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REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO REVIEW OF COMPLAINTS HANDLING WITHIN NEW SOUTH WALES HEALTH

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At Sydney on Thursday 14 September 2006

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The Committee met at 11.30 a.m.

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PRESENT

Ms S. P. Hale (Acting Chair)

The Hon. Dr A. Chesterfield-Evans
The Hon. A. R. Fazio
The Hon. D. T. Harwin
The Hon. R. M. Parker
The Hon. M. J. Pavey
The Hon. C. M. Robertson
The Hon. H. S. Tsang

ROBYN KRUK, Director General, New South Wales Health, affirmed and examined, and

KATHERINE McGRATH, Deputy Director General, New South Wales Health, and

CLIFFORD FREDERICK HUGHES, Chief Executive Officer, Clinical Excellence Commission, sworn and examined:

ACTING CHAIR: Welcome to the General Purpose Standing Committee No. 2 inquiry into the review of complaints handling within New South Wales Health. This inquiry is a follow-up to a previous inquiry by this Committee into complaints handling procedures. The report of this inquiry, which was tabled in 2004, included a commitment that the Committee would conduct an inquiry into the progress made in implementing the Committee's recommendations. With this in mind, the Committee advertised its new terms of reference and subsequently resolved to hold today's hearing.

The Committee has previously authorised the media to broadcast sound and audio excerpts of its public proceedings. Copies of guidelines covering the broadcast of proceedings are available on the table by the door. In accordance with the Legislative Council's guidelines for the broadcast of proceedings, members of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photos. In reporting the proceedings of this Committee the media must take responsibility for what they publish or for 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. 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.

The Committee prefers to conduct its hearings in public. However, the Committee may decide to hear certain evidence in private if there is a need to do so. If such a case arises, I will ask the public and the media to leave the room for a short time. I ask that everyone please turn off their mobile phones during these proceedings.

Are the witnesses conversant with the terms of reference of the Committee?

ALL WITNESSES: Yes.

ACTING CHAIR: Ms Kruk, would you like to commence by making a brief opening statement?

Ms KRUK: I welcome the opportunity to make a brief opening statement. I think Professor Hughes will as well. As I have indicated when I have appeared before this Committee before, I will not go into any individual patient matters. I am happy to take on notice any matters raised by the Committee. I am not a clinician but I also have respect for privacy issues.

The last time I appeared before this Committee on matters regarding complaints handling was May 2004. Since that time NSW Health has implemented or made significant progress in implementing the Legislative Council inquiry and the Walker special commission of inquiry recommendations that were supported by the Government. I understand a summary of the progress made by NSW Health, including the initiatives and changes undertaken by the former South Western Sydney Area Health Service, was provided to this Committee earlier this year. However, I am happy to send the Committee a further progress report, if the Committee so wishes. The Independent Commission Against Corruption [ICAC] and the Health Care Complaints Commission [HCCC] have both completed and publicly reported on the majority of the allegations on matters referred to them. The ICAC released reports in April 2005 and September 2005. In both reports the ICAC found there was no evidence or insufficient evidence to substantiate allegations of corrupt conduct. I understand only one ICAC investigation remains outstanding.

Although the ICAC found no evidence or insufficient evidence to substantiate the allegations of corrupt conduct, the ICAC investigations along with those of the upper House inquiry and Bret Walker did identify to NSW Health that we needed to improve how we managed complaints and to accelerate our quality and safety initiatives. I would briefly like to run the Committee through what we have done in that period of time. Since those inquiries commenced or were held, we have invested substantial sums and an enormous amount of effort into patient safety and quality programs and improvements in the New South Wales public health system. We are currently spending $60 million over five years to implement the Patient Safety and Clinical Quality Program. The program has been reviewed and commended by the University of New South Wales. Some of the major initiatives under this program are as follows: first, a uniform incident information management system in all area health services. This system allows the public health system to electronically capture, analyse and manage incidents occurring in real time. We are the first jurisdiction to ensure that roll-out.

Second, the establishment of clinical governance units in each area health service with clearly defined points of accountability for safety and quality. Third, the establishment of the Clinical Excellence Commission [CEC] to promote and support better clinical quality and provide advice to the Minister and the health system where systemic improvements can be made. This was a clear recommendation of the Walker report. Four, a quality system assessment program, which is a system of auditing New South Wales health services by the CEC to ensure quality and safety processes are effectively implemented. We have also appointed a designated senior complaints officer in every health service, who is available 24 hours a day, seven days a week to register complaints and ensure appropriate action is taken to resolve complaints from staff and the community. In 2005 we also requested health services to report complaints through IIMS. The use of IIMS to collect complaints information should result in an increase in the number of complaints we record and will help to increase our knowledge of the number and type of complaints made across the entire health system.

Further training of staff in regards to the recording and finalising of complaints information entered onto IIMS is occurring. This will help to overcome any initial teething issues. I think some of the parties appearing before the inquiry after NSW Health and the CEC identify some issues in that regard but are very supportive of the system. I am pleased to note that advances made by NSW Health in implementing improved systems for complaints management is acknowledged in a number of submissions made to this inquiry. We have introduced new or revised policy in the following areas: complaints management, complaints or concern about a clinician, open disclosure, look-back policy, patient identification focusing on correct patient procedure and site, and incident management. These were matters, I think, that members of your inquiry raised previously about how we ensure a consistent approach is taken where there are matters that relate to more than one incident.

We have new programs running to reduce falls and to improve infection control through heightening the importance of hand hygiene practices. We have provided clinical staff with a clinicians' tool kit, which is an educational resource that provides clinicians with a guide about the tools available to them for identifying problems with systems of care and individual clinicians' practices. Over the past four years more than 3,000 NSW Health employees have been trained in managing incidents. This includes specific training in investigating techniques, known as root cause analysis. I think Dr Chesterfield-Evans asked a number of questions at the last inquiry about the training that would be offered. The RCA train-the-trainer courses have commenced with over 100 health professionals now skilled to train other professionals in the RCA investigation techniques. In addition, training is soon to be rolled out to improve clinical leadership. I am sure that later on Cliff will touch on this issue and the newly released open disclosure policy.

Last year we established a Corporate Governance and Risk Management Branch within the Department of Health to lead the development, review and co-ordination of corporate governance and risk management processes across NSW Health. This was an issue that this inquiry asked me about when I appeared previously. This branch monitors and co-ordinates the department's response to external oversight bodies such as the HCCC, the ICAC and the NSW Ombudsman's Office. It also monitors the responses by the department and NSW Health to recommendations made by the Coroner, the NSW Ombudsman and the HCCC to ensure that appropriate follow-up action to recommendations occurs. Although primary responsibility for complaints management still rests with the relevant health service, if a complainant is dissatisfied with a service's handling of the matter, they may refer their concern to the department for consideration by the Corporate Governance and Risk Management Branch.

A workforce shortage, particularly in specialist clinical roles, remains a challenge in New South Wales, as it does nationally and internationally. The creation of the new area health service structures has ensured that each area now has a link to a major teaching hospital or university to bolster clinical training. The reforms have also linked health services with medical work force shortages to health services where it was easier to recruit medical staff. This is a positive initiative in terms of patient safety and quality. In regard to training, NSW Health is making a substantial investment in postgraduate medical training through the New South Wales Institute of Medical Education and Training [IMET]. At the request of the Government, IMET has been reviewing specialty training since 2004. This has resulted in groundbreaking network training programs and basic physician training, with basic physician, surgical and psychiatry training commencing this year.

These network training programs are streamlining the training for some of our most skilled doctors, enabling them to progress through their specialty training with improved supervision and education support. The improved networks of hospital training has also increased rural community access to senior doctors in training and provided greater equity in the distribution of the work force. Members will remember that this was an issue of major concern in the Camden and Campbelltown events.

I would like to touch on information we currently publicly report and deal with the issue of transparency. The New South Wales public health system publicly reports on a range of quality and safety data, including the following issues. Firstly, we publish key performance indicators in department and health service annual reports, which includes unplanned and unexpected hospital readmissions. The Australian Capital Territory and Western Australia are the only other Australian jurisdictions to report this data.

Secondly, as to the annual incident management reports, New South Wales is the first State or Territory in Australia to provide public reporting on all serious incidents that affect patients. Victoria, South Australia and Western Australia report on sentinel events. However, New South Wales reports both sentinel events and all serious incident data. Thirdly, we report New South Wales infection control rates, which includes aggregate data on hospital-inquired infections. New South Wales was the first State to report this information publicly. It is available on the department's public web page. New South Wales is not only a leader in reporting but also in the investigative tools used to examine and review serious incidents. In 2003 when New South Wales introduced root cause analysis under the New South Wales Safety Improvement Program, we were the first State in Australia to put in place a systematic process for examining serious events and to use the evidence obtained from those processes to determine our priorities for quality and safety improvement and training. These go to the heart of this Committee's terms of reference.

In 2004 and 2005 the Department of Health released the New South Wales Patient Safety and Clinical Quality Program reports detailing the number and type of the most serious incidents that occur in the New South Wales public health system, this number being 429 in the year 2004-05. This represents .03 per cent of all admissions to the New South Wales hospital system. The New South Wales public health system is the first health system in Australia to publicly report on all severity assessment code 1 incidents—or SAC 1s as I will refer to them—occurring in its public health facilities. With the introduction of IIMS we are also the first jurisdiction to have a truly statewide system for the management of all incidents that occur in our health system.

Over 100,000 public health staff can now immediately notify or report any incident. As members would be aware, not all incidents that occur in the health system have serious consequences. Although over 97 per cent of our IIMS notifications are severity assessment code 3 or severity assessment code 4 and result in minimal or no harm, this information is invaluable for health services to learn about our system vulnerabilities and to plan quality and safety initiatives. The IIM system is allowing NSW Health to take work under the New South Wales Patient Safety and Quality Program to the next level. The universality of IIMS across the health system lets us conduct system-wide analysis of diverse events to identify trends and causes and to implement preventative strategies. However, for the first time we are now also able to quickly and efficiently flow data back to clinicians in the workplace so that they can directly utilise this information in real time to improve patient safety.

I would like to touch on the issue of privilege. In a system as large and complex as the New South Wales public health system it is unrealistic to expect that mistakes will not occur. Equipment

may fail, systems may prove inadequate and errors of judgement may occur. Regrettably, at times this may result in harm to patients. That is why accurate incident reporting systems are critical if we are going to learn why errors occur and focus on endeavours to prevent them reoccurring and improve the quality and safety of our health care services. That is why NSW Health has invested time and effort in developing the RCA process and the IIM system and entered into the training of health staff to use these tools.

A fundamental element of both the RCA process and the successful introduction of the IIM system is the willingness of clinicians and health staff to participate in reporting and reviewing adverse events. A culture of openness, which allows staff to report errors in confidence without fear of reprisal or public humiliation, is critical to an effective incident reporting system. A component of the IIM system is the reportable incident brief. The reportable incident brief system provides for the reporting of serious adverse clinical incidents to one of the New South Wales specially privileged committees. It provides an early opportunity for examination and review at a central level to ensure the appropriate response to an individual incident is in train. It also ensures that urgent statewide system responses, such as safety alerts and changes to policy, can be developed when they are required. Examples of these include the introduction of the correct patient, correct procedure and correct site policy.

These RIBs, as reportable incident briefs are known, are reported to the New South Wales Department of Health Reportable Incident Review Committee. This committee is responsible for examining and monitoring serious clinical incidents within the health system and overseeing investigations, identifying issues relating to morbidity and mortality that may have statewide implications, and providing advice and policy development to effect health care system improvement. The Reportable Incident Review Committee has been granted special privilege in response to concerns that publication of examination of individual incidents would discourage medical practitioners, nurses and other health professionals from participating in the system with openness and candour. The concerns expressed by staff are not new and the Reportable Incident Review Committee is not the first or only NSW Health committee to be established under privilege.

Privilege is important for a number of reasons. First, it guarantees participation in reporting. Secondly, it facilitates frankness and candour of participants in the examination of individual incidents. Third, it protects the privacy of individual patients. The special privilege that applies to the Reportable Incident Review Committee is set out in section 23 of the Health Administration Act 1982 and has been in use in New South Wales for over 25 years. The Health Administration Act 1982 also provides similar statutory protection for quality assurance committees and the root cause analysis investigation. The former privilege was introduced and passed through the Parliament in 1989. The latter privilege was introduced and passed through Parliament in 2004. In 1989 when former Health Minister Peter Collins was affording privilege to quality assurance committees through the Health Administration (Quality Assurance Committees) Amendment Bill, he said in his second reading speech:

> It is widely recognised that the review and evaluation of practices and procedures in health care settings is essential to ensuring the adequacy and appropriateness of the services provided. It is further recognised that the effectiveness of any process of service review is dependent on the willingness of those rendering the service to engage in frank and open discussions about the practices and procedures under review.

Mr Collins accurately espoused the principle underlying privilege in the health care setting, whether this be for quality assurance committees at a local level, special committees at the statewide level or the root cause analysis investigation process within area health services.

Currently, the Reportable Incident Review Committee is one of five specially privileged committees in New South Wales. The other committees, which I am sure are known to you, are the: Maternal and Perinatal Committee, which dates back to the 1930s; the Special Committee Investigating Deaths under Anaesthesia, which was first convened in 1960; the Special Committee Investigating Deaths Associated with Surgery; and the Mental Health Sentinel Events Review Committee. Statutory protection for incident reporting and investigation and the work of specially privileged committees does not affect open disclosure. It does not reduce transparency because the system has been set up to ensure that patients and their families have access to information about the care provided to them.

Statutory privilege works hand in hand with the implementation of the open disclosure standard and ensures that patients and their families are informed of the incident when it occurs. All serious clinical incidents are investigated through root cause analysis and the investigation reports are available to patients and their families. As I have said previously, NSW Health publishes an annual report with the number and details of the most serious incidents that occur in its facilities. This ensures public transparency. More recently, the New South Wales Department of Health and the Clinical Excellence Commission extended the level of information publicly available by making public the number and type of all incidents reported through the IIM system. We are endeavouring to strike an appropriate balance between providing health professionals with sufficient protection so that we can encourage them to report and participate frankly in reviewing incidents with the need for transparent and ongoing public reporting. This is an issue that Bret Walker clearly picked up in his investigations.

The New South Wales Department of Health strongly supports clinicians in the approach they are taking to openly and voluntarily reporting incidents. To ensure that continues, we need to provide security and protection for certain aspects of the reporting and review process. In his final report Bret Walker states:

> Balance is required which accounts for the public interest and the community having access to information as well as patients having access to information about the way in which they are treated. The public interest in health care professionals taking part in quality assurance and improvement activities by contributing to adverse events is also part of that equation.

Madam Acting Chair, thank you very much for the opportunity to make an opening address.

ACTING CHAIR: Professor Hughes, do you have an opening statement?

Professor HUGHES: Yes, I do.

ACTING CHAIR: Could it be tabled or could you make it very brief given that we are short on time?

Professor HUGHES: I will make it brief.

ACTING CHAIR: Thank you.

Professor HUGHES: Thank you for letting me address the Committee today. As a chief executive officer, perhaps I should explain that this is an unusual position for me. For 25 years I served as a cardiothoracic, or heart and lung, surgeon at Prince Alfred and I see myself first and foremost as a clinician. I am still working on the safety and quality of health care. I have had quite vast experience in the system at all levels, from when I was a very junior intern through to being head of a very large department, and I recognise the complexity of NSW Health, with over 200 institutions, 100,000 staff members and eight newly defined area health services. It is not perfect but it does have the hallmark of a desire to continually improve the quality and safety of health care.

Our organisation, which is just over two years old, has a mission to make health care in New South Wales demonstrably safer and better for patients and a more rewarding workplace. It is a bifocal view of New South Wales health. The first plane of focus is clearly on our patients. The second plane is clearly on our most valuable resource, our staff. It is this dual focus that explains my role from an active, indeed hectic, clinical practice to that of a chief executive. I remain first and foremost a clinician, and that is my passion.

Ms Kruk has outlined the information management system. This was one of the first tasks that the CEC became involved in once it was established. It is a very useful electronic reporting system that enables all staff to report events through the system. I had the privilege of presenting the first 12 months data from the system to the health system itself at the Fourth Australian Conference in Health Care in Melbourne just two weeks ago. Madam Acting Chair, I have the documents that we can table for the benefit of members, including the two posters that we presented at the conference and the abstracts that go with them. This is the first time in Australian health care that such comprehensive data has been made available in a public format. It covers 125,000 incident reports. Some 88,000 of those were specifically clinical incidents. The others related to the other areas where we collect

information, including complaints; staff, patient and visitor issues; and also corporate issues. But it is the clinical issues that most concern me as a practising surgeon.

Before Mr Walker completed his inquiry into Camden we had a system that in part relied on the courage of the occasional whistleblower to report incidents. They were often then beset by fear, paranoia and sometimes mistrust. They were occasionally ignored. They were sometimes denied and occasionally even ostracised, even in the system itself. But in the short time since then and with the co-operation of the Department of Health and the CEC we now have a system that voluntarily provides 10,000 incident reports per month. The Committee will be pleased to know that by far the majority of these are of minor significance. They are near misses or they are not associated with patient harm at all. Ms Kruk referred to the SAC1 events, which are the most serious of those. There were about 420 last year. I have a table of the coding system in the information that I will provide to Committee members. So, despite the massive increase in reporting, we have seen no significant change in the number of serious adverse events that are becoming apparent from this voluntary code of self-reporting.

The second major function of the CEC is to provide monitoring of the quality systems that exist across NSW Health to ensure that our institutions are active and proactively effective in measuring their own performance. The Quality Systems Assessment Program developed by the CEC is a program that enables each area to self-lodge predetermined evidence on safety and quality processes. They do that each year. There will be three levels of reporting: firstly, at an area health service level; secondly, at an institutional or clinical stream level; and ultimately at a departmental or clinical unit level, such as the department that I managed at Prince Alfred. This process will complement the national accreditation processes that are already in place. The first of these levels is undergoing pilot for testing as we speak in three area health services and the preliminary data shows it to be an extremely efficient measure of system compliance. It has also showed areas of improvement.

ACTING CHAIR: Excuse me, Professor Hughes, is there much more?

Professor HUGHES: No. I am almost finished, Madam Acting Chair. The tenders for the other two levels have just closed and are under review at the moment. The other three areas for the CEC, which I will list without detailing, are organisational development and education—and we are embarking on a clinical leadership program for all clinicians, no matter who they might be. We are also developing programs around communication for clinical care and communication for patient handover—issues that we found came out of the RCA analysis. The second portfolio is information management, including the management of deaths associated with surgery and with anaesthesia, which has been spectacularly successful over the past 25 years in changing clinical practice. Finally, there is clinical practice improvement, where the CEC, with its resources, works with clinicians in the workplace on projects such as hand hygiene, the appropriate and safe use of blood, supervision for junior medical and nursing staff, and the children's emergency care project, which is also detailed in the information that I will provide.

The role of the CEC is like a torch, which lights the path towards better quality of care and makes the journey safer for both patients and staff alike. It is important that we ensure that the twin batteries of accountability and a secure environment to discuss and learn are not removed. The light must remain focused on the path ahead and on our own feet. It should not be focused on the face of the trekkers where it may only blind the walker and put him or her and those who follow in jeopardy. My first clinical steps were frightening. There were adverse events, but my last were successful because I had continued to learn during the 7,000 cases I had the opportunity to perform. I am now simply a guide for those who follow the path ahead. It is a long journey. I look forward to the challenge.

The Hon. ROBYN PARKER: I seek some clarification on reportable incidents and the IIMS summaries mentioned in the opening statement. Can you tell the Committee what advice you received about making information privileged in terms of recent events in applications under the Freedom of Information Act?

Ms KRUK: As I indicated in my opening address, the issue of privilege is not a new one. When we were rolling out through the State the IIM system and when discussions were underway with clinicians right throughout the State, their major concern was that their engagement in this

exercise—and this is clinicians at all levels—would, in effect, at some stage be subject to abuse, misuse, and I think those concerns are picked up in the UMP submission and also in the AMA submission. As Professor Hughes has indicated, a system of this type totally relies on voluntary reporting in those areas and the involvement of clinicians in the review process to ascertain where we have to actually change some of the settings.

The issue of privilege is not a new one. The very concerns by clinicians was that their involvement would actually be jeopardised through the misuse of that information so the privilege that has been extended to the Reportable Incident Review Committee is the same privilege that has applied to existing committees for over 25 years.

The Hon. ROBYN PARKER: What advice did you receive relating to that?

Ms KRUK: I am unsure of the meaning of your question.

The Hon. ROBYN PARKER: Was that information only made privileged after the Opposition requested information under the Freedom of Information Act?

Ms KRUK: It is worth probably going back. When we set of the system in place I had a meeting with the Ombudsman to look at the appropriate controls that should be in place surrounding reportable incident briefs but arguably more importantly about reporting generally. The Ombudsman, I was very pleased to indicate, was supportive of the need firstly to undertake a statewide consistent approach to the collection of data and secondly to ensure that appropriate protections were put in place in relation to this data when it was compiled to enable, in effect, improvements in the health system to take place.

The issue of privilege is one that has been considered for some period of time. I think members are aware when privilege was actually extended. I can find that date out; I do not have that date in my papers. We have received FOI requests in relation to the question of privilege that has caused unease across the health system. I think Professor Hughes has made some commentary in that regard. I similarly received representations from a number of the colleges. It is a matter of concern obviously to all parties involved in open and transparent reporting. I stress again—and I think Ms Parker you ought to know that—that the question of privilege and protection of this information is not a new one and has been supported by health Ministers of both parties for over 25 years.

The Hon. ROBYN PARKER: I am aware of that but was this committee established under privilege?

Ms KRUK: This committee actually went back to 2003 and was an internal quality review committee. What was clear with the changes that we introduced across the State with the rollover of the IIM system was that we needed to look at the functions of that committee. Those changes to the role of that committee were undertaken in 2004. I am quite happy to give you those exact dates. I consider it to be success. As I indicated when I appeared before you, one of the success measures of this system would be increase in the number of reports made. What was clear with the number of reports that were being made through the health system was that we needed a well established, well run clearinghouse within NSW Health to ensure that all the SAC 1s were sent to an appropriate point for the action and that there was a mechanism in place to ensure the follow-up of action in that regard. The Reportable Incident Review Committee has been in place for over two years. The extension of privilege occurred in the last few months. I am quite happy to give you the date, but I would have to take that on notice.

The Hon. ROBYN PARKER: My information is that there was a freedom of information request on 31 May—

The Hon. CHRISTINE ROBERTSON: Point of order: These questions are outside the terms of reference of this inquiry, which relates to the implementation of the recommendations from the original inquiry of General Purpose Standing Committee No. 2 in relation to clinical quality.

The Hon. ROBYN PARKER: To the point of order: These issues were raised in the opening statement of Ms Kruk and are relevant to the inquiry and the terms of reference.

The Hon. CHRISTINE ROBERTSON: Further to the point of order: The member's questions seek to obtain detailed information about specific incidents. They are politically based questions that bear no relationship to this inquiry.

The Hon. ROBYN PARKER: Further to the point of order: My questions relate directly to Ms Kruk's opening statement, which was about reportable incidents and privilege being extended. They are certainly relevant to the terms of reference of this inquiry. Reportable incidents relate to clinical excellence and governance.

ACTING CHAIR: I rule that the questions are relevant. They follow on from the opening statement and therefore I rule that they are in order.

Ms KRUK: Can I just add that we have, in the past few years, received other freedom of information requests for data of this type. As I indicated, the Ombudsman has, in personal discussions with me, been very supportive of the need to protect the integrity of the system to ensure that we have the continuing engagement of the clinicians. He made that comment on the clear understanding that we would publicly report, which we have done; we have done that twice. He also made that statement in clear understanding that the patient, the one where the focus should be and where the focus will remain, has total access to the outcome of any RCA.

That is arguably the most important part of the equation, from a health practitioner, from the person who holds the accountability in this regard. It is important that I have a system that can actually look on a statewide basis where our risks and vulnerabilities are, where I can actually establish on the basis of data, rather than individuals putting their hands up and saying, "I believe there is a problem here; would you please help me", to have a database that actually says: these are the areas where a statewide approach is required. We have, I believe, very strong arrangements in place to deal with medical negligence or misconduct. That is a totally other domain and I am prepared to touch on that.

The IIM system and the reportable incident briefing system [RIBS] is a system that ensures when there is a problem that has more than one incident behind it, in other words, statewide relevance, that action occurs. This is an issue that your Committee raised with me last time. You quite legitimately said, "Robyn, how do you ensure that if there is an issue where there is a piece of equipment that should not be used on a statewide basis, where it is shown with one event there is a problem, how do you ensure that the rest of the health system can actually pick up that learning?" The RIB system does that. It does it in an incredibly timely manner, and I will put it on the record, that I find it incredibly distressing that something which should enjoy bipartisan support, something which is an initiative that has been well established and recognised to be the part of a good policy response to quality and safety, becomes the subject of political debate and media game playing. I am sorry to speak like that with passion but I actually think it is inconsistent with the terms of reference of this Committee. Your committee is looking quite clearly at what needs to be done to improve quality, safety and learning across the health system. I am sorry, I have had my moment's passion.

The Hon. ROBYN PARKER: Just to clarify, you are taking it on notice?

Ms KRUK: I will find the exact dates for you. I think you heard my response about the fact we have had—

The Hon. ROBYN PARKER: It was, in fact, privilege extended on 28 July. Would you be able to confirm that date?

Ms KRUK: I will confirm that.

The Hon. ROBYN PARKER: You are aware that freedom of information requests, the most recent one we are talking about, requested that names of patients and clinicians be deleted, so there was no attempt to identify particular people, is that correct?

Ms KRUK: I understand, and it is not as simple as blacking out a name. It goes back to what sits at the heart of the preparedness of a clinician to actually actively participate in this, and I may ask

Professor Hughes to comment. There is an issue of individual patient privacy, which I think is quite critical, but there is also the preparedness of an individual to put their hand up and say, "Look I have concern about what has happened here" and they have concern about the conduct of a colleague or a particular piece of equipment.

The very encouraging thing about the IIM system so far is that individuals have not felt the need to do that anonymously. The trust in the system is quite significant. I think the UMP in their paper to this inquiry makes it quite clear. And I might actually just take the liberty of quoting one of their comments.

> Protection in this context does not imply protection from appropriate accountability. Rather, it involves protection from unfair process, denial of natural justice, premature personal consent and criticism, trial by media and scapegoating. Inevitably—

And I should not say "inevitably" because it is not in all instances; "In some instances"—

> where there is an adverse event the immediate call by the media and some political parties are to call for the sacking of individuals involved.

The protection of privilege in this regard seeks to ensure that natural justice is actually applied and a proper investigation can actually occur, but at its heart it has to do with the openness of the process, the trust in the process. It does not in any way offset the need for the patient who is involved being given the full account of what actually happens. Can I ask Professor Hughes to comment because, as a clinician, he will have experienced this?

ACTING CHAIR: Briefly, if possible.

Professor HUGHES: I have worked on privilege committees now for most of my practising life, firstly with the Anaesthetic Committee and then with the special committee investigating deaths associated with surgery. The Anaesthetic Committee, which has been functioning for over 25 years now, is without doubt the first of its type around the world and has made significant changes to practice and the safety of anaesthesia across this country and it has been based here in New South Wales. Dr Ross Holland established that committee. It is not a secret committee, it is a privileged committee and it acts just as a jury does, to discuss the evidence that is given to it in a privileged form in great detail.

Believe me, the robust discussions in those juries of peers are enormous and it is combative at times, but it produces the sort of report—this is in your tabled documents at Tab 12—that is a guide at the end of the day on the lessons learned by that jury of peers. This is the value of these committees. These discussions would not be possible without the protection of privilege to a very small part of the process. The CEC is totally committed to public reporting of documents such as this, of the total documentation of IIMS data across the system, but we need to have the jury of peers to guide us on the appropriate path for effective, corrective action to change, as with anaesthesia, from—to use an industrial term—2 sigma, which is not very good, to 6 sigma, which is the best industrial standard the safety and quality we can achieve.

The Hon. ROBYN PARKER: In terms of the reporting of information, you said that that is annually. When is that reported?

Ms KRUK: Currently we report on an annual basis. There are regular communications between the Clinical Excellence Commission and the area health service as well. What is important—and I am speaking from a non-clinical basis; I am sure Professor McGrath and Professor Hughes will add to that—is that it gives you the opportunity to look at trends. It gives you the opportunity to get a very detailed picture of where major vulnerabilities are on a systemwide basis. So the capture of that data but the response to that data is quite clinical. Professor McGrath's domain of responsibility includes the reportable incident committee.

Professor McGRATH: There have been two annual reports now of the SAC1 events across New South Wales Health. I would have to get the exact months in which they were done, but the last one was published late last year and the previous one early in 2005. We are in the process of preparing the report for 2006. It has been considered in discussions with the Ombudsman, to which the Director General referred, about the issue of release of individual events. The Ombudsman was very happy

with the approach of protecting individual events provided there was public disclosure. So that report has been published annually, and it has usually been put into the public domain with a media launch, presented by the Minister in each of those reports. So it has been a very public event, and those reports are widely available.

The Hon. ROBYN PARKER: And the next one will be when?

Professor McGRATH: We expect that probably in about October.

Ms KRUK: Before the end of the year.

The Hon. ROBYN PARKER: Would it not be better to report more frequently than once a year?

ACTING CHAIR: Perhaps you might take that on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ms Kruk, your opening statement, which was about half an hour long, was all very laudable, but I want to know where the people who blew the whistle are now. Can you give us a rundown of the people who gave evidence in the Campbelltown inquiry, for example? Where are they now? How many of them are working in the health system? I gather that none of the nurses is and some of the doctors have left as well. Is that right?

Ms KRUK: I will have to take the more detailed part of where the parties are up to in the system on notice. I think a number are employed within the health system. They sought reemployment successfully within the health system. I am unsure about the medical practitioners. It is best that I take it on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you give us a list of the people who gave evidence in the last inquiry, what they are doing now, and how many of them are in the health system?

Ms KRUK: What their current status is—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And what they are doing now.

Ms KRUK: I am happy to do that. I can confirm that I am certainly aware that two are still employed in the health system. Of the medical practitioners, I am unsure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are a number of people and you will come back to me with a list.

Ms KRUK: Yes I will.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Of the people who were whistleblowers generally within the health system, I suppose that is defined as people who have made a protected disclosure and requested support from the Protected Disclosures Act. Do you have a list of them and what has happened to them? From the whistleblowers lobby group, it would suggest that if you make a decent disclosure you are in big trouble. Certainly, people have come to me prior to this hearing with information that I could use if I were minded to and said, "for God's sake, don't say this for X time because I am worried about something else". So there is still a lot of lack of confidence out there that they can make a disclosure and not be penalised. Coming back to my question, can you give me a list of the people who have made protected disclosures and where they are now?

Ms KRUK: I think that may be a problem in terms of their own privacy. I certainly would not maintain a list of protected disclosures. You will recall that Mr Walker, in his recommendations, suggested strengthening the provisions ensuring protection for protected disclosures and those amendments were made. Can I go back to what the IIM system data is? It actually allows someone to anonymously put forward a complaint. The encouraging thing was that I think the bulk of parties—

and I might ask Professor Hughes to comment—did not feel the need to do so anonymously but they certainly have the opportunity to do so. They can do it online. Arguably, it is—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But with respect—

Ms KRUK: Can I have a chance to finish?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have had a long time.

Ms KRUK: Arguably, if you are going to ask the question, I need the time. The issue is that they have other avenues that they can actually now raise concerns, as Professor Hughes said, other than putting their hand up or doing it at some fear of retribution. So the avenues are there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The point is that a lot of complainants, if they were to do it anonymously, have the problem that only three or four people would know about that case. And if you looked at those three or four people only probably one would be distressed about what happened. Therefore, they are pretty easily identified. So how useful anonymity is is another question. Coming to your other point about the privacy of whistleblowers, it is all very well to say, "We can't give you the name of whistleblowers because that would blow their cover", but if they have all had their careers damaged and now they are all quietly sitting secretly having their privacy protected, where collectively they have all had a pretty bad deal, all these fine words do not add up to much. Certainly, the whistleblowers association is saying, "Look, you make a proper disclosure and you are in big trouble". That is what they are saying to me.

Ms KRUK: The issue is that they have avenues through the IIM system to make an anonymous complaint. I go back to my earlier comments in response to the Hon. Robyn Parker's question; if that information is misused for whatever purpose and their identity becomes known through that process, they have very little reason to have confidence in the ability to report and not get some retribution, particularly when you have calls for sacking for some parties in the media. The IIM system is an avenue for people to raise those concerns without the retribution fears that they may have had previously.

Professor HUGHES: I think the issues here are important to understand. Firstly, you used the word "complaints". Complaints are a very small percentage of the incidents that we receive in IIMS. We know from the Commonwealth of Pennsylvania, for instance, with a similar sort of program about as old as ours, that less than 15 per cent of the incidents are associated with a complaint. So to rely on complaints will not allow us to make significant systems improvement.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean complaints from patients or relatives. I am talking about using the "complaint" word generically for anybody who says, "This is a suboptimal process or outcome"—in a sense, someone reporting something. I have used the word generically. I think when you say "complaint" you mean a patient or relative complaint.

Professor HUGHES: That is a report that comes through to the incident information management system, that is correct, and that is a much greater area. Staff are given the opportunity to do that anonymously. I cannot give the exact figure off the top of my head but a very large percentage are happy to have their name attached to the report because they believe that the system will act. The reportable incident review committee must act within a given timeframe of receiving that report and to make the processes within the department work so that we are driving system change quickly. We do not want to wait two, three or four years for other processes to come with a legislative or a coronial or some other inquiry to tell us where the changes should have been made when the jury of peers can make a rapid assessment and introduce particularly statewide or systemwide changes to improve quality. That is my passion for getting this information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that peer review sufficiently distanced from the thing? Obviously, if someone is complaining about the process in a small surgical department, the peers are presumably the other surgeons or the other people involved in the process that is being reported or complained about.

Professor McGRATH: Can I raise an issue here, because there is part of our policy that is important and critical to what you are talking about and that is the role of the senior complaints officer? Very specifically out of the findings of the Campbelltown and Camden inquiry was this issue that you raised: How are people who have a problem that they are fearful of raising protected in the process? The creation of the senior complaints officer was a very clear requirement—I think it was raised in the Walker inquiry, but I might be wrong about that. The need for a senior person to whom a staff member, a patient or their relative could go in complete anonymity and be assured that the problem would be addressed and their own interests protected was a very clear requirement of the outcome of that previous inquiry. That is now in place in every area health service and our policy includes making sure that that role and that facility is available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Professor Hughes, have you had any complaints or notifications about a private hospital in the Lismore area?

Professor HUGHES: I will have to take that on notice. We do not look at individual cases; we look at the sum total analysis. If it was a SAC1 event that would be managed by the department immediately, according to the usual processes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that means that you would not be notified unless the department notified you?

Professor HUGHES: No. We receive the report of the incident review committee on the aggregate data that they look at and the recommendations from the root cause analyses that are conducted and we analyse the recommendations and provide, as we have done in the data that we published two weeks ago, learnings for the system from that data. If I could just return to the issue of distance, to respond to the Hon. Dr Arthur Chesterfield-Evans' earlier question, the answer is that there is significant distance between each of the committees with privilege and those commissions that are involved in cases. The surgical community is a relatively small community, but in that committee and in the anaesthetic committee, if a member of the committee was aware of or involved in the particular hospital from which an incident came, he or she would be excused from the process around that particular case discussion.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For example, if there was suboptimal management and it was reported in a private hospital, would it need aggregate data or something from another report to get you aware of it?

Ms KRUK: I think you would be aware of the fact that Minister Hatzistergos has foreshadowed that he will be introducing legislative amendment to the private hospitals legislation. Previously it has only been the case that these provisions apply to the public health system. He has arguably asked the question, and also discussed it with the private hospital sector that it is sensible that similar provisions apply to private hospitals. So he will be introducing legislation to ensure that that occurs. The private hospital sector has received that in a supportive manner. A number of them are already involved in the incident reporting system, but it will ensure that both public and private hospitals are dealt with in a similar manner.

Professor McGRATH: Just to clarify the detail of how our processes work, the individual events such as the SAC1s come through the department. The CEC's role is to look at aggregate data, the individual incidents, the department's role. In relation to private hospitals, if they report that through and they are encouraged at the moment until they are required under legislation through the process Ms Kruk just referred to, a number of them currently voluntarily report those to us. They come through the private hospital branch, and the private hospital branch has the ability to go in and do an investigation within a private hospital. That has happened on a number of occasions based on information coming through. If it is a question of clinical practice and the private hospital or a complainant is aware, that then would be an issue referred to the HCCC for review by the appropriate registration board. So those mechanisms are available now. The new proposals will greatly strengthen that process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the Government contracts out its delivery of a certain specific specialist service to a private hospital and there is a problem, currently

that might or might not be noticed by the public hospital system that contracted to them and if he is noticed it would not necessarily be reported to Professor Hughes, is that right?

Professor McGRATH: No. I am probably familiar with the circumstances that you are referring to in Lismore. The issue there is that if these are public patients the responsible authority remains the area health service for the management of those patients. Any complaints with the provision of services by a private provider in relation to public patients should be made and would be made to the area health service, and it is required to ensure that the quality is appropriate and to undertake any investigation or refer to the appropriate authorities that can undertake an investigation should there be concerns raised.

There have been concerns raised at Lismore about some patients, about the process of awarding contracts under the private provider surgical process in Lismore. I think the area health service has undertaken a full investigation of that and I think there is some commercial competition in complainants related to that, underpin the nature of those, but if those are public patients the complaint would come through to the department. Individual complaints do not go to the CEC; individual complaints, specific events, come through the RIBS to the department. Or, if there is a particular complaint then they come through the department's responsibility to investigate and make sure those investigations occur appropriately around individual events. The CEC's role is to look at the aggregated data and trends and advise on strategies to address emerging trends of causes of adverse events.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that the complaints in Lismore were commercially motivated rather than clinically genuine?

Professor McGRATH: I do not want to go into the specific details of that but if it is the case you are referring to, they were fully investigated and there was no cause found for the complaints about which the concerns were raised. There was no clinical basis for the concerns raised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was another incident in Wollongong with regard to pain management where there was what would appear to have been a fairly simple clinical error which was then investigated and the investigation would seem not to have been at arm's length. So while it would seem that acknowledging the mistake and an apology might have been sufficient, in fact, it became highly investigated and highly abstruse—unclear. If you are not aware of that case perhaps you could take it on notice.

Ms KRUK: I am happy to take that case on notice with the cautions I mentioned earlier. If you could give me the details I would be happy to look at that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are doctors not able to apologise in a frank manner to patients without enduring legal liability? Because it seems that what the patients most want is an apology and what the lawyers are least willing to let the doctors give is an apology. So in all this process has that simple human factor been addressed and solved?

Ms KRUK: That is probably at the heart of a great number of complaints. Our policy, the open disclosure policy, which you are probably familiar with, explicitly acknowledges the need to apologise to recognise the individual circumstances. That apology, and I am sure Professor Hughes could add to this, does not mean that you have to accept a liability, and there have been provisions to make that quite clear. I think Professor Hughes would have struck that in his own clinical career, and, personally, from my own experience with families that have experienced some distress, that is quite critical in the resolution of a matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it usually implies, "I have made a mistake and I will apologise". You do not apologise if you have not made a mistake. So, in a sense, the lawyers are right to the extent that the admission of error by somebody or something is implicit before the apology was necessary.

Professor HUGHES: If I may answer that? As a practising clinician for 25 years with lots of adverse events over the years—I hasten to say well within the benchmark for my specialty—if I may be permitted a very personal anecdote: the first patient I operated on as a consultant died two hours

after a very successful, very simple heart operation. It was devastating. About two years later we had 11 patients in our unit who were given a contaminated solution that we inject into the heart to stop it while we operate. Five of those patients were to go on and to die. There was an error somewhere in the system; but it was never discovered, despite the coronial inquiries.

But long before we knew what had happened, one of my senior colleagues called all the families together and he and I sat down with the 11 families and said, "This is a terrible thing that has happened. It is awful. We are truly sorry that this has happened. We are not going to do another operation until we have got these patients out of the woods". And we did not. We said, "We are going to leave no stone unturned until we find out what the cause was". We knew it was an infection; we knew it had occurred somewhere in the processing of that solution, which was beyond our control as individual clinicians. But we said sorry. None of those patients took legal action.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the question is can you make a generic policy about this?

Professor HUGHES: Let me explain the reasons we do have a generic policy. Not only did none of those patients take legal action, but two of them came back to the same hospital and the same surgeons to have repeat surgery many years later because they had confidence that the clinicians were actually on their side and were empathic with them. And, surely, in this day and age we can allow our clinicians to be empathic with the people that, after all, they went to work to help. The open disclosure policy that has been developed after a lot of discussion across the system is an effective way of empowering clinicians who are worried that something went wrong.

That first patient of mine, until I actually saw the pathology report—and it took several months for the coroner to release it and show that my grafts were actually working—I felt awful. But we were actually able to get alongside families and say, " We are on your side. We can move forward together and find the answers and change the system", and the open disclosure policy is a first in this country. It has been discussed nationally now for many, many years but New South Wales is actually doing it across the system with the support of our colleagues from the legal fraternity, the medical defence organisations.

The Hon. AMANDA FAZIO: Professor Hughes, what initiatives have the CEC and NSW Health undertaken to improve medication and safety in New South Wales' public hospitals?

Professor HUGHES: The CEC has looked at the IIMS data and recognised that medication safety is the number-two issue that is raised from our reporting system. We have worked with the New South Wales Therapeutic Advisory Group [TAG] to develop a number of indicators of pharmaceutical management, that is, the management of medication throughout the system. We have been doing some work with a group from Canada known as ISMP to develop some indicators of where errors occur in the distribution of medication across the system. We have worked with the TAG to develop other indicators of safety, including a medication safety self-assessment tool and a medication safety self-assessment for antithrombotic therapy—that is actually the management of one of our more frightening complications when a patient develops a clot in the leg or the lung and it can be catastrophically fatal—to ensure that our patients are getting the best management of those issues with the drugs that are given.

We are currently talking to the quality and safety branch about doing a process of pharmaceutical review in all high-risk patients with medications; that is, the elderly, those that are taking five or more medications, those that do not have carers, to make sure that the medication that they go home on is the most appropriate for their safety. This is a very extensive program; it has been well funded by the Government and is now coming to fruition, and we believe there will be an online measurement of indicators for each hospital to understand how well they are managing medications very shortly.

The Hon. CHRISTINE ROBERTSON: In the patients' safety and quality reports released by NSW Health falls are identified as one of the major contributing factors to serious adverse events occurring in the New South Wales' public hospital system. What is NSW Health doing to try to reduce the number of falls and harm caused by falls, particularly to older persons?

Professor HUGHES: Falls are not only a problem in hospitals, they are one of our biggest problems in the community, particularly with the ageing of the population, and they are going to consume enormous amount of resources. It is therefore pleasing to note that the Minister announced in 2004 an $8.5 million program for a falls policy over four years in New South Wales. This is the only State in Australia that has a statewide falls program. The falls program co-ordinator is based in the CEC and the CEC is funding in each area health service an individual falls project officer who is working with the community and the staff to develop new ways of managing the elderly, who are most likely to fall. We are also working with the community on projects around safe pathways, safe steps and the like; on programs to ensure flexibility, stability and balance in the elderly, which are the commonest risks for falls in the community.

If I may again be permitted a brief anecdote. In one of my visits to a rural centre last year, shortly after I started the job, I came across a unit who had recognised that this was a problem in their own area. They had vinyl floors; it was a cold country area; the farmers' wives used to knit bedsocks. They had a process for giving fluid tablets late afternoon. They also did their handover round at the end of a normal shift at 10 o'clock at night. So at about 10 o'clock at night the fluid tablets were working. The farmers' wives were not going to bother those very busy nurses who were doing something over there with all the charts—the handover round. And they had a very high incidence of falls. So the staff themselves did some very simple things: they changed the timing of the fluid tablets to the morning; they removed bedsocks; they also got rid of talcum powder from the floor, from the wards—that is, the whole ward, not just the floor where they spilt it; and they did their ward rounds at night by the patient's bedside for handover. They reduced the incidence of falls in that ward by 75 per cent.

It is our task to roll out those messages to all the other wards in the system. This is part of the $8.5 million program that we are developing. And, as we speak, my project officer has just been to Coffs Harbour and to Broken Hill to work with local teams to manage falls not only in hospitals but also in the community.

Ms KRUK: Were it not for the IIMS system we would not know that falls, which anecdotally you may believe to be important, were important as we have actually found them to be. The issue is the solutions will vary on a site-by-site location. I think that is a particularly good example where the staff themselves, as soon as they see the data, can actually do something to rectify it by such a simple change in practice. In other areas it may require physical modification, but it is one of the top five things that we recognise across the State that we have to take proactive action on and we will get a significant increase in relation to quality and safety across the health system as a whole.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could you please send me the details of that wonderful program?

Ms KRUK: Yes.

The Hon. HENRY TSANG: Professor Hughes, you mentioned your first operation and the infection. There is increasing concern about hospital-acquired infections. What is the CEC doing to promote programs that assist with the reduction of hospital-acquired infections?

Professor HUGHES: I think we all recognise that for as long as there has been health care there has been a battle with the organisms that cause infection. And when people come into the complex environment that health care facilities are, there is a concentration of bacteria or bugs that can cause infection. Therefore, we have to have particularly strong programs around hygiene to control this continuing battle, particularly as we have trouble staying ahead of the bugs themselves; they develop resistance to antibiotics very, very quickly, particularly the group known as multi-resistant organisms [MROs], one of which is golden staph you hear about, which particularly develops resistance and is then known as a multi-resistant staphylococcus aureus [MRSA].

The CEC has set aside a significant budget to address this problem at its very root. One hundred and fifty years ago Florence Nightingale told us that washing hands was likely to change infection in the soldiers coming back for amputation from the field. She did not know about bugs at that stage but she did know that when hygiene was at its best infection was at its lowest. We have taken exactly that program and looked at the current science around hand hygiene as one particular

example. We used to learn to wash our hands for 20 minutes when I first started in surgery. Then we got new soaps and we reduced that to five or 10 minutes. But now we actually have alcohol-based solutions, which, when they are simply sprayed on or wiped on to the hand, we get a 90 per cent-plus kill of the organisms that are likely to transmit infection. The hand hygiene program that we have rolled out across the State since January this year—in fact, a bit before that—aims to put these alcohol solutions by every patient's bed: they are near patient alcohol solutions so that all staff can use them between every single patient visit.

Not only are we doing that, but we are also measuring the effectiveness of the campaign. We are measuring how often clinical staff use the alcohol wipes to improve hygiene, and we believe it will be significantly better than it was with the basin, which was usually down the corridor, a long way away, it was messy, and it was not used appropriately. This is a staff education exercise, and we are doing some evaluation around that. As part of that program, we are putting posters in every public hospital across the State. In the package are some of the posters we are using. Some have some humourous intent, deliberately, to engage the young staff—medical, nursing, physiotherapists and others—in the program. They will rotate by a talking wall phenomenon around hospitals across the State for the rest of the year. We have also put a hand hygiene project officer to work with other programs in infection control deliberately to improve hand hygiene, and to help us try to win this battle, which is going to go on for as long as we continue to invade people in our hospitals with invasive procedures.

The Hon. CHRISTINE ROBERTSON: In your opening statement you mentioned that the department had established a corporate governance and risk management branch. Would you tell the Committee what it is doing to improve quality and safety in the health system?

Ms KRUK: I touched on that in my opening statement. If a coroner makes a recommendation about a particular case that has ramifications beyond that case, it is important to have a mechanism, and I think your Committee picked on that issue when I appeared before you a few years ago, to ensure that there is an appropriate system-wide response. The governance branch, as we have termed it, is literally responsible for looking at reports that come from the Coroner, the Health Care Complaints Commission [HCCC]—to ensure there is that system-wide response—the Ombudsman, the ICAC, or various other regulatory oversight structures. It is the mechanism to ensure that individual recommendations are given consideration on a broader statewide basis to make that judgment where we need to ensure that a health alert is issued in relation to a particular piece of equipment, whether changes need to be made in the training curricula for clinicians, which is an issue that the Coroner has made recommendations on in the last few months, or where there are clear concerns that extend beyond a particular individual patient occasion of care.

This was an issue that Bret Walker successfully picked up in his inquiry as being important. The governance unit is another part of that platform of ensuring that there is a system-wide response and those learnings actually extend beyond one particular occasion of care. That has facilitated very close contact between the Department of Health and the HCCC on a quarterly basis. There were issues between the two structures prior to this time. It ensures a very regular communication with our office and with the Coroner. Obviously, the Coroner is involved in a number of events that impact with the health system. It enables the development of good, timely policy on matters that the Coroner is also involved in. It is a new function. It is a function that we have built up in the last couple of years, and it is another important plank in our response to quality and safety.

The Hon. AMANDA FAZIO: You will probably have to take this question on notice, but I want to ask you about the percentage of people whose interaction with New South Wales Health is less than satisfactory. These inquiries tend to ignore the fact that the vast majority of people who go into hospitals or community health centres in New South Wales are quite pleased with their treatment and the outcomes. I have two elderly relatives who have had major surgery in New South Wales public hospitals in the last six months. They are quite happy and very pleased with the outcomes of their surgeries. If we could get that type of information it might assist us to put into perspective the general outcomes of people who go into the New South Wales public health system.

Ms KRUK: I will certainly take it on notice. We were talking about that on the way in. Obviously, our complaints system is focused on matters of concern where things are not optimum. One of the clinicians commented to me this morning that we should equally capture compliments

because, in his experience, the compliments well and truly outweigh the complaints that were raised in an area health service. It is valid feedback, because we have focused on areas of operability to pick up any system-wide learning. That has been our focus. The significant initiative that is planned and is already under way in some area health services, but one where a statewide approach is sensible, is to annually look at satisfaction with our services on a statewide basis. The number of area health services, and certainly the Ambulance Service undertakes these on an annual basis.

The satisfaction ratings are always well into the nineties. We need a consistent measure on a statewide basis to capture that and to give recognition where recognition is due. In the last couple of weeks I have been involved in consultation on the State Plan with Ministers from the Cabinet. Your experience is as mine, I would come back to New South Wales for surgery if I were overseas, and I am a person who, on a daily basis, sees all the security assessment code one incidents. In many ways we totally under sell the strength and quality of our health system. But that in no way takes away our responsibility when adverse events occur to ensure that we deal with them and that we pick up any learnings on a system-wide basis. I will do what I can in collecting the data that you seek.

ACTING CHAIR: I thank you and your staff for appearing and giving evidence before the Committee. You have taken a number of questions on notice. I have a further eight questions that I would like you to take on notice, and it is possible that members of the Committee will also have additional questions. We would be pleased if you could return answers to the committee within 28 days of your receiving the questions.

Ms KRUK: I have 610 questions following on from the estimates hearing. But I will make every effort. I also put the offer on the table that if there are issues raised in the submissions that your Committee receives, I am happy to include a response to those. Obviously, a number of matters are of great relevance to the operation of the quality and safety systems. Yes, I will endeavour to respond in those timeframes. Thank you for the opportunity to provide an opening address. It was important to address some of the issues that I raised in our submission that may have been overtaken.

(The witnesses withdrew)

(Luncheon adjournment)

ALLEN ROBERT THOMAS, Director, Medico-legal, Strategic Policy and Training, Australian Medical Association (NSW), and

SCOTT STEWART CHAPMAN, Lawyer, Tresscox Lawyers, Legal Advisor to the Australian Medical Association (NSW), sworn and examined:

ACTING CHAIR: Are you conversant with the terms of reference of the inquiry?

BOTH WITNESSES: Yes.

ACTING CHAIR: Do either of you have an opening statement?

Mr THOMAS: Yes. I last appeared before the Committee on 24 March 2004 representing the Australian Medical Association (NSW). Our submission and my evidence on that occasion went to matters of principle rather than specifics. We reflected concerns on that occasion that not enough was being done to address risk management and quality assurance, which we believe can only begin with a strong, if not total, commitment to incident reporting in the New South Wales public health system. I am pleased to indicate in my evidence today that a major step has been taken by New South Wales Health and the Government by addressing concerns the subject of my previous attendance. The AMA submission on this occasion takes, with the assistance of our external legal advisers, a more forensic overview of the past 30-odd months since I last appeared.

In essence, we had concerns relating to what we see as gaps in privilege for doctors participating in the RCA processes and certain relevant definitions that arise under policy directions of New South Wales Health and the legal status of those policies. We are concerned as to whether there is a natural justice environment within RCA processes. Importantly, we have anecdotal advice there is little if any evidence of feedback to clinicians of outcomes and the implementation of recommendations that flow from the RCA process.

Our submission goes in some detail to these concerns and on this occasion lastly touches upon referrals of medical practitioners to the Medical Board that might arise from the RCA investigation and the level of representation available in those circumstances. What we seek now, as much as we are able to influence this Committee and the Government, is more clarity and certainty to enable the advice that we give to our members to be appropriate within RCA processes and in the event that they are referred from that process to disciplinary tribunals. Thank you.

ACTING CHAIR: Mr Chapman?

Mr CHAPMAN: No, thank you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If someone were unhappy with the doctor and simply sued them, which is the normal legal model, would all this procedure and open disclosure help or would it merely make it easier for a plaintiff lawyer?

Mr THOMAS: I think I need to address that, as the principal that we flow from in this is to make a better health system for the community. As to whether open disclosure would make it easier for a legal process of reckless indifference or negligence to be sustained, I really do not know. But certainly it would make information available to plaintiff lawyers a lot more openly than we understand it even with the reservations we have, much more open than what we understand the RCA process is now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why I asked the question is, the concept of open disclosure and the concept of adversarial justice are opposites. If you have the Health Department by policies working at one model and the legal system working at the other, you really have the horse going in two different directions at once, have you not?

Mr THOMAS: What we are attempting to do is limit the exposure not only of medical practitioners but also allied health personnel to a process that would automatically launch them into an adversarial system of tort or whatever with a view to ensuring that any mistakes that are made or

improvements in the system that can be made should be contained within a process that does not allow an adversarial process to commence before those outcomes are available. What we are saying is that privilege does not mean no accountability. If reckless indifference or negligence or—Heaven help us—criminality, is found to have occurred in the delivery of health services, there are processes by which the doctor would still be dealt with by both, I believe, common law and the disciplinary provisions that arise under the Medical Practice Act and also the Health Care Complaints Act.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your submission, or the one Tresscox has written on the AMA's behalf, you have more or less said the policy is all very well but you want some changes to the Medical Practice Act.

Mr THOMAS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that more or less asking for immunity from prosecution if the doctor fesses up or makes a complaint or indicates a problem or in some way implicates himself or herself or the system in which he works?

Mr THOMAS: Certainly not. The process under the Medical Practice Act would be a disciplinary process that would have outcomes for the doctor but certainly would not prohibit further common law action by a patient who felt they had a poor outcome or were aggrieved by whatever health services a doctor applied. They can run in parallel.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you not trying to have your cake and eat it, though? If there is an internal process that leads to a corrective action taken within the profession—let us assume it is not criminal, it is a mistake of judgment or a poor interaction between a number of people within the system, system failures—obviously some action is taken within the system to correct that: education, better mentoring, whatever it may be. That is fine, but if you then let the lawyers have a bash as well, are you not trying to ride the two horses going in two different directions?

Mr THOMAS: That is what the process is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is what it currently is.

Mr THOMAS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But we are here to decide what it might be, not what it is, and the AMA's position is in the interest of doctors.

Mr THOMAS: It is in the interests of the community as well. We believe that the process we have outlined here is for the betterment of the community and certainly for the education of doctors as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not want to go into the difference between the AMA's interest in patients and interest in doctors. I want to get the AMA's position on torts. Some people, probably including myself, think there should be a no fault system and that the disciplinary procedures should be in house—rather than have the threat of adversarial litigation hanging over a doctor's head—within the policy and procedures of the Health department.

Mr THOMAS: Certainly a no fault system removes the lottery that a lot of litigants may not be able to address because of lack of funds, or whatever. A no fault system is certainly something that I understand has been looked at by the Motor Accidents Authority of New South Wales for catastrophic injuries. Perhaps I am not addressing the question with as much specifics as you would like.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is terribly simple. Are you in favour of no fault or not?

The Hon. CHRISTINE ROBERTSON: In terms of litigation?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. Is my question not clear?

Mr THOMAS: It is now. Certainly if there is a no fault process it would be something that the AMA would need to look at very clearly. At this moment it is not a policy.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The AMA does not have a policy in favour of no fault?

Mr THOMAS: Not at this stage, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I thought in the subtext of your submission you wanted changes in the law that reflected the open disclosure policy.

Mr THOMAS: What we want is changes in the law that protect our members from limiting themselves to participate in the process. That may be part of open disclosure and there are certainly guides about open disclosure. But in that process we have to be assured that the reservations that doctors or any other allied health professional would have in participating in an RCA process are removed to the benefit of everybody.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that not the same as I said before? If a doctor confesses and says exactly what happened and it implicates him in an error of judgment, you want a change in the law so that his statement is not used by a tort lawyer in the lottery and does not have an adverse effect on the doctor. In other words, is the doctor better off by shutting up and not letting them find out or is he better off by 'fessing up and thereby improving the system? You are talking about limiting the vulnerability of doctors who engage in an open process. Is that not really talking about immunity from prosecution, or limited or partial immunity, if a doctor participates in the open disclosure policy?

Mr THOMAS: No, I do not believe it does.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not think it is the same thing?

Mr THOMAS: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there precedents for this sort of situation in the aviation industry or other models?

Mr THOMAS: I am unaware of that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the AMA believe that the health system is looking after doctors who discuss problems within the health system?

Mr THOMAS: Certainly what has occurred over the past 30 months has been a major step forward. But as I have said, we have had our external legal advisers take a more forensic look at the legislation that embraces these processes, and they have raised issues that we now bring to the Committee in this submission as concerns.

The Hon. ROBYN PARKER: In terms of the outcome of root cause analysis, following such a process being carried out is an action taken?

Mr THOMAS: I understand that the process is that those outcomes are reported to the chief executive of the particular area health service. I indicated in my opening remarks that we have anecdotal advice that that information does not flow back to the clinicians at the coalface. That is a very general statement for me to make but it would be certainly something that we would raise with New South Wales Health to say if you are going to have these processes, hopefully for educative purposes there needs to be feedback to not only individual clinicians but area health services and hospitals to allow them to compare and contrast themselves to what is occurring in other parts of the State. We do not believe that there is enough impetus at that final end of the process now.

The Hon. ROBYN PARKER: You say they go through the process or pay lip service to going through the process and then that information is contained. What do you think is the reason the process is not going further in terms of feedback and action?

Mr THOMAS: I think a lot of it would be under the review of the chief executive of the area. All outcomes are not necessarily from RCA matters that may require action. They may require various levels of action. What we are concerned about is that there does not appear to be enough of that flowing back to the clinicians. An RCA process, by its heading, is a process arising from a very serious incident. It would be important for our members to be aware of those outcomes—whether they are systemic or resulted from poor performance of a clinician—to enable an educative process to start.

The Hon. ROBYN PARKER: That would seem to be obvious. As to the causation statements from RCAs, where is that information kept? Where can people access that information?

Mr THOMAS: I understand that it starts with the chief executive and it is at his discretion as to whether that information goes back to NSW Health. I would say that the repository for that would either be with the Clinical Excellence Commission or with a repository at NSW Health.

The Hon. ROBYN PARKER: Surely it is to benefit all concerned if that information is available, do you think?

Mr THOMAS: Yes, I do.

The Hon. ROBYN PARKER: Does that include the public as well?

Mr THOMAS: Those reports, I understand, are made available by the Government to the public and are published on a basis, I hesitate to use the word "regular", I think annually at the moment.

The Hon. ROBYN PARKER: We had previous evidence from Professor McGrath that they were producing a report annually, she did not know the date but it would be with a media presentation and package. She said she was looking for trends. Would you suggest that an annual review is sufficient to review trends or that monthly or quarterly reports would be more appropriate?

Mr THOMAS: I am certainly not a statistician, but generally my view of trends is that they need to be looked at over a period of time for a trend to be established. The shorter the period, even though there may be a movement in the trend, may be of little statistical significance. As to whether reports should be made sooner for the purposes of public knowledge, that is a matter for the Government, of course.

The Hon. ROBYN PARKER: In terms of information to your members about disciplinary processes, do you feel the actions and responsibilities of an RCA team are clear to your members?

Mr THOMAS: There are policy directives issued by NSW Health. If a member of ours is subject to or asked to be part of an RCA team, then we attempt to give them as much information as we possibly can using those policy directives as guidelines.

The Hon. CHRISTINE ROBERTSON: I know that there is an issue about feedback to clinicians. I gather it eventually gets there but it is often felt by the clinicians who have participated that it has not been timely. I do not complain about that system, but do you have any ideas about improving the process so that the clinicians, who often have been happily involved in investigating the issue, get to implement the changes required? Do you have any ideas about improving the process?

Mr THOMAS: A better process would be to have critical timelines, that is, once the report comes out there would be a timeline for making that available to the persons involved rather than perhaps a discretionary overview that can be taken by a chief executive, as occurs at the moment.

The Hon. CHRISTINE ROBERTSON: Would it be over the top for the review team—and it is not always just clinicians involved—for a formal roundtable discussion within a timeframe? Would it be a sensible proposal for it to become a permanent part of the process that the health

workers and investigating team sit around after the process is finished and go through the issues for their own environment?

Mr THOMAS: We have the reservations that I have expressed as to the process or lack of it now. I am always one on behalf of the AMA to be prepared to accept that if another process can be put in place that encourages discussion about the outcomes that would be a very helpful thing. As you have quite rightly said, an RCA process does not just involve the doctors. It can involve nurses, physiotherapists, anyone who has had involvement with the patient. If that leads to an educative process for better outcomes, then I can only see that as a good thing.

The Hon. CHRISTINE ROBERTSON: I have a perception that your criticisms will be quite useful to the inquiry, the RCA and the CEC. I am trying to project what positive recommendations might flow from them. You have picked up on the issues. Do you see what I mean?

Mr THOMAS: We are mindful of ensuring that in the process there are no gaps for the health services providers, be they doctors or allied health professionals, that will see them hung out to dry because they do not have the legislative embrace to enable them to come forward voluntarily and willingly to provide evidence to the RCA process.

The Hon. CHRISTINE ROBERTSON: We heard that there is privilege for that. But you say in your submission that they may come forward and not be covered by privilege.

Mr THOMAS: That is why we are seeking clarification.

The Hon. CHRISTINE ROBERTSON: Is that legal advice?

Mr THOMAS: Yes, we need clarity about this. If it is not there we are obliged to advise our members in a certain way. If we believe the privilege is comprehensive they will be advised in that way. The way that we see the legislation at the moment is that there is some uncertainty.

The Hon. CHRISTINE ROBERTSON: I understand that you are conferring quite well with NSW Health. You are part of some process.

Mr THOMAS: Yes, we are indeed.

The Hon. CHRISTINE ROBERTSON: Have these issues been presented and you are working with them or are these new issues?

Mr THOMAS: No. We have not raised our relationship with NSW Health—it waxes and wains, being a representative of the medical profession. We are due to meet with the Director General of Health next week, and certainly my colleagues and I will have an opportunity to bring this forward as an issue. We recently conferred extensively with NSW Health on the introduction of processes within the private system as well. So, although we may disagree about certain aspects of it, we are willing partners in the discussion with them.

The Hon. CHRISTINE ROBERTSON: Yes. The Hon. Dr Arthur Chesterfield-Evans brought up that issue this morning. I have not quite finished my questioning. I am not asking dorothy dixers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You cannot in this case.

The Hon. CHRISTINE ROBERTSON: I could if I wanted to. On page 8 of your submission you refer to prepared documentation. By whom is it prepared?

Mr CHAPMAN: That goes to the issue of somebody outside the constituted RCA team preparing the document for that team.

The Hon. CHRISTINE ROBERTSON: And that is a privilege problem.

Mr THOMAS: Yes.

Mr CHAPMAN: On one view, the document can be privileged within the context of the RCA but not in the hands of the person who produced it.

The Hon. CHRISTINE ROBERTSON: I see.

Mr CHAPMAN: I do not know whether that is correct, but it appears to be uncertain on our reading of it.

The Hon. CHRISTINE ROBERTSON: Thank you. You say that if an RCA team is not properly constituted privilege will not attach to that team's investigation. I guess that making directives about the constitution of an RCA team has a considerable difficulty because the definition of an incident directs who is required to form part of an RCA team. For example, you do not want the gut surgeon on your heart surgeon's RCA team. Do you see what I mean?

Mr CHAPMAN: I think that point goes more to this issue. Given that the constitution of the RCA team is dealt with under the Health Administration Act, if it is not constituted according to law what does that mean for the privilege that would otherwise attach to that team and what it does? We believe there is some looseness.

The Hon. CHRISTINE ROBERTSON: You have raised some complex legal questions.

Mr CHAPMAN: Sure. We are not seeking answers to them today but we are raising those issues because they go to the general thrust of the submission from a legal perspective, and that is the only basis on which I will speak today. The thrust of our submission is that we just want certainty and clarity—as much as one can achieve that—in this system so that as much as possible those who are involved in these processes understand where they stand.

The Hon. AMANDA FAZIO: Do you know of any instances when an RCA team has not been properly constituted?

Mr CHAPMAN: I am not aware of one.

The Hon. AMANDA FAZIO: So this is just a hypothetical what-if?

Mr CHAPMAN: I do not know.

The Hon. CHRISTINE ROBERTSON: I have heard of an incident where clinicians were extremely unhappy that they did not receive feedback. That incident was resolved through a higher level of communication among different sectors of the health system. As to process recommendations, you need to say something stronger than "They've got to talk nicely to each other." I am sorry to keep harping on about this but I am thinking of some sort of resolution regarding a possible recommendation because that appears to be a major issue in the implementation process. Do you have any more ideas? It looks a bit wishy-washy to say, "They should talk to each other."

Mr THOMAS: We encourage talk. I would generally be of the view that the process as it is, and despite our concerns, is a major step forward. What we do not want to do now is take three steps back into the darkness again. So anything that this Committee would recommend that encourages education and discussion of outcomes I think would be warmly welcomed by the AMA.

The Hon. CHRISTINE ROBERTSON: Thank you for your honest answers.

The Hon. ROBYN PARKER: Mr Thomas, we are all aware of the need to have open disclosure without people fearing that they will face reprisals as a result of that disclosure—hence the establishment of the inquiry in the first place and the outcomes of that. Do you think people disclose information about incidents willingly?

Mr THOMAS: I know that in the past they would not have. They move forward now, despite our reservations, with some comfort within the process. Open disclosure is an issue that is still

being debated nationally. I must come from a very altruistic view on behalf of the profession—that is, they are now in an environment where there is no need to hide mistakes. In that environment I believe they come forward willingly.

The Hon. ROBYN PARKER: Do you further believe that environment encourages clinicians to provide all sorts of information or do you think there are instances when they do not provide information, particularly because they are afraid of reprisals from within the department—for example, their budgets might get cut or lists might be cancelled?

Mr THOMAS: I do not know that they would be afraid of that. I think in some circumstances it may occur. But there is a very strong contractual arrangement about visiting doctors—the ones whom we represent—that provides in-house dispute mechanisms for issues such as that to be aired. For argument's sake, if a proceduralist had in his contract 400 routine hours annually and the administration, following an RCA outcome, decided that he would be reduced to 250 hours, we would be looking very closely at that within a contractual arrangement in the hospital. I cannot say that I have evidence from a member that that has occurred.

The Hon. ROBYN PARKER: Are you aware of cases where practitioners have had lists cancelled due to issues with management in a department or a particular hospital?

Mr THOMAS: The cancellation of lists is a concern for us. It is usually budget driven. We are concerned about bracket creep in the hospital. Whereas hospitals used to close for three weeks at Christmas and a week at Easter, now we have low-activity days and the close-down periods over the festive season are extending and at school holidays. That affects the delivery of services quite significantly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you involved with any of the doctors involved in the Campbelltown inquiry?

Mr THOMAS: I was, indeed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were any of the doctors who gave evidence disadvantaged by that process?

Mr THOMAS: Not that I am aware of. I know that there were a number, following the recommendations of Mr Walker, SC, that were referred on—a couple to the Coroner, some to the medical board and some to the Health Care Complaints Commission. They were a significant number. I think the result was that the matters that were dealt with before the medical board were reduced to approximately six—it may have been less than that. But I cannot say that any doctor who gave evidence before this honourable Committee was victimised by the health administration.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You cannot say they were but can you say they were not?

Mr THOMAS: No, I am unable to say that because following the appearances before this Committee we gave extensive assistance to a number of doctors from Campbelltown and Camden—both visiting and salaried doctors—to support them through the processes that Mr Walker instituted. I am not able to answer that question with an affirmative or a negative.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you say anything about the whistleblower doctors who gave evidence to this Committee—I am particularly interested in whistleblowers because without them we have no progress; obviously if people are caught up in questions about their political involvement in the process they are in a different category from those who gave evidence or made the complaint or observation—in the sense that they backed up the complaints of the whistleblower nurses? Can you comment on that?

Mr THOMAS: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that because the AMA has not kept track of that? It seems that no-one is following the whistleblowers and looking at what happens to them. That worries me.

Mr THOMAS: Are you talking about individual doctors?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. There are not that many of them.

Mr THOMAS: We are in the position of representing visiting doctors, not salaried doctors.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But a number of visiting doctors came to us as part of that process and said some fairly strong things.

Mr THOMAS: There were some doctors whom we continued to support after the process but, in the main, that related to the disciplinary processes they were required to undergo rather than any vexatiousness arising from the administration at either Camden or Campbelltown.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you cannot answer my questions about the ones who were not personally accused of any misdemeanours but who gave evidence about the process and the situation. Can you comment on them?

Mr THOMAS: No. I expect our members—and I head up a relatively large team at the AMA—to contact us with concerns. If any issues arose from appearing before this Committee we would know about it fairly quickly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they were members.

Mr THOMAS: Yes, if they were members. Because of the breadth of the investigatory nature of this committee during the Camden and Campbelltown issues, we also assisted doctors who were non-members because, on a lot of occasions, their insurance policies, especially salaried doctors, covered them for their clinical work in the hospital but did not cover them for disciplinary proceedings. This was a major event for the AMA that took us away from our normal service delivery to our members and we embraced those non-members as well on behalf of the profession.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well done. I notice in your submission that in one way you are asking for the privileges relating to the root cause analysis hearings to be increased?

Mr THOMAS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you are saying that if doctors are not happy they should not co-operate or should protest about the RCA people or proceedings. Are you not really sitting on the fence as far as whether you are protecting doctors from the RCA process and open disclosure because you are concerned that tort will still go ahead?

Mr THOMAS: But tort will always go ahead.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, no, you could reform it so that it would not?

Mr THOMAS: If there was no fault legislation introduced, that may occur.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you have not advocated that?

Mr THOMAS: No, it is not a formal policy of the AMA because the advice that we have from our colleagues in New Zealand is that the no fault process is not as clear-cut as everyone would think. There are very strong disciplinary arrangements that flow from a no fault process, as I understand it operates in New Zealand.

The Hon. CHRISTINE ROBERTSON: We had a lot of evidence during the previous inquiry in relation to medical practitioners participating in the quality programs?

Mr THOMAS: Yes.

The Hon. CHRISTINE ROBERTSON: Do you know if that has improved?

Mr THOMAS: I consider that this root cause analysis process is integral to it and, as I have said, our concerns relate to the perhaps lack of impetus in terms of feedback to the clinicians but that is where the quality assurance arises from.

The Hon. CHRISTINE ROBERTSON: But has the clinician's participation increased since we did the inquiry approximately 18 months ago? Are there more doctors playing the game?

Mr THOMAS: I would like to think they always play the game.

The Hon. CHRISTINE ROBERTSON: Participating in this quality assurance?

Mr THOMAS: There are two things that touch upon that. The first is that the Medical Board now requires, with respect to continuing the registration of a doctor, advice on continuing professional development, as does the learned colleges, so unless they are able to demonstrate that they are involving themselves in quality assurance, of which continuing professional development would be a part, I would believe that they may find themselves subject to some inquiry from those registration authorities.

ACTING CHAIR: Thank you for coming today and providing your submissions and answering questions. Members of the Committee may have further questions and we would appreciate a response within 28 days of your receiving those questions, if possible. Would you be prepared to answer those?

Mr THOMAS: Certainly.

(The witnesses withdrew)

HELEN JANE TURNBULL, Solicitor, Legal Manager, Disciplinary Services, United Medical Protection, and

DAVID IAN BROWN, Lawyer and General Manager, Claims and Legal Services, United Medical Protection, sworn and examined:

ACTING CHAIR: Are you conversant with the terms of reference of this Committee?

Ms TURNBULL: Yes.

Mr BROWN: I am.

ACTING CHAIR: Would either of you care to make an opening statement before questions commence?

Mr BROWN: I would like to make a brief opening statement. This opening statement is designed simply to put our submission in context. United Medical Protection is a medical defence organisation with an insurance subsidiary, Australasian Medical Insurance, and because of that, its dealings with doctors fall into two general categories. On the one hand, it deals with incidents that are going to give rise to an insurance claim against the insurance arm, and they could be civil proceedings, disciplinary cases for coronial inquests, for example. Secondly, United Medical Protection provides medico-legal advice to doctors. Doctors regularly contact our in-house legal and medical staff for advice and the advice relates to matters arising out of practice such as medical records, confidentiality, answering subpoenas and so on.

I think it is quite important to note in terms of complaints that one of the issues that members raise with United Medical Protection when they seek advice is that they simply say, "I've been asked to prepare a report" and "I have been asked to attend an interview". It is often quite unclear how or why they are being required to prepare a report or attend an interview. That is very relevant, we think, in terms of issues such as root cause analysis, open disclosure and other investigative streams within the hospital system.

One of the first roles that we have is to try to clarify for our members precisely where they are heading and the difference between those different streams of investigation and complaint can be very important in terms of the nature of the process, the documents that are produced in the process and the consequences for our member. We think we have a key role in trying to help members to participate in those streams with confidence and there is a lot more work yet to be done to ensure that clinicians are aware and confident about each of those different streams. We are really pleased to have had the opportunity to work more closely in the last few years particularly with NSW Health to try to address that.

One of the key messages is simply that United Medical Protection strongly supports the open disclosure process for example and that was the subject of a formal voting procedure when the national standard was being developed. United supports the open disclosure process because whilst it is difficult to prove categorically, we have a strong feeling that litigation is actually reduced where patients feel that they have received frank information and that they are being supported when something has gone wrong. It is quite a challenge to get that message across to our members, who may traditionally have thought that as their insurers we would not be very pleased about open disclosure. That is one of our particular challenges.

Hand-in-hand with that goes the need for us to ensure that members are properly protected and supported when they do participate in various complaints processes and disclosures. If I can just, on a procedural matter, draw attention to one matter. We have identified one little typographical error in our submission at 3.2 on page 2, which should state, "We were concerned about premature personal comment and criticism of our members" and it has been mistyped as "consent". Obviously we are happy to answer the Committee's questions. Ms Turnbull, who is the legal manager with particular concern to disciplinary matters, is better placed than I am to answer matters dealing with disciplinary processes, root cause analysis and matters relating to Camden, Campbelltown and those sorts of areas.

I am better placed to talk about open disclosure and policies in relation to complaints against a clinician.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I note in your submission that you voice similar concerns to the AMA in the sense that if you support open process, you want to be certain that—as you put it—streams of information from the open disclosure and RCA process do not end up in the tort law stream. That is what you are hinting at. Do you support a no fault system?

Ms TURNBULL: I think there are certain difficulties with a no fault system. As you can tell I am a New Zealander so I grew up in a no fault system. I have obviously had personal experience. Certainly in the seventies in the heyday when no fault compensation was big in New Zealand it was an incredibly successful system but nowadays there are real issues as to cost. However, there are certain benefits to no fault compensation that New South Wales should certainly look at, particularly in the area of long-term care for severely injured patients, the ones who suffer significant permanent injuries.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are talking about medical misadventure with catastrophic results and the insurance thereof, are you?

Ms TURNBULL: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So your cost objections to the New Zealand no fault system relate to the cost of the long-term care and the absence of awards in the insurance, is that what you mean?

Ms TURNBULL: No, the cost issue of running a no fault system is enormous, particularly for a small country like New Zealand. It does have a big impact and it is one factor. However, what I am suggesting is that there is potential here in New South Wales to look at a smaller scale in relation to particular patients who have suffered catastrophic injuries and have a smaller sort of system. I think it is fairer for the patients and fairer for society here.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Perhaps we should define our terms here. When I say "no fault", I mean if the doctors participate in some open disclosure root cause analysis, that they are then not held at fault—

Ms TURNBULL: Oh, I see what you mean.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: —under a tort system. In other words, there is immunity, a privileged system. I am not talking about how you pay for whatever misadventures there are. Presumably that is different.

Ms TURNBULL: I am talking about the no fault system that is apparent in New Zealand.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My experience of New Zealand's medical mistakes is actually quite extensive, believe it or not, through coincidental happenstance.

The Hon. DON HARWIN: Have you ever practised in New Zealand?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes I have, but it was not my mistake that I was interested in over there. My impression was that the system did not work very well in the sense that if mistakes were made, they were covered over quite adequately really.

Ms TURNBULL: There is a very strong disciplinary process in New Zealand that runs parallel to the no fault system. Again, it is all separate pathways. There is the disciplinary pathway in New Zealand, there is the no-fault system and there is obviously the complaint commission in New Zealand that deals with complaints generally. These are all separate pathways. When a doctor is involved in a disciplinary process in New Zealand, for instance, that runs parallel to the no-fault system.

Mr BROWN: One important point is that, with or without an adversarial litigation system, it will always be the case that somebody who participates in an open disclosure for example may have

personal exposure. It may be criminal exposure. It may be being required to give evidence before the coroner. It may be disciplinary. So while the no-fault tort system for example can remove financial burden, in terms of personal and reputation damage and protection of practising rights and so on, it does not solve that problem necessarily for the doctor. So in terms of fairness of process, the concerns will remain. We would be concerned to ensure that there is a transparent, fair process where a doctor knows exactly what the consequences are of what they are doing, with or without a tort system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does United advocate a privilege system where people cannot just sue in tort? Do you advocate a system where the system is in a sense within the profession that investigates a situation and then decides punishment but the plaintiff cannot sue in common law and add that layer of insurance and redress?

Mr BROWN: We have never articulated a particular policy position to that effect. We have responded to what the current environment is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would basically look at what the market is demanding and presumably provide that for the people who insure with you?

Mr BROWN: That is the immediate concern, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you do not take a policy position on that?

Mr BROWN: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have an opinion of what is the best situation?

Mr BROWN: I think the difficulty in answering that is that the devil is obviously in the detail. If you use a term like "no fault" precisely what will it mean in terms of consequences for clinicians?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When I say "no fault"—perhaps I should have defined that at the beginning—I mean clinicians unable to be sued at common law by patients or their relatives.

Mr BROWN: As I say, it is not something we have taken a position on, and I think you need to explore precisely how that would play out. I think having some protection in place for doctors who participate in investigative streams in terms of, for example, expressions of regret not being used as evidence of liability, I think those sorts of steps are very important.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have made quite a lot in your submission about streaming, in other words, if you go in a stream where you apologise to the relative and then you co-operate in an open disclosure and a root cause analysis process, the information gleaned from that process and the admission that an adverse event had occurred which you feel sufficiently responsible for in that you have apologised might lead to problems within an adversarial tort framework.

Mr BROWN: I think the difficulty is that you cannot build a fence around a human and quarantine the human. It is the documents that are produced, for example, that we are particularly concerned about.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure.

Mr BROWN: If someone apologises to a patient, they may or may not be a criminal, for example. In other words, you can never be sure precisely what the consequences for a particular human will be but the documents that are produced in an open disclosure process or an RCA process, how they track, can be very important.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are asking for privilege for the documents and not the individual.

Mr BROWN: I do not think you can attach privilege to an individual.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No but the facts that come out in an open process may then be used to repeat that process in a different forum, of course, and that is in essence a problem.

Mr BROWN: That is the problem, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To say you cannot use this document when I can ask you the same question that led to that document is clearly a problem.

Mr BROWN: Yes.

The Hon. CHRISTINE ROBERTSON: How could you take that away?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Only by obstructing a tort process in order to get the other documents which would allow you to improve the identification of problems.

The Hon. CHRISTINE ROBERTSON: The ability to use the document twice.

Mr BROWN: Some of these problems get down to practical details such as timing. For example, if there is an adverse incident, then the material that is contained in the progress notes in the hospital record or the operation report will see the light of day no matter what. What we are much more concerned about are things like a document hastily brought into existence within hours of an incident to meet a reporting requirement at a time when the real facts may not be known at all. That kind of document could be dangerous because it can have all sorts of assumptions and guesses and hearsay and so on. Those are far more dangerous than real hospital records. They waste people's time and money, and cause damage.

The Hon. AMANDA FAZIO: Is that what you are talking about at paragraph 3.6 in your submission?

Mr BROWN: That is part of what we are implying, yes.

The Hon. CHRISTINE ROBERTSON: The issue in paragraph 3.9 relates to some of the persons involved in RCAs not actually having the skills to deliver the investigatory process. I gather from your document that that has been resolved through consultations, that this sort of example case study Doctor B will not happen again in your estimation, or do you think there is more?

Mr BROWN: I think there is a way to go. In terms of our dealings with New South Wales Health and with doctors in the hospital system, there is still a lot more to be done in terms of education, training, development and so on so that people have a stronger awareness of the principles of fair investigation, basic principles of what triggers an investigation, setting timetables and so on. Some people are obviously very strong at that sort of thing but some people are not.

The Hon. CHRISTINE ROBERTSON: That anaesthetists's experience just indicates somebody could not be bothered speaking to them properly. What is your idea on how this can be resolved—some direction about those who are being asked questions being given specific information about why or?

Mr BROWN: Yes. I think at the start of any investigation one key point is—

The Hon. CHRISTINE ROBERTSON: Health workers are not usually good cops.

Mr BROWN: At the start of any investigation it is very important that someone is aware that there is an investigation, what it is about, what the anticipated timeframes are, some sort of agreed

procedure about what the parties will do if there is slippage in terms of timeframes so people have some trust in the process.

The Hon. CHRISTINE ROBERTSON: That is from the side of the person who is being investigated. From the persons who may have come forward—the Hon. Dr Arthur Chesterfield-Evans' "whistleblowers"—with an issue, if the health service person who is the investigator may have some difficulty with perhaps reprisals upon those who have put the issue on the table or those from the person being investigated before you have actually rounded up what is going on.

Mr BROWN: I imagine that that is possible and that you need some sort of whistleblower process and policy in place so that people are protected.

The Hon. CHRISTINE ROBERTSON: That could be difficult in small working environments.

Mr BROWN: Yes.

The Hon. CHRISTINE ROBERTSON: There was another issue that you raised about small working environments. I only understand this and certainly the Committee will have to make an inquiry. I understand that you have put forward the issue about the person who is in charge of the clinical services may be the perpetrator and the investigator, how would you do this, and I understand that the majority of health services in the country now focus on a cluster and their area roles would mean that that issue, do you actually know that?

Mr BROWN: I believe there is quite a bit of progress being made along those lines but I am not an expert at it by any means.

The Hon. CHRISTINE ROBERTSON: That is okay. I just wondered if you knew. Did you bring this to the attention of the department?

Mr BROWN: We have raised issues like that with the department, yes. A related issue we have raised with the department is that when you take something like, for example, the national open disclosure standard it will obviously have quite different application in practice in a small country hospital compared to a large city hospital where different people have different roles and so on and the importance of having a local practical implementation.

The Hon. AMANDA FAZIO: Have you been happy with the response the department has given you when you have approached it about these particular issues relating to disclosures and other matters?

Mr BROWN: Yes, we have. Particularly in the past two or three years, the degree of consultation has been very good.

The Hon. AMANDA FAZIO: And co-operative in terms of resolving issues?

Mr BROWN: Yes. They are getting our active participation in some of the steering committees. There has been some contributions to department documents and so on provided by MDOs to get that perspective so it has been very good.

The Hon. CHRISTINE ROBERTSON: In relation to the no-fault policies in New Zealand, do you know if any comparative studies have been done on health outcomes between the tort policies and the no-fault policies?

Ms TURNBULL: I am not aware, I am sorry.

The Hon. CHRISTINE ROBERTSON: That would be interesting, would it not?

Mr BROWN: One of the contextual things is that we are aware—I have no idea about comparisons between New Zealand and Australia but obviously the number of matters that become the subject of a complaint or litigation is very small by comparison to the number of adverse incidents.

One thing that obviously interests us is why do some quite serious adverse incidents result in a claim or complaint and others do not? Of course, a great many adverse incidents do not, which tends to tell us that a lot of doctors a lot of the time are doing something right when there is an adverse incident.

The Hon. AMANDA FAZIO: Do you think it could also have something to do with some people being perhaps more realistic that not every procedure or cause if you go into hospital is guaranteed to have a 100 per cent successful outcome?

Mr BROWN: That is a strong factor, and I think as clinicians have become more focused on giving proper advice and warnings before a procedure, that helps to modify expectations. It is much more helpful if you can speak to a patient after a problem and say, "As we have discussed, this is how it may have happened."

The Hon. AMANDA FAZIO: Do you think your members are giving more information about possible adverse consequences in the current climate than they ever have before?

Mr BROWN: Very definitely, yes. There is still obviously a range of expertise but overall there is much more focus on it.

The Hon. DON HARWIN: Do you believe better reporting is required, or do you think the current annual report is adequate?

Mr BROWN: In relation to, sorry, RCA outcomes or?

The Hon. CHRISTINE ROBERTSON: Yes, clinical excellence, RCA.

Mr BROWN: I think you need a period of time in which to spot a trend. I think reporting has to be about systems trends and that kind of being. Whether that means you do it more often than annually, I am not sure, but I do not think, for example, there is any great good point in reporting publicly the outcomes of RCAs immediately after the event or something of that kind. I do not think there is any particular benefit in that. So whether it is annually or twice a year, I am not sure whether it makes much difference.

The Hon. DON HARWIN: Do you believe the public has the ability at present to make informed judgements under the current system?

Mr BROWN: I am sorry, informed judgments about?

The Hon. DON HARWIN: In terms of the previous question, as a follow-up.

Mr BROWN: Yes, I do. It is a difficult question because it is a matter of precisely what the public needs to be informed about and wants to know about and can usefully apply.

The Hon. DON HARWIN: I accept that. Is there anything else you want to add?

Mr BROWN: No.

The Hon. AMANDA FAZIO: Do you think “M.D.A” is realistic?

Mr BROWN: One thing is that when we close the doors at our office the walls do not shake quite as much.

ACTING CHAIR: Thank you, Mr Brown and Ms Turnbull. There is a possibility the Committee may decide that there may be additional questions to which it would like answers. If it does so decide, would you be happy to provide those answers?

Mr BROWN: Certainly.

(The witnesses withdrew)

(Short adjournment)

ROSEMARY BARRINGTON BRYANT, Executive Director, Royal College of Nursing Australia, and

ELIZABETH RUTH FOLEY, Director Policy, Royal College of Nursing Australia, and

ROBERT DAVID THOMAS O'DONOHUE, Registered Nurse, Royal College of Nursing Australia, sworn and examined:

ACTING CHAIR: Ms Bryant, in what capacity are you appearing before the Committee, as an individual or as a representative of an organisation?

Ms BRYANT: I am a representative of Royal College of Nursing Australia.

ACTING CHAIR: Are you conversant with the terms of reference?

Ms BRYANT: Yes.

ACTING CHAIR: Ms Foley, in what capacity are you appearing before the Committee, as an individual or as a representative of an organisation?

Ms FOLEY: As a director of Royal College of Nursing Australia.

ACTING CHAIR: Are you familiar with the terms of reference?

Ms FOLEY: Yes.

ACTING CHAIR: Mr O'Donohue, in what capacity are you appearing before the Committee, as an individual or as a representative of an organisation?

Mr O'DONOHUE: I am representing here as the vice president of the Royal College of Nursing Australia.

ACTING CHAIR: Are you conversant with the terms of reference?

Mr O'DONOHUE: Yes, I am.

ACTING CHAIR: Would any of you wish to make an opening statement?

Ms FOLEY: The Royal College of Nursing Australia welcomes the opportunity to appear before this Committee to provide clarification on issues referred to in our written submission on the issue of complaints handling within NSW Health and to provide additional information to assist the Committee in its deliberations. As the peak national professional organisation for Australian nurses, the college has an interest in complaints handling procedures throughout the health sector, particularly as these impact on nursing and the profession's ability to deliver safe, competent care. The college supports measures taken by the New South Wales Government following the recommendations made from the inquiry in 2004, which has sought to address processes for data collection and the monitoring of complaints made by consumers of health care, and protective strategies for health care professionals.

In addition, the college would like to discuss with the Committee measures for enhancing outcomes of health care for the New South Wales public, such as appropriate numbers and mix of qualified health care professionals to deliver safe care; maintenance of competence to practice, with investment in continuing professional development; and retention of qualified staff through valuing of clinical and organisational decision-making skills.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With regard to the Campbelltown inquiry and whistleblower nurses, has the college kept track of where those nurses are now and what has happened to them?

Ms BRYANT: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the college generally look after nurse whistleblowers?

Ms BRYANT: The college is a professional organisation and our mission is around promoting safe care and adequate standards of care for the community. We do not represent nurses as such. That role is undertaken by our colleagues in the Australian Nursing Federation, or in this State, the New South Wales Nurses Association.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are a professional standards body, not a union, in effect?

Ms BRYANT: Yes, not a union. So we do not look after individuals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But do you have concerns as to the outcomes that might happen to people as people dedicated to open disclosure standards?

Ms BRYANT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you would obviously be concerned about quality control?

Ms BRYANT: Of course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the quality control ends up in front of a committee of this House, then clearly there is at least a perceived problem?

Ms FOLEY: Yes. As has been indicated, we do not advocate for individual nurses but we are interested in legislation and policies that protect nurses, in this case in a whistleblowing situation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I note in your submission that you say there has not been, to your knowledge, any educative function in terms of complaints from the Clinical Excellence Commission?

Ms FOLEY: Yes. As indicated in our introductory statement, we are pleased that there have been processes put in place at what we would call the back end of looking at dealing with complaints, but we are particularly interested, as a professional organisation, in ensuring that there are processes at what you might term the front end of this whole process within the health care system of ensuring that there are appropriate numbers and skill mix of staff, that staff have appropriate qualifications for the care that they are providing and that opportunities are provided for ongoing education or staff for the area which they are practising. So that there are processes in place for people to be able to deliver safe, competent care so that the outcomes of health care for the consumers of that care are protected.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In essence, your part in the prevention of adverse events is in making sure that the people working are working in areas where they can be sure that they have the competency and the resources to minimise the chances of there being adverse events?

Ms FOLEY: Exactly. Whilst there is a need for processes in place if complaints need to be made, that is good and proper, but we want to try to work before that happens to prevent people needing to go to a process of complaining, because the care that they are receiving is competent and safe.

Ms BRYANT: In terms of what Elizabeth has just indicated, we are interested in ensuring that not only is the front end okay but we are certainly interested in the open disclosure and the other mechanisms or systems that you could put in place to ensure that consumers have their complaints dealt with adequately. But we are more interested in prevention rather than what you would call the end result.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You might say there is the front end, which is having adequate staff to not make a mistake; then there is the middle bit, which is identifying the mistakes; and then there is the back end, which is presumably punishing or re-educating or taking consequential action?

Ms BRYANT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As far as the middle bit is concerned, which is identifying and reporting problems, do you think there has been any change since this new policy has come in, in practice?

Mr O'DONOHUE: There certainly have been some structured processes put in place. There has been information technology put in place; there have been some efforts through the clinical governance. However, all of that is resting on the fact that staff have the means to be able to spend the time to deal with and to improve their care in an environment which is supported by evidence. If your question is also asking about the fundamental structures being in place, then there is still a need for those areas to be strengthened.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly we heard from the health department this morning at some length about the wondrous changes that have been made. What I am asking you is from the point of view of another aware and hopefully disinterested body in terms of whether it is succeeding or not, do you think there has been a culture change and/or has the IT—which allows, presumably, the cases to be compared and rolled up more easily than if they were all paper notes—led to any change in culture or change in behaviour?

Mr O'DONOHUE: Overall, I think there is still a long way to travel. There is still a culture out there that has not wholly embraced evidence-based practice, let alone adopted it, as Mr Bryant and Ms Foley have said, dealing with the front end. That has not been seized as it is not happening to any great extent. There are pockets of it. However, it is not wholesale.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there more clinical meetings to discuss the performance of units or hospitals with open disclosure and discussions than there were? In one of the presentations we had about what wondrous things the Health Department was doing—this was some years ago, not since the Campbelltown inquiry—they talked about the desirability with the Clinical Excellence Commission, or whatever its predecessor was called, of having regular meetings where you air your dirty laundry and discuss how to improve things. Have those types of clinical meetings become more common, more open and more useful?

Mr O'DONOHUE: Yes, they have. As I said, there have been some systematic changes across the organisation. However, staff have to have the resources to attend and move through the lengthy process because those committee structures and reviews take some time to develop. As I said, without adequate resources that becomes very difficult. It is always on a short time line.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that these clinical meetings that involve a systematic presentation of problem cases or a systematic presentation of results compared to other comparable units are not happening very much or, if they are, there are problems for relevant people to attend them?

Mr O'DONOHUE: They are happening. I am saying that the time is very stretched to do those. There will always be very good examples of where this is happening. It was happening beforehand and it continues to happen. If you look at the average staffing from a nurse's perspective on a ward area, the changes to nursing numbers still remain very pressured.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The average nurse has no chance of getting enough time off to go to these meetings, is that your bottom line?

Mr O'DONOHUE: That is right, yes.

Ms FOLEY: Any cultural change will take a while to take effect, plus a process of trust has to be developed. Even thought these processes have been put in place, for staff to fully embrace

them—I will talk from a nurse's point of view, but other health professionals are involved too—they need to be able to see that a genuine attempt is being made at executive levels to want to make a change. It is our understanding that processes have been put in place with the removal of area health service boards so that nurses are not now directly engaged in decision making at all levels through to executive levels. That compromises nurses' trust in the system about whatever it is you are talking about, any changes, any reforms that need to be made. That will compromise nurses' trust that there is a genuine attempt being made to affect those reforms and to engage them in those reforms. We need to consider this whole area. It is not just simply complaints handling and mechanisms put into monitor those, there is a broader imperative here.

The Hon. AMANDA FAZIO: I want to ask a few questions on issues you raised in your submission. Paragraph 3.4 refers to recommendation 10, which was that the Government convene a summit on medical adversity within the next 12 months. We have been advised by the Department of Health that until it reviews the new reporting system it is not prepared to convene a summit. Do you think it is necessary to hold a summit?

Ms BRYANT: Unless the purpose of the summit is well articulated and the desired outcomes are well articulated, and the information in those outcomes is going to assist the rest of the health sector within New South Wales and even across the border then, no, because there is no point in having a talkfest for the sake of it. But sharing information on how adverse events are managed at the hospital level is certainly a worthy cause if that would be the purpose of such an event. Obviously, there are national conferences on patient safety events. There was one in Melbourne about three weeks ago but not specifically dealing with what is happening in New South Wales. I am giving you a yes no answer, really, not a definitive answer. It is qualified.

The Hon. AMANDA FAZIO: Paragraph 3.5 refers to recommendation 15, which relates to mandatory reporting. Your comments on the recommendations say that we need more research and focus specifically on implications of mandatory reporting. What sort of research would you envisage to resolve that?

Ms BRYANT: Mandatory reporting in any of the social science areas that we know about has its pluses and minuses. Before one implements such a system, which would be a big change and resource intensive, and would require a change in behaviour on the part of health professionals, managers and so on, you would need to be sure that the efficacy of the outcome was going to help you. That would be a comment on that.

Ms FOLEY: This does not specifically answer your question about specific research, but mandatory reporting, and I sound like a broken record, comes back to trust. If staff feel that they are being respected and valued within the system within which they are working, if they feel that they can trust management then a mandatory process will have a whole different connotation than if they are working in a system that is punitive and that they see it as a blame-and-shame type of system. The element of trust, of having a just system set up, and of having very clear processes where people feel that they are going to be genuinely listened to will mean that a mandatory system will have more effect. But we would caution going down that track at this stage.

The Hon. AMANDA FAZIO: Paragraph 3.6 refers to recommendation 16 and talks about a clinical team doing regular reviews of each area health service. Have you had any discussions with New South Wales Health in relation to the astonishment of these teams?

Ms BRYANT: I do not think so, no. I am trying to recall, but I do not think so.

The Hon. AMANDA FAZIO: In relation to recommendation 60 you commented that it is critical that a clinical team means a multidisciplinary team. My understanding is that they were going to be multidisciplinary. Do you have any evidence that they are not, or have you had any concerns raised with you by people in the nursing field that these clinical teams do not include all the health professionals who need to be involved?

Ms BRYANT: When we speak with our medical colleagues, it is my experience that our medical colleagues believe they own the term "clinical", that "clinical" means doctors. I have had debates with them on occasion about the use of the term "clinical". That is why we would not

normally use the term "clinical". In this situation we would use a more explanatory term, multidisciplinary. That is why we made that comment.

Mr O'DONOHUE: In the structures that have been implemented to date I have seen examples of clinical staff who have been involved in the care of a patient that has come under question and those staff are then involved. What is less clear to me is who is leading those teams. Sometimes it has not been systemised and it is the most appropriate person on the occasion rather than defaulting to a medical officer because they believe that they are the most appropriate person to undertake that leadership role.

The Hon. CHRISTINE ROBERTSON: It is in relation to root cause analysis?

Mr O'DONOHUE: Yes.

Ms FOLEY: In terms of multidisciplinary teams, clinicians often mean multidisciplinary in terms of palliative care, medical, surgical or whatever. For us multidisciplinary would mean all of the health professionals involved in a person's care, but we would also like to see consumers of health care involved in that too. We believe that to get the most optimal outcomes of health care, consumers must play a very central part in health care.

The Hon. AMANDA FAZIO: Even though it was a while ago, I am reasonably sure that in the previous inquiry that led to the recommendations we are now reviewing it was put to us by some witnesses that in some cases nurse unit managers would have a better overview of the range of care that had been provided to a particular patient than a specialist. Would you concur with that view?

Ms BRYANT: Yes.

Ms FOLEY: Yes.

Mr O'DONOHUE: Yes.

The Hon. CHRISTINE ROBERTSON: I asked about RCAs because you commented in your submission about permanent clinical teams, which may be palliative, and that is what the recommendation referred to, rather than the RCA process. Would you agree with that?

Ms BRYANT: Yes.

Ms FOLEY: Yes.

Mr O'DONOHUE: Yes.

The Hon. CHRISTINE ROBERTSON: Did you think this was a reasonable recommendation, except that that you were concerned about representation?

Ms BRYANT: Yes.

Ms FOLEY: Yes.

The Hon. CHRISTINE ROBERTSON: Do you think that nurses have the same issues in relation to the possibility of a statement to an RCA being used by the author for other some purpose outside the protected disclosure process of the RCA? Have you had time to read the other submissions?

Ms BRYANT: No.

Ms FOLEY: No.

Mr O'DONOHUE: No.

The Hon. CHRISTINE ROBERTSON: Have you been involved at all in the Clinical Excellence Commission conferences on specific issues?

Ms BRYANT: No. We are a national body. We are in Canberra. Robert is a local New South Wales person, but the answer to that is no.

The Hon. DON HARWIN: We have just under 100,000 registered nurses in New South Wales?

Ms BRYANT: Yes.

The Hon. DON HARWIN: And just over 30,000 who work in public hospitals?

Ms BRYANT: Yes.

The Hon. DON HARWIN: Obviously there is a significant number of nurses who do not work within the hospital system at the moment?

Ms BRYANT: Yes.

The Hon. DON HARWIN: Maybe as many as 50,000?

Ms BRYANT: Yes.

The Hon. DON HARWIN: Or maybe a bit more? Do you think the way complaints have been and are still being handled is part of the problem, why some nurses choose to leave the profession? I think, for example, the statistics say 20 per cent of nurses leave the profession within three years of starting work. What role do you think dissatisfaction nurses have with the complaint system plays in producing those statistics?

Ms BRYANT: Of course, without doing research on this, this is anecdotal what I am about to say. Certainly there is evidence around nurses leaving the system for a variety of reasons. In some cases it would be difficult for an individual to really pinpoint why exactly he or she chooses to leave. If complaints are handled badly and individuals are named and shamed, to use the vernacular, that is probably a part of a wider culture of nurses not being treated as professionals and not being able to work and practice, care for patients, in the manner in which may believe they have been taught or they believe is the appropriate standard. So, there is evidence around nurses generally leaving because of these factors. The extent to which complaint handling contributes to that, I could hazard a guess, but I do not have any firm evidence.

The Hon. DON HARWIN: Obviously there is a range of reasons?

Ms BRYANT: Yes.

The Hon. DON HARWIN: Compared to some of the other reasons for the number of nurses leaving the system and therefore the shortage we have in public hospitals, where does dealing with complaints rank with some of the others? What other ones would be more salient in why they leave? About where do you think it ranks?

Ms BRYANT: So, a hierarchy?

The Hon. DON HARWIN: Yes.

Ms BRYANT: I think probably at the top of the tree is the number of staff and the workloads. They are really pushing nurses out to work in other areas. There is a shift work, the hours of work, the intensity of the work and to some degree the length of time, the overtime, and so on, that is necessary. I think they are probably at the top of the tree. I think on the next rung from is the culture within the hospital system and to some degree we have a culture that is almost redolent of what there was when I was a student nurse in the 1960s. That does not change. The way the hospital system and

the hierarchical functioning still exist. Generations X and Y today are not interested in that. They have very different goals from those that some of my era did have going back.

On that same level, I believe if there is a culture still of blaming, of heads on a platter, that is more used in the political environment, but pinpointing a nurse who fault it is that someone fell out of bed and fractured their femur, for example, that devastates an individual. There is evidence of medical practitioners having big effects, psychological effects, having made a mistake, on their whole career—not the whole career but their willingness to stay within the system and the way they view the profession and their professional goals. There is a paper I can refer you to, if you are interested. I think the author is Christianson. There is evidence I am aware of in that area of the effect making a mistake and how it is handled has on a medical practitioner's career. I do not have any examples from nursing, it is just anecdotal.

The Hon. DON HARWIN: If you could, that would be very helpful.

Ms BRYANT: I would be happy to provide that.

The Hon. DON HARWIN: I am sorry I was unable to be here this morning. You were not here during Ms Kruk's evidence?

Ms BRYANT: No, we were not.

The Hon. DON HARWIN: I am going to ask a question that is relevant to some of the comments she made but it is still probably relevant as it is an issue of some comment. Is the Royal College of Nurses in favour of making reportable incident briefs privileged?

Ms BRYANT: Yes.

The Hon. DON HARWIN: Are you in favour of making the summaries and reports of the reportable incident briefs privileged, the summaries and reports of the briefs?

Ms BRYANT: I think so, yes.

The Hon. AMANDA FAZIO: You can always take it on notice if you do not have a position.

Ms BRYANT: Perhaps we might just take it on notice, yes.

The Hon. DON HARWIN: Would the college be in favour of releasing reportable incident briefs where the incident was the result of equipment failure and not as a result therefore of the treatment of nursing staff or medical staff?

Ms BRYANT: Yes, well—

The Hon. DON HARWIN: Obviously it would be great if you could give an answer now but if you have to take it on notice—

Ms BRYANT: I am trying to think of the pros and cons very quickly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think you should take it on notice. These are multifactorial, are they not?

Ms BRYANT: Yes. I think we will have to take that on notice, yes.

The Hon. DON HARWIN: Is the college in favour of the annual patient clinical report being reported monthly or quarterly?

Ms FOLEY: I will let Robert answer, but I think from a practical point of view, having worked in a nursing resource management position, we want to make sure that any reporting process does not cause a burden to people, and that reports can be prepared in a timely manner and sensible

consideration can be given to making sure that reports are giving information that people need, rather than putting pressure on people to spend all their days collecting data and not being able to do any other work around that.

The Hon. DON HARWIN: Obviously you speak for the college and therefore for nurses, but do you not feel the public has a right to know what is happening in public hospitals? Do you not think there should be a balance, and concerns that are raised in the reports and summaries I have been talking about, the public has a right to know?

Ms BRYANT: Yes, the public does have a right to know, but the public also needs to be informed and educated about what the statistics mean. Publishing league tables, raw data, without any accompanying information or commentary can do more harm than good, in that it may prejudice individuals', the community's, perception of the health system and may be deleterious in their using the health system in the future. League tables are reported in many jurisdictions in the United States and there is some reporting now in the United Kingdom, but as an example, if you take something crude like the death rate, the number of deaths, for example, in a large teaching hospital in the middle of Sydney, the percentage of deaths per patient admissions, or whatever, would be much greater than in a different facility. This has to be explained to the public so they do not lose their confidence in the system. So, yes is the answer, but it must be done in a responsible and informative manner as opposed to again pointing fingers.

ACTING CHAIR: The time has expired, but do you have any objection to us taking five more minutes for questions?

Ms BRYANT: No.

The Hon. DON HARWIN: Following on from the answer you have just given and the perspective you bring to it, what about the issue of time lag? Is it not the case under current arrangements if there was an incident of concern in July 2006 we would not know about it until October or November 2007? Do you think that is an acceptable level of information being disclosed to the public and really, given the public interest in the quality of care, is it really an acceptable approach?

Mr O'DONOHUE: If I could start, and then I will hand over. I understand the tenet of your question and where you are coming from. I think what we had certainly indicated before, consumer participation in the process is vital. The population as a whole, the community as a whole, need to know. Yes, I think there is a process of time. However, making sure that there are adequate quality processes in place that consumers—and that is the average consumers, not professional consumers, these are real people—can scrutinise, ask the questions that concern them, is vital. I think that is very much a point we tried to put forward before.

The Hon. DON HARWIN: So, 15 months is okay?

Mr O'DONOHUE: No, I am not saying that. I am saying they should be on the reviews. They should be there right up front, listening to the evidence that is being presented, working through the issues. That is very important so they understand the context and can work through that.

The Hon. DON HARWIN: What is a more realistic sort of timetable, do you think? If you cannot answer, take it on notice, but I am interested to know what the perspective of the college is.

Ms FOLEY: I think it is academic discussing time frames. We have tried to put forward our view that patient education is important. It is important for consumers, it is important for the individual consumer involved in the incident. You are worried about what time frame people will hear about it. The important thing is the process is open disclosure at the time, so those people immediately involved in the incident get resolution. I believe that is much more important than the time frame in which the public might hear about the incident.

The Hon. CHRISTINE ROBERTSON: I recognise that you are a Federal body. Is anyone from your body involved in the Health department's consultation process, the implementation and quality issues?

Ms FOLEY: Not at this stage. We can certainly seek that representation.

The Hon. CHRISTINE ROBERTSON: Do you want to be?

Ms FOLEY: Yes, we would like to be.

The Hon. CHRISTINE ROBERTSON: Do you provide or are you involved in clinical excellence training, quality training for nurses or root cause analysis training?

Ms FOLEY: No.

The Hon. CHRISTINE ROBERTSON: Do you have any of those programs?

Ms FOLEY: No.

The Hon. CHRISTINE ROBERTSON: Do you have quality assurance programs?

Ms FOLEY: No.

The Hon. CHRISTINE ROBERTSON: Do you undertake the nurse practitioners training?

Ms FOLEY: No, we do not. That is done through universities.

The Hon. CHRISTINE ROBERTSON: Do you know the professional group in New South Wales that makes up the bulk of the quality assurance implementation staff and RCA practitioners?

Ms FOLEY: They are all doctors and nurses.

Mr O'DONOHUE: Nurses would. It is not exclusive across New South Wales but certainly nurses are appointed as patient safety officers. In terms of the root cause analysis, there are often a number of nurses who are on those groups.

The Hon. CHRISTINE ROBERTSON: Do you know of any area health service where there is community participation in the clinical teams?

Mr O'DONOHUE: No, I do not.

The Hon. CHRISTINE ROBERTSON: I am a nurse by trade. Being a nurse offers incredible options across the board because of the basic training. Nurses have received a 41 per cent increase in pay since 2000, 14 hours maternity leave, 10-hour overnight shifts. All sorts of things have happened in New South Wales to improve nursing and increase career options. I recall there have always been issues with staffing of nurses. Long before any changes or differences in staffing that may be envisaged now, nurses made a decision to move into other areas. Do you think that nurse training gives nurses greater options and choice?

Ms BRYANT: The undergraduate education that nurses receive now—and New South Wales was the first State to move into the higher education sector holus bolus—is very broad. The undergraduate programs try to provide the students with a broad background and a taste of some of the areas that nurses may eventually be employed in or the specialties they may choose. But there are so many specialties and so many different types of nursing that it is impossible to provide that within the basic undergraduate education. It is our experience that the graduates are equipped then to go out and obviously gain more specialised knowledge and skills in the particular area in which they wish to practice.

The Hon. CHRISTINE ROBERTSON: It might explain the 90,000-odd registered and the 45,5000 not in the public system?

Ms BRYANT: Yes.

Ms FOLEY: Going on from talking about the reasons why nurses leave—the question that Don asked—I think that some of the frustration for nurses is that they have a broad-based education now. They are not just educated in a particular hospital facility to provide care for specific medical people, as was the case 20, 30 years ago. The frustration then is they are educationally prepared to provide a very high level of clinical decision-making across a broad range of clinical areas, whether that be in an acute facility, community, remote or rural, and they enter a system that has not changed, as Rosemary indicated before, and where they are not given the appropriate valuing or respect for their participation in clinical care.

The Hon. CHRISTINE ROBERTSON: Have you read the information on the implementation of the process that is being put through NSW Health in relation to the clinical excellence and quality programs?

Ms FOLEY: Yes, some of it.

The Hon. CHRISTINE ROBERTSON: Nurses have a big space in there.

Ms FOLEY: Yes.

ACTING CHAIR: Thank you very much for the evidence you have provided to the Committee. You have taken several questions on notice. We would be pleased if you would respond to those. There is a possibility that Committee members may have further questions. Would you be happy to answer those?

Ms BRYANT: Of course. Thank you for the opportunity.

(The witnesses withdrew)

(The Committee adjourned at 4.20 p.m.)