REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 2

INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH

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At Sydney on Tuesday 23 March 2004

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The Committee met at 9.30 a.m.

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PRESENT

Reverend the Hon. Gordon Moyes (Chair)

The Hon. Tony Catanzariti
The Hon. Hon. Dr A. Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. Patricia Forsythe
The Hon. Robyn Parker
The Hon. Christine Robertson

CHAIR: Good morning, ladies and gentlemen. Welcome to the third public hearing of the inquiry of General Purpose Standing Committee No. 2 into complaint handling procedures within NSW Health. Before we commence the taking of evidence I will make some comments about aspects of the Committee's inquiry. This inquiry will raise difficult issues for many participants: the relatives and friends of people who have experienced an adverse event in the health system, health workers who have sought to draw attention to poor practices; as well as practitioners and managers whose ability and professionalism have been challenged. I therefore ask that the media and any other persons in the audience demonstrate sensitivity in any approach made to witnesses during this inquiry, particularly immediately after the giving of their evidence.

The inquiry's terms of reference require the Committee to examine the system for handling complaints in New South Wales and whether the health system in this State encourages people to reflect upon errors. People's individual experiences of the system will help the Committee understand how the complaint handling system works, or does not work. I ask everyone who is interacting with the Committee to reflect upon the terms of reference and to assist the Committee to use these difficult experiences to improve the health system. The Committee does not propose to duplicate other inquiries or investigate or conciliate individual complaints.

It should also be remembered that the privilege that applies to parliamentary proceedings, including committee hearings, is absolute. It exists so Parliament can properly investigate matters such as this. It is not intended to provide a forum for people to make adverse reflections about others. The terms of reference refer to failings of systems, not individuals. I therefore ask witnesses to minimise their mention of individual health care workers unless it is absolutely necessary to address the terms of reference. Individuals who are subject to adverse comments in this forum may be invited to respond to the criticisms raised, either in writing or as witnesses before the Committee. This is not an automatic right but rather will depend on a decision of the Committee in view of the circumstances of the evidence given.

I would also ask that witnesses be mindful of the ethical and legal implications of disclosing personal information about patients. Health practitioners and managers should only discuss personal information about a client or a patient if they are specific to the terms of reference and that person has authorised them to do so. I ask my fellow Committee members to consider the ethical duties owed by practitioners to patients when pursuing lines of questioning. It is likely that some of the matters raised during this hearing may be the subject of legal proceedings elsewhere, such as in the Industrial Relations Commission, a disciplinary tribunal or the special inquiry being conducted by Bret Walker. The sub judice convention requires the Committee to consider the impact of discussing a matter that is being considered by a court of law. The weight of opinion supports the view that a parliamentary committee may discuss a matter that is being considered by another inquiry. This would include investigations undertaken by the Independent Commission Against Corruption. Nevertheless, I remind people today that this inquiry is about systemic issues and not the culpability or otherwise of particular individuals. If you have concerns about any of these issues please raise them at any time with me and with the Committee and we will consider your concerns.

The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of the guidelines covering broadcast of the proceedings are available from the table by the door. In accordance with the Legislate Council guidelines for the broadcast proceedings, members of the Committee and witnesses may be filmed or recorded but people in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee the media must take responsibility for what they publish or what interpretation is placed upon anything that is said before the Committee. Witnesses, members and their staff are advised that any messages should be delivered through the attendants or Committee clerks. I advise that under the standing orders of the Legislative Council evidence given before the Committee and any documents presented to the Committee that have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person. I ask you to turn off your mobile phones please. I will repeat what I said the other day: I have an automatic $25 on the spot fine for anybody whose phone goes off. The proceeds will go to the parliamentarians' superannuation fund, which is rather short of funds at this time, so I understand. I welcome both witnesses to the morning session.

PETER MYLAN, Assistant Secretary, Health Services Union, sworn and examined:

ANTHONY LLEWELLYN, member, Health Services Union, affirmed and examined:

CHAIR: In what capacity do you appear?

Dr LLEWELLYN: I am a psychiatry registrar with Hunter Mental Health Services and I am here in an official capacity for the union.

Mr MYLAN: I am here in an official capacity representing the union.

CHAIR: Mr Mylan, would you like to give an opening statement?

Mr MYLAN: I would. The Health Services Union has sought advice from our membership. I point out at the outset that membership of the union is 35,000-odd members in New South Wales. It is representative of New South Wales public hospitals, community health and ambulance; in addition to the aged care sector and private hospitals. The majority of the membership are employed in connection with public health. That would include members ranging from junior medical officers, health managers, allied health workers and professionals as well as administrative staff and including support staff. In my opening statement I indicate to the Committee—if I am repeating what has been said previously I apologise—that health care workers in New South Wales clearly indicate to the union their concern about the low morale that currently exists in the system. Obviously a lot of that is attributable to the heavy media attention to health at the moment. But certainly health care workers for some time have had a level of distrust and concern with management and management's apparent inabilities on occasion to address issues in the workplace, management's attitudes at times that seek to blame individuals rather than looking at proper analysis of systems failures. It is the understanding of health care workers that most faults that occur are usually system failures and it is rare that failures occur as a result of individuals.

Members also indicate to us a concern about management in that if they dare to put their hand up often they are singled out or dammed for speaking out. There is also a view that approaches by management are inconsistent within area health services and sometimes across area health services, and that leads to concerns by our members. Members also feel that there needs to be an approach to review processes that look at accreditation of hospitals. Members have indicated to us that there would appear to be a change over the years where individual hospitals were reviewed and accredited on an individual basis or in previous years on a rural health basis. They feel that more recently, with the development of area health services, there do not appear to be the same consistency and reviews as may have occurred in the past.

I add that recently members have also indicated to the union that there may be some ways to assist in the future for addressing this current climate in the health system and distrust of management. Members have indicated to us that there would seem to be a lot of benefit with the formation of committees—committees represented not by senior managers but certainly by staff who are qualified in the allied health field, doctors or people with a nursing background. They feel that that would lead to better patient safety, improve delivery of care and go a long way to restore the faith of the community in the health care system.

Additionally, we understand that a practice has been in place for some time—the representation of this practice has dwindled over the years—in relation to the employment of patient representatives. Members have indicated to us in the responses we received that in those workplaces where patient representatives are employed there are good outcomes, that they are good representatives for patients who have difficulties understanding the system or treatment by health professionals. They feel that if those representatives are increased and also given encouragement they can have a degree of independence from their employer. There is much benefit in their assistance to patients and visitors in a mediation-type process rather than an attitude of complaint and complain referral.

The final comment I would make is that members have indicated to us as well that the Department of Health would appear in more recent times to have entered into a way of investigating concerns and complaints and that relates to the root cause analysis system that is something that is fairly new. Whilst generally the majority of our members indicate that that is a more detailed and better system, there are some warnings that members would placed upon that. They would include training. A number of our members have indicated that

they may have participated in a two-day training course in regard to root cause analysis but feel that there is little or no follow-up to the retention of that training and understanding of matters. They feel that there needs to be proper support for people that are investigating the process to have a clear understanding that it is to review, assess and analyse matters that are being investigated, not to be targeted individuals.

Clearly, there is a view that more health workers should be directly employed or involved in root cause analysis as opposed to, say, senior managers as they may not have a knowledge or clinical understanding of the matters at hand.

CHAIR: Is it the opinion of your members that there is a blame culture within NSW Health?

Mr MYLAN: That has certainly come across from all the information that we have gleaned. There appears to be a style of management that addresses the individual person who may have been implicated, or who may have put up his or her hand to say that there is an issue. It is felt that that could lead in the future to people being reluctant to putting up their hands and coming forward. It is developing into a culture.

The Hon. PATRICIA FORSYTHE: You referred in your statement to a current climate of blame. Does that suggest that there has been a change in policy over time? Is this culture of blame a recent feature?

Mr MYLAN: Yes. The best that I can interpret from recent information we have received—when I say recent I am thinking more likely from the 1980s and 1990s to the present day—is that a lot of people who are employed in the health system are long-term employees. They certainly would be in a position to relate to how things might have been done before. To assist in qualifying that, there seems to be a view that changes have occurred with the establishment of area health services. There are types of autonomy that appear to occur at an area health service level as opposed to previously where it may have been a consistent view from a region or a State-based view from the Department of Health.

The Hon. AMANDA FAZIO: Dr Llewellyn, in your submission under the heading "Sharing of information in an open discussion of failures and improvement of care", you state:

> Most junior doctors are threatened about voicing criticism in front of more senior clinicians. They automatically assume that because of their position, the senior clinician has more knowledge and more authority. Personal career paths may be threatened or perceived to be threatened by speaking up or speaking out of turn.

What do you think could be done to overcome that concern? I note that your submission was on behalf of junior doctors in the health system. What do you think could be done to overcome that problem?

Dr LLEWELLYN: Some things have already been done, particularly in relation to the work of the Postgraduate Medical Council for the first couple of years of training of doctors straight out of medical school. That has had a beneficial effect on the entire system. Before that there were particularly dangerous situations where interns and residents were placed in levels of duties that were way above their ability and they were left to work things out for themselves. I am talking about things like consenting patients for operations that they had no knowledge about. That certainly has improved things.

But the Postgraduate Medical Council is an arm's length approach. It is not always present in the hospitals. After that level, particularly at the registrar level, that is, where career paths are particularly important, a culture of openness about the complaint process would lead to an improvement. I think most junior doctors are unaware of the systems of clinical governance that are in place at the moment in the hospital system. They are unaware that when an inquiry such as a serious incident review takes place it is not about them being blamed but about trying to work out the system problems that were involved in the case. I think they see their senior consultants as being the ones that make decisions about these sorts of things and themselves as being powerless or not necessarily in the process.

Including junior doctors in the training and the process of quality improvement would lead to some improvements. I think that needs to start at the medical student level. Leaving it until after graduating from medical school is too late. I made this point in my statement. The need for good clinical teaching and seconding time for all doctors in that process in the hospital system is paramount. We are all under stress. We feel that every day. We are encouraged to treat patients more quickly every day and to discharge them more quickly from the system because the system is under strain. One of the first things to go in a system under strain is the process

of good clinical teaching, which is important. It actually leads to improvements in the long term. But if you are under pressure often it is the first thing to go.

It would be helpful if we allowed consultants, registrars and junior doctors time to reflect on the process of their work, to ask questions and to research things along an evidence-based line. Some process could be put in place so that there is a recognition of the importance of clinical teaching, not only for doctors but also for all health professionals in the system. It may be as important as patient outcomes and research outcomes. I think that would go along way towards helping in the process.

CHAIR: I had intended asking you whether you wanted to make a statement before we started questioning you on your submission. Do you wish to add to what you have already said by way of an opening statement?

Dr LLEWELLYN: I am happy to answer questions. I only said that as a bit of background.

CHAIR: You might want to emphasise some of the things in your submission.

Dr LLEWELLYN: As a background I have been a medical officer for seven years now. I am in my final year of psychiatry training, although I have some examinations to finish off. I work in Newcastle as a psychiatry registrar. I have had some brief experience in medical administration as well. One of my particular points is that of teaching. I have already addressed that in the question. I guess the other important part, as Peter picked up, is the recent process to training. Professionals in quality improvement exercises such as root cause analysis need to be across the board in health structures, not just at the top. In my area we had training for about 150 people. Most of those people were senior. If that involves a train the trainer course, or trainers training people below them that is fine. There were only four senior registrars at that training in the Hunter. It does need to start at a more junior level.

CHAIR: You make the point that training really should start in the clinical training years?

Dr LLEWELLYN: I think it should start in your learning years at university. I brought some copies of the two papers that I quoted in my submission. There is a lot of good evidence that the culture of covering up medical error amongst doctors begins in the medical student years. Whilst doctors do not deliberately set out to cause errors, the socialisation of doctors starting from the medical student years seems to lead to various denials of error, distancing from error and discounting errors in the process. That is because of the shared adversity that people have to go through, first, to enter medical school; second, to pass some pretty difficult examinations; and, third, to be competitively competing for some even harder to get into training programs.

Once people get into the tribal group of being a doctor, they share their adversity amongst themselves and behaviours are adopted. As long as the person is sometimes seen to be behaving like a professional it is common for other doctors to ignore the errors. Similarly, no-one wants to dob in a colleague if they do not feel that they have got enough evidence to do so, in particular, when the power relationship is difficult or unequal. Often the error will be picked up. If, for example, a consultant is not being reviewed by other consultants—they are in other parts of the hospital—the person who might pick up the error is the junior registrar or the nurse. At times they have not got the power relationship to do something about it.

Often when the junior person does speak out and perhaps approaches another consultant about it there have been instances where that person does not feel that the consultant has taken the matter seriously enough. In my paper I did talk about psychiatry. I did that not because psychiatry is a particular problem. We are actually fairly open-minded about these things. I am happy that I am working in psychiatry because we take a systems approach. The fact that someone has gone to the lengths of researching adverse training experiences in psychiatry is a good thing. I suspect that there is some other literature in other specialties. If you look into some of the problems in some other areas of medicine you will find that they are even worse. I stress that, even though I brought up psychiatry in my submission, I am not particularly targeting it as a problem area.

The Hon. ROBYN PARKER: You mentioned in your submission and you referred today to the system being under pressure and strain. You talked about streamlining the cost in the delivery of care. How much do you think insufficient resources contribute to the culture that you are talking about?

Dr LLEWELLYN: I think a significant amount. We are under pressure, not only for managers but for other staff, to deal with a patient quickly. We deal with a field of uncertainty. People think that medicine is a clear science. It is not. A lot of the things that we do have no real good evidence base. We are just realising that and we are reviewing things. A patient turns up with a certain complaint. We are told that it is one thing. We get encouraged to close our minds to other possibilities and to focus on determining a diagnosis and a course of treatment. If something happens out of the ordinary once a person has been initially reviewed in a hospital that can often be ignored.

We are not encouraged to undertake a review of things some of the time. The patient is supposed to follow a clinical pathway. If a patient falls outside the clinical pathway it can be sometimes to his or her detriment. Good, conscientious doctors will pick up on things, but they might not be able to do so. If they have not got the time to go to the library, look up an interesting case and find out the variabilities about it that is bad thing.

The Hon. ROBYN PARKER: Has that pressure been greater over a period of time? Has there been a time when it has increased?

Dr LLEWELLYN: I did my training in Tasmania. As a medical student it seemed to me that there was more time to consider things. That is going back 15 years now. I moved to New South Wales after I finished my medical student training. In that time I have worked in a number of hospitals. It seems to me that, over the last few years, pressure has mounted and there is evidence of that. It is a multifactorial problem. There are many reasons for that. Certainly the funding basis for health needs improving, but I think both State and Federal governments need to work on that. It involves not just the public hospital system but also the private system and the aged care system, et cetera. I am sure that you are aware of all those factors. But, yes, I do think that pressure is mounting. I think the system is at breaking point, not just in a few crucial areas but also in a number of areas.

The Hon. PATRICIA FORSYTHE: I refer to an issue that has been a recurring theme in our inquiry, that is, the Camden and Campbelltown areas. I refer, in particular, to the Camden maternity unit. You said in your submission that you had only a week within which to receive submissions from your members. During the course of that period, or since that time, have you received any submissions from medical staff about whether the Camden maternity unit was opened before appropriate clinical staff had been put in place?

Mr MYLAN: The union has not received any formal submissions from members in the Camden and Campbelltown areas, be it from medical or support staff.

CHAIR: Not even after the press outlined what was happening?

Mr MYLAN: Only to the degree that staff are concerned about the issue of morale and not feeling comfortable in the environment. That is the extent of it. No members have advised us of wrongdoing or expressed concern about a procedure or any individual.

CHAIR: Are you saying that members are concerned only about their own welfare and not about the system and the patients?

Mr MYLAN: Certainly not. Of course, there was a time when the staff were concerned for their welfare. Management took steps at that time because of activity in the community. It is certainly not beyond that. The staff are concerned about the community view that things go wrong in health. That is a jaded view. Members work with people every day and do their best to provide the appropriate levels of care with the resources and the knowledge they have. They are concerned that people may feel they are not doing their best. If there are systems or measures in place that do not lead to the best outcomes it is a concern to them and to patients and visitors coming to their workplace.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I refer back to a point made by Dr Llewellyn about quality control and the ability to complain to one's boss. Particular mention was made of surgery and that if one complained one would get an adverse career outcome. I can give good personal evidence about that. Does the union collect information for the junior staff about how good their bosses are? There should be an avenue to collect information outside the system. In other words, does anyone ask whether a consultant teaches his staff

anything or are they simply a convenience so that he can go sleep at night? Does the union try or intend to collect information about complaints or any systematic information?

Dr LLEWELLYN: We collect complaints. Our primary focus is obviously the industrial arena. We treat teaching and training as part of that, but only one part. Doctor members and doctors in general have the ability to complain in a variety of ways. Therefore, it is not possible for our union to collect all complaints. For instance, a doctor may complain to his or her college of training, the Postgraduate Medical Council, the hospital concerned, the Australian Medical Association [AMA] or our union. They are the main ways of complaining about a particular issue. We recently had a case involving an obstetrics registrar who was told her training place would not be kept open when she fell pregnant. We went in to bat for her and won; we ensured that she could return to work once she had fulfilled her wish to have a family and to become an obstetrician, which is not unreasonable in a field that affects women. Surgery is a particular field, but in a number of other fields one is encouraged to be a professional and dedicate oneself to the patients and to follow the tribe. Many junior doctor members recognise the importance of having a life outside work. That is good for patients because it means the doctor has a rounded view of the importance of things other medicine and has the ability to reflect on treating the whole person. There are probably some senior members of the profession who still very much see themselves as dedicated doctors and everything else comes after that. Hopefully that is changing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Everyone is collecting a little bit of quality control or complaint information, and presumably everyone is doing a little bit of training. However, the Postgraduate Medical Council still has a bunch of doctors who are mates of the doctors who are there. Would the union find it too large a job to systematically collect reports on all the consultants involved in training programs? The college has training programs and they are all very hierarchical. Does the union itself have a role in collecting that information, just as consumer associations collect information about washing machines?

Dr LLEWELLYN: We would be happy to take on that role. The problem is that there are so many players in the system. The colleges are independent of the area health services and the Commonwealth Government. Tying up all those areas would be a huge task. However, the more avenues junior doctors have to raise issues in an anonymous or external fashion the more helpful it will be. Certainly, having an external player, such as the union, will be useful. However, we will never get over the problem of junior doctors not wanting to speak out of turn. Some will feel that no matter how anonymous or external the system, their career may be threatened by doing so.

The Hon. CHRISTINE ROBERTSON: Have you had much experience of the way the complaints process deals with hospitality workers?

Mr MYLAN: Yes. There is an array of levels of supervisory staff from leading hands to supervisors to managers. There appears to be a view that if a matter is raised, and a review and assessment are required, it will be done at a higher level and recommendations or changes will be made. We find that that does not often occur. Middle management will not have the knowledge or ability to deal with the issue and it is often referred back to staff who may not have the necessary training and no real supervisory responsibility. There is an attitude of blame because the people who have to deal with the issues are not given support or assistance from senior managers. In the hotel service or domestic area it is a discipline process in which an individual will be held accountable. These matters arise on a regular basis without any recommendation about how an incident might be prevented in the future. Without that support from management, individuals go underground and, not knowing what to do in the future, come up with other options to avoid being disciplined. They may not necessarily be the right options, but without clear direction and support that is a common approach and outcome. All areas appear to have developed a policy and procedures manual for investigating allegations of poor performance. Those policies seem to focus on finding an individual responsible and charging him or her under a section of the policy.

The Hon. CHRISTINE ROBERTSON: It is not unlike what was described. How involved are your members in the Institute for Clinical Excellence [ICE] program?

Dr LLEWELLYN: The root cause analysis training is run by the ICE. It is primarily run by consultant staff or persons in medal administration. So, there would be very little involvement, apart from junior doctors who are training in medical administration.

The Hon. CHRISTINE ROBERTSON: Would it be more effective if more clinical doctors were involved in the program?

Dr LLEWELLYN: I do not know much more about the program than what I picked up in the root cause analysis training. If it trained broad clinical government skills and issues of quality improvement it would be useful for all doctors, and the earlier they did it the better. As I noted in my submission, we have changed a great deal over the past few years. When I trained we did not do much about evidence-based medicine. Now it is on the tip of the tongue of all medical students. It is not much of a step from there to quality assurance and improvement and doing things in a quality cycle rather than simply the way they have always been done and not questioning it. If those skills were taught at the medical school stage, reinforced at the junior doctor and registrar level and refresher courses provided at the consultant level the training would be effective. Again, it should be aimed not only at doctors but also at other health professionals. Health professional members have been requesting funding to look at proving efficacy in certain treatments and have been denied because the status of physiotherapy, or whatever, is not at the same level as medicine. If it were done across the broad profession it would be useful.

The Hon. PATRICIA FORSYTHE: In your submission you refer to root cause analysis and state that it is being used by managers to intimidate staff. Do you have some examples of that?

Dr LLEWELLYN: That was from other members.

Mr MYLAN: There is a misunderstanding about the benefits of a root cause analysis. That may be the result of a lack of training and understanding of the process. As I said, members feel that it has always been a fact-finding and disciplinary procedure. They know that after a number of steps they will be disciplined and as a result they are not willing subscribe to it. That obviously relates to lack of training. Benefits are experienced at the medical level as a result of training. One of the problems the union has found with allied health staff, and certainly support staff, is the lack of training or the ability to gain access to training. A great deal of money is provided for training professional staff, but there is little for the support staff. We are now in a different culture, training has moved on from the quick seminar and a test at the end of the day. It now involves competencies and people being recognised at a certificate level. If that level of training were pursued, people would be more supportive and trusting of the process. Of course, I believe that would also lead to better outcomes. Conclusions would be reached and recommendations implemented rather than individuals being disciplined.

The Hon. PATRICIA FORSYTHE: A member suggested that there is a structural issue in the way health may be set up that gives rise to some problems. Reference is made to investigations usually being performed by senior managers who have little first-hand understanding of the issues, but who often act to remove themselves from responsibility. Is that also related to the area system?

Mr MYLAN: Yes it is. Health, like any organisation, will have many managers who may not necessarily have a background in health or who have a limited background. Managers will manage according to the information available to them and will implement the policies placed before them. However, we often find that it is better to have a matter investigated by someone who is knowledgeable about and works in the area. Such a person has a far better understanding of the issues and is better able to investigate and seek outcomes and also to understand what members are saying about the problems in their profession or in the ward in which they work. A manager may not be totally familiar with the people and they may be reluctant to provide further information because of what might occur in their ward or profession. The managers want outcomes and they follow the points in the policy, which is clearly deficient.

The Hon. PATRICIA FORSYTHE: Do you do surveys of whether some areas are more prone to complaints from members? Do you have a view about those that work well and those that do not?

Mr MYLAN: Not a specific survey to ask that specific question, but the union has conducted surveys over, I would think, the last 18 months or two years of the wider membership, not just in public health, asking a range of questions, ranging from their view of their employer to all sorts of views about the union or problems in the workplace and how things can be improved. There have been some indications from members, as recently as our union's annual conference, that some areas do not handle investigations as well as others or have a particular style. That has certainly been brought to our attention.

The Hon. PATRICIA FORSYTHE: Are you prepared to identify those areas?

Mr MYLAN: Yes, I could. One that springs to mind and has been raised formally by our union to the Department of Health or the Western Sydney Area Health Service is that there appears to be certainly a very committed culture there, to just reach an outcome and discipline someone. Also we found deficiencies in the area's policies and procedures manuals for dealing with fact finding and disciplinary procedures. That was brought to the attention of the Department of Health after the area failed to address the concerns we raised, which were that the Department of Health had put out a guideline in regards to disciplinary procedures and so forth. The area health services have a certain amount of autonomy whereby they can develop their own procedures based on that. The Western Sydney Area Health Service did not comply. We pointed that out. It was not addressed and we had to take the matter to the people at the Department of Health to have it addressed.

The Hon. PATRICIA FORSYTHE: Has it now been addressed?

Mr MYLAN: It has been addressed. The Department of Health intervened in that matter. In addition to that there are a couple of cases where our members have been investigated. Some of them featured in the media just recently. They were clearly, as we would see it, examples of why the Industrial Relations Commission reported that people were certainly set up and trapped in a situation where they could be disciplined, and that clearly serves as no means of addressing a problem. We believe it is just looking for an outcome and it was quite disappointing that an area health service would resort to that. Of course there was additional expense in tying up health workers in the industrial court and it was quite an expensive and lengthy dispute in the Industrial Relations Commission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your submission—I am not sure whether it was your comment or Dr Llewellyn's—but you counter pointed root cause analysis as a management tool versus patient advocates which keep the patient focused and in a sense deals with the problem in a rather concrete way rather than as managerial analysis. Would you comment on which you think should be done, or do think they both should be done, or do you think we should simply have patient advocates and that root cause analysis would become fairly clear?

Dr LLEWELLYN: The root cause analysis and patient advocates are not a general panacea for the system on their own. Quality improvement is a complex area.. I would be wary of an area health service that suddenly springs up and says " Well, we do root cause analyses on all our serious incidents now."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is what they say though, is it not?

Dr LLEWELLYN: It may well be. Root cause analysis [RCA] is a very intensive process. It ties up a lot of resources for one particular incident. You cannot do it for every serious incident. In my opinion sometimes it is being done inappropriately in some instances because it is being seen as the thing we do all the time. It is being pushed a little bit by coronial inquiries where it is expected that an RCA be done on everything that appears in front of the Coroner. There are other ways of quality assurance that involve consumer participation and appropriate complaints handling. I think I mentioned in my submission that most doctors—at least junior doctors—are not appreciative or do not realise the benefits of addressing a complaint in the appropriate way as actually being helpful to the system, not being an attack on the system. Consumers can often see the holes in the system from a different point of view, which actually points out the problem. I think a system—each area health service or each hospital or community health team, whatever it might be—needs to have appropriate quality assurance programs in place and they will vary, depending on the needs of the particular system. A general "We do RCAs" across-the-board is not going to solve the problem. It is just another way of possibly hiding the problem or being seen to do something.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they eating up unreasonable amounts of resources? I have had it said to me that people are spending so much time analysing things that they cannot get their own work done. That is someone who is a relatively senior clinician in your discipline.

Dr LLEWELLYN: I would suspect so, particularly if it is the same people being called upon to do a batch of RCAs. I think we have had 60 or more in our area for less than a year's time. They tie up people for up to a day and a half in total with meetings—meeting with the committee, then meeting with people you have to interview. Sometimes it can be longer than that. It is fairly expensive in wages to review everything that might come up when it may well be more appropriate that some of these things should go to the serious incidents review committee and some should be dealt with by a morbidity and mortality meeting or some should be

discussed in a peer review meeting, et cetera. As long as you can document that you are doing these things, I think that is the main thing, and the outcomes from it. You may decide to change something in the system and then find when you review it that it has actually not been beneficial, but at least you have made the attempt. Then the process is to review things again and have another go. That is the cycle of quality.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So RCAs might be suffering from the law of diminishing returns if you do too many of them?

Dr LLEWELLYN: I would suspect so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With patient advocates, I gather that not much in the way of resources has been put into patient advocacy within the system, is that correct? Is that your analysis of the situation?

Dr LLEWELLYN: Within mental health it is fairly mandatory. We have consumer representatives as part of the National Mental Health Strategy, but it is variable in other parts of the system. Within the Hunter Area Health Service I am not sure—I may be wrong—but I do not think there are any patient advocates in the general system, but Peter might want to answer that.

Mr MYLAN: Yes. I wish to add that it is not consistent. It seems to be more of a matter of a local hospital or area health service and whether they choose to have them. We have found or been advised from the membership that where they do exist they certainly have a role to play where it may not prevent somebody from referring a matter to the Health Care Complaints Commission [HCCC]—and certainly if that was seen as being relevant, that would occur—but may be able to provide mediation, if they can be removed from the hospital if you like in their employment role and be able to be a fair advocate while understanding the issues between a health care worker or a medical professional and explaining and understanding the concerns of the patient or the visitor. Often that may lead to a more harmonious understanding and a satisfactory outcome, which we would certainly see as being positive.

The Hon. CHRISTINE ROBERTSON: The first of two issues I have follows on from that answer. Do you think that having a special person in an office, especially in some of these larger health services or hospitals, who is called the patient advocate is the way to go, or do you think it would be preferable to increase the education and knowledge among the entire workforce so that they understand the system and advocacy?

Dr LLEWELLYN: I think both. The danger of having one person tied up in that role is that that person may not be a great person in the role. Sometimes these people do have their own agendas. With consumer representatives in mental health, sometimes they become sick and that becomes a problem. When they are good, they are really helpful, but sometimes they can set up a splitting environment on a ward where they set staff against each other, et cetera. The person needs to be as well qualified and trained in the role as any other person and well supported. I would not want to be that person because it is a fine line to walk between looking after patients when your employer is potentially the hospital and your manager is a manager of the hospital and they have to meet those two demands. I would also say that it is not only the patients that need advocacy in the system, it is the carers, and sometimes they are forgotten. Sometimes the view of the patient and the carer is quite opposing and the carers feel left out, so there is a need for that too. I think that involving consumers in the process of reviewing what we do, why we do it, et cetera, is important and certainly that is the way that research is going in terms of medicine, and that is important. But, again, but I do not think it is something that most junior doctors are aware of. They sometimes see a complaint as being a personal attack on them. It is not about that. It is often that the person is frustrated by the entire system and the doctor just cops it because they are the most convenient person at the time.

The Hon. CHRISTINE ROBERTSON: We have also received evidence from the Department of Health and some of the area health services about their processes for quality. Of course, root cause analysis, when you are talking about the issue as a whole, is only a small piece. My concern is implementation on the ground. What you have demonstrated today he is that neither of your groups is integral to the implementation of the State's world-class quality program. Apart from the training—often people will obstruct getting that training anyway because of where they have come from—do you have any other ideas about implementation? Do you know what I am saying? I am talking about this entire plan that obviously you are not getting, but someone in your area would be beavering away at it.

Dr LLEWELLYN: You have hit it on the head. One thing is actually getting doctors to be able to get the time to do these sorts of training exercises. It is a feat of magic in itself sometimes. There are so many things that we are now required to do as mandatory training. We are supposed to do child protection, fire training, back training, and there will be suicide prevention training soon, and there will be aggression training. You will spend your entire day training and not actually seeing patients or researching things. I am not sure I would go as far as to say that some of these things should be mandated, but it certainly should be part of the performance appraisal process, particularly for senior clinicians that probably all of that—things like teaching, supervision, peer review—are reviewed and checked off as something that has been done for the past six months or 12 months, or whatever.

The Hon. CHRISTINE ROBERTSON: It is a bit hard to measure who wants to play. That is the problem, is it not?

Dr LLEWELLYN: Yes. If it is part of your work contract, I think that is the way of ensuring that it occurs more across-the-board.

The Hon. ROBYN PARKER: Dr Llewellyn, the Hunter Area Health Service is trialling or piloting an incidents monitoring system. Can you give us your views on how that process is working?

Dr LLEWELLYN: I think that dovetails into the RCA, actually. It is a sort of overarching process and reports straight to the quality unit, which I believe is in the clinical governance unit of the Hunter Area Health Service. Basically a score card is looked at when each incident comes in and checked off by I think a number of people and it is then decided by a manager at a reasonably senior level what process should be followed from there, whether it is just referred to a regular meeting or a serious incident review or a root cause analysis. Within mental health, we have taken the view that all serious incidents such as suicide or violent acts will be referred to a root cause analysis process. I believe we have undertaken about eight or 10 of those of our own so we are very proactive in that.

Again I think we feel that we have been forced to do that and possibly it might be a useful thing, but we have not got any feedback so far to determine whether the changes that have been implemented have worked or have been beneficial. The root cause analysis is supposed to look at things that were not intended to happen. While a suicide certainly would not be wanted in psychiatry, it is one of the foreseen possibilities so it seems a little nonsensical to me that we would be investigating something like that along a root cause analysis line. Maybe there is another better process of doing it. As I pointed out before, we really do not have a lot of evidence for a lot of the things we do in medicine. We just do them because they have been done. We are reviewing that, but that sort of literature is really only 10 or 20 years old.

The Hon. PATRICIA FORSYTHE: In any of these exercises, are you able to suggest from time to time whether the hospital's public relations department is getting involved? Is it often about covering up what might have happened, or is it generally about trying to find solutions?

Dr LLEWELLYN: Sometimes it is about genuinely finding solutions. It has been suggested that it is something that would be publicised, but I am not aware of any particular cases when that has occurred.

Mr MYLAN: I know a number of area health services employ a public health unit and public media persons from time to time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you keep a top box of hospitals that have more complaints lodged against them? A lady from the Medical Error Action Group received a lot of complaints and basically had a list of hospitals in order of how good or bad they were in terms of the complaints she received. Do you have anything to do with those, or do you have your own list?

Dr LLEWELLYN: I do not think so. To comment on that, the science behind that report was a bit iffy—the bigger hospitals got the most complaints and therefore ranked first. That is not surprising if there are more patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure. It depends on how well the organisation is known in different areas.

Dr LLEWELLYN: Exactly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But presumably you have a more diffused membership. You might be able to get an idea which hospitals have bad problems, or you may see it from an industrial spectrum.

Mr MYLAN: It is better to say that it is an industrial organisation. We may only see it through an industrial perspective. We would certainly take that on board through special committees that the union has formed in relation to doctors and the professional delegates forums that we have representing allied health. They would indicate to us if they had particular concerns about health areas that we would deal with at the local level in the first place, and at a more senior level if necessary. It is not that we have a special hot box in which we list those workplaces or a particular manager's name.

The Hon. AMANDA FAZIO: In the submissions from the Health Services Union, to which Mr Mylan has been speaking, and in Dr Llewellyn's submission, a number of recommendations have been made based on our terms of reference. Do you have any other suggestions that you would like to put to the Committee for its consideration when drawing up recommendations from this inquiry?

Mr MYLAN: Just one has sprung to mind, that is training and looking for suitable people for the role of patient advocate, or root cause analysis. For Health to get the right people, it may well be a consideration to encourage people who wish to be trained and proficient in that area, that they come forward rather than training everyone, or them having a expectation of the responsibility of the position held. Often people have a specific interest in a matter and may have more of a flair and a committed responsibility to addressing those points. We would encourage Health to take that on board, to determine that, and to have some recognition of individuals' additional skills.

Research documents of Dr Llewellyn tabled.

(The witness withdrew)

PATRICIA ANN McDERMOTT, Acting Director of Public Affairs, North Shore and Ryde Health Service, Royal North Shore Hospital, sworn and examined, and

STEPHEN TIMOTHY DENNIS CHRISTLEY, Chief Executive Officer, Northern Sydney Area Health Service and Central Coast Area Health Service, Royal North Shore Hospital, affirmed and examined:

CHAIR: Earlier I read out a statement, which I will not repeat, about the responsibilities of witness and those of the Committee. In what official capacity do you each appear?

Ms McDERMOTT: I am here as a representative for the Northern Sydney Area Health Service.

Dr CHRISTLEY: I am representing Northern Sydney and Central Coast area health services.

CHAIR: Do either of you wish to make an opening statement?

Ms McDERMOTT: Yes, Mr Chairman. I will outline the duties of public affairs as we see them in the Northern Sydney Area Health Service. We maintain and enhance the reputation of Northern Sydney Health by seeking media coverage of Northern Sydney Health activities, including clinical achievements, health services, research, teaching and health promotion, and by responding to media and community requests for information. We act as general counsel on media and community interest matters to Northern Sydney board members, executive, staff and patients. We receive internal and external communications, including publications and a web site. We administer a staff reward and recognition system, and events, and publicise the work of affiliated groups.

We support fundraising activities. We have some responsibilities for recruitment and recognition of volunteers. We undertake other activities as required including speaking engagements, tours, displays, opening of facilities, announcements, filming and equipment hire. We respond to requests from the Minister and the Department Of Health. Northern Sydney Health public affairs officers work to bring the benefits of medical, scientific and health research activities and clinical expertise to the attention of the people of Northern Sydney and New South Wales. In doing so, we believe we also attract and retain the very best nursing, medical and allied health staff.

The Hon. PATRICIA FORSYTHE: Ms McDermott, how long have you been in your current position?

Ms McDERMOTT: Approximately seven years.

The Hon. PATRICIA FORSYTHE: To whom do you report? How does it work?

Ms McDERMOTT: Until recently I have reported directly to either the executive director and the now named general manager of the Royal North Shore Hospital. However, in the last month or so there has been a change in public affairs at Northern Sydney. It has been areaised—I know that is a mouthful, but it has been made into an area department, rather than a direct hospital department. In that case I report to Dr Christley.

CHAIR: Are you saying you are now responsible for Ryde as well?

Ms McDERMOTT: Yes, indeed. There is a two-part answer to that question. Recently Northern Sydney Area Health Service divided into three sectors; Hornsby Ku-ring-gai, Royal North Shore and Ryde, and the Northern Beaches. I became responsible for Royal North Shore and Ryde as part of my job in public affairs for Royal North Shore Hospital. In addition, somewhat more recently, there has been a change in our department in that we are going to be areaised—rather, we are areaised—and in such case we have responsibility for all public affairs for Northern Sydney Health.

CHAIR: I feel sorry for anyone who is areaised. Does Greenwich come under your responsibility?

Ms McDERMOTT: Greenwich is part of the Hope health care system, of the Anglican Church, but it is also partnered with the Sydney health group hospitals, yes.

The Hon. PATRICIA FORSYTHE: That areaisation, which may not be a real word—

The Hon. CHRISTINE ROBERTSON: It is a malapropism.

The Hon. PATRICIA FORSYTHE: Was that decision taken by the area health service or by NSW Health?

Ms McDERMOTT: By the area.

The Hon. PATRICIA FORSYTHE: What is your grade and salary?

Ms McDERMOTT: I am a health services manager grade 4.

The Hon. PATRICIA FORSYTHE: You have talked about your role as a public relations officer. What is your role when a contentious issue arises to do with patient care or when you are aware of a complaint?

Ms McDERMOTT: Our department does not handle clinical complaints, I need to make that very clear. Those are handled, as you discussed earlier this morning, by the patient representative and sometimes directly through to the general managers of services and to Dr Christley in his position as chief executive officer. In terms of contentious issues it may well be that we are asked to come in, in an advisory capacity, but it would always be with other senior managers and, very likely, the general manager or the CEO.

The Hon. PATRICIA FORSYTHE: In your opening statement you said that you respond to requests from the Minister or NSW Health. How closely do you liaise with both NSW Health and the Minister's office?

Ms McDERMOTT: I said that we respond to requests and that frequency obviously varies week-to-week and month-to-month. In the Department of Health, as an area media liaison officer, I meet with the department three or four times a year in a face-to-face group meeting. All of us in New South Wales do this and we meet together to discuss issues of mutual interest and concern. It is certainly a professional development program as well. We meet with members of the Communications Division in the Department of Health. Every two weeks I have a teleconference with the same people; in other words, representatives from all the area health services and representatives from the Department of Health as well. We discuss issues of interest at that time, events we may be planning, and things we are looking at doing. From time to time we also have phone calls from them if they are seeking information, or we ring them to seek advice.

The Hon. PATRICIA FORSYTHE: Can you be both proactive and reactive? For example, if you see a good news story do you suggest that it might be used as the basis for a broad story at the departmental or ministerial level?

Ms McDERMOTT: No, rarely would I suggest that. I certaifnly mention that we are looking at that and have some good news, because that is part of our job, for all the reasons I outlined earlier. It would not be up to me and not in my area of expertise to suggest that it be used in a wider basis.

The Hon. PATRICIA FORSYTHE: Recently a case was used from your area that attracted some publicity involving baby Paris Panetta. Can you outline your role in the press conference held by the Minister on 19 February in relation to baby Paris Panetta?

Ms McDERMOTT: I had no role in the actual press conference.

The Hon. PATRICIA FORSYTHE: How did the story advance, if you like, from the hospital to the Minister's office?

Ms McDERMOTT: To give some background, we had an established relationship with the Panetta family. Baby Paris, as you may be aware, was the second-smallest baby born in New South Wales to survive, with the help of the neonatal intensive care unit at Royal North Shore Hospital, of which we are very proud. Not only did she survive, she is actually doing extremely well. We were made aware of this through our fundraising department and we thought of it immediately is a wonderful story. We approached the Panetta family and established a rapport with Mrs Panetta.

At the time we held off doing the usual thing, which would be, perhaps, to look for local media interest. I thought in this case it would be good to look at the whole issue of neonatal intensive care, what it achieves, what are the high points and the new developments. Baby Paris was an excellent example of how well we were doing in that area.

At the time Mrs Panetta's mother was ill. Mrs Panetta was keen to do the story but asked us to wait until the situation was resolved. We agreed to do so. It was mentioned in the teleconferences to which I referred earlier—they used to take place once a week but now they are about every two weeks—that the story would be a good idea to do sometime down the track but we were waiting for Mrs Panetta's mother's health issues to be resolved. On the day of the press conference—19 February—I was contacted by a member of the Minister's office and asked about Mrs Panetta and whether I thought it was possible that she might think positively about coming in and participating in such press conference. Of course, I did not know whether she would or not. At the same time it was suggested that we might also ask the neonatologist who had been most responsible for baby Paris's care to attend. As you have heard from the earlier witnesses, neonatologists have busy lives and I knew that it would probably be difficult for him to move appointments and so forth. However, I agreed to ask. And that is what I did. I first rang the doctor in question and asked—

The Hon. PATRICIA FORSYTHE: You said that you were contacted "on the day". What sort of time was it?

Ms McDERMOTT: It was about 10.30 to 11 o'clock in the morning.

The Hon. PATRICIA FORSYTHE: Was Mrs Panetta aware before the press conference of other issues that were running in Parliament at that time?

Ms McDERMOTT: It is hard for me to speak on her behalf. I formed the opinion that she was generally aware—as I think most people in New South Wales are—that there is certainly media interest and public interest in health but I cannot be sure of her detailed knowledge of the situation.

The Hon. PATRICIA FORSYTHE: What sorts of conversations did you have with the Minister's press secretary about how Mrs Panetta's story should be told?

Ms McDERMOTT: I do not think it was the Minister's press secretary who contacted me. I had no conversation with him about how the story should be told. He simply asked me to establish whether or not Mrs Panetta and the neonatologist would be interested in taking part in such a press conference.

The Hon. PATRICIA FORSYTHE: If it was not the Minister's press secretary who was it?

Ms McDERMOTT: I think it may have been a policy adviser to the Minister.

The Hon. PATRICIA FORSYTHE: Do you have a name?

Ms McDERMOTT: I can give you a name. It was Mr Nathan Rees.

The Hon. PATRICIA FORSYTHE: Thank you. This story then attracted a fair bit of media interest. As I recall, the next day the *Daily Telegraph* ran a piece suggesting that you had suggested to Mrs Panetta that she would do you a "big favour" if she was prepared to participate in the story. Do you know where the *Daily Telegraph* would have got that quote?

Ms McDERMOTT: Mrs Panetta told me that the *Telegraph* had rung her.

The Hon. PATRICIA FORSYTHE: In the follow-up to that have you had discussions with Mrs Panetta about how the issue was handled by the media at the time?

Ms McDERMOTT: No, I have not.

The Hon. PATRICIA FORSYTHE: You suggested that beforehand you had a relationship with Mrs Panetta. But you have had none since then.

Ms McDERMOTT: I have spoken to Mrs Panetta since then but not to discuss how the media handled the issue.

The Hon. AMANDA FAZIO: Is it the case that Mrs Panetta had already spoken to the hospital and agreed to be involved with publicity regarding her satisfaction with the level of care that Paris received well before this issue came up in February?

Ms McDERMOTT: Yes, that is right.

The Hon. AMANDA FAZIO: Did Mrs Panetta indicate to you at that time why she was happy to discuss the care that was delivered to her child?

Ms McDERMOTT: Without talking in any detail about Mrs Panetta's family because I have not established her willingness to have me do so and I only know a few details, she was delighted that her child survived. It was obviously a difficult and tricky situation during the pregnancy, delivery and subsequent care of the baby. I think most mothers would be delighted to have the results that she had and she was happy to speak about it publicly—I imagine probably to encourage other mothers and families in the same situation and to recognise the skills that were brought to bear in Paris's care.

The Hon. AMANDA FAZIO: You said that Paris was the second smallest baby born.

Ms McDERMOTT: I believe so.

The Hon. AMANDA FAZIO: Do you know where the other child who was born earlier received his or her care?

Ms McDERMOTT: No, I do not.

The Hon. PATRICIA FORSYTHE: For the sake of completeness, I return to the issue of the quote in the *Daily Telegraph.* Were you misquoted?

Ms McDERMOTT: Could you tell me what the quote is, please?

The Hon. PATRICIA FORSYTHE: You were quoted as telling Mrs Panetta that she would do you a "big favour" by appearing in the story.

Ms McDERMOTT: I believe that is a misquote. I have a pretty clear idea of my discussions with Mrs Panetta. As I mentioned to you, I had already spoken to her—as had members of my immediate staff—in early February to establish what we would like to do with the story. However, as I said, we decided to hold off in deference—

The Hon. PATRICIA FORSYTHE: Did you suggest Parliament House as a venue when you talked to her?

Ms McDERMOTT: No, I had nothing to do with the setting up of the press conference. In briefing her and asking Mrs Panetta whether she would be prepared to come in, I reminded her, or pointed out to her as she already knew, that there were certain issues in health and that in our minds it would be rather nice to show some of the good side of things—this triumph, if you like—on the part of her and her baby. She was very happy to consider it.

Dr CHRISTLEY: It is not an uncommon circumstance for people to want to express public appreciation of care received in hospital. In fact, at the opening of the neonatal intensive care unit building that Mrs Panetta's baby was treated in two patients spoke about their experiences.

The Hon. PATRICIA FORSYTHE: Did you have any discussions with the Minister's office about, or take directions in relation to, this story?

The Hon. AMANDA FAZIO: Dr Christley, in your time in the medical system how would you describe the standard of care that was delivered to Mrs Panetta's daughter?

Dr CHRISTLEY: My time in the medical system includes about six months working in neonatal intensive care units in my distant past, so I have a bit of experience of the intensity both in terms of the physical and the emotional requirements of caring for small neonates. By virtue of her survival, Paris, first, had very good care; and, second, was probably a pretty exceptional baby.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If I may pick up on that point, you said that the care was pretty exceptional. I presume that you mean the post-birth care.

Dr CHRISTLEY: I am not aware of the antenatal care. As you would be well aware, the outcome for a neonate is from antenatal to birth and the postnatal care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but the greatest gains in terms of health dollars saved are in antenatal care, which means that babies are not born so small.

Dr CHRISTLEY: We are probably on the same side of the wicket. Certainly I think the effort put into smoking prevention, making sure that women get antenatal care and particularly targeting those who are at risk and ensuring as far as we can that they are followed up assertively is very important.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does Royal North Shore Hospital have an antenatal clinic?

Dr CHRISTLEY: Yes. It runs a number of different models of antenatal care, ranging from the traditional model through to team midwifery approaches. At Ryde Hospital recently there has been a caseload midwifery approach adopted. So in terms of varieties of models of care, within the Royal North Shore-Ryde sector and across the area health service there is a variety of models of care for people to tailor their individual requirements to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In small-birth babies is there a backward look in the sense that a small baby is an adverse event in terms of antenatal care although it may be seen as simply a difficult start? Is there any backward feed that way?

Dr CHRISTLEY: There is both a forward and a backward look. Royal North Shore Hospital has I think probably one of the best perinatal units in the country, headed by a professor at the University of Sydney. It offers very good antenatal care of at-risk pregnancies for not only the public sector but private sector people in Northern Sydney and beyond. If you then have an unanticipated or undiagnosed adverse foetal outcome that would be a reason to look back through the quality system. The important thing is the prospective look. Without wanting to wax for too long about why I do what I do, I do what I do because I got interested in how the health system works to prevent morbidity not to pick it up when it happens.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In their evidence to the Committee, representatives from the Medical Error Action Group commented, "When you look at it from that angle but just based on the group's research there are certainly problems in hospitals on the lower North Shore. They have either got a very careful media person in that area who has stopped it getting into the media."

Dr CHRISTLEY: I think one of the previous witnesses made a comment as to the methodology of those reports. I think the care provided in Northern Sydney hospitals and in other hospitals that I have experience of has a number of safeguards. In the North Shore context, in terms of the issues that we have been talking about today in the brief time that I have been here, there are patient representatives. A retrospective note audit is conducted on a large sample of records when flagged by any indicator. From that there is an analysis as to whether any systematic issues need to be picked up relating to patient care or any sporadic rather than systematic issues. There is a very comprehensive review—probably one of the best in the country—of patient outcomes and system issues. So I do not think it has anything to do with public affairs, as Pat said.

If I can make one other comment about complaints—this is perhaps a better way to judge how the system performs—I said before that at the North Shore opening a couple of people spoke well about their care in the system. At the quality week official function the year before a person who had been a complainant about the health system stood up and talked about her experience as a complainant. She had come from Queensland to do so. Because she was listened to she had seen a systematic change in the health system. She was in palliative care

in one of our major metropolitan hospitals. I think that is really the judge of the health system: if people can come through—sometimes it is because health deals with difficult emotional times and it is the reaction of the individual and sometimes the system has done the wrong thing—and be advocates for the health system I think you have achieved something.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would not accept the statement "There are certainly problems in hospitals on the lower North Shore"?

Dr CHRISTLEY: I do not think anybody could say that there are not problems. If you say that—I hope that I am not going to say anything about anybody who might have spoken previously because there are inevitably problems in any system—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She is taking a comparative approach.

Dr CHRISTLEY: I could comment about the interaction of the Medical Error Action Group and some of the quality improvement processes at North Shore. We tried to bring them in to some improvement processes but there was a breakdown in the relationship. The quality improvement people's perspective was one of no delivery on promises.

CHAIR: Could you elaborate a little on that point?

Dr CHRISTLEY: I do not want to go too far down that path but a nationally funded project was run out of a quality unit in North Shore where it was looking for consumer inputs. It was not a very successful relationship in terms of getting constructive input from consumers and it ended up going elsewhere to get that input. The people trying to run that project had credibility and certainly were not coming from a management perspective but from clinician and process improvement perspectives. That is not to condemn anything that is being said.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that to do with the Medical Error Action Group having to be paid for its time?

Dr CHRISTLEY: It did get rather expensive as time went on with no return. That was one of the issues.

The Hon. PATRICIA FORSYTHE: Ms McDermott, returning to 19 February so that I get the complete picture, you said that at 10.30 in the morning there were some decisions or thoughts that you might wish to do the Paris Panetta press conference on that day. When was the decision taken to have the press conference at Parliament House?

Ms McDERMOTT: I did not take any decision about that. As I said, the press conference was—

The Hon. PATRICIA FORSYTHE: When were you advised that it was to be in Parliament House?

Ms McDERMOTT: It was suggested to me before I rang the two people who would be likely to participate, that is Mrs Panetta and the neonatologist, that four o'clock was an appropriate time.

The Hon. PATRICIA FORSYTHE: In Parliament House?

Ms McDERMOTT: Yes.

The Hon. PATRICIA FORSYTHE: Where did the idea of doing Paris Panetta on that day originate? Was that a decision that you had taken, or was it put to you that it might be something that should happen that day?

Ms McDERMOTT: It was just put to me that morning that it was something we could do that day. As I mentioned to you, from early February we had been speaking to Mrs Panetta about doing something.

The Hon. PATRICIA FORSYTHE: Was the organising of the press conference done at ministerial office level?

Ms McDERMOTT: It would have been. It certainly was not done by us.

The Hon. PATRICIA FORSYTHE: Was the health of baby Paris checked on to see how she was going at that stage?

Ms McDERMOTT: Yes. This is quite an important point because the health of our patients, both of those in hospital and those who have been in hospital recently, is paramount. My first call was not to Mrs Panetta, but to the neonatologist because I am not a clinician and I have no ability to decide on anyone's health at that level. In speaking to him, he had no reservations. He also pointed out at the time that Mrs Panetta was a strong and feisty person who would make her own wishes very clear. In other words, if she did not wish to participate she would certainly say so. I also believe very strongly, and I imagine that Dr Christley and perhaps most of you would agree, there is not anyone who knows a child better than its mother. I was relying on Mrs Panetta and her feelings about how comfortable she would be travelling with her child and in being part of the day's events. I was confident, because of my earlier conversations with her and because of the doctor's comments, that she would certainly not be backward in coming forward and stating what she felt about this. In that case I felt comfortable in speaking to her about it.

The Hon. PATRICIA FORSYTHE: What are the protocols for dealing with both good news and bad news stories with the Minister's office?

Ms McDERMOTT: I do not deal with the Minister's office very often about stories. We have occasional contact when there is something of interest. Most of that seems to be made via the Department of Health. I speak to them and speak to people there. They may or may not pass on information to the Minister's office, and I do not know in what way that is done. The most contact we generally have with the Minister's office is to do with events, with things that are coming up. We may prepare a briefing note, for example for the opening of the building or the Minister coming to officiate at a ceremony, or in some other capacity. I do not think in the seven years that I have been in my present position I have dealt with them in the sense of bad news or good news per se.

The Hon. PATRICIA FORSYTHE: This was quite an unusual event?

Ms McDERMOTT: It was rare, yes. I do not think unusual would be correct, but rare would be correct.

The Hon. CHRISTINE ROBERTSON: Would a good news story about your hospital, with all of the media, in Parliament House be a fantastic coup in the terms of reference you read out earlier? Is it a really good thing to happen?

Ms McDERMOTT: Yes, generally. It would not be a bad thing to happen.

The Hon. CHRISTINE ROBERTSON: It would fit in well with your agenda, and the news that it would happen at Parliament House meant that you would get full media, is that correct?

Ms McDERMOTT: Yes, that is right. We might expect to get full media—

The Hon. CHRISTINE ROBERTSON: But you do not always.

Ms McDERMOTT: Certainly not. It very much depends on what else is happening on the day, staffing and so on.

The Hon. CHRISTINE ROBERTSON: One of the issues that seems to have come up during evidence in the inquiry is the implementation of the clinical governance programs and complaints handling. Including the development of a culture of learning, could you give us an outline of how that is going in the areas you look after?

Dr CHRISTLEY: It is a bit like my comment that you can never say everything is perfect. It is a journey. I think we are a far way along the journey. Your last point was training, and I think training is fundamentally important, not just the root cause analysis training, but we need to train people in clinical process improvement. Significant numbers of people have been trained in clinical process improvement. In fact, the clinical process improvement training program is housed at North Shore. We have just implemented a one-day

program—the previous one was one week—to give people an understanding of how you look at health care systematically, how you can measure and how you can improve. That understanding is very important because you do not need to go through a whole lot of scientific exercise to take that understanding to any problem that you encounter in the health care system and try to look at it in a way of how to improve the process of the interaction between different parts of the health system rather than historically people living in silos of occasions and if anything went wrong it was somebody else's fault rather than something about the way the system was working systematically.

We still have elements of that culture, but what I see is an increasing openness at all levels in the health system, both health systems, to talk about things that are wrong and report incidents. For example the Treasury Managed Fund and the mandatory reporting by medical staff of incidents where they feel there may be a liability issue is a very important thing. Often senior medical staff did sit a bit outside the system and did not necessarily report. They report to their insurer, but the health system was not always aware as it would have liked to have been of events. The root cause analysis system has been discussed at some length, and that is a very important component of what we do. The question of when you do an RCA and when you do not do an RCA, and I you going over old ground when you do is something that the system needs to develop a response to. There are also a large number of things that are not SAC one or SAC two on the security scoring, large volumes of incidents that should come through the complaints system, through incident reports, through a range of different avenues. That is also useful information in looking at what are some of the areas we have made.

The Hon. CHRISTINE ROBERTSON: Does anyone have time to analyse it?

Dr CHRISTLEY: That is where the implementation of the AIMS system, that was discussed as having been piloted in the Hunter, will be important. However, analysis is being done. In both the health services that I have accountability for in the last couple of weeks I have looked into attempting to almost reverse engineer information to produce an idea of what some of the trends around falls , for example, might be or other patient events. Where both of the health systems are going now is to risk rate those and try to look at how we direct or improvement resources to make sure that we are addressing the things of potential or real significance in terms of patient outcome.

The Hon. ROBYN PARKER: A person spoke earlier today about a loss of autonomy with the area health services. Could you explain?

Dr CHRISTLEY: I was not here when that comment was made. Could you expand upon it?

The Hon. ROBYN PARKER: Is that your view, that there has been a loss of autonomy in terms of complaint mechanisms within hospitals?

Dr CHRISTLEY: No. In many ways, health is going from being a cottage industry to other larger, more process-driven industry. You need to standardise certain things. You cannot protocolise everything. We still rely on the skills and goodwill of the professionals who are at the front line. Ultimately, they are the ones making the decisions. The difference between a pure process engineering in the manufacturing industry and health is that health is not stable, it is chaotic. Everyone who comes in has something different. There is a high level of skill in fitting particular patients into the system. In terms of standardisation, if that is what is meant by loss of autonomy, I do not see it as that. The only way we can learn is by having more standard ways of reporting and analysing so that we can identify best practice and share best practice across the system. I think that it would be a major risk if what people have been doing with that information was attempting to be controlled because people at a professional level need to go to work through in their local context what has happened in particular clinical circumstances or a range of clinical circumstances to come up with the right answer. But I do not think every health service can be an island. We are a complex health system and we have a lot to learn as a health system.

CHAIR: The witness was saying that since there have been area health services there has been a rise in the culture of blame.

Dr CHRISTLEY: That is an interesting observation. I would actually turn it around on society if that were true. Society is developing more of a culture of blame and in society there is a lack of personal responsibility that people are tending to take. I do not see area health services in any such culture as being linked. In fact, probably the best way to break down a culture of blame is to develop the culture and systems that

we were talking about earlier around understanding care processes and working to improve those care processes because what you recognise very quickly as you try to do that is that there ain't a lot of point in blaming the person in the next department because you have probably contributed, or the system has contributed to whatever has led to that. We have an opportunity to break down any blame culture through the processes of change that are happening in our health system at the moment. I think it is a very positive time. But the health system is often under stress and that certainly can, at times, go back towards a culture of blame.

The Hon. ROBYN PARKER: Going back to the Panetta case, could you elaborate on something you said earlier about contact with the Minister's office in relation to a story such as this. He said it was rare. Do you mean by that it was unprecedented?

Ms McDERMOTT: For me it probably was. I do not think I have been involved in such a way before.

Dr CHRISTLEY: Can I just point out an organisational thing? Ms McDermott recently changed roles. There was another person that would have related within the health service. That person is no longer in the health service. Part of the change to areaisation was changing some of those relationships. Basically, areaisation was recognising that people were producing material or dealing with issues and duplicating, and that this was an opportunity to standardise some of the communication tools. But I cannot comment on the frequency of the contact that Ms McDermott had. Ms McDermott would expect that to occur only over the last three or four months since the role changed.

The Hon. ROBYN PARKER: Nevertheless would it be a rare occasion for your department to have contact with the Minister's office?

Ms McDERMOTT: Yes, reasonably rare.

The Hon. ROBYN PARKER: Unprecedented?

The Hon. AMANDA FAZIO: Weren't you listening earlier? Ms McDermott has already answered that it was a rare occurrence.

Ms McDERMOTT: Unprecedented is quite a strong word. I think I would be wrong to say unprecedented because one would like to think that the Minister and his department could contact us when required, obviously, for information.

The Hon. CHRISTINE ROBERTSON: Did you not say this particular issue was put on the agenda at your joint teleconference meeting when the Minister's office was available?

Ms McDERMOTT: Yes, we have a joint teleconference meeting every two weeks and occasionally, not at every meeting, representatives from the Minister's office sit in on that teleconference.

The Hon. ROBYN PARKER: Who do you normally deal with in NSW Health on legal issues?

Ms McDERMOTT: We would deal with the communications department.

The Hon. ROBYN PARKER: In relation to this issue, did you draft the media release?

Ms McDERMOTT: No, I did not. I am not aware that a media release was issued. I have not seen one.

The Hon. ROBYN PARKER: Did you handle any post press conference media conference?

Ms McDERMOTT: No, I did not.

The Hon. AMANDA FAZIO: Would you say that the morale of medical staff within Northern Sydney Area Health Service was dented by some of the general attacks on the system that have occurred over the last 12 months?

Dr CHRISTLEY: People working in the health system do react to the sort of media coverage that we get. It is particularly strong if it is local. I can give an example, but I do not know whether it is productive. There

was a case that was certainly right in the local media, probably in the metropolitan media, of a patient who was in one of the Northern Sydney hospitals for some time before being transferred to the Children's Hospital for urgent surgery. It was a clinical situation that is quite difficult to diagnose. I have the highest regard for the doctors looking after that patient. To go back into the past, I was the registrar working for those doctors about 15 or 20 years ago, and I know their commitment to care. In any event, this patient was difficult to diagnose. It had a bit of an underlying condition that made it difficult to diagnose.

It became one of those cases that is brought before the media and accusations were made of poor clinical care and lack of communication from the health system, and accusations that particular things that that child suffered were consequences of the delay in diagnosis. They were in fact precursors to the diagnosis. The other thing that I am aware of that was not reported was that the particular consultant involved had not only communicated all of the difficulties to the family; he had actually been across to the New Children's Hospital—a fair trip across Sydney—to visit the parents to talk to them to maintain that relationship. In those circumstances then, yes, people do feel quite demoralised, distressed or disturbed by the sort of imputations that are made about their care or their commitment to their patients.

The Hon. AMANDA FAZIO: Do you think that the area health service promoting a good news story in terms of very good patient outcomes as in the case of Paris Panetta is a legitimate way to try to give the morale of staff a bit of a boost by saying, "Here is something that our health service has done that was a very good patient outcome and we are letting people know about it and you should feel proud about your work in the system"?

Dr CHRISTLEY: Yes, I believe that is legitimate in terms of staff morale.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have areaised your system. It has been said that this areaisation into smaller units again has meant that it is more parochial and it is harder to get the influence from outside. That has been said for the south-western area, I understand. Can you tell us why you areaised your area and broke it into three smaller units?

Dr CHRISTLEY: It is not so much that we broke it up; we took what was originally a hospital-based identity and we tried to change that to a more integrated "we are a set of health services that provide services to a community" identity. So instead of having five acute hospitals we now regard ourselves as having three groups of services, including community health services. There are a number of reasons for doing that. Care is no longer—as everybody would know, I think—hospital based. It no longer occurs particularly within one hospital; you often need to get the resources of two hospitals to work together. The strong thing that we kept in Northern Sydney Health was that these were not islands, though. You might have read in the metropolitan media the Sunday before last about new service models at Ryde. I alluded to maternity services earlier on. Those did not arise out of the people in Ryde sitting in isolation thinking about the service model at Ryde; they arose out of three or four years of debate, as clinicians working in the maternity field, medical nursing and allied health and consumers about what would be appropriate models of care to address a couple of things: community need and the fact that we cannot duplicate the same service everywhere because there are not the medical, nursing or other resources to do so.

It is not even money: you do not have the skilled staff to have 24-hour on-site paediatric registrars everywhere et cetera, et cetera. So it is very much not an island and I think the challenge for us is to make sure that not being an island extends beyond area health service boundaries as well so that we have that debate about service profession in a broader population, because for some services a population of 250,000, which is our sort of model, is the right model. Indeed, back in Ron Phillips' time as health Minister they produced a document referring to Normal Town. It took 250,000 people as an average population and said, "These are the sorts of health issues we are going to have for this population. These are the sorts of service issues that might arise." But when you look at neurosurgery and you look at the population base you might need to run a neurosurgical service you see that the minimum people would probably say would be a million. So you need across-area health services to be able to ensure you have good prehospital care, good interhospital transfers and a range of things that we certainly cannot permit, if they exist, to remain or, if they do not exist, grow any of this sort of parochial boundaries around health care.

(The witnesses withdrew)

(Short adjournment)

FIONA TITO WHEATLAND, PhD Scholar, Australian National University, Research School of Social Sciences, sworn and examined:

CHAIR: Ms Tito Wheatland, you heard what I said earlier in relation to witnesses. Are you appearing before the Committee in a private capacity?

Ms TITO WHEATLAND: Yes, I am.

CHAIR: We have before us the lengthy statement that you made. Would you like to speak to your submission first and we will then ask you questions?

Ms TITO WHEATLAND: I thought what I should do is give people a bit of my background in order to fill them in. Coming as a PhD scholar is really at the end of my journey rather than at the beginning. In the early 1990s I was a Commonwealth public servant tasked, under Brian Howe's ministry, with chairing the professional indemnity review and looking at medical indemnity matters. The report of that review also commissioned a quality of Australian health care study, which was the first Australian-based study to look at the frequency of adverse events in the health system. Before that I was a workers compensation person and a disability reformer in the law reform area. So I have a legal background.

I suppose that came to the health care sector without the blinkers of being a health care person. Rather, I was someone with an occupational health and safety and road accident safety background. That influenced very much the sort of research work we commissioned under the professional indemnity review and the theories that I have been working on ever since. I thought that was relevant information. The Review of Professional Indemnity Arrangements for Health Care Professionals was a study in which both New South Wales and South Australia participated at the time. That study showed that there were about 18,000 preventable deaths throughout the Australian hospital system, et cetera, and quite a significant level of permanent disability. All up, the best part of half a million adverse events involved patient harm of some kind.

CHAIR: Those 18,000 preventable deaths were over what period?

Ms TITO WHEATLAND: That was in a 12-month period over the whole of Australia. It was an Australian figure. If you would like me to answer additional questions about that study I can provide you with further information.

CHAIR: It just said that 16.6 per cent of hospital admissions were associated with adverse events leading to death. I was not quite sure over what period of time.

Ms TITO WHEATLAND: I think 16.6 per cent were adverse events, but not all of them led to death. I think that figure was just under 1 per cent.

CHAIR: The submission does state:

> This Study showed that around 16.6% of hospitals admissions were associated with an adverse event leading to death, disability or prolongation of hospital stay.

Ms TITO WHEATLAND: It includes all those things—death, disability or prolongation of hospital stay. I finished the report of the professional indemnity review at the end of 1995. My father then developed cancer. I became a carer for him and he eventually died. During that period I guess I became an advocate for him in the health care system. We cared for him at home most of the time but we had lots of interfaces with the public hospital system. While the care in many areas was good there were also some not so good parts about it. That motivated me to become involved as a consumer representative.

I ran a business called Enduring Solutions, which I am no longer running. In addition to that I did some volunteer work as a consumer representative with the Health Care Consumers Association of the Australian Capital Territory. I am still on the working group for consumers of the Quality and Safety Council working group. I was on the committee of the Consumers Health Forum. I have done quite a lot of work in the mental health area looking at quality and safety. Currently, I am an official with the mental health system in the

Australian Capital Territory. I am a consumer representative on the planning group for the National Medication Safety Breakthrough Collaborative.

I have been a consumer participant on three root cause analyses in the Australian Capital Territory. We have actually started having consumers involved. I am also on the Australian Capital Territory Quality and Safety Forum as a consumer representative. I am a consumer representative on the Better Practice Co-ordinating Committee of the Royal Australasian College of Physicians. That might be useful background information to let you know where I come from and what is my understanding of this problem—a broad systems-based issue. The process that has occurred so far—the termination of the employment of Amanda Adrian for completing the report—is a very negative step in the quality and safety process.

I was saying earlier that getting the culture of health care to change is a bit like trying to turn a battleship round. It takes a long time. You have to keep going in the same direction for a long time. When Amanda produced the report that is here—a very thorough document—she was taking a systems-based approach, which is exactly what is considered to be best practice and which has been followed by reports from Bristol and reports from Western Australia. I believe that it was not appropriate in that context for her to have had her services terminated. In my experience, after dealing with a lot of doctors, it has simply allowed them to say, "See, there is no learning organisation in the end. If you stick your head up you get it kicked." That has had an unfortunate effect. We have moved towards a focus on culture. As Amanda's report states, we have moved towards a just culture for dealing with these things.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You referred to the dismissal of Amanda Adrian. After reading the report it seems as though the Health Care Complaints Commission was not set up to do a systemic analysis of a hospital. Rather, it was set up to look at individual complaints on the assumption that many of them were miscommunications. It was set up to look at little bits of information rather than at the big picture. The big picture—the volume of material given to it by the so-called whistleblower nurses—was quite a big administrative challenge. It took it some time to gear up to meet that challenge; therefore, the delay may have been inherent in the design. Would you comment on that?

Ms TITO WHEATLAND: That is definitely so. I was actually chair of the Health Rights Advisory Council in the Australian Capital Territory, which had a role similar to the role of your parliamentary Committee—oversighting the complaints body. Our complaints body in the Australian Capital Territory has the capacity for a systems-based approach. Generally, it takes quite a long time. Most of the cases that I have overseen were not nearly as complex as the one that was undertaken here. I would have expected it to have done a proper job on this and to have looked at it appropriately.

The time that was taken was actually unreasonable. The other question—the terms of reference and the nature and capacity of existing New South Wales legislation—is also true. It is actually much more individually complaints focused. There are provisions to allow for something bigger than that. I would have thought that the experience you would all have now had, after looking at the report, would highlight the fact that there is a need to ensure that there are appropriate powers and capacities to allow that body to do a better job.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With reference to public perception, I think you came up with the idea that a lot of people die in hospitals or that there are a lot of adverse events in hospitals?

Ms TITO WHEATLAND: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That fact is well known to people inside hospitals, but it has not been so well known to the public, until your seminal paper. There has been a lot of talk and analysis since then. Has the number of adverse events dropped, or is it rather a talkfest without much action?

Ms TITO WHEATLAND: It is not possible to say that for certain either way. I would be surprised if it had dropped very much. People talk about root cause analysis, quality improvement and all those sorts of things as though they have been around forever. I went to the first lot of root cause analysis training in the Australian Capital Territory, which was about six weeks after it started here. We have done three similar courses of training. It would be optimistic if we tried to look at some of those methodologies as having delivered outcomes in declining mortality and morbidity. At the same time I think the report spells it out in a lot of cases.

A lot of the time there is enormous tension in the old way of finding an individual to blame. In the situation of the nurses, management was there. People were looking to have someone to blame when there were arguments and everything within the team. It seems to me that we are still a fair way from the culture that would be most likely to foster a learning environment—people coming forward and saying, "I do not think that is right." There is still a huge power imbalance between doctors and nurses in the system. For nursing staff to come up and say, "I am sorry, can you stop, I do not think that is a great idea?" is far away from the reality of a lot of the positions in which nurses find themselves. I think we are stepping on the road but we are not yet there by any stretch.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is not the imbalance of power now between administrators and doctors and nurses—in other words, administrators on one side and clinical staff on the other?

Ms TITO WHEATLAND: There are imbalances all the way up and all the way across. It is a complex mess everywhere, in the sense of people having different hierarchies within those areas. Both need to be engaged actively in the change process and are caught up in it in that they started with one model and are moving to another. It is one of the reasons I believe we are all learning at the moment. A culture that engenders shooting the messenger—whether it is nursing staff or Amanda Adrian—is not appropriate. We need to recognise that this is a learning process. Patients need to know as well. My view, which I have retained after the reviews, is that if people know more about how the health system operates and all the things that can go wrong and they are better prepared to be their own advocates or to have someone with them to question when something appears to be wrong we have a much safer system. We need everyone engaged in that battle. James Reason was out here recently and said that his pilot analogy had been used wrongly. Pilots have about 15 minutes at the beginning of the flight and 15 minutes at the end when they are actively engaged with all the equipment. The rest of the time they are fulfilling what he calls a custodial function. Doctors, nurses and patients interact moment by moment all through the day, over shifts and often in difficult circumstances with people who are ill, stressed and so on. Professor Reason says that everyone must be engaged in that battle—consumers, providers and everyone involved in the organisation of the system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You say "within the system". If there are external constraints, for example, the budget is imposed on the administrators and they cannot staff facilities, they are then running to two masters—the health system and the budget constraints. Does the pilot analogy hold? At some point we must say who is responsible. If we were to get the administrators here and ask them whether they were subject to such a budget and whether they had to close down a service because they had no option but to say no to reasonable clinical requests what would they say? Where does the buck stop? It must stop somewhere.

Ms TITO WHEATLAND: I agree. In a democracy such as ours the buck stops with the people elected by taxpayers in terms of the amount of money allocated to the health care budget. I am not saying that no-one is responsible; I am saying that everyone is responsible, but no-one is responsible for all of the bits. If the problem is a budget shortfall, the issue is at a different level. If we are talking about an overall shortfall in the health budget, that is one issue. However, If we are talking about allocation, that is a manager's job. In terms of quality care, it is not a problem that can be automatically fixed by throwing money at it. Everything has a layer of accountability within it. Until this sort of analysis is done, we cannot know whether it is a money question.

The Hon. AMANDA FAZIO: I refer to the Health Care Complaints Commission [HCCC]. Its role is to investigate complaints about individual incidents, patients and clinicians. In more recent years it has been looking at systemic issues rather than individual cases. Has that not impinged on the way in which we respond to complaints handling? A witness from the medical review body said the other day that if a doctor has done something wrong and it takes five years to finalise the investigation it is difficult to prosecute that person if for the past three years he or she has been working and not done anything that has resulted in a bad patient outcome. Has that shift in the focus short changed people with individual complaints that the HCCC should have been investigating?

Ms TITO WHEATLAND: I am not an expert in terms of the number of cases handled by the New South Wales HCCC over the years. All I can say is that the general model used in New South Wales, because of its connection to the prosecutorial function, is different from that in other jurisdictions. It is hard to hurry those claims. A just hearing must be held about what the consumer and the provider are doing. In the end, that is the group that will do the prosecution. It is almost embedded in the legislation that this will be a more time-consuming process than in some other jurisdictions that have a greater focus on conciliation of complaints

where appropriate. It was not set up simply for that purpose. The first object under the Act is to facilitate the maintenance of standards of health services in New South Wales. That is not only an individual complaints-handling function; it is a broader function. The legislation was enacted before most of these developments started. In 1993, when the legislation was framed, it arose directly out of the Chelmsford inquiries. It is in its historical place, but that does not mean it does not need to be revisited.

The Hon. AMANDA FAZIO: You state strongly in your submission that the former commissioner had been hard done by in being replaced.

Ms TITO WHEATLAND: Yes.

The Hon. AMANDA FAZIO: Have you had a formal working relationship with the former commissioner?

Ms TITO WHEATLAND: I have not worked with her on a contractual basis. I have worked in health complaints and she has worked in health complaints. I had quite a bit to do with her over that time. The first time I met her was after I finished the review. She did an article on the work of the review and placed it on the quality and safety agenda.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said there were 18,000 adverse events, and about 1 per cent resulted in deaths.

Ms TITO WHEATLAND: No. The figure of 18,000 is the number of deaths as a component of all the adverse events.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is nearly as many deaths as are caused by tobacco.

CHAIR: I thought you said it was 18,000 deaths or disability—

Ms TITO WHEATLAND: The *Medical Journal of Australia* article extrapolated the 16.6 per cent of hospital admissions to the Australian hospitals population. The figures are for 1994, which is when the article was published. That data showed there were 18,000 deaths. These figures are off the top of my head. There were 470,000 events, 250,000 of which were considered to be strongly preventable, and 18,000 that involved permanent disabilities, 17,000—

CHAIR: I ask because, even allowing for the fact that many people will go to hospital to die, this means that one in every six hospital admissions ends in death.

Ms TITO WHEATLAND: No. You are confusing the two figures. There are 18,000 deaths and many more than one in six admissions. One in six are adverse events.

CHAIR: So, of all adverse events, one in six results in death.

Ms TITO WHEATLAND: No, one in six hospital admissions involve an adverse event and—

CHAIR: Of those adverse events, 18,000 result in deaths.

Ms TITO WHEATLAND: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are all these adverse events. You have not undertaken a survey, but you suspect that that has not changed very much. Is it not then necessary for someone like the whistleblower nurses to say that unsatisfactory things are going on? At what point do we need activists to say that all the research has been done and we now need action?

Ms TITO WHEATLAND: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say that they play a valuable role in drawing the world's attention to adverse events in hospitals?

Ms TITO WHEATLAND: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you agree with the *Sunday* program, which I believe you were on—

Ms TITO WHEATLAND: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ross Wilson said the same thing.

Ms TITO WHEATLAND: I do not have a television, so I have not seen it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How very prudent of you. It was stated that the whistleblower nurses put their case and it was then suggested that Campbelltown was no worse than anywhere else. One had the feeling that that was correct.

Ms TITO WHEATLAND: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the situation was unsatisfactory.

Ms TITO WHEATLAND: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you agree?

Ms TITO WHEATLAND: Yes. That is the reality of health care almost everywhere. One simply needs to scratch the surface a little. There is no systematic way of doing it unless an investigation like this has been carried out. In the Australian Capital Territory we get these reports and look at our system to see what we can fix. In almost every case, from Bristol, King Edward Memorial Hospital and this report, we have identified shortfalls in our systems. Bringing any of this to public attention is important.

I think that people need to understand the risks of health care. Health care is not just the glowing stories. It is not just the happy endings. It is all of these things as well. I think that one of the problems with the health care system a lot of the time is that it is quite good.

Doctors, as you would, are very happy to talk about the positives, very happy to say that they have a miracle cure and that this can be fabulous, but when you look at the statistics, for almost every miracle cure there are some pretty downside bits with it as well. People come in when they hear a story that is all positive expecting that always the babies that are born at whatever the baby was born at will survive and will be fabulous but the level of disability of kids who are born at a very early age is very, very high. People do not know about that. They see the happy headlines. In relation to health care, you hope that when you go in that it is going to be fine. You have to rely on that. You have to have trust in the system sufficient to actually put yourself essentially when you are asleep in the hands of someone who literally has your life in their hands sometimes, so we want to trust. It has not been something that people wanted to know about, either.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: After your work, should not someone be doing that sort of thing regularly? If so, who?

Ms TITO WHEATLAND: The Council for Quality and Safety in Health Care has been looking at that and trying to get organised to get a study done, and it has not happened to my knowledge so far. I am hoping that in the end we will have that sort of ongoing thing. We have got incident monitoring happening in most States now where you do get a picture of those adverse events that are occurring. You need to have a culture where people accept that it is a good idea to report. I heard several people this morning say that the number of complaints have gone up and therefore it is a bad hospital. In fact, it is the converse; if you are getting lots of complaints and you are hearing lots of things about things that are wrong, then you have a better opportunity to fix things up. If you have people not complaining and not protesting and not coming up and saying that things are wrong, then you are more likely to have an unsafe system, in my view. You are much better to encourage people to come forward.

CHAIR: How do you rate New South Wales in comparison to other States in willingness to handle complaints?

Ms TITO WHEATLAND: I do not think you are any better or worse, really. I mean, you have got a different method, that is all. The pilot that is happening now in the incident monitoring area means that you have not got statewide data yet whereas States like South Australia have, so I think it is variable depending on where people have picked up different things. But, for example, in the root cause analysis area, I think you would be leading the field and a lot of the work with things like the clinical systems report program that the college has done, you are picking up in terms of acute cardiac syndrome and people presenting with stroke in the emergency department. You are way ahead of the game in that area.

CHAIR: Have you noticed within the State variations between area health services?

Ms TITO WHEATLAND: I do not have that insight because I do not work in this jurisdiction. You would have to have very detailed information. Most of that is not publicly available. Most of that is not available for someone who is not an insider. Even things like the incidence of litigation, which is something I asked for to be publicly collected so that we could actually all know what was happening, is only now starting to happen. You are way ahead of the game here in New South Wales. You have legislation that most other States are envious of in terms of the collection of data, but it is not publicly available so that makes it quite difficult for someone such as myself who is not an insider of the health care system to make a comment and to actually know whether or not things are going in the right direction.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely this data should be public?

Ms TITO WHEATLAND: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that an academic such yourself can work on the same topic?

Ms TITO WHEATLAND: Yes, I agree. That is what I have been arguing for for seven years.

The Hon. AMANDA FAZIO: Can I ask you about the Institute of Clinical Excellence that has been established? Can you give us some comments on what you think is the value of the Institute of Clinical Excellence and if you have any other comments about it?

Ms TITO WHEATLAND: I think the Institute of Clinical Excellence [ICE] has been good in the things that it has picked up. I mean, it has been the driver for the root cause analysis training and stuff and I think that has been a really important transformation in terms of people's understanding of how you can use, say, incident monitoring data to actually help to improve your system. My experience with that, particularly as a consumer looking at it, is that it is a very rigorous process. The other work that I am aware of—I do not actually know the full scope of their work, but their work is called the clinical systems support program and implementation of Towards a Safer Culture [TASC] throughout the system. I know about that because I was a consumer representative on the TASC project when it was just a small pilot and I think that has been excellent. It is hard for me to actually judge, other than in those two areas where I have had some knowledge of it.

The Hon. AMANDA FAZIO: You said in the ACT health system, they introduced root cause analysis just after New South Wales introduced it. Are you aware of other States that have opted to go along the path?

Ms TITO WHEATLAND: My understanding is that the national council has looked at it as something that is going to be done everywhere. My understanding is that all States are actually starting down the path. They are in various different stages of development. For example, New South Wales, because you did widespread disseminated training with ICE, has gone much more through the area system than we have. For example, in the ACT we have only done probably a dozen or across the four areas that it has been done. That is because we have been piloting and trialling and trying to work out how to refine the methodology, et cetera, so I suspect you have a broader set of experiences here than some of the other jurisdictions, but everywhere is doing it now. I mean it is world's best practice that was done in veterans' administration in the US that this work came from, and it was brought in by the quality and safety council. You are at the leading edge internationally as well.

The Hon. PATRICIA FORSYTHE: So far we have heard from nurses earlier in the inquiry who, having spoken out and highlighted what they saw as problems with the system, seem to have been rewarded by being intimidated or harassed or bullied. We also heard today from the union and in its submission it highlights the fact that often you get investigation by senior managers who do their best to remove themselves from responsibility for any of it. It seems to me that it does not matter what the system is, it is implementation and that at the heart of all this is cultural issues.

Ms TITO WHEATLAND: Yes.

The Hon. PATRICIA FORSYTHE: I am not sure how we take some of that forward.

Ms TITO WHEATLAND: Well, what I have to say is that messenger shooting in this area is a long-honoured tradition. Having been the chair of the Professional Indemnity Review, that was the end of my senior public service career at the Commonwealth level. I actually understand the whole issue about whistleblowing in that sort of sense. I think that people did not want to know when we started. Arthur Chesterfield-Evans said some very kind things about the review's work being seminal, but it was terminal at the beginning. It was not seen as something anyone wanted to know about. I was actually asked before the report was finished to leave my position on the basis that they would shut the review down and it would be all very quiet and we did not need to know about it, did we. The political people were wonderful and supported me but the bureaucracy at that stage did not want to know about it. This is the Commonwealth bureaucracy. I was told that I lacked moral flexibility.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What a lovely way of putting it.

Ms TITO WHEATLAND: So what I am saying is that it is a cultural issue. People dying is bad press. This is the system whose whole culture is about providing care. It sees itself in that way. There is a wonderful article by a person named Lucien Leap called "Into the Heart of Darkness", which looks at medical doctors, when an error occurs and how they experience that. Because the culture has been traditionally to say that there are no errors in health care—that is the view that was put to me when I first started and I just kept saying then how come people are dying, and that these must be errors: It has taken a while—people are now at the point of saying, yes, these things happen, bad things happen sometimes when you get into hospital and you have to be aware of those things when you are going into hospital.

I think that it was very unfortunate for the nursing people. I think the report identified those things as being unjust processes in some areas. I have not got in-depth understanding of every one of the cases but certainly what I have read in this report indicates to me that it was unjust, what was done to a lot of the nurses, but at the same time I think what needs to happen is it is that power balance thing. You need a mechanism. We have had to do it in one of our hospitals. You cannot get a nurse who feels uncomfortable at the moment to report something and say that a doctor is messing up. You have to have what we call the big red button where someone who is aware of something happening has the capacity to do that and it will be a no-blame situation. If you are really concerned about it being a patient's advocacy issue, you can hit the red button. If it is wrong, then that is okay, and if it is right, then that is okay too. So it moves it out of having to challenge what are intrinsically power structures within those things.

The Hon. PATRICIA FORSYTHE: So the culture of denial of intimidation or bullying or harassment could occur. I assume you would say that managers are just in a state of denial if they are not prepared to acknowledge that that has been the effect of people speaking out?

Ms TITO WHEATLAND: Yes, and I think the other thing is, as I said, there is a complex relationship between doctors who were considered to be highly valuable resources in one sort of sense by managers and who can also often go to politicians and cause difficulties, so there are all these other power dynamics that come in there. Traditionally the system has theoretically being patient centred, but it is not. It has been doctor centred and doctor focused, and creating a system out of that which is client focused, consumer focused and patient focused in a real way—I mean, for a patient to actually say, "I am sorry, can you stop doing that? I need to find out have you washed your hands." That is what we are now supposed to be able to do. I just cannot think of the number of doctors, if I actually said that to them, who would be affronted. While that might be safe care for me and similarly to expect a nurse to say, "Excuse me, doctor … ", one of the biggest issues is hand washing, just in terms of regular infections and that sort of thing that have catastrophic effects on patients.

For the nurses to say to a doctor, "Excuse me, doctor, have you washed your hands properly?" would be considered subordination in a lot of areas, and it probably would be one of the best things you could do for patient safety, to make sure that all patients said that and that nursing staff said that. But to do that, you have to have patients who have a sense of their own power to do it and you have to have the nurses who will do it and doctors who are willing to hear. I think that is part of the culture change process that we are engaging in that the moment. I am not underestimating how hard it is for doctors to come at this now because they have actually come through, most of them, a training situation. You have young doctors now who are learning about adverse events and adverse events prevention and that they can make mistakes. But a lot of doctors who are there now and doctors who have made it into management and managers that have been there have come through a system where theoretically at least doctors did not make mistakes. That is why there has not been a culture of safety.

I looked at it from an occupational health and safety angle when I came in and I was used to looking at signs that said, "Warning—Do not stick hands in here they will get chopped off" because everyone assumes that if you are a worker in a factory that that danger will not be there. But there is machinery that is designed in bizarre ways. I mean, we had one where we had a number of deaths in the incident monitoring system in anaesthetics where you had a machine that could either suck or blow, depending on which way you turned the knob. If it sucked, it killed you, if it blew, it was okay. There were quite a number of deaths before they worked out that you had to put a device in to ensure that you could not put it in the wrong end. In an industrial context, you cannot imagine that sort of thing being allowed through the design process, but because the assumption is that there is always perfect performance, you are never tired, you are not going to make any mistakes at all, you do not put in a safe system. We are just getting to that point now. To have people even acknowledge that the system is actually flawed and that there are human beings in it where mistakes are made is the first step. Unfortunately there are people who are continuing to be harmed along the way while we have been going through the transformation.

The Hon. AMANDA FAZIO: Following on from that, within a complaints handling system in health—any health system—how do you deal with that public perception that people are not going to die when they are in hospital or, for example, that premature babies will be okay? There tends to be this perception that there have been so many advances in medical science that your 88-year-old granny who has organ failure is not going to die.

Ms TITO WHEATLAND: Yes.

The Hon. AMANDA FAZIO: How do you cope with that?

Ms TITO WHEATLAND: That is why we have public discussion and openness about what goes wrong in Health. What it can and cannot deliver involves a humility of people in the health system to be able to say they cannot deliver miracles. We are asking people who have been trained to be very individualistic in situations and to feel themselves as miracle-workers, to actually have a whole transformation in terms of their culture and their understanding of themselves. The more we publish data, the more we have publicly available information, the more we are educated; even right back at school, about what health care meetings and what is good and what is bad with health care. A lot of people still do not know their medication risks. The doctor tells them to take something and sometimes they are not provided with relevant information. We have had a whole lot of pushes to try to get that information out, but it involves people feeling that they can ask some of those questions. People need to go to clinicians who let them ask those questions.

The Hon. TONY CATANZARITI: In your opinion how do you get the professions to get together to work out problems, to be able to talk to one another. How do you get the doctors, nurses and associates together? This seems to be a culture we have to overcome.

Ms TITO WHEATLAND: I agree with you. It is making real the idea that everything is patient-centred. If you start with a patient and look at what is going to happen to that person, and having a doctor, a nurse, or whatever, as separate pillars into it does not make any sense. You need someone that holds the person and carries them through. That involves a team, by necessity. Sometimes that involves restructuring the way we are doing work and involves having time for people to plan things. For example, in the Australian Capital Territory at the moment one thing that defines whether a patient is complex involves two doctors, because they are not used to working together and planning. We need to have a mechanism that brings those two clinicians together, each of whom has wonderful skills but do not necessarily work on the same parts, the same organism, of the human being.

We are trying to imbed in the culture that team-based approach. Some of that starts back at the beginning, but it also has to be modelled in the workplace now. If we are waiting for people to get through doctor school now, we will have a lot more dead people and damage people before we get that change. We need to have that modelled on a day-to-day basis, and I think that is what the Institute of Clinical Excellence and places like that do. We get clinical leaders to say that there are other ways of doing things, it involves really very different paradigm shifts.

The Hon. ROBYN PARKER: Is there a difference in attitude between making a complaint across different disciplines within the health care system? Is it an across-the-board attitude or are some disciplines more prepared to have a culture of learning?

Ms TITO WHEATLAND: It would be hard for me to say; not everyone likes having a complaint made against them, because often there is a fear that it would be a punitive exercise. Quite rightly it has been, in very many cases. I do not think it is particularly professional grouping specific. Traditionally what has happened, because of the hierarchy, is that the nursing staff have borne the brunt for a complaint about a team process because they are the lowest power person in the team. No, I do not think there could be evidence that one group is better than another. No-one is well skilled in that at the moment. You need to have some training for all health professionals in how to do it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I had not realised that your seminal paper was a terminal paper, I must admit. It did strike me that after such a famous paper I never saw anything more from you. I thought that was odd, because usually eminent professors keep on publishing, as it were.

Ms TITO WHEATLAND: I have kept publishing, but I am no longer a public servant.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But nothing as high a profile as your initial paper. Could you give a potted history of what has happened; now, nine years down the track and what you did is not being done regularly anywhere. What has been happening since then? After that huge number of deaths we are still waiting for nurses to blow the whistle.

Ms TITO WHEATLAND: I think there are changes, progress is happening.

The Hon. CHRISTINE ROBERTSON: I believe it was a trigger.

Ms TITO WHEATLAND: Yes, I agree with you. That is what I have kept hoping for. I honestly think that there have been changes but we have not got there yet. As I said, is like turning around a battleship, and we need to keep putting the messages in the same direction so that the battleship keeps moving. Initially we had a task force, then the national expert advisory group over a few years, and then the Commonwealth task force, the council, which Bruce Barraclough chairs. Over that whole period, part of my report was to do with the medical indemnity side of things and that was not picked up. Subsequently it has proved to be correct, what we predicted would happen. Things from it are now being picked up. The quality agenda moved faster than the medical indemnity agenda, ironically. The medical indemnity agenda has had a big rush because it hit crisis point.

One of the problems is—like with the 18,000 people—when we looked at the analysis of the deaths, half of those people were expected to die sometime in the next 12 months, another quarter were people with very complex health-care needs who had a higher risk of dying and the other quarter we would not have expected to die. So people have always associated, quite appropriately in a lot of cases, that the health system will not necessarily deliver life at the end point, nor should it sometimes. When my dad was dying he would have liked nothing better than a health-care system that did not.

(The witness withdrew)

(Luncheon adjournment)

GILES YATES, Investigation/Resolution Officer, Health Care Complaints Commission,

BRUCE GREETHAM, Former Manager, Partnerships and Quality, Health Care Complaints Commission, and

BRIAN McMAHON, Manager, Patient Support Service, Health Care Complaints Commission, affirmed and examined:

SUSAN LOUISE DONNELLY, Assistant Commissioner, Health Care Complaints Commission, and

WILLIAM GRANT, Former Acting Commissioner, Health Care Complaints Commission, sworn and examined:

CHAIR: Ladies and gentlemen, we welcome you to this third day of public hearings. I made statements this morning, which I do not propose to go over, indicating what can and cannot be discussed: the fact that the Committee is open to the press and so on. I will also make a further statement concerning privilege, as it is very important on this occasion of evidence being given by representatives of the Health Care Complaints Commission [HCCC]. It should be remembered that the privilege that applies to parliamentary proceedings, including Committee hearings, is absolute. It exists so that Parliament can investigate matters such as this properly. It is not intended to provide a forum for people to make adverse reflections about others. The terms of reference refers to the failure of systems not individuals, and therefore I ask all witnesses to minimise their mention of individual health care workers unless it is absolutely necessary in addressing the terms of reference. Individuals who are the subject of adverse comments in this forum may be invited to respond to the criticisms raised either in writing or as a witness before the Committee. That is not an automatic right, rather it is a decision of this Committee. I also ask you to be mindful of the ethical and legal implications of disclosing personal information about patients without their authorisation.

It is likely that some of the issues to be raised in the hearing may be subject to legal proceedings elsewhere, including the Industrial Relations Commission, a disciplinary tribunal or the special inquiry being conducted by Bret Walker. The sub judice convention requires the Committee to consider the impact of discussing a matter that is being considered by a court of law. The weight of opinion supports the view that a parliamentary committee may discuss any matter that is being considered by another inquiry. This would include investigations undertaken by ICAC. At this point I need to acknowledge the role of the joint parliamentary committee with the statutory role of oversight of the HCCC. The fact that one parliamentary committee is inquiring into a matter or has an oversight role does not prevent another different committee from inquiring into some of the same issues, provided it is relevant to the terms of reference. I trust that our current inquiry will assist the Committee on the Health Care Complaints Commission in its work, as I am sure that the previous work of that Committee will also assist this current inquiry.

Mr Grant, you have given us a submission. Have others of you also submitted a submission to the Committee?

Ms DONNELLY: No.

CHAIR: Mr Grant, would you like to speak to the submission and then we will move to questions?

Mr GRANT: I would like to make a short opening statement. Chair and members of the Committee, thank you for the opportunity to make this opening statement, which will be in three short parts. First, I wish to provide a brief overview of the activities of the Health Care Complaints Commission. The Health Care Complaints Commission acts in the public interest by receiving, reviewing and investigating complaints about health care. It is an independent statutory body established by the Health Care Complaints Act 1993. The commission receives and deals with complaints concerning the care and treatment provided by health practitioners in consultation with the relevant health practitioner registration board and health services; resolves complaints with parties; provides opportunities and support for people to resolve their complaints and concerns locally, for example, through the patient support office; investigates complaints and takes appropriate action; prosecutes cases before disciplinary bodies, for example, the medical tribunal; provides training in complaints management to area health services, registration boards and private health organisations; publishes and

distributes information about its work and activities; advises the Minister and others on trends and complaints; and consults with consumers and other key stakeholders.

Research and experience has shown that complaints are best resolved locally if possible. Many complaints are about communication problems, and in the first instance the commission encourages complainants to try to resolve the complaints locally as long as it does not involve the complainant's or another person's safety or raise serious issues that need investigation. As required by the legislation, a complaint must be in writing in order for the commission to consider it. If necessary, the commission will assist a person to put a complaint in writing. The commission must assess a written complaint upon receipt. In some instances the commission may decide to ask the complainant to resolve the complaint with another party, refer the complaint to the patient support service for assisted resolution, or seek further information within 60 days. The commission may also decide to refer the complaint to conciliation, with the consent of all parties; refer the complaint to another organisation or person for investigation, for example, an area health service; investigate the complaints; or decline to deal with the complaint.

If the complaint is about a registered health practitioner, the commission is required to provide details of the complaint to the relevant registration authority. If the complaint is about a health facility—for example, a public or private hospital, community health centre or nursing home—the commission must notify the director general of health that a complaint has been made, what it is about and who made it. In the last financial year the commission received 2,718 complaints, which is in line with previous years. By far the greatest number of complaints—about 50 per cent—concerned clinical standards. The commission investigates about 10 per cent of complaints received each year.

As to improvements to the commission, there has been much media coverage and debate about the role of the commission since the release of its report into the Macarthur Health Service. My role as acting commissioner had been to review the commission's structure, procedures and legislation, with a view to focusing the commission on its primary function of investigating serious complaints concerning the conduct of health practitioners and the care and treatment of patients by health practitioners. Since commencing as acting commissioner in December 2003, I have reviewed the commission's structure and operations and made recommendations about how it can be improved. This included a submission outlining legislative reform to the Health Care Complaints Act 1993 developed for consideration by the Minister and the Cabinet Office. Part of the commission's problems has been the fact that its legislation has limited its ability to undertake efficient investigations.

I should mention that a new acting commissioner has been appointed as of yesterday—Judge Kenneth Taylor—and a new deputy commissioner's position has been advertised. A specialist team has been established to undertake the investigation of a large number of individual health practitioners, medical practitioners and nurses arising from the initial investigation into Campbelltown and Camden hospitals. The team comprises four investigation officers from the commission and two lawyers from the Crown Solicitor's Office under the guidance of both senior and junior counsel. A backlog reduction strategy has been developed to enable the commission to finalise all outstanding order investigations over the next 15 months. As part of that strategy a review of all outstanding investigation files to identify the most appropriate method of finalising each case has been completed. New tools have been developed to better manage the investigation process. These tools include an issues identification document, evidence matrix, a revised investigation plan and an investigation report template.

The functional areas responsible for assessing complaints and for conducting investigations have been divided into separate teams with a view to increasing managerial focus on each of those areas of activity. The decision-making tool and process for assessing complaints are currently being reviewed. Systems have been put in place to monitor the workload of individual officers together with the number and status of complaints in both the assessment and investigation phases. The commission is moving to utilise a preliminary investigation model, which will see for some complaints a more thorough review of the issues arising in the complaints before assessment, utilising investigative, legal and clinical input.

In relation to patient support service, we put in a submission concentrating on external programs and projects that we run to assist area health services and other bodies. I do not propose to go over that, but I would like to refer to the patient support service, which was mentioned only briefly in our submission. The commission will only ever investigate relatively small numbers of complaints so there needs to be other mechanisms available to complainants to assist them to resolve their complaints. The patient support service was established

late in 1996 to assist consumers to resolve their concerns of public and private health services, and individual practitioners at the local level. It aims to assist in the timely, efficient and effective resolution of health concerns, assist consumers and health providers to understand approaches to local resolution of health concerns, empower people to have a positive and active role in their health care and to resolve their own concerns, facilitate access to appropriate health care, promote and protect the rights of consumers.

Currently the PSS does not offer mediation or conciliation. However, it uses aspects of the mediation and conciliation processes, and shares a common focus with them in that it aims to resolve health care complaints between the parties. There are 11 patient support officers in New South Wales, 10 are outposted in area health services, six within the metropolitan area based in Randwick, Balmain, Mount Druitt, Liverpool, Penrith and St Leonards and four in regional areas based in Newcastle, Wollongong, Dubbo and Lismore. One outpatient support officer is based in the commission and provides relief services. The PSS manager is also based at the commission. In 2002-03 the PSS provided a service to 3,888 people with health concerns, a slight increase in the previous year of 3,842 during the same period. The PSS closed 3,729 files, some of which had been opened in previous financial years.

About 21 per cent of clients are provided with information to assist them to obtain health and community services, and exercise their health rights or find out how to contact consumer support groups. Some just want to talk generally about health issues. The majority of clients, 79 per cent, were provided with support, for example listening and clarifying them, and assisting advocacy services, for example arranging and or attending resolution meetings between consumers and health services. Telephone inquiry officers for the commission referred the majority of clients, 46 per cent, while the commission's assessment committee referred 28 per cent of clients to the PSS. Telephone inquiry officers referred people who telephoned the commission, but who had not lodged a formal complaint. These people may request assistance from an independent third party and the local resolution of their concerns with a health service provider.

Telephone inquiry officers also referred people with communication difficulties who need further assistance to clarify concerns and to write letters of complaint. The effectiveness of the PSS has been demonstrated by the outcomes achieved: 79.5 percent of matters were resolved or partially resolved. A high level of client satisfaction was demonstrated by satisfaction surveys, and by the findings of an external review that was conducted in May 1999. In summary, the effectiveness of the PSS derived from the fact that it is an accessible and prompt service, it is independent of the health service providers, it has access to resources and expertise through the commission, for example, medical advisers, it uses variable models of discrete resolution and it has a thorough understanding of the complexities of the health system.

CHAIR: Did I hear you say there were about 2,700 complaints?

Mr GRANT: Annually.

CHAIR: You investigated a certain percentage of them?

Mr GRANT: About 10 per cent. It varies.

CHAIR: About 270 a year?

Mr GRANT: Yes, close to that number. It fluctuates, but that has been an average of the past two years.

CHAIR: The 658 to area health services, that seems to me to leave a large number every year. This is the accumulated backlog?

Mr GRANT: The accumulated backlog is really only in terms of investigations. That is because it has taken some number of years to finish some complaints. If I can illustrate—

CHAIR: I want to get this right. You are telling me you receive about 1,700 complaints that are not sent off to area health services, and are not dealt with by the commission, but about 1,700 of them are then left. What happens to those?

Mr GRANT: Some of those go to conciliation, through the conciliation registry. Some go to patient support officers. Some are resolved directly between the parties. Some are frivolous or vexatious. There is a whole variety of means whereby those complaints are handled.

CHAIR: The backlog comes out of the 200 or so you investigate?

Mr GRANT: Every year. Yes, that is right

CHAIR: There has been this accumulation so that some of them have been there for five years, et cetera?

Mr GRANT: That is right. Just two figures that might assist in that regard, there are in excess of 320 complaints at the moment that are more than 18 months old and there are somewhere around 140 complaints that are more than three years old.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What happens to the people who are complained about in that time? I gather that some nurses have been in suspended animation and not able to be employed for years on end. Is that still the situation?

Mr GRANT: I do not think there are many of those matters where there is an actual suspension. Usually some expedition is given to matters where practitioners are suspended.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If there are only two employers in the town and the complaint arose out of something that was said to one employer and the other chooses not to employee those people because they have had trouble with the other one, they are effectively not suspended by judicial process, commission or registration boards, but they are suspended in practice. Does the commission take that into account?

Mr GRANT: I am not satisfied with the length of time that it takes to investigate matters. Your initial comment that these matters hang over people's heads for an incredibly long period of time is entirely correct, and it produces adverse consequences, I am sure, not only for practitioners but also for complaints.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, under your regime, there is a statistical tale, reports will be written and they will be brought to a conclusion?

Mr GRANT: We have called it our backlog reduction strategy, and it is to take place over the next 15 months. The aim of that strategy, and it is already under way, is to recruit additional investigators, and concentrate on the backlog. The aim, at the end of the 15-month-period, is to have no matter on our books that is older than 12 months. There may be the odd matter that comes in from time to time that is a substantial and very large, complex matter—we have had those over the years—but the vast majority of complaints, the aim will be to complete them within 12 months and to resolve that backlog over the next 15 months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I note that you have patient support officers. Do you have practitioner support officers for people whose careers have been ruined by complaints hanging over their heads, some of whom I know?

Mr GRANT: We have no such position in the commission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Might that be a good idea?

Mr GRANT: I am not so sure. I would hope that the practitioners have some sort of support from other organisations. I do not know that it is a matter for the commission to support officers. The best way we can support them is by expeditiously resolving the matters before the commission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly, but if there is a big backlog then presumably there is a backlog of harm as well.

Mr GRANT: Yes, I think that is true.

The Hon. PATRICIA FORSYTHE: Did you say at the beginning that you said you had been Acting Health Care Complaints Commissioner until last Sunday?

Mr GRANT: I was, indeed.

The Hon. PATRICIA FORSYTHE: And you have been replaced?

Mr GRANT: Judge Taylor, district court judge, took office yesterday as Acting Commissioner.

The Hon. PATRICIA FORSYTHE: I understand that the commission is judged to be an independent body, but in that process what is the interaction between the commission and New South Wales Health, and the commission and the Minister's office on a normal basis?

Mr GRANT: We raise matters frequently in an official capacity with New South Wales Health. We do that regularly and ongoing. We have to do things under the statute in relation to that. We have also had a fairly good partnership with New South Wales Health over the years whereby I think the Director-General talked about all the initiatives that had been put in place to raise the standard of complaint handling within those organisations. The commission has consulted extensively and dealt with those matters over the years, and more recently we have had responsibility for providing training to area health services in complaint handling.

CHAIR: On your list of what you offer, the area health services can choose between six options.

Mr GRANT: It may be more than six, but they are allowed five out of a list of somewhere around eight or ten areas that they want to focus on in that year.

CHAIR: The HCCC is an independent body. You have a close liaison with NSW Health. Who appoints the commissioner and to whom is the commissioner responsible?

Mr GRANT: As understand it, the commissioner is appointed by the Minister, but there is also an oversight responsibility by the joint parliamentary committee.

CHAIR: It is not really an independent body?

Mr GRANT: It is under the statute. It has independent responsibilities, and there is a provision in the legislation, from memory, which says that the commission is under the direction and control of the Minister. But it lists half a dozen or eight particular items, including assessing a complaint, investigating a complaint, resolving the complaint, prosecuting a complaint where it is not subject to the direction and control of the Minister.

The Hon. PATRICIA FORSYTHE: Did you feel that blow nurses had genuine concerns for the welfare of patients at Camden and Campbelltown hospitals?

Mr GREETHAM: I was always impressed with the performance in setting out and speeding up of what they considered to be very real concerns about their local health service. They did so at some cost to their personal and professional lives. The report dealt with the investigation incidents and found that the majority of concerns they raised were founded and substantiated.

The Hon. PATRICIA FORSYTHE: At any stage did you feel frustrated by the matter of time that the investigation was taking to deal with the whistleblowers' allegations?

Mr GREETHAM: Mr Grant indicated his concerns with the delays in the investigation. I have worked there for some time and I have seen the fall-out of those delayed investigations. I share the view that 12 months is an inappropriate time frame. I understood that the longer the investigation took, the longer the disquiet and distress of the informants would be. We were dealing with a massive amount of information. We had to ensure that we were dealing with that appropriately, and there is the tension between resources dedicated to the task, the information needs of the parties.

The Hon. PATRICIA FORSYTHE: From the evidence brought forward from the nurses, were you able to conclude anything about the culture of the Camden and Campbelltown hospitals? Were they an open and honest place in which to work?

Mr GREETHAM: Bear in mind that the investigation was focusing on one continuum that stretched across two campuses, Camden and Campbelltown. We did not look into every aspect of NHS. What the report notes, I believe, was pockets of a culture, part of the old system culture hierarchical protective, and we observed other examples including that the culture was more focused on learning and open. It was variable.

Certainly I do not think many people would argue that there is a current focus on quality and safety in the health system and part of that focus is looking at the culture of organisations.

The Hon. PATRICIA FORSYTHE: Was the decision in March of 2003 to reopen the HCCC investigation the result of the Alan Jones campaign?

Mr GREETHAM: From my position I was primarily responsible for the systems investigation and that continued as far as I was concerned from the beginning until the report was published. In March I interviewed informants for the first time. I was not aware of any part investigation being concluded prior to that time or opened after that time. I do know that the investigations of clinical incidents were resourced sometime in March or late February.

The Hon. PATRICIA FORSYTHE: In relation to the initial investigation, do you believe there was any political interference that may have played a part in that early investigation?

Mr GREETHAM: I had no communication with the Minister's office or any other MP.

The Hon. PATRICIA FORSYTHE: What about from the commissioner in relation to it?

The Hon. CHRISTINE ROBERTSON: How does the commissioner's participation immediately turn into political—

The Hon. PATRICIA FORSYTHE: I did not say participation; I said communication.

Mr GREETHAM: It is hard for me to understand that question. In terms of managing the systems investigation, certainly there was nothing that I would consider interference of any sort of political nature.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say that the HCCC as it was constituted, say, at the end of 2002 had its model of investigation of communications problems between people fairly junior in the system or isolated in the system and not as a system-wide problem? There were communications between patients and doctors or areas involving small segments of the health system but not a systemic problem. In other words, you were not really set up to look at big systemic issues in terms of resources or philosophy.

Mr GREETHAM: I had been at the commission for 16 years. One of my first major investigations was the care provided to people in boarding houses who had significant psychiatric disabilities. The report prompted appropriate action in the assessment of people at boarding houses and finding appropriate supported accommodation for those people. I do not remember the date but it was many years ago. I was also involved in the Dubbo and Canterbury investigations where we probed and looked at the systems and the practitioner accountabilities. That was several years ago. In our earlier days when we did not have a range of processes for complaints management you could easily argue that a number of the matters we were investigating were matters that would be more adequately dealt with through conciliation or local resolution. However, I understand that there are fairly stringent assessment processes at the commission and I would expect that matters warranting investigation would go down that channel. I am not able to comment on the pool of matters that are currently open in the commission.

Mr GRANT: May I respond in part to that? It may be an answer to your question if I am allowed to do that. From what I have seen my view is that the Macarthur investigation drew enormous resources out of the commission. Nearly all the senior managers were involved to some extent in trying to resolve the Macarthur matter. I think that the size of Macarthur actually overwhelmed the commission in part. I think that was the

thrust of your question. I have gone so far in the legislative review that I had provided to the Minister and the Cabinet Office as to say that I think there should be a special power in the legislation, as with the ICAC legislation, to bring someone in as an acting commissioner and hive off a particularly long, complex and difficult matter without interfering on the day-to-day running of the organisation.

The Hon. PATRICIA FORSYTHE: In relation to the process of complaints handling that you referred to, is it a fact that the initial investigation concluded back in January 2002 without the whistleblower nurses having been interviewed? If so, how would you have been able to draw conclusions without interviewing the nurses?

Mr GREETHAM: I am not aware of the investigation concluding at that time. Around that time an interim report was published, and people may have drawn conclusions from that that certainly were not—

The Hon. PATRICIA FORSYTHE: What was the purpose of the report?

Mr GREETHAM: As I understand it, it was an interim report—it was not a public report—to provide key stakeholders with an update of where the investigation was at that time.

The Hon. PATRICIA FORSYTHE: Was it a normal process to publish such an interim report?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Had it been done before?

Mr GREETHAM: I am just scanning. It would not have occurred very often, and I think with our usual complaints process I cannot comment—

The Hon. PATRICIA FORSYTHE: Who sought the report?

Mr GREETHAM: I am not aware that anyone sought the report.

CHAIR: But it would be unusual for you half way through an inquiry to produce an interim report when no-one had asked for it.

Mr GREETHAM: That question would probably be best put to the then commissioner. I cannot help you with that matter.

Mr GRANT: Can I just say in a general nature that the former commissioner had control over this investigation from the beginning. From material that I have looked at and examined it is obvious that the former commissioner determined matters all the way through the investigation from the start to the end. Individual officers had input into some of the decisions from time to time but the beginning and end of responsibility for what happened during that investigation rests with the former commissioner.

CHAIR: We can address those questions to her on Monday when she is here before us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why did the HCCC not interview the people who were complained about? The whistleblower nurses were not interviewed except with a solicitor in the beginning and then you did not interview the people being complained about either. Is that correct?

Mr GRANT: Perhaps I will start. My understanding is that some interviews were conducted with whistleblower nurses in about November-December 2002. There were then some further interviews on I think 5 March 2003 and then there were some more follow-ups with some of those nurses during, I think, the remainder of 2003 through to about November 2003.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The ones in 2002 were conducted with the HCCC solicitor, Sarah Connors, present, were they not?

Mr GRANT: I think they were conducted by one of the legal practitioners in the commission and also I think one of the investigators.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And was the suggestion put to the whistleblower nurses at that time that they were personally at risk in making this complaint?

Mr GRANT: I had a look at that since that was raised in the transcript of, I think, the first days hearing before this body. From what I can see there was an attempt by the legal officer to point out to the whistleblower nurses that documents that they were producing such as patient records et cetera were not necessarily protected by any form of authority in the HCCC legislation. That was done out of fairness; it was not done to frighten them off. It was not done to alarm them, although I can well understand why someone would be alarmed to get that information. But there was no particular statutory protection for people producing records that were not their records.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that not a huge oversight if you are within the umbrella of ensuring quality health care to simply say, "I have no information but I have brought you this and I reckon if you go and look there you will find the information"? That is a fairly absurd position, is it not?

Mr GRANT: There is no protection to people bringing forward these complaints. There are no linkages as I have no doubt you have noted between the Protected Disclosures Act and the HCCC. It is not one of the organisations mentioned in that legislation. That is another issue that I have suggested really needs to be addressed in the legislative review.

The Hon. CHRISTINE ROBERTSON: Mr Grant, it was mentioned a little earlier about the resources required for one of these special investigations. You have already said that if the investigation is huge an extra commissioner should be appointed. Can you outline what you are proposing in your review to fix this problem for the future?

Mr GRANT: Firstly, we have set up the Macarthur team that I talked about earlier. That is to look at individual matters coming out of the first report. That involves a combination of investigative, legal and clinical expertise to look at those matters and try to resolve those matters quickly through a quick investigation. In terms of the general run of things, I have mentioned in my suggestions for legislative reform that I do think there needs to be some form of special part of the legislation similar to what is in the ICAC legislation where you can bring in outside resources and look at matters promptly and efficiently. I suppose the other thing I would say, which touches on your question, is that I have also suggested that there should be a preliminary investigation model similar to that conducted by the ICAC.

My understanding from the ICAC figures of last year is that the ICAC did something like 105 preliminary investigations, which I think resulted in something like 29 full investigations. So when matters that came into the HCCC and they are not matters that are going to be hived off somewhere else, they are serious matters that deserve some sort of consideration of investigation, my model is that there should be a preliminary investigation of those matters involving legal, investigative and medical resources to ascertain how serious the matter is and whether there is a matter there that comes within the terms of the legislation that should be investigated. That should be done up front to try to move all those things forward. Part of the legislative review suggestion is that powers should be given to the HCCC similar to those available to the ICAC and the Ombudsman to call for documents, medical records or whatever or call for a response from parties to try to resolve those complaints—many of them, hopefully, right up front. Some matters it will always be obvious should be investigated. You do not even muck around with preliminary investigation with serious sexual assault allegations; you put them straight into investigation. But with other matters, particularly clinical standards, there is a real debate about whether it will produce a result that might result in disciplinary action or not. So I think the more you focus up front with those resources—and even if you are going to investigate them you clarify the issues. You have got clinical and legal input. You can then focus on those and hopefully resolve the vast majority of those well within a 12-month timeframe.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I come back to the question I asked before. If Sarah Connors just happened to be an investigation officer who just happened to be a solicitor why was she the first person doing the investigation? Is that normal practice?

Mr GRANT: No, normally investigations are conducted by investigation officers. I cannot advise you whether Sarah was an investigation officer at that stage with legal qualifications; I can say at the moment she is in the legal team but I was moving her into investigations looking at backlog reduction to put those teams of

specialists together but I can come back, as anyone can tell you, and let you know what their status was at that time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The feeling of the nurses—you may have heard in evidence—was that this was a discouragement tactic, that they were to be frightened off.

Mr GRANT: Yes. I can understand that view, particularly if you are given some warning about the documents that you are producing. It was not intended to be that way but I certainly understand why it was perceived to be that way. I cannot say why Sarah was put in charge of that. It might be a matter for the commissioner when you interview her next week. All I can say is that there was also an investigator involved in that. It may have been to utilise her experience in trying to interview significant numbers of people at the one time. I do not know. But I can certainly get an answer for you on that if you wish it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Another question I wish to ask relates to the no blame culture. Dr Fiona Tito has been in favour of that. My understanding was that Amanda Adrian is in favour of that. How do you reconcile that with professional accountability, particularly in the case of people such as the administrators of Macarthur?

Mr GRANT: I have a different view. My view is that the commission is there to investigate complaints. Those complaints sometimes result in disciplinary action. I do not see any philosophies of no blame cultures or anything else having any part to play in the way the commission administers its legislation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Its report on Macarthur did not really call for anything in particular to be done. Is that not the criticism that has been levelled at it?

Mr GRANT: I am not aware that there are many criticisms of what is in the report. It provides many helpful recommendations on system reform, et cetera. I think the criticism about what is not in the report relates to individual accountability. I think those criticisms are justified.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The fact that there was not individual accountability is why the HCCC has been criticised and why Amanda Adrian is no longer there.

Mr GRANT: I would agree with the first part, but I cannot comment on the second part.

The Hon. AMANDA FAZIO: I would like to ask a question that I have asked other witnesses this morning. My question relates to the role of the HCCC and to an issue that has been raised with me. By looking at systemic problems rather than at individual practitioner problems, the length of time that claims were taking had reached such a stage that no action could be taken against individual practitioners. They had been working in the health system and they had not been making mistakes for two or three years after the incidents started to be investigated, therefore, you could not punish them. A de facto statute of limitations had come into play. You are putting more resources into clearing that backlog. What do you think about the issue of natural justice and about those people who had complaints about those practitioners, but the time lapse prevented any action from being taken?

Mr GRANT: The backlog reduction strategy will not eliminate matters purely because of a lapse of time. One consideration that you would have to give relates to the length of time it is taking to investigate the matter and the likely outcomes. I have no doubt that, if a matter is three or four years old, or older, by the time it gets to a medical tribunal, the tribunal must be influenced, at least when it comes to penalty, by the fact that perhaps that person has had a spotless character since he or she may or may not have committed some form of unsatisfactory professional conduct. It is a live issue. It is one of the main reasons why the commission must resolve matters in a more expeditious fashion. There is no doubt about that. I do not think it stops you from taking matters forward, but it severely impacts on the sorts of orders that you may get a tribunal to make if a matter has been hanging around for three or four years.

CHAIR: It is not just the professionals, the doctors or clinicians that are being held in abeyance; it is also people who may have raised the complaints, such as nurses and others, or very junior staff. Frequently they are moved sideways, they are dismissed, they are suspended, or something else happens. For a matter to go on for five years is a complete denial of justice.

Mr GRANT: I can do nothing other than agree with you. I do not throw in the complainants in relation to that. Most of these people live with these issues hanging over their heads for a period of time. They need quick closure. I do not think we have performed very well in giving some of these complainants closure of their matters by taking so long to investigate.

The Hon. PATRICIA FORSYTHE: Is there a system in place to monitor the implementation of any recommendations that arise out of complaints investigation?

Mr GRANT: If we investigate a matter and it produces a result is there some form of appellate process?

The Hon. PATRICIA FORSYTHE: Yes.

Mr GRANT: Yes, there is. If you like, there is an appellate process if we decide not to assess a complaint for investigation. We can ask for it to be reviewed and we can ask for a review of the outcome of an investigation as well.

The Hon. TONY CATANZARITI: How do you prioritise these investigations? What is your practice?

Mr GRANT: There was an assessment process to prioritise, if you like, whether it goes into investigation. There is some priority within investigations depending upon the factual circumstances. For example, you may have a practitioner suspended by the medical board. Therefore, it is obvious that you have to expedite that matter because that practitioner cannot practice. That, again, is a form of natural justice, if you like, to try to resolve those matters quickly.

The Hon. TONY CATANZARITI: I am referring to the backlog of case. Do some cases wait a little longer than others?

Mr GRANT: We will be starting with matters that are over three years old and we will be focusing on them. We will also be starting with matters that are very close to finalisation, resulting in a few issues, et cetera. We will be trying to finalise those as quickly as we can. There is backlog reduction strategy. If you would like, I would be happy to make it available to the Committee.

The Hon. CHRISTINE ROBERTSON: If you are concentrating on putting so many resources into reducing this backlog how will you maintain current complaints?

Mr GRANT: A separate team will be getting matters that are six months or younger and it will also be dealing with matters as they come in. It will be operating within that 12-month time frame. So there will be two backlog teams. One team will deal with pharmacy matters because they are a speciality. I think there are about 100 of those in the backlog. We will be focusing a special team on them, with special resources and special clinical assistance.

CHAIR: The Government has announced that it will provide substantial additional amounts of money to enable you to employ persons to do that work.

Mr GRANT: The total for the backlog in Macarthur is about $75.7 million.

The Hon. ROBYN PARKER: Once you have made a recommendation I understand that you then follow an appeal process. Is your recommendation tracked to ensure that that course of action is followed?

Mr GRANT: Are you asking whether we have any quality control within the investigation process?

The Hon. ROBYN PARKER: Yes.

Mr GRANT: The investigations are reviewed by investigation managers. Ultimately, the practice has been for investigation reports to come up to the commissioner to be signed off before they are issued. So there are two or three different levels of checking the results of the investigation before they are actually finalised.

The Hon. AMANDA FAZIO: A number of people have referred to the problems relating to the quality of care that a patient receives. A lot of the time you can put that down to a communication problem. That has

been a significant contributor. I refer to having a satisfactory complaints resolution system. Communication with everyone involved—the person who has had the complaint made against him or her and the person making the complaint—is an important aspect. What will you be doing to ensure that everybody is kept in the loop and is informed about what is happening with complaints that the HCCC is handling, given that that was a criticism? People were being told, "The HCCC is looking into it", and then they would not hear any more for a long time.

Mr GRANT: I think a speedier resolution would go a long way towards improving people's knowledge about what is happening with the complaints system. We are reviewing the correspondence that we send to people—complainants and respondents, et cetera. I have found it to be deficient in giving proper explanations for certain decisions made by the commission. Staff of the commission are looking at those template levels to make them a little more user friendly and to give people a bit more of an explanation. If we are not going to investigate matter we have to tell people why, otherwise they will not get closure. They will want to have appellate processes in place to do that. If we can be a little more expansive on why we did not think it necessary to investigate, or even why after investigation it has not resulted in someone being taken, for example, to the medical tribunal, perhaps we can get more effective closure for some people. That has been a deficiency in the commission. We are looking at that.

CHAIR: We have directed all our questions to two former members of the HCCC. The other three witnesses are current members of the HCCC. Does anyone have any questions for those witnesses?

The Hon. CHRISTINE ROBERTSON: What do you as a group think about all these massive changes? Are they positive moves forward?

Ms DONNELLY: There is a lot of support amongst the staff for these changes. It is providing more direction. There is also a feeling about being more in control of handling matters. It is distressing to staff when they inherit a file that might be a couple of years old—a file that somebody else has dealt with. The file is moved on to them and they have to go back through it and try to work out what needs to happen. They might have to go back and track down people again. I think it is seen in a positive light. The additional resources are welcome, as the commission has been struggling for many years. It has been very underresourced. I would say that it is a positive move.

Dr Yates: The main issue for investigating officers is the caseload. If the changes result in smaller caseloads—and I think the additional resources will result in smaller caseloads—investigators will be happy about that. It will mean that we will be able to finish our investigations more quickly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why did the HCC not interview people who were being complained about, in particular, in Macarthur?

Mr GRANT: I cannot really answer that, apart from giving you a general observation. Someone else might be able to help you.

CHAIR: Ask the question on Monday.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that a couple of investigators were involved in it—Dr Yates and Mr Greetham? Why did you not interview the people who were being complained about?

Dr Yates: At the beginning of the investigation we did not have any individuals identified as respondents to the complaint. In fact, the whole way through the investigation there was never a decision to assess individuals as respondents to the complaint. The only respondent to the complaint was the Macarthur Health Service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So all the complaints about management did not have any names attached to them?

Dr Yates: There were names in the information provided by the nurse informants.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why were they not interviewed?

Dr Yates: The commission did not assess the complaint in such a way that they were identified as respondents to the complaint.

CHAIR: Who was responsible for making that decision?

Dr Yates: The commission assesses complaints, so that means the commissioner.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that you are one of the investigating officers?

Dr Yates: Yes, I am.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously the commissioner was not saying, "Three or four people have been named as being in positions of authority and as having the power to act or not to act on these nurses complaints." Presumably they complained to these people and when there was no action they complained to you. So, in a sense, only a relatively small number of people are involved. Did you recommend to the commissioner that those people be questioned? Was it your recommendation that they should be questioned, or did you not make a recommendation?

Mr GRANT: It is my understanding that some managers were interviewed by the HCCC. I cannot tell you right now who they were and when it was. Some of the senior managers in the health service were interviewed.

The Hon. CHRISTINE ROBERTSON: Many of these matters are very definitely industrial relations and human resources management issues. I do not think anyone would debate that. How would that involve you, or would it involve you?

Dr YATES: The allegation that nurses were being disciplined to discourage them from making complaints about quality and safety was an important issue that was properly investigated.

CHAIR: It was not simply an industrial matter.

The Hon. ROBYN PARKER: Is Brett Salmon still working as an investigator for the HCCC?

Mr GRANT: Yes, he is.

The Hon. ROBYN PARKER: How appropriate is that given his response to a complainant, "What do you think I would do, wipe my arse with it?"

Mr GRANT: That was entirely inappropriate. He was disciplined at the time and he apologised to the person concerned. I understand that that apology was accepted. He did the wrong thing, he conceded that, and he was reprimanded.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Grant, when I referred to accountability you said that you saw your function as investigating. Presumably you think disciplinary action and retraining in respect of people found wanting is someone else's responsibility. Is it your position that you are not required to determine accountability, you are merely required to investigate and presumably someone else will act on your conclusions?

Mr GRANT: Yes. The commission has no responsibility for discipline beyond taking disciplinary proceedings before the Medical Tribunal of New South Wales or the various lower level committees that exist for doctors and nurses.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you merely present the case for prosecution stating that a person was found to be accountable and there were deficiencies?

Mr GRANT: Indeed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would not allow the two to come together. Is it someone else's function to bring them together?

Mr GRANT: We do not carry out the disciplinary action; that is a matter for the New South Wales Medical Board or an area health service. We also reprimand in our investigation reports. We can refer people to the board for counselling. We do a range of things. However, we do not carry out disciplinary functions; we seek the order from the various tribunals and hopefully someone else carries out some other action as a result, such as deregistration or the imposition of conditions on a right to practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: By that logic Amanda Adrian's report on Macarthur Health Service is consistent. It found deficiencies but did not attribute blame.

Mr GRANT: It is not consistent because it did not address individual accountability. That is required under the legislation; individual accountability should be addressed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The deficiency was that accountability did not exist. Are you saying that it should be attributed and publicly?

Mr GRANT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is blame; that would amount to pointing the finger at someone whose career is in huge jeopardy.

Mr GRANT: That is what the legislation requires. We investigate and report and, if necessary, take action against individuals under various pieces of legislation by referring a complaint to the appropriate tribunal or board.

CHAIR: Thank you for your contributions today.

The witnesses withdrew.

(Short adjournment)

BRIAN WILLIAM JOHNSTON, Chief Executive, Australian Council on Healthcare Standards, and

HEATHER McDONALD, Executive Manager—Customer Services, Australian Council on Healthcare Standards, sworn and examined:

CHAIR: Earlier in the day I made statements about the nature of evidence and privilege. I assume that you know that, to save saying all those things again. In what capacity do you appear before the Committee?

Mr JOHNSTON: I am here in an official capacity.

Ms McDONALD: I am here in an official capacity also.

CHAIR: Mr Johnston, we received a submission from you, which we have seen and read, but I suggest you might like to speak to it first, if you so desire.

Mr JOHNSTON: Certainly. Very briefly—a submission was provided in response to an invitation to do so and it coincided with some work that we were doing in looking at the performance of organisations nationally because complaints handling is a topical issue at the present time on a national scale. We have provided information to the Committee because we thought it might be useful in your deliberations. I will not go through it verbatim, unless members of the Committee would like me to.

CHAIR: No. Just give an overview and we will begin asking questions.

Mr JOHNSTON: First of all, I have described the process very briefly in the front part of the submission, and then I have reflected on the results of an analysis of some 228 organisations that were surveyed nationally in the first nine months of last year. The conclusions that we have drawn at this stage are set out on page five of the submission. In very general terms, we concluded that the private sector does better than the public sector, but there can be reasons for that. Certainly the majority of organisations Australiawide have complaints handling systems in place. One of the major shortcomings, as reflected in the information we have provided, is that a substantial number of those organisations do not evaluate their systems to make sure that they are working effectively. The final point is, I suppose, food for thought for the Australian Council of Healthcare Standards [ACHS]: Mindful of the national discussion about complaints handling, we are looking quite seriously at whether or not complaints handling, instead of being part of the patient's rights and responsibilities section, should in fact be given a higher priority in the program.

CHAIR: Totally separate area.

Mr JOHNSTON: That is all I have prepared to say by way of introduction.

CHAIR: Having had several hospitals in the past judged by some of your surveys and others, the interesting thing that I find is that you can have the same administration over several hospitals and quite different cultures in those hospitals.

Mr JOHNSTON: Yes. I share that observation, from my own experiences as a surveyor in the past.

The Hon. PATRICIA FORSYTHE: Has the Macarthur Health Service been the subject of a quality review? If so, how was it judged?

Mr JOHNSTON: Perhaps I could answer that in a slightly elongated form. Macarthur Health Service was not a member of our program until it rejoined in March 2002.

CHAIR: But it had been, though, had it not?

Mr JOHNSTON: Up until 1996, but by the end of 1996, both of those two hospitals, which were separate members, had withdrawn. They had followed another process and they rejoined in March 2002 as Macarthur Health Service, being part of the South Western Sydney Area Health Service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When did they join—October?

Mr JOHNSTON: They rejoined in March 2002.

CHAIR: They did have a quality assurance program running up until that time, though, did they not?

Mr JOHNSTON: They certainly did, yes. My understanding is very much so.

The Hon. PATRICIA FORSYTHE: When they rejoined, did you then do an evaluation? Were they given an accreditation?

Mr JOHNSTON: They were, and that evaluation took place in June 2003. The amount of time that elapsed from when they rejoined to when they were surveyed is a little bit at the long end of the time scale that normally applies, but it is not simply a matter of an organisation joining our program and a week later being surveyed. There is more required of an organisation in terms of the way in which it wants to present itself, so there are time scales that apply and normally at the very best a new organisation joining our program would not be surveyed in less than nine months. So the 15 months that applied on that occasion was at the far end of the time scale, but not unusual.

The Hon. PATRICIA FORSYTHE: What accreditation was it given?

Mr JOHNSTON: It was awarded two years accreditation. We have a maximum period of time available of four years, and reflected the finding of the survey team on that occasion.

CHAIR: The survey team would have found quite a number of deficiencies there?

Mr JOHNSTON: The survey team was very mindful that there was at that time an investigation continuing, but had not yet reported, by the Health Care Complaints Commission [HCCC] where a number of very serious issues had been raised publicly by that stage. There was no interim report available to the team. They were mindful that that review was in process. Their focus was on the systems that were in place. Some of those systems have not yet had enough time to run to enable them to be satisfied that they were achieving at an extraordinarily high level, but in many ways this survey reflected quite favourably on what the surveyors found at Macarthur in June 2003.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you not aware of the HCCC report at that time? The interim one had come out, had it not?

Mr JOHNSTON: To the best of my knowledge, the interim one had not come out.

The Hon. CHRISTINE ROBERTSON: It was not ever published. It was leaked.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was not public but it would have been known to the people at Macarthur, surely.

Mr JOHNSTON: Yes, I presume it was. I do not know. I was not a member of the survey team. As I said, our surveyors were aware that the inquiry was ongoing, but I think that the only thing that had occurred up to that point in time was newspaper publicity—some media publicity.

CHAIR: I mention to members of the Committee something that I have just realised. The person who was in charge of the program in the Macarthur area when they had your surveys and when they were working at quality assurance—when that program ceased in the late 90s—I actually employed the person in charge of the program. I will not ask any questions about that or subsequently.

Mr JOHNSTON: I understand.

CHAIR: I have just realised that the person I added to my quality staff was the person who was running the programs with you, so I will refrain from questions on that. I declare that interest.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it against the public interest for you to bring any knowledge you have on the subject?

CHAIR: I do not have any knowledge on the subject.

The Hon. CHRISTINE ROBERTSON: I would be interested to know when you did that survey 2003, did they have an external survey body in the absence of you people?

Mr JOHNSTON: Yes, they did.

The Hon. CHRISTINE ROBERTSON: Can you tell me whether there were an awful lot of recommendations for the two-year review time?

Mr JOHNSTON: From our report?

The Hon. CHRISTINE ROBERTSON: From your report.

Mr JOHNSTON: I have not brought a copy of the report with me. There were a reasonable number, but not an unusual number of recommendations. If I could just defer to my colleague, I think that would be best.

Ms McDONALD: We actually encouraged recommendations because it was a way forward for the organisation.

The Hon. CHRISTINE ROBERTSON: Yes, I understand the process.

Ms McDONALD: We have 19 mandatory criteria, so they would have all got recommendations for those, I would imagine.

The Hon. CHRISTINE ROBERTSON: And you have no recollection whether or not there were major issues in relation to management and human resources?

Mr JOHNSTON: My recollection is that, no, there were no major issues. There may well have been comment, but I do not recall.

The Hon. CHRISTINE ROBERTSON: Does your process allow for that sort of information to come out, to be found, to be identified?

Mr JOHNSTON: Yes, but not from us. If I could explain that—I think it warrants explanation—by saying that the nature of the organisation is that it is a membership-based program and the report, once it is available, is the property of the member organisation, not of ACHS. What the member organisation decides to do with that report, how public they decide to make it whether in the public or private sector, is completely in their hands.

The Hon. CHRISTINE ROBERTSON: I guess I am not interested in whether the public knew. I am interested in whether it was brought to the attention of Macarthur Health Service whether there were some problems in human resources or management. Was there any way could have been picked up from your process?

Mr JOHNSTON: By the time we had—as the process was developing, or when the report was available?

The Hon. CHRISTINE ROBERTSON: I guess as the process was going on and the report.

Ms McDONALD: Yes. What happens is the team talked to the administrative management the whole time, so that there are no surprises at the end of the report. When they leave the organisation, the organisation is pretty much aware of what is going to be in the report. We now have a process where they get a draft report after the survey and correct errors of fact before it goes to vote, so it is quite an open and transparent process in that respect. Is that sort of thing you are asking?

The Hon. CHRISTINE ROBERTSON: No. We have had evidence that obviously there were some problems in people management in this institution. I just want to know whether your process could pick that up.

Mr JOHNSTON: It can. Again, it is a slightly longwinded explanation. Fundamentally, what the organisation moves towards is a self-assessment. That forms the basis of the information that informs the survey team about what the organisation believes is its level of achievement or, if you like, conformity with the standards and criteria that we set down.

That part of the process takes time, to build that body of information. The organisation is self-assessing over an extended period. If, in looking at our criteria they found deficiencies in their current processes, yes, there would have been a trigger that would have been available at either a local area or area health service level to the extent that they were involved to prompt further inquiries. That is quite possible; whether it actually happened, I am sorry I could not comment on that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say you are membership-based, is that effectively saying you are a self-regulatory body of the constituent members?

Mr JOHNSTON: There are two comments I would like to make. Organisations join the ACHS quality improvement program as a member. The owner, if you like, of the organisation—because it is a not-for-profit organisation—is the Australian health care system, and our council, which consists of some 28 organisations, includes all State and Territory governments, the majority of medical colleges and all peak industry organisations, with the exception of one at present, which is shortly to join. Effectively that is the governance process. In some respects you may well argue that it is self-regulatory, but it is subject to an enormous number of influences from various sections of the health industry, including the consumer movement.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You just had a brand-new member come in who wants to be accredited, gets some flak in the media, and gets an accreditation that is pretty favourable. Is that what has happened?

Mr JOHNSTON: I would take issue with that. It is important to read the report to reach a balanced view about the outcome of that survey for Macarthur Health Service. Your words that I would be concerned about are "pretty favourable". The report is a very balanced and comprehensive one, I believe.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that the report is not necessarily publicly available. If it were not favourable, presumably a hospital could simply stick it in a bottom drawer forever, could it?

Mr JOHNSTON: It could, except that Macarthur would have had reporting obligations to South Western Sydney. I am not quite sure of the relationship between the area health services and the Department of Health in New South Wales as to whether they require information to be provided on the outcome of reports, which happens in other States.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it is not necessarily a pre-requisite for your examinations?

Mr JOHNSTON: No, it is not, but any document in the public sector, of course, would be discoverable under the freedom of information provisions, I would imagine.

The Hon. PATRICIA FORSYTHE: Would you elaborate on what you mean by required in other States? Is it by regulation of the health department, legislation, or some other means?

Mr JOHNSTON: Administrative decree. Queensland is a good example, where the various districts are required to report on the outcome of their surveys and certainly to provide information about the more serious recommendations that have been made and, I understand, advice about what actions have been taken to correct those shortcomings.

The Hon. PATRICIA FORSYTHE: To whom?

Mr JOHNSTON: The Department of Health in Queensland.

The Hon. PATRICIA FORSYTHE: Does that then become public information?

Mr JOHNSTON: Not that I am aware of, but I do not know.

Ms McDONALD: Victoria has it in its performance agreements with the CEOs of each network. They all have to have some accreditation system and give the results to the Department of Health.

The Hon. PATRICIA FORSYTHE: Would you recommend some changes in New South Wales to ensure that there is an accountability mechanism provided within the system?

Mr JOHNSTON: I am not part of government.

The Hon. PATRICIA FORSYTHE: Which State works best?

Mr JOHNSTON: I think the Queensland system is quite a good model, to be honest. I add that it is important that many organisations make no secret of their accreditation performance. Some organisations place the report on their web site. We give it to them in a format.

CHAIR: They could put it on their front gatepost.

Mr JOHNSTON: I have worked in hospitals where I have made so many copies of the report that there is no way it could be considered to be anything other than public. The one thing we did not do was publish it in the local press. But 300, 400 or 500 copies were—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But is it discretionary?

Mr JOHNSTON: It is discretionary, yes.

The Hon. CHRISTINE ROBERTSON: What is the process when you go back in two years, what happens to the people? That would sort out the bottom drawer stuff.

Mr JOHNSTON: The very first focus is what progress has been made against the recommendations that were identified at the earlier review. That is a very important part of what is done. We also have a further look at the performance against the mandatory criteria, which go more towards the patient safety, in particular, and staff safety as well. Its major focus is what progress has been made. If there is inaction, that is cause for concern.

Ms McDONALD: I think it actually starts earlier than that, because after an accreditation review, as Macarthur had last year, they are required to do a quality action plan on the recommendations made at the time of survey. If the quality action plan does not indicate where they should be going, we can say that it is not good enough, something else needs to be done. If that is not done, they can lose accreditation between reviews. It is not a given, particularly since this year we have introduced a new version of our standards. Many more organisations have not reached full accreditation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were there any incidents while you were doing the accreditation of the emergency department?

Mr JOHNSTON: Not that I am aware of.

Ms McDONALD: I cannot answer that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was there any problem with access block in the emergency department?

Mr JOHNSTON: I am not trying to be difficult, but I do not remember the report in that level of detail.

CHAIR: What about Camden?

Mr JOHNSTON: I could make inquiries, but you can also get the same information from Macarthur.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If I put it to you that it was an incident with a psychiatric patient in the emergency department access block and that it was a problem, what do you say about that?

Ms McDONALD: I would have to say that I know there was something and we had an in-depth review happening at the same time. An in-depth review means that we are surveying the mental health part of the service to the national mental health standards. I know there was some issue about that, but I cannot remember how it is written up or what happened.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is that some assurance was received and the accreditation went ahead. That brings me to my next question: You said some hospitals do not assess the effectiveness of their systems, do you?

Mr JOHNSTON: Of our systems?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Mr JOHNSTON: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In the case with the psychiatric access block, have you reassessed the effectiveness of the system that was accredited?

Mr JOHNSTON: We have not been back to Macarthur to look at that issue. If an incident has occurred while a survey has been in progress, and my colleague seems to recall that it was noted in the report, it might have been the subject of discussion at that time. I do not know how atypical that incident was in terms of what the system specifies, whether it was a breakdown in the performance of an individual or group of individuals, or whether the system was found to have a flaw in it. The fact that an incident occurs would not stop the survey, but it might be commented upon. It would be looked at in the total scheme of the observations that were made at that time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the problem was an access block and an incident had drawn attention to that, it is my understanding that in most emergency departments the length of time that people have been waiting is written on a whiteboard. So you could see how much access block there was. Is access block a big feature of emergency departments in general? Does it impinge on accreditation? How widespread is it in the system, because we hear a lot about code reds?

Ms McDONALD: Certainly one of our standards is access, and it is one of our mandatory criteria. It would be reviewed every two years in every survey.

Mr JOHNSTON: And yes, of course, it is a national problem. There are now fairly sophisticated monitoring systems or databases created in major emergency departments that record the time of a person's arrival at the point of triage and the time at which treatment commences for that individual.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: By that logic does everyone with access block become accredited? Is that the end point?

Mr JOHNSTON: No, but it would be a matter of comment in numerous reports about issues relating to access that may affect the outcome of the survey or the accreditation decision for an organisation.

Ms McDONALD: That may be the reason some people are getting a two-year result rather than a four-year result. Currently we are evaluating our results since the beginning of last year. We have nearly 300 organisations so we are using that data at the moment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it satisfactory at a national level that you, as the accreditation body, find that everyone has access block and everyone is getting accreditation?

Mr JOHNSTON: Not everyone has access block all the time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But there is a fair bit of it about.

Mr JOHNSTON: There is a lot of it about. The reasons for that can be quite complex and very difficult to understand. It may well be a shortage of staff, or decisions by the local population to seek treatment for minor issues at local emergency departments.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That does not give access block. Usually access block is referred to as between the emergency and the bed in the ward, the hospital trolley in the corridor.

Mr JOHNSTON: Yes, it does, but it can also refer to the time to treatment. No-one likes to see people waiting for long periods of time in emergency departments, even if their condition is not life threatening. It is still stressful for the individual and the accompanying people. From my experience of working in hospitals no-one treats that lightly, but sometimes it does happen.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But access block is different from waiting time is it not?

Mr JOHNSTON: Access block is very different from waiting time. Access block is access to a bed, once a decision to admit has been made. There is a range of strategies which have been tried and tested and are being trialled throughout the country at present.

The Hon. PATRICIA FORSYTHE: How does Macarthur Health Service compare to other public health services in New South Wales?

Mr JOHNSTON: On the basis of the review that we conducted last year and on reading the report you would have to say it is performing at a reasonable level.

The Hon. PATRICIA FORSYTHE: Macarthur is better than a number of others?

Mr JOHNSTON: Quite possibly.

The Hon. PATRICIA FORSYTHE: Can you name the others?

Mr JOHNSTON: No, I cannot. I should make it quite clear that the rules under which the organisations operate are set by the stakeholder organisations that make up our council. If they are of a mind, particularly the government representatives, that they would like more transparency in terms of making available the reports that we produce, organisationally I certainly would have no problem and neither would my senior staff.

The Hon. CHRISTINE ROBERTSON: I know you have done a phenomenal amount of work to push your survey process into an outcome-based process, but because you are a survey by nature you will definitely pick up more process indicators that are evidence-based in their outcomes. Is that recognised when you do accreditation? Do the health services and your council work off the premise that accreditation is the be all and end all of the whole process? A lot of health services think that, but I want to know what you think.

Mr JOHNSTON: I will give a very personal view: Anyone who joined our programs so that they can get a certificate to hang on the wall of the foyer of the hospital or board room is, quite frankly, wasting their time. We are more interested in, and I have been personally interested in, the culture that is created within the organisation. The organisations that have the least problems are the people who take quality seriously, they do not need ACHS to come along and do a survey. It is useful, because it is a third-party assessment by an independent organisation and the standards and criteria we provide gives a framework for action and thinking within an organisation. There is nothing structurally wrong with that. At the end of the day the organisations that do well, and the people within them, are those organisations which take the quality agenda seriously. They are in the majority, from my experience.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you look at the processes, do you look at cases that might give trouble in practice? In other words, do you look at the notes and how things are going? The complaints of the whistleblower nurses are about bad processes, bad treatment. You may have a situation in which the statistics look fine, but there would need to be a few bad treatments to bring the death rate up. The policies and procedures may look fine, but things are not being delivered as well as they might be. On the face

of it, since we are having this inquiry, that seems to be the situation. Do you have a reality check on what is going on?

Mr JOHNSTON: Absolutely. The hospital makes certain statements in its self-evaluation. The essential ingredient of the survey is one of verification, and that takes place in a number of ways.

Members of the survey team look at medical records—they look at a sample because it is not physically possible to look at every one—to see how comprehensive the notes have been. In fact, medical record note taking—this is a clinician, not a doctor, comment—is one area of concern to ACHS, and something that we are doing something about at the moment. In fact, there has recently been publicity about a case in New South Wales, for example, where note taking was found to be a major point of comment by the Coroner in his findings. We also talk to the staff on the unit—both medical and other clinical staff, particularly nurses—as part of the process of verifying the statements of performance that the organisation has made.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you look at a random sample of notes or do you look only at notes in problem cases? Presumably you have a system of identifying problems and cases that have been managed suboptimally. Do you look just at those notes or at a random sample of notes?

Mr JOHNSTON: We would not necessarily look at every one but the typical practice of surveyors is to decide on the day they arrive from a series of strategies for calling for a sample of records. That might extend to pulling the records themselves or it might extend to asking for all cases admitted on a certain day or series of days, quite at random and unknown to the staff before they were asked to be pulled. To make sure that the records requested are provided one can look at the admission register for a particular day. A selection of complaints files may be drawn and a review made of the content of the record in respect of the matter that is being complained about. A series of strategies can be used. But it would not be all files.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In terms of staffing, it has been said that some people are put in acting positions just before you guys arrive to make educators or whatever look good and those acting positions may not persist for long after you have gone. Do you have any way of assessing that situation?

Mr JOHNSTON: That is probably the one point that people mention to you quickest when you arrive as a surveyor.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That they are only acting?

Mr JOHNSTON: Yes, or that they were only appointed in the past six months. My personal view—I think it reflects an organisational view—is that we regard that very poorly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think it might be more than a coincidence?

Mr JOHNSTON: I believe it is happening less now than it used to—much less.

Ms McDONALD: But organisations still put in people as quality co-ordinators eight weeks before a survey.

Mr JOHNSTON: I think it is very noticeable. As a member of the survey team, when that has occurred in the past it has been a particular matter of comment. I think it goes to the culture that might exist in a particular organisation—not always, but it may.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When I worked in hospitals the fuss for weeks before you guys arrived was unbelievable. One could not help but think that things were dressed up very carefully.

Mr JOHNSTON: It is very easy to see through that.

CHAIR: It would be very noticeable. You must have your records.

The Hon. CHRISTINE ROBERTSON: So the process these days is not about the one-off visit. Can you describe the process between times?

Mr JOHNSTON: Certainly. There is self-assessment and then an organisation-wide survey. A report is generated and the organisation is required to produce a quality action plan, as my colleague mentioned earlier. That usually follows within six months of the survey. Eighteen months to two years, but approximately two years, after the organisation-wide survey there is a periodic review that again checks on progress and reviews other outstanding issues. Another quality action plan arises from that periodic review and then you are back into the cycle of the next self-assessment. That is in a normal environment. There can be other circumstances that require intervention.

The Hon. CHRISTINE ROBERTSON: NSW Health produces a document that gives statistics on returns to theatre, readmissions and so on. Do you have that information about an institution when you are doing your survey?

Mr JOHNSTON: Yes.

The Hon. CHRISTINE ROBERTSON: How do you utilise that information?

Mr JOHNSTON: It is part of the briefing information that surveyors have available to them prior to going to a particular facility or organisation.

Ms McDONALD: They are our clinical indicators. We collect that information as clinical indicators so that the organisation—

The Hon. CHRISTINE ROBERTSON: I know about your clinical indicators. These are indicators that the department collects as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You perform this function as a membership organisation so some groups may not choose to join the organisation and may choose not to have accreditation processes at all. Is that correct?

Mr JOHNSTON: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If one were looking at this issue from a governmental perspective one could say, first, some people may not choose to be accredited; and, second, it would be better if the membership did not have discretion on what it could do with the reports. Would it not be better if you were an independent government-funded organisation that simply went out and conducted inspections? The only downside would be that someone had to fund it.

Mr JOHNSTON: Someone funds it now in a variety of ways—public and private sector. One of our strengths is that we cover the public and private sectors and both of those sectors see strengths in being equated to one another—they are measured against the same standards that apply to the other side. The payment of a membership fee gives a sense of ownership to the organisation and develops a sense of commitment. There is always tension between what might be a more regulatory approach and encouraging a quality-improvement culture within an organisation. Clinical staff—if I can use that term generally—tended not to be all that enthusiastic about regulation. Our experience has been—this has also been the experience in other countries in the world—that you get a better result if you focus on the culture and encourage people to pursue quality and support them in that aim rather than requiring them to do so.

There is always a tension and a need for balance. So, whilst we are voluntary, the reality for most organisations in this country, particularly in the private sector, is that if you are not accredited either by us or by one of the other organisations it is very difficult to conform to performance requirements in the public sector—between the funding authority or the central government. In the private sector you cannot be financially viable because the health insurance funds require accreditation, without specifying us, as a condition of payment of benefits.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are assuming that a regulatory body could not have the quality tools built in that you have.

Mr JOHNSTON: Yes, it could, but it pulls it that much closer to government.

CHAIR: More and more governments and private health insurance companies are demanding that kind of accreditation.

Mr JOHNSTON: That is true.

CHAIR: I have two questions about complaints handling. The ACHS developed the Equip Program, which was continuous improvement in quality, and then you conducted a survey throughout Australia. What were your findings about the way that complaints are handled?

Mr JOHNSTON: We tried to summarise our findings in the attachment to a submission. Basically, organisations have systems in place and the majority of them function quite well.

CHAIR: How did New South Wales compare with the other States? I want this to go on the record rather than simply appear in the document.

Mr JOHNSTON: New South Wales' performance was approximately the same as that of the other States.

CHAIR: You indicate in your report that the better part of that performance was from the private sector. Leaving aside the private sector, how did NSW Health perform in comparison with the other States?

Mr JOHNSTON: Do you mean the individual members within NSW Health?

CHAIR: Yes.

Mr JOHNSTON: I would not change my comments from that which I made before: it performed at a reasonable level.

CHAIR: You told me that you were thinking now of making complaints handling a separate special issue. Why would you do that?

Mr JOHNSTON: If you look at the 30-year history of ACHS you will see that we have produced 16 editions of our standards in various forms. The very first edition and the current edition are chalk and cheese. Standards have been an evolutionary and a very dynamic process. From time to time there is a need to focus on different issues without wanting to swamp member organisations with requirements. So from time to time we change our focus.

CHAIR: Is it not true to say that you would not establish an entirely new set of criteria if complaints handling were being done well?

Mr JOHNSTON: That is true. I think our submission says that 26 per cent of organisations not reaching an MA rating is cause for concern—certainly to my mind. The standards committee of my organisation that reports to the board will consider this issue in light of both national and State developments. That is why I shared that comment in our submission.

The Hon. PATRICIA FORSYTHE: I asked you earlier where Macarthur Health Service sat in comparison. I also asked whether other material was available and you said no. Is it possible to make that information available to the Committee in confidence?

Mr JOHNSTON: I certainly do not have any problem making available a copy of the report, but it is not within my purview. I seek the Committee's guidance; I am certainly not trying to be obstructionist in any way. But I would have thought that that report could be made available by request to the Department of Health.

Ms McDONALD: Or from Macarthur Health Service.

Mr JOHNSTON: Whatever the appropriate processes are. We feel a little constrained because of the nature of the contractual obligations.

CHAIR: We could certainly ask Macarthur Health Service to provide that information. Thank you for appearing before the Committee today and for sharing your knowledge with us.

(The witnesses withdrew)

GEOFFREY MICHAEL DULHUNTY, Acting Executive Director, College of Nursing, Sydney, and

LEANNE LANCASTER, Nurse Educator, College of Nursing, Sydney, sworn and examined:

CHAIR: I have made some statements about the role of privilege and so on. I will take it that you understand those issues. Mr Dulhunty, are you acting on behalf of the organisation?

Mr DULHUNTY: I am acting on behalf of the organisation and Professor Judy Lumby, the executive director, who is in Vietnam at the moment.

CHAIR: Ms Lancaster, in what capacity are you appearing before the Committee?

Ms LANCASTER: I am appearing as a private citizen.

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

Mr DULHUNTY: Yes. The College of Nursing is a non-partisan peak professional nursing body and has been established since 1949. The college is a professional nursing organisation and a significant provider of postgraduate and continuing professional development, which has more than 7,000 registered or enrolled nurses participating in its courses annually. The college provides policy advice at State and national levels and lobbies government on issues affecting nurses, nursing and health care.

The college staff sits on many peak health committees, task forces and projects at both State and National levels. These include membership of, or input into, the Ministerial Steering Committee on Clinical Quality, the Clinical Council, the Australian Council for Safety and Quality in Health Care, the Open Disclosure Consortium, the Best Practice Guidelines on Complaint Management for Health Care Services and the Turning Wrongs into Right project workshops. Therefore, the college is committed to open disclosure, open communication with consumers and a culture that learns from mistakes. The college believes that nurses always have been, and continue to be, involved in an active and open discussion surrounding complaints for the improvement of health care. Unfortunately, and despite nursing being the largest provision in health care, it is largely invisible.

Nurses, despite being seen by the community as a most trustworthy profession, are still not recognised by many in the health professions as skilled professionals, and we continue to be affected by the dominant medical culture in contemporary health care. The health care system has presented many challenges to the college in terms of how to provide flexible, high-quality, clinical relevant education to nurses to prepare them to meet the changing needs of the health sector. For example, both the report of the New South Wales Health Council 2000 and the New South Wales Ministerial Advisory Committee on Health Services in Smaller Towns, the Sinclair report 1999, and the subsequent Government action plans confirm the importance of providing ongoing education as a means of facilitating the recruitment and retention of a skilled nursing work force. The college is committed to a process by which nurses will take responsibility for their continuing competence, and have documentation for the registering authority if audited. In this way our mandate to ensure public safety is validated.

These views were also expressed in the college's submission to the National Review of Nursing Education. This submission, and its inherent views, lead to a policy paper that was forwarded to the New South Wales Nurses Registration Board recommending a progression towards the introduction of requirements for recency of practice and mandatory continuing professional education for ongoing registration. The college liaises with the Health Care Complaints Commission. Our input includes the provision of independent expert witnesses and advice to the courts and tribunals. We also undertake remediation of nurses referred to us from the Nurses Registration Tribunal and professional standards committees. The college has also provided a customised education programs to clinical facilities that may address the clinical practice deficit identified through a complaint process.

We tailor education programs that focus on any clinical knowledge deficits, and facilitate clinical reflection of clinicians on their workplace so that change, if required, can occur from an evidence-based and critical perspective. The college believes that there are issues surrounding the culture of complaints handling in health. It also believes that these are not insurmountable. Rhetoric, policy and programs need to be reflected in

practice. Clinicians at all levels must be heard and supported. Health care must begin to embrace a client-centred focus where, regardless of status, clinicians work together for the better good and safety of the patient and, ultimately, for the betterment of health care in this State.

Nurses have and will always have the mandate of patient advocacy. To ensure that nurses and nursing will continue to actively participate in health, nurse leaders must be both nurtured and supported in the health system. The multiskilling of senior nurses, the majority of whom may well look after housekeeping, grounds, security, corporate services, budgets and clinical practice, does little to focus on issues of clinical care and nursing practice. Nurse managers, who traditionally have been role models and supporters of excellence in clinical practice, are too busy putting out everyone else's fires to focus on the primary goal: good patient care. The college thanks you for this opportunity, and is more than happy to assist the Government in any way it can.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are now at the College of Nursing?

Ms LANCASTER: I am.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But your previous job was at Macarthur?

Ms LANCASTER: In my previous job I was employed as a clinical nurse educator within the emergency department at Campbelltown Hospital from October 2000 to October 2001. I then went on the secondment to the college, and during that secondment I took on a permanent position at the college.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you find that there was good education in the Macarthur area?

Ms LANCASTER: I found that there was no education when I arrived.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You set it up?

Ms LANCASTER: No, I was employed purely for the emergency department as a clinical nurse educator. There was very little ongoing continuing education within the facility, and I can only relate to Campbelltown Hospital. I was quite surprised that there was no formal education department within the facility. Within two weeks of arriving and starting in my job within the emergency department I had nurses from all over the hospital come and ask me to do education for them throughout the facility.

The Hon. AMANDA FAZIO: What was the time frame during which you were there?

Ms LANCASTER: October 2000 to October 2001, 12 months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You set up education in emergency care, did you?

Ms LANCASTER: I did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were management supportive of your efforts?

Ms LANCASTER: Within the emergency department I had enormous support from both medical and nursing staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who were they? Which people?

Ms LANCASTER: Do you want names?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, sure.

Ms LANCASTER: Dr David Hugelmeyer commenced in the September and I commenced in the October. We had a really invaluable relationship insofar as he was very supportive of nurse education to the point of offering to give over funds from medical education to support the nurses. Ann Whiteman was the Nurse

Unit Manager at the time, and she was extremely supportive of anything I wanted to implement as far as education went.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you have time to do those things?

Ms LANCASTER: There are not enough hours in the day for education.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were staff released to do the education?

Ms LANCASTER: There was no facility available to released staff for education. There were some courses outside the facility that were funded by New South Wales Health that staff were released to. There were some occasions when staff could be released to external education programs to attend seminars, et cetera. As far as internal education, we had to schedule that around down periods, within the departmental workload and may be run repeat sessions over 24-hour-period to accommodate all the staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was it systematic? Did each staff person get rotated through so that each person got a certain number of hours per year?

Ms LANCASTER: There was no way in which I could have accomplished that. What I did within the first month of arriving, I did an educational needs analysis of the staff within the department, identified areas that they identified as deficits in basic education in the department, then set up a plan for the next 12 months. Part of that was to set up a continuing education program, which we ran sessions throughout the week at varying times. Those sessions were divided into mandatory and non-mandatory. Mandatory sessions related to policy changes, practice changes and things such as 9831, which was the mental health triage that was a big issue when I arrived there. What happened was that staff had to attend those sessions as nominated on the advertisement within a time frame. They were ricked off an attendance list so that I had a register of who had attended the sessions.

CHAIR: Did that include evening staff, night staff and weekend staff?

Ms LANCASTER: It did. I did some night shifts and evening shifts. I worked four 10-hour days so that I could cross over the evening and the day staff. That was negotiated at the time I was employed. I negotiated four 10-hour days so that I could accomplish that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This sounds pretty good. Was this sort of thing general throughout the hospital?

Ms LANCASTER: There was only one part-time educator that I was aware of within the Macarthur Health Service when I ran the orientation program for new staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was no other educator, apart from you?

Ms LANCASTER: To the best of my knowledge no one was designated as an educator.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Nowhere else in the whole of Macarthur Health?

Ms LANCASTER: To the best of my knowledge, no.

The Hon. PATRICIA FORSYTHE: How does that compare to your experience in other health services?

Ms LANCASTER: Previous to that I had been employed for 10 years at Liverpool, on and off over a 10-year period, and I had been employed in a private facility outside of Liverpool, as well as in the US in a large trauma centre. Liverpool has a very well set up education department that does, on occasion, cross over to address area needs. I have not been in that area health service in Liverpool for about four years, so that is as current as my knowledge is there. But when I was at Liverpool I was the course co-ordinator for the Graduate Certificate in Emergency Nursing, which is a post graduate specialty qualification. It does not compare at all. Most of the wards will have a clinical nurse educator. Those areas, different divisions, depending on specialty within those divisions may have nurse educators and under those nurse educators you have clinical educators

working. At Macarthur I was employed as a clinical nurse educator, and at interview we negotiated the fact that after 6 to 12 months we would review it and, hopefully, upgrade that to a nurse educator position because management recognised there was a serious need for that level, but the funding was not available at that time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How was the overall standard of nursing at Macarthur, would you say, compared to, say, Liverpool where they have nurse education?

Ms LANCASTER: I can only refer to the emergency department, because that is where I worked at Macarthur. In my needs analysis when I commenced there I found the staff to be very well educated. Some 60 per cent of respondents in the survey, and I have a report if you would like it, had graduate certificate level education.

CHAIR: Which they had done in other places?

Ms LANCASTER: Yes. Most of them had gone to the New South Wales College of Nursing as it was called then. Some had commenced it and completed it with the Liverpool Health Service, which ran its own graduate certificate programs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that the Macarthur ones in the emergency department were quite well educated when you got there?

Ms LANCASTER: They had done extensive post graduate work?

The Hon. ROBYN PARKER: When you say management recognised the need, who do you mean by "management"?

Ms LANCASTER: I mean the Nurse Unit Manager within the emergency department. I could not comment to anybody else because I did not discuss those issues with anybody else there. But before I went to apply for the position I went out to have a look at the facility, the resources and how it worked as preparation to apply for the position. I had discussions with some of the clinical nurse specialists, I think there were probably one or two of them within the emergency department, some of the senior clinicians, and I also spoke with the Nurse Unit Manager. They all recognised that there was a definite need for an educator role within the department.

The Hon. AMANDA FAZIO: You stated that when you were at Liverpool a much greater emphasis was given to education there than when you went to Campbelltown.

Ms LANCASTER: No, it was not an emphasis it is just that services were more available at Liverpool than they were at Campbelltown.

The Hon. AMANDA FAZIO: What do you think determines the priority that is given to education within the different facilities?

Ms LANCASTER: In general or within Macarthur as opposed to Liverpool?

The Hon. AMANDA FAZIO: Both, actually.

Ms LANCASTER: My general experience within Health has been money and if there are any budget cuts my general experience is that education is seen as unnecessary and a nice extra. Education is cut before anything else and that may mean that if I were employed as the nurse educator I would be pulled out of that education role and put on to the floor.

The Hon. AMANDA FAZIO: In comparison between Liverpool and Campbelltown, what do you think was the real difference there?

Ms LANCASTER: I think the emphasis was equal. Both recognised that it was important. However, the ability to supply it was not equal.

The Hon. AMANDA FAZIO: One of the groups who came in this morning to give evidence recommended that greater emphasis be given to the importance of clinical review committees, including ethics committees, and that those committees have a broad cross-section of people who work in our health system, including doctors, nurses and allied health professionals. From the point of view of the College of Nursing do you support the recommendation? Do you believe that that will assist in complaints handling procedures within the department if that were to happen?

Mr DULHUNTY: If it were multidisciplinary and representative of staff in Health, yes I do.

The Hon. AMANDA FAZIO: Do you see that there is any impediment to that happening now?

Mr DULHUNTY: No.

The Hon. AMANDA FAZIO: It just does not always happen?

Mr DULHUNTY: It does not always happen, and depending on the area or the facility there is no consistency in approach.

The Hon. PATRICIA FORSYTHE: Earlier you said that one of the roles of the college is to provide expert witnesses. In relation specifically to many of the allegations that have arisen out of the whistleblowing nurses at Campbelltown and Camden and investigations by the HCCC, was the college ever called upon to provide expert witnesses?

Mr DULHUNTY: Not in this instance, no.

The Hon. PATRICIA FORSYTHE: Given that the complaints arose from the efforts of nurses, would you regard it as unusual that you were not called upon at all?

Mr DULHUNTY: No. It depends on what pool of expert witnesses the commission might have from time to time. It collects its own witnesses. Usually we provide witnesses where it cannot source a witness or it wants someone who is from a very specialist specialty. We source those for it as we do brokerage for other services in terms of law firms et cetera.

The Hon. AMANDA FAZIO: We also heard evidence this morning—quite an intriguing plea, actually—that education on issues such as clinical governance, complaints handling, trying to improve the quality of patient care through learning from mistakes and all those things should be embedded into the training that people receive before they are out there in the work force rather than training people to be doctors and nurses and then when they get into the work environment saying to them, "Oh, and by the way, you need to have an understanding of these issues too." I would be interested in comments from both of you.

Ms LANCASTER: I think it should be embedded in part of nurses training. However, with nurses currently being educated within the university system, I do not think there is any way to standardise what comes through the programs. There are very broad criteria that people have to meet within those programs. I trained back in the old system and across the new system: part of my training was in the university and part was in the hospital system. The clinical governance part was passed on to me during my clinical training within the facility. I think nurses would benefit from that: they would not be starting on a back foot once they get into the clinical setting.

Mr DULHUNTY: I previously held an academic appointment and I hold and adjunct associate professorship at the moment. I think it needs to be in the undergraduate program. One of the difficulties is that the undergraduate program is so crammed at the moment that you would have to try to find some space to put more information in. But it needs to be in preparation for professional practice. I do some teaching occasionally on professional issues with postgraduate students. It is sometimes questioned as to what the whole concept of clinical governance means. I am talking about practising clinicians, who seem to think that the model of clinical governance is where you blame the most senior in the organisation for anything that happens in a clinical area. Cynically, it could be perceived to be that way. But they have no clear understanding of the model. There is a lot of policy around open disclosure but it is not necessarily seen as practised at the bedside even though, thankfully, it seems that clinicians will sit down in a specific area and look at issues. But it is not generalised or it is not systematised across the service or the facility. It just depends on the culture of the unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ms Lancaster, I understand that you were on the critical care committee at Campbelltown.

Ms LANCASTER: I was on and off. I did not attend all meetings but I was at some of the meetings of the Critical Care Committee.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have had conflicting evidence on Nola Fraser. I am told she was also on that committee.

Ms LANCASTER: Yes, she was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you put in complaints through that committee?

Ms LANCASTER: Complaints were usually lodged from the clinical face via incident reports and I did lodge incident reports and sent them through the channels that they were supposed to go through, which was the nurse unit manager, who then forwarded them up the chain of command.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did Nola Fraser do that also?

Ms LANCASTER: Yes, I am sure she did. We had discussed some incidents in the past. I cannot recall specific incidents where she was concerned but she did lodge incident report forms, as we all did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were they discussed at the Critical Care Committee appropriately?

Ms LANCASTER: Some issues were discussed at the critical care meeting.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were any not discussed?

Ms LANCASTER: I could not tell you how many incident report forms I would have put in or that I would have counselled my staff to put in.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say that the ones that you did put in were adequately discussed by that committee?

Ms LANCASTER: To the best of my recall none made it to that committee.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean that they were culled before they got there?

Ms LANCASTER: I do not know the process once they hit senior management. I do not know what happened once they got there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you were putting the incident reports in at one end and watching the committee work at the other. You must have been able to see the beginning of the process and what came through at the end of the process.

Ms LANCASTER: I was not a permanent member of that committee. I went on occasion to that committee when the nurse unit manager was not able to attend or they felt that it was better that my education background would serve the meeting better.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that committee worked adequately to look at the quality of critical care that it was set up to look at?

Ms LANCASTER: When complaints came to the committee I felt that the committee worked to try to look at a solution and put in some measures to prevent a recurrence of a particular incident. Again,

recommendations come from that committee. Were those recommendations ever put into practice? Not to my knowledge.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are saying that the Critical Care Committee did generally take appropriate action in terms of the committee itself but it was not implemented. Is that when you are saying?

Ms LANCASTER: Well, I did not see any implementation in the 12 months I was there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean you saw that they were not implemented or you did not? You saw nothing or you saw lack of action?

Ms LANCASTER: I saw lack of action in the 12 months that I was there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So management was not supportive of the conclusions of the Critical Care Committee, is that your opinion?

Ms LANCASTER: In the timeframe that I was there they did not appear to be supportive. However, I was not privy to management meetings so I could not tell you the discussions that resulted from the recommendations from the committee or whether there was a plan of action from management side to be put into action at a later date.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you did not observe the fruits of any action plan?

Ms LANCASTER: I did not observe the fruits of any action while I was there.

The Hon. CHRISTINE ROBERTSON: Who was on the committee?

Ms LANCASTER: Dr Hugelmeyer was the emergency department director. Dr Lim was there on occasion. He was here on Friday. Nola Fraser was there. Malcolm Masso was there. I cannot recall anybody else off the top of my head.

The Hon. CHRISTINE ROBERTSON: I just wanted to make sure that the committee was across the board.

Ms LANCASTER: It was. There were nursing and medical representatives included.

The Hon. PATRICIA FORSYTHE: Is there any way that Jennifer Collins would not have been aware of the nature of the complaints that were being dealt with by that committee?

Ms LANCASTER: To the best of my knowledge Malcolm Masso was the chair of that committee in the time that I was there and I would perceive that what was fed from that committee to Jennifer would have come through Malcolm. I cannot comment as to whether he fed that through to her or not. I was not privy to any discussions there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were the minutes an accurate representation of what had occurred at the meetings?

Ms LANCASTER: I could not comment on that, I am sorry. I never—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you not get a copy of the minutes?

Ms LANCASTER: I do not recall ever reading the minutes of the meeting. I was an ad hoc member.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They would have gone to the person who you were representing, in effect.

Ms LANCASTER: That is correct.

The Hon. AMANDA FAZIO: We heard evidence earlier than recommended that area health services be required to focus more and report more on their success as clinical teaching entities. From your personal experience or from the experience of the College of Nursing would you support giving greater emphasis to education within the health system?

Ms LANCASTER: I would support that. If you look at it from that perspective, Liverpool is very much a centre for educational excellence with the way in which the education department is set up there and how it supports research within the facility and within the projects that are governed by their research centre. In my short time at Campbelltown we published one of our quality projects from the emergency department. However, it was a shame that the people that participated only found out because I personally sent copies to them as opposed to the facility recognising that at the time.

The Hon. PATRICIA FORSYTHE: How would you sum up the culture at Campbelltown at the time you were there? I guess you can only talk about the emergency unit. What was the culture like?

Ms LANCASTER: The culture of the staff on the floor within the emergency department?

The Hon. PATRICIA FORSYTHE: Yes.

Ms LANCASTER: They were very hard working. They were keen for education, hungry for it. When I first started they were very excited about the fact that they had an educator coming on board. The reality of the clinical situation within emergency was that they were extremely understaffed and underresourced. It did not allow for a very good environment for education but the staff actually went out of their way to participate in education. They would come in on their own time to attend the education sessions. They would offer to give education sessions on their own time. It was an environment that they were aware had inadequacies and they needed to fix them. They were keen to try to fix them. But the environment of the health facility as a whole was one very much that they were the poor cousins of the bigger picture and did not have access to those—

CHAIR: We have come to the end of our time. Are there any final questions?

The Hon. CHRISTINE ROBERTSON: Today we have had very good evidence about the problems relating to the hierarchical structure of the health system, dealing with complaints, quality et cetera. Did you have any positive ideas? I know that nurses have struggled with this issue for years. Somebody must have some positive ideas. It is not just nurses; it is a junior doctors, allied health people. How can we address this issue? powerlessness makes it more difficult for people to contribute positively.

Mr DULHUNTY: I made a comment in the opening address about freeing up nurse leaders so that they can provide clinical leadership positions. It needs to be across the board. The multiskilled mentality of giving everyone an extra portfolio and constantly adding to it has really taken away the focus from the patient. We also think there is some value in mentoring. I think, with respect, medicine does that quite well in terms of having senior clinicians available to mentor junior clinicians on the unit. At the moment we have tied up a lot of resources. Nurses are so busy they do not have time to be mentoring and supervising junior nurses. I think we need to look at a mentor program and provide some leaders in clinical practice, champion some leaders. There are plenty out there trying but they are drowning.

The Hon. AMANDA FAZIO: The complaints handling system that NSW Health has introduced is based on the Veterans Administration system in the States. We have heard from a number of witnesses that that is world's best practice in terms of the system. What suggestions do you have to make sure that that world's best practice system becomes world's best practice reality in New South Wales?

Mr DULHUNTY: That it is adequately resourced and that there is a system in place that ensures that peer reviewers and expert clinicians are indeed those sorts of people and are recognised by peers as being expert. I sit with another hat on the Nurses Tribunal. There has been a problem with peer reviewers or expert reviewers appearing before the tribunal who really do not have the level of expertise that they should. I think it is about ensuring adequate resources and that there are experts and peer reviewers who fulfil the criteria of expert for want of a better title.

The Hon. ROBYN PARKER: Ms Lancaster, you mentioned that you had worked for a year at Campbelltown and were working well with Dr Hugelmeyer. Why did you decide to leave?

Ms LANCASTER: My career path at Campbelltown was very limited. It became apparent that the nurses educator role was not going to eventuate in the foreseeable future. An opportunity for secondment to the College of Nursing came up and I applied for that position and was successful. Initially it was to be for six months to twelve months, and I would then go back to Campbelltown. However, while I was that the college another position became available that was more suited to my educational career. I am doing a masters in education at the moment. That is the direction I wanted to take. If Campbelltown had offered me a better career path then I probably would have stayed because I do enjoy the clinical setting and teaching at the bedside, and did for a number of years prior to that. But unfortunately the funding was not available to progress that career path for me.

The Hon. ROBYN PARKER: I have a couple of general questions about the registration of nurses. Is it true that there is no requirement for ongoing education for a reregistration of nursing? You just pay your money and you are reregistered?

Mr DULHUNTY: The only requirement is a $35 cheque. New South Wales is the only State or Territory that has no requirement for re-registration.

The Hon. ROBYN PARKER: What is your view on that? Do you think that is appropriate?

Mr DULHUNTY: No, the college does not think it is appropriate. We wrote a submission to the Nurses Registration Board prior to the review of the Nurses Act. The reviewed Act is up for promulgation. We suggested that there be mandatory, continuing, professional development. We have established a program around that that requires a minimum level of participation in active committees, professional bodies, conferences, et cetera. It is still self-regulation, but it is regulation that is open to audit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Nurses Registration Board, in its evidence, was not clear about who was responsible for quality standards and the accreditation of nurses in New South Wales. It stated that a number of bodies were responsible. It did not say, "We are responsible", or it did not delegate that responsibility to anybody else. That is my understanding of its evidence. Do you regard yourselves as being responsible for ongoing training and accreditation with the Nurses Registration Board, in a sense, giving the okay to a knowledge framework that you might have created?

Mr DULHUNTY: Whilst we work with the Nurses Registration Board it is the regulatory authority. It works under the auspices of the Act and it is held responsible for protecting the community. We are under no such Act. We see ourselves as a significant provider of post-graduate education—the largest nursing faculty in Australia. We take our role seriously and ensure that we have contemporary and clinically focused programs. Unfortunately, the Nurses Registration Board does not regulate post-graduate or post-enrolment education in this State. It only regulates preparation for practice, degrees for nursing and what will be diplomas for enrolled nurses. Other than that it has no role.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you offer training but you do not presumably audit for quality any other training that is going on? Would you regard that as the job of the Nurses Registration Board, or would you be willing to do that?

Mr DULHUNTY: We used to have an accreditation program but, because of the business case, it was never successful so the program was finished. That is where we laid open all post-graduate programs to peer review and brought in the speciality organisations and representatives of the specialities to ensure that the program content met the aims. Then we gave them a three-year or five-year accreditation, somewhat like the Australian Council on Healthcare Standards accreditation, in that it was a quality program for the period of that endorsement.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So in general terms you would regard yourself as responsible for nurse education in New South Wales?

Mr DULHUNTY: Post-enrolment and post-registration, a large part of it, yes.

CHAIR: Thank you for appearing before the Committee today.

(The witnesses withdrew)

(Public hearing adjourned at 4.04 p.m.)

REPORT OF PROCEEDINGS IN CAMERA BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 2

INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH

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At Sydney on Tuesday 23 March 2004

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The Committee met in camera at 4.25 p.m.

[Published by resolution of the Committee, 23 March 2004]

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PRESENT

Reverend the Hon. Gordon Moyes (Chair)

The Hon. Tony Catanzariti
The Hon. Hon. Dr Arthur Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. Patricia Forsythe
The Hon. Robyn Parker
The Hon. Christine Robertson

GISELLE CLARE SIMMONS, Registered Nurse, sworn and examined:

CHAIR: Thank you for attending before the Committee today. This is an in camera hearing. Do you want us in any way to use your name?

Ms SIMMONS: Yes, I do.

CHAIR: You are happy for us to use your name?

Ms SIMMONS: Yes, I am.

CHAIR: As part of the published evidence?

Ms SIMMONS: Yes.

CHAIR: Are you appearing before the Committee as a private individual?

Ms SIMMONS: Yes, I am.

CHAIR: Do you want to make a statement? We will then ask you some questions.

Ms SIMMONS: I would like to state the reason why I am here. I am here because I believe in what I do. I have been a nurse for 20 years. I believe in better health and in good health care. I want to see the system change for the better and I want to see the culture of nursing change with it.

CHAIR: Would you like to tell us why this has become so important to you?

Ms SIMMONS: My dad, who is retired, follows the news. He reads the newspapers, Parliament and everything else. He was the one who told me what was happening in the South Western Sydney Area Health Service. The HCCC initially found the matters in Campbelltown not to be so. Because I had worked within the system for a long period of time I knew differently. I knew that the system would not change unless people came forward and told the truth.

The Hon. PATRICIA FORSYTHE: Would you outline what positions you have held in the South Western Sydney Area Health Service?

Ms SIMMONS: I started there in 1990 as a registered nurse. In 1991 I became a clinical nurse specialist in intensive care. From there I became a clinical nurse educator. We grew from a small intensive care unit to a 25-bed intensive care unit and recruited at least 50 new staff members a year. I developed an orientation program that encompassed their learning needs whilst they were in intensive care and I wrote many booklets. That was over a seven-year or eight-year period. I found that, as an educator, I could only do so much. I wanted to become nurse unit manager [NUM] because that is a position of leadership and I could create more change. I became acting nurse unit manager of the intensive care and coronary care unit. It was a seconded position.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said you were in the South Western Sydney Area Health Service. Which hospital were you in?

Ms SIMMONS: As a senior nurse and educator I was at Liverpool intensive care unit. As acting nurse unit manager I was at Fairfield intensive care unit.

The Hon. PATRICIA FORSYTHE: What did you witness during your period as acting NUM in the intensive care unit at Fairfield hospital?

Ms SIMMONS: I wanted a career. This was my way in because it was that kind of position. I was told before I took that job that there were many issues in health at Fairfield. When I got there I was absolutely amazed. I had worked in a tertiary unit where patients had received best practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: At Liverpool?

Ms SIMMONS: At Liverpool. It is perfect. I went to Fairfield where there were very little resources and very little money. People had big hearts. The people on the floor were trying really hard. Many of the managers were exceeding at what they were doing but they were being blocked from a hospital point of view and from an area level. There was not enough money. I saw that patients received inadequate care. Instead of patients receiving best practice, many of them did not. I saw people die. I saw people who should have received better care much earlier and it did not always get picked up.

The Hon. CHRISTINE ROBERTSON: In what year did you go to Fairfield?

Ms SIMMONS: In 2002.

The Hon. ROBYN PARKER: What did you do about that?

Ms SIMMONS: I did many things. The one thing that I could change was what was happening with nursing staff in the intensive care unit. The nurses had been there a long time. Most of the staff who were there were Filipino, so I had to accept that there was a difference in culture. They did not like conflict. They would rather lie down and die than stand up for what was right. There were many things. The first thing that I did was to establish that they did not do physical assessment of all their patients. I basically worked as an educator during that period. I worked 10 to 12 hours a day.

I worked very hard. I set about educating the staff and improving their performance as nurses. They were great. To that point no-one had come along and said, "There are gaps here, but this is what we are going to do to get there." I implemented physical assessment on patients. I changed the way they were documented. I started running workshops so that they would be more highly skilled, that they would pick up that patients were sick, and that they would know what to do when patients were unwell.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say "no assessment", do you mean that they did not do physical assessments of the patients?

Ms SIMMONS: Not from head to toe. They performed observations, but they did not put everything together. The intensivists at Liverpool Hospital had a different philosophy; that is, nurses were there for 24 hours a day and the intensivists were there for shorter periods. For good patient care we were a team and nurses needed to be highly trained. We were trained to do a physical assessment from head to toe. We would look at everything—electrolytes, blood gases and so on—and say that the patient requires this, this and this. It obviously improved care. When I first started at Fairfield Hospital they did not do head-to-toe assessments. They also did not use flow charts. That was a big thing for me. They did not do them because they had huge silver boards and putting flow charts on them would have been cumbersome and awkward. On day three I went to Liverpool Hospital and begged, borrowed and stole the old plastic boards we once used. I then conducted in-service training. I taught the nurses how to do physical assessments and wrote guidelines. I then supervised that and every day on the ward round I ensured they understood what I wanted and that it was being done. They were getting better at it; they were wonderful.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say that they needed better care earlier, presumably you mean they were not getting care because people did not diagnose them.

Ms SIMMONS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they died of not being diagnosed early enough. Is that what you mean? Or was there a shortage of equipment or drugs?

Ms SIMMONS: There were many issues. The biggest thing was that they could not get trained medical staff—doctors do not want to work at Fairfield Hospital; they would prefer to work at Royal Prince Alfred Hospital and Saint Vincent's Hospital. That was probably the biggest issue. We had an excellent chief medical officer [CMO] who usually worked Monday to Friday. He was wonderful. While he was there care was excellent. After hours it depended on which CMO they could get for the night. Some were very good and some were psych trained. What would they know about a person with septic shock who required specialised care? They would not know what to do. It depended on the medical staff on duty. There were many experts. Within

the nursing staff there was a wide cross section of experience. Some nurses were experts, but they were too scared to say to a doctor, "Look, I think that this is wrong and we should to this." South Western Sydney Area Health Service put out guidelines saying that if a person met certain criteria they should be transferred. More often than not the patients were not transported.

The Hon. CHRISTINE ROBERTSON: I need to understand the role delineation of the Fairfield Hospital intensive care unit.

Ms SIMMONS: That was a problem.

The Hon. CHRISTINE ROBERTSON: Its role delineation is ventilation.

Ms SIMMONS: It is short-term ventilation.

The Hon. CHRISTINE ROBERTSON: It is no longer than 24 hours.

Ms SIMMONS: That is what it was supposed to be. However, we would then have to find an intensive care bed somewhere in the State.

The Hon. CHRISTINE ROBERTSON: So they were not necessarily sticking to that delineation.

Ms SIMMONS: We could not get the patients transferred out in some instances.

The Hon. CHRISTINE ROBERTSON: And you did not have a director of critical care.

Ms SIMMONS: No, we did not. They have advertised, but—

The Hon. CHRISTINE ROBERTSON: So Fairfield Hospital is like a district hospital.

Ms SIMMONS: That is correct. It is very similar to Campbelltown Hospital.

The Hon. PATRICIA FORSYTHE: Given the changes that you were making, what was the response of your superiors—the critical care committee, the area health service and so on?

Ms SIMMONS: The nursing staff loved it and felt supported. They learnt a lot from the workshops. I conducted a four-hour haemodynamic workshop just before Christmas. I taught the nurses about the three different types of shock and management techniques. One of the nursing staff picked up that a person was critically ill. To this day I am exceptionally proud of her. The situation was handled very badly. A man had come in severely dehydrated after two weeks of vomiting and diarrhoea. He had been sent to the ward and it was not picked up that he was in shock and acute renal failure. The nursing staff on the night shift picked up that he had no urine output and they were concerned. The documentation from the medical staff was poor. The patient was eventually transferred to intensive care. However, it was still not recognised that he was critically ill by the medical staff on duty.

The nurse recognised that the patient was in acute renal failure and required fluid therapy and, obviously, ongoing treatment. She rang me at home very distressed and in tears. She told me what she had done. She put fluid up against a doctor's order. I was disappointed because she challenged the doctor and the doctor would not have it. He told the nurses in question that she had no right to question his treatment. I said to her that I would like to speak to the nursing supervisor on duty. We had that patient transferred to another intensive care unit where he was intubated and ventilated. He required a lot of fluid therapy and so on and he went on to dialysis. The nurse saved that man's life. Everything happened after that. Until then they were happy for me to educate the staff and to implement new policies and guidelines. I went through the place with a fine-tooth comb. I had a meeting with the medical director, the director of nursing, the doctor in question and the CMO. That is when it all started.

The Hon. PATRICIA FORSYTHE: When what started?

Ms SIMMONS: I suppose you would call it harassment, bullying.

The Hon. AMANDA FAZIO: Was that directed only towards you or was it also directed towards the nurse who found the problems and challenged the doctor's treatment?

Ms SIMMONS: No, because as nurse unit manager I protected and supported her 100 per cent. I said at the meeting that we had to put in place a better way of dealing with the situation the next time it happed. We talked about how the nurses could challenge what was happening, or discuss patient care in a better way. We also discussed the process of transferring patients out of a district intensive care unit to a tertiary intensive care unit with less drama. We implemented a policy dealing with that.

CHAIR: What was the nature of the harassment?

Ms SIMMONS: I was told by the medical superintendent that nurses were not allowed to question doctors and that I did not have enough knowledge to be able to question a doctor. I knew what was going to happen. I got to work early and went to medical records and got the case file. I wanted to make it a positive rather than a negative experience and to improve patient care. I looked at the person's care in emergency, in the wards and in intensive care. I talked about the issues I had and how we could improve the process. I spoke about the patient, the pathophysiology and the chest x-ray because the doctor in question said the patient was not in hypovolaemic shock. I looked at the chest x-ray, the blood tests, the blood gas and the observations and quickly realised that the patient had pulmonary oedema—a condition involving fluid on the lungs. The patient was severely volume depleted. I was told throughout the meeting that that was not my job. I explained that it was difficult for me because I was the nurse unit manager and, as such, was responsible for patient care. I did not have a director and that was the position I was put in.

The Hon. CHRISTINE ROBERTSON: Is this the area medical director or the hospital medical superintendent?

Ms SIMMONS: The hospital medical superintendent. He was very rude and I did not get any backup from the deputy director of nursing.

The Hon. CHRISTINE ROBERTSON: Do all these hospitals have a medical superintendent?

Ms SIMMONS: I cannot speak for all hospitals, but Fairfield Hospital had one.

The Hon. CHRISTINE ROBERTSON: Does Campbelltown Hospital also have one?

Ms SIMMONS: I do not know.

The Hon. PATRICIA FORSYTHE: Having had this experience, did you take it further? For example, did you outline your concerns to the Minister at the time, Craig Knowles.

Ms SIMMONS: Before that I took better steps. Once I realised what I was facing, I talked to other nurse group managers within the hospital. They had been in the system a lot longer than I had. They had a much harder fight because they had been doing it for a lot longer and they told me that there were ways of doing things. If I wanted to implement things that the Director of Nursing would not allow, then there were ways of going around that. So we talked about that. We also discussed—

The Hon. CHRISTINE ROBERTSON: It is just that there is all this literature that Arthur and I are both laughing about. It is about the doctor-nurse relationship.

Ms SIMMONS: Yes, I am sorry. They told me to work smarter.

The Hon. CHRISTINE ROBERTSON: She is describing it very well.

Ms SIMMONS: What we did, as nursing group managers in critical care, was we got together and with educators and the CMO of ICU who was wonderful and the director of ED and as a group we thought—we took it to the critical care committee within the hospital. It has gone on record—it is within the minutes—that care at Fairfield Hospital was substandard and that I raised it and said that I had major concerns with this. So then we talked about—and I also talked about the incident that happened in December and that it should not be looked at like that; that it is a process, and if you want to deliver best care you have to, like, not have any ego

and say how can we do better next time. So we talked about forming a committee that would look at patients that did not receive best practice and how could we do better next time. So we talked about that.

We also talked about the role of the intensive care/coronary care at Fairfield and where it was going. It was brought to my attention that at the next area meeting they were going to discuss that because it would not stay the way it was. If they wanted to look at that, then change had to be made. We discussed what it was like. I worked at Liverpool intensive care. I knew that there were never any beds. It was a very busy intensive care unit and so we actually put together our ideas on how to improve the process, but that was a group. As a group, we did not have power so I did take it to the area critical care meeting and I wanted to discuss several patients because by this time it was, I think, close to February and our CMO had gone on holidays. We had some CMOs from all over the place and we had a lot of incidents happened where patients did not receive best practice. So I went, armed with patient and case studies and I discuss that at the area meeting, and I told them that it was important, and that was struck from the minutes, what I said, by Colin Macarthur.

The Hon. CHRISTINE ROBERTSON: Who is?

Ms SIMMONS: He is like the CEO of the area

The Hon. ROBYN PARKER: Colin Macarthur. Why did he do that, do you think?

The Hon. CHRISTINE ROBERTSON: That is not what he is.

Ms SIMMONS: I am sorry, yes. He holds a high position within that area.

CHAIR: Colin?

Ms SIMMONS: Macarthur.

CHAIR: Colin Macarthur, yes.

The Hon. CHRISTINE ROBERTSON: Do you know who he is?

CHAIR: No. I do not know his official position, but I know the name, yes. So he held that area position?

Ms SIMMONS: That is right. This is an area critical care meeting.

CHAIR: So what was his response to you?

Ms SIMMONS: He did not want to know about it. He said to me that this had all been discussed before and I said, "But I believe that the purpose of this meeting is to discuss the role of Fairfield intensive care/coronary care unit and as such if you are going to discuss the role and you are going to leave it the way it is, then we need to improve it." So I discussed the patients and he had that struck from the minutes and said that we were wasting time and let us move on to the next agenda item.

The Hon. PATRICIA FORSYTHE: When did you have an opportunity to talk to the Minister?

Ms SIMMONS: That happened only two weeks later—roughly two weeks later—but what had happened in the meantime was that a patient that was in her forties came in with asthma. You do not see many of them, but she came in in severe status. She left it probably a little bit too long and she needed to be intubated and ventilated and to go to the intensive care unit that could manage her. There was not one doctor in the hospital that could tube her so she ended up dying with a hypoxic cardiac arrest. For me, I was devastated. I had the educators of emergency come down to my office and they were all in tears about it and they said, "Let's go to the media." I said, "No. I don't want to go down that path. I want to follow the right process and improve patient care the right way." Shortly after that I think it was maybe two days later I went to a nurse practitioner workshop. By this stage I had realised that I had damaged my career. It had been hinted by the Director of Nursing and the Deputy Director of Nursing that I would never work as a nursing manager again, so then I was thinking—

The Hon. CHRISTINE ROBERTSON: At Liverpool?

Ms SIMMONS: At Fairfield. You cannot get a job as a nursing manager unless you can have a reference, and they were not prepared to do that because of the way I had stood up for patient care. So I started to think about my career again. I am an expert in my field so I attended a nurse practitioner workshop because I thought maybe that is the way to go. I met the Minister for Health then, Craig Knowles, and it was an informal forum at the end of the day. They actually had spoken about Fairfield earlier in the day and many of the nurses came and chatted to me during the lunch break because I was still very upset about what was happening. I do really believe in what I do. So he opened it up by saying it was an informal forum and that he wanted to discuss whatever we wanted to discuss.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you took him literally!

Ms SIMMONS: I know, I know. In hindsight, yes, I see that, but being a very passionate nurse that I am, I told him what was happening at Fairfield and that people were dying who should not be dying. He asked me for my name and where I worked and I am very proud of that. I am not going to hide that so I told him who I was and where I worked, quivering in my boots. Then he argued the point with me and he said that he had fought hard and that Liverpool was, you know, a place of excellence. I said to him, "I worked there. I have worked there for 12 years and you are not going to get an argument out of me. I love working in the intensive care unit. Patients received best practice. But I am now working in a periphery hospital within the area and that is not the case there and people are dying there or if they are not dying we are not managing them properly because there are not the resources there." He just bullied me, he harassed me, he spoke over the top of me, he told that I did not know what I was talking about, and he was quite rude.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This was at the meeting?

Ms SIMMONS: That is right, yes.

The Hon. CHRISTINE ROBERTSON: So, in your own health service is there no overarching critical care group that looks after—

Ms SIMMONS: Well, that is the area critical care.

The Hon. CHRISTINE ROBERTSON: That is what I am talking about.

Ms SIMMONS: Well, that is where I went to two weeks before that, but did not receive any help. I mean I was new in my job. I had been an educator for seven years and as an acting nursing group manager I was not really sure where to go. I was asking for help but I did not get it.

The Hon. ROBYN PARKER: Where did you go? You went back to work after that. What happened after that?

Ms SIMMONS: I actually went in with the educator from Fairfield emergency and all the way home I cried because I thought, "What have I done? I have really done it now." She tried to allay my fears but she knew what was going to happen to me as well. So when I got back to work I was called into the Director of Nursing's office and I was told—it was a story—I was told that the nursing unit manager was coming back early, but I was not that stupid. I knew what had happened. I sat there and chatted to this lady for a period of time but not once did they acknowledge what I had achieved, and I did achieve a lot in a very short period of time. I did it in a way—I was told when I went to Fairfield that I would not create change, that the nursing staff would not change, and they did. They loved it. It was not a very nice interview. Not once did I feel—

CHAIR: Could I clarify this? You were told that the position that you were filling at that stage, that someone else was coming back?

Ms SIMMONS: That is right.

CHAIR: And would take over your position?

Ms SIMMONS: That is right.

CHAIR: And you would be moved out—where?

Ms SIMMONS: Back to Liverpool to intensive care to be an educator again, but I had already spoken to the nurse unit manager that was there before me because, like, she fought really hard for patient care—very, very hard for years—and I had the utmost respect for what she had tried to achieve as well. We spoke about the problems and I actually approached her for advice. I was told that she did not want to come back, that she was forced to come back, because that way they could get rid of me. The Director of Nursing also told me, "You don't say what you said to the Minister for Health and expect to have a job at the end of it." I knew. It was the area Director of Nursing that really put me in the picture. She told me that after that meeting, he then went to the people in the Department of Health that he needed to speak to. He then spoke to people from the South Western Sydney Area Health Service and he had me removed from my position.

The Hon. TONY CATANZARITI: Can you clarify something for me please?

Ms SIMMONS: Sure.

The Hon. TONY CATANZARITI: When you went to Fairfield, did you go to a permanent position?

Ms SIMMONS: No, it was a secondment temporary position for six months.

The Hon. TONY CATANZARITI: So the other person came back?

Ms SIMMONS: That is right.

The Hon. TONY CATANZARITI: Within the six months?

Ms SIMMONS: That is right, and that is a possibility, but it was the way that it was done. It was not done because she wanted to come back. She then left. She was looking for a job and she did not want to come back because she had reached a point in her career where she wanted to move on and she had her hands crossed for many years and had achieved what she wanted to achieve. So she actually came back for a very short period of time and then left.

The Hon. ROBYN PARKER: What about the Nurses Association? Did you contact them?

Ms SIMMONS: Yes, I did. I contacted them on two issues—the issue regarding Fairfield and the issues I had with the bullying and harassment at Liverpool, and they were no help.

The Hon. ROBYN PARKER: When they helpful?

Ms SIMMONS: No, they were not.

The Hon. ROBYN PARKER: So are you still working in the South Western Sydney Area Health Service?

Ms SIMMONS: No. After I returned to Liverpool as an educator, I went and spoke to the area Director of Nursing and I was there for three hours. We spoke about what happened at Fairfield and what was happening at Liverpool. I was basically told that I would not be promoted within the South Western Sydney Area Health Service because of what I had done and that maybe if I moved area health, then I might have a chance in five or 10 years down the track. I could rebuild my career in the meantime, learn from what had happened to me, and possibly at the end of it I might have a career.

The Hon. PATRICIA FORSYTHE: So what were you meant to learn?

Ms SIMMONS: I was to learn not to rock the boat.

The Hon. PATRICIA FORSYTHE: You said, "learn from what had happened to me", so what they were saying to you was—

Ms SIMMONS: Do not be a patient advocate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So presumably you have a family in south western Sydney?

Ms SIMMONS: I am a single mum. I have four children that I financially support by myself, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Right. So you obviously have them all at school and so on there?

Ms SIMMONS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And so moving to some other area was not really a proposition—at least it was considerably inconvenient, put it that way?

Ms SIMMONS: It was. It was a very stressful time in my life and it made me really think about what was important in my life—obviously my children are number one—and lots of things. I mean, I bring my kids up to have good values and good beliefs. I want them to be well educated. I want them to do well in life and I have brought them up to be honest and, you know, have all the things that you want them to have, and here is their mum, totally distressed about what had happened to them. I was devastated. What do I do? Did I teach them, well, no, in life you have to be dishonest and do all the wrong things in life to get on. I went through a lot. I mean, my parents live just down the road from me. I told them that I had to move. I sold my house and I moved. They were devastated. I mean, it has meant not just me moving: Because they care for my children, they are in the process of moving as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So where are you now?

Ms SIMMONS: I am in Wollongong.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And do you work in Wollongong?

Ms SIMMONS: I work in Wollongong Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you working in intensive care there?

Ms SIMMONS: No. That was part of my plan—like, where do I go now—and I have actually rethought what I want to do. I am now working in emergency.

The Hon. ROBYN PARKER: Are you on the same sort of level as you were before, though?

Ms SIMMONS: No. I am now working as a registered nurse back on the floor doing shift work.

CHAIR: Was that a major drop in salary?

Ms SIMMONS: Well, yes and no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Shift penalty pushed it up?

Ms SIMMONS: The hardest thing for me has been when you are a single mum and you are trying to bring your children up, that you are there for them after school, and do their homework with them and you take them to their sporting interests and all those kinds of things. That has been difficult with the shift work. My pay has dropped a little bit but you do not work hard at a career after 18 years and at the end of it go back on the floor. Like I love looking after patients—I do—I will always love doing that, so I mean I still love my job, but the reason why I wanted to go into management was because I realised that I could do more as a leader than as one person nursing a patient on the floor, and that is what I was setting myself up for.

The Hon. AMANDA FAZIO: In relation to those two specific incidents that you have told us about where the patient care was inadequate, did you lodge incident reports about those?

Ms SIMMONS: Yes, I did.

The Hon. AMANDA FAZIO: What was the process, what response did you have to lodging those?

Ms SIMMONS: I learned quite a bit from Liverpool. Liverpool functioned very well as far as following the processes. I figured that if I wanted to change, there was no point in being verballed and that everything needed to be documented. I asked the doctors and the nursing staff, and with myself, we completed incident reports on all the patients that did not receive best practice. That was then lodged and the deputy director of nursing at Fairfield reviewed those incident reports. Of the incident reports I put in I never once received a report from the deputy director of nursing on how we could improve that process.

The Hon. AMANDA FAZIO: You do not think that there was adequate follow-up on the issues that were included in those incident reports?

Ms SIMMONS: No, absolutely not. No follow-up.

The Hon. AMANDA FAZIO: The whole idea of putting in the incident report was to improve practice.

Ms SIMMONS: That is exactly right. The one thing I have utmost respect for is intensive care at Liverpool. The one thing they have firmly placed in my mind is that it is a continuum. We constantly try to achieve best practice. Things are changing all the time. That is one of the reasons why we put in incident reports, not to go mad on people, not to make people feel inadequate, but just to improve patient care. That was not the way that they were received at Fairfield and they were not dealt with.

The Hon. CHRISTINE ROBERTSON: Is there an area director of critical care yet?

Ms SIMMONS: There now is, I believe.

The Hon. CHRISTINE ROBERTSON: When did he or she start?

Ms SIMMONS: After I finished, after I completed my position at Fairfield. I spoke to that person, because I have, again, the utmost respect for that person. A lot of people, including that person, had tried to improve the process and were more than willing to be included in a committee that we wanted to commence to look at best practice and improve what we were doing.

The Hon. CHRISTINE ROBERTSON: You would expect a couple of the hospitals at your level to be represented on the committee?

Ms SIMMONS: That is right. I do not want to give the wrong impression. That is what I am concerned about. I am so proud of being a nurse and proud of many other nurses that I work with and I really feel for the staff at Campbelltown and Camden who feel that they have been victimised and that they have not been acknowledged. What I have seen in my time as a nurse is that many of the nurses and doctors on the floor gives of themselves 200 per cent. They are a wonderful team. I have seen corruption, I was very naive and am not naive any more. I see a group of people in administration that block new ideas and change and improving the process. I do not know why, because it would cost less money in Health to do what we should do.

The Hon. PATRICIA FORSYTHE: Earlier you said that you believe that the Minister effectively cost you your job.

Ms SIMMONS: He did.

The Hon. PATRICIA FORSYTHE: Why are you so confident?

Ms SIMMONS: Because I spoke to the director of nursing and the area director of nursing and they told me.

The Hon. PATRICIA FORSYTHE: What did they say?

Ms SIMMONS: The director of nursing, she was very guarded. When she took me into the office I actually started to write down the things she said to me, because I thought "Here we go again".

The Hon. PATRICIA FORSYTHE: What is the time frame? When are you talking about?

Ms SIMMONS: That was just shortly after I got back from the nurse practitioner workshop. She was away for a couple of days—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you give the dates?

Ms SIMMONS: I would have to go to the folder I have with me, it would take some time to go through it.

The Hon. ROBYN PARKER: It was almost immediately.

Ms SIMMONS: It was, within a week. She was away for a couple of days and when she came back I went straight to the office. At the end of the meeting, I kept pushing it, I said, "It was because of what I said at the nurse practitioner workshop". At the end of the meeting she said, "Yes, you don't say what you said to the Minister for Health and expect to have a job at the end of it". It was exactly what the area director of nursing said to me. She told me a little bit more. She told me about what happened after the meeting, that he involved the people from the Department of Health and spoke to people in the South Eastern Sydney Area Health Service. She told me that my name was known within the Department of Health, that I was the nurse that told the Minister for Health that people were dying.

The Hon. ROBYN PARKER: When you said "he", did you mean the Minister?

Ms SIMMONS: Yes.

The Hon. PATRICIA FORSYTHE: Did she suggest that anything would happen before the election? Or were you talking through a political time frame involved in this?

Ms SIMMONS: Yes, it was mentioned. She did say to me, "Giselle, it is just before the election", and better keep hiding that, what I had done. Obviously she spoke to me about Campbelltown as well and that the timing was really off for doing what I did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not know who were the intermediate people who were part of that push?

Ms SIMMONS: No, I could not tell you that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you could give us the dates and the people involved in that?

Ms SIMMONS: I can tell you that the director of nursing was the person that ended up telling me that I was out of my job.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that at Liverpool hospital or the area?

Ms SIMMONS: Fairfield.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Fairfield Hospital?

Ms SIMMONS: Yes, but I do not know the people he spoke to that spoke to her.

The Hon. ROBYN PARKER: Who is "he"?

Ms SIMMONS: The Minister, Craig Knowles.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Minister who spoke to her, the director of nursing?

Ms SIMMONS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So she is the one who told you that you had the bullet, effectively?

Ms SIMMONS: Yes. And she would not give me a reference either.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you had to leave because you were being replaced by the person who you were supposedly filling in for?

Ms SIMMONS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And when you left you would not get a reference, but you could go back to your substantive job in the intensive care unit at Liverpool?

Ms SIMMONS: That is right, they had to do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that your career was at a dead end, at the point that you were Liverpool?

Ms SIMMONS: That is right. After the nurse practitioner workshop I knew that there were practitioner positions going in Bankstown Hospital, in emergency. I applied as a registered nurse because I was not sure how long it would take them to fill those positions. I did not even get an interview to be registered nurse, and that is because of who I am.

The Hon. AMANDA FAZIO: Can anyone be put into the nurse practitioner jobs?

Ms SIMMONS: I did not apply for a nurse practitioner role. I applied for a registered nurse role.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you were being demoted, why did you go to Wollongong when you could have had a registered nurses position at either Liverpool, where you were, or at Bankstown?

Ms SIMMONS: It was not worth it. I got back to Liverpool. When it comes to Liverpool intensive care unit I would send my family and my friends there because the level of care is superb.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you did not want to stay there, did you?

Ms SIMMONS: No, because, unfortunately, the culture within Liverpool intensive care unit is not what it should be, and never been. Throughout my time as a registered nurse no-one cared about me, who I was. I was just a girl on the floor. When I became an educator I was a person who had a voice, I was a person who could change the process. From that point people noted who I was and the co-director of critical care, one could say if I am being very honest, she did not like me. As an educator I was pulled up for going running during my lunch hour. I was taken to the office of the director of nursing; I had gone through a separation, I had four small children, I went for a run in my lunch hour to de-stress, it was better than smoking, and I was told that I was parading my body around the intensive care unit and was embarrassing the doctors.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Half your luck.

Ms SIMMONS: That was not the only occasion, there were many, and it was personal, it was bullying and it was harassment. That is what I received. I fought hard for the educational process that is now in place at Liverpool. I did not take no for an answer. I had a vision and I held to my vision, which was quite difficult because there were a lot of strong personalities. I went to the World Intensive Care Congress and presented our educational plan for intensive care. It is unique and I am very proud of it. I was one of many that developed that process and because I fought against old ways and introduced new ways, I was not well received. On top of that

to be bullied from a personal point of view is why I left the unit. It was not pleasant. I loved working with nurses on the floor.

CHAIR: Ms Simmons, what you have told us is very distressing and we feel for you as a person. Have you referred any of this information to the Health Care Complaints Commission [HCCC]?

Ms SIMMONS: I spoke to the area director of nursing and asked where I could go with this. I had already rung the union.

CHAIR: You were not getting any help from the union?

Ms SIMMONS: No, no help from the union.

CHAIR: Did anyone mention the ICAC?

Ms SIMMONS: No, not at that stage. She did say that what I could have done was rather than speak to the Minister of Health, I could have contacted the HCCC at that time. That is not something that many nurses would have known about. Our process of reporting at times has been quite poor, so I did not know I had that avenue. I thought about it. I had to support four children and I needed a job. I was concerned that what happened to the girls are Campbelltown would happen to me. So I moved instead.

CHAIR: You shifted areas and made a choice to not make a formal complaint to the ICAC or the HCCC, because you felt that would finish you? Is that correct?

Ms SIMMONS: That is correct. That I would never work as a nurse again. And I love my job.

CHAIR: It would finish your role in NSW Health.

Ms SIMMONS: That's right. No-one knew who I was. I went to Wollongong and no-one knew who I was.

CHAIR: Do you fear for your future at the Wollongong emergency unit?

Ms SIMMONS: When I started at Wollongong I did not tell anyone who I was, because I was worried and concerned, obviously. I thought if there was any chance of rebuilding my career I would have to start from scratch again. Since then, in December 2003, I have submitted evidence to the ICAC and from that process I informed my nursing manager and administration that that was what I had done. I explained the reason why and they have been 100 per cent supportive.

CHAIR: I reassure you and inform you that the Director-General of NSW Health has made it very clear in our discussions with her that no person giving evidence here shall suffer any consequences of any kind. If a person who gives evidence suffers any consequences that is a contempt of Parliament, which is a very, very serious matter. If you find any sense of retribution in any way whatever you must report that to us.

Ms SIMMONS: Thank you.

The Hon. TONY CATANZARITI: Earlier in your evidence you were hesitant when asked where you were working now. Was the reason because you were worried?

Ms SIMMONS: I have gone on the public record for the first time. When I went through the ICAC inquiry I was anonymous. I was informed that if I did not go on the public record and use my name my information could be used as evidence, and that it would only be background knowledge. I think what I have seen and the evidence that I have, because I have folder full of evidence, is very important if we want to change the health system.

The Hon. TONY CATANZARITI: When you went with the question asked of you, you were very hesitant when you answered. I felt something was there, that you were trying to not say.

Ms SIMMONS: I do not want to be classified as a dobber. I do not one people to get the wrong idea about why I am doing this.

CHAIR: To reassure you, I will ask you in a moment if you will confirm that you do not mind this transcript being published, but I want you to know that to help you in your current position, we can remove the word "Wollongong" wherever it appears and to keep it secret. If you wish we can do that.

Ms SIMMONS: They know I am here. They have been very supportive.

CHAIR: Okay. I just wanted you to be aware.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you wish to give us all that evidence? Do you want to cull it?

Ms SIMMONS: I have to copy it. No, there is nothing that I am ashamed of in this folder.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We will copy it; you do not have to pay for the photocopying.

Ms SIMMONS: ICAC needs to get it as well.

The Hon. CHRISTINE ROBERTSON: I would like to ask a question in relation to some evidence by representatives of the Nurses Registration Board. They have a wonderful little black folder that they say goes to all new graduates about the complaints process and nurses rights. Did you ever see it?

Ms SIMMONS: No, but I have been trained for a long time. I started my training in 1983.

The Hon. CHRISTINE ROBERTSON: I think it is an important issue because graduates get it but the old folk have not been picked up.

Ms SIMMONS: The one thing that I would really like to see change in the culture of nursing is people not being scared to come forward. They would not do it as a way of getting at people or making anything personal—nothing should be—it would only be to improve the process and patient care. We should not be scared to come forward.

CHAIR: Giselle, thank you for all that information. I have some concerns about the documents.

Ms SIMMONS: They are originals and my only copies.

[*Interruption*]

CHAIR: We have probably asked the important questions that we wanted to ask. We thank you for coming here today and for being a very courageous person. You have obviously been through a great deal, and we are trying to correct that. Are you happy for us to publish what you have said this afternoon?

Ms SIMMONS: Yes.

Resolved by order of the Committee to be published.

(Conclusion of evidence in camera)

(The witness withdrew)

(The Committee adjourned at 5.20 p.m.)