PORTFOLIO COMMITTEE NO. 2 - HEALTH

Monday 2 December 2024

Examination of proposed expenditure for the portfolio areas

HEALTH AND REGIONAL HEALTH

UNCORRECTED

The Committee met at 9:15.

MEMBERS

Dr Amanda Cohn (Chair)

The Hon. Wes Fang
The Hon. Dr Sarah Kaine
The Hon. Emily Suvaal
The Hon. Damien Tudehope

MEMBERS VIA VIDEOCONFERENCE

Ms Cate Faehrmann

CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

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

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

The CHAIR: Welcome to the supplementary hearing of the Portfolio Committee No. 2 - Health inquiry into budget estimates 2024-2025. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders past and present and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander people joining us today. My name is Dr Amanda Cohn, and I am the Chair of the Committee. Today the Committee will examine the proposed expenditure for the portfolios of Health and Regional Health. I ask everyone in the room to please turn their mobile phones to silent.

Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures. Welcome back, and thank you for making the time to give evidence today.

Ms SUSAN PEARCE, AM, Secretary, NSW Health, on former oath

Mr SCOTT McLACHLAN, Acting Deputy Secretary, Health System Strategy and Patient Experience, NSW Health, sworn and examined

Mr MATTHEW DALY, Deputy Secretary, System Sustainability and Performance, NSW Health, sworn and examined

Mr ALFA D'AMATO, Deputy Secretary, Financial Services and Asset Management, and Chief Financial Officer, NSW Health, on former oath

Dr MICHELLE CRETIKOS, PSM, Acting Chief Health Officer, and Deputy Secretary, Population and Public Health, NSW Health, affirmed and examined

Mr LUKE SLOANE, Deputy Secretary, Rural and Regional Health, NSW Health, on former affirmation

Mr PHIL MINNS, Deputy Secretary, People, Culture and Governance, NSW Health, before the Committee via videoconference, on former oath

Ms EMMA SKULANDER, Acting Chief Executive, Health Infrastructure, NSW Health, on former affirmation

Dr DOMINIC MORGAN, ASM, Chief Executive, NSW Ambulance, on former affirmation

Ms KATHY DEMPSEY, Chief Infection Prevention and Control Practitioner, and Healthcare Associated Infections Adviser, Clinical Excellence Commission, sworn and examined

The CHAIR: Today's hearing will be conducted from 9.15 a.m. to 1.00 p.m., with a 15-minute break at 11.00 a.m. During this session, there'll be questions from the crossbench and Opposition members only and then 15 minutes allocated for Government questions at 10.45 a.m. and at 12.45 p.m. I will start crossbench questions. It has recently been publicly reported that a number of public hospitals have been refusing to provide abortion services—notably, Orange hospital and Queanbeyan hospital. In both of those instances, the Minister very quickly intervened to make sure that those services were restored, which I really appreciate. What's being done by the department to ensure that that's not happening anywhere else?

SUSAN PEARCE: Thank you, Dr Cohn, for your question. NSW Health is committed to the provision of reproductive care for women. I want to be very clear about that. We've recently written to all chief executives to remind them of their obligations and to remind them that if they, for whatever reason, need to make some alteration to service provision in that area or any other, they require my approval to do so. The Health Services Act points to that direction for local health districts. They don't have the ability to abruptly withdraw services without the approval of the health secretary. They have been reminded of that.

In addition to that, we have recently completed a mapping exercise of the services offered across NSW Health, noting that, in regard to abortion care for women, this is not something that solely rests with NSW Health. It is a partnership between ourselves, private providers, non-government organisations and so on. In addition to that, though, it's important that we're able to give women the opportunity and the ability to find their way through what can be a very complex part of the health system, and we're committed to doing that. So there's a further piece of work happening at the moment to look at what that looks like on a district-by-district basis. We know, for example, that the Hunter New England Local Health District has a very good wayfinding, if I can put it that way, in that sort of language.

We need to make sure that all women across the State have got access to the care that they need. So we're looking at what we provide beyond all of those things that I've mentioned, and we'll continue to work closely with Minister Park and his office in respect of what our services look like, going into the future. But, at the moment, they're the types of things that are happening. I'd like to apologise on behalf of NSW Health to any woman who feels that she was not able to receive the care that she needed when she needed it, whether it's with us or elsewhere. We take very seriously our responsibility in this area. I cannot state that clearly enough to you. I might ask Mr McLachlan, if that's all right, just to add a couple of comments in that regard.

SCOTT McLACHLAN: Dr Cohn, this is something we take very seriously. We have strengthened some of our hospital-based abortion care services in recent weeks, and that has meant some changes at both Orange and Queanbeyan. In addition, the extensive networking and stocktake across the State of both the local health district services and the other providers in the community is happening at the moment. That will help us look at where the gaps are and issues across different regions and parts of the State that we need to strengthen. We do give a commitment that this is an opportunity for women to have access to care right across the community.

The CHAIR: I appreciate the commitment that both of you have just restated. Mr McLachlan, you mentioned that in recent weeks some of that access had been strengthened in hospitals. Are you referring to the letter written by Ms Pearce, or is there other work the Committee should be aware of?

SCOTT McLACHLAN: There is work happening across several local health districts that is looking at both the clinics and the procedural capability of hospitals. In some regions those new clinics have been stood up to help access for women, and the surgical capacity for women between nine and 15 weeks that need a procedure to terminate the baby is also being strengthened.

The CHAIR: When I asked the Minister representing the Minister for Health in the upper House about funding for abortion services, she referred to the SEARCH program and an extension of funding for that program, which is very welcome. Could you speak to some of the detail of that extension or what's actually being funded?

SCOTT McLACHLAN: Sure. The SEARCH program was funded in the first year of the four-year additional funding. That has provided a lot of opportunity, particularly in regional areas, to improve access for women seeking abortion. More than 800 people have accessed the pregnancy options counselling. Over 550 women accessed a medical abortion through the SEARCH partners, and 50 women were supported to access surgical abortion out of that. It's a network of a lot of the community providers to improve access in rural and regional areas, and that's, I think, been successful in doing that. It's still in the early days. There's some way to go to strengthen the service.

The CHAIR: As I'm sure, you're aware, earlier this year the TGA changed its guidelines for the prescription of medical abortion, allowing nurses and midwives to prescribe, which isn't currently permitted by the legislation in New South Wales. Do you have any indication of how many nursing and midwifery practitioners in the State it would enable to provide that service? Would it bolster the service?

SUSAN PEARCE: I think we'd have to take that one on notice. We obviously have hundreds of nurse practitioners across the State. It would be, to some extent, dependent on their area of practice. Clearly, I'm aware that the Government is prepared to consider that in respect of the New South Wales legislation. We obviously would welcome that from a State health system perspective. We don't want to be an outlier in this regard, in respect of the rest of the country. Certainly, from our perspective, given our strong support for nurse practitioners within our own organisation, it's something we would absolutely support. But we've got to work through those legislative amendments, if the Government is minded to do so, obviously with the support of others, into the future.

The CHAIR: While we're talking about legislation, I understand that the five-year review of the Abortion Law Reform Act 2019 was due in October. Can you update us on the status of that review?

SUSAN PEARCE: I'd have to take that one on notice.

The CHAIR: I also wanted to ask about training for the workforce. You mentioned nurses and midwives, who may or may not have abortion care in their scope. Particularly for a procedure like abortion, which is primarily provided by external partners or general practitioners and not in public hospitals, it means that trainee health practitioners aren't exposed to that kind of care very frequently. Is there any work being done to support the workforce to become trained in providing abortion care?

SCOTT McLACHLAN: There is. Right across the whole network, including the private providers, Family Planning Australia do some training and support for clinicians that I think has been invaluable in a rapidly changing environment. We certainly provide support for our clinicians through the local health districts, particularly in women's health centres and through to the procedural services.

The CHAIR: I have some questions about the status of the safe staffing levels rollout. Ms Pearce is nodding.

SUSAN PEARCE: Mr Minns.

The CHAIR: Mr Minns, could you provide us an update on the status of the rollout of safe staffing levels?

PHIL MINNS: I will look for the relevant information in my pack, but we are proceeding to roll out at level five and six EDs. We've got a forward list of the additional sites that we want to roll out to, and the Minister has asked us to look at the potential to roll out to level three and four emergency departments in the new year. It might be better if I return later when I can give you direct numbers, because I'm struggling with internet speed here at the moment.

The CHAIR: Thanks, Mr Minns. I am very happy to come back to it later this morning. I'm interested in both the numbers and the specific list. If you have that list of sites, where they're up to in the rollout and what hospitals, or what departments specifically, are on the forward list, I would be very interested in that.

PHIL MINNS: Yes. I think I can do that, certainly for the current list. The forward list will probably be the range of options that we still need to reach agreement with the association on.

The CHAIR: There was a very recent announcement of $200 million of additional funding to address the backlog of elective surgery, which I'm sure is very welcome in the community. Which hospitals are intended to take on that work?

SUSAN PEARCE: I'll pass to Mr Daly to respond to that. It will obviously be widespread across the State, but Matthew has a clearer view of what's happening there.

MATTHEW DALY: Each LHD right across the State will be receiving a proportion of that $200 million, which was made up of 186 and also some interim funding to pick up those cases that were cancelled during the three days of industrial stoppage. It varies on an LHD to LHD basis for two reasons. One is that some have variable numbers of overdues, and predominantly those that have overdues or breached surgical patients are also ahead of their activity. So it's those hospitals that will be receiving slightly more money than others in order to bridge the activity that they've overdelivered on in their service agreement, plus sufficient funds to bring their breached surgical patients back to pre-COVID levels, which is the obvious objective which we did achieve not all that long ago. But with big numbers it moves very quickly if there's any interruption.

The CHAIR: Are you confident that you've got the workforce willing to do the overtime to staff the extra theatres?

MATTHEW DALY: Yes. Certainly the feedback from the chief executives is that they're wanting to, I guess, try and rebuild our surgical capacity within our public hospitals. I think, given the size of the breached patients that accumulated over the COVID interruptions, together with workforce shortages, that placed a slightly higher dependence on private hospital contracts. They clearly, particularly the more recent work, became unaffordable. So there will still be some private work, but not to the proportion that it was. The objective is about rebuilding our theatre and perioperative capacity back to what it was pre-COVID.

The CHAIR: In the reporting of the waitlists increasing again, there was commentary about the burden on public hospitals of winter viruses. To what extent was that problem caused by COVID itself?

MATTHEW DALY: As Kerry Chant advised me, with the great modelling and then reporting that she does, for the first time this winter we had a triple peak of COVID, RSV and influenza. All three peaked at exactly the same time. It's really interesting looking back over past winters, you see the various peaks of the viruses but this is the first time that all three peaked at exactly the same time. So, yes, that put a lot of pressure on our EDs, and not just for the lower triage categories but also some very sick people. The nature of health service management is that there is always some squeezing the balloon over the winter period in order to manage unplanned presentations, of which we saw a significant spike over this winter. But, to their credit, the LHDs and chief executives have moved to address that. This funding support, particularly for those LHDs that were over their activity target, certainly facilitates that, such that I'm very confident that we'll be returning to pre-COVID by the end of this financial year.

The CHAIR: In terms of the winter virus issue, including a number of viruses, what preventive measures were put into place coming into winter to try to minimise the impact of that on the hospital system?

MATTHEW DALY: Every winter we ask the LHDs to prepare pre-winter plans, and that is both preventative as well as reactionary. We can fairly accurately predict spikes in presentations, although I think on 5 June this winter we had over 10,000 presentations in one day. None of our modelling can predict a 10,000-presentation day, when a typical busy day is in the high sevens, low eights. Sometimes it gets up to the nines, but to crack 10,000, as it did at the very beginning of winter, was a real wake-up call for us all. The LHDs responded appropriately by executing their winter plans. There was a very strong marketing campaign, not only through Population Health for the public to take up immunisation, but also we're very active in trying to encourage our staff to get immunised, which we provide at no charge, for all the obvious reasons: It benefits both individuals and the community.

The CHAIR: As a former GP, I'm a strong supporter of immunisation campaigning, but my question might be better for Population Health. In terms of preventing community spread of viruses coming into winter to reduce that burden on hospitals, were there any other measures taken in addition to immunisation?

SUSAN PEARCE: I might start off, if that's okay, Dr Cohn, and then pass to Dr Cretikos or to Kathy. First of all, we obviously do a lot of public messaging throughout winter. We have, sadly, as a consequence of the

pandemic period of COVID, increased the following on our social media channels substantially. As a consequence of that, our ability to communicate with the public has improved. We do a lot of social media messaging, in addition to other public messaging—the usual things: Don't go to work if you're sick, wash your hands, wear a mask et cetera.

In addition to that, within our hospitals we established throughout the pandemic our risk matrix for how we would deal with our workplaces—our hospitals—when COVID is peaking, and other respiratory illnesses as well. I'm sure Dr Cretikos and Ms Dempsey can talk you through that in more detail, but, essentially, whereas once we had a statewide mandate around, for example, the wearing of masks in our hospitals, now we have the ability for a much more nuanced approach to that so that all of the local health districts are aware of the risk matrix and they make their assessments based on what they're seeing in their local community.

If COVID is peaking then they will obviously implement the wearing of masks. Probably only three weeks ago now I was out in Mudgee visiting the hospital there. In particular areas of the hospital, and in the clinical areas, the staff were wearing masks. As a visitor to the hospital, obviously, I was asked to wear one as well, as we were walking around talking to the staff. That's an example of, at a local level, "Look, we've got a few cases in the community and we'd like to address that within the organisation." That's what they do, and that's communicated to them as well. Michelle, did you have anything you wish to add to that?

MICHELLE CRETIKOS: Other than the communications, the weekly surveillance reports are providing, as timely as possible, advice to the community on when we're expecting to see an increase in the rates of COVID, influenza or RSV in the community, in an attempt to advise people—particularly those who may be more vulnerable or at risk of both—that that is a good time to go and get vaccinated, if they haven't been vaccinated recently, and also to take extra care if they're visiting any facilities or visiting anybody that's more vulnerable in the community.

The CHAIR: Ms Pearce, you gave the example of Mudgee Hospital, which is really helpful. I appreciate this may need to be taken on notice, but I'd be interested in, over the winter, which local health districts or which hospitals in addition to Mudgee actually did re-implement universal precautions for respiratory infections.

SUSAN PEARCE: I think that would be very difficult for us to collect. We could do it at a high level across the districts. Across 226 hospitals, it would be very difficult for us to collect that information, so I'll take that on notice and provide to you what we can. As I say, it is clearly communicated to chief executives when the risk panel meets. If they believe that there is a requirement for a more universal approach to be put in place, that is communicated to the system. If they meet and determine that we're at the foundation level, or we've gone up a level to yellow, then that is also communicated. It is then incumbent upon the chief executives across the system to enforce that. My view of it—I do a lot of getting out to our hospitals—is that they tend to err on the side of caution with respect to the application of that risk matrix.

The CHAIR: At a previous estimates, I raised the issue of particularly vulnerable patients—for example, people with immunocompromise—having to request staff to wear a mask, and that request, on occasion, not being met. Has any work been done to communicate the importance of that, particularly when patients request it?

SUSAN PEARCE: I think it would be very difficult for someone, if they were in hospital feeling scared, to ask somebody to put a mask on. We've talked to the system about this. As I say, it's very hard to apply that issue that you're raising universally across the system, which is why I refer back to the risk matrix—that is, when you've got high levels of any respiratory disease circulating, it's important that our staff are given that guidance. Obviously, we would, in all cases, seek to allay any patients' concerns or fears in hospital. I'm sure our chief executives would agree.

The Hon. DAMIEN TUDEHOPE: Mr Daly, probably this is your forte, or it appears it is. How many elective surgeries were cancelled as a result of industrial action taken in November?

MATTHEW DALY: I knew it on a day-by-day basis. It was approximately 500 on each of the first two days—I've probably got a note in here, which I'll get specifically—and 702 on the third day of the industrial action. All of those have since received their surgical therapy, whatever it was, or they've been rescheduled to do so.

The Hon. DAMIEN TUDEHOPE: Just on the estimate you've made, it's about 1,700 over three days?

MATTHEW DALY: That's my recollection, yes.

The Hon. DAMIEN TUDEHOPE: And the number which have actually been completed?

MATTHEW DALY: All from the first day and, from my understanding, all from the second day of industrial action. The third day, I haven't had confirmation. But I can confirm that, if they haven't actually received their surgery, they are re-booked already to do so.

The Hon. DAMIEN TUDEHOPE: The Government has announced $200 million in additional funding to boost overdue surgeries. Over what period of time do you anticipate that being rolled out?

MATTHEW DALY: The objective that the Government has asked us to deliver on for that funding is to achieve it by the end of this financial year, so by 30 June. I'm engaging with the chief executives to ensure that they get their numbers back to pre-pandemic levels.

The Hon. DAMIEN TUDEHOPE: Is there a formula in terms of the manner in which that funding is going to be distributed across the system?

MATTHEW DALY: Yes. There are a number of components of the distribution. Obviously, the number of breach patients is the first one. Secondly, an influence—because we're not here to reinforce bad behaviour. If they're above their activity target for which they've been funded in their service agreement, that's also an influence. We also have equity adjusters that take in growth for population and ageing that is also applied. It varies from district to district for obvious demographic reasons.

The Hon. DAMIEN TUDEHOPE: You're not suggesting that the nurses' behaviour is bad behaviour, are you?

MATTHEW DALY: No. "Bad behaviour" might be a poor choice of words.

The Hon. WES FANG: But it was a choice of words.

MATTHEW DALY: It is a choice of words. But if it was an outcome of breached patients, and they were under their activity target, then they are, in essence, already funded for it. So it wouldn't be appropriate for me to double fund activity for which they are already funded.

The Hon. DAMIEN TUDEHOPE: The Minister was suggesting yesterday that some of the backlog which had increased—I think there has been a substantive increase in the backlog and waiting times for surgery. Has that increased because of industrial action?

MATTHEW DALY: To the tune of those numbers, yes.

The Hon. DAMIEN TUDEHOPE: But you caught that up, didn't you just tell me?

MATTHEW DALY: I'm sorry?

The Hon. DAMIEN TUDEHOPE: Haven't you caught that up?

MATTHEW DALY: From the industrial action?

The Hon. DAMIEN TUDEHOPE: Yes.

MATTHEW DALY: Yes. As I said, most of those people have been treated. But in so being treated they've deferred other patients who otherwise would have been treated in that spot had it not been for the cancellation during the industrial day. So whilst everyone that has been treated has either received their surgery, or has a date for it, that has dislodged other people who otherwise would have received their surgery on those dates.

The Hon. DAMIEN TUDEHOPE: So it's not true, necessarily, to say that industrial action is the sole reason for the increase in the delays for elective surgery, is it?

MATTHEW DALY: No.

The Hon. DAMIEN TUDEHOPE: What would you say are the additional reasons for those delays?

MATTHEW DALY: I would say, in addition to the industrial action, winter is always a delaying factor inasmuch as unplanned presentations have to be responded to. Sometimes that requires hospitals and districts in their winter planning to slow down some planned surgery, elective surgery, in order to make sure they can meet all the needs of unplanned presentations, through emergency departments predominantly. I think the growth in demand and referrals is such that the budget allocation for this year of $200 million is in recognition of that. That's creating the capacity to ensure we do get back to pre-pandemic levels.

The Hon. DAMIEN TUDEHOPE: Are there any local area health districts which are, in fact, going to meet their targets by 31 December?

MATTHEW DALY: They all give me projections on a monthly basis. A number of LHDs are actually still predicting zero breached patients just by the nature of their BAU management. So, yes, some are already predicting that they'll be at pre-pandemic levels at the end of December. The expectation is that'll be continued within their service agreement envelope, with the support of this additional funding if it's required.

The Hon. DAMIEN TUDEHOPE: Let me understand. This additional funding, is this coming from within the Health budget, or is it new money?

ALFA D'AMATO: It's new money.

The Hon. DAMIEN TUDEHOPE: It's new money?

ALFA D'AMATO: Correct.

The Hon. DAMIEN TUDEHOPE: There's no reduction in any of the other Health spending as a result of this $200 million?

ALFA D'AMATO: That's correct.

The Hon. DAMIEN TUDEHOPE: In relation to the negotiations with the nurses and midwives union, how many of those negotiations have you attended?

SUSAN PEARCE: I have been in a few meetings with the Nurses and Midwives' Association leadership. Mr Minns, equally, has been in a number of those meetings. I couldn't give you the exact number. I'd have to come back to you on that, Mr Tudehope.

The Hon. DAMIEN TUDEHOPE: Has the Minister been in attendance at those meetings?

SUSAN PEARCE: The Minister has certainly been in attendance, yes.

The Hon. DAMIEN TUDEHOPE: How many of those meetings?

SUSAN PEARCE: I would have take that on notice.

The Hon. DAMIEN TUDEHOPE: Has the Premier ever attended any of those meetings?

SUSAN PEARCE: I don't recall. When I've been there—is that what you're asking me?

The Hon. DAMIEN TUDEHOPE: Yes.

SUSAN PEARCE: Not that I can recall, but I know that the Premier has had meetings with the Nurses and Midwives' Association leadership team.

The Hon. DAMIEN TUDEHOPE: As part of the wage negotiation?

SUSAN PEARCE: That's my understanding, yes.

The Hon. DAMIEN TUDEHOPE: Has that been in a direct meeting just with them one on one, or were officials—

SUSAN PEARCE: I think you would need to direct that question to the Premier, Mr Tudehope.

The Hon. DAMIEN TUDEHOPE: When were you first made aware that safe staffing levels was a trade-off for wages?

SUSAN PEARCE: The term "trade-off" is something that—is not the way I would describe it. I think that in the various discussions—and I will pass to Mr Minns—there have been suggestions put forward at various times about what could be done to achieve an increase in pay for nurses within the Government's wages policy. Obviously, this matter is before the industrial commission, so that is a forum where things are raised and discussed as potential options. But, if it's okay, I'll pass to Mr Minns to—

The Hon. DAMIEN TUDEHOPE: I'll come back to you, but I'm happy to hear from Mr Minns.

PHIL MINNS: Mr Tudehope, when we were following the recommendation of the Industrial Relations Commission President to undertake four weeks of intensive negotiations, those negotiations were conducted by the association, ministry and representatives of the Minister's office, the Treasurer's office, the Premier's office and the Minister for Industrial Relations' office. We met multiple times a week across those four weeks. It was probably in the beginning of the second week that, under the program agenda that was worked out with the association and the facilitator of those meetings, the Government presented the idea of options to enable movement to occur on the current government wages offer. That would've included the consideration of a delay or slowdown to safe staffing level rollout.

The Hon. DAMIEN TUDEHOPE: I take it that you are suggesting that comprises part of the bargaining parameters on behalf of the Government.

PHIL MINNS: I think that's fair to describe it that way, yes.

The Hon. DAMIEN TUDEHOPE: What are the other bargaining parameters which the Government has in fact adopted for the purposes of trying to find an outcome with the nurses to achieve their request for a 15 per cent pay rise?

PHIL MINNS: The principal alternatives, in addition to the timing around safe staffing, was to look at whether or not the wage increase was uniform across all levels of nursing and ward coverage, or whether there was the potential to address the areas where the comparative pay position to other jurisdictions was under the most pressure. It's not the case that either New South Wales or the other States have the same kind of incremental structure across the salary bands. It was identified that the areas where NSW Health was under the most comparative pressure were at the assistant in nursing, enrolled nurse and registered nurse year one and year two, so options to look at addressing those classifications initially, and spreading that over a multi-year agreement was another consideration. Then the final one was to look at the repurposing of funding associated with tertiary scholarships related to nursing roles.

The Hon. DAMIEN TUDEHOPE: Would you identify any of those as productivity enhancements?

PHIL MINNS: They're all mechanisms that generate a savings to otherwise committed expense, which would then be available to be directed towards a wages outcome.

The Hon. DAMIEN TUDEHOPE: But it's not a productivity outcome, is it? It's properly just defined as a cost saving rather than a productivity outcome.

PHIL MINNS: Potentially. If there was a Treasury economist present, I'd get them to define "productivity" and see what they'd say, but it is a re-use of allocated funding.

The Hon. DAMIEN TUDEHOPE: Given that 60 per cent of the recurrent expenditure is related to employee expenses, would you agree that it's going to be difficult to find savings in Health to pay for any wage deal above 10.5 per cent?

PHIL MINNS: All things to do with the Health budget are difficult; there's no other way of looking at it. It's because of our size and scale that, whatever we do, the numbers multiply through. I think Mr D'Amato could give you the precise percentage of employee-related expense in the budget, but it is around 60 per cent.

The Hon. DAMIEN TUDEHOPE: Would you agree with that? Is it 60 per cent?

ALFA D'AMATO: That's correct.

The Hon. DAMIEN TUDEHOPE: Have you been able to identify how you would afford a 15 per cent pay rise if that was to be awarded by the Industrial Relations Commission?

ALFA D'AMATO: At this stage, I think we made a commitment in respect to savings and I don't think there are opportunities for us to identify savings of that magnitude.

The Hon. DAMIEN TUDEHOPE: On 13 November the Premier said that the Government has made an offer to the association regarding RN1 and RN2 nurses, and I think you made reference to this earlier. He said, "We will negotiate with the union about boosting, in particular, RN1 and RN2 wages so that they could be second or even first in the nation." Are you aware of that offer?

SUSAN PEARCE: I'm aware of those discussions.

The Hon. DAMIEN TUDEHOPE: Is there an offer?

SUSAN PEARCE: Again, I'll go back to Mr Minns for the status of that.

PHIL MINNS: The nature of the four weeks of discussions/negotiations with the association was that we agreed to work through an exploration of various fact bases. One of the fact bases was what could you do if you determined or decided to be creative about how you structured increases, addressing the market position with other jurisdictions. I don't think it's the case that only one idea with respect to that smoothing and spreading across three years was canvassed. I think more than one was canvassed. But, ultimately, the association was not keen on that method of progressing the conversation. We didn't put it in writing on a piece of paper as an offer. We presented some worked calculation tables that showed how you could do it differently, and doing something about RN1s and RN2s was certainly amongst that mix.

The Hon. DAMIEN TUDEHOPE: An RN1 nurse, as I understand it, currently earns about $70,000 in New South Wales. Is that right?

PHIL MINNS: That will be their base rate before you look at what they might take home as pay associated with their shift loadings et cetera.

The Hon. DAMIEN TUDEHOPE: I accept that. However, as a base rate, if you were going to make it the best in the country and to, for example, exceed Queensland, that would require an 18 per cent increase, would it not?

PHIL MINNS: I don't have the numbers in front of me, Mr Tudehope, but it would be a significant increase.

The Hon. DAMIEN TUDEHOPE: Is that what the Government has offered the association for RN1 nurses?

PHIL MINNS: I think what we did was canvass that option in the forum that I've described, with the membership that I've described. It just wasn't met with any particular enthusiasm. It's probably a bit of a definitional point about whether or not an offer has been made. What we were doing was trying to problem-solve to see if we could make progress in the negotiations. Beyond canvassing those ideas, they didn't receive a lot of pick-up or take-up. Consequently, the parties accepted that that wasn't a route forward.

The Hon. DAMIEN TUDEHOPE: I'll come back to that. I just want to ask Ms Skulander some questions on Rouse Hill Hospital. Ms Skulander, have any costings been undertaken to determine how much it's going to cost to add a birthing unit at Rouse Hill Hospital?

EMMA SKULANDER: Yes, they have.

The Hon. DAMIEN TUDEHOPE: Are you able to provide us with those costings?

EMMA SKULANDER: I am not. That is information that has been requested of me, but—

The Hon. DAMIEN TUDEHOPE: Have you provided advice to the Minister on the costings?

EMMA SKULANDER: I have and/or it's on its way to the Minister. I was asked that question last week. I have prepared a brief, which is probably on its way to his desk.

The Hon. DAMIEN TUDEHOPE: Okay. I will put this to you: Are the costings roughly $200 million?

EMMA SKULANDER: I actually do not know the answer to that question. I'll have to take it on notice.

The Hon. DAMIEN TUDEHOPE: You do know the answer and you're not telling me. Isn't that the case?

EMMA SKULANDER: I think it depends on specifically what you want to know the costing of because there is range of costings that relate to that number, which are outlined in that brief.

The Hon. DAMIEN TUDEHOPE: Would you agree that, based on the population growth in Rouse Hill, they will require a birthing unit by the 2030s? Is that right?

EMMA SKULANDER: My understanding is that it's within the 2030s, but towards the back end of the 2030s, when you consider it against the entire catchment of Western Sydney Local Health District.

The Hon. DAMIEN TUDEHOPE: When was the Minister first made aware of the fact that Rouse Hill Hospital wouldn't have a birthing unit?

The Hon. Dr SARAH KAINE: Point of order: Mr Tudehope is asking the witness about when the Minister was made aware of something. I think that's a question that's better asked of the Minister, not the witness.

The Hon. DAMIEN TUDEHOPE: Sorry?

The Hon. Dr SARAH KAINE: You are asking the witness to give evidence about when the Minister found out—

The CHAIR: I think that's actually a fair point of order. Mr Tudehope might be able to rephrase the question.

The Hon. DAMIEN TUDEHOPE: When did the department first provide that advice to the Minister?

EMMA SKULANDER: I actually don't know the answer to that question because it would've been before my time in the acting chief executive position. I am able to take that on notice.

The Hon. DAMIEN TUDEHOPE: Ms Pearce, do you know? Does anyone know when the department first advised the Minister that a birthing unit would be required at Rouse Hill Hospital?

SUSAN PEARCE: Mr Tudehope, with respect, you are assuming something on our behalf. You're sort of putting us in a position of agreeing with what you're saying in terms of the modelling for Rouse Hill Hospital. We are happy to take on notice any advice we've provided with respect to maternity services at Rouse Hill Hospital. My understanding is that the work was done with the district, who look at the requirements for birthing services in Western Sydney. We would have formed—as the district would have—a clinical services plan with respect to what's required. But we'll need to take it on notice.

The Hon. DAMIEN TUDEHOPE: But would you agree that the original plan for the hospital didn't include a birthing unit?

SUSAN PEARCE: I'll need to take that on notice.

The Hon. DAMIEN TUDEHOPE: Can I now ask you about pill testing. Ms Pearce, I take it you will be attending the drug summit?

SUSAN PEARCE: No, I'm not attending.

The Hon. DAMIEN TUDEHOPE: Is anyone from the department attending?

SUSAN PEARCE: Certainly there are, yes.

The Hon. WES FANG: Can I just clarify about the question Mr Tudehope asked about Rouse Hill? Was there an offer to table that document? Was that taken on notice?

The Hon. DAMIEN TUDEHOPE: They took it on notice.

The Hon. WES FANG: Will the document be provided to us?

The CHAIR: The question was taken on notice. By my recollection, no document was referred to. I wanted to follow up on some of the Opposition's questions about the surgical waitlist. I appreciate this question may need to be taken on notice. How many elective surgeries were either cancelled or postponed during the four-week pause for intensive negotiations with the nurses union?

SUSAN PEARCE: My understanding is that there were no cancellations or pauses associated with the negotiations.

The CHAIR: Just to be clear, I'm not asking about postponements or cancellations associated with the negotiations, just for other routine or operational—

SUSAN PEARCE: During that time frame?

The CHAIR: Yes, that's right.

SUSAN PEARCE: We will have to take that on notice. What I will say to you is this: There was certainly no statewide pausing of surgery at any time this year.

The CHAIR: Certainly. To be clear, that's not what I'm alleging at all.

SUSAN PEARCE: Well, what are you asking me?

The CHAIR: I am aware of data at a local level from the local branch of the Nurses and Midwives' Association in the town that I live in that far more elective surgeries are postponed or cancelled in the average month for operational reasons such as staffing or bed blocks than were cancelled on the three days of industrial actions this year. I am seeking data around that.

SUSAN PEARCE: Are you talking about Albury hospital?

The CHAIR: I'm talking specifically about Albury but I'm interested in whether that is the same statewide or not. I am asking you to provide that data. I'm happy for it to be taken on notice.

SUSAN PEARCE: Sure.

The CHAIR: The other thing I wanted to ask about with the elective surgery waitlist was the NSW Health elective surgery waitlist review by Ernst and Young. I have a redacted version of that report if other Committee members are interested in it. The report found that "clinical reviews which resulted in a clinical urgency category decrease were noted to be influenced by non-patient factors such as resourcing constraints or likelihood of exceeding the maximum recommended procedure period". It's talking about adjustments to the

waitlist for non-clinical reasons. That's obviously a distressing finding. What's been done since then to address that issue?

SUSAN PEARCE: I'll pass to Mr Daly on that report specifically, but NSW Health has a policy for the management of elective surgery patients. It is our expectation that local health districts adhere to that policy. That means that if there is to be a movement of someone's clinical category, that is signed off by their treating clinician. However, there are circumstances where, as we have just discussed, for other operational reasons it is necessary to alter somebody's scheduled surgery.

We have talked about what's happened this year with respect to some industrial action and the winter period. You might have an infrastructure issue. For example, recently in Broken Hill, with the power issues, they had some disruptions to their surgical program—albeit briefly, but it did happen. The reason we do reports like the one you've just referred to is to ensure that there is adherence to the policy. When we learn or there is a point to the fact that the policy may not be being adhered to, then that is raised with the chief executive and they're asked to ensure that they're meeting their policy obligations. But I will pass to Mr Daly.

MATTHEW DALY: The policy is pretty clear. There are patient reasons. There are clinical reasons. There are even surgeon and anaesthetist reasons. Sometimes a surgeon might ring in sick and it gets postponed for those reasons as well. But the policy outlines how you actually respond to that to ensure that the patient is not disadvantaged. If there is a cancellation, even for the patient's deteriorating condition, they don't start the clock again. Rather, they go back on at the next available opportunity without going back to the beginning. There were some occasions in the review—and we do these reviews every couple of years to make sure the system is compliant with the policy for the obvious reasons you are asking. Where we found there hadn't been 100 per cent compliance, we're seeking confirmation of adjusted practice to ensure compliance going forward. We will recheck that at a not too distant time.

The CHAIR: The report also referred to internal perceived pressure to avoid breaches. Is anything being done to change the reporting requirements or address those barriers to accurately reporting the waitlist?

MATTHEW DALY: I think every health worker works under pressure to avoid any delay in any patient's treatment. On the one hand that's a positive reflection and displays again how committed our staff are to making sure a patient receives treatment in the appropriate time frame, as indicated by their lead clinician. I'm not aware of any specific case where anyone has been pressured to change or delay a case. If there was, I'd respond quite appropriately.

SUSAN PEARCE: Can I also add, I think it's worth noting that the absolute majority of patients have no change to their clinical urgency category—the absolute majority. That's followed by another large number of patients who have their category changed as a consequence of their readiness for care. We're talking about a very small proportion of a very large elective surgery program in the context of a lot of system pressure. I think the context around that needs to be noted by the Committee.

The CHAIR: Sure. If I can come back to Mr Daly, what I'm referring to are the specific instances where the clinical urgency category was influenced by non-patient factors. So if someone's clinical condition actually changes, of course that's a good reason to change the urgency category, but the report noted, for example, that as people were approaching the maximum recommended wait time, they were far more likely to have their urgency changed and, in some cases, that was for the purposes of the reporting of the wait list, rather than because someone's condition had actually changed. That's my specific concern here.

MATTHEW DALY: Yes, I can understand how one could choose to read it that way. However, the reality is, with the hundreds of thousands of surgeries we do every year, they can't review the wait list for those approaching their breach period every day of that period. So what tends to happen is that they do review those cases to actually ensure and identify the most acute cases so that they don't breach. On occasion, they're referred back to the surgeon and say, "Unless you can schedule this patient to come in over the next week or two weeks, they will breach. Can you assess the clinical urgency of that patient?" On occasions, once reviewed by the treating surgeon, they've reclassified because they viewed the patient at that time as not actually meeting the urgency classification. That could be going from a category 1 within 30 days to a category 2 within 90 days. That's either determined by the treating surgeon, or the reclassification occurs with the oversight of the director of surgery for that particular hospital.

The CHAIR: So are you satisfied that the local health districts referred to in that report were doing that per policy?

MATTHEW DALY: I think it's fair to say like any big organisation there are slip-ups about consistency, but my job is to ensure consistency in every hospital in every part of the New South Wales health system. That's

why we do these reviews to see if there is a lapse of practice—so that we can ask for them to correct it. That's exactly what we're doing in this case, as has happened in the last couple of years, that at least I've been observing.

The CHAIR: Moving forward, how will you ensure that that's continuing?

MATTHEW DALY: We will continue to do these—audit is too strong a word but, in essence, it's a type of surgical audit to ensure compliance with the policy.

The CHAIR: I will come back to COVID. We were interrupted by the bell. Ms Pearce, you were just starting to talk about hospital-acquired COVID, which, as you know, is an interest of mine. There was data released through a GIPAA request in September that showed that over 6,000 patients had COVID-19 with onset during their hospital admission and 297 deaths. When I've asked about hospital-acquired COVID in the past, Dr Chant advised that hospital-acquired COVID data is not collected or aggregated. Is that still the case, given those likely rates of hospital-acquired COVID from those numbers?

SUSAN PEARCE: Dr Cohn, as you'd be aware, we've written to you as the Chair of this Committee to clarify that information that was released under the GIPAA and also in consideration of the questions that you have asked, and we appreciate your interest in this area. We don't systematically collect COVID transmission in hospital, as we've said. The data that was collected for the GIPAA was prepared for that GIPAA, with a large number of caveats. That is because—and I will get Dr Cretikos to comment further on this because she's far more expert in this area than I am—there are a range of issues with respect to how you can reliably capture that information because of the way COVID behaves.

What is as important, in our view—which is why we have Ms Dempsey here today as an expert in infection prevention control—is how, at a hospital level, you continue to use universal precautions to protect both staff and patients against any transmissible infectious disease. It is something that hospital systems are well practised at, whether it's for MRSA or influenza, the use of universal protections to protect staff and patients alike. So I appreciate it's a very complex area, which is why we wrote to you as the chair of the Committee to clarify our position on this. We maintain the view, and as Dr Chant—she is, for the benefit of the Committee, away on a long-planned overseas trip at the moment. She has tried to explain the fact that we don't systematically collect that information because of all of the issues associated with it. I'll pass to Dr Cretikos.

MICHELLE CRETIKOS: The issue primarily with COVID is that the incubation period for COVID is one to 14 days. It makes it very difficult to determine the number of people who actually acquired COVID in hospital because they may have acquired COVID before presenting to hospital but only became symptomatic some time during that period. Without doing detailed questioning of the patient and their exposures, it's very difficult to know whether somebody acquired it in hospital or prior to hospital. It's more important to be able to act on the information to ensure that the appropriate infection prevention and control processes are in place. Rather than trying to spend a lot of time and effort determining where the acquisition occurred, it's more important to make sure that the appropriate procedures are taking place.

The CHAIR: If I can follow that up, in Victoria they aggregate and report data on hospital-acquired COVID, and their criteria for a hospital-acquired COVID case include symptom onset more than two days after admission, as well as a couple of other criteria. I'm interested to understand what you see as different between New South Wales and Victoria. Why have they got a workable definition to be able to produce this kind of data?

SUSAN PEARCE: Could I perhaps offer some distance here? I've spoken to my counterpart in Victoria with respect to what they're doing there presently. One of the issues is that, during the pandemic, State by State it's fair to say there were differences of opinion about certain elements of the pandemic. I think this is probably one of those. The manner in which Victoria is currently reporting and collecting, it relies on, in my view, knowing that the patient was negative for COVID upon admission. They don't know that. They do not test patients routinely presenting to hospital for COVID.

I've confirmed that with the Victorian Health secretary—on the way here this morning while I was stuck in the traffic, in fact—because I was interested to understand, because I know you have asked that question of us before, why Victoria does that. I was curious to understand, are we missing something here? I think, on balance, it's fair to say that their data, even during the conversation I had with him earlier this morning, is fairly unreliable as a consequence of that very issue. If I go to hospital today, unless you know for certain that I'm negative, how can you make that assumption? I will pass back to Dr Cretikos.

MICHELLE CRETIKOS: I think it's important to note that information may be collected for various reasons and it may be that this may be being used as an indication of further information or further investigation that may need to be done. In my view, it would never be a definitive indication of whether something was acquired in hospital or not. That definition that you've just described is not consistent with most of the definitions that are being applied internationally. It would, again, be non-definitive, which would really be attempting to assign a sort

of probabilistic estimate of whether a person may have acquired in COVID in hospital or not. Two days is extremely early in the incubation period, so I would say, on balance, there would be quite a substantial proportion of people that would probably not have acquired COVID in hospital, but it would all probabilistic. You wouldn't be able to be definitive.

The CHAIR: In the letter that you wrote, Ms Pearce—and thank you for that—you advised that Health had commenced a project to determine the relationship between the data released in response to the GIPAA and the likelihood of the patient having acquired COVID in hospital. Could you update the Committee on what that project involves?

MICHELLE CRETIKOS: That process is underway. We are linking the data that was provided as part of the GIPAA to the notification data that we have to make a better assessment of the timeline between when a notification was first made about COVID, when they were admitted to hospital and their length of stay in hospital. But, again, this is unlikely to be definitive because we would not have sufficient information to determine whether COVID was acquired in hospital or not; it would just allow a slightly greater assessment of the probability of whether COVID was acquired in hospital or not. The information isn't sufficient to make that as a definitive piece of information.

The CHAIR: With the kind of numbers of the GIPAA application over 6,000—I appreciate you've put significant caveats on that data—it's still concerning for the community that there might be as many as 6,000 people catching COVID in hospitals. In what way is that actually impacting practice and infection control in hospitals?

MICHELLE CRETIKOS: I think it may be best to ask Kathy Dempsey if she could talk about that.

KATHY DEMPSEY: In terms of infection prevention and control, we have standard and transmission-based precautions. We've still got contact tracing for any cases that turn positive within our hospitals. That's continued in hospital, and that's a requirement under the guidelines. If we look at comparing the GIPAA data to our incident management, we can at least halve that figure. But, again, to actually go through all of those line by line to determine which exactly were health care acquired would take an awful amount of resources. I guess the determination is whether it's required, and it wouldn't change the guidelines that we currently have in place.

The CHAIR: And you've said that contact tracing is still undertaken for all of the COVID cases, which is excellent. But if contact tracing is being undertaken, surely that can be used to then validate the figures, whether it was hospital acquired or not.

KATHY DEMPSEY: Contact tracing for infection prevention and control is slightly different to public health contact tracing. It's based on the local team and the local program. They'll do line listings and they'll pick up patients who are positive, and then they'll contact trace those that are in immediate. So it's not something that you would collect data on, but it would then be something that you would overlay your infection prevention and control guidelines on.

The CHAIR: If contact tracing for a hospitalised patient involves the people in their immediate areas—I'm thinking about people on a two-bed or a four-bed ward—surely that is useful information to then determine that a case was hospital acquired or not.

KATHY DEMPSEY: It is locally, and it's acted upon locally. It's not something from a statewide perspective.

The CHAIR: If there was interest at a statewide level in collecting that data, could it be acquired from those local practitioners who are doing that work?

SUSAN PEARCE: I think the point that Ms Dempsey's making is that it wouldn't change the guidelines. Fundamentally, obviously—let's be clear—we don't want people acquiring any type of transmissible disease in our hospitals, whether it's COVID, influenza, RSV, MRSA or any of it. But the guidelines exist that protect against all of those things, which is why I talked earlier about the risk escalation panel that we have, so that when we know that things are peaking at a statewide level then—and then we haven't gone back to a statewide mandate of mask wearing for some time, but that's not to say that, at a local level, that wouldn't be mandated. So I think what we're saying is we have an interest in it as well. The collection of the data could be useful for forums like this. But, in practice, we have processes in place to protect our patients and our staff. They're not foolproof. There are always going to be issues, no matter how hard you try, but I think what Ms Dempsey's saying—and I don't want to put words in her mouth—is that it wouldn't alter the way we would act on it.

The CHAIR: I suppose, for clarification—I am a bit of a data wonk, but I'm asking because I'm contacted by the families of people who've died from COVID in hospital, who are seeking reassurance that everything that can be done is being done to prevent that from happening to someone else.

SUSAN PEARCE: And that's why we're saying we have a very robust infection prevention control framework that is acted upon and is taken seriously. I would say that in any circumstance where there is an unexpected death in one of our hospitals, that will be investigated and the health service would be in contact with families throughout. We're very open if we've erred, and we do our best to support people in all circumstances.

The Hon. DAMIEN TUDEHOPE: Ms Pearce, I was asking you just before, in my last line of questions, about the department's position in relation to pill testing, and you indicated that the department would be represented at the drug summit. Does the department have a position which it will be putting to the drug summit?

SUSAN PEARCE: With respect to pill testing?

The Hon. DAMIEN TUDEHOPE: Yes.

SUSAN PEARCE: Not to my knowledge, no.

The Hon. DAMIEN TUDEHOPE: Has the department commissioned any review of the pill testing or substance testing at all?

SUSAN PEARCE: I would have to pass to Dr Cretikos to see if she has a response to that. Not that I'm aware of.

MICHELLE CRETIKOS: In preparation for the drug summit, we have provided some background papers, which are currently available on the NSW Health website, that describe the current situation in relation to many aspects of drug and alcohol treatment and prevention, which includes monitoring and reporting on drug trends in New South Wales, which includes description of potential ways in which monitoring and reporting on drug trends could occur.

The Hon. DAMIEN TUDEHOPE: Specifically, has any work been done to review the data relating to pill testing and substance testing?

MICHELLE CRETIKOS: We currently have processes in New South Wales to monitor adverse events relating to drugs, ingestion of drugs, which includes both clinical surveillance and surveillance of police seizures. We review and act on that information as part of our current processes.

The Hon. DAMIEN TUDEHOPE: I'm asking, though, in terms of a submission to the drug summit. Has the department formed a view about the efficacy of pill testing?

MICHELLE CRETIKOS: I don't think we'd want to pre-empt the discussions that are about to occur at the Sydney forums for the drug summit.

The Hon. DAMIEN TUDEHOPE: Have you done a review which might educate the drug summit in relation to the department's view?

MICHELLE CRETIKOS: As I mentioned, the information about the available processes is available in the background paper, which is available on the Health website.

The Hon. DAMIEN TUDEHOPE: Who would have done that review work? Did you do that work?

MICHELLE CRETIKOS: I didn't personally, no.

The Hon. DAMIEN TUDEHOPE: Who did it?

MICHELLE CRETIKOS: That background paper was prepared by people within the Ministry of Health, drawing on information that is available about the various options.

SUSAN PEARCE: I think, Mr Tudehope, if I might say, that's quite different to the department having a position. The provision of information that is relevant to the attendees at a drug summit is not the same as the department having a position. It is not for us to have a position.

The Hon. DAMIEN TUDEHOPE: Then my point remains. Has the department commissioned any review of the current pill testing arrangements in New South Wales?

SUSAN PEARCE: Not that I'm aware of, but I'd have to take that on notice.

The Hon. DAMIEN TUDEHOPE: Dr Cretikos?

MICHELLE CRETIKOS: I just mentioned that we currently review the information about drug overdoses and drug incidents. That's available to us through clinical and through forensic information that is captured through police seizures and through the Coroner. But I think you're asking a slightly different question.

The Hon. DAMIEN TUDEHOPE: I am. I'm specifically directing a question about whether the department has commissioned a review about the current arrangements in relation to pill testing.

SUSAN PEARCE: I think we'll take that on notice, Mr Tudehope. Not that I'm aware of. Dr Cretikos is referring to—and you'll note, again, through our social media channels and other media releases, we put out alerts if we find, for example, that there are other toxic substances contained in heroin and so on, and that's what Michelle's referring to. We do that now. You're obviously asking about pill testing as it relates to events and so on. We'll take that on notice, but I will restate it is not for NSW Health to have a position. We provide information broadly with respect to what exists in other places, but that's against a whole range of other things. The drug summit that the Government has commissioned will examine matters. It's got independent people reporting, as you know: John Brogden and Carmel Tebbutt. They will take into account what they hear at the drug summit and make some recommendations. We are participating in that process. It is not a matter for NSW Health to predetermine.

The Hon. DAMIEN TUDEHOPE: I understand that. You would be aware, of course, of the Government's final response to the special commission of inquiry. They provided this position:

> The NSW Government does not support substance testing and is not satisfied that sufficient evidence exists to justify its introduction.

That was the Government's position then. Ms Pearce, are you aware of whether that position has changed?

SUSAN PEARCE: No, I'm not.

The Hon. DAMIEN TUDEHOPE: So, as of the second of—

SUSAN PEARCE: I'm sorry, Mr Tudehope. I'm not trying to be difficult but you're losing me. Are you referring to the ice inquiry?

The Hon. DAMIEN TUDEHOPE: Yes.

SUSAN PEARCE: What year was that conducted?

The Hon. DAMIEN TUDEHOPE: We were in government.

SUSAN PEARCE: That's why I'm getting a bit lost, because I'm not sure which government you're referring to.

The Hon. DAMIEN TUDEHOPE: It was the Government at the time, which was the Coalition.

SUSAN PEARCE: You, yes.

The Hon. WES FANG: The better one.

The Hon. DAMIEN TUDEHOPE: Are you aware of whether that position has changed?

SUSAN PEARCE: I think your question would need to be directed to the Government. I'm not the Government.

The Hon. DAMIEN TUDEHOPE: The inquiry was 2020, and I think the response of the Government was in 2022, maybe 2023.

The Hon. Dr SARAH KAINE: Point of order: I think Ms Pearce has indicated that, given—

The Hon. DAMIEN TUDEHOPE: I'm comfortable with it.

The Hon. Dr SARAH KAINE: So there's no question there. It's just that Ms Pearce has already indicated the answer to that, which is not in our tenure. She's not the Government and it's not in our tenure anyway.

The Hon. EMILY SUVAAL: It's out of order.

The Hon. Dr SARAH KAINE: It's out of order.

The Hon. DAMIEN TUDEHOPE: Ms Pearce, in terms of the position taken by the department and in respect of the drug summit, will the department be making a submission?

SUSAN PEARCE: No, I don't believe so, because we're there to assist the Government to run and organise the drug summit, with a large number of attendees and people invited. It is, again, not a matter for NSW Health to put a submission or its view. We are the servants of the government of the day and we will carry out what is determined once approved by the current Government.

The Hon. DAMIEN TUDEHOPE: Has the Minister sought any advice in relation to a potential change in respect of pill testing?

SUSAN PEARCE: Not that I'm aware of.

The Hon. DAMIEN TUDEHOPE: Dr Cretikos, are you aware?

MICHELLE CRETIKOS: I'm not aware of any specific advice. The information that is available currently on the website is factual background information to provide and support discussion at the drug summit.

The Hon. DAMIEN TUDEHOPE: So you would say, as we sit here today, that there is no information available to you, Ms Pearce, which would indicate that the Government expects to make an announcement changing its position in relation to pill testing?

The Hon. EMILY SUVAAL: Point of order: This question is clearly seeking to elucidate an opinion from a public servant about Government policy, which is out of order under the procedural fairness resolution of the House.

The CHAIR: I'll uphold that. Similar to this morning, you might be able to rephrase questions to be suitable for the bureaucrats.

The Hon. DAMIEN TUDEHOPE: If the Government had sought to move to a position where it would change its policy on pill testing—to the best of your knowledge, they haven't sought advice from the department in respect of that position?

SUSAN PEARCE: With respect, I don't think the Government is pre-empting the outcome of the drug summit, and neither are we. I can't add any more to you, Mr Tudehope, I'm sorry. I have nothing to offer in that question.

The Hon. WES FANG: Ms Pearce, born-before-arrival rates—are you aware of what they are in relation to maternity issues?

SUSAN PEARCE: Yes.

The Hon. WES FANG: Does the department track them?

SUSAN PEARCE: If we do, it's not something that I'm currently aware of.

The Hon. WES FANG: So it's not really something that's been raised and addressed within the department?

SUSAN PEARCE: You're talking about babies that might be born on the way to hospital?

The Hon. WES FANG: Yes.

SUSAN PEARCE: Not specifically, no.

The Hon. WES FANG: Is it your opinion that they—sorry, I won't ask your opinion. Do you believe that the rates are increasing or decreasing at this stage?

SUSAN PEARCE: Nothing that I've seen would indicate an increase. But, given that I've just said to you that I'm not aware that we collect that data, it would be very difficult for me to make that assessment.

The Hon. WES FANG: That's totally fine. If you could take on notice what work is being done in the department around the born-before-arrival rates, that would be great.

SUSAN PEARCE: Sure, happy to—noting that not all babies born in New South Wales come to a New South Wales public hospital, to be clear.

The Hon. WES FANG: I appreciate that. I'm just after what data you might have available.

SUSAN PEARCE: Sure.

The Hon. WES FANG: Can you tell me how many maternity services have closed within the last 12 months?

SUSAN PEARCE: I would need to take that on notice.

The Hon. WES FANG: Is there a plan for Muswellbrook to reinstate birthing services?

SUSAN PEARCE: I would need to take that on notice.

The Hon. WES FANG: What birthing services exist at Parkes?

SUSAN PEARCE: Between Forbes and Parkes, obviously over a number of years, given their very close proximity—and both with very nice facilities—there has been quite a lot of work with respect to the birthing

services at both. Unless you know, Mr McLachlan, as a former chief executive there—but it's been a while—I would need take on notice the current arrangements. But, given that we're talking about two facilities that are quite close together, you will appreciate that it has been important over time to consolidate services at one rather than trying to spread them thinly across two. But I'd need to come back to you on the current state of affairs at Parkes.

The Hon. WES FANG: That is quite prescient of you because my next question is this: Is Forbes effectively the new maternity centre for Parkes?

SUSAN PEARCE: I don't know that I would necessarily characterise it in that way, but this is an issue that has been going on for many, many years. The decisions around maternity services in Parkes and Forbes have been discussed for a significant number of years. Partly it's because, as I say, they've got two facilities there that are both very nice. It is well documented that we've had challenges with respect to midwifery in particular across the State, and that is something that's felt right across the country. My point is that we do the best with what we've got. If that means we need to consolidate services in a hospital that is 20 or perhaps 30 minutes away from another in the interests of providing safe care, which is really our priority, then that's what we've had to do. Would we love to have a fully staffed service all over the place? Maybe. But we need to also be mindful of what we're doing with our health budget, which goes back to your time in government. You would be well aware of these issues.

The Hon. WES FANG: That's why I can sense a level of defensiveness.

SUSAN PEARCE: No, I'm not defensive; I'm just tired.

The Hon. WES FANG: It's literally just a question I was just seeking to elucidate on.

The CHAIR: Mr Fang, I'd ask you not to characterise the emotion of the witnesses. I don't think that's in order.

The Hon. Dr SARAH KAINE: It's not in order at all.

The Hon. EMILY SUVAAL: It doesn't add anything.

The Hon. WES FANG: I appreciate that, Chair.

The Hon. Dr SARAH KAINE: It's patronising.

The Hon. WES FANG: I don't want people to feel as if there's a level of attack here. I'm literally just asking some questions.

The Hon. Dr SARAH KAINE: I think Ms Pearce is well qualified to be able to answer your questions, Mr Fang.

The Hon. WES FANG: I appreciate that. She's phenomenal. I genuinely believe that.

The Hon. EMILY SUVAAL: Hear, hear!

The Hon. WES FANG: In relation to what you were saying before, the now Government, when they were in opposition, were quite vocal about their plans for birthing services in rural and regional New South Wales. Ms Pearce, can you tell me what the Government plan is to ensure that rural and regional New South Wales women and their families can birth in or close to their communities?

SUSAN PEARCE: I think I'd take the broader question on notice. Mr McLachlan may be able to assist. One of the things that we're very committed to, and the Government is committed to, is the expansion of midwifery group practice models across the State. We are seeing a number of those increase. Just last week I was down in southern New South Wales and in the Illawarra. We've just started the country's first Birthing on Country service with Waminda. That is also giving access to Aboriginal women to be able to birth on country. So there is a strong commitment to improving the number of sites, particularly for midwifery group practices. But I'll hand to Mr McLachlan for any follow-up.

SCOTT McLACHLAN: There have been some major investments in additional maternity-led care and antenatal and postnatal support services for mothers. That is seeing some significant improvements in those services across the whole of the State. The delivery of birthing services in our hospitals has been challenged by workforce shortages and challenges—both midwives and obstetrician gynaecologists.

The Hon. WES FANG: Again, it is quite prescient that you provided those responses because my next question is when will there be targets, timelines and accountabilities for health services to ensure that rural and regional women and their babies in New South Wales have access to MGP, the Midwifery Group Practice?

SUSAN PEARCE: I don't know that I can characterise that as targets, timelines and accountabilities. We work through the models of care based on local need and based on the staffing we have available. In certain areas of the State, it has been more challenging. Midwifery Group Practice models are very good models. The midwives who work in them enjoy working in them, but they're very labour-intensive models.

The Hon. WES FANG: I think you may have misunderstood the question that I asked, which was when will there be targets? Have the Government indicated that it will, in the funded rollout—

SUSAN PEARCE: I'm trying to answer that question; I didn't misunderstand. What I'm saying is that it's not really a matter of targets. It's a matter of the expectation being put to the health system, as it has been, and then responding to that, and they are. The ministry obviously works very closely with the local health districts in this regard. But to try to put a target on it is a simplification of a very complex issue.

The Hon. WES FANG: You would appreciate, though, that targets, timelines and accountabilities provide for us the ability to measure and judge the rollout.

SUSAN PEARCE: Yes.

The Hon. WES FANG: So that might actually be of assistance when we are looking to see the effectiveness of any program. Are you aware that in New South Wales less than 11 per cent of the models are MGP, and that is one of the lowest figures of the States in the country?

SUSAN PEARCE: No.

The Hon. WES FANG: In relation to Gosford Private Hospital, they have indicated that only a few years after launching their state-of-the-art facilities they are going to close that facility in March next year. Do you see this as a trend that's potentially going to be replicated in other health districts?

SUSAN PEARCE: I don't think I could comment on that. Gosford Private Hospital is not a NSW Health entity.

The Hon. WES FANG: If I extrapolate the answer that you've provided, there is no planning, then? If there is a closure in private hospitals, the public system is going to have to take up the influx of those additional patients.

SUSAN PEARCE: At a local level, in particular areas across the State, there is engagement, hospital to hospital, with respect to what's happening. The private health system has made some commentary with regard to some pressures that they are having around private maternity services. But, in all circumstances where those issues occur, of course we work closely with the private provider to understand what that may look like with regard to our hospitals—Gosford included. We also then would look at any staff who may be looking for a job at our facilities. They are not all the same story. We would work through that on a case-by-case basis. But I don't know that it's reasonable to expect that the State public health system is trying to predict across the State where a private maternity service may no longer be viable and spending time and money in planning for that.

The Hon. WES FANG: But you would also agree that the closure of private centres would mean that there would be an influx into the public system, correct?

SUSAN PEARCE: It may. It depends on where the private maternity service is.

The Hon. WES FANG: Can you provide—and I imagine it will be on notice—how many beds each regional hospital has?

SUSAN PEARCE: Do you mean how many beds in total?

The Hon. WES FANG: Yes, for each regional hospital.

SUSAN PEARCE: Okay.

The Hon. WES FANG: I imagine that's on notice.

SUSAN PEARCE: Yes, I don't have that off the top of my head.

The Hon. WES FANG: No, I didn't expect you would, which is why I suspected it might be on notice.

The CHAIR: Before we come to Government questions, there is a little bit of leftover time. I propose to split that three minutes between the crossbench and Opposition.

SUSAN PEARCE: Dr Cohn, if it may assist you, Mr Minns is ready for the safe staffing question when you are.

The CHAIR: That will take longer than three minutes. I have a question about the Hartley House medical ward at Bellinger River District Hospital. I understand that was closed last year for lift replacement but then remained closed because of staffing shortages. Is there a timeline for the reopening of that ward?

SUSAN PEARCE: I'd have to take that on notice.

The CHAIR: While you're taking that on notice, I have a follow-up question. At the time the announcement was made that it was because of staffing shortages, I'm interested to understand what support the ministry or the department is providing to that local health district to staff that unit. I think people are quite distressed by having to travel to Coffs Harbour.

SUSAN PEARCE: Sure.

The CHAIR: This year there have been more than 80 meningococcal infections in Australia, and I understand that more than 80 per cent of those have been meningococcal B. At the moment, per Health's own public health advice, meningococcal B vaccination is recommended for infants and young children, and young adults living in close quarters, some laboratory personnel and individuals with certain medical conditions, but it's only funded under the National Immunisation Program for people with certain medical conditions and Aboriginal and Torres Strait Islander people. Are enough at-risk people vaccinated in New South Wales?

MICHELLE CRETIKOS: Sorry, do you mean at risk for meningococcal disease specifically?

The CHAIR: Yes.

MICHELLE CRETIKOS: As I understand, the New South Wales rates for meningococcal disease are very similar to the rates in other States and Territories in Australia, and we obviously support the provision of vaccines that are available under the National Immunisation Program, which includes meningococcal ACWY.

The CHAIR: My question is specifically about meningococcal B, which I understand makes up the majority of cases of meningococcal in the last year. Specifically, do you have data on vaccination rates in New South Wales?

MICHELLE CRETIKOS: I'd have to take that on notice.

The CHAIR: I appreciate that this may well need to be taken on notice as well, but have there been particular localised outbreaks or clusters of meningococcal B in New South Wales?

MICHELLE CRETIKOS: I'll take that on notice.

The Hon. WES FANG: Ms Pearce, how many nurses left Blacktown Hospital in 2022?

SUSAN PEARCE: I would need to take that on notice, Mr Fang.

The Hon. WES FANG: Do you think you might be able to come back to me with an answer before we finish at one o'clock today?

SUSAN PEARCE: I'll try.

The Hon. WES FANG: Thank you; I appreciate that. Before the last election, the Premier said that the number that had left was 19, then 25, then 21, then 30. Then he went back to 25 again, then 27, then 29, then 30. And, again, he went to 33 and then 31. Did he receive any advice from the department before making those claims public at press conferences?

The Hon. EMILY SUVAAL: Point of order: The question, as I understood it, related to questions that the now Premier made in opposition. Although, to be fair, it wasn't quite clear to me what the question was and how it related to the Consolidated Revenue of the Health budget.

The CHAIR: I remind Committee members that, in the absence of the Minister, questions need to be framed appropriately for departmental witnesses.

The Hon. WES FANG: Chair, I think I was framing it correctly. It's clear that the number of nurses that were claimed by the now Premier to have left Blacktown Hospital varied in the lead-up to the election. I'm now seeking clarity about the number of nurses that left and whether any advice was given to the now Premier before he made claims to the public prior to the election.

SUSAN PEARCE: Mr Fang, if I can be clear, you're asking us to tell you whether we gave the current Premier, when he was the Leader of the Opposition, information from the department in the lead-up to an election campaign?

The Hon. WES FANG: I think I already know the answer.

SUSAN PEARCE: The answer is no.

The Hon. WES FANG: That's what I would have understood, which is why I think it's interesting that the Premier made those claims.

SUSAN PEARCE: You'll have to put that to the Premier. I'm sorry. We are not—

The Hon. WES FANG: I probably will, but what I need—

The CHAIR: Mr Fang, to the point of order, I'm going to rule all of the parts of this question about claims made by the Premier when he was in opposition out of order. There was a part of the question relating to the nursing workforce at Blacktown Hospital that's potentially in order if you want to continue.

The Hon. WES FANG: I think I got on record what I needed to get on record. I appreciate that.

The Hon. DAMIEN TUDEHOPE: You were asked some questions about meningococcal, Ms Pearce. Would the department support a statewide meningococcal B vaccination program?

SUSAN PEARCE: Mr Tudehope, we've responded to questions about vaccinations in this Committee previously. Our position, generally, is that we look to the Commonwealth and their PBAC processes to determine vaccinations that are rolled out across the country because it is a very difficult situation. We experienced this over a number of years with States jumping out and giving free vaccinations for this and that that are outside of those Commonwealth guidelines. Obviously, we would comply with whatever the Commonwealth puts forward, but we prefer that the process is managed in a systematic way and advised to the whole country rather than going on a State-by-State basis.

The Hon. DAMIEN TUDEHOPE: Potentially, it could be a fifty-fifty split of Commonwealth funding—

SUSAN PEARCE: I couldn't comment.

The CHAIR: That brings us to Government questions, if there are any.

The Hon. EMILY SUVAAL: We have no questions, Chair.

The CHAIR: There being no Government questions, we will go to morning tea.

LUKE SLOANE: Sorry, Chair, can I make two points of clarification in support of my midwifery colleagues back to Mr Fang? Midwifery group practice is just one continuity of care practice for midwifery across New South Wales. In regional areas it needs to be based on the place and needs, so there are probably about five or six different continuity of care practices, of which midwifery group practice is but one. It needs to reference the population and be supportive of whatever that region is—one town, one town, sort of thing.

The other point of clarification that Ms Dempsey and I have talked about previously is that, although we keep using it out of respect, I think the term "universal precautions" is very outdated—back to the 1990s. Now it is "standard precautions", and there's an infection control policy in place for NSW Health and an infection control handbook. There are six or seven basic, fundamental things. I just mention that because you asked about implementing that. That's always in play for NSW Health facilities: There is a baseline of standard precautions, which includes respiratory, personal protective equipment, handwashing and several other fundamental components of infection prevention and control. I just wanted that for clarity of the record.

(Short adjournment)

The CHAIR: Welcome back, everyone. We're going to start with questions from the crossbench.

Ms CATE FAEHRMANN: Good morning, everybody. I wanted to start with some questions about the media release that was issued, I think, overnight or yesterday in relation to the drug summit funding—or funding at the week of the drug summit. It says:

> … $224 million funding boost from the NSW Government to enhance health services over four years, including $78 million in Greater Sydney.

Then it lists a range of different treatment services, and what have you, that this money is going towards. How much of that is new money and how much of it is a part of what the Government has already announced two years ago in terms of the $500 million ice inquiry funding that came out of that process? Is any of this new, or is that just continuing to roll that out?

SUSAN PEARCE: Are you happy to take that, Michelle?

MICHELLE CRETIKOS: I understand that that funding is the response to the special commission of inquiry funding that is being continued to be implemented across New South Wales.

Ms CATE FAEHRMANN: I asked some questions last—I think they were questions on notice, actually, that weren't part of budget estimates last July. There wasn't too much of a breakdown, but, for example, part of that said—let's just choose one. I'm just trying to work out how much is being allocated per year and how much is still to be allocated of that $500 million funding. When I asked about it last year, the answer I got back—let's take the MERIT program. It said that $29½ million, approximately, was going to go to public sector and NGO health services to support court diversion programs, including the Magistrates Early Referral into Treatment and Drug Court Dubbo and Sydney. The announcement today has $4½ million for the expansion of access to treatment and support. That $4½ million, can I ask, is that the first part of that $29½ million? Is it the second tranche for the next year? I assume it is part of that $29½ million.

MICHELLE CRETIKOS: I'd have to take that on notice to be absolutely sure.

Ms CATE FAEHRMANN: Just to be clear, the $224 million funding in the media release sent out today is not new money. That's just a continuation of the $500 million ice inquiry funding rollout. Is the $225 million just the one year, or is it an announcement that this is the remaining expenditure for the next 2½ years, three years? Are we expecting more announcements, or is this it?

MICHELLE CRETIKOS: I'll just take on notice to get the exact clarification of which part of the funding is for which year.

Ms CATE FAEHRMANN: Just so you're aware, I will be putting in supplementary questions asking for a lot of detail for the breakdown in this funding. I have spoken with numerous representatives of organisations, as well as alcohol and other drug services and advocacy groups, that say the transparency around exactly how this $500 million funding is being spent and the improvements in terms of outcomes for the alcohol and other drug sector and for clients is very opaque. If I put in supplementary questions—and maybe Ms Pearce might direct this to you—is it possible that we're at a position now where we can get a detailed breakdown, so that the community knows where the money is going, what's working and what isn't, to have all of that transparency around what is a significant amount of additional funding, and to make sure that it is additional?

SUSAN PEARCE: We'll take that on notice, Ms Faehrmann, and do our best for you.

Ms CATE FAEHRMANN: Last year I asked for that detailed breakdown and got a not-detailed breakdown. The question is what are the additional supports and services that would not have been provided without that $500 million. A lot has gone to the LHDs, as you're aware. In my questions last year, there was approximately $196 million that was going to the LHDs to support alcohol and other drug treatment and support services. Is there somewhere that lists what additional services have been provided in terms of the LHDs for that funding? Is there a separate reporting requirement for that funding to be able to prove that? You would think the Government would want to know this and for them to come back and say, "Here's what we've done against the $500 million, and here's what's working and what isn't." I am assuming that is happening.

SUSAN PEARCE: We'll take that on notice and come back to you with the specifics. Clearly, whenever there is government funding announced for enhancements or, indeed, election commitments, we do track that money to make sure that it's being directed to the place that it's intended. We're happy to come back to you on that one on notice.

Ms CATE FAEHRMANN: Thanks, Ms Pearce. I can assure you the answers aren't just for me in terms of the interest. There is a lot of interest out there for this. I want to turn to pill testing or drug checking. Has NSW Health undertaken any investigations into how a drug checking service would operate in New South Wales if the Government was to change its policy and allow it?

SUSAN PEARCE: I might pass to Dr Cretikos on that one. We did answer a series of questions before the morning tea break with respect to pill testing.

Ms CATE FAEHRMANN: My apologies.

SUSAN PEARCE: No, that's quite all right. We made it clear that NSW Health is not making a submission to the drug summit, nor is it up to us to put forward a view. But we have provided papers for the purposes of the drug summit, which are publicly available on our website, so that those attending can have a look at a range of things to see what's happening in this space. But I'll pass to Dr Cretikos, who is here in the absence of Dr Chant, who is currently on a well-deserved break.

MICHELLE CRETIKOS: I'll just reference again the background paper that's made available, *Monitoring and reporting on drug trends in NSW*. It's available on the NSW Health website. It describes various

mechanisms for monitoring and reporting, which would include the current processes for monitoring and reporting that I referred to earlier, as well as some of the information that we've collected about various ways of conducting drug checking services.

Ms CATE FAEHRMANN: When you just said, "various ways of conducting drug checking services", did you say that was available on the website?

MICHELLE CRETIKOS: Yes, that's correct.

Ms CATE FAEHRMANN: What is the document or report called?

MICHELLE CRETIKOS: It's called *Monitoring and reporting on drug trends in NSW*.

Ms CATE FAEHRMANN: Speaking of that, I have noticed that over the past couple of weeks, there have been several more New South Wales drug alerts, including one just a couple of week ago that there were multiple heroin overdoses following use of cocaine. That was issued on 21 November. There were also nitazenes causing overdoses in people. Those are fake oxytocin tablets. That is a slightly different issue, but still nitazenes in the drug market. How concerned is NSW Health about this summer in terms of contaminated drugs in the common recreational drugs market? How concerned is NSW Health?

MICHELLE CRETIKOS: I think we have and continue to treat this as a serious issue and a public health concern. We do have surveillance and warning systems in place to ensure that whenever we become aware of a new or emerging issue, we can make information available to the community and to clinicians to ensure that people can take appropriate precautions—including, for example, carrying naloxone—and that clinicians are aware of unusual circumstances such as heroin in cocaine.

Ms CATE FAEHRMANN: But is NSW Health getting information or is it worried that this summer there may be an increase in overdoses as a result of what seems to be an increasingly contaminated illegal drugs market?

MICHELLE CRETIKOS: I think we are maintaining all of the processes that we would normally have in place. I don't think that there is a particular concern, other than the obvious general concern that people may experience substantial, severe adverse effects because of unusual or unknown substances that may be circulating.

Ms CATE FAEHRMANN: Are you getting information from the police or Federal Police, for example, that this summer we could have more contaminated drugs on the market than previous summers?

MICHELLE CRETIKOS: I'm not aware of any advice that would indicate that there was something particularly unusual to be aware of for this summer.

Ms CATE FAEHRMANN: So NSW Health isn't getting any advice from the police or the Australian Federal Police—I assume it's probably the Australian Border Force or the Australian Federal Police—expressing any concern about increasingly contaminated drugs on the market?

SUSAN PEARCE: Ms Faehrmann, we might take that on notice, just so, for the abundance of caution, we can give you the correct answer. But what we're saying is that we're not aware of anything in particular in that regard. But if you could just allow us to check our systems to make sure that we're correct on that, we would be very happy to come back to you. If we can do that before the end of the hearing, we'll do so.

Ms CATE FAEHRMANN: Back in May, the Australian Federal Police and Australian Border Force issued a media release entitled, "Rising imports of potent drug nitazene raises concern." I assumed they would also be communicating with NSW Health and the health agencies. Can I just check, Ms Pearce, whether there is a multi-agency group that gets together to talk about the illegal drug market and issues pertaining to that and what to look out for? I'm sure there is such a committee or working group. Is that correct?

SUSAN PEARCE: To the specifics of your question, could you allow me to also confirm that? I will do that before the end of the hearing.

Ms CATE FAEHRMANN: About the working group with the police?

SUSAN PEARCE: Yes.

Ms CATE FAEHRMANN: I want to turn to the issue of PFAS. Does NSW Health have a particular fact sheet on PFAS, or are you now directing people to the Australian Federal agency for their fact sheet on PFAS?

MICHELLE CRETIKOS: I think we generally direct people to the Australian Government information, but I'd need to check whether we have a specific one or not.

Ms CATE FAEHRMANN: Is there a reason why? NSW Health has its own fact sheets on a huge range of things. Why, for this, are you directing it? Where do you draw the line in terms of what you issue fact sheets on and what you refer to the Federal health department? For most things you would have a NSW Health fact sheet on issues of concern, wouldn't you?

MICHELLE CRETIKOS: Not necessarily. It depends on whether there's information that would need to be specifically tailored to New South Wales. If the information is already available publicly through other government agencies, then we would generally refer to that information.

Ms CATE FAEHRMANN: So there was a NSW Health PFAS fact sheet. There used to be one. There was one at least up until April this year. However, I understand that the Hunter New England LHD—I do have some emails in front of me because I've started to get back the batch of documents from the SO 52 on PFAS. That's all started to come back; there's lots of boxes to go through. Initially, there's concern raised by the Hunter New England LHD, asking or suggesting that the NSW Health PFAS fact sheet be updated to perhaps incorporate the IARC—the International Association for Research on Cancer—decision to update PFOA and PFOS. Since then, it appears that NSW Health has actually withdrawn its fact sheet, as opposed to updating it. Would that be a correct assumption?

SUSAN PEARCE: Ms Faehrmann, I think we're going to have to take it on notice. I can see that NSW Health has got the latest guidance on PFAS in drinking water and refers to the NHMRC-proposed guidelines released on 21 October this year. But you will appreciate that it's a complex multi-agency issue; it's not just resting with NSW Health. If we could just come back to you on notice with the specifics around our updated guidelines, we'd be very happy to do that. Obviously the NHMRC release is relevant to this and that's only at the end of October this year, so it would be useful if we could review that and come back to you on that one.

Ms CATE FAEHRMANN: Okay. I might put in some questions on notice. St Vincent's Health Network was provided with $1.63 million over three years to deliver the service, which was the health intervention appointment for the EDDI scheme—the Early Drug Diversion Initiative. We've spoken about this before in budget estimates that a very surprisingly low number of the thousands upon thousands of people who were caught using or possessing a small quantity of drugs by the police—a very low number—has accessed that service. Do you have an update on how many have actually attended the health intervention service at St Vincent's?

MICHELLE CRETIKOS: Again, there's public information on the drug summit in the background papers. It has a fact sheet on drug data trends and the criminal justice system, which includes information about the diversion programs. That would be the latest information available.

Ms CATE FAEHRMANN: I did have a look at those documents. Thank you very much for producing them. I would suggest it's probably roughly the same amount—maybe 25 or 30, something like that but not very much—unless something has changed significantly. An amount of $1.63 million over three years to provide that health intervention service is quite a lot of money considering, on average, it would seem that the service might get one call a week. What else is St Vincent's Health Network doing with the $1.63 million? Have you enquired about that?

SUSAN PEARCE: We would have to take that one on notice, Ms Faehrmann, and come back to you on that as well.

Ms CATE FAEHRMANN: With the information that NSW Health provided via the email that went out to the Sydney attendees of the drug summit—which I think went out on Friday—linked to those information packs, which you have rightly pointed out to me. They're very useful. When were they finished and when did they go up on the website? Was it on Friday?

MICHELLE CRETIKOS: I believe the background papers went up the Friday before, but I'd need to double-check that. We made them available to registered participants shortly after that.

Ms CATE FAEHRMANN: Yes, you're right. It was the twenty-second. I'm getting my dates confused. Is there a reason why they weren't provided in time for Griffith and Lismore? How long has NSW Health been working on pulling these documents together?

MICHELLE CRETIKOS: There was a process to finalise. These background papers have been oversighted by an interagency committee, and only once the approval for release was obtained did we put those up.

The Hon. DAMIEN TUDEHOPE: I'm going to ask a couple of questions on the IVF program. Who made the decision to cut the rebates in relation to that? Was that Health generated or was it Treasury?

ALFA D'AMATO: I need to take this on notice because I believe that there was a continuation of the scheme.

The Hon. DAMIEN TUDEHOPE: The variation of the scheme, but it was the decision to move to a new scheme motivated by Health or by Treasury?

ALFA D'AMATO: Can I take that on notice?

The Hon. DAMIEN TUDEHOPE: Yes, sure. The second thing is that there was a proposal that when 12,000 women had accessed the scheme, there would be an evaluation of the scheme. Has that been done?

SCOTT McLACHLAN: I'm not aware of an evaluation, but there has been a reframing of the scheme to be means-tested. That comes into effect from around—

The Hon. DAMIEN TUDEHOPE: No, I'm aware of the new scheme or the new details; I just wondered what the position was in respect of the program in its former state. Had any evaluation been done of that program?

SCOTT McLACHLAN: I haven't got that information.

The Hon. DAMIEN TUDEHOPE: Ms Skulander, could I return to you for half a moment? You told us earlier that there were various options available and a briefing had gone to the Minister.

EMMA SKULANDER: In relation to?

The Hon. DAMIEN TUDEHOPE: The birthing unit at Rouse Hill Hospital.

EMMA SKULANDER: A briefing has gone to the Minister. Whether the Minister has received the briefing or not, I'm not sure. It's in the approvals chain.

The Hon. DAMIEN TUDEHOPE: But a briefing has gone?

EMMA SKULANDER: In relation to the options, I think I was referencing the scope of what would or could be provided with birthing services.

The Hon. DAMIEN TUDEHOPE: Can you give us some detail in relation to those options?

EMMA SKULANDER: I guess the point to make is that when providing a birthing service at a hospital, it isn't simply the birthing service itself.

The Hon. DAMIEN TUDEHOPE: Those wraparound facilities.

EMMA SKULANDER: It comes with a suite of other things as well as the workforce that would be required with that as well. So the brief outlines all of that within there and provides that advice to the Minister.

The Hon. DAMIEN TUDEHOPE: Can you provide a copy of that to the Committee?

EMMA SKULANDER: I will have to confirm that. I can take the question on notice to confirm if I'm able to provide the brief.

The Hon. DAMIEN TUDEHOPE: In terms of the proposal which you have put to the Minister, have you outlined the various funding options in respect of those options which you have identified?

EMMA SKULANDER: No, my request from the Minister was to provide an outline of what would be required to provide birthing services at Rouse Hill, and that's the question that's answered within the brief.

The Hon. DAMIEN TUDEHOPE: But are you aware that, potentially, in terms of the options, the cost of the options of providing that new birthing unit at Rouse Hill Hospital is about $200 million?

EMMA SKULANDER: I am aware that there is a proposal within that brief around a suite of services that can be provided, and the number there, I think, is Cabinet in confidence or a confidential number, but I will take that one on notice and confirm.

The Hon. DAMIEN TUDEHOPE: So this is something that has gone to Cabinet?

EMMA SKULANDER: The briefing itself is to inform the Minister, and I don't know the answer to the question.

The Hon. DAMIEN TUDEHOPE: Ms Pearce, can I come back to you in relation to LHD budgets. Are you able to provide any advice about how many local health districts are currently over budget? Or perhaps that's something for Mr Daly, I don't know, or Mr D'Amato.

SUSAN PEARCE: It's probably something for our chief financial officer.

ALFA D'AMATO: We regularly work with the districts in particular throughout the financial year to assess their budget positions, so I can take that on notice. Ultimately, the annual report, which was tabled to Parliament a few weeks ago, will include the financial position of each district in their reports. That's for the last financial year.

The Hon. DAMIEN TUDEHOPE: To your knowledge, are any over budget?

ALFA D'AMATO: I think that there is pressure, yes.

The Hon. DAMIEN TUDEHOPE: Which ones?

ALFA D'AMATO: I think that it's too early to say, given that we still have seven months left in the financial year to determine who is going to land over budget. Historically, there has been pressure across a number of districts. We tend to see pressure where there is extra activity or where there are new builds. We obviously tend to manage at the aggregate and, at the aggregate, we manage the budget.

The Hon. DAMIEN TUDEHOPE: You're the person who monitors this?

ALFA D'AMATO: Yes.

The Hon. DAMIEN TUDEHOPE: Which ones are under pressure?

ALFA D'AMATO: I think that there are numbers but for different reasons. So I guess—

The Hon. DAMIEN TUDEHOPE: Give me an example of one that is under pressure and why.

ALFA D'AMATO: Probably one that comes to my mind might be one like Nepean Blue Mountains. The pressure is predominantly due to the fact there has been a large development, and we're monitoring with the district the performance and the impact that the large development has on the operating budget.

The Hon. DAMIEN TUDEHOPE: That's one. Are there any others?

SUSAN PEARCE: I think, if I may, Mr Tudehope, the point that Mr D'Amato's trying to make is that they're not all equal. Where we've had, historically, budget pressure is often associated with significant capital programs, which then drives increased operational cost. I think Nepean is a good example of that at the moment. We are still, as is the rest of the country, normalising our budget profiles against the backdrop of the pandemic, and there is no question that the pandemic disrupted our financial position. You are aware of the increased amount of money that the health system received during that time. As you're also aware, with the surgical catch-up that we were required to perform, the increase in activity associated with that is quite substantial.

So this time of the year is a difficult time of the year for you to be asking us that question, because we're coming off winter. We get through the summer period, and then we start to see a truer picture form, and it's really not until we get close to the end of the financial year that we can talk with great certainty around what the district picture looks like. Part of the reason for that is the districts cashflow their budget arrangements differently. They're not all the same, and so the wash-up of that, in addition to further budget supplementations that may occur, just as we discussed this morning—the additional $200 million that we have just been given from Government will be distributed across the system. That will also alter their current budget position. We're not trying to be difficult with respect to how we answer this question, but the reality of it is it's not a straightforward picture across the system.

The Hon. DAMIEN TUDEHOPE: I understand it's tricky. But the on-ground experience in relation to exactly what you've said is that CEOs or chief executives will be making decisions with an eye to whether their budgets are over budget at a particular time, and there are two things. They can have an expectation that they will receive more money next year in respect of their budget or, alternatively, they've got to start to look to be making savings. In your experience, Ms Pearce or Mr D'Amato, what is it? Are they going to be receiving more money next year, or are they going to be asked to be making savings?

The Hon. Dr SARAH KAINE: Point of order: That question is very hypothetical. It's about what might be happening at a later point in time, when particular things might happen across a period of time for the next budget. I'm not sure that's reasonable to ask.

The Hon. EMILY SUVAAL: To the point of order: It's completely outside the terms of reference for the scope of this inquiry, which is the consolidated revenue of this budget, not what might be in the next budget.

The CHAIR: I don't think the question is out of order, but I appreciate it may be very challenging to answer, and I'm happy for the witness to answer as they see fit.

SUSAN PEARCE: I think Mr D'Amato can assist in terms of how we look at this year against last year's budget with respect to the percentage increase in the overall health budget. I think that is relevant to your question.

We can't, obviously, pre-empt what Government may determine with respect to our budget next year. Obviously, the other factor sitting in amongst all of this is the current discussions with the Commonwealth with respect to the National Health Reform Agreement, which is another factor that's playing into the health budget at the present time.

What I will say, though, is this: As a person who's worked in the New South Wales health system for more than three decades, it has always been incumbent on chief executives to manage their budget in the interests of the public of New South Wales. That includes sensible financial management. It also includes—and this is something we pride ourselves on here—keeping our patients and our staff safe, regardless of the budget position. So we take that very seriously. I think, during the pandemic, the budget arrangements were in a very different space, and the way that we were spending money was quite different. We are now drawing our system back to a normalised budget position. But, Alfa, if you could just comment with respect to the percentage increase now with this latest enhancement, against last year, that might be useful for the Committee.

ALFA D'AMATO: Certainly. The underlying budget has increased by 5 per cent, as you might have seen in the budget papers. With the addition of $180 million that was allocated for additional activity, that percentage is moving more towards 5.7 per cent. That's the increase year on year, and that's the growth rate that we have in this year's budget.

The Hon. DAMIEN TUDEHOPE: I understand all that, Ms Pearce, and I'm not reflecting in any way about how seriously you take your obligations to patients within the public health system. What I'm saying is, though, there will be targets, for example, about elective surgeries. Are there any targets which are set for LHDs, in terms of where they would go with elective surgeries?

SUSAN PEARCE: We purchase a volume of surgery from districts as part of the annual service agreement process. Matthew can contribute further to that. We then expect them to perform against that purchased activity, and part of this latest budget enhancement that we've just received will be to address areas where they are over activity, where we've got an increased number of overdue patients and so on. But, Matthew, did you want to comment further about that?

MATTHEW DALY: Yes. I think recent announcements really typified the process. That was, with the issuance of the budget, three or four months activity under our belt. It was pretty clear that a number of the LHDs—not all—were going to struggle to meet unplanned presentations, in addition to the known, planned or elective surgical demands, which are all very predictable.

The Hon. DAMIEN TUDEHOPE: Which ones?

MATTHEW DALY: I haven't got the whole list in front of me. But I can say—

The Hon. DAMIEN TUDEHOPE: Can you take that on notice?

MATTHEW DALY: Yes. We can give those who are projecting on zero that I'd spoken to earlier. But it was after—

The Hon. DAMIEN TUDEHOPE: But those ones that aren't also on track.

MATTHEW DALY: Yes. They're not on track now. They may be on track in December or March or June. Every LHD has given me projections right through to June. But, when it became that apparent, we engaged through our Minister to Government. I guess that was the response that we've seen, with the announcement last week, and now I have immense confidence that all planned surgeries will revert to pre-pandemic levels.

The Hon. DAMIEN TUDEHOPE: Can I just go back and ask some questions about, this time, the Milton hospital? The chief executive of the Illawarra LHD has suggested that birthing services will not return to Milton Ulladulla Hospital. Is that correct?

SUSAN PEARCE: I would need to check what the chief executive has said. I know that there has been ongoing discussion at Milton Ulladulla for quite a long time with respect to its birthing services, and the district is committed to identifying a model that is safe and effective and sustainable. So they're looking at the models as part of the draft health services plan. But, beyond that, I'd have to take that on notice.

The Hon. DAMIEN TUDEHOPE: I accept what you say, but I'll tell you what she said to a community forum. She said, "As outlined during the recent community consultation, the current hospital does not have the appropriate facilities to safely resume birthing services." Is that accurate?

SUSAN PEARCE: Again, I would have to seek more information and come back to you, Mr Tudehope. I don't want to pre-empt what has been said. When was that said?

The Hon. DAMIEN TUDEHOPE: I'd have to come back to you with the date in relation to that, but I will confirm.

SUSAN PEARCE: I'm asking the question because the issue of birthing at Milton has been a longstanding issue.

The Hon. DAMIEN TUDEHOPE: There are various public statements in relation to the manner in which—because the current Government did make a commitment to return those birthing services to Milton hospital, did it not?

SUSAN PEARCE: I would need to take that on notice. I'm not sure what they've made a commitment about with respect to Milton.

The Hon. DAMIEN TUDEHOPE: Currently, of course, there's a suggestion that because of the absence of birthing services at Milton Ulladulla Hospital mothers are being asked to consider having their birthing at home. Are you aware of that?

SUSAN PEARCE: We do provide home birth services across NSW Health, but it is not the situation that, in the absence of providing in-hospital birthing services, we expect people to birth at home. Birthing at home is not for everyone. We respect that, obviously. The reason I'm asking you about the timing of that comment is because the issue of birthing at Milton hospital has been going on for many, many years, certainly well before this current Government was in place. So we have had arrangements for women for birthing at other hospitals within the Illawarra. If a woman wanted to have a home birthing arrangement, of course where that is possible we would support that, but that is not our alternate model to in-hospital birthing services. I want to be very clear about that.

The Hon. DAMIEN TUDEHOPE: It wouldn't be my preference.

SUSAN PEARCE: Nor mine. I wouldn't expect that you would have a preference on that, but it certainly wouldn't be mine.

The Hon. DAMIEN TUDEHOPE: Well, I've been at quite a few. To return to that quote, it was today that the chief executive made that observation.

SUSAN PEARCE: I'm happy to follow up with her and understand what's happening. I do know that, as I said at the start, there's been a community consultation around services at Milton. So I'm happy to come back to the Committee on notice on that one.

The Hon. DAMIEN TUDEHOPE: Mr Minns, I would hate you to think that we had neglected you. You did make some observations in relation to some potential offers to RN1s and RN2 nurses for the purpose of negotiations with the Nurses and Midwives' Association. Do you recall telling me that earlier?

PHIL MINNS: Yes, Mr Tudehope.

The Hon. DAMIEN TUDEHOPE: Are you able to provide me with a copy of the proposal which was put to the association?

PHIL MINNS: Well, as I indicated earlier, it was a sort of table of options that was presented as a PowerPoint deck. I think I would need to seek advice on whether or not I can share that, given that it was done within good faith bargaining between the Government and the association.

The Hon. DAMIEN TUDEHOPE: Well, transparency is always part of good faith. Could I ask you something else, Mr Minns? The Premier made some observations in relation to non-frontline staff working from home. What percentage of non-frontline staff are currently working from home?

PHIL MINNS: I couldn't give you the percentage but I could talk to you a little bit about that entire issue, if that would be helpful.

The Hon. DAMIEN TUDEHOPE: The Premier mandated in August last year that non-frontline public sector workers would return to the office at least three days a week. Has this been implemented by the department to date?

PHIL MINNS: Broadly, yes. In many respects, noting that the number of clinical and non-clinical staff in NSW Health is not very large, most of them have been working—if they have been working from home—in a hybrid arrangement. The circular that was issued by the Premier's Department secretary required us to revisit our policy with a focus on achieving a stronger workplace presence, and so we've largely done that. We consulted with both our unions and our workforce. We got many hundreds of pieces of feedback. Certainly, our major unions offered feedback. We're at the point where we're about one to two weeks away from having consolidated all that

feedback and made adjustments to the proposed flexible working policy, and it will then be published and distributed and fully rolled out.

The Hon. DAMIEN TUDEHOPE: Do you keep data on this, though?

PHIL MINNS: We have some data in relation to 1 Reserve Road. What I would advise about 1 Reserve Road is that when we moved in during the first year of the pandemic, we developed the site, or the building, as an activity-based working arrangement, which means that, in terms of the number of staff allocated to the building, we would expect that around about 80 to 85 per cent would have been in attendance as a maximum at any one time, given out-of-office meetings and various issues.

When we moved into the building, we had about 2,200 staff allocated to 1 Reserve Road. We now have more than 4,000 allocated to 1 Reserve Road. That's a reflection of decisions that were taken during the pandemic when other leases were coming up for renewal, where we had staff largely working from home for a significant part of the time. In those circumstances, we didn't think it was a good use of public funds to keep extending leases, so we reallocated staff back to 1 Reserve Road as their primary place of work. Clearly, we don't want them all to attend on the same day, because we have effective accommodation for about 2,200 and we've got 4,000 allocated to the building.

What we're trying to do, and we have commenced doing, has produced an increase in the number of staff in the order of 300 to 400 that are attending the building. But if we look at the most recent data I saw, more than I think 3,300—I will confirm that number for you—were attending the building. So, in large measure, we already had a kind of hybrid arrangement. There would've been not many people that we supported working permanently from home. We've started making it very clear since the Premier's Department circular, even while we worked through the revision of our policy and consultation on it, what the intent of that direction was. As a result, we've started to try and encourage our executive directors and directors to work with their teams to get a balanced attendance across the week.

The Hon. WES FANG: It looks like Mr Minns is working from home today, indeed.

PHIL MINNS: I'm working from home because I'm incapacitated. Moving anywhere significant is a bit of a challenge.

The Hon. WES FANG: I appreciate that.

The CHAIR: We're all able to participate by videoconference in 2024, including Committee members. I will come back to abortion. I asked a question about it this morning. It's come to my attention that the Parliament published on its website while we've been in this hearing the document that I was seeking, which was tabled in the Legislative Assembly on Friday, which was the *Report on the Statutory Review of the Abortion Law Reform Act 2019*. In particular, I'm interested in the recommendation that the Ministry of Health explore ways to increase understanding and awareness of section 9 of the Act, being conscientious objection. The reason for my question is something that was described in some really excellent peer-reviewed research, which I might seek to table at the end of the hearing. This is from the journal of *Rural and Remote Health* from Dr Anna Noonan, who is topically based in Orange, who essentially described obstruction from conscientious objectors who are in senior leadership positions in hospital management. How do you see that that might be addressed through the policy documents and training?

SUSAN PEARCE: Thank you for the question, and thanks for raising that again because it was on my list to come back to for you today. Can I start by saying, though, that the report also finds that, overall, the Act is operating well with regard to improving the legislative access and treatment for terminations of pregnancy. The three recommendations—we'd already covered off on the nurse practitioners this morning. The issue you've referred to—I've had a look at section 9 of the Act. It's quite clear that it refers to conscientious objectors ensuring that, if they wish to object, they then notify the woman of that and give them options for where they can seek assistance and help. I think there are two different things here. One is that it is not a matter for hospital managers to make decisions as a conscientious objector with regard to the provisions of abortion care in the health service. I will be very clear about that. There is no manager in New South Wales that has the ability to make that decision.

With respect to clinicians, certainly that is clearly an issue. We respect the fact that people have different views on this topic. I think we need to do more, as the report highlights in these recommendations, to ensure that if a clinician wishes to object or does object, that they are aware that it is also incumbent on them to assist that woman to find care where they need it. We will definitely, as part of the other work that we're doing around abortion care, take that on and seek to improve the general wayfinding—I don't like that turn of phrase, but I think you understand what I'm getting at—and that the access to those services is made clearer to women, including how that contends with conscientious objection.

The CHAIR: I understand that Mr Minns had an answer to the questions I asked this morning about the safe staffing level rollout.

SUSAN PEARCE: Yes, thank you very much. Phil, over to you for safe staffing levels.

PHIL MINNS: As at about two weeks ago, 21 November, we have worked through the rollout of safe staffing levels at 17 level 5/6 emergency departments and we have allocated 473.92 FTE to be rolled out at those sites. As at 21 November, 112.81 FTE have commenced in roles. I can take you through the 17 or I can provide it on notice; whatever you prefer, Chair.

The CHAIR: Can I just clarify? You said 112-something FTE have commenced. Does that mean the remainder are new vacant positions that are currently recruiting? What's the status of the remainder?

PHIL MINNS: That's correct, they're in recruitment. The earliest implementation dates were Liverpool and Royal North Shore. They date back to 2 May when they were allocated their FTE. As an illustrative case, Liverpool has commenced 34.32 FTE of an allocated total of 35.83, so they are very close to the full complement. Then we rolled out to Port Macquarie and Lismore in July; Coffs Harbour and RPA in August; John Hunter, Bankstown and Campbelltown a week later in August; Wollongong and Tamworth in early October; Gosford, Wagga Wagga Base, Nepean, St George, and the Children's Hospital at Westmead all commenced in early November; and Orange commenced and had their allocation on 18 November. It does obviously take time to recruit to the roles. Liverpool is the closest to a full complement at this stage, but we continue to work through.

Just by way of illustration, Orange was probably due to occur in the same first week of November, but there were some matters raised locally and with the association that needed another deep dive, which those councils did jointly, and they eventually resolved the position on the number of FTE that needed to be allocated. There are a further eight, or thereabouts, of level 5/6 EDs that are still in development, and the Minister has asked that we turn our attention to the level 3/4 emergency departments. We will try to finish the eight and then we will move to the 3/4 from about April next year. I make the point that the time to people actually being employed on the ground—from the evidence I've seen—is a pretty substantial improvement on what was achieved in other jurisdictions that have moved to a similar staffing model.

The CHAIR: I appreciate you being able to get that list today, rather than us waiting three weeks for answers on notice, given the time of year. Just to clarify, those are all talking about emergency departments. Are there plans yet for other departments?

PHIL MINNS: There are 17 sites that are level 5/6 emergency departments, and the next candidate for rollout are the 3/4 emergency departments. In part, there's a process whereby we agreed with the association—or the task force members do—about treatment spaces that safe staffing levels should apply to, and that is done in a very rigorous way, involving local people. That's the work that we have to do. We've also rolled out about 50 roles that we would describe as support to implementation at LHDs because it is a major, significant change and it does need to be resourced locally. We've provided funded positions for that resourcing.

The CHAIR: I've got a couple of questions about David Berry Hospital. I understand that the Government has opposed legislating against the site of the old hospital from being sold, but that there has been ongoing consultation with the community, and the Government has said it's not its intention to sell it off. Can you provide an update about that community consultation around what the use of the site might be?

SUSAN PEARCE: I'd love to be able to give you the synopsis of that, but I think that community consultation has been extensive and we would need to come back to the Committee on that one on notice because I think that process is still ongoing. I'm not sure how much we can help you in the interim until we get to the end of that and then present that back through to government in terms of what options may exist. But clearly there was a commitment to consult widely, and I know that community in Berry is obviously very active and very interested in the site and the use of that land.

The CHAIR: Is there an expected time frame for that consultation?

LUKE SLOANE: Yes. The next lot of consultation will occur in March next year. It will continue to cover off local residents, clinicians, staff and the Aboriginal community and local Elders, and it will be inclusive of environmental and heritage groups and any other interested parties that are involved.

The CHAIR: I appreciate the time it has taken to be quite thorough. Is there an intention at the end of that process for submissions to be made publicly available, or is that only being provided to government?

SUSAN PEARCE: I'm not aware of that.

LUKE SLOANE: I don't know.

The CHAIR: Has there been any consideration of retaining end-of-life care services specifically at David Berry Hospital? I understand the argument has been well made for rehabilitation services to be co-located with acute care services. What will be the status of end-of-life care in that local community?

SUSAN PEARCE: My understanding is that the enhanced services around Berry, including Shoalhaven hospital, which is currently under development—we were down there last week looking at that—will be a better standard for people at end of life. That's fundamentally what has obviously started this entire discussion. I don't want to pre-empt the outcome of that consultation, but clearly what we do want for people at the end of their life is to be in an environment that's fit for purpose, and we need to let that consultation take its course.

The CHAIR: Without trying to pre-empt the results of the consultation, is it one of the options that's considered?

SUSAN PEARCE: I'm not aware if it is or if it isn't. I think we've been fairly clear about what the standard of the building there presently is. Clearly we want to be able to put that land and that area to the best possible use. I think we've been pretty clear on the position around end-of-life care at Berry.

The CHAIR: I have a question for Ms Skulander. I'm following up on a question I asked at the previous estimates about Royal North Shore Hospital. You took a question on notice about the lot that's known as 4B, which was previously part of the health campus. Thank you for the answer that you provided on notice. I understand that the Medical Staff Council at Royal North Shore Hospital have made a submission to Government opposing the current planned rezoning and development on that lot which doesn't align with Health's previous plan. Has Health also made a submission opposing that current development?

EMMA SKULANDER: I'm aware of a submission that was put forward by the local health district. I provided input into a submission from a town planning perspective, because we have town planning expertise within Health Infrastructure. I think that was provided as part of the local health district's submission, but that's the context that I'm aware of from Health.

The CHAIR: I have a couple of questions which may be prior to your time, so I appreciate they may need to be taken on notice. Why was that land on the campus given to Property New South Wales rather than retained for Health, given the intention was that a proportion of residential housing might be key worker housing or directly associated with the health precinct?

EMMA SKULANDER: I'm nodding because I'm aware of the original intention, but I wasn't privy to the decision-making there around why it was, I think, declared surplus and given to Property. I'll take that on notice to provide the context.

The CHAIR: Can I ask as well—also before your time—if there was any financial or other benefit that Health or the local health district obtained because of passing that land over to Property New South Wales?

EMMA SKULANDER: I will have to confirm that.

The CHAIR: I've got a much broader question that might be for you, Ms Pearce. I'm interested in LGBTQIA+ data collection, particularly in the context of significant public debate earlier this year around the census and many advocacy groups making it clear how valuable accurate data is for service planning and particularly for health service planning. I'm interested in the work that might be underway in improving data collection.

SUSAN PEARCE: Is there anyone who is across that at the moment?

SCOTT McLACHLAN: I can. Yes, we're doing a lot of work around LGBTQIA+ services right across the State, improving access into our health services and doing a lot of work with our staff around understanding some of the challenges that people come with. In terms of the data collection, there are some new data collections underway. We don't have the results of those yet.

The CHAIR: Can I ask on notice, then, for where that's up to? I'm specifically interested in data collection in this instance rather than service delivery, although I've asked many questions about the health strategy before.

SCOTT McLACHLAN: Sure.

SUSAN PEARCE: I can see in my notes here, Dr Cohn, that a working group's been established to consider the next steps to improve the collection of sex, gender, sexuality and other variations of sex characteristics data. The other thing to mention that you'd be aware, of course, is that we do have the Single Digital Patient Record currently being implemented across NSW Health. We see this as a really significant opportunity to improve our data collection for LGBTQI+ patients, but broader than that. The team that are implementing the

SDPR are working closely with Epic and the LGBTQI+ community in respect to the data that's being collected. We certainly—perhaps at a future estimates hearing—might be in a better position to give you some more information on that, because we do have a really unique opportunity with the SDPR to be able to capture the data once for the whole State so that when a patient presents to a different part of the health system, they don't have to give their story all over again. That will include, obviously, those statistics. I think we'll have more to say at a point in time, but there is work underway in that regard.

The CHAIR: Thank you. Please consider yourselves on notice for February. I would love more detail.

SUSAN PEARCE: I shall look forward to that.

The CHAIR: With my last few minutes—sorry, it might be for Ms Skulander again. I should have done these in order. The Cootamundra Hospital health service plan—is there an updated timeline for the release of the plan?

EMMA SKULANDER: That is not for me, apologies. I'm not involved in the health service planning at the front end of that point.

The CHAIR: My apologies. Who is that question best directed to?

SUSAN PEARCE: It would be Mr McLachlan, but we're just looking through our notes here to see if we've got anything to offer to you for Cootamundra. If we can perhaps find that and come back before the end of the hearing, we will.

The Hon. WES FANG: If you're not able to, can you take it on notice?

SUSAN PEARCE: Yes.

The CHAIR: My usual question for Mr Sloane—the rural generalist program for next year. How many positions are there confirmed and have they all been filled?

LUKE SLOANE: That's a good question. At present—I might have to come back to you. The last time that we spoke we had the 29 confirmed positions. As I informed the Committee before, we can go up to 80, and that was on top of previous, but I might need to confirm where we're up to with regard to positions at this point of time because we have the second round of recruitment in, I think, September.

The CHAIR: That's all right. I was hoping by this point of the year—

LUKE SLOANE: The numbers move a little bit because people accept at the time of recruitment and then that number changes as we get closer to the start of the clinical year.

The CHAIR: No worries. If you're going to take it on notice, I'd also be interested in the breakdown of the speciality area that people are pursuing—emergency medicine, obstetrics, anaesthetics.

LUKE SLOANE: Yes, no problems. We can come back with that.

The Hon. WES FANG: Mr Morgan, intensive care paramedics—how many are there across New South Wales?

DOMINIC MORGAN: There are 401 in the metropolitan area. For the first time I can report that we've got more trained intensive care paramedics in regional New South Wales, 422. There's a total of 826 statewide trained.

The Hon. WES FANG: Sorry, you said 401 and then 422. That's not 826.

DOMINIC MORGAN: Let me just get those numbers, but the total is 826.

The Hon. WES FANG: We have a discrepancy of three there, but that's all right. We'll move on. Extended care paramedics—how many are there across New South Wales?

DOMINIC MORGAN: I'll get those figures for you as well. So 401 ICPs in the metropolitan area and 425 in regional—group total of 826.

The Hon. WES FANG: Beautiful. At least you had the total number good.

DOMINIC MORGAN: That's right. ECPs, there's a total of 112 statewide.

The Hon. WES FANG: Do you have a breakdown between metro and regional?

DOMINIC MORGAN: We do. Predominantly they're in the metro area. There are 97 in the metro and the remainder in regional.

The Hon. WES FANG: You'd be aware that at the last election the now Government, then the Opposition, made a commitment for 500 regional paramedics. How many of those will be intensive care paramedics?

DOMINIC MORGAN: The commitment as I understand it was for registered paramedics.

The Hon. WES FANG: I have the election costing request form in front of me, which actually says:

> Labor will provide $150 million over four years towards hiring 500 paramedics (who will be intensive care/extended care paramedics) …

Of those 500, how many will be intensive care paramedics?

DOMINIC MORGAN: As I understand it, the election commitment was for 500 registered paramedics. I think what you're looking at is a costing sheet.

The Hon. WES FANG: Yes.

DOMINIC MORGAN: That would be a question for Government as to why the election commitment was different from the costing sheet.

The Hon. WES FANG: I guess I am seeking to do some preparatory work at the moment. The costing that was submitted by the Labor Government, the then Opposition, indicated that they would provide 500 paramedics to rural and regional communities, and of those 500, they would be a mix of intensive care or extended care paramedics.

The Hon. Dr SARAH KAINE: Point of order: Mr Fang appears to be preparing a question about a commitment or statements made while the now Government was in opposition. I may have been pre-emptive, but I'm presuming Mr Fang wouldn't be asking a question about that—

The Hon. WES FANG: I wouldn't call it pre-emptive. I'd say it's wasting my time.

The CHAIR: I'll repeat the ruling of this morning that the part of this question that might be about regional paramedic numbers is probably in order but perhaps not the parts about commitments made in previous terms.

The Hon. WES FANG: I'm looking at this information, which was provided prior to the election. I am asking what the Government has asked for in relation to a rollout of this election commitment. You've indicated that the election commitment is different to what was given to the Parliamentary Budget Office for costing. I am seeking to understand what the Minister has asked you to provide.

DOMINIC MORGAN: Five hundred registered paramedics.

The Hon. WES FANG: Has the Minister asked you to provide that any of those paramedics be intensive care paramedics?

DOMINIC MORGAN: That's a separate program. That's the one that I was referring to before, where we are rolling out intensive care paramedics across regional New South Wales.

The Hon. WES FANG: With the 500 paramedics that were promised at the election, the community shouldn't expect any of them to be intensive care or extended care paramedics. Is that correct?

DOMINIC MORGAN: From the election commitment?

The Hon. WES FANG: Yes.

DOMINIC MORGAN: No.

The Hon. WES FANG: What is the role of an intensive care paramedic?

DOMINIC MORGAN: The role of an intensive care paramedic is a specialist position. They have skills that we refer to as high-acuity low-occurrence skills. These are advanced things like placing endotracheal tubes into patients' lungs, placing needles into bones to get venous access, and giving a range of high-end pharmaceuticals.

The Hon. WES FANG: How would you describe the role of an extended care paramedic?

DOMINIC MORGAN: Extended care paramedics are part of a scheme that we have to reduce the number of patients attending emergency departments. They deal predominantly with chronic and complex conditions that may be able to be treated by another part of the health system more appropriately, rather than the emergency department.

The Hon. WES FANG: What is the data that drives where you place those paramedics, both intensive care and extended care paramedics?

DOMINIC MORGAN: We have what's called a role delineation plan. We also have a clinical capability framework. Essentially what these two documents seek to do is identify locations where, based on a whole series of service planning criteria but you can assume that, obviously, activity and workload are a significant part of that—make it safe for these practitioners, on balance, to be able to do work with it, to undertake their advanced skills.

The Hon. WES FANG: Of the 500 that were promised in the election commitment, has the Government asked you to do any preparatory work or any placement work in relation to making any of those 500 extended care paramedics?

DOMINIC MORGAN: No, we have the separate program.

The Hon. WES FANG: Who makes the decision as to where those paramedics are rolled out, both the intensive care and extended care paramedics?

DOMINIC MORGAN: Through the service planning methodology, we determine a hierarchy of places that would benefit from the placement of additional paramedics. Then we go out with a series of locations that we consult on with the workforce and the industrial bodies. Then, as a result of those things, we put them into those locations.

The Hon. WES FANG: Just so that I'm clear, none of the 500 paramedics that are being rolled out into rural and regional communities are going to be or are expected to be intensive care or extended care paramedics. Is that correct?

DOMINIC MORGAN: That is correct. It's a separate program for intensive care paramedics, where 246 are being converted from registered paramedics into intensive care paramedic positions.

The Hon. WES FANG: At this stage it looks like we've only got 15 extended care paramedics in all of rural and regional New South Wales. Is that correct?

DOMINIC MORGAN: That is correct.

The Hon. WES FANG: Can I ask you—just in relation to one of my pet loves—how much money was pledged by the Minns Labor Government to build regional helicopter ambulance bases?

DOMINIC MORGAN: I'm not aware of how much the Government committed.

The Hon. WES FANG: You haven't been asked to provide advice on or do any investigations into the rolling out of any new helicopter ambulance bases?

DOMINIC MORGAN: Yes, we are aware that there is a Government commitment. I think in the last budget papers there was a provision for $60 million worth of capital for the three bases. I believe that's correct.

ALFA D'AMATO: Yes, that's approximately correct.

The Hon. WES FANG: So $60 million?

DOMINIC MORGAN: Yes.

The Hon. WES FANG: How is the delivery of the first one going?

DOMINIC MORGAN: The primary issue is about securing the funding to actually run the helicopters, so we've undertaken modelling to identify the top four locations. On the basis that we're able to secure ongoing additional funding in the out years to operate those helicopters, then that'll be finalised.

The Hon. WES FANG: Prior to the election, the Government made a commitment that they would roll out new helicopter bases and that they would roll out three of them. As I understand it, you are saying that there is $60 million allocated for the construction of those three bases, but there is no recurrent funding or operational funding for helicopters to be placed at those bases and no preparatory work has been done to deliver those bases. Is that a fair assumption as to where we are at?

DOMINIC MORGAN: No, actually, I can confirm that $63.95 million is the capital.

The Hon. WES FANG: That's good.

DOMINIC MORGAN: In answer to your question about preparatory work, I point to my answer before, which was that we've undertaken modelling, we've identified the top four locations where we would prioritise those—

The Hon. WES FANG: Where are those locations?

DOMINIC MORGAN: I believe that's Cabinet information at the moment.

The Hon. WES FANG: Who is going to be the loser? You've got promised three, and you've got four. Someone's going to be a loser.

DOMINIC MORGAN: I could give you 12.

The Hon. WES FANG: I can give you more than 12.

DOMINIC MORGAN: Exactly.

The Hon. WES FANG: But clearly you have been planning for four.

DOMINIC MORGAN: I don't think you can draw that conclusion.

The Hon. WES FANG: Sorry, you've identified four and the Government will deliver three. Someone is going to lose out here, aren't they?

DOMINIC MORGAN: I don't think you can draw that conclusion.

The Hon. WES FANG: I point back to the costings around the commitment that was made by the then Opposition and now Government. "What assumptions have been made in deriving the financial impacts in your estimated costing?" It says, "One helicopter ambulance base should be 'built' a year across the forward estimates." Is it fair to say that that commitment and that assumption hasn't been delivered on by this Government?

DOMINIC MORGAN: It takes approximately two years, even if you order the helicopter on the day that you decide to do it. At the moment, we would be expecting that we will go forward and that there will be funding identified in future years in relation to the operation of those helicopters. That hasn't occurred this financial year, but I couldn't comment on what the Government might do in future years.

The Hon. WES FANG: You say it takes approximately two years between a commitment and the delivery—

DOMINIC MORGAN: Just to be clear, that is for a new helicopter. There are other options that might be available to the Government if they wish to bring that forward.

The Hon. WES FANG: I think we're at cross-purposes here. There is obviously the issue around the bases themselves and the delivery of those bases. The Government has committed to three bases. But then there are the contractual arrangements around the operation of the helicopters, the crewing and staffing, et cetera. That is obviously part of a commercial contract, I imagine, with Toll Ambulance Rescue. Let's park that to the side. I am talking now about the delivery of regional bases. The commitment was that there would be one base built per year in the forward estimates. That was the commitment from the Minns Labor Opposition at the time that they put forward their costings. Has any work been done to commence the work to deliver on that commitment?

DOMINIC MORGAN: Yes, that's correct. We've identified the locations and the priorities for the areas where they would be built. That is the preparatory work you are referring to.

The Hon. WES FANG: When do we expect that the first regional base will be operational in the forward estimates?

DOMINIC MORGAN: It will depend on future funding being provided to operate those bases.

The Hon. WES FANG: The Government hasn't committed to you that they will provide that funding?

DOMINIC MORGAN: No. All I can say is that we don't have it this year. I can't comment on what they might do on the out years.

The Hon. WES FANG: But the funding for the base delivery is there. Is that correct?

DOMINIC MORGAN: To build the building, yes.

The Hon. WES FANG: But no work has been done in relation to the delivery of a building? When are we going to see bricks and mortar built? Forget about the contract; when are we going to see a base delivered?

DOMINIC MORGAN: Going back to your first question, "Has work been done?" Yes, work has been done in identifying the locations that have been modelled. That now has to be considered by the Government. Part of operationalising those bases is to secure ongoing funding.

The Hon. WES FANG: If I'm to read that answer in plain English, there has been no decision made about the location of those bases, there have been no contracts signed or even put forward—

The Hon. EMILY SUVAAL: Point of order: I take a point of order around what I believe Mr Fang is canvassing in this question. Mr Morgan quite clearly indicated in a previous answer that some of the information here is subject to Cabinet-in-confidence provisions. I remind Mr Fang of that and the fact that this question has already been extensively canvassed and answered.

The CHAIR: I'll uphold the point of order. There have also been some quite long statements leading into these questions that—

The Hon. WES FANG: To the point of order: I'm asking when bricks and mortar will be delivered in relation to just the base. I'm not asking about Cabinet in confidence. I'm not asking for the locations, although it indicates that there are four. I just want to know when—

The CHAIR: Please stick to the part of the question that might be in order.

The Hon. EMILY SUVAAL: And the Chair's ruling.

The Hon. WES FANG: Yes, but Cabinet in confidence—

The Hon. EMILY SUVAAL: The Chair has ruled.

The CHAIR: The Minister isn't here, and it's not appropriate to ask political questions of the departmental witnesses.

The Hon. WES FANG: All right. If that's the way we're going to play it, that's fine.

The Hon. EMILY SUVAAL: The Chair has made a ruling, and you need to uphold it.

The Hon. WES FANG: I will ask the request again then, rephrased. When can the community expect to see the first opening of a bricks-and-mortar base in a rural or regional setting?

DOMINIC MORGAN: That will depend on the timing of approvals.

The Hon. WES FANG: So nothing is in train as yet?

DOMINIC MORGAN: Do you—

SUSAN PEARCE: Sorry, Dom. I think, Mr Fang, the Ambulance chief executive has indicated that there's preparatory work occurring. You'll appreciate that this is a complex issue because helicopter bases are, to be perfectly honest, quite contentious in respect of their location. We need to do some very careful planning here because we've had other issues in the past where we have had bases that subsequently have been required to be moved, so it's important that work is done. We've indicated that the money for the capital planning is there. We'll be very happy to come back to the Committee with further information that we are permitted to provide, but our job is to make a proper assessment of this so that we can, in the best interests of the communities we serve, give that information to government. Alfa, did you have anything else to add from a budget perspective on this, or does that sum it up?

ALFA D'AMATO: Yes, if I may add just one thing—

The Hon. WES FANG: Before I take that additional answer, I just want to indicate, Ms Pearce, that the reason I'm asking these questions is because what you've identified, I know already. It is hard to deliver these things. What I'm seeking to point out here is that, prior to being elected, the Premier made commitments around his delivery of one per year—

The Hon. Dr SARAH KAINE: Point of order—

The Hon. WES FANG: —and that was never deliverable.

The CHAIR: Mr Fang, I need to hear the point of order, and I think I know what it is.

The Hon. Dr SARAH KAINE: There are multiple points of order that I could go with. The one that I'll go with on this occasion is that—

The Hon. WES FANG: All right. I'll move on. I will move on.

The Hon. Dr SARAH KAINE: Excuse me, Mr Fang. I'm speaking, and it's not appropriate for you to keep speaking over people, including me.

The Hon. WES FANG: You're wasting my time, but that's okay.

The Hon. EMILY SUVAAL: There's a point of order.

The Hon. Dr SARAH KAINE: The point to of order is that you need to treat all of the witnesses with respect. You're getting very close to badgering—

The Hon. WES FANG: No, I'm not.

The Hon. Dr SARAH KAINE: —and it's not appropriate that you speak over—

The Hon. WES FANG: You didn't deliver what you promised. You can run defence all you like.

The CHAIR: Mr Fang, there is plenty of time for us in the Chamber to take note of answers and make our own statements. You need to be asking questions.

The Hon. WES FANG: We will. I'm going to move on to a different topic now. In July 2022 the then Opposition leader, Chris Minns, claimed that patients were stuck outside emergency departments and being treated in tents. The local health district issued a statement confirming that Canterbury Hospital emergency department had established enhanced screening inside a marquee to enable point-of-care testing for patients who were symptomatic with COVID. Did the department give any advice to Chris Minns before he made public statements about patients being treated in tents?

The Hon. Dr SARAH KAINE: Point of order: Just checking, was that again before we were in government and not about the health Minister?

The CHAIR: I've ruled multiple times today that the departmental witnesses shouldn't be asked for opinions on things stated by politicians before or after elections.

The Hon. WES FANG: To the point of order: It's not an opinion. What I'm seeking to do is to understand whether there was advice. I don't believe there was. All I'm seeking is a clarification of if there was or not. That is a reasonable question in circumstances where I'm asking what advice was provided prior to something happening. That is well within order and I'm just asking. I expect the answer is no, but I'd just like to know.

The Hon. EMILY SUVAAL: To the point of order: The resolution establishing the budget estimates committees states:

> Questions must be relevant to the matter that has been referred to a committee for inquiry and report.

I'm reading from the *Budget Estimates Guide 2024-25*. It continues:

> In the case of the Budget Estimates inquiry, this refers to the estimates of expenditure from the Consolidated Fund and other matters covered by the budget papers.

The question that you are asking is in relation to something that may or may not have occurred in 2022-23, which is well outside the terms of reference establishing this Committee of inquiry.

The CHAIR: I think there's a fairly broad latitude in precedent from chairs of portfolio committees about the kinds of questions that can be asked, and they do often stray outside of expenditure in this year's budget. However, Mr Fang, you've really strayed into statements where you'd like to point out a particular thing, rather than actually asking a question of the witnesses.

The Hon. WES FANG: To the point of order: I've asked the question and then I've been interrupted by the Government members. But I'm literally just asking a question. It's a point of clarification, if anything. I haven't stated what I'm seeking to do with this; I'm just asking the question.

The Hon. EMILY SUVAAL: Point of order: Mr Fang continues to flout your rulings.

The Hon. WES FANG: There was no ruling on this. Don't waste my time, Emily.

The Hon. EMILY SUVAAL: It's straying closer to the need to call him to order.

The Hon. WES FANG: It's funny how—

The Hon. EMILY SUVAAL: If he has a position around dissenting from a ruling then he should do so, but otherwise I'd ask him to refrain from continual commentary on your rulings.

The Hon. WES FANG: It's particularly interesting how defensive they are when Chris Minns is raised, but I'm just asking—

The CHAIR: At this point Mr Fang is choosing to debate the point of order rather than debate the subject matter in front of the Committee. That's his choice. Please ask a specific question without an associated statement.

The Hon. WES FANG: The last question I'll ask is in relation to the drug summit. On 1 November 2024 there was $9.8 million promised for the Murrumbidgee Local Health District for drug treatment. On

4 November there was $21 million promised for the northern region—the Lismore area—for drug treatment. Why is there such a discrepancy in the amount of money that was promised between the two areas, given that one is a predominantly Coalition/Independent electorate and the Lismore area has received more than double in a few days after a drug summit has been announced?

The Hon. Dr SARAH KAINE: Point of order—

The Hon. WES FANG: How was the funding—

SUSAN PEARCE: If you are suggesting that we make funding decisions on party political lines, I can tell you I categorically—categorically—reject that. I think you know us better than to suggest any such thing. In respect of how the Government decides to—

The Hon. WES FANG: Well, no, I'm sorry. Now I will take a point of order here.

The CHAIR: I haven't heard the previous one yet.

The Hon. Dr SARAH KAINE: My point of order was that Mr Fang was asking an outrageous political question that was effectively—and Ms Pearce completely dealt with it—slandering the reputations of these public servants. I don't need to go further with that. I think Ms Pearce dealt has with that.

The CHAIR: The witness chose to answer the question, so I don't feel the need to rule on that

The Hon. WES FANG: I'm now going to take a point of order. I'm asking as to the rationale for why there's a differential between an announcement that was made three days prior to another one, one being a Labor electorate that received more than double the amount of funding, and how—

The CHAIR: This is not a point of order; you're just restating the question to get it on the record. The witness has answered the question. If you continue, I'm going to have to call you to order.

The Hon. WES FANG: I still haven't got to my point of order yet.

The CHAIR: This is not a point of order. The time has expired. There's a handful of minutes left if the Opposition wants to continue.

The Hon. DAMIEN TUDEHOPE: Have the 160 psychiatrists that have allegedly left the system caused some concern in relation to the manner in which they will be replaced?

SUSAN PEARCE: I might get Mr Minns to respond to that, Mr Tudehope, if you wouldn't mind.

PHIL MINNS: We've currently got 95.1, plus 36.5 vacancies when we did a survey of psychiatrists in November. The reason there are two numbers there is that the 95.1 are vacant roles but they are actually being filled with alternative workforce, so either with a VMO locum or—I think it would basically be a VMO locum, because I don't we have agency psychiatrists. So 36.5 per cent of our staff specialist positions are currently unfilled, and we're not able to get an alternative workforce to those positions. A 30 per cent vacancy rate but noting that not all 30 per cent remain unfilled.

That does create undesirable aspects to the running of the service, and most particularly it means that it can have impacts for the ability of various services to train trainees, and it can have an impact and we believe it is having an impact on workload associated with call-backs and call-outs for staff specialists. It's an issue. It's one of those workforce challenges that we face. There are others. It's one that does exist nationally because psychiatry is one of the four tranche 1 expedited pathways that is being worked on by all jurisdictions through the Health Ministers Meeting framework, to see if we can expedite the movement into practice by psychiatrists from a limited number of countries where AHPRA is of the view, supported by the Ministers, that their qualifications are equivalent.

The Hon. DAMIEN TUDEHOPE: There are two things, then. Letters of resignation have been sent by 160 psychiatrists. I think the evidence you've just—

PHIL MINNS: I'm not aware of that, Mr Tudehope, because we have received about—it may have changed since I last looked—113 resignation letters that have been supplied to our chief executives. The other claim is a claim in the media by ASMOF.

The Hon. DAMIEN TUDEHOPE: I accept that. You've suggested that you are sourcing now VMOs to replace them. What's the cost of doing that?

PHIL MINNS: It will vary, but it's a class of premium labour. Particularly if it's a locum for a service that is out of metropolitan Sydney or in regional New South Wales, where they might be struggling with their level of vacancies, then, to some degree, the market will set the VMO rate. Remember that these are what I would

call VMO locums. They're not VMOs. Visiting medical officers—psychiatrists—who work in our system, there's about 420-plus of them. We've got them and we have about 420, or thereabouts, staff specialist psychiatry positions, and I've mentioned the number that have vacancies and are being filled with alternative sources.

The CHAIR: I'm not going to ask any more questions. I just want to finish by thanking all of the witnesses—I know you're all very busy—for making the time to come back for a supplementary hearing, on behalf of the Committee members but also the communities that we're here to represent. We're all about to go on a break for the holiday season, and some of you might be, but I also want to thank all the NSW Health staff who are working through the holidays, keeping us all safe. It's really important work, and the Committee really appreciates that.

EMMA SKULANDER: Do you mind if I correct a statement that I made to you earlier, in relation to Royal North Shore?

The CHAIR: Please.

EMMA SKULANDER: Just around the submissions issue, I referenced the town planning advice we provided. Health Infrastructure provided that in a separate submission, but a submission also went from Northern Sydney Local Health District and from the Northern Sydney Local Health District chair. There were three submissions from Health.

LUKE SLOANE: Chair, if you're happy, I'll quickly run through the RGSEP numbers. We have a total of 40, so 19 from the new recruitment this year; 21 continuing on the program from last year, with a further seven being recruited. Where that number ends up after that recruitment episode, we're not sure, but the total is 40 on the program at the moment. Completing or being completed in 2024, specialty-wise, we've got eight emergency medicine ASTs, seven obstetrics ASTs, one anaesthetics AST. We have one mental health AST and one adult internal medicine AST. Starting in 2025, we have a further one emergency medicine AST, one obstetrics AST, two anaesthetics AST, one palliative care AST, which is quite exciting, and a further adult internal medicine AST as well.

The CHAIR: Thank you. It's great to hear that that's growing.

LUKE SLOANE: They're spread across all of the local health districts, bar Far West, but we're quite confident we may get a couple for Far West Local Health District in the coming round of recruitment, which is exciting.

The CHAIR: Thank you. I should have asked. Is there anyone else who wants to add anything? Thanks, everyone. Questions from the Government?

The Hon. EMILY SUVAAL: We're very satisfied with the fulsome responses from the health officials. No questions from us. Thank you from us all as well.

The CHAIR: As usual, the secretariat will be in touch with any questions on notice or any supplementary questions.

(The witnesses withdrew.)

The Committee proceeded to deliberate.