REPORT OF PROCEEDINGS BEFORE

JOINT SELECT COMMITTEE ON THE ROYAL NORTH SHORE HOSPITAL

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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At Sydney on Monday 26 November 2007

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The Committee met at 3.15 p.m.

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PRESENT

Reverend the Hon. F. J. Nile (Chair)

Legislative Council	**Legislative Assembly**
The Hon. A. R. Fazio	Mr M. J. Daley
The Hon. J. A. Gardiner	Mr P. R. Draper
	Dr A. D. McDonald
	Mrs J. G. Skinner

CHAIR: Welcome to the fourth public hearing of the inquiry into the Royal North Shore Hospital. Before we commence I would like to make some comments about aspects of the Committee's inquiry. This inquiry will raise difficult issues for many participants: former patients and their families who have concerns about the care they received at the Royal North Shore Hospital, as well as doctors and managers whose professionalism may be questioned, or who have decided to voice their concerns about clinical and management issues at the hospital. I therefore ask that the media and other persons in the audience demonstrate sensitivity in any approach made to witnesses during this inquiry, particularly immediately after the giving of evidence.

The inquiry's terms of reference require the Committee to examine staffing and management systems, resource allocation, and complaints handling processes at the Royal North Shore Hospital. I ask witnesses to reflect on the terms of reference and to assist the Committee to use these experiences to improve patient care at the Royal North Shore Hospital. This Committee is not able to investigate or conciliate individual complaints: this is the role of other bodies such as individual health service complaints units, the Health Care Complaints Commission, or the Coroner. Information about how to make a healthcare complaint can be obtained from the Health Care Complaints Commission. Contact details for the commission may be found on the table at the back of this room.

What witnesses say to this Committee today is covered by parliamentary privilege. This means that no legal or other action can be taken against you by anyone in relation to what you say in your evidence. Any action taken against you for giving evidence may constitute a contempt of the Parliament. This protection does not, however, cover anything you may say after the hearing, or outside of this room today. Any comments you make to the media once you leave the witness table are not covered by parliamentary privilege. It should also be remembered that the privilege that applies to parliamentary proceedings, including committee hearings, 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 doctors or managers unless it is absolutely essential in their addressing of the terms of reference. Individuals who are subject to adverse comments in this hearing may be invited to respond to the criticisms raised, either in writing or as a witness before the Committee. This is not an automatic right but, rather, a decision of the Committee that will depend on 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. Doctors and managers should only discuss personal information about a client or a patient if it is specific to the terms of reference and that person has authorised them to do so. I would also ask my fellow Committee members to consider the ethical duties owed by doctors to patients when pursuing lines of questions.

It is likely that some of the matters raised during the hearings may be the subject of legal proceedings elsewhere. 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. Nevertheless, I remind people today that this inquiry is about systemic issues and not the culpability or otherwise of particular individuals.

The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of guidelines governing broadcast of the proceedings are available from the table by the door. I point out that, in accordance with these guidelines, a member of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee, the media must take responsibility for what they publish or what interpretation is placed on anything that is said before the Committee.

Witnesses, members and their staff are advised that any messages should be delivered through the attendant on duty or through the Committee clerks. I would ask that everyone please turn off any mobile phones during the proceedings. I welcome our first witness for today, Dr Denis King.

DENIS WARWICK KING, Executive Clinical Director, South Eastern Sydney and Illawarra Area Health Service, affirmed and examined:

CHAIR: If you should consider at any stage that certain evidence you wish to give or documents you may wish to tender should be heard or seen only by the Committee please indicate that fact and the Committee will consider your request. Would you like to start by making a brief statement?

Dr KING: I would rather just take questions. I have an overall knowledge of the health system and a specific knowledge of North Shore as a result of a review I did there of surgical services three years ago. I have no particular comments to make. I am happy to take questions.

Mrs JILLIAN SKINNER: Thank you very much for agreeing to speak to us, Dr King. I refer to the surgical services review that we have been circulated—very late in the piece but I have managed to skim through it. I have the final report dated 6 September 2004. We also then got a letter dated 10 June 2005, which is sort of a report on how the implementation was going. The first document is 33 pages long; the second document is a flimsy seven pages with very little detail in it. I would like to ask you some questions about what you think has happened or what has not happened and what should happen from hereon in.

In your report there is a comment on page 28—and I will read it because I suspect you do not have the document in front of you—in relation to operating theatre capacity at the hospital. You make a statement about increasing weekend capacity to create a third theatre and you talk about establishing at least two regularly scheduled non-elective lists per week. Do you know if those things have happened at North Shore?

Dr KING: I have no idea of what implementation that report has made. I have had no feedback or follow-up.

Mrs JILLIAN SKINNER: I will not go through it in detail but one of the things you recommend is about operating theatre times starting at eight o'clock and going on until five o'clock. We have heard evidence here from most of the doctors at the hospital that these things are not in place, that in fact often there is surgery scheduled for eight o'clock but does not start until 11 o'clock because there are not enough intensive care beds and so on. The question is, what happens when these reviews are conducted to ensure that, in fact, the recommendations are followed and we do get improvements?

Dr KING: Again, I cannot answer specifically in relation to North Shore. The implementation reports like the one we did becomes a matter for local management. As I recall—it is three years ago—one of the issues about after-hours in the operating theatre and what we thought was a relatively inefficient use of that reflected that the organisation of the services during the week was, to our mind, sub-optimal. I think we did recommend some increase in the weekend operating in particular but as an interim measure until the time during the week was effectively used and until, as I recall, the intervention of a neuroradiology service that had just been established and with an original budgeted workload of 50 per annum, which had gone to 250, which was not budgeted, as we understood it. This was having a significant impact upon the weekend and after-hours work, and we felt that management, broadly speaking, should come to terms with the effective use of in-hours work during the week and with a clear statement about where that particular service—which was an excellent service—was heading and how it would be funded and so on.

So, our suggestions, as I recall, for the expansion of the weekend work was hopefully going to be an interim measure until some of the other more fundamental issues had been dealt with.

Mrs JILLIAN SKINNER: One of the other fundamental issues that are covered in this report is the lack of beds, and in particular—since you have mentioned neurosurgery—ICU beds. We have heard evidence here from the neurosurgeon at the hospital who is very frustrated because he could not operate on patients because there were no intensive care beds—this is not at weekends, this is mid-week. Is that something we need to look at in making recommendations, do you think?

Dr KING: I would think this is not a problem that was confined to North Shore; it is a problem across the system and the way in which the intensive care bed allocations are used. Again, it is a frequent problem with the conflicting priorities within intensive care and, as often does happen, things that are perceived to be elective and to a degree discretionary, tend to go to the bottom of the queue. So, I think this is a pretty common thing across the system, that the only way in which any pressure can be absorbed is by elective surgery, and elective surgery does tend to be postponed under those circumstances, and for good clinical reasons. But it is a relatively inefficient way to do things because you have an awful lot of people hanging around for half the day with nothing to do. But again, this is a problem across the system.

Mrs JILLIAN SKINNER: I do not think he was talking about elective patients. The other thing in the report is an acknowledgement of the breakdown in clinicians' involvement in some of the management decisions. That seems to be a universally expressed view among the clinicians who appeared here. What is your view about how important that is in moving forward if we are going to try to resolve—

Dr KING: Once that happens it can almost be a downward spiral in that the people who often know best how to resolve problems at the coalface—I mean this is sort of management 101 now; you give responsibility to the people who know how to make things work—if the people who have the responsibility of making things work on a day-to-day basis and understand how the system works are effectively excluded from the process or there is no response to their views, then they tend to become somewhat dispirited and actually then put in less than they might. It is a disengagement of the senior clinicians in particular, experienced clinicians in particular, and, again, that was something we did find. Another impact of that we found was that, partly as a result perhaps, there did not appear to be a clear strategic direction of surgical services, and that affected both North Shore and Ryde. We thought there were opportunities for improvement. But that depended on the establishment of a clear direction, which ideally does involve senior clinicians because, one, they often have quite good ideas and, two, they are the ones who are going to have to make it work. We felt that was a failing at the time. I think the report reflects that.

Mrs JILLIAN SKINNER: It does. In fact, the summary on the last page of this report could easily be the summary of our report. Sadly, your report is dated September 2004 and here we are in November 2007 and the same words appear: morale, sustainable progress and sustainable process involving framework and nursing. These are the same issues that are now being talked about. As to the clinical services plan, the doctors have said they have been working on it but nothing has happened. While there is great hope that something will come out of this inquiry, many clinicians are saying how do they know something will happen because they have heard it all before. What do you think we should do? Do we need to monitor it to see that it is actually happening?

Dr KING: We had similar problems in South East some three years ago and went through the same process. We did establish a clinical services plan. These are not always easy in that every time you do one of these things you tend to intrude upon entrenched interests, if you like, traditional patterns of work and all that sort of stuff. We embarked on this in South East about three years ago with some success, not entirely but some success. That was based around a couple of principles. Firstly, you need to involve the clinicians. Much of the planning was done by senior clinicians. Secondly, you need role delineation. Perhaps it was more difficult in South East because in Illawarra we had four principal referral hospitals and North Shore has only one, and that does make it easier—in other words, role delineation, which you have to manage practically. We have to move away from the concept of every hospital doing everything. We have had some significant successes along those lines. I think you will find our report did allude to that in terms of Ryde. There may be some reason for optimism—and I understand your remarks about personal comments—but one of the people who was heavily involved in and effectively ran the process of clinical services planning in South East is the new chief executive of North Sydney. One would hope that he saw that as a positive experience. So there may be an opportunity to do that. I think that is a process that they should undertake.

The Hon. AMANDA FAZIO: The Committee has heard about access block from both the emergency department and intensive care. We have also been told of instances where doctors have had to delay surgery because of apparent lack of beds and/or staff to attend to patients. What do you think are the most successful ways to resolve these problems? Is it a case of needing more beds or are there other strategies that use existing beds and existing resources more effectively?

Dr KING: Access block again is a problem with the increasing numbers of people coming through the emergency department. All you can do is to attempt to use the resources you have got in the most effective way that you can. Again, this came out of some of our planning in South East. We delineated the roles of hospitals. The hospital next door which had offered general acute surgical services, for example—I was mainly involved in the surgical aspects of this plan at the time—still ran a general surgical service and was still occupying much of its resources doing a service that was offered more comprehensively at St Vincent's, Prince of Wales and Prince Alfred. That struck us as being not terribly sensible. We changed the role of Sydney Hospital to become an elective hospital with six operating theatres going full time doing much the same sort of thing. What that does is take a whole chunk of work out of other institutions and let them handle the work more efficiently. Within a defined budget the more efficiently you can do each of the components the more likely you are to be able to manage these problems.

We had a problem with orthopaedics both in the central sector at St George and Sutherland with long waiting lists and terrible delays in terms of getting patients with hand surgery and acute orthopaedic problems into theatre. We, therefore, established an elective joint service at Sutherland and in the process now have orthopaedic theatres at St George that run at about 85 per cent occupancy, which for an emergency theatre is pretty high. All the hand services have now gone to Sutherland. So we do not have these two- and three-day delays anymore for people requiring hand surgery. They come in and are seen and treated within a 24-hour timeframe. In the process the elective work has been more effectively managed at Sutherland and our waiting lists have gone right within departmental guidelines. We are doing more work, we are doing it more effectively and we are doing it more cost effectively.

We took ophthalmology and put it in Sydney Hospital, where now, I think, there are four ophthalmology theatres going full time. Every time we did these things there were concerns expressed. Most of them ended up being expressed in the media. We were told that we would see people dying in Macquarie Street from lack of services. We have not encountered any yet, and that was three years ago. Broadly speaking, contrary to the opinion of many, I think there is plenty of money in health, it is just that we use it quite badly. We should not put our hands out for more money until we show that we can deal with the money we have got effectively. To answer your question, you have got to take the resources you have got and use them as effectively as you can. Once you have used them effectively, if you still have a problem, then you need more resources. There are ways to do what we do more effectively.

Ms CARMEL TEBBUTT: We have heard a great deal from witnesses about the importance of keeping bed occupancy rates at about 85 per cent and that the only way to effectively run a hospital is when bed occupancy is at that level. We have heard from others that it is not always the best indicator and that hospitals can operate safely at higher levels if they use their resources more effectively, which I believe is what you have just been saying. What is your view on bed occupancy rates? Is there a rate that can be struck that is a safe level at which to operate a hospital?

Dr KING: Again, I think that comes from the time when every ward did a bit of everything. I think it predates role delineation within and between organisations. There is no doubt that you can use your resources if they are predictable, which certainly much of it is. Even the emergency loads are more predictable than people often imagine. If you can take those components that are predictable and use them to their capacity, then the overall level of utilisation can go up. There is no doubt that if you are looking at peak demands, such as respiratory wards in winter, you certainly have to have a bit of leeway. But the old 85 per cent rule or concept comes from when everything was going into the same ward and you had to allow for all the vagaries. That process can be managed better. What you also have to understand then, of course, is that very many of our staffing levels are based on occupancies of that rate. As you push the occupancy rate up, the pressure on the staff does go up. So you have to make the necessary adjustments to the staffing levels at the same time.

Mr MICHAEL DALEY: Doctor, one of the constant themes of evidence that has been put before this Committee is that there is a serious lack of engagement and has been for some time between clinicians and management at Royal North Shore Hospital. What recommendation do you think we could usefully make to assist in more meaningful engagement?

Dr KING: The one thing about clinician management, the ones that have been attended to have been successful and, in fact, have also been successful and busy in their practices. You want the people who are successful and busy, who know how to organise their time and who know how to run a business. You do not want the time service. You want the people who are busy. That is critical. As I recall from our review, it was often the fact that the non-involvement by surgeons was bemoaned, yet the meetings were held, I think, at two o'clock on a Wednesday afternoon, or something like that. Any busy surgeon is not going to be available then. You have to make the necessary adjustments. You have to go out and actively recruit the people who are busy and, therefore, make the necessary accommodations. For our own clinical services planning process in South East the meetings were held at six or seven o'clock at night. They were teleconferenced and the bureaucrats, to their credit, turned up and stayed till 10 or 11 o'clock, or however late it may take. That is the first thing.

You have to send out a signal that you are going to listen. But the critical thing in all this is if you get the right people, who are the busy people, and you sit them around the table at another committee meeting and they talk and talk, they come up with some suggestions and then you ignore them, you will lose them after one or two meetings. If you can make such a recommendation, you should make sure that the bureaucrats actually listen and implement. Health has moved in 15 years. There was a period of clinical management in New South Wales 15 years ago. At that time there was even budgetary responsibility. I think that is when the system ran at its most efficient.

Mr MICHAEL DALEY: Budgetary responsibility by the clinicians?

Dr KING: By the clinicians. When I first became clinical director at St George, in the first two years we had budgetary responsibility and we increased throughput by 40 per cent on the same budget. We do not know how to run hospitals but we know how hospitals run, if you know what I mean, and we had the necessary support, which is the other thing. You cannot take the sort of people we are talking about and make them try and read balance sheets, add up numbers and all this sort of stuff. You have to give them the necessary support. That is where this often does fall over. You have to understand the difference between administration and management. You want these people to manage the service, not to administer it. You want their high-level strategic input, their enthusiasm, their capacity to make their colleagues understand where they are heading.

When I went back as divisional director, briefly, 10 years later I could not order a biro. In the end, I thought, "What's this?" If you devolve responsibility and you do not devolve authority, you are devolving blame. That has tended to happen in New South Wales in the last little while, over some time now. That is a problem. You have to devolve genuine authority to make the decisions, be that by either the capacity to write a cheque, which is always the best, or alternatively have some more enlightened administrators who understand that it is in everyone's interest to listen to people. If you listen to people and listen to the clinicians of whom I am talking and they believe that what they are saying is being listened to and changes are being made, you will keep their interest. You will not have any problems with that. If you could make a recommendation, it would be to make management listen to their clinicians.

CHAIR: Dr King, we have a copy of your review dated 6 September 2004, which is excellent, as has been said by other Committee members. The recommendations you made are positive and practical. Who authorised you to conduct the review?

Dr KING: It was the general manager of the hospital at the time. I believe it arose out of some concerns that had been expressed by the surgeons the previous year about the management of the operating theatres. We were asked to review that and the surgical services, and that is where it started. So it was the general manager at the time.

CHAIR: It was not supervised by the Department of Health?

Dr KING: No, it was an internal review commissioned by Deb Latta.

CHAIR: There was no process to follow up your final recommendations. You said here:

> A report on progress should be produced by February 2005. A discussion paper and plan addressing the secondary issues above and other issues raised in the consultancy report should be produced for circulation at the same time with a view to finalisation of a longer term vision and plan by June 2005.

From your earlier answers it seems there was no process to check that these positive steps were followed.

Dr KING: I am not in a position to know. We did not receive any more communication about the report and I have no feedback on any level of implementation.

CHAIR: Do you think that was a satisfactory response to the important inquiry that you conducted?

Dr KING: As I recall, we offered to remain involved if the hospital thought that was appropriate. We were invited to do the review and had no effective standing, if you like. It is very hard then to intrude on the process. One has to assume that if the review is commissioned there is a reason for it and recommendations are likely to be implemented.

CHAIR: Do you think one of the problems with Royal North Shore Hospital were the many changes in general managers? Would that have been a factor?

Dr KING: Without being specific about North Shore, yes. The frequent changes of general managers cannot be a good thing and, of course, it begs the question as to why that should be the case.

CHAIR: So it means from what we are hearing a lot of your recommendations have been ignored?

Dr KING: Again, I am not in a position to know.

Mr PETER DRAPER: We have heard from a number of people, orthopaedic and anaesthetics, saying that over 50 per cent of their workload is carried out after 5.00 p.m. and on weekends, and that is putting a lot of stress and pressure on them. Is that unique to North Shore? Does that happen elsewhere in the system?

Dr KING: It sounds a very high proportion again, and it would tend to indicate that the in-hours management of workload is not what it may have been. Again I have given examples of where we have had similar problems with hands and orthopaedics and by moving elective orthopaedics out without decreasing orthopaedic times at St George, by moving hands to Sydney, we managed to bring the vast majority of emergency work within hours. By emergency work, we often have 24 hours or so to get this sorted and it is far preferable to do it in an organised fashion in the daylight hours when people are fully awake and when all the resources are there than overnight. So, it can be done but it is a matter of understanding the workload and managing it and clearing out some of those things that impede doing the work in hours, which again is where we saw potentially quite a large role for Ryde to clear the decks for North Shore and to increase the elective capacity of Ryde quite substantially.

CHAIR: If you had to make one major recommendation for the Royal North Shore Hospital what would you recommend today from what you have heard in the media and so on about the hospital?

Dr KING: Engage their senior clinicians. Make them think they are being listened to.

CHAIR: That gets back to restoring the medical staff council, these types of things?

Dr KING: Medical staff councils in most places are almost semi-political organisations that represent the overall requirements of the medical staff council and what the medical staff as a whole see as the hospital's medico-political requirements. I think we are talking here about people who commit a significant part of the week to manage a service and take responsibility for the management of the service. Medical staff councils have traditionally not done this. They have had quite a different role in our hospitals and for good reason. I am talking about a group of senior clinicians who are engaged to be heavily and directly involved in management and making real decisions.

CHAIR: How do we get them to do that?

Dr KING: I have already spoken to a couple of my colleagues over there. I said, "I think the new CE is good, you should give him a go." You have to go and talk to them. It was put to me the first time I got involved, "You have complained about this problem, now I am going to give you a chance to fix it." If they are complaining about it, go back and say okay you want to fix it, you should go.

(The witness withdrew)

ALISON FRANCES MAYHEW, Nursing Unit Manager, Royal North Shore Hospital, on former oath, and

FIONO ELIZABETH CARMICHAEL, Nursing Unit Manager, Royal North Shore Hospital, affirmed and examined:

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

Ms MAYHEW: I do. I thank the Committee for this opportunity to speak to you. Fiona and I have closely followed the inquiry but have been disappointed with the minimal input from the nursing profession. Whilst a number of our medical colleagues have made some valid points we do not believe that the very core of the issue at Royal North Shore has been addressed. The nursing profession provides direct care 24 hours a day and leads a multidisciplinary term to ensure that all patients' needs are met. Due to this commitment, it is the nursing staff who has a true understanding of how decisions made at the executive level can directly affect patient care. Nursing staff are working within a system that simply does not allow them to provide the quality of care they believe is basic and necessary. The current environment lacks adequate resources, does not engage nurses in policy development and demands that we improve capacity despite a lack of nursing resources.

We believe this is a direct result of a changing management structure that occurred in 2006. The restructure removed nursing leaders from organisational responsibility, which meant that nursing no longer had an operational voice at an executive level. This impact on the daily operational function has been profound. There is no direct link from the clinical or ward level for nursing staff to raise operational concerns in relation to patient care, nursing safety and the allocation of adequate resources. In 2006 the nursing body at Royal North Shore Hospital lodged their concerns regarding the restructure. These concerns included an increase in clinical incidents, poor staff morale, reduction in retention and recruitment and an increase in patient complaints. This had been previously experienced in hospitals in New Zealand and Canada where similar structures had already been implemented.

We have seen a breakdown in communication, a lack of support, an increase in workload for the nursing unit managers. Divisional executives are not seen often for weeks at a time. Meetings are cancelled and urgent requisitions for clinical items take days to be signed off. Excessive pressure is placed on nursing staff to improve patient flow and reduce access block. We believe this has led to the hospital's inability to retain its nursing staff and recruit into current vacancies. There is a lack of consultation with clinicians surrounding changes being made at a clinical level. Our view is that the director of nursing position is now all consumed by patient flow issues rather than clinical and professional standards.

Many nurses acknowledge there is a need for change to enable our demand to meet our current capacity. However, over the past few months its own strategies to create capacity are directed at nurses, leading to an increase in nursing workload rather than looking at inefficient processes that impact on patient flow delays. Our nursing handovers are examined for bed block issues by hospital management and the nursing unit managers are consumed by this charge planning for the majority of their day. This leaves little time for other responsibilities such as leadership and quality improvement. Many wards are now working with numerous nursing vacancies. Nursing unit managers have been asking for generic hospital advertising to be placed since April this year. This request has only just been completed in the past month, a notoriously bad time of the year to attempt any recruitment. The recruitment process is lengthy and unreliable and ward staff are working huge amounts of overtime to compensate for the hundred nursing vacancies within the organisation, and there is an expectation by management that working one nurse shortage is acceptable. Agency staff are still not working full shifts despite requests over the past two years to do so. Lastly, I publicly acknowledge the continued professionalism displayed by nurses at Royal North Shore. They have continued to maintain high standards of patient care despite the negative media publicity and the continuing pressures placed upon them by the organisation.

CHAIR: Ms Carmichael, do you wish to make any statement?

Ms CARMICHAEL: No, we wrote that together.

CHAIR: We will move on then to Mrs Skinner.

Mrs JILLIAN SKINNER: Thank you both very much indeed for coming in. I am very pleased. You can see from the *Hansard* that we have now had extra nurses appearing. I am very grateful to you because your earlier evidence, Alison, was extremely valuable, I thought. Can I build on some of the comments you have made? When you were talking about the pressure on nurse unit managers in particular to do things like this charge planning, and all of those administrative tasks, and which are really about output and not patient outcomes, you also talked about the director of nursing. There have been suggestions that we need to look at making that a leadership role again with more of a focus on pastoral care for the nursing workforce and getting rid of the silo attitude that has developed with the structures of the divisions. Would either of you care to comment about that?

Ms CARMICHAEL: I think we definitely do need a director of nursing that is going to provide us more of an organisational voice than a professional voice. As Alison and I have stated, the position at the moment is entirely focused with patient flow. With our structure we have no organisational link to her and she is a representative for us at executive level, on a professional level only.

Mrs JILLIAN SKINNER: So it is really going back to the old role before the restructure?

Ms CARMICHAEL: That is right, yes.

Mrs JILLIAN SKINNER: You talked about vacancies and getting nurses, and that is one of the things I remember from your earlier evidence, Alison. Can I confirm that you just said you started the process of filling some vacancies back in April and you are only now getting around to doing that?

Ms MAYHEW: We originally approached the director of nursing as we were concerned about the vacancies in hospital, and in April we put forward could we possibly put in a generic advertisement for the hospital to try to recruit some nurses into the hospital. We wrote the advertisement and had it ready to go but unfortunately it was only put in last month.

Mrs JILLIAN SKINNER: So the Government's announcement that we are going to have a massive 12 extra beds at Royal North Shore, without nurses to look after the patients in those beds, is that a bit of a wasted exercise?

Ms CARMICHAEL: Absolutely.

Mrs JILLIAN SKINNER: Can I talk to you about some of the ideas that might be considered to attract nurses not only to apply but to stay? Is the HECS fee on registered nurses courses an impediment to people taking up nursing and then staying on?

Ms CARMICHAEL: I cannot comment about HECS.

Ms MAYHEW: I think in particular at Royal North Shore, ever since the restructure in 2006, there is no career path for nurses within the hospital. As far as Fiona and I could go from an operational level is to where we are now.

Mrs JILLIAN SKINNER: So you want more of a career path so there is an opportunity for advancement?

Ms MAYHEW: There are other positions in the hospital but those nursing positions do not have accountability or delegation. It was spoken about three years ago with HECS as one of the options to recruit or attract people into the nursing profession. Something like that needs to come from a government level, yes.

Mrs JILLIAN SKINNER: I think you, Alison, but some others also talked about nurses in areas like mental health, which is very hard to get nurses to work in, and the status of working there. Is there an opportunity to do the education required to do that as part of a postgraduate course with a salary that would be equivalent to an advancement there?

Ms CARMICHAEL: There are postgraduate courses that are available and you are rewarded financially for that. I could not tell you whether mental health was one of those.

Mrs JILLIAN SKINNER: I think it is not. Generally the morale and the environment you are working in, most reviews of nurses say that is as important if not more important than the money you earn?

Ms CARMICHAEL: I guess it is the team around you. If you have a good team and you have a good support network, absolutely.

Mrs JILLIAN SKINNER: Other witnesses have talked about things like childcare, parking, and those obvious support initiatives and benefits for nurses would help. Do you think that is right?

Ms MAYHEW: Yes, definitely.

Ms CARMICHAEL: Yes.

Mrs JILLIAN SKINNER: Is there anything else you would like us to consider in a report?

Ms MAYHEW: I think one of the major things, especially in retaining nurses at Royal North Shore Hospital, is the current culture and the lack of communication lines within the organisation, down from an executive level to the clinician level. As nursing unit managers we are not often involved in any policy-making until the actual policy is just about ready to start and then unfortunately it is a policy that does not work at the ground floor and needs to be re-looked at. If we had been engaged in the first place and had been asked and consulted then possibly we could have come through with something a little more reliable than what has come through.

Mrs JILLIAN SKINNER: It seems to me that they are missing out on the most experienced people right there at the coalface.

The Hon. JENNIFER GARDINER: You have mentioned the lack of backup in respect of pharmacy. Can you tell us how that might reflect on the standard of patient care? Also is fundraising for minor equipment an issue for you?

Ms CARMICHAEL: Pharmacy have had incredible shortages over the past 12 months and what they instigated was rolling out not having a pharmacist per week on each ward, so that every ward had a turn at not having a pharmacist. Then it was demonstrated that not having a ward pharmacist for an entire week posed serious patient safety issues, so they then decided that one day per week one ward would not have a pharmacist, so that they could distribute the pharmacists elsewhere within the organisation. The obvious risk is that patients do not get reviewed, their medications do not get reviewed, their charting does not get reviewed; they could have incorrect doses, incorrect drugs—

The Hon. JENNIFER GARDINER: What happens to patients in those circumstances?

Ms CARMICHAEL: A lot of the education is actually given by the nursing staff on the floor. There is also the aspect that all of our charts have to be sent to pharmacy, so the charts are off the ward for often two or three hours at a time. Patients miss out on analgesia, miss out on antibiotics—it is dangerous.

Ms MAYHEW: We asked previously what sort of strategies the hospital would put in place whilst there was a decline in pharmacists in the hospital and their strategy was to leave areas without a pharmacist.

The Hon. JENNIFER GARDINER: That is called a strategy, is it?

Ms MAYHEW: Mm.

The Hon. JENNIFER GARDINER: On fundraising for small items of equipment, do you have to get involved in that or does the hospital have to do that, taking blood pressure—

Ms MAYHEW: You will find that most wards are declined vital monitoring machines and there is not enough money in the budget for those particular pieces of equipment, so what we then tend to do is have a sausage sizzle or a raffle or something to try to gather the funds for the equipment that is necessary on the ward.

The Hon. JENNIFER GARDINER: When you say "we", do you have to do that yourselves?

Ms MAYHEW: Nurses, yes.

Ms CARMICHAEL: The nurses.

Dr ANDREW McDONALD: I understand the Minister is releasing extra beds to meet increased demand and also extra money for a recruitment package to encourage nurses to become nurse practitioners or to work in the emergency department. What do you think of that?

Ms MAYHEW: I think it is a bandaid solution for what is necessary within the hospital. Opening more beds always seems to be the quick fix for any health crisis. Twelve extra beds would be twelve extra patients within the hospital that would not receive proper nursing care due to our current vacancies. While we do need nurse practitioners within the hospital system, we do not have enough nurses to fill other nursing vacancies, so I think it would be difficult to find nurse practitioners. I think we really need to look at pulling nurses back into the hospital system, into a system that respects nurses and involves nurses in the decision making that happens in that organisation.

The Hon. AMANDA FAZIO: Would not the placement of nurse practitioners in the system provide another career option for nurses who want to stay in the system or would it not be an incentive for nurses who left the system because they wanted to do work more like a nurse practitioner to come back in? Might it actually provide a better career path and also be valuable in attracting nurses back to the profession?

Ms MAYHEW: Yes, but I think you will find that part of the criteria for a nurse practitioner is that they have to provide a certain amount of clinical evidence showing where they have worked in the clinical environment, so for those people who have been outside of nursing for a long time I do not believe that they would fill the criteria for the nurse practitioner.

Mr MICHAEL DALEY: I understand that there has not been an active branch of the nurses' association at the hospital for some time. Would it benefit your colleagues if the branch was reactivated?

Ms MAYHEW: It is active. It was dormant for a while. I had been the branch president last year and stood down for other roles and responsibilities I had in the hospital. There were two people keeping the association active, or dormant, in the hospital, but unfortunately there has been a view within the hospital that the association is frowned upon.

Mr MICHAEL DALEY: Is that by management or clinicians?

Ms MAYHEW: Management.

CHAIR: Because of that, nurses are reluctant to be in the association?

Ms MAYHEW: They are part of the association and they are members of the association, like if something ever happened in the hospital and they needed it for legal representation, but as far as anything else goes they are not really prepared to be active within the association.

CHAIR: We have had other evidence that nurses feel that, because it is frowned upon, they do not become active in it?

Ms MAYHEW: That is right.

CHAIR: Do you think that comes from the doctor level or management?

Ms CARMICHAEL: It comes from management.

Ms MAYHEW: Management, yes.

Ms CARMEL TEBBUTT: What has the impact of the inquiry been on the morale of nurses, and other staff, if you want to comment on that as well?

Ms CARMICHAEL: Morale is bad at the moment anyway. I can only speak on behalf of my nursing staff. Every day that they open the paper they see another article that says something negative. The organisation has tried to counteract that by providing feel-good stories and by providing the staff with positive letters of feedback from the community, and I think that that does work, but in my area I have 10 vacancies at the moment and I just have not been able to recruit into those vacancies. There just does not seem to be the nursing skill mix that I need. Having said that, with all the media, it is difficult to recruit into a place that is being publicised as not a great place to work, for various reasons, and often what is said in the media is not accurate either, as you all know.

The inquiry has had a very negative effect on the nursing staff on a day-to-day basis. Patients are making multiple complaints about things that in the past they possibly would not have complained about. Perhaps the windows might have been dirty, but in the past, "Well, we're getting good nursing care" or "I'm happy with my doctor, so that doesn't really matter", whereas now every little thing seems to be—it is a knock-on effect—something to be complained about. The nursing staff are really copping it at the bedside definitely.

The Hon. AMANDA FAZIO: We have heard a lot in the inquiry, and there has been a lot of coverage in the media, about bullying and harassment at the hospital and also mismanagement of grievances that staff might have put in. Based on your experience, how could bullying be handled better and how could grievances be handled better? Do you have any suggestions in terms of recommendations we might want to make in this area?

Ms MAYHEW: Firstly, we were disappointed with the review. There were 88 people interviewed and only 44 of those people were nurses, so we do not believe that it gives a true representation of the issues at Royal North Shore Hospital. With grievances being dealt with, unfortunately, when the restructure happened within the hospital a lot of human resources personnel were removed from the hospital and those responsibilities have gone back to nursing unit managers. It is difficult for us to try to get advice and support in dealing with grievances so those grievances could be extended for a long time. With bullying, I think it is a by-product of the frustrations coming down from every level. We have pressures and obviously benchmarks placed by the Department of Health, which then go through to the area and are then passed down to the hospital, and unfortunately the strategies are to pass them down to the immediate coalface, so with the bullying I think it is just the frustration within the health system at the moment that no one is listening. My suggestion would be to provide more human resources staff within the organisation and possibly look at how management is dealing with the pressures.

CHAIR: How many nurses are you short in the whole Royal North Shore Hospital?

Ms CARMICHAEL: I think there are probably 100 full-time equivalents.

CHAIR: And the agency nurses are not quite filling their role; you said they are not doing the full shifts?

Ms CARMICHAEL: No, the nursing unit managers have been asking for two years for the agency staff to be rostered for a full eight or ten hour shift and that is still not happening.

CHAIR: Does that affect the handover to the next nurse?

Ms CARMICHAEL: Well, they are trying to do eight hours work in six hours, so there is a lag time between the time that the agency nurse finishes and the time that the afternoon staff takes over that patient load.

CHAIR: How do you communicate all the details of where the patient is to the next nurse if there is a gap of two hours?

Ms CARMICHAEL: It is usually the nursing unit manager that takes the handover from the agency staff and fills in the gap until the afternoon staff member arrives.

CHAIR: You may have to do that for more than one person?

Ms MAYHEW: Yes.

Ms CARMICHAEL: Sometimes.

CHAIR: How many nurses are you each supervising in your unit?

Ms MAYHEW: Per shift?

CHAIR: Yes, on a shift, roughly?

Ms MAYHEW: I only have about five per shift.

CHAIR: I have seven.

Ms MAYHEW: But if there are two agency nurses then that could be up to eight patients that I need to supervise whilst waiting for the agency staff to start.

CHAIR: Have you had any problems working with the orderlies, what they call PSA people?

Ms MAYHEW: I have not personally.

CHAIR: Have you heard of problems with them?

Ms MAYHEW: No.

Ms CARMICHAEL: No, they are a fully-fledged staff member. They work as hard as the rest of us.

CHAIR: Do they take instructions or requests from the nurses?

Ms MAYHEW: Yes.

Ms CARMICHAEL: Yes.

CHAIR: You have not had any of them say, "No, I won't do that"?

Ms MAYHEW: I never have, no.

Ms CARMICHAEL: Not from my PSAs, no.

CHAIR: It seems as if the review or restructure in 2006 left the nurses out of it. You did not have much input?

Ms MAYHEW: No, you are right. We had written numerous letters to the area executive at the time expressing our concerns with the restructure and to the general management within the hospital at the time. Unfortunately, some of those letters were never responded to and I guess what we are now seeing is pretty much what we said would happen if the restructure was implemented.

CHAIR: So everyone was hoping that the restructure would improve the situation and it has had the opposite effect in your view?

Ms MAYHEW: Yes.

Mr PETER DRAPER: You mentioned before about cooperatively putting together the ad that did not run until recently. What has the response been now that it is actually running, do you know?

Ms CARMICHAEL: I could not comment on exact figures.

Ms MAYHEW: There were four after the first week. I am not sure—anything past there.

Mr PETER DRAPER: There seems to be a clear conflict between patient flow and patient care, especially given the lack of consultation with nurses. Do you think that that can be resolved without the input of the nurses?

Ms CARMICHAEL: Without their input?

Mr PETER DRAPER: Yes, because it seems at the moment that the hierarchy are trying to do everything without the input of the nurses. I am just wondering whether they can do an effective job without opening the lines of communication and actually involving the people who are on the coalface?

Ms CARMICHAEL: I do not think they can do it without us. Do you?

Ms MAYHEW: No, I do not.

Mr PETER DRAPER: I just find it interesting that they try.

Ms MAYHEW: And it is unfortunate that we do not have a nurse who has constant contact with the operational level of the hospital sitting at the executive table any more, so we believe that our concerns are not being tabled at that executive level.

Mr PETER DRAPER: That would be a positive first step, in your opinion?

Ms CARMICHAEL: Definitely.

Ms MAYHEW: Yes, it definitely would be.

CHAIR: Who would it be, the Director of Nursing? Who would be the person with input at the operational level?

Ms MAYHEW: There is an operational nurse manager within each division but they have no accountability and no delegation within the hospital. We had argued that that position needed some authority. The NUMs do not report to that person and they have been excluded from the executive table even though their portfolio is basically patient flow. So we had asked at the beginning of the year if those positions could sit at the executive table to be able to at least debate and put forward ideas that would work at the clinical level. But that has been denied.

CHAIR: We heard that the general manager has set up a nurses task force or some body upon which he said he is trying to have interaction. Is that realistic or is it a bit of window-dressing? Is it practical?

Ms MAYHEW: Let us be honest: I would like to call it window-dressing.

Ms CARMICHAEL: We have not had too much involvement in the findings of that task force or the plan of action. In fact, the first email I saw about that was today, with some action planning process. Prior to this I knew that there were nurses who were meeting but only because one of them is one of my nurses. But I was not aware of any sort of action plan that had been put in place.

CHAIR: Would unit managers not be involved in that task force?

Ms MAYHEW: You would hope so.

CHAIR: So they have hand-picked some nurses to be involved in the task force.

Ms CARMICHAEL: No. We were asked whether or not there were nurses in particular areas who were interested and who felt confident enough to say how they felt, and one of my nurses put her hand up and said, yes, she was happy to speak to the task force. But apart from that I do not know how they were picked.

Ms MAYHEW: I do not know how to contact the task force. I do not know when they meet. I do not know if we can place anything on their agenda.

CHAIR: So it is not representative of the nurses in the way it is operating?

Ms CARMICHAEL: Not a true reflection, no.

CHAIR: You mentioned the advertisements in the newspapers. Obviously if the morale of nurses is very low any potential nurse will ask, "What are things like?" and they will not be enthusiastic about applying. That is the dilemma we are now facing.

Ms MAYHEW: Yes. Unfortunately, the news had reached the United Kingdom. Several wards had recruited nurses from the United Kingdom but once the media got across there they declined those positions.

CHAIR: Thank you very much for providing valuable information to the inquiry. We appreciate that very much. Hopefully we have had the nurses' input today.

Ms CARMICHAEL: Thank you.

Ms MAYHEW: Thank you.

CHAIR: That concludes the public hearing. Thank you, ladies and gentlemen, for your attendance.

(The witnesses withdrew)

(The Committee adjourned at 4.18 p.m.)