed". That would be a worry because what would be the purpose of collecting it?

More concerning is the fact that it is not actioned where there are clear indications of poor performance and poor outcomes. NSW Health told us this morning that it was focused on outcomes. I am concerned about what that would be in New South Wales.

Ms O'CONNOR: The statement "disturbing examples nationally and internationally of data that is collected" is not limited to the ACHS Clinical Indicator Program. I think there is always a discussion about the number of performance measures that are required either federally or within organisations or for financial targets, so that is actually a broader statement. In terms of the Clinical Indicator Program, we do see an improvement and we do submit those reports to organisations every six months. The indicators are developed by the medical colleges and the organisations are definitely actioning those indicators because we are seeing an increase in the trends of improvement across the majority of the sets.

Mr RYAN PARK: I will get some more on notice on that. Halfway down page 4 there is a paragraph that interests me because, again, this is about outcomes. It states:

> Measures also need to be embedded in the flow of patient care so that we can clearly identify unintended consequences. In other words, how does the 4-hour target—

which relates to accident and emergency—

> data look when we evaluate;
>
> - Repeat visit / return …
> - Clinical deterioration within less than 12 hours …

- Number of bed moves / ward changes per admission

My question is: Is NSW Health looking at those outcome-based things as well as the four hours? The four-hour target is one thing but clearly it can be—I will not use the word "manipulated"—distorted when you have some of those things. For example, we have all heard in our local health districts of someone presenting at an emergency department who has been told to go home after being assessed, reviewed and looked at within the four hours, but they are back again the next day. That is probably not a good outcome, as NSW Health puts it. Is NSW Health measuring, as a part of the indicators around the four hours, those things you have said there?

Ms O'CONNOR: I would like to stress ACHS's role in the performance framework. We are a not-for-profit accreditation organisation, so we are assessing the healthcare organisations to 10 National Safety and Quality Standards. We are not assessing or providing information regarding that to the Ministry of Health. To be able to provide a commentary on that to the Ministry of Health is beyond the scope of what ACHS does as an accrediting organisation.

Mr RYAN PARK: Sure. As you are accrediting some of our hospitals—and you make an accurate point here—do you know whether the NSW Health sites that you are accrediting have taken up some of the issues that you have raised? I think those issues are very good.

Dr LOW: In relation to when the survey team goes in to review processes and systems that the hospital has in place, as Ms O'Connor mentioned, the Clinical Indicator Program is a volunteer program but I think NSW Health and the CEC also have indicators that hospitals have to collect and they would report mainly to the jurisdiction when they look at the data they have to submit. For us, when we go in to look at it from the viewpoint of the 10 national standards, the 10 national standards do not prescriptively say that this has to be looked at but we do look at whether there have been any adverse events or incidents within the hospitals. To date we have not had any that have flagged this as an issue from the survey itself, but the hospitals do provide evidence that they are collecting indicators, whether they be ACHS indicators or other sets of required ones from the jurisdiction.

The CHAIR: Is the four-hour key performance indicator a good thing to have?

Ms O'CONNOR: I am not sure that we are qualified to be able to provide that information.

The CHAIR: I understand that your chief executive officer was unable to come today, and she is the author of the report. The report raises a number of questions.

Ms O'CONNOR: Obviously the research is indicating that you need to consider more than just the measure; you cannot look at it without the context of the other factors.

Dr LOW: In her submission she has also referenced international literature, so it was not looking at just the Australian context.

Mr GREG PIPER: Halfway down page 4 there is a heading of "Transparent monitoring and reporting processes both internally to Boards and externally to Government", and the submission refers to boards and the need for competency across a certain number of areas. Can you expand on the significance of the skill sets and competence of board members and boards, and on how your organisation finds the competence of boards generally?

Dr LOW: Referring to when we do the accreditation surveys, standard 1 of the 10 national standards has a focus on governance within the organisation. That focus has ensured in a way that the accreditation is not about just the frontline staff running around and preparing six months in advance for an accreditation survey, but the standards, criteria and elements now require that the boards are interviewed as well as surveyed and have to understand the standards required from them. They have consciously had to become more focused on and understanding of how the healthcare organisationoperates.

Mr GREG PIPER: In the accreditation process, does that mean that each board member would typically be interviewed or is it is a representative sample? Are they represented by the CEO or the chairman of the board, or would each of the board members, their skill set and competency in these areas, be examined?

Dr LOW: In terms of the accreditation survey, it could be either, depending on who is available at the time of the survey, but the responsibility for ensuring good board governance is from the healthcare organisation itself, because it would have to look at skill based matrix for each of the board members, qualifications and also whether they have an evaluation process in place.

The CHAIR: The submission makes the point that developing measurement tools and benchmarks is a subjective exercise. How do you recommend best balancing all relevant factors to ensure that performance standards and priorities are able to effectively monitor the service delivery and drive improvements?

Ms O'CONNOR: I think there is tremendous value in benchmarking. I will describe what we use the clinical indicators for: They are designed to indicate or flag problems that need addressing rather than promoting the definitive answers for the healthcare organisations, so they do identify the variation within the data results. They assess, compare and determine the potential to improve the care within an organisation, so they are a tool for quality improvement to assess whether the standards are being met. We find that we are having an increase in organisations collecting indicators, and they are voluntary. They receive a report every six months showing where they are trended in terms of a benchmark of everybody who collects the indicator and also a peer group. We find that they use that internally at their organisations. They do provide any activities to drive improvement as evidence for the accreditation surveys as well.

Mr RYAN PARK: How are you funded?

Dr LOW: As a not-for-profit the way we are funded is from the organisation's membership fees and we also have a grant in terms of education in the healthcare industry from New South Wales.

Mr GREG PIPER: Could I ask a question about a term used in the submission? It is a quote from somebody else—Professor Russell Mannion—in the conclusion on page six. I think I understand what the term means but could you explain it simply? In bold, the second sub dot point says:

> It was interesting to note that risk-adjusted in-hospital mortality rates for selected DRGs is not included as a KPI.

"Risk-adjusted in-hospital mortality rates" is not explained in the submission. I think I understand but I would be pleased if you could explain it simply. It is not something you can explain off the top of your head, a common term?

Ms O'CONNOR: It is a quote from Russell Mannion.

Dr LOW: Can we take it on notice?

Mr GREG PIPER: You can. My guess is that it relates to the mortality of younger people who would not be anticipated to die from a procedure or illness, as opposed to those who are over 90 and chronic smokers who we would expect are probably going to go into hospital and not come out again. I would appreciate if that could be explained.

Dr LOW: The article was based on the United Kingdom and United States.

Mr GREG PIPER: It was, but it was quoted as part of the conclusion.

The CHAIR: Thank you for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Are you happy to provide a written reply to any further questions within 14 days of receipt?

Dr LOW: Yes.

Ms O'CONNOR: Yes.

(The witnesses withdrew)

SAMANTHA GAVEL, Privacy Commissioner, NSW Information and Privacy Commission, sworn and examined

ROXANE MARCELLE-SHAW, Director, Investigation and Reporting, NSW Information and Privacy Commission, affirmed and examined

The CHAIR: I welcome Ms Gavel and Ms Marcelle-Shaw from the Office of the Privacy Commissioner. Thank you for appearing before the Committee today to give evidence. Do either of you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Ms MARCELLE-SHAW: No.

Ms GAVEL: No.

The CHAIR: Do you have an opening statement?

Ms GAVEL: Yes. I appreciate the opportunity to address the Committee today. There is no doubt that some of the greatest challenges and opportunities in the delivery of effective efficient healthcare services involve the appropriate handling and protection of health information. These are complex issues that include not just privacy but the related and distinct aspects of confidentiality and security. Privacy is an essential element of quality health service delivery. The former privacy commissioner's written submissions made recommendations according to the terms of reference of the inquiry, each of which I support as mechanisms through which appropriate privacy protections will enhance the management of healthcare delivery in New South Wales.

Public trust and confidence in the healthcare system, and particularly the confidence that their personal and health information is secure and protected, is key to achieving good clinical care and practice outcomes. Patients must be confident that any information they divulge will be used appropriately, treated as confidential and accessible when sought. Where patients do not possess this confidence, clinical outcomes may be compromised as vital information can be withheld. I acknowledge the submission made by the previous acting privacy commissioner addresses many of these questions and given my recent appointment welcome the opportunity to present my own views on key issues and hear from the Committee about its priorities.

As New South Wales Privacy Commissioner, I have responsibility for the protection of the privacy of New South Wales citizens. The relevant legislation establishing my position and statutory functions is the Privacy and Personal Information Act 1989 and the Health Records and Information Privacy Act 2002. The Health Records and Information Privacy Act aims to promote fair and responsible handling of health information. The Act contains 15 privacy principles that are legal obligations describing what organisations must do when they collect, store, use or disclose health information.

The current regulatory framework includes a number of safeguards to promote the privacy of information collected in the health setting, including the requirement for all New South Wales public sector agencies to develop a privacy management plan detailing the measures they propose to take to ensure compliance with the Privacy and Personal Information Act 1989 and the Health Records and Information Privacy Act 2002. Complaints about possible infringements of health privacy can be made to the agency directly, which is what happens most often, or to the information and privacy commissioner. The number of complaints received by the information and privacy commissioner in relation to breaches of health information privacy has increased over the past five years, but with some variation in trends. The majority of complaints received relate to individual's request to access their health record or improper use or disclosure of their health information.

As technology develops so too does the challenge of ensuring privacy is maintained. Electronic health records have brought together large quantities of personal health information about individuals. This makes the information easily accessible to healthcare practitioners but also potentially for unauthorised and unlawful purposes in the absence of appropriate safeguards. My Health Record, a centralised electronic medical record system operated by the Federal Government, is anticipated to switch to an opt-out model in 2018, as announced in the 2017 budget. Consideration will need to be given to its interaction with relevant New South Wales legislation, including health privacy principle 15 in the Health Records and Information Privacy Act 2002, which prevents health information being included in the health records linkage system without consent, unless an exemption applies. As consistently advocated by the former New South Wales Privacy Commissioner, a client-centric approach to electronic health records, where individuals have control over the use of their health information, is the best approach to dealing with individuals and their health information. The implementation of robust technical safeguards is vital to bolstering consumer confidence in the safety and security of electronic health records. It is also important that agencies engage with staff and ensure that cultural drivers such as training, clear procedures and robust governance are in place. This will assist consumers to feel secure that, once they opt in to an eHealth system, their information will be handled and protected in the way they were assured it would be.

The effective delivery of health care cannot exist without regard to the health privacy principles articulated in the Health Records and Information Privacy Act. As the use of electronic health records and datasets grows, great care should be taken to incorporate privacy by design, with a focus on data security, data minimisation and providing regular audits to ensure these qualities are maintained. This approach is premised on the view that privacy and security are embedded directly into eHealth records and if health information is aggregated for secondary uses, such as research, it is robustly de-identified. De-identification of data is one route to enable appropriate data sharing for improved outcomes and transparency. In New South Wales, the Centre for Health Record Linkage is one example of how to perform linkages of health-related data in accordance with privacy requirements and provide researchers with de-identified datasets.

A robust complaints monitoring and reporting system is essential to drive improvements in privacy management. A system that identifies trends or recurring issues will assist agencies to focus on those areas where privacy risks are apparent and to develop new strategies and policy for addressing these risks. The Information and Privacy Commission identifies trends and systemic issues in relation to privacy breaches as part of the annual report on the work of the commission. I encourage all New South Wales agencies dealing with health information to adopt privacy as a key objective in their performance framework, to deliver effective eHealth-enabled healthcare services across New South Wales. In line with the eHealth Strategy for NSW Health 2016- 2026, a trusted digital environment for storage of medical records is required to ensure security, privacy and legislative controls are built into all eHealth programs.

It is incumbent on agencies to ensure that patients and clients are fully informed in the instance that their privacy has been breached. To that end, public confidence in the delivery of health care and eHealth record systems could be strengthened by the introduction of a mandatory data breach notification scheme. Another option for improving transparency and public trust would be the inclusion of reporting on privacy complaints and/or breaches by the Bureau of Health Information. The Information and Privacy Commission intends to develop guidance for agencies about responses to data breaches in 2018. Another specific priority for 2018 is to deliver guidance to the public, general practitioners and healthcare providers on access to medical records to help improve understanding and compliance in what can be a complex area. More broadly, there may be benefits in reviewing the Health Records and Information Privacy Act to ensure it continues to provide the protection the community expects in a rapidly changing environment. I understand that such a review may occur in future and I look forward to contributing to it.

The CHAIR: How would you characterise the current health system in how well it responds to privacy concerns?

Ms GAVEL: I have only been the Privacy Commissioner since early September. I am aware that there was a significant data breach earlier in the year. Interestingly, it was actually a low-level breach. It was not what we probably expect these days—more of a high-tech breach—from an eHealth record because it was records found in a bin. None the less, I am not aware that there are significant problems with the management of records in relation to NSW Health, apart from that high-profile breach.

The CHAIR: Appreciating that you are new to the job, would you say that the system has effective safeguards to protect the privacy of customers?

Ms GAVEL: From what I have seen so far, I would say that it has but it is always important to keep looking at what you have got, particularly as we get more and more technology, in coming years more and more people will take up the eHealth record. It is always important to keep focusing on these issues, looking at what we are doing and making sure that we are aware of what is going on in the broader environment to make sure that our systems remain safe and that we continue to put new processes in place to keep them safe, where needed.

Mr MARK TAYLOR: I want to share with you a scenario that has been put to the Committee during this inquiry—namely, an elderly parent of a 40-year-old son or daughter, who has a mental health issue, having difficulty accessing information about their child's treatment or a pathway for them because of privacy concerns. Is that an issue you receive complaints about? Could a legislative amendment be sought or do you see some other avenue for working through those issues?

Ms GAVEL: I might make a general comment and then I will ask Ms Marcelle-Shaw whether she can add anything further. As I mentioned in my opening statement, we are looking at doing some work in the coming year on access to medical records so that the public and carers can have better information and a better understanding of what information they can access. Also, of course, the health providers have a better understanding of their obligations in terms of providing access to the public. Do you wish to add anything further?

Ms MARCELLE-SHAW: Looking back over the data for the past few years, it is not a significant trend in the matters that come to the Privacy Commissioner. However, it is a scenario that we are familiar with as to the issues that may arise. There are mechanisms under the Health Records and Information Privacy Act and under the Privacy and Personal Information Act for authorised access to the health records of another person, typically for a guardianship or some of those arrangements but also for health service providers to go to nearest or next of kin to consult on access to health records. It is certainly an issue that I think the Privacy Commissioner and her team would be interested to hear more about. It is certainly an issue that we can look at in terms of the guidance that the Information and Privacy Commission makes available, in addition to the guidance that health service providers particularly through their health manual can address.

Mr GREG PIPER: Does the office of the Privacy Commissioner fall under the Department of Premier and Cabinet?

Ms GAVEL: No, we are in the Justice cluster. We are under the Attorney General.

Mr GREG PIPER: There has been a change—to some extent that change has been gradual but it is now rapidly changing—to dealing more and more with electronic issues, a digital privacy paradigm if you like, rather than the old paper trail—for example, those 1,600 records that were found in the bin. Does that have implications for the resourcing of your office? Does the office of the Privacy Commissioner have the capacity to deal with the challenges ahead? In this inquiry we are only talking about health but it is much broader than that. Do you think that the changes that are coming about—eHealth, My Health Record and things like that—are going to increase the load on your organisation?

Ms GAVEL: That is an interesting point. If you look at privacy 10 or 15 years ago, you could say it was a fairly quiet space; you could not say that today. Privacy is increasingly at the front and centre of the work the New South Wales Government and other governments, both here and overseas, are doing. Yes, we have a lot of important work to do. The rapidly developing technology is going to increase some of that work and probably help us with some of the work as well. We are very aware of the resourcing issue, and we will be going into business planning later this week to make sure that we can fit the projects that we need into the business plan to cover the whole of the Information and Privacy Commission. The commission delayed business planning until I came on board, so that I was able to have input into that, which I am very grateful for. We will be making sure that with the resources we have we can manage all of those projects in the way that is required. The other thing to say is that if, down the track, I felt that more resourcing was needed then I would certainly talk to the appropriate people about that. So far, we are managing the workload very well. Privacy has just come back into the Information and Privacy Commission; it has been reintegrated into the office. We have more staff to work across all of the areas, and I will be keeping an eye on that.

Mr GREG PIPER: Commissioner, you have access to IT experts in particular fields—for example, in dealing with health issues. Who advises you about not just the principles around the My Health Record but the technical aspects that could be at risk of failure or infiltration for illegal purposes? Do you have internal or external advisers?

Ms GAVEL: We do not necessarily have to understand all the technical details of the solutions that are being put in place, but we do need to be aware of the need for those solutions so that we can advise agencies in the work that we are doing with them. Just through the work I have been doing since I came into the office—and that is only in a couple of months—I have become aware of all sorts of technical solutions, such as de-identification and other areas that can help to protect the privacy of individuals.

Ms MARCELLE-SHAW: I can confirm what the Commissioner has said and add that the Information and Privacy Commission will never be able to have all of the expertise in-house for all of the demands of our work that require specialist knowledge. We are very adept at building particular relationships to bring in expertise as and when required, whether through ongoing liaison with counterparts across the States and Territories and Commonwealth to leverage their knowledge and expertise or through establishing appropriate steering committees or advisory committees to bring experts to the table to assist in developing the thinking within the IPC to apply to particular projects. In recent times, we have engaged with people like Data61 within the CSIRO to understand the technical and technological implications of some of the digital transformation that we are experiencing within New South Wales. We keep a finger on the pulse through many avenues and then bring in expertise as and when our particular areas of work demand it.

Mr GREG PIPER: You indicated that you have the capacity to deal with your workload within your portion of the Attorney General's budget. Do you have any concerns about the resourcing of your office as the load might increase?

Ms GAVEL: The office has its own budget, which is over $5 million. As all of us in government know, we need to work within the funding that is given to us because it comes from the taxpayers of New South Wales. We have an obligation to make sure that we work in the most efficient and effective way with the funds that we are given. Obviously, if issues come up or work programs come up that mean that we need additional funding then there are processes for asking for additional funds. At the moment I do not see any issues, but I have only been in the office for a couple of months. I feel at the moment that everything is workable, but should there be an issue further down the track or a new project or a need that I identify, I would work through that to make sure that I have the funding needed.

Mr RYAN PARK: In point 23 of your submission you say that you would encourage NSW Health to adopt privacy as a key objective in the performance framework, particularly around the delivery of eHealth. Have you had any feedback on this suggestion? Do you know what NSW Health is doing in relation to this issue?

Ms GAVEL: At this stage it is a bit difficult for me to comment on that, because I have not really been in the role long enough. I will be working with Health on some of these issues, but I have not had the chance to interact with them.

Mr RYAN PARK: I am happy for you to take that on notice.

Ms GAVEL: That would be good.

Mr RYAN PARK: In your submission you talk about the concerns that Aboriginal people have about the level of privacy or lack thereof. You know that privacy concerns are greater for Aboriginal people, as well as for young people. Do you know what Health is doing in relation to the concerns of Aboriginal people?

Ms GAVEL: Again, that is a question that I should take on notice. I should clarify that this submission was put together by the former Privacy Commissioner who, having worked in the area for a number of years, had a lot more detail.

Mr RYAN PARK: I am happy for you to take those two questions on notice.

The CHAIR: You give examples of making data collection opt-in. Do you think this will result in a significant downturn in the volume of data collected, or will there be any other negative ramifications?

Ms GAVEL: I think the former Privacy Commissioner mentioned that in relation to the eHealth record, not in relation to data generally. Her view strongly was that the eHealth record having an opt-in system is more privacy respectful. I think that was initially the system that the Commonwealth put in place, but for various reasons they have decided to make it opt-out going forward. My office will be having discussions with the Commonwealth and other States and Territories in more detail on how that would work and particularly how it would sit with the New South Wales legislation. Of course, in the Health Records and Information Privacy Act 2002 [HRIP Act] there needs to be consent for that information. We will need to work through those issues.

The CHAIR: Who actually owns the information? If patient records are held by a local area health network, are they owned by the patient or by the network?

Ms GAVEL: If I am answering that question from this side, I will be going from my previous understanding of the health system. The eHealth record was initially known as the Personally Controlled Electronic Health Record, so the idea was that it would belong to the consumer. I am not sure to what extent that is still the case. We would all be aware that the eHealth record at the Commonwealth level has been around for many years, and there have been challenges in getting it in place. Some of the ways it was envisaged have had to change to meet the practicalities of getting it to work.

Ms MARCELLE-SHAW: I would only add that if you put notions of ownership to one side, our HRIP and Privacy and Personal Information Protection [PPIP] Acts recognise that the patient or the consumer has rights of access and rights to correct and to amend those records and that information and to have records and health information made available to the practitioners of their choice. The emphasis of the statutory regime is to ensure that patients, consumers and citizens have control over the information held by health service providers.

Mr LEE EVANS: If privacy protection were included as a performance marker in the New South Wales health framework, how would this be benchmarked and measured?

Ms GAVEL: That is an interesting question. When I had a look at the submission, it was one of the questions that I had: How will this actually work in practice? When I had a look at the Health Performance Framework there is quite a lot of detail and not all of it necessarily relates to privacy. Again, I think I should take that on notice. I emphasise again that this submission was done by the former Privacy Commissioner. I do not have any insight into her thinking and why she put certain things into the submission.

The CHAIR: Thank you for appearing before us today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions within 14 days of receipt?

Ms GAVEL: Yes, certainly.

(The witnesses withdrew)

(Luncheon adjournment)

MARK JASON TONGA, Chair, Disability Council of NSW, sworn and examined

EILEEN BALDRY, Deputy Chair, Disability Council of NSW, affirmed and examined

The CHAIR: I welcome Mr Tonga and Ms Baldry from the Disability Council of NSW. Thank you for appearing before the Committee today to give evidence. Do either of you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Mr TONGA: No.

Professor BALDRY: No.

The CHAIR: Do you want to make an opening statement before the commencement of questions?

Mr TONGA: Yes, I would like to invite my colleague and Deputy Vice Chancellor Professor Eileen Baldry, University of New South Wales, to make an opening statement on behalf of the Disability Council of NSW.

Professor BALDRY: The Committee has our submission and I want to draw your attention to some aspects in that submission. A key factor that we wish to raise to the attention of the Committee is the importance of building the capacity of healthcare practitioners and services to increase skills and services. We will talk a little bit more about that or we can be questioned about it so that people with disability receive the same standard of care as other people in New South Wales. I will draw a couple of things to your attention. The Disability Council has a remit to advise the Minister, but the Minister has also given us his approval and support in this period of time when we are moving through to the NDIS and that all services are being transitioned to NDIS support. We are also meeting with the Ministers from all the other major areas, not just disability.

We feel that mainstreaming is going to be a really major aspect of our work in the future because only 10 per cent of people who have disability will get an NDIS package, and all of the rest will need to go to mainstream services. People with disability who do have an NDIS package will still need to go to mainstream services. So there is a large amount of work to be done that we feel we are representing in our submission, in particular, of course in regard to health. We commend our submission to the Committee and would like to discuss with you how the New South Wales Government supports this process.

The CHAIR: How effective are the current NSW Health frameworks in responding to the specific needs of people with a disability?

Mr TONGA: As you can see in our report it just highlights the inequalities that Australians living with a disability are treated, and we would like to see progress in supporting Australians living with a disability. We are looking for legislative changes to address this matter and we are here before you to bring that to your attention.

Professor BALDRY: Part of the remit again of the council is to ensure that we hear and listen to the community of people with disability. What we hear from people with disability is that at the moment the mainstream health services on the whole are very poorly equipped to address the differing needs of people with disability. And it is also very important that health professionals, particularly in emergency circumstances, emergency rooms and at admission, are aware of who they may be facing so that there is not an assumption made that a person does not know what they are talking about or that they do not ask the person what their needs are, and do not listen, and do not get the right kind of support.

For example, not only the obvious things like Auslan interpreting or any other form of interpreting but also we draw your attention to the fact that the majority of people with disability in Australia have a cognitive disability, so intellectual disability, borderline intellectual disability and various forms of autism. These groups of people find it extremely difficult to make their way through mainstream health services. We draw that to your attention as an example of how mainstream health needs to be built in its capacity to address the needs.

Mr TONGA: Yes, we see a system failure there and we encourage Health and the Government to support those frontline services with training and funding to identify people coming through the system and that they be given the right support to address whatever because everyone in Australia is entitled to that right. We are looking for legislative changes for that.

The CHAIR: Your recommendation 11 calls for urgent updates to NSW Health data practices and recommendation 12 urges that data collection feed into reporting frameworks for monitoring. Will you expand on that?

Professor BALDRY: I can talk from personal experience of my own research and a quite deep knowledge of Professor Trollor's work. I presume you might be meeting with Professor Trollor and my other colleagues at other universities, for example, at the University of New South Wales, Sydney University and so on. One of the things that we find is that there is very poor data recording for people with disability integrated with Health so there may be reasonable data recorded by current disability services but that is not connected to the health system.

We also find that people may come to a health service and their disability is recorded or there is a recognition that they have a disability. They then go to another health service and that information is not shared. This makes it extraordinarily difficult for people with disability to be able to be treated equally because of a number of things. Having to tell their story a number of times is very difficult. It is also very difficult for some people with communication difficulty to get across to the people they are seeing what the issues are, what their needs are and what their experience has been. Really good data is very important from that point of view and that data should be available and shared, with all of the caveats around confidentiality.

There is another very important reason to ensure there is good data and that is so that we know what is happening. At the moment, for example, Professor Trollor has gathered a very large linked data set and that was the only way in which we were able to see that there was such a substantially higher mortality rate for people with cognitive impairment, for example, and such a higher use of health systems in ways that were inefficient and ineffective.

In my own work I look at people with disability who end up in the criminal justice system. Today in New South Wales there are 13,000 or 13,500 people in prison and half of them have a mental health disorder, cognitive disability, hearing impairment or some other form of disability. It was not until I did a similar thing and did some linked data that we were able to see the extent of that and what that meant for cost. The costs of not seeing the whole picture are extraordinary—from a mortality point of view, from the point of view of over servicing or under servicing, from the point of view of many people being managed by the wrong groups such as by police rather than by health services or by disability services. It is not until we have clear data and good data which shows us in an aggregate sense what is going on for people with disability that we can then address it and we can also see the level of expenditure which could be avoided and the level of distress which could be avoided. I think good data that is protected but that can be linked between services is extremely important.

Mr TONGA: I might just highlight too that it is the invisible disabilities that we have in our community that are not easily identifiable by a wheelchair or whatnot. They are the Australians walking through our community. Having data like this could identify that cohort of people in our community and give them the right remedial help.

The CHAIR: Could you give us an example of a particular service that is not sharing information and how it could be shared or where that data could be deposited?

Professor BALDRY: I could give you many examples. Let me give an example of the Community Justice Program [CJP]. I do not know if you have heard of it but it is for people with intellectual disability who are caught in the criminal justice system and are returning time and again but who really should have disability services. The difficulty that the CJP has in connecting the people in the CJP—and this is not a lot of people, it is about 400—with their health data so that there can be a seamless and efficient way of supporting that group has been extremely difficult. Why? Because at the moment all of our data sits separately. You may have heard of the Centre for Health Record Linkage, or CHeReL, which is a health linking data system which is based at the University of Technology Sydney. All data linkage now goes through the CHeReL if you want to do research which involves Health. That is a huge step in the right direction but what really needs to happen in New South Wales—and I know that some work is being done on this at the highest levels—is we need to have data that can speak to each other. At the moment we do not.

Every agency collects its own style of data for its own purposes. Police, for example, have their own Computerised Operational Policing System, or COPS. Corrections has its own Offender Integrated Management System, or OIMS. The Department of Family and Community Services is now integrating its data but it had four different data sets which did not speak to each other. For people with complex support needs such as the people we are talking about there needs to be sufficient and good information for health services to know who they are seeing and the kinds of services that those people require. It could be by linking it through Medicare but it does not happen at the moment. It is not properly linked. It needs to be live linked. Western Australia has had this for a very long time but we can do it. It is a big job, but particularly for people with disability and particularly now that we are getting rid of our disability service organisations who used to try to manage this there is a very important encumbrance on us to ensure that it happens properly.

The CHAIR: Would that require legislative change?

Professor BALDRY: It may well do. It does not require legislative change, for example, with the CHeReL. The CHeReL can link if the data custodian allows that to happen and generally that is given approval if there is a bona fide reason. The CHeReL, for example, can link and merge data and that does not require further legislative change but it may well do if what we want to see is live linked data. I think that is probably the direction that we need to go. It certainly will require important confidentiality and privacy frameworks but we know how to do that. It is not difficult. I know that the council would support that as long as there were enough protections.

Mr RYAN PARK: When reading your submission I was interested in the part where you said that the Disability Council took the opportunity to remind the New South Wales Government of its rights under the Convention on the Rights of Persons with Disabilities. One of the provisions I was not aware fully aware of and perhaps I should have been was:

> Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner.

Can you talk a bit more about the discrimination that people with a disability experience, particularly with health insurance?

Mr TONGA: I think it is, like for RMS and all organisations, an update of information. Everyone has been put into one group, and, of course, there are people like myself and others with a disability who want to access mainstream services, and there is no frontline training and information to be flexible to allow us to access health. I will give you a story. I went to apply for my CTP and I had to tell them I do not drive and I had to tell them that I get my own staff to drive for me. Now that did not fit into their thinking; it is just not in their data. So that increased my levy up to $200 and I just thought that it was a bit unfair because they ask these questions that determine the level of CTP that you have got to pay. Things like that are not within the conversation in the community and the organisations like Health and all the services that people like myself want to access.

Professor BALDRY: If I could add something here? The framework in which we can understand what Mark has just discussed with you is the position that the council comes from, and that is a critical disability approach. This is the social theory of disability, and I imagine that you have already had people talking to you about this but just to reiterate: this recognises that someone might have an impairment of some sort or a number of impairments, but it is the way in which society treats them—it is the cultural, physical, financial frameworks which disable people. Mark has a range of disabilities but he is disabled to the extent that we do not assist and accommodate and provide the right kind of supports.

What we are talking about here, and the reason that we wanted to remind the Committee that it is very important that the Committee relooks at the Convention on the Rights of Persons with Disabilities, is that that is the position that that convention takes. That convention requires States that have signed up to the convention to basically provide affirmative action. Rather than penalise someone for having an impairment or a disability, we provide the right kind of support and lift them to the same level, so to speak, in terms of insurance, in terms of really anything. And that is the whole purpose of the convention: to ensure that people with disability are treated with respect and not only equally but with equity because equity requires some affirmative action.

Mr LEE EVANS: In relation to mortality data on page 13 of your submission, as chair of the Ombudsman committee for Parliament, I suggest you might write the committee a letter on this because, as I say, it is a biennial report and I cannot see any reason we would cease doing it other than, obviously, the people reporting being told not to. I would like to have a conversation about that with the Ombudsman and see if we can sort that through if we could.

Professor BALDRY: Okay. So we will write a specific letter about the issues around reporting death.

Mr LEE EVANS: Yes, the mortality data under part 3C of the NSW Ombudsman Act 1974, because I think the point you have made in that part is that if you stop taking that data it vanishes out of sight and it is important that we keep that data even if it is just going to be in New South Wales.

Professor BALDRY: Exactly right. An extra point on that, and, again, this is from Professor Trollor's work, he also found that when he gathered that data and tried to link it he was finding a lot of anomalies in that, in not only the way it was reported but in the attribution in the data. So it is a really important aspect and, as you say, we will write.

Mr LEE EVANS: Also it will highlight patterns of care, patterns of what is happening in the future. So it is most important.

Professor BALDRY: I am very happy to do that.

Mr GREG PIPER: Mr Tonga and Professor Baldry, thank you for being here to advise us in our process. I just looked at your website and a thing that stands out at the very top for the Disability Council of NSW is that you are the official adviser to the New South Wales Government, obviously through Minister Williams. However, we have quite a large number of other groups who were established to advocate in typically a very specific space and they are currently quite concerned about the implementation of the National Disability Insurance Scheme [NDIS] and what that might mean for their future. I am not quite sure whether or not the Minister and the Government take the view that your council covers all of those areas and they are concerned that there is no funding stream for them for the implementation. I was just wondering whether or not you have given any advice in that space, whether it is to the Minister or to any other people, or have given any thought to the issues of all of those other groups that may well dissolve under the implementation of the NDIS.

Mr TONGA: The Disability Council has got four subcommittees; they are working on employment, inclusion, NDIS transition and housing. So we do have a subgroup looking to the NDIS transition. It is concerning to the council. Recently we had the advocacy issues—they wanted to take away advocacy. It is important to give people a voice out there and independent support. As you said, there are concerns with the plans, and taking that away is removing the choice of control that the NDIS is here for and we would like to encourage any support from this Committee to support the advocacy. Yes, we are working closely, we are drilling into the system. Our Minister has been aware of the situation and he has been updated constantly, not only by us but by other advisory committees. I support the NDIS—it is a great institution and it is a great piece of work, but it takes time and we are working on it.

Professor BALDRY: Perhaps I can add some other things that the council has been thinking about in this area. The council actually cannot advocate—we are not an advocacy body. We are in contact with many of the NGOs and many individuals; people write to us and ask us to advocate on things, but we cannot do that. All we can do is pass that on to the Minister, and Mark meets with the Minister regularly. With the demise of the advocacy organisations, because the NDIS does not fund advocacy, as I am sure you know, the New South Wales Government has in the past, and we are very worried about that.

Mr GREG PIPER: That was what I was getting to. There is a vacuum there and there is a need for advocacy rather than the service you provide to the Minister, which is an advisory service; it is not for you to go in to be a champion on a specific issue, it is more an objective advisory group.

Professor BALDRY: That is correct.

Mr TONGA: We are the eyes and ears of the Minister and we pick up through our networks at the grassroots what is happening there. We have our finger on the pulse, and we ensure that our Minister is up to date and brought clear into that. We try to recommend some solutions and we are looking forward to working with our Minister to address that.

Professor BALDRY: One of the things we might share with you is that this has exercised the council considerably over particularly the last year. The council had a roundtable with key NGO groups last year and the loss of advocacy capacity was almost at the top of their list, so that has been a concern. I guess the only way that the council can push this forward is via our Minister and we have been speaking with him about that but, as I said, our Minister has been very pleased for us to meet with other ministers. We also want to send this through to Premier and Cabinet, for example, because we know that this is an issue that will affect government capacity. It is a concern to us.

Mr TONGA: At the moment it is a complicated NDIS, so having that advocacy support is important to get the message across, and get it right and get it done once—for once and for all—and not chew up the public money. We have raised it with our Premier that the advocacy is much needed, so support from this Committee would be appreciated.

Mr GREG PIPER: I have a question in relation to a paragraph on page 9 of your submission. I am hoping you might expand on it. I have no problem with it except for the way in which it is termed. It states:

> In the health sector, institutionalised ableism can lead to both overdiagnosis and underdiagnosis of people with disability, particularly of people with intellectual disability.

Can you explain that a little more or give a scenario of where that is the case?

Professor BALDRY: Yes. I can start, and I am sure Mr Tonga will add to this. The clearest example of the issue here is people with cognitive disability. A scenario: Someone who has intellectual disability, who has difficulty communicating exactly what the issue is for them, who becomes very defensive or highly anxious when pushed or when they feel threatened, and who may not have a support person with them or their support person might be a family member who does not feel strong enough to really advocate for them, turns up to emergency and may have something that looks like a stomach bug, and they have difficulty in explaining just what it is that they have. Emergency in hospital is so pressed—I am not blaming staff because they have to get through huge numbers rapidly—and it has an ableist attitude, which is one that says, "I expect you to be able to communicate to me what your problems are. Come on: Explain that properly to me, or explain more clearly what that is," and the person is unable to explain it properly. So the doctor says, "Look, you've probably got a 24-hour bug. Take something. Here's a script. Off you go." The reality is that that person actually has something serious. It may be an ulcer, it might be—

Mr GREG PIPER: With the scenario you have given, it could be a bowel obstruction, an immediate life-threatening situation, and someone with a moderate to severe intellectual disability—

Professor BALDRY: Is not able to communicate.

Mr GREG PIPER: All they can do is the most basic expression of some pain.

Professor BALDRY: Yes. That is exactly right. We see in these circumstances that that person goes home, the next day they are worse and they come back to hospital—they may even have to come back three times. Eventually it is a critical, life-threatening situation. So the assumption that everybody is going to be able to communicate exactly what is wrong with them is this notion of ableism. It is not because doctors and nurses are nasty or anything like that—

Mr GREG PIPER: Typically they are not, no.

Professor BALDRY: —it is that they have not been trained in how to work with someone with moderate to severe intellectual disability.

Mr GREG PIPER: I do not want to advocate for institutionalised care as such, but the extension to that question is that some of the concerns that have been raised, particularly regarding people with intellectual disabilities, are that with the loss of large residential centres there is the loss of an in-house medical officer. That officer is often a person who has been in a care scenario looking after these people for a long time and who can therefore second-guess or understand if somebody has a genuine complaint that is not psychosomatic or something like that. Is this something that the council has given consideration to: how medical services can be provided in a meaningful way without—

Professor BALDRY: Without going back to an institution, for example.

Mr GREG PIPER: —or without failures due to ableism. I am not advocating institutions; I am asking how we can make sure that this ableism, as you have referred to it, does not become a major factor as we move to transition people who fit the scenario you gave.

Professor BALDRY: There have been really good proposals put by people like Professor Trollor that the council has supported and recommended to our Minister around a framework in which the health service can and should work. This requires further training, the data and attention by the service providers. Let us say that people have been brought out of an institutional setting and are in perhaps an individual but supportive group area and they have a support person. The agency or the organisation that supports that person ensures that their general practitioner knows what the issues are with that person so that there is a clear and direct understanding of what is going on so that the person does not just turn up without support. There are some very good frameworks which have been recommended—I have forgotten the name of those: Connections or something—and we can certainly send them to you if you do not have them.

Mr GREG PIPER: Can you take that on board and could it be provided?

Professor BALDRY: I will make sure.

The CHAIR: The Committee thanks you for appearing today. The Committee may wish to send you additional questions in writing the replies to which will form part of your evidence and be made public. Are you happy to provide a written reply to any further questions within 14 days of receipt?

Professor BALDRY: Yes.

Mr TONGA: Yes.

(The witnesses withdrew)

CHARLOTTE HESPE, Chair, Royal Australian College of General Practitioners, NSW and ACT, sworn and examined

BRADLEY FRANKUM, President, Australian Medical Association NSW, affirmed and examined

RAFFI QASABIAN, Chair, NSW Regional Committee, Royal Australasian College of Surgeons, affirmed and examined

The CHAIR: I welcome Associate Professor Dr Hespe, Professor Bradley and Dr Qasabian from the Royal Australian College of General Practitioners, Australian Medical Association NSW and Royal Australasian College of Surgeons. Thank you for appearing before the Committee today to give evidence. Do either of you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?Would any or all of you like to make an opening statement?

Dr QASABIAN: No.

Associate Professor HESPE: No.

Professor FRANKUM: No.

The CHAIR: This question is directed to all of you: How capable is the existing New South Wales health system of being able to drive broader improvements specifically to the overall health of the community?

Associate Professor HESPE: I am happy to launch in. As a general practitioner [GP] one of the biggest frustrations for us in the current system is the siloed care and data. We, as GPs, feel constantly frustrated about the inability to appropriately share data through the systems. For instance, we are now able to get what are still called "discharge summaries" from a hospital concerning a patient's care. Can I say they should be renamed "clinical handover of care"? The patient is never discharged from care completely, it is about that continuum of care. Until we think about it as a continuum of care, whether it be in the community or the hospital, I do not think we will improve how we deliver that care.

As a GP I am unable to send my data into that system. There has been a little bit of progress about maybe being able to send data in for making appointments, in terms of referrals, but sending meaningful data to ensure patient safety and for a better understanding of patient care, that is a ridiculous no-go. There are different systems in different local health districts. There have been major improvements in being able to share across the boundaries but there are still boundaries in place, which are artificial from a patient's perspective. Just being able to get a proper understanding of what is happening across the whole system is virtually impossible at this point in time.

The CHAIR: In an ideal world there would be one database and all service providers in the healthcare space dealing with a patient could delve into that?

Associate Professor HESPE: Yes. It is as frustrating for the specialists too. For instance, my practice is in Glebe. I am close to Royal Prince Alfred Hospital, Balmain Hospital, Sydney Hospital, St Vincent's Hospital, and depending upon where the patients might live they might be at Royal North Shore. If they get taken by an ambulance to a hospital that is not the one where they have been looked after there seems to be a complete block about accessing the data or the records to ensure continuity of care. There is a huge amount of money wasted in redoing investigations completely inappropriately because, "I am the person in charge now and I do not trust that what they did over there was right. So, I am not going to access it, I am going to redo it." There might be value in redoing something sometimes, but we have to work as a team and start to trust that we are working towards the same goal. Then we can save a huge amount of money, increase efficiency and patient satisfaction. Sometimes doctors do not think about how awful it is for a patient to undergo an investigation two or three times because the doctor does not think that they can trust it having been done somewhere else properly.

Mr GREG PIPER: Associate Professor Hespe, you are saying there is a two-tiered problem: One is systemic about data sharing and the other is cultural within the profession?

Associate Professor HESPE: Yes. If we are on the same page with data in the first place you will start to build up the culture of trust. Some of it is coming with the My Health Record. As someone who is proactively looking at it I see that it is going to be a much better thing for the patient because they will have somewhere where they do have some of the data they can share. At the moment it is a mixed botch load of what goes up, what does not, what is actually really accessible versus a PDF document that you cannot do much with so it does not improve the safety of the care as well as helping the doctors who are now looking after them.

Professor FRANKUM: I agree with all of that. There is a large amount of data being collected but the use of that data and integration is problematic. The local health districts and the primary health networks are talking about integrated care and meeting to discuss that but it is in its infancy. It is proving very difficult to do integrated care in a meaningful way. Public hospitals function 24 hours a day, and a lot of the work gets done in the evenings and on weekends. General practice, not entirely, is largely during the week or daytime hours. We have not overcome that barrier of seeing people in hospitals after hours and trying to find out more information about them. Often it is at a time when they are unable to communicate that to us themselves and we cannot contact their primary doctors to get more information.

The fragmentation of care is dangerous, frustrating, expensive and it puts the safety of patients at risk. The information management systems we are using in hospitals are very slow to improve and modernise. At my hospital we still write handwritten notes in a patient's file and we still write handwritten prescriptions. In my private practice it is all computerised. I can prescribe much more safely in my private practice because the computer keeps a record of what I have prescribed, the doses and all of that. The most junior people in the system, the interns and residents who are writing prescriptions in hospitals, do not have the advantage of those safety systems. Again, that makes it so much more dangerous for patients. If you add to that the levels of activity in the public hospital system, particularly in the emergency departments, you can see the scope for mistakes and the risks to the safety of patients are amplified by those levels of activity and busyness on the part of the staff.

Dr QASABIAN: I would also like to say that I agree with everything that has been said from the surgical point of view. I am the Deputy Chair of the Collaborating Hospitals' Audit of Surgical Mortality, better known as CHASM. Certainly some of the deaths that are discussed in that committee are due to patients turning up to a hospital following surgery with a complication, but timely treatment is not being implemented because of the fragmented nature of the way things are at the moment—not being able to get access to previous records or the surgeon who did the surgery in a private hospital, for example, may not be available for contact. From that point of view I absolutely agree.

From the point of view of broader improvements in the care of the community from a surgical point of view, we are very fortunate to be part of CHASM. The Royal Australasian College of Surgeons works closely with the Clinical Excellence Commission and Carrie Marr. We have now been able to join forces and share the data that the State Government gathers on hospital mortality with the Royal Australasian College of Surgeons. It is now being put into a central database that the fellows of the college can also access. Something that the Health Education and Training Institute [HETI] is looking at now is trying to standardise morbidity and mortality meetings. The standard of morbidity and mortality meetings is very variable amongst different hospitals in New South Wales. We are trying to look at some ways of standardising those so that we get more meaningful results from those.

One of the main issues, which seems to be a recurring theme certainly in my chairmanship of the State committee, is a feeling of disenfranchisement by the country surgeons and, consequently, the patients. There is difficulty in drawing surgeons to the country for very complicated reasons—workforce issues, attracting spouses to the country, et cetera—but there are also issues regarding a feeling in the rural setting of appropriate follow-up with general practitioners. For example, I think general practitioners can no longer claim Medicare benefits schedule [MBS] No. 105 to follow up patients. This really disadvantages patients. They have to travel long distances to see their surgeons again, whereas before they could be followed up by the general practitioners. Certainly there are issues in the country that keep recurring, which I think we can improve on.

Associate Professor HESPE: Just as an aside, they have actually changed the follow-up. General practitioners can claim for it now.

Dr QASABIAN: They can?

Associate Professor HESPE: Yes.

Dr QASABIAN: Thank you.

Associate Professor HESPE: One of the big things from a general practice perspective is about the whole integrated care project that has been happening from a broad Ministry of Health perspective in New South Wales. It should be congratulated. Some of the projects that have been piloted and funded are really successful. But my issue is that they still continue to be just that—pilots. There seems to have been no bigger plan about rolling them out widely. For instance, there has been an amazingly successful body of work done in Western Sydney with the general practitioners there. They have done a lot of work looking at how they can share data across the system between the general practitioner records and the hospitals to really achieve integrated care, yet every time I broach "Why are we not rolling that out into other local health districts?" I am met with silence. It seems to me to be completely ridiculous. Why can we not do this small rollout? If it is successful, then let us move it into other areas, rather than keeping it in one locus of success.

The CHAIR: Do you have any idea why that is so?

Associate Professor HESPE: It always seems to be told to you that it is about the budget. I cannot say anything more than that. From a primary health networks [PHNs] perspective we do not get money to be able to do anything in terms of integrated care. We are highly dependent on having money from NSW Health to actually work with them to do that. It is a very frustrating space to be sitting in, seeing some successful projects around you but not being able to do anything.

Mr RYAN PARK: As the shadow Treasurer one of things that interests me is the demand for health services outstripping population growth and the ever-increasing health expenditure. Professor Frankum, in your submission you talk about patient demand outstripping population in chronic diseases—cardiovascular, obesity, diabetes, cancer, and mental illness—as well as an ageing population. I note you say that we need more evidence to support this but surely there must now be a body of evidence that says these conditions are costing us exponentially in terms of the growth in overall health services. Are we doing enough to try to manage them in a value way? I do not mean that disrespectfully. Are we intervening early enough and saving us from a heavy cliff at the end? Is that what you are referring to in your submission or is it something else? I find trying to manage some of these chronic issues, which the evidence indicates are only going to get worse, fascinating. If we do not do that, how do we continue to manage an ever-increasing budget?

Professor FRANKUM: The evidence is that the demand for emergency department care is increasing above the rate of population growth, but also that the triage categories of the patients presenting are higher. If it were just a matter of people not being able to get in to see their general practitioner on the weekend or after hours, you would expect to see the lower triage categories. People are presenting sicker to the hospital more often and most of those people are presenting with exacerbations of chronic disease. Not all, some of it is injury and acute things but a lot of it is chronic disease people who deteriorate. We do not really know the reasons for that but I guess my theory is that the failure of primary care in some ways—this is not a criticism—to deal with those people at an earlier stage is resulting in more hospital care needed. That might be access to primary care or it might be continuity in finding a general practitioner that you can see regularly. It might also be a consequence of a lack of funding for preventative and early intervention care generally through the system. We know that the health dollars we spend on prevention are very low but they are a very good investment because they actually do prevent problems down the track.

Part of the difficulty with preventative care is structural as well. If you think about it, the Commonwealth has an important role in preventative care, as does the State. Who is going to pay for what? New South Wales has a very good program looking at preventing or reducing obesity in children, and I applaud that. I think it will pay dividends in the long term, but we do not have it for adults. With 65 per cent of the population being overweight or obese, the Commonwealth does not have any sort of meaningful obesity plan either. I agree with you that we need to look at shifting some of our funding towards prevention, health education, health literacy and better support in primary care to do all of that. That will take some of the burden off our public hospitals.

Our public hospitals are expected to be everything to everybody. Even in the middle of the flu epidemic, when our emergency departments were inundated with patients, we were still expected to keep up our elective surgical numbers. If you were designing a system, if you had an LHD, surely you would have a hospital that deals with elective surgery and then have some acute facilities to deal with the much less predictable workload that is coming through the doorway. Then you would have certainty for your elective surgical patients and you do not interrupt the acute care of patients. That is not the system we have, although we could have it.

Another issue alluded to by Professor Hespe is that we have 15 LHDs. There was a good reason to set those up, and in many ways they do good work. But it is to the detriment of a State plan for a lot of services that not every LHD can provide. A lot of the coordination or referral patterns within our State system are historical rather than logical. If you are working in a general practice in Guyra or Gunnedah or wherever, it is very much about who you know and you have referred patients to in the past as to whether you get the care for your patient that they need. I think we could do much better at having State plans for rare illnesses and sparsely populated areas of the State, where the referral and transfer pathways would be much clearer and help everybody. I think we have work to do in all of those areas. We do some things very well, but we spend an awful lot of money on treating patients for illnesses that probably could have been prevented.

Associate Professor HESPE: I would love to talk to this. As a GP this is my absolute passion because it is where we can really make a big difference. International evidence is definitely emerging about the role of early intervention in the lower tiers of, first, the well and then those you have recognised as having risk factors you can work with. The Health Care Home model that is being rolled out as a trial as a national perspective unfortunately is only targeting the top two tiers, the population that is already chronically unwell. As far as I am concerned, the patient-centred medical home model with the idea that the Health Care Home tried to say it was doing is about the benefits you get from the bottom two tiers, where you have engaged patients and you can increase health literacy and build a relationship in order to follow through with better care.

I would be very happy to talk more about how that might work, because there is evidence about continuity of care being aligned with better health outcomes. A colleague has been looking at whether it is continuity of care with one GP or continuity of care with a practice versus not being aligned to anybody. It looks like continuity of care, which means being aligned to a practice, is just as good as being aligned to one GP. Of course, having one person you identify with is the best in terms of having better health care.

We have an amazing opportunity in New South Wales, and in Australia, because GPs by and large are well regarded by the public. But our current systems of care are not really valuing that. We pay for volume, not value. Until we do an about face and start to value value and give some incentives, we are going to struggle with getting any further with what we are doing. The other thing is the introduction of innovative models of care. Again, our current system of payment is a fee for service—and I have no problem with that per se—but some of the innovative models of care can change the way that patient flows work, for instance when going into hospitals. Some of these models are done over an app, with the first tiering determining whether I can manage a situation by a text message or email and, if red flags come up, they are contacted to come into the practice. We are not used to this model and are not really comfortable with it, but overseas they are using this innovative type of care and it is really good. It means you get access to care at the right moment. A lot of the time the worried well are taking up unnecessary places both in general practice and in accident and emergency, and this model means you can siphon them away after a conversation.

Mr RYAN PARK: I have worked in government departments and I know that in the Illawarra Shoalhaven Local Health District some innovative things are happening and you mentioned some good programs in Western Sydney. If a model is proven to be working well, why is it not rolled out to different areas? I know there are differences in population groups, but there are similarities. How quickly does Health roll out a proven effective model? Health talks a lot about value, and that is fine. In my area Anthony Okely works on childhood obesity, but I often read in the Australian Institute of Health and Welfare reports about obesity hotspots, and they are usually in the same areas. These reports do not change much over time, so I question whether there is an active forum for local health districts to find out about good programs and research and how to implement any good models of care.

Professor FRANKUM: There is a forum for the LHD executives and board each year to get together. There are innovation forums held by NSW Health, where people share these ideas. That does happen, but there is no compulsion for the LHDs to institute whatever that good idea was—it is discretionary

Mr RYAN PARK: Why not?

Professor FRANKUM: Part of the old problem used to be that the control was so centralised that nobody ever used any innovation or initiative in their local area because they were too frightened to do anything that could mean they would get stomped on by central office. Then we went to the LHD system that we have now and it was much more a case of having a chief executive and a board and a budget and the buck stopping there. That is well and good except when we do not share ideas and we do not have services that we can use for the population in our LHD. We have to start sharing. There have been some bad examples of LHDs almost competing with each other, rather than working with each other. We need to get to a situation that is a bit of a hybrid, where good ideas get compulsorily rolled out across the State but LHDs still have the chance to use their own initiative and innovation. The secretary of the ministry would probably agree with that assessment, although I should not speak for her.

Mr RYAN PARK: I have to tell you it is frustrating. We are spending an enormous amount of money and it frustrates me enormously that we reinvent the wheel over and over again. I have often asked public servants would it not be easier to pick up a phone and ask a person what they are doing in "x" and get that information and use it. I am not saying you cannot tailor it but obesity in Western Sydney has been a problem since Adam was a boy and there are certain things that grate people. When I go out and about they say, "We are doing this Ryan. It has saved admissions here there and everywhere", yet when I talk about it to my LHD no-one knows about it, and they are in the system.

Associate Professor HESPE: Obesity is probably not the best one to look at. I say that because I think obesity is one of those where it needs to be across the whole thing about social services and education et cetera because we know increasingly that the root cause factor behind obesity is more than just eating and exercising. Until we address the all-cause analysis of where obesity is coming from, even to what happens with the obese mother who is pregnant and that actually pre-programs the baby to be obese, and what your gut biome looks like is a conversation, and is not a good one to talk about.

As a general practitioner, particularly in the space where I work because I see lots of great ideas being rolled out in different LHDs and it is very much up to your own space as to what they adopt. I am chair of Central and Eastern Sydney Primary Health Network which means that I have the joy, or otherwise, of working with both Sydney Local Health District, South-East Sydney Local Health District, St Vincent's Network and the Children's Network and I am the only PHN that has that particular joy. The others have been aligned more as a one-on-one.

That brings challenges and opportunities because you get to see as a PHN exactly what one is doing versus another one but the big frustration about seeing is there is this competition—I do not know what it is—but a reluctance that one is seen as doing something really successfully and I just cannot get the other one to even engage with the thought that that might be a good idea. Until we get that culture change, it is a really frustrating thing. Then you have St Vincent's that does everything differently, and that is fine in one sort of space, but it is very difficult for all of the GPs and the specialists who are working in there. We have got all of these different cultures and systems, referral things.

We do this thing called Health Pathways which from my perspective is the best thing. NSW Health has been fantastic. It has supported that rollout but it has taken me 2½ years to get what is now the best Health Pathways site in Australia from Sydney Local Health District to even start in the other two. You have great evidence that it is fantastic and well adopted and everybody was yelling out for it and I still could not get it moving.

Dr QASABIAN: Certainly I think there is an opportunity for LHDs to share information and the Surgical Services Task Force, under the Agency for Clinical Innovations [ACI], was established to optimise access to elective surgery for patients. They are supportive of an initiative called NSQIP—I do not know if you have heard of it—developed by the American College of Surgeons and it enhances the ability of the hospital to zero in on preventable complications. I think that is now in four different LHDs, or it might be in four hospitals in three LHDs. That is certainly an opportunity where real data is not just being collected but analysed and there is an opportunity to then share that with the other LHDs but there has to be willingness, of course, to share that.

Mr GREG PIPER: We need to invite this panel back for another hour. I believe you heard the evidence of the Disability Council of NSW when I asked about the implications of the roll-out of the NDIS and the policy position of devolving from large residential settings and therefore many people with developmental disability, in particular, now accessing their local GP services. Do we need to do more in that space to make sure that GPs are ready for that and are capable? You heard some of those concerns that apply not just for GPs but obviously the specialists, surgical specialists et cetera. What are your thoughts about the implications?

Associate Professor HESPE: It is like any major change: there is going to be a very rocky road as you implement it. I cannot but think the NDIS is a great concept and I congratulate the roll-out of it. In terms of the actual roll-out it has been inordinately difficult. It is very, very hard for both those who have got disability as well as the GPs who have felt very under resourced in how to support and go forward. From my perspective, and I am not talking about a person with an intellectual disability so it is someone who is much more empowered, someone who is highly health literate, knew what it was what she wanted, was able to speak up for herself, to actually get the package that she wanted. Now she cannot access the package because there are no services out there for her to actually be able to purchase them. So she runs the risk of losing all her funds, because she will not have used them in the time frame which you are supposed to, which then means, of course, that apparently you did not need them in the first place, even though you could not actually access them because the services were not there.

For my patient who has got an intellectual disability it has been a very, very difficult time not only being able to give them a voice as to what are the appropriate services that they might need but also to then go back next week about how do we make sure that the services that they need are actually there for them, and they are the services that they want, given that those are not out there yet. It is really tricky. A lot of the GPs are not as empowered as me of being an advocate. I am quite happy to go out there and be an advocate but a lot of people do not feel like they can get out from behind their desk and do the sort of level of advocacy that is actually required. The PHN has been trying.

When we first were rolling it out they took away transport and interpreter services as something that was just provided to them as a matter of course, and it came out of their budget and is not an absolute right to have the interpreter there. If you have an intellectual disability and you do not speak English as your language, it has just been really, really difficult.

Professor FRANKUM: If you are a disabled person you would hope and expect that a public hospital would be a safe haven for you to receive care, but the evidence is that they are just not. The levels of discrimination against disabled people, people with disabilities, in public hospitals is very high from healthcare workers as well as the support staff. Now I will not pretend to know the reasons for that but I think part of it is that hospitals are so pressured in terms of throughput and as soon as you have a patient with a complex disability it slows you down.

Mr GREG PIPER: Ten times the resources, maybe.

Professor FRANKUM: Yes, and it broadens to the elderly and to non-English speaking people or the people with complex social problems as well. So those people are not as safe in public hospitals as they need to be largely because emergency departments are busy chaotic places. Mental health is probably the other really big area where we just actually do not have enough acute mental health beds in the system, and the beds we have are poorly distributed. What we find is that people with disabilities regularly end up having incidents occurring in hospital that we have to investigate and the same things come up time and time again: nobody listens to their carers who know them the best, people do not take the time to sit down and try to figure out their problems, or sadly perhaps, sometimes people are treated as if they are not quite deserving of the same level of care as others. I think we have got a lot of work to do in hospitals to make them better places for the most vulnerable in our community.

The CHAIR: We have run out of time. The Committee may wish to send you some additional questions in writing, the replies to which would form part of your evidence and be made public. Would you be happy to answers those within 14 days of receipt?

Professor FRANKUM: Yes, we are happy to help.

The CHAIR: Thank you once again for appearing today. It has been very enlightening.

(The witnesses withdrew)

(Short adjournment)

BRETT HOLMES, General Secretary, NSW Nurses and Midwives' Association, affirmed and examined

MARC HOPKINS, Senior Professional Officer, NSW Nurses and Midwives' Association, affirmed and examined

The CHAIR: Thanks for coming along today and appearing before the Committee to give evidence. Before we proceed do you have any questions concerning the procedural information sent to you in relation to witnesses and the hearing process?

Mr HOLMES: No, I do not.

The CHAIR: Would either or both of you like to make an opening statement?

Mr HOLMES: I would like to take that opportunity. With the permission of the Committee, I would also like to table a report which is very fresh since we had the opportunity to put in our submission. It is a survey of our mental health members undertaken in October, so it is fresh off the press. I will subsequently refer to another survey undertaken by the Australian College of Mental Health Nurses, which I have some copies of. We will submit that at the end.

The NSW Nurses and Midwives' Association, as we said in our submission, represents more than 62,000 nurses and midwives in the State. We cover all areas where nurses and midwives and assistants in nursing work. The association welcomed the opportunity to make a submission, particularly on the issue of mental health and the use of seclusion and restraint as it became one of the reasons for the extension of the Committee's terms of reference. The Nurses and Midwives' Association holds the view that the use of seclusion and restraint can be reduced in New South Wales but only with the right support and resources in place. Seclusion must remain an option and necessary last resort to ensure optimum safety in New South Wales mental health facilities.

Systemic issues within mental health services have been created by inadequate funding of public mental health services over many years. The Nurses and Midwives' Association conducted a survey of mental health members in September and October this year. This survey, which I have presented to you, highlights the effects of long-term unrealistic budget constraints and a non-specialised and inexperienced mental health workforce with a poor retention of senior mental health qualified nurses. This has resulted in critical levels of safety for clients and staff, with less than ideal and costly outcomes for clients of mental health services.

The survey went out to approximately 2,500 members who have identified themselves as mental health nurses and members of the association with 340 completing the survey, a response rate of 13.6 per cent of the mental health membership of the association. The survey results correlate with a similar survey undertaken by the Australian College of Mental Health Nurses in conjunction with Flinders University of behalf of the National Mental Health Commission with the aim of understanding cultural and other barriers in the ongoing reduction in seclusion and restraint in mental health settings in Australia. It was released on Friday, so I am not sure that the college has had an opportunity to make a submission; however, as I am referring to it I would like to make it available to the Committee. I have five copies.

Some of the main themes that our report identified were that safer nursing staff numbers with appropriate staff rostering and skill mix were essential and there is a lack of mental health intensive care beds across the State. They are sometimes called MHICU and other times they are called PHICU, standing for psychiatric intensive care. More recently they have been termed "mental health care beds". There is a lack of those beds, with the high dependency unit or observation beds having to fill the role of mental health intensive care unit beds with less funding than the mental health intensive care beds but often with the same patient acuity. That issue arose and has been a major problem for some time, which is quite concerning.

There is a need for more mental health qualified staff and more access to mental health education for nursing staff new to the mental health workforce, especially at the clinical level. There is an inappropriate employment of assistants in nursing in the acute mental health sector and poor retention of senior staff to mentor nursing staff new to the mental health workforce. There is a need for a better career structure for mental health nursing with employment of staff to management positions who clearly display the necessary mental health nursing skills and knowledge required in their role. There are excessively high levels of time required for documentation, which directly impacts on time with patients. This is a workloads issue. If that documentation is to be adhered to then it requires more nursing staff. There is a lack of consultation with nursing staff on many levels. Decisions are often made at the top.

In our original submission an example is that we proposed that there should be a new observation standard. Lo and behold, the Ministry of Health has produced a new statewide policy direction numbered

2017-025. It requires very high levels of observation and recording of those observations. Later on in the report we will point out the fact that whilst we wanted that, there was a complete lack of consultation about it. We believe that if that policy is to be instituted then there must be more nurses to undertake it, otherwise every mental health nurse who is required to undertake that policy is setting themselves up for failure simply because the additional time that is required to undertake it in accordance with policy is not available in nursing hours per patient day. "Be careful what you ask for" is another common refrain. We have asked for a statewide observation standard but what has been arrived at has severe consequences on the staff that are supposed to be able to undertake that in accordance with the directive.

Our latest report is provided to inform this inquiry into the management of healthcare delivery in New South Wales on some of the issues faced by the mental health nursing workforce in New South Wales. Just referring to that issue of the number of mental health intensive care beds—I am not sure this has been pointed out to the Committee before—officially, there are only 62 mental health intensive care beds in this State that are funded as intensive care beds. The State is extremely short-supplied in relation to those beds. There is always extremely high demand, and waiting times can vary up to weeks at a time, if a bed ever becomes available for those patients. We were informed in 2015 by Mr Peter Carter, Acting Director, Mental Health and Drug and Alcohol Office, that mental health intensive care beds catered for the most disturbed mental health patients who are unable to be cared for safely with local health districts' acute care options.

Mental health intensive care units are tertiary-level units funded at the highest level of funding of any mental health service in New South Wales to allow a level of staff to safely stabilise a person's condition. High dependency units [HDU] and observation beds are not tertiary-level services, nor are they funded by the Ministry of Health at the same rate as mental health intensive care unit services. They are, in fact, funded at the same rate as acute care beds. So where observation units or high dependency units are created in those facilities that do not have access to mental health intensive care, they are funded at six nursing hours per patient day, and that is the same that any adult acute in-patient mental health unit attached to a public hospital is funded at. If they are in one of our former large psychiatric hospitals, then they are only funded at 5.5 nursing hours per patient day, which is, frankly, inadequate for the types of patients that are there.

In order to look after those patients, more nurses are allocated to the high dependency unit and that means fewer nurses are available in the acute care parts of that particular unit. So if there is a separation of high dependency from the acute care, the acute care misses out as a result of the high dependency patients. That is unsatisfactory. There are 270 high dependency units or observation beds across New South Wales mental health services. They are underfunded and under-resourced to cope with highly aggressive patients requiring a higher use of seclusion to manage high-risk clients that are required to be the de facto mental health intensive care units. Arising from that, we would recommend that there needs to be an immediate increase in the funding for more mental health intensive care beds and units across the State to reduce the exposure of clients and staff to the risks associated with managing very high-risk clients within under-resourced mental health units, especially units isolated by distance from any supporting mental health intensive care unit. There also needs to be a consistent referral process to streamline access to those mental health intensive care unit beds.

The next issue that the survey addresses is recruitment and retention of nurses in mental health. I refer the Committee to page 10 of the survey report and request the Committee read the comments from nurses who are brutally frank and honest with their views. I quote one very telling comment: There is only so long that people can put up with endless abuse, violence, physical assaults, working understaffed, being made to work overtime, being bullied by management, working with wards over census—it is not an attractive place to work. Over census means that they admit more patients into the ward than they have beds for them, and then at night, if they are able, they sleep them out in some other wards or beds or find other arrangements to try and fit them into wards, which just adds to danger and risk.

Our second recommendation is that the Government stop refusing to negotiate about nurse-to-patient ratios and skill mix in all of our mental health units. If Government truly wants to commit to a better mental health service, it must commit to enforceable staffing requirements that will ensure skilled and qualified nurses are retained in our mental health services, both inpatient and community. If nurses are fearful for their own and patient safety as a result of not enough skilled staff, then there is little prospect of them being able to reduce or eliminate restraint for seclusion in our system.

Our third recommendation is that the practice of using assistants in nursing to provide one-to-one observation and care—we call it specialling—for acutely unwell mental health patients be ceased. Ninety-two per cent of our survey respondents believe this is an unsafe and dangerous practice, and it is unsafe for patients and staff, but it is the cheap option that seems to be taken.

Our fourth recommendation is that if patients require one-to-one care or observation that should not be at the expense of the other patients' access to care. Additional nursing hours must be provided for one-to-one care. Currently, it is often the case that that one-to-one nurse is taken out of the standard nursing hours, and the other patients miss out as a result of that. In the survey, 68.93 per cent identified a lack of nursing staff numbers frequently for the acuity of patients to reduce seclusion and restraint. Only 18.05 per cent often, and 4.14 per cent always, have appropriate nursing staff member numbers for acuity of patients to reduce seclusion and restraint. That leaves 68.93 per cent of the respondents in the position of high exposure to a foreseeable risk. Eighty-one per cent of the respondents say that they have unfilled nursing positions at their place of work. Only 5.9 per cent of respondents indicated they are staffed to full capacity.

I believe that the very frank observations from our members, which are included in the report, are a valuable insight into what is faced at the ward level, the bedside level, in our mental health units at the moment. We truly wish to see a better outcome for mental health patients, but we also fear that the profession of mental health nursing is at a critical point where it becomes more and more difficult to stay in the profession. Those of us who were one of the last to be trained in a psychiatric nursing certificate are now at the point of leaving—leaving as early as possible—accessing their superannuation, because of the level of risk and the level of inability to recognise the skills and advice of people with many decades of experience. I, of course, have not practised at the bedside for more than 27 years, but I know that my members are doing it a lot more difficult—it is tougher for them now than it ever was when I trained in 1984 to 1987.

The CHAIR: Mr Hopkins?

Mr HOPKINS: No, thank you.

The CHAIR: How many MHICU beds should New South Wales have?

Mr HOLMES: We believe that the high dependency units and observation units are actually acting largely as mental health intensive care units. Whether it would go to that full 270, we believe that that should be an examination of what sort of patients are being admitted to those units and the level of care that they are requiring. The latest observation requirements—level one is one-to-one care, so that the person is within arm's length; level two is 15-minutely observations. Level one is line of sight, but close enough to be able to respond immediately. The level two 15-minutely observations, which they say should not be used very often, take 15 minutes by the time that you observe the person, record it and go back to observe them again. It becomes almost one-to-one as well. There is simply not enough staffing in our units and it is not recognised as requiring one-to-one, but that is a consequence of the new policy which in theory we would support but we fear, as I said, that we are setting people up to fail.

The CHAIR: Is there a world's best practice or benchmark that would calculate the number of mental health intensive care unit beds that New South Wales would need?

Mr HOPKINS: That is a good question, but Australia is pretty different to a lot of the other countries because of the tyranny of distance. The other problem that a lot of these HDU and obs beds find is, because of the rural location of them, they have to manage the client before they can transfer them. It could be who knows how long to get them settled enough to be able to transfer them. Then there are a lot of problems—it is actually in the survey—with transport, negotiating transport and communicating with the other service to get the person transferred. Sometimes it can take a number of weeks to get a transfer happening.

I do not know whether a worldwide standard would be able to be used in New South Wales or any of the bigger States of Australia. In my mind it is more about having those beds in locations that are easily accessible, even in the rural areas, so that you do not have that problem of trying to settle them before you transfer them, because once you get them settled, they do not need the transfer. This is what is happening with a lot of the obs and HDU beds: They are unfunded but they are still managing these clients who are really unwell. They cannot get a bed—they cannot transfer them—because they are so unwell, so they end up having to manage them until they are well, so they are doing de facto the PICU or MHICU bed work.

The CHAIR: You mentioned earlier that at question 26 of the survey 75 per cent named excessive documentation as issues that affect their workload. Can you tell me about the documentation that is required and the means for collecting that data?

Mr HOPKINS: It is getting the funding through the documentation. You have probably heard others talk about this as well and the fact that they have to complete the documentation before they can get the funding. There is a big emphasis on having the documentation done but with MH-OAT when people come in they have to be assessed and then followed through. It can take a few hours just to document an assessment. When people see somebody in the community they have to go back and document what has happened so that they have that documentation evidence to then make sure that they get the funding. The amount of documentation—even with the new policy that has come through—that has been required by the nursing staff is taking away the hours that they should be having with patients. Some of them said that in the survey. I think there are some quotes in there that they are only getting three hours of patient time because they are doing all these other things in the meantime. They have to meet all these other requirements along the way.

The CHAIR: Is it your experience, or do you hear from the members that some of the documentation is unnecessary?

Mr HOPKINS: Perhaps some of the members think it is unnecessary. One of the other things that came through quite strongly was the amount of abuse that staff were having, and the documentation of that verbal abuse does not get a look-in anymore. Staff are under chronic verbal abuse all the time—again, you will be able to read this in the survey responses—and they say they do not even have time to do the IIMS anymore and would not even think about it because there is just no time to do it. That is one of the documentation things. It becomes a catch 22 because if they are not doing the IIMS—

Mr RYAN PARK: They are not reporting it.

Mr HOPKINS: Exactly. And then management says—

Mr RYAN PARK: It's not a problem.

Mr HOLMES: It is not happening.

Mr HOPKINS: —it is not happening, and they are saying, "But we don't have time to do it." It becomes a chronic circle. I would not say that some of that documentation is unnecessary—I can see the reason for it—but I think that there needs to be less workload on the staff by having more staff to be able to share that workload. Does that make sense?

Mr RYAN PARK: I have been interested in the ratios issue for some time. This morning NSW Health said that ratios are problematic because they are too rigid. Tell me if I have that wrong; if I have misread that I will take it back but I am pretty sure that is what was said.

Mr HOLMES: I would say you were accurate.

Mr RYAN PARK: NSW Health witnesses said it is too rigid. What do they mean by that, and what is wrong with that view, Mr Holmes?

Mr HOLMES: I think what they mean by that is that they cannot shortcut—

Mr RYAN PARK: They prefer to do it by hours—sorry?

Mr HOLMES: The award provides a nursing hours model which can be converted into ratios for easier understanding. When I talked about six nursing hours per patient day in an adult mental health inpatient unit, they manage that six hours per day by the average numbers of patients in beds at midnight, which is an inaccurate reflection of what has happened during the day, and then they multiply that over seven days—

Mr RYAN PARK: To get the number.

Mr HOLMES: —to get the number for the week. What then happens, of course, is that out of that they take the specialling hours. Notionally, if you are a mental health patient, you should be able to expect somewhere around six hours of nursing care out of your 24 as devoted to you. But when there is a patient in the ward that requires a special for which there are no additional hours given, you lose those hours. One of the most important things about mental health nursing is interaction between the patient or client and their nursing and other health staff. That is one of the most important things and that is why when people are acutely unwell they are allocated one-to-one. Why is there a fear of ratios? Because when people start counting they start finding out that they have been short-changed and that they are short-changed on a shift-by-shift basis. We have recently uncovered across John Hunter Hospital, for instance, 7,000 nursing hours in a seven-month period not used and not allocated. We have suspicions that that is rife across the system.

We know that because of the shortage of mental health nurses that registered nurses are often replaced by assistants in nursing and there has been a practice of replacing people who were initially allocated eight-hour shifts or an eight-hour span with a six-hour casual, so they cut short as well. The ratios model, if it was implemented in its purest form, would require that the numbers be done and people would say, "You haven't got enough staff here to look after this number of patients at any point in time." We had to come to a conclusion in our agreement that the only thing in New South Wales we could obtain at the time from the former Labor Government, and subsequently the current Government, was an agreement to nursing hours per patient day, but ratios are expressed in the award as a result of that, so people should understand it.

Mr RYAN PARK: We have a situation that industrial relations articulated about the Illawarra health district, of which you are aware, concerning maternity services in Wollongong. They have articulated to me, the nurses and midwives there, that it is not a matter of dollars, it is that vacancies have not been filled. I raised that today with NSW Health and NSW Health says it is because of a lack of available staff. It is not a remote or rural area where I could understand it would be a population issue; this is the State's third largest city, and a large hospital. I am concerned that this large hospital is saying it is having problems in recruitment and problems over the flu season. This does not appear to be a one-off during flu season issue, it appears to be a problem of shortages of nurses and midwives in the midwifery unit. NSW Health says it is because of availability of getting nurses and midwives. Is that accurate? If you cannot get them at a large regional hospital where it is not a bad place to live, what happens at smaller hospitals or smaller population centres?

Mr HOLMES: In relation to midwives I believe there is current pressure on the number of midwives. There are unique circumstances at Wollongong where they previously had a supply from Wollongong university, however, it stopped its midwifery education programs so Wollongong was left without a continual top-up from those newly graduating midwives. That has had a flow-on effect. One of the other problems in the health service is that there is an extraordinarily long period of time between a vacancy being identified and recruitment being undertaken and actually bringing people on board. It can be up to three months where you are waiting to fill that vacancy and in the meantime they use casuals, overtime, not fill it, or use assistants in nursing, a lower classification without education at the level required. That is what we are seeing.

For years we have talked about the need to streamline the recruitment process. You need to make an effort, if you want to run a health system, to staff it, otherwise you need to be honest with people and say you cannot manage the system or offer a service. There is no doubt that there is little tolerance in our community for errors, mistakes and omissions that lead to bad outcomes, particularly in midwifery services. No-one expects a bad outcome in our midwifery services. We see a surprisingly good situation. Those ones that turn bad—there are too many of them, frankly—are really horrific and people are devastated, including the staff, but nothing like the patients and families.

Back to mental health. We think there is a crisis looming. How do you encourage someone to take up mental health nursing if their experience is to walk into an acute mental health unit that is understaffed. You have one or more psychotic patients bouncing around the walls, threatening people, being highly dangerous, and everyone is saying, "Our KPIs say we cannot use seclusion here and going near them for restraint requires six people and we only have five, so we have to wait for security to come from the other side of the hospital to help us." That sort of experience is not impressive for a person who has not experienced mental health nursing nor has a mental health background.

The education program has to fit every speciality in and mental health nursing is only one of those specialities. There is inadequate training within the basic course to fit in easily into the mental health unit. My own experience is that I had 18 months to undertake a mental health certificate in those days and even at the end I was just a beginning practitioner. This is a volatile workplace to walk into and your first impression can be a fairly stinging one if you get into a situation where you are seeing a person who is affected by methamphetamine and is not controllable by normal means. That is a pretty scary thing. That is happening more and more and is happening in rural areas. People in emergency departments are experiencing that.

The whole issue then becomes quite difficult to manage if you do not have the option of seclusion. The only other option is that these people run away and the coroner has a deep dislike of nurses not containing people, even when their own personal safety is at risk. Nurses are caught in a difficult situation in mental health services. We believe that you have to make substantial efforts to encourage people to undertake mental health nursing but you have to do that and say to them, "We will provide enough staff so that it feels and is safe to work."

The CHAIR: There will be, no doubt, some questions that the Committee members would like to send you in writing, the replies to which will form part of your evidence. Are you happy to receive those questions and reply within 14 days?

Mr HOLMES: I indicate that my colleague's manager has allowed him to take annual leave in a week's time.

Mr HOPKINS: I can honestly say I need it.

Mr HOLMES: I would seek your indulgence on the 14-day timetable.

The CHAIR: We are happy to extend that, there is no formal application required.

(The witnesses withdrew)

JAIME COMBER, Policy Officer, BEING, affirmed and examined

The CHAIR: I welcome Ms Comber before the Committee. Are there any questions that you may have concerning the procedural information sent to you in relation to witnesses and the hearing processes?

Ms COMBER: No.

The CHAIR: Would you like to make an opening statement?

Ms COMBER: Yes. The information we gathered that informed our submission came from our consultations and also a survey that we ran of people with a lived experience mental health issue. We are the peak body representing people with a lived experience mental health issue. In the data that we collected there were three key things that came through. The first was that people really wanted a lot more transparency about data and they wanted the reporting that they got to be understandable and easily available. At the moment people are having difficulty finding this online when they are looking into services and also they are not provided with it when they are entering services. The second point was some concerns that we found about the accurate collection of data—whether things such as seclusion and restraint are being accurately recorded. The third point was that people really wanted to see a clearer connection between the data that was being collected and then action that was being taken from it—for example, the Your Experience of Service [YES] survey. People thought it was great to have that data and to have that data available but they then wanted to know what was happening with it. Because they were giving that data, they could become quite disenchanted if they did not see that next step in the process.

The CHAIR: Could you give the Committee a real-life example but names are to be kept confidential?

Ms COMBER: Do you mean of the final?

The CHAIR: Yes.

Ms COMBER: For example, someone we spoke to at a mental health unit had an interaction with a staff member that did not go particularly well and they reported it. They talked to the official visitors about it, they talked to someone on the unit about it and they talked to us about it. Then there was basically no follow-up done and they felt that they had, I guess, gone out of their way and felt quite vulnerable giving that information. It was hard for them to see what came out of that.

The CHAIR: How would you characterise the degree of access consumers have to performance information for mental health services in New South Wales?

Ms COMBER: From what people have told us, poor.

The CHAIR: What can we do better?

Ms COMBER: In Victoria it is mandated in the Mental Health Act that the chief psychiatrist will report on mental health data. I think having something like that where every year a concise, easily understandable report is provided that people can then go and access would be really helpful. I think people would really appreciate having that kind of overview of the services. Something that happens now with YES, is that there is a board in a lot of mental health units now that shows the most recent reporting of the YES data. We think that is really great. I think people really appreciate seeing that kind of information about other things too, like the clinician-to-consumer ratio and that kind of information.

Mr MARK TAYLOR: Do you have any commentary on the privacy legislation? Has that impeded some of the things you do or how is it working in the system?

Ms COMBER: I do not have any comments on the particular privacy legislation. We did hear from people that they were concerned about privacy.

Mr MARK TAYLOR: What types of concern were they expressing?

Ms COMBER: People are concerned that when they share information, if it is not private, it will affect their future treatment, and it will affect the way that people treat them going into services in the future. This is something that we wrestle with a little bit as an organisation as well because if we go into a unit and we speak to, say, three people and then we report on that, they are obviously very easily identifiable from that information. It is definitely a challenge and it is something that is important to people to have their privacy respected.

Mr GREG PIPER: The issue of people with a lived experience in mental health is very complex and as an advocate for those people it is really difficult to get that point out. I appreciate your efforts in that space. In your submission you ask for better public reporting and you told the Committee about the requirement in the Victorian model for the chief psychiatrist to report annually. On page four of your submission you recommend, and I quote:

> Alter the Mental Health Act 2007 to be aligned with contemporary thinking about Mental health legislation and transparency … public reporting on major issues in mental health services, including seclusion and restraint …

The Committee has had quite a bit of discussion on that today.

Ms COMBER: I am sure.

Mr GREG PIPER: For example, the safety issues and the failures that have happened. Your recommendation also includes public reporting on electroconvulsive therapy [ECT]. Electroconvulsive therapy is quite often unpopular with the consumer but in some cases from a clinical perspective it has been demonstrated to be extremely effective. What is your main concern about those quite conclusive actions in your recommendation?

Ms COMBER: With ECT we find that some people have it and they feel like they had it but in a coercive way, and they were really unhappy with that, but some people are also very happy with the outcome of ECT. We do find that there is a mixed experience among consumers. We would like to see really accurate reporting of that data so that we can see if some areas administer ECT a lot more than other regions. So when people are going into services they can really make an informed choice and understand what they are going to be getting from that service. I think that is the same with seclusion and restraint. I mentioned before that one of the things we are concerned about with seclusion and restraint is that it is being accurately recorded when it does and does not happen.

Mr GREG PIPER: From time to time across the spectrum we will see the need for seclusion and restraint, and whether or not it is used will often come down to the staffing levels provided. But with ECT, where it is prescribed in the same way as a psychotropic drug, would it not be used more because there is a particular expertise in a geographic area? For example, there may be a professor of psychiatry and his staff who have a particular expertise in ECT so you will see greater use of it in those areas?

Ms COMBER: Possibly that is true but if that is happening I think we would still want to know how much it is happening in that area so we could establish whether it is the case that there is a clinician who has that particular expertise and tends to recommend that a lot, or if it is the case that people are being more coerced or more strongly encouraged to have ECT perhaps when they do not want to have it.

Mr GREG PIPER: For the people coming to your organisation it is a very intense and personal issue. How do you engage with them? What is the interaction with your organisation? How do people learn about you and come to you knowing that you are an advocacy group?

Ms COMBER: We run a lot of consultation. We go out to different communities. Last week I was in Tamworth talking to people. Some of those consultations will be in community spaces, some will be inpatient units or rehabilitation units. We do a lot of things in that way. We also do a lot of surveys, online surveys, getting people's opinions as well. When we are trying to get more people to respond to those surveys we might reach out through our networks, for example, through peer workers in different local health districts and through our other contacts to try and get in touch with as many people as possible.

Mr GREG PIPER: Does social media become part of that?

Ms COMBER: Of course.

The CHAIR: What balance is required in health services to achieve performance indicators and financial efficiency while ensuring that patient care is not compromised?

Ms COMBER: As someone coming from a consumer perspective, obviously our priority is to have the best possible patient care. The last witness alluded to our knowing that more incidents of seclusion and restraint happen when staff are not trained in de-escalation. Having a high-quality level of care makes a huge difference to people, and there is a long-term financial goal that is achieved in that way because if people have really good experiences of care then they are more likely to progress further on their recovery journey without using the services as much down the track. They may also approach services before they have deteriorated if there is a high level of trust in services because they know that they will get good care.

The CHAIR: Please talk more about accessing services prior to a significant deterioration in their condition and repeat presentations. Is there a more appropriate way of dealing with someone having a psychotic episode than their being assessed at accident and emergency? Perhaps a person would be less inclined to present at A and E if they have to explain their condition again.

Ms COMBER: Sure, having really good community services and people knowing about those services and being connected to those services will obviously reduce the number of people presenting to hospital. There is also a lot that can be done within A and E to improve people's experiences. For example, I talked to someone recently who had been a long-term user of hospital services. He had recently been to an emergency unit where they had rooms specifically for people with mental health issues, so that if they are distressed there is a quiet place where they can calm down and feel safe. This had made a huge difference to him because he had sat in one of these rooms for 20 minutes after which a clinician talked to him and he felt ready to leave and continue with his life. In the past, he would have been very distressed and probably sedated before being taken into the mental health unit. For him, that might not have been necessary.

The CHAIR: What is the follow-up experience of your clients once they have been discharged from a mental health unit?

Ms COMBER: It is a mixed bag and it depends on the area. Some people leave the mental health unit with a list of GPs, and some people leave the mental health unit really connected with services in the area. We would like to see a lot more consistency in the experiences people have and people connected with community services before they leave the hospital so that they have much smoother transition.

The CHAIR: Is that not happening now?

Ms COMBER: It does sometimes happen, but if it happened to a greater extent—for example, if community services met with people in the units so that they knew who they would be interacting with in the community—that would make a big difference. There is a current review of the transfer of care policy, so this might change in the near future.

The CHAIR: We have been discussing access to data and integrating the database to provide clinicians with more timely information to make an assessment.

Ms COMBER: Also better systems to share information between different clinicians even within a unit could help. For example, when a person has had a physical health experience and then goes into a mental health unit, it would be helpful to share that information.

The CHAIR: One issue in giving people control over their health records is there may be instances where people do not believe they have a mental health disorder but that is stated on the record, so they refute the record.

Ms COMBER: It is definitely possible that that could happen. Are you concerned about something in particular?

The CHAIR: Access to that record might be denied to clinicians because the person disputes the veracity of it.

Ms COMBER: Except the record is accurate.

The CHAIR: I had a recent experience of looking at 3,000 pages of documents on a person's living room table trying to convince the State that she did not have a mental disorder, although she clearly did. If a person has control over who accesses their medical files in the future in a perfect world where we have an app on our phone that allows or denies permission, that could be a consideration.

Ms COMBER: This is obviously an ongoing dilemma for us, because we want people to access the best care while also wanting people to be empowered to make choices about what care they get themselves. I do not have a particularly simple answer to quite a complicated dilemma. Increasing trust as much as possible between people and clinicians by providing really good service is probably the best step that we can take towards solving this dilemma, as well as working with people's families and others around them, their support network. That is another helpful step in navigating the dilemma.

The CHAIR: Can you speak to your clients' experiences with the Public Guardian?

Ms COMBER: What we have heard most about the Public Guardian is that they are a bit overstretched and do not necessarily have the time to really get to know the person properly and support their decision-making. People have not necessarily found the Public Guardian responsive enough. You know about the guardianship review that was recently undertaken. The recommendation we made to that was that people needed to build more of a relationship with the people they provide services to, so that we can move towards a supported decision-making model rather than the current model.

Mr LEE EVANS: When we were in Lismore we attended a public consultation and somebody in the audience told us about a friend who wanted to access their 38-year-old child's mental health record. How could that be handled?

Ms COMBER: Had the person requested that the family member not have access?

Mr LEE EVANS: Yes.

Mr GREG PIPER: The person seeking the record was a parent and felt that they should have access as a parent, regardless of the legal situation.

Mr LEE EVANS: The nub of the problem was that they were acting out on NSW Health because it was following privacy guidelines. Is work required on that area or is it okay?

Ms COMBER: This is something that we hear about. I think ultimately the decision should rest with the consumer about who does have access to know what is happening with them. We hear about it in the other direction too where carers have not been told when they should have been told. There are situations where people have abusive relationships with their carers or with their parents and would prefer for them not to have that situation. I do not think that some kind of blanket rule where parents are entitled to have access to the healthcare information of their adult children is ever going to be appropriate.

The CHAIR: The Committee may have some more questions which will be sent to you in writing. Are you happy to reply to those within 14 days.

Ms COMBER: No problem.

(The witness withdrew)

(The Committee adjourned at 4.01 p.m.)