REPORT OF PROCEEDINGS BEFORE

JOINT SELECT COMMITTEE ON THE ROYAL NORTH SHORE HOSPITAL

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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At Sydney on Monday 12 November 2007

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The Committee met at 9.30 a.m.

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PRESENT

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

Legislative Council
The Hon. A. R. Fazio
The Hon. J. A. Gardiner

Legislative Assembly
Mr M. J. Daley
Mr P. R. Draper
Dr A. McDonald
Mrs J. G. Skinner
Ms C. M. Tebbutt

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

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

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

I would also ask that witnesses be mindful of the ethical and legal implications of disclosing personal information about patients. Doctors and managers should only discuss personal information about a client or a patient if it is specific to the terms of reference and that person has authorised them to do so. I would also ask my fellow Committee members to consider the ethical duties owed by practitioners to patients when pursuing lines of questions. It is likely that some of the matters raised during the hearings may be the subject of legal proceedings elsewhere. The sub judice convention requires the Committee to consider the impact of discussing a matter that is being considered by a court of law. The weight of opinion supports the view that a parliamentary committee may discuss a matter that has been considered by another inquiry; nevertheless, I remind people today that this inquiry is about systematic issues and not the culpability or otherwise of particular individuals.

The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of guidelines governing the broadcast of proceedings are available from the table by the door. I point out that in accordance with Legislative Council 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 photographs. In reporting the proceedings of this Committee the media must take responsibility for what they publish or what interpretation is placed on anything that is said before this Committee. Witnesses, members and their staff are advised that any messages should be delivered through the attendant on duty or through the Committee clerks. I also ask that everyone please turn off any mobile telephones during the proceedings.

I welcome our first witnesses for today: the Minister for Health the Hon. Reba Meagher and representatives of NSW Health. I do not need to swear in the Minister as she has taken an oath as a member, but I need to swear in members of NSW Health.

DEBORA MARGARET PICONE, Director General, NSW Health, and

KENNETH REGINALD BARKER, Chief Financial Officer, NSW Health, sworn and examined:

RICHARD JOHN MATTHEWS, Deputy Director General, NSW Health, affirmed and examined:

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

Professor PICONE: Yes, I am.

Dr MATTHEWS: I am.

Mr BARKER: Yes.

CHAIR: Minister, would you like to make a brief opening statement?

Ms REBA MEAGHER: Yes, thank you. I would like to thank you for giving me the opportunity to appear today and I want to say at the outset that this Committee will receive my full cooperation and that of my department. This parliamentary inquiry is the most appropriate forum to scrutinise the performance and management of Royal North Shore Hospital. The inquiry will provide an opportunity for the concerns that have been publicly raised to be placed in the broader context of the many challenges associated with the delivery of public health care. The New South Wales health system is not perfect—no system is—and it is unreasonable to expect it to be so. However, it is reasonable for the public to expect that we will strive for improvement at every opportunity. That is why when things go wrong we acknowledge the failure, we investigate the cause, we learn the lessons and we put those lessons into practice. We build on the strengths of our system.

There are over 100,000 people working to deliver public health care in New South Wales. They treat tens of millions of patients each year. The overwhelming majority of people are impressed with the level of care they receive, but we want all members of the public to have that same level of satisfaction with the health system. Soon after coming to the health portfolio it became clear to me that there were management performance issues at Royal North Shore Hospital. That is why I have been active in pushing for change at the hospital. There are no simple one-line solutions; it is not just a question of more funding, although we have increased the funding for the hospital; it is not just a question of more beds, although we have increased the number of beds at the hospital. Primarily, it is the relationship between the leading clinicians and the hospital management that drives improvement.

The performance at Royal North Shore Hospital was a concern to me because it was lagging behind its peer hospital facilities despite being provided with greater funds on a case-mix analysis. These initial concerns have been borne out by more detailed analysis, which is presented in the department's submission. In her first week the new Director General of Health replaced the chief executive of the area health service and put in place a new management team. The new team has been getting on with the job of implementing improvements and responding when new issues arise. I can say that there are already positive improvements being implemented at the hospital. I am meeting with the new chief executive weekly and have made it clear that the hospital's performance must be improved.

There has been improvement in the key emergency department performance indicators. The latest off-stretcher and triage statistics available have all demonstrated improved performance. The number of patients entering the emergency department from an ambulance within 30 minutes moved from 63 per cent in September to 71.2 per cent in October. Triage category 3 performance for October improved significantly from 70 per cent of patients treated within the target of 30 minutes to 76.1 per cent and in triage category 4 performance improved from 72 per cent of patients treated within the target of 60 minutes in September to 82.6 per cent in October. These early results are pleasing and I would like to commend all the hardworking doctors, nurses and allied health professionals for their continued excellent work. The results also demonstrate the new management culture is starting to achieve tangible results.

We are getting on with the job also of lifting morale and performance at the hospital. As individual circumstances have arisen I have taken action to have them investigated and addressed. The

circumstances experienced by Jana Horska and Mark Dreyer demonstrate this point. Shortly after this case was brought to my attention in late September I announced an investigation into procedures governing the treatment of women presenting with signs of miscarriage. Professor Walters, the head of the Royal Hospital for Women at Randwick, and Professor Hughes, the head of the Clinical Excellence Commission, have since reported back to me. This report has been made available to the public. The findings have been used to develop a new model of care for women who present at hospital with signs of miscarriage or complications, with appropriate clinical care and emotional support. Last week in Parliament I announced a new investment of $4.5 million to be spent in the remainder of this financial year to provide improved care for women in the early stages of pregnancy.

The issue of bullying has been a concern at Royal North Shore Hospital, having been raised with the former management sometime ago. I accept that the former management at Royal North Shore Hospital made an error in not immediately addressing cultural and systemwide concerns over bullying at the hospital. But when these matters were brought to my attention I acted immediately.

Verne Dalton and Judith Meppem were commissioned to undertake a complete review, including all previous investigations into allegations of bullying. The new management team is now leading the charge for change and improvement. It has established a professional practice unit which directly reports to the chief executive on staff complaints, and will also refer patient complaints, where appropriate, to the Health Care Complaints Commission. They completed their report in late September. The report has been released to staff, and staff forums have been convened by the new chief executive to ensure that all staff are aware of the zero tolerance policy to bullying and to get their input and support for the implementation of change. An external facilitator, Professor Trevor Waring, the Chancellor of the University of Newcastle, was engaged to facilitate these mandatory information and education sessions for all staff.

The new chief executive has established a nursing task force consisting of nurses from across the hospital. The nursing task force now meets weekly and reports to the chief executive on a fortnightly basis. I met with this task force earlier in the month to hear first hand the issues they were concerned about and to ensure a plan of action for improvement was developed with the full input of nursing staff. The task force has developed a plan and a timetable for action to address specific concerns relating to management systems failure on staffing, the workplace environment and management and nursing communication issues within the hospital. Improvements in all these areas will result in improved patient care.

A number of actions have already been implemented, including a review of the nursing rosters, a review of employment-related processes to streamline the recruitment of nurses, the commencement of a recruitment campaign for the vacant nursing positions and the appointment of a nurse manager to coordinate nurse link programs like the Nurse Reconnect program and targeted overseas recruitment. A new clinical reference group has also been established, bringing together senior doctors from across the hospital to work with the chief executive to develop and implement a new plan for Royal North Shore Hospital.

I met with these senior doctors at their first meeting on 2 October and I was impressed by their commitment and their willingness to make improvements at the hospital. They, too, have committed to give the new executive team an opportunity to make improvements and to work with them to achieve this goal. This is an important step in re-engaging clinicians in decision making at the hospital. I have visited Royal North Shore Hospital on number of occasions in recent weeks and have taken the opportunity to speak directly with staff. I take this opportunity to thank the hardworking staff at the hospital for the work that they do, often under very difficult circumstances. I know they are committed, as I am, to working with the new management to get this world-class hospital back on the front foot. I am happy to answer any questions.

Mrs JILLIAN SKINNER: You talked about the budget for the hospital. I know that there has been a dispute about some of the figures that have been released from the area about the actual working budget for the hospital. Can you comment about the claims that in fact the budget was $18 million overspent last year and the year before, and that in fact the budget this year is $13 million less than budgeted last year?

Ms REBA MEAGHER: First, I make the point that the budget for Royal North Shore Hospital has increased by 157 per cent since 1995.[1] In more recent times that equates to $34.2 million over the last two years, and in fact we have increased the operating budget for the hospital by $9.5 million on last year. So our investment continues to rise in Royal North Shore Hospital. However, the hospital is operating over its allocated budget at this point in time. One of the areas of concern to me when I talk about the poor performance of the hospital I am also referring to poor financial management of the hospital. The new chief executive is working to address that, but I have also made it very clear that there will be no cuts to nurses, no cuts to doctors and no cuts to beds, and our investment in front-line services will continue to increase on those important areas.

But it is important that the hospital financial management is improved and there have been a number of ideas floated with the chief executive to look at ways to do that. One example is to review the current fleet of vehicles used by the hospital. It is anticipated that there may be some waste identified there, and it has also been a priority for the new management to ensure that we are able to transfer as many casual and agency staff into full-time positions because that will also reduce the overheads at the hospital but it will improve patient care as a result as well. So we are moving to a more permanent staff, basically.

Mrs JILLIAN SKINNER: One message I received this morning is that the hospital will cut the maintenance budget by half as one of the measures to try to claw back this budget overrun. Would you think that that was an appropriate measure?

Ms REBA MEAGHER: I certainly have not had any discussions with the chief executive. I understand that he will be appearing later today and may be able to give you additional information on strategies that have been identified. But it is important to highlight that we are investing significantly in Royal North Shore Hospital, including the $702 million redevelopment of the hospital which will be getting underway.

Mrs JILLIAN SKINNER: It is a bit overdue and a long way off, so I do not think it will fix the problem immediately.

Ms REBA MEAGHER: Stage one has been completed, and that is the $55 million redevelopment of the Douglas building, which is a new emergency department, paediatrics and maternity.

Mrs JILLIAN SKINNER: Very fine buildings but does not fix the problem.

Ms REBA MEAGHER: We have also just signed an understanding with the University of Sydney where the New South Wales Government has contributed $61 million and the University $30 million for the new research and education building. So there is continued and ongoing investment in Royal North Shore Hospital because it is one of our leading teaching hospitals.

Mrs JILLIAN SKINNER: Tell me about the investment in cleaning. Recently there was a spring-clean in the hospital. The clinicians I have spoken to told me that it is the best clean they have had in 10 years, just before this Committee happened to visit. Can you tell me how dirty it was when you first visited a few weeks ago, and whether it was acceptable?

Ms REBA MEAGHER: The issue of cleaning was first raised by the nurses when they met with the chief executive on 25 September. They identified at that meeting that the cleanliness of the hospital was not up to scratch. The new chief executive gave a commitment to act on the nurses' concerns. That is an example of good management, responsive management, and a management team that is determined to improve staff morale. So I thought it was very important that in fact there was a demonstrable commitment to act on the concerns raised by the nurses. When you are organising a complete top to toe of the hospital it takes a week or two to get organised—

Mrs JILLIAN SKINNER: And money. How much money did it take?

[1] The Committee has been advised that the budget increase of 157 per cent referred to by the Minister relates to the Northern Sydney Central Coast Area Health Service, rather than the Royal North Shore Hospital.

Ms REBA MEAGHER: That is a question that would again be directed to the chief executive, but the management has acted promptly on the concerns raised by nurses.

Mrs JILLIAN SKINNER: You referred to the relationship between clinicians and management at the hospital and the appointment of a clinical reference group. You said you were very impressed with those doctors when you met with them. Would it surprise you to know that in their submission they think that that committee is pretty hopeless because it has no terms of reference and there is certainly unhappiness among the clinicians about previous reviews that have been done, never implemented, and they do not hold much hope for the future of this one?

Ms REBA MEAGHER: I have not seen the submission to which you are referring so I am unaware of its contents. I can only speak with what I know, and I met with those doctors on 2 October and they assured me that they see the appointment of a new chief executive as an opportunity to move forward and to put the hospital back on the front foot. It is an opportunity to build better relationships with management, a new management plan for the hospital that not only allows greater responsiveness of management to clinician concerns but allows greater input by clinicians in the running of the hospital, and I would be very disappointed if that opportunity was lost. There have been problems at Royal North Shore Hospital and I think we all have to work cooperatively to work through those problems and put this hospital back on the front foot.

Mrs JILLIAN SKINNER: One of the things they complain about is the lack of clinical service plans for this hospital and other hospitals in the area. You would have to understand that it is extremely difficult for doctors and others who are heads of divisions to plan for the future, to know how many patients they can treat and so on, if there are no clinical service plans. How do you answer that?

Ms REBA MEAGHER: I have had discussions with my new chief executive around the importance of a clinical services plan for the area health service, and I have given him six months to complete one. He has already indicated to me that he has started on the framework for putting together the reference groups for clinicians to have involvement in the development of those plans so the preliminary work is underway. I, too, believe it is very important and overdue that the area has a clinical service plan. That is why he is being tasked to get up and running as soon as possible.

Mrs JILLIAN SKINNER: But you understand that the Premier, when he was the Minister for Health, described the creation of clinical service plans as the blueprint for the future and promised to have them available in mid 2006. The director general would know about this because she did the one for south-eastern Sydney. How many other areas do not have clinical service plans?

Ms REBA MEAGHER: I reiterate, we have tasked the chief executive with developing a clinical service plan for North Sydney-Central Coast.

The Hon. JENNIFER GARDINER: I would like to follow up on that. One year ago this week I asked the then Minister for Health, the Hon. John Hatzistergos, for the draft clinical service plans for area health services across the State. You are telling us that the Royal North Shore Hospital's new chief executive officer has been given another six months to come up with one. That is incredible, especially as Mr Hatzistergos said a year ago that some of those draft clinical service plans had gone through the cabinet process or were going through it.

Ms REBA MEAGHER: You have answered your own questions because draft plans were done at North Sydney-Central Coast. I am interested in seeing a blueprint for the way services are going to be delivered in that area health service, and that is yet to be completed. But drafts were done previously.

The Hon. JENNIFER GARDINER: You did not answer Mrs Skinner's question. How many clinical service plans are still to see the light of day in this State?

Ms REBA MEAGHER: I will have to come back with a response to that.

CHAIR: You will take that on notice?

Ms REBA MEAGHER: Yes.

The Hon. JENNIFER GARDINER: Minister, you referred to the cleanliness of the hospital and the time line as far as you are aware of notice being given of its unclean condition. Royal North Shore Hospital did not suddenly get dirty, did it? One submission to the inquiry is from a doctor who had been at the hospital for 16 years—he resigned this year. He refers to the killing of live cockroaches on operating theatre tables during operations and no response when he forwarded a written complaint and requested one. That is not acceptable, is it?

Ms REBA MEAGHER: It is certainly not acceptable. But that is why the new management has responded to concerns of staff at the hospital and ordered its complete cleaning. Again, I am unaware of the documentation to which you refer because I have not had the benefit of seeing it. We are certainly committed to ensuring that our hospitals are of an appropriate standard to be able to deliver good clinical care.

The Hon. JENNIFER GARDINER: I am referring to submission No. 13, which was lodged by Dr Jeffery Sleye Hughes. You will be able to read that.

Ms CARMEL TEBBUTT: Minister, we have already heard from you about some of the improvements underway at Royal North Shore Hospital. Can you tell us more about the plans for the redevelopment of the hospital?

Ms REBA MEAGHER: The $702-million redevelopment of Royal North Shore Hospital and Community Health Services is the biggest capital health works project in New South Wales. The project includes a new main hospital building, with new operating theatres and procedure rooms, a new emergency department and new day stay and ward areas. There will also be new community health facilities on the campus. A new high-quality working environment will provide more convenient and better integrated patient care across disciplines and help to attract and retain staff.

I am advised that the new hospital will provide 626 beds, including 46 critical care beds and 40 mental health beds. As part of the redevelopment, the New South Wales Government has allocated more than $61 million to the construction of a new purpose-built facility for education and research. The consolidation of research and education into a new purpose-built facility will create a dynamic environment with a greater capacity for teams to share knowledge and resources.

In September this year, the University of Sydney committed $30 million towards stage two of the facility. This will allow for the construction of an additional four floors specifically designed for medical research, providing accommodation for up to 350 researchers. The first major milestone—the completion of the research and education building—is due in September 2008. This will allow decanting of the current buildings and then commencement of the main hospital. Planning for the redevelopment has progressed over a number of years and has involved a wide range of stakeholders.

Area health service planning involving clinicians and consumers commenced in 2002. When the project reached detailed planning in March 2006, a redevelopment clinical advisory group was established. The group meets on a monthly basis with the general manager to discuss the issues involved in the redevelopment project. Consultation on the detailed design of the redevelopment occurred in October and November 2006 and involved all clinical and non-clinical departments. The planning process has recognised clinicians' concerns regarding the capacity of the redevelopment, most notably with the design and number of operating rooms, the anticipated growth in maternity services and the number of general and intensive care unit beds. In May 2007, an additional operating room was supported by New South Wales Health following a review and clinician consultation.

The redevelopment will now provide 29 operating and procedure rooms, which is an additional seven on current capacity, and further opportunities for expansion will be built into the hospital design. I am advised that plans for the redevelopment include office space next to the operating theatres that can be converted to additional operating theatre capacity if required in the future. The redevelopment will also locate 12 high-dependency unit beds alongside the intensive care unit to provide flexibility for future upgrades.

With regard the maternity services, I understand there are opportunities for future expansion within the new Douglas Building to meet any additional growth in the demand for these services. The establishment of a level four-five facility at Frenchs Forest will also provide opportunities to share the forecast demand increases in the Northern Beaches and northern suburbs areas. Tenders for the redevelopment of the main hospital building were called in late May 2007 and the public-private partnership proponent submissions closed on 16 November 2007. Subject to development consent for the successful design, construction works are anticipated to commence on the main hospital in late 2008 following completion of the research and education building. The delivery of the Royal North Shore redevelopment as a public-private partnership will see the new hospital operating in 2012. With this magnificent new development, the Government is continuing its commitment to the ongoing health care of the people of North Shore.

Mr MICHAEL DALEY: A number of times in recent weeks you have publicly stated that you have not been happy with the care given to certain patients at Royal North Shore Hospital. How do you propose that under your tenure New South Wales Health will learn from these shortcomings?

Ms REBA MEAGHER: As I said in my opening statement, the New South Wales health system is not perfect, but no health system is. It is unrealistic to expect perfection, but it is my commitment to work with our doctors, nurses, ambulance officers and other health staff to continue to strive for it. There will be times when people's experience within the health system does not meet their expectations about the care they want or the care we believe they deserve. When someone has been let down by our health system, I will apologise. But it is important that we go further than that; we must acknowledge our mistakes, learn from them and provide answers to patients. However, importantly, we must make our system stronger so that we can prevent it from happening again.

That is why we have a clinical excellence commission. The commission is a key component of the New South Wales patient safety and clinical quality program launched by the Government to improve frontline clinical care. The program is ambitious and sets the agenda for one of Australia's most comprehensive clinical quality programs ensuring that patient safety and excellence in health care are the top priority for the New South Wales health system. That is also why the Government has rolled out the Incident Information Management System across all area health services. This system has been in place since May 2005 and provides a comprehensive, systematic mechanism to enable incidents to be electronically notified and managed.

Another important initiative for the New South Wales patient safety and clinical quality program is the statewide implementation of the open disclosure policy. That policy ensures that patients and their carers are informed that an accident has occurred, that an investigation will be untaken and that patients and their carers will be advised of the results of the incident investigation process. That is why these individual circumstances have arisen at Royal North Shore Hospital. I have taken action to have them investigated and addressed. We learn from our mistakes so that we can make the system stronger.

Mr MICHAEL DALEY: Professor Picone, recently the Committee visited the hospital. I, for one, was very impressed with what I saw of the standard of care and the facilities there. Obviously, such a visit does not enable one to see behind the scenes in management issues. In your capacity, what do you think has gone wrong at the hospital, particularly in relation to management shortcomings?

Professor PICONE: Firstly, I thank the Committee for the opportunity to contribute to these deliberations. I begin by stating that New South Wales has an excellent health care system, one of the best in the world. The Royal North Shore Hospital is an essential part of that system and it is a hospital with a proud history of service to its community and to the State. All health services, both in New South Wales and across the developed world, are under pressure from increased demand, greater complexity and severity of illnesses, new technologies, more expensive medication regimes, the ageing population and workforce pressures and finite resources.

With respect to the provision of direct patient care services at the Royal North Shore Hospital, it continues to be a national and international leader in a number of areas. Today, as we speak, patients attending that hospital in the following areas are attending a hospital of international repute: critical care services, cancer diagnosis and treatment, cardiovascular disease, spinal cord injury, severe burn injury, neonatal intensive care, neurosurgery, and pain management and

anaesthesia, just to name a few. Mr Chair, we have detailed all the services that the hospital provides in our submission.

I would like to underscore the commitment and calibre of all the staff. There exists a strong team of clinicians, nurses and allied health professionals and support staff, and today I acknowledge their contribution. It is clear that the Royal North Shore Hospital has had difficulty meeting these challenges in recent years, particularly in the key areas of financial management, patient access and staff morale. Area health services and their facilities operate in a complex environment and senior management have always had to balance competing priorities. The New South Wales Government has implemented significant reform supported by substantial additional investment, particularly increased hospital bed capacity, improved emergency department access, additional elective surgery activity and improvements in clinical quality and safety systems, which the Minister touched on a short time ago.

This year the New South Wales Government is investing $12.5 billion in Health, making Health the largest portfolio with almost one-third of the State's budget. Increased investment at the Royal North Shore Hospital and across the State has come with expectations that patient access to treatment and care will improve. In health care, managers have a core responsibility to balance financial performance, to achieve targets and to ensure appropriate standards of quality and safety. It is often claimed that Royal North Shore Hospital management have concentrated on access targets and standards of patient care at the expense of financial discipline, or, the other side of the argument is, that quality or access issues are caused by limited funding. However, financial problems are generally symptomatic of wider—

The Hon. JENNIFER GARDINER: Point of order: Professor Picone is simply quoting the Executive Summary of the NSW Health submission, which we already have. She does not need to read it.

CHAIR: Professor, you could refer the Committee to the submission. It has been tabled, and we have copies of it.

Professor PICONE: Yes, sir. I would like to touch on some of the issues, because I think I need to get to the heart of why issues at the Royal North Shore are different from other hospitals. In summary, in three areas there are issues at that hospital that have come together. One relates to the financial management of the hospital, the second relates to access issues and the third relates to staff morale. We had to ask ourselves why is it that the Royal North Shore Hospital found itself in these difficulties given that it faces the same demand pressures as any other principal referral institution. In terms of actual demand on its emergency department, it has less than some of our other larger emergency departments.

My view is that these issues have not been resolved at a management level and that we have not had the leadership that we needed to resolve those. The Minister raised these issues with me on my appointment as director general of NSW Health, and I discussed those issues with the then Chief Executive Officer of the Northern Sydney Central Coast Area Health Service, Dr Stephen Christley. It was my view that we needed new leadership to take the hospital forward. The Minister has touched on some of the issues in the brief that we have given Matthew Daly, the new Chief Executive of the service. In relation to staff morale, what has been most evident to me in my discussions with the senior clinical staff of the hospital is that they have over time disengaged in the clinical management and leadership roles within the hospital.

Their view about that is that they have tried and that the issues they have raised have not been addressed or taken forward. I met the group there in the new clinical reference group when I attended that evening with the Minister. I have talked to many of them since then and they seem to me to be re-engaged with the process and quite keen to get the hospital back on the front foot. My other comments are in the executive summary of the departmental submission.

CHAIR: When the Committee inspected the hospital recently, we saw the infamous treatment room. Minister, has there been some change of policy? It did appear to be a storeroom with about six oxygen tanks and a lot of other equipment, with staff coming in and going out while getting supplies. That is not a good atmosphere for a patient who expects 100 per cent care. Have you made any change in that regard?

Ms REBA MEAGHER: The treatment room is used for patient care and has been used for patient care for a long time. It is equipped with oxygen, suction and a patient buzzer. I went on the night with the director general to discuss with the nurses the decisions they had made in relation to the care of a patient. They assured me that they use that room because it affords them a greater line of observation from the nurses' station, and they felt that it was quite important in the appropriate clinical management of this elderly woman. So, the treatment rooms will continue to be used until we redevelop the hospital.

CHAIR: In your opening remarks you mentioned some changes that have occurred with patients experiencing potential miscarriage, such as Ms Horska's tragic case. Perhaps you cannot prevent a miscarriage, but would you outline what steps you have taken to prevent another situation like that occurring, the drama that occurred that night?

Ms REBA MEAGHER: That case demonstrated that we do need a more appropriate model of care to deal with women presenting to emergency departments. They are not like other people sitting in a waiting room with a temperature or a sprained ankle; they should be afforded more privacy and more dignity. The models of care that we have announced involve the establishment of early pregnancy units in those larger hospitals that do not already have them. A number of hospitals already do and they employ those alternative models of care. The models involve rolling out the expansion of early pregnancy assessment units across 47 smaller rural and regional hospitals.

The fundamental principle of the new models of care is to divert women away from the emergency department as soon as they have been triaged so that they are not sitting in an inappropriate environment, such as an emergency department waiting room, but that they go on to those parts of the hospital where staff are available who are specialised in providing the level of not only treatment but also of emotional support that women in those circumstances need.

Last week I was able to announce in Parliament that we have secured an additional $4.5 million to help establish these new models across the system. It will also involve the expansion of the use of a hotline so that women, 24 hours a day seven days a week, will be able to ring an advice line for support. At the moment that line is only available to general practitioners, but we will be investing in, I think, an extra $900,000 so it will be available to the public, which will be an important support for women as well.

CHAIR: The other inquiry you set up into that case of Mrs Horska, we received a copy of that report. The report raised the issue of whether there is too much pressure on the triage nurse and it raised some issues about the function of the triage nurse, who is trying to classify patients and deciding how long they should wait before they see a doctor. Is any review being undertaken as to whether that system needs to be modified in some way?

Ms REBA MEAGHER: The recommendations from that report have been referred to the Emergency Care Task Force, which I set up recently and which engages the heads of emergency departments, and they will give consideration to how best we can implement the findings of that report.

CHAIR: When I visited the hospital, one or two senior staff there—professors—indicated to me that Royal North Shore Hospital used to be one of the top hospitals 10 or 12 years ago and there was some accreditation system that was in that category, and now it is on the bottom. The professors have given some explanation. Is there any simple explanation or summary as to why that hospital declined so dramatically over that period?

Ms REBA MEAGHER: I would like to preface that by saying that the hospital still delivers excellent quality care, and when you consider the size of the institution, that places in context when looking at other complaints when people are not necessarily satisfied with the level of care they have received. This hospital has around 50,000 people present to the emergency department each year. It performs 48,000 separations or operations each year and it provides occasions of service to out patients on 850,000 occasions. So, it is a huge facility that is internationally renowned, also for the specialised services it offers—cardiology, spinal and burns. This is a facility that is able to and continues to deliver first-class care. The issue of concern, of course, is that doctors and nurses have

done that without the support they should have been able to expect from better quality management, and that is an issue we are now trying to address.

Mr PETER DRAPER: I would like to ask Professor Picone—reading through the submissions, one of the common threads is the number of acute care beds available in the hospital. For a layman, could you define acute care beds and advise the Committee how many beds are available in that hospital?

Professor PICONE: An acute care bed ranges from surgical, medical beds, could be neonatal cots, intensive care beds. Dr Matthews is flicking through to make certain I get this absolutely right. We have 599 acute care beds at the Royal North Shore Hospital. They can be mental health beds. There is another range of beds called subacute beds and then transitional care beds. So, at the Royal North Shore Hospital we have, not wishing to bore you, day only beds, which exclude the renal beds and the emergency medical unit, of 28; 321 medical, surgical beds; 20 acute spinal; 25 acute geriatric; 36 intensive care beds; 20 paediatric beds; 32 maternity beds; 25 NICU—that is, neonatal intensive care unit and special care beds; 24 bassinettes, and they range from level one cots to level three; burns and plastics, 12; renal dialysis treatment chairs, 18; drug and alcohol, 14. That is subtotal off 145. And then the subtotal of acute beds is 575 and then we have 24 mental health psychiatric acute care beds, giving us a total of 599.

Mr PETER DRAPER: It was interesting reading in the submission of some clinicians that they dispute that figure. Is there any reason why the clinicians' view is different to that express today?

Professor PICONE: One of the issues we have learned about over the past couple of months is that the management information systems within the hospital are not up to scratch. So, what I would think is basic information for clinician managers, say a medical department head, a head of division or a nursing manager of a ward or unit, a lot of those information systems and information are not present. So, that leads to these sorts of confusing situations. It is fairly historic in hospitals that we always like to debate beds. It is sort of a pastime. But there is a bed if the patient occupies it at midnight, and that is how we do our counts. We have a count called a 12 midnight census and we count the number of patients in beds at 12 midnight. That never lies. That comes off a Department of Health reporting system, but it seems to me from my discussions with the senior medical and nursing staff that that information is not getting to the heads of department, and that leads to these sorts of confusions. I have had those debates with some senior people myself over the past couple of weeks and it has been full and frank and quite enjoyable.

Dr MATTHEWS: If I could add, having had some conversations with those doctors, doctors tend to go and count beds that are relevant to them. So, if you are working in the emergency department you look at the medical and surgical beds and you look at the ICU, because the statewide beds such as the burns and spinal beds are not of such direct relevance. Because things like bassinettes and cots, which are available for very sick neonatal and can be transferred around the State, are not of direct relevance to your particular work, you may not include that in your count. I think it may be that the numbers we have quoted, and the Minister has quoted, are correct and it may be that the numbers that doctors have been talking about are correct within their frame of reference.

There are always difficulties of definition. We look at funded beds, available beds and occupied beds. The occupied beds tell you exactly what the occupancy rates are when you take them as a percentage of your funded beds. It is considered safe from a quality and safety perspective to have somewhere between 85 per cent and 90 per cent of your beds occupied, and doctors become concerned when occupancy rates creep up to 100 per cent. So, in the number of beds, it is terribly important to be absolutely clear what question you are asking and what answer you get.

Mrs JILLIAN SKINNER: To follow on from that, beds is a question that has arisen from just about everyone of the submissions, and it has in just about every review of access block in emergency departments. The reason Jana Horska could not be taken beyond the waiting room, for example, into the emergency department was that all the beds there were full because there was a block getting an inpatient bed in the wards. So, I suspect what the doctors are talking about are the medical, surgical and ICU beds because they are the ones that mostly impact on patients waiting for treatment in the emergency department. Am I right?

Professor PICONE: And also the paediatric beds and also cots, because, as you know, the Royal North Shore Hospital has quite a large paediatric load—

Mrs JILLIAN SKINNER: But they do not wait in the same waiting room, though.

Professor PICONE: —and the mental health beds as well are all relevant to the emergency department.

Mrs JILLIAN SKINNER: Can I ask a question of Mr Barker? Mr Barker, one of the submissions—and it is from the 18 members of the Department of Cardiology at the hospital, which you have rightly said does absolutely wonderful work, and I think everybody here would acknowledge that—states:

> RNSH regularly receives its "Budget" in August—nearly two months into the Financial Year. The year always starts with a deficit of several million dollars inherited from the previous year plus a 6-8% cut …

It goes on later to say:

> The Budget "bottom line" is generally regarded as having been manipulated during the closing months of the FY by the transfer of all manner of funds eg Trust Funds and Capital Expenditure Funds into the General Fund to bolster Management's performance.

Do you know anything about this practice?

Mr BARKER: I will try to answer this question in a couple of phases because you asked a number of questions within the one question. I refer to the budget allocation process arising from a review that we did of Royal North Shore Hospital back in 2005. In the 2005-06 allocation letter, in the 2006-07 allocation letter, and in the current allocation letter we defined when health chief executives must issue allocation letters. For the year just concluded it was 31 July, the year before that was 31 August, and this year we again mandated 31 July. However, with the change of administration we gave the acting chief executive officer a further month, so this year the allocation letters would have been issued on 31 August. For the previous year they told us that they were issued on 31 July. I can only tell you what I have been told in relation to that question.

Referring to adjustments at the end of the year, I am not aware whether that is a specific issue that occurs. One of the things we have required since 2005-06 is for allocation letters to be issued to each of the facilities. At a hospital like Royal North Shore the chief executive would allocate the budget for Royal North Shore and included in that are overheads and direct costs. For Royal North Shore they would also allocate a budget within the major divisions, so it is rolled up. We also have a process that reconciles what has been approved in the departmental process back to the department's allocation.

One of the issues within northern Sydney is that they keep a substantial amount of money called area overheads, or area costs. Up until last year that has generally enabled the area to balance itself out. Whilst Royal North Shore has exceeded its budget there has been an area cost overhead provision that has balanced the area out in ballpark figures come 30 June this year. That needs to be recognised when you are talking about the overrun for Royal North Shore because the area has had money and it has then been able to offset that. To my knowledge, because we get information about how they have moved their budget, it does not mean that they have not deliberately moved their budget by tens of millions of dollars.

Mrs JILLIAN SKINNER: What about trust funds, Mr Barker?

Mr BARKER: General Fund (General) is the key performance indicator outside that. If doctors have made those submissions I would really need to go back to area. It may involve their internal auditor going through and reviewing those allocations.

Mrs JILLIAN SKINNER: Was a matter was brought to your attention in 2005 about the shifting of a cancer bequest of $3 million to pay bottom line? Was that drawn to your attention?

Mr BARKER: That was never brought to my attention in 2005. If you have some assertion of that nature I am happy, through the area, to have that investigated.

Mrs JILLIAN SKINNER: Thank you. Does an internal auditor look at the books?

Mr BARKER: There are two things. There are internal auditors and they are directly responsible to the chief executive. They will do an audit program that is approved by their audit and risk management committee, or words to that effect. Also, the department will often issue advice on what internal auditors shall do, as opposed to what is discretionary. So there are certain things that we require them to do and then they report back to the department. Over the top of that the Auditor-General is required, by legislation, to audit the financial records of the area health service. He goes through a process to ensure that the accounts are signed off by the chief executive officer to reflect a true and fair view of the area's financial affairs. A range of supporting notes complying with accounting standards detail the funds that they hold on behalf of special purpose and trust account responsibilities.

Mrs JILLIAN SKINNER: There have been suggestions from the cardiologists that some of the work they do and some of the very senior positions in that hospital are funded through private donations, through a foundation, through the Royal North Shore Hospital and their own efforts, rather than the Government.

Mr BARKER: Referring to the special purpose and trust accounts, a pure trust fund is set up under a trustee, which is a little more complicated than a special purpose account. With a special purpose account, if money had been given by a group of individuals, an individual, an organisation—there are a lot of non-government type organisations—registered clubs, Lions clubs, and that type of thing, they give it for a specific purpose. The area can then spend that money only for the specific purpose. If the specific purpose has a relationship to cardiology, in my view it is quite appropriate to spend it on cardiology. Other funds are also given which are generally called public contributions where they are general funds. Let me rephrase that. They are given for the general purpose of a hospital. It is then up to the chief executives to determine how to use that.

The other issue is not knowing whether cardiologists are visiting medical officers or staff specialists. If they are staff specialists there is an approved way that they can bill for private patients. That comes into what we call a number one account. The number one account then allows the hospital to take drawings in line with an agreed policy for the cost of the hospital providing those services to a cardiologist's private patients. The private patients then take drawings for their efforts and charge account and audit fees. At the end of the year the residual in the number one account goes into a number two account. There is a policy out on how the number two account can be used and it is generally used for things like training, education and study leave for cardiologists. It is also used to buy plant and equipment in respect of the hospital.

Mrs JILLIAN SKINNER: Where are all these budget documents published? Part of the problem is that nobody—

Mr BARKER: That would be on our website.

Mrs JILLIAN SKINNER: Is that for each of the area health services and hospitals?

Mr BARKER: No. I am saying that in relation to the number one and number two accounts quite a transparent departmental circular is on our website.

Mrs JILLIAN SKINNER: So the doctors at Royal North Shore Hospital could find out?

Mr BARKER: I would be very surprised if any staff specialists were not fully au fait with how their number one and number two accounts worked.

Professor PICONE: Could I add to that? From years and years of working with staff specialists around the number one and number two accounts, it is common practice to use the number two account for the joint purchase of equipment. From time to time you may get a staff specialist who does not agree and who likes that little nest egg to build up. That generally requires some negotiation at the time between the chief executive and the staff specialist. I remember having a very interesting set of circumstances in one of the hospitals I worked at where a doctor did not want to use the number

two account for the purchase of equipment, and in fact did quite a large media exercise around the lack of so-called equipment for the use of treatment of private patients in public hospitals. The only drawings on that account had been for the two Teaching English to Speakers of Other Languages overseas conferences and two motor vehicles. So there are tensions at times, not often, between staff specialists and the use of the number two account.

Mrs JILLIAN SKINNER: I wish to ask another question relating to funding. Correspondence from a doctor at Royal North Shore Hospital to the Coroner in relation to the Vanessa Anderson inquiry talked about doctors and registrars being paid for by foreign governments and, in particular, nominated an amount that was supposed to be used for training purposes but which was not. The allegation was that that was not the case. How frequent is that, and is it the case?

Professor PICONE: The internal audit and audit processes of the area health service would pick up any of those issues. I recall this matter that you raised. At the time I did ask for the internal auditors at the hospital to look at that. Let me also say that it is not uncommon for funds to be provided directly to a hospital for training purposes. We have to understand that the Royal North Shore Hospital has been established for 123 years, has international connections all over the globe, and has regularly taken registrars from international postings. Those arrangements are often made between senior clinicians.

Mrs JILLIAN SKINNER: Provided the money is spent for the purposes for which it was designed, for example, training, and not something else?

Professor PICONE: The issue you raise is quite correct. I understand—and I will take this question on notice and provide the audit—that there was a long-term arrangement over those funds going into a special purpose and trust account. But my understanding was that that was not known to the hospital at the time and the hospital clearly incurs costs in the training of registrars. So that was another one of those local discussions you have to have about what is fair and reasonable, what would go into your trust accounts, and then what is a reasonable cost to the hospital for the purposes of training.

Dr ANDREW McDONALD: Last week other members of the Committee and I were fortunate to be able to visit Royal North Shore Hospital. I have been in a few hospitals in my time and can state quite clearly that Royal North Shore Hospital is a very impressive hospital. We have heard that Royal North Shore Hospital does not perform well in benchmarks such as waiting times in the emergency department, and that the whole hospital needs to be rebuilt. What does that mean for patient treatment, and what does it mean for their experience or their time in hospital?

Dr MATTHEWS: That is a very interesting question and I will try to be as concise as I can. I note from the terms of reference that we are talking about the quality of patient care and I think, in general. the quality of patient care provided at this hospital is extremely high, and I think that is backed up by its national reputation. The experience of care is, of course, a different matter and how you are treated in a real personal way, often in a busy setting, is a different matter and something that that in the health system we need to work quite hard on, particularly in busy emergency departments.

Royal North Shore has about just under 50,000 presentations to its emergency department. To put that into perspective, it is about average for its peers. We rank hospitals according to peer groups. John Hunter, Liverpool, Royal Prince Alfred, St George and Westmead are all what we call A1 hospitals. Liverpool Hospital has about 57,000—quite a few more presentations than Royal North Shore—and John Hunter has the greatest number at just over 58,000.

The performance in the emergency department is measured in seven different ways. There is the off-stretcher time, which is the percentage of patients who are handed from the ambulance to the emergency department clinicians within 30 minutes. There is access block, which is the percentage of patients who are transferred from the emergency department to a ward where admission is the decision. Eight hours is the benchmark, and then there are performance benchmarks for five different triage categories. Each patient is given a triage category, according to standard definitions, by the triage nurse on arrival and that performance is ranked.

In line with the general performance, there are, I think, some interesting challenges for Mr Daly in improving the performance in the emergency department to reach the State benchmarks. In terms of costs—and this is an important point—the Minister mentioned that the hospital admitted just under 49,000 people and discharged the same number, of course. This was very close to the target number last year, but in terms of the cost, when you compared the cost of those procedures on what we call a case-weighted separation—sorry about the technical terms, Chair, but we have a classification system where we benchmark the costs for every procedure.

For instance, if I am admitted for a total hip replacement in Royal North Shore, Prince Alfred or Liverpool, it is possible to compare the length of stay and the actual cost that that hospital incurred in replacing my hip, and we can do that for every type of admission or separation, as we call them. The facts are that when you compare Royal North Shore Hospital to its peer group hospitals, in other words, the top level 5-6 teaching hospitals, the hospital is more expensive for its procedures than its peer group by around about $400 per case on a case-weighted separation basis. So that if Royal North Shore had provided those 49,000 occasions of care at the same average cost as the other peer group hospitals, it would have been about $80 million better off. So there are significant performance issues.

That sits at the funding side and if I am a patient clearly whether or not that hospital is performing in terms of cost as well or not as Liverpool or Royal Prince Alfred is not of great interest to me. What I am interested in is a good quality operation, a good quality recovery and a good experience of the general care that is provided for me. I am not aware of any evidence that suggests that there was any difference between Royal North Shore and its peers on that basis and I think it would be useful to ask those questions of Professors Hughes and Barraclough this afternoon and I believe that hospital, and indeed this system, performs very favourable when compared internationally in terms of critical incidents and adverse events.

We now have the systems through the incident reporting systems, the severity assessment code ratings and the root cause analysis that are conducted as a result of those that actually look at peer hospitals in terms of incidents, in terms of investigations and compare very well across the State and reasonably well interstate and internationally.

Dr ANDREW McDONALD: That moves on to my next question. You have talked about off-stretcher time, access block and triage categories. Lack of beds has been identified by some commentators as contributing to the pressure on the public health system. Would you agree with that?

Dr MATTHEWS: There have been about, I think from memory, 1,800 additional beds over the last three or four years. Models of care in health are changing, and have changed, quite considerably. I remember well when I was an intern many, many years ago if you were being admitted to have a cartilage removed from your knee, you had a 10-day stay in hospital. Today if you are having a cartilage removed from your knee it is done as a day-only procedure and you do not actually go anywhere near that thing called a bed. That is one example.

If you look at renal dialysis, if you look at chemotherapy for cancer patients, if you look at lengths of stay for people who are being operated on, you will see that over the last 20 to 30 years, all of those things have changed considerably and many people who used to occupy a bed, no longer occupy a bed. Beds are somewhat of an obsession, but I think it is far more useful to actually look at how many people are receiving care—and that number has increased each year—and if the care that they are receiving is appropriate and safe, that is from the patient perspective. Then, from our departmental perspective, it is critical to look at relative efficiencies because it is our responsibility to use the available resources as efficiently as possible without compromising quality of care.

Dr ANDREW McDONALD: That leads to my next question—

Professor PICONE: Sorry, Dr McDonald, but I want to touch on a couple of points because I think this is extremely important and it is an issue that is debated in the system, this question of what constitutes a bed. We still operate in an old currency. For example, when we talk about post-acute hospital care, which the Royal North Shore has been an absolute leader in that we have turned to in the general health system to guide developments elsewhere, to describe it so that people understand it, we actually end up calling it a bed equivalent but it really is six weeks of intensive community-based

care at home for the patient, or nine weeks—there are different packages—but we actually have to describe them as bed equivalents.

It seems to me that the time might be coming that while beds are of some interest, actually what is far more interesting is how many patients were actually treated by the hospital. It is a very outdated way of describing what we do. I was actually around later than Dr Matthews by a decade, I think, and I remember when we did abdominal peritoneal resections where the patient had a massive wound, with five or six major drains, in agonising post-operative pain as we tried to manage the pain—this was in a ward that I ran—and they would have a 21-day stay. This operation is for a terrible form of cancer and those patients, due to new surgical techniques, now have a two or three day stay. This health care system of ours now provides treatment that we could not have imagined was possible for patients even a decade ago. That is a very important consideration for this Committee. I just wanted to add that.

Dr ANDREW McDONALD: Can I finish my question now, Chairman?

CHAIR: No. Your time is up. I have just a general question. There have been some reports of cases at the Royal North Shore Hospital, one where a surgeon believed that a patient's life was at risk and a bureaucrat, according to the reports, said, "No, you cannot proceed with the operation." I am just wondering, how do you relate this tension between the hospital management overriding a surgeon's judgment that an operation is actually necessary? Is that a common practice?

Ms REBA MEAGHER: If somebody's life was at risk, that would not occur.

CHAIR: According to the surgeon, he believed the patient was at risk.

Professor PICONE: If I recall that patient care matter, that was a delay in a spinal operation and a senior surgeon made some early commentary in the media in relation to that. My understanding is that there has since been a discussion with that surgeon and he is not quite as convicted at the time that he actually said to a management person, "This patient might die" and the management person ignored that. So, we could provide that notice for you to explain that set of circumstances. That has since been looked into at some length. And to answer your question—

CHAIR: Behind my question is how do you resolve this tension between a surgeon and a bureaucrat making what perhaps was an economic decision?

Professor PICONE: Could I say that in the 33 years I have been in the system I have never seen nor been involved in or heard of a case where a manager would overrule a doctor who says that this patient is going to die if I cannot do X. That is an anathema to what we do. I would be most surprised, to answer your second question, that this occurs on a regular basis. If that was the case, we have implemented a new reporting system—I know you will hear some of that this afternoon from Professor Hughes and Professor Barraclough—to report that. In my view, that would be a serious incident that would require a report. I would notify that as a SAC 1 or 2. That doctor would be entitled to report that administrator, if that occurred. I would encourage any doctor in the New South Wales health system or nurse to do exactly the same.

CHAIR: There is another case that has been reported today in *The Australian*, which is in the submissions we have received, regarding Joyce Batterham, a 90-year-old lady. Again, it is a very tragic case, but my basic question is why does a patient had to wait from 6 p.m. to 3 a.m. to see a doctor when, obviously, there are some very serious health concerns? That seems to be occurring at Royal North Shore Hospital.

Professor PICONE: I have not seen the individual clinical details of the care of that patient, but I do understand that this is the matter of a coronial inquest in any event. But Mr Daly may have better particulars for you.

CHAIR: My question deals with the principle about these delays that seem to occur.

Dr MATTHEWS: I just want it to be absolutely clear about your previous question. At no time do managers or bureaucrats interfere with the care of individual patients. That is quite clear. The

care provided to individual patients is a matter for the clinicians. No manager should interfere in that process.

CHAIR: Is there any procedure where the surgeon feels he should ask the manager for approval as to why the situation arose?

Dr MATTHEWS: Well—

CHAIR: Or was the manager just wandering around? It seems as if there seemed to be some practice, as if I should have approval or—

Professor PICONE: Mr Daly will have better details on that matter, but I understand it was in relation to the approval of an emergency operating theatre. But also, there are other issues in relation to the availability of an intensive care bed. I understand Professor Fisher may be giving evidence at some stage during this inquiry; you may wish to ask him in relation to that particular patient as well.

CHAIR: Thank you very much for appearing. The time—

The Hon. AMANDA FAZIO: Mr Chair, I was wondering if I could ask two questions to be taken on notice?

CHAIR: Yes. We will have any questions on notice. If there are any questions members wish to place on notice?

Mrs JILLIAN SKINNER: No, but I would like to offer an invitation to see if the Minister would accept an invitation to return to the Committee if after we have heard the evidence of other witnesses we feel there are further questions to be answered.

Ms REBA MEAGHER: I am happy to stay longer today if there are questions that remain unanswered. I have made myself available today. I am happy to answer any questions on notice and I am happy also to answer any questions in the Parliament.

Mrs JILLIAN SKINNER: And to come back after we have heard from the other witnesses in the inquiry?

Ms REBA MEAGHER: As I have said, I am happy to make myself available for longer today.

Mrs JILLIAN SKINNER: Not to come back, Minister?

Ms REBA MEAGHER: No.

Mrs JILLIAN SKINNER: You are not going to come back?

CHAIR: We will follow it up in due course. The Committee will make a decision on that. We can have questions on notice.

Ms REBA MEAGHER: That is right.

CHAIR: We have not had very many in the hearing, but there may be some others submitted to you. Could we have those answers, say, within seven days just to assist us?

Ms REBA MEAGHER: Certainly.

Professor PICONE: Yes.

The Hon. AMANDA FAZIO: Can I just ask these two questions to be taken on notice. The first one follows on from Dr McDonald's question, that is, to find out about the levels of access block Royal North Shore Hospital is experiencing and, particularly, on the evening when Jana Horska had

the miscarriage. The second question on notice is a simple explanation of the resource distribution formula. I have tried to look it up and get a bit of a handle on it, but I think a brief written explanation from the department might help the Committee members in their deliberations.

CHAIR: Thank you very much Minister and departmental staff. We appreciate you giving us your valuable time.

(Short adjournment)

MARY DOWLING, Manager, Professional Practice Unit, Northern Sydney Central Coast Area Health Service,

NEVILLE ONLEY, Acting Director of Finance, Northern Sydney Central Coast Area Health Service,

CAROL POLLOCK, Chairperson, Area Health Advisory Council, Northern Sydney Central Coast Area Health Service,

JULIE HARTLEY-JONES, Acting Director, Clinical Operations, Northern Sydney Central Coast Area Health Service,

MATTHEW DALY, Chief Executive, Northern Sydney Central Coast Area Health Service,

ROBERT WRIGHT, Acting Chief Finance Officer, North Sydney Central Coast Area Health Service, and

JENNY BECKER, Director, Workforce Development, Northern Sydney Central Coast Area Health Service, sworn and examined:

CHAIR: Mr Daly, do you wish to make a brief opening statement?

Mr DALY: Yes, if I may. Following the departure of Stephen Christley as Chief Executive of Northern Sydney Central Coast Area Health Service in July 2007, which was shortly followed by the Director of Clinical Operations and the Chief Financial Officer, I took up appointment as the new chief executive of the area health service on 24 September 2007. On my second day as chief executive I suspended my diary appointments to travel from Gosford to Royal North Shore Hospital in response to a plea for help which came from a group of nursing staff. Thus the commencement of the nursing task force. That evening the tragic events of a lady presenting to the emergency department of Royal North Shore Hospital with a threatened miscarriage unfolded.

Royal North Shore Hospital is one of the iconic teaching hospitals in the New South Wales public health system, with national and international reputations in a host of clinical specialties and with an enviable research profile, as evidenced by the flood of National Health and Medical Research Council grants secured this year. It is a superb centre for teaching and training, and a leader in primary health and health promotion of initiatives.

So, despite all the truly remarkable performances at individual and unit level, why do we find ourselves here today? From my perspective, the root cause is, firstly, the loss of staff engagement, particularly clinician engagement, in the governance of the hospital, and secondly, a failure in managing and responding to complaints. This loss of engagement means a loss of opportunity for managers to have the benefit, indeed necessary input, of clinicians into decisions about how to most effectively utilise resources. This disengagement has led to levels of frustration, cynicism and poor morale, which I have witnessed as I have talked to staff at all levels across the hospital. The lack of effective and meaningful partnerships with clinicians has also impacted on the hospital's capacity to make the right investment decisions and set priorities to live within budget allocations provided to it. This has been exacerbated by a lack of internal controls and poor business information systems that has seen staff grow beyond enhancement funding received by Royal North Shore.

Since my appointment I have been overwhelmed by the willingness of clinical staff of all disciplines to come forward and say, "We want to be part of the solution." Hence the clinical reference group, which is guiding the development of a management plan supported by specialist groups, including a community consultative committee, to re-establish Royal North Shore as not just a superb teaching hospital but a great place to work. This willingness is also manifesting itself in an active clinical division management structure, re-established and led by the current general manager, which will, when fully developed, help embed clinician involvement at the operational level.

I have embarked on a turnaround plan for Royal North Shore Hospital. The key elements of this plan will be highlighted in the area health service's submission to this inquiry. The plan is

addressing management systems and support, access performance, and staff engagement and morale. But no hospital stands alone in the 2007 health care environment. The role of Royal North Shore in the network of hospitals that make up the Northern Sydney Central Coast Area Health Service is not defined or clear to the clinicians or the community. Clinicians from Wyong to St Leonards have made it clear to me—and I totally agree—that the area health service lacks a clinical services plan, a plan that is to clearly delineate the role of all hospitals, that will underpin decisions about how the resources within the area health service will be applied, and will aim to achieve equity of access and better outcomes for patients.

The plan will enable area-wide clinical networks to be consistently developed across the full spectrum of services, to enhance standards and deliver services as close as practicable to where patients live. In driving the implementation for this plan I will be highly reliant on our clinical network leaders and their advice so that this area health service operates as a true network of interconnecting and complementary health facilities delivering for its community.

I am confident that in addressing the issues raised in the area health service's submission, together with the input from the hospital's senior clinicians and advice from this inquiry, we can return this fine hospital to a situation where staff can proudly say, "I work at Royal North Shore Hospital." Thank you for the opportunity to speak to the inquiry.

Mrs JILLIAN SKINNER: It has been said in evidence this morning that Royal North Shore Hospital is more expensive than its peer hospitals in providing services. Both the director general and the Minister have said that that is the case. But they have also said that management information systems are not up to scratch. How confident can we be about the cost of services if the information systems are not up to scratch, and about whether we are not comparing something that is not accurate with other hospitals?

Mr DALY: I think it is fair to say that at this point in time confidence would not be extremely high, for two reasons. First, the case mix data that is used for comparative purposes has not been used as a management tool within Royal North Shore Hospital, or the area health service at large for that matter, and clinicians have had very little input into what those figures mean and how those costs are determined.

In the six weeks that I have been at the area health service it has come very clearly from clinicians that they have not seen the data and they do not have the capacity to understand the data. We are working very hard and are now starting to produce first drafts of the data, it having been purified to a level of reliability that I can take to senior clinicians and say, "Can you give me advice as to why?"

Mrs JILLIAN SKINNER: So it may well be that Royal North Shore is not more expensive than its peers. For example, as has been advised to me previously by the chair of a medical staff council, when patients are being looked at they are only looking at one of the elements of care that are required, and therefore it is skewing the length of stay that should be considered appropriate for that patient. That would change dramatically the cost of the occasion of service, would it not?

Mr DALY: Yes. Well, I would hope to have data that is purified and is reliable in the very near future. I have given a commitment through the clinical reference group, that is well represented by senior clinicians, but I will take that data to them and have them advise me.

Mrs JILLIAN SKINNER: Do you have terms of reference for the clinical reference group?

Mr DALY: Yes, I do.

Mrs JILLIAN SKINNER: Could you please provide that?

Mr DALY: Can we provide that to the inquiry?

CHAIR: Yes, take that on notice.

Mr DALY: Yes.

Mrs JILLIAN SKINNER: Because in one submission there is a suggestion that the clinical reference group has not had terms of reference. Maybe that has been changed since that was written.

Mr DALY: It certainly has terms of reference.

Mrs JILLIAN SKINNER: And that at the very first meeting, you referred to a number of reviews that had been done, some five I think, that the clinicians say have never been acted upon. Would that be correct?

Mr DALY: Yes, the basis of the management plan is in fact the compilation of reviews under five specialist headings that had been undertaken. I think I have said quite publicly that Royal North Shore has been reviewed to death. The problem has been that the recommendations of those reviews have not been adequately implemented. So the clinical reference group agreed with me that the basis of the management plan would be about revisiting those recommendations, that group giving the advice about how we should be implementing them, assuming that they are still timely and appropriate to implement. That is the basis of the management plan.

Mrs JILLIAN SKINNER: Mr Daly, one of the doctors in a submission to this inquiry, Dr Jeffrey Sleye-Hughes, has talked about a litany of complaints that led to his resignation recently. He talks about multiple patients with clinically confirmed infected joints or compound fractures being left to "rot in the ward" for 18 hours or more due to inappropriate theatre management. Would you care to comment about that?

Mr DALY: That particular complaint and that doctor's resignation was brought to my attention this morning. It was subject to a number of discussions with management of the hospital and a commitment to address the issues raised. I am not actually across the status of all those complaints.

Mrs JILLIAN SKINNER: There are many complaints and I will not read them all. This one is in a submission that will be made public. But one that really alarms me is this:

> … operating tables breaking in two due to age/fatigue failure whilst the patient was anaesthetised, a spinal injury only being avoided due to the anaesthetist catching the upper portion of the bed before the patient came to harm.

This is not the first time this kind of complaint has been made public about equipment at the hospital being antiquated and putting lives at risk. Is that a fair comment, do you think?

Mr DALY: Certainly I am aware that the incident occurred and maintenance subsequently resolved the issue as it related to the operating theatre. I am also aware that there was no injury to the patient due to the good work of theatre staff.

Mrs JILLIAN SKINNER: Catching the patient, yes.

Mr DALY: I guess that is one of the issues in a financial plan that we need to address—addressing capital needs of that hospital.

Mrs JILLIAN SKINNER: One of the things that has been brought to my attention just this morning is that it is being proposed to slash the maintenance staff at all hospitals in the area as a means of saving money:

> … the proposed reduction at Royal North Shore Hospital of 50 per cent from 35 to 18 to maintain 53 buildings of approximately 50 acres.

Would that be a surprise to you?

Mr DALY: It would be because I am aware of no proposal to halve the maintenance budget or maintenance staff of that hospital. A proposal like that and that significant would certainly need the chief executive to sign off, and no proposal has come to me in that regard.

Mrs JILLIAN SKINNER: Could I ask you about the budget of the Royal North Shore Hospital. There has been much discussion about what the Minister proposes as a budget and

documents that have been sent to me that show cost of services for the year to date, which was the end of September, and which show that in fact the budget for Royal North Shore was $10.393 million over budget at that point, and a further document showing that the way strategies had been suggested to claw back $18 million from this year's budget. Are they correct, those working documents?

Mr DALY: Every hospital in the area health service is required to prepare a budget plan to meet its financial allocation each year. That addresses issues to do with known growth, local service enhancements and, hopefully in consultation with their senior clinicians, new priorities and investment decisions. They have to be funded and the reality is that sometimes things have to be funded at the expense of others. That is why all back-of-house functions are always the first things that are reviewed in order to maintain the highest dollar at clinical service level.

Mrs JILLIAN SKINNER: I do not know whether this question should be directed to you, Mr Daley, or Mr Wright, but there is a suggestion in one of these submissions that there has been a shift of trust funds at the end of financial year to cover the bottom line. Are you aware of that practice, either of you?

Mr DALY: I am not, but—

Mr WRIGHT: I am aware that in some years gone by there was a practice some years ago whereby some expenditure out of the general fund, when the hospital was having trouble with its budget, may have looked at the special purpose and trust funds to try to see if there were trust funds there they could use to offset the financial problem to pay for equipment they had bought out of the general fund.

Mrs JILLIAN SKINNER: Therefore, was a suggestion of $3 million, which was a cancer bequest, ever brought to your attention—that that money had been shifted to cover the bottom line?

Mr WRIGHT: I think it was cancer that was brought to my attention recently; that it was needed to be reviewed because there was a suggestion that some money may have been inappropriately used. That is an area that we are looking at.

Mrs JILLIAN SKINNER: Mr Daley, can I ask you whether you think that that is appropriate—money that has been left to a hospital as a bequest for cancer actually being used to help to cover bottom line deficiencies?

Mr DALY: No. Special purpose and trust funds have deeds that are quite clear and quite specific about what funds can be used for, or not. It is not uncommon at all for special purpose and trust funds to be used quite regularly for the purchase of capital equipment. Every hospital in this State would do that on a routine basis. But for any funds to be used outside the terms of the deed specifically as it relates to donor funds, the rules around that are very, very clear. In my 29 years in Health, I have never seen them breached.

Mrs JILLIAN SKINNER: Mr Wright, if that has happened, what action should be taken?

Mr WRIGHT: We are in the process of reviewing that to determine the extent of the problem.

Mrs JILLIAN SKINNER: Thank you. Mr Daley, I do not know whether you can answer this, but one of the points made by the Minister and the director general this morning is the claim that there has been additional elective surgery done at the Royal North Shore Hospital. Documents I have obtained under freedom of information from the area health service show that in fact to the year 2002 there were 8,800 and elective operations done and in the year 2006 there were 8,329, so there was actually a decrease in the number of elective procedures. Would you care to comment on that?

Mr DALY: Yes. I guess the proof is in the pudding. I think the hospital can be very proud of the way it has dramatically reduced the number of patients waiting for non-urgent elective surgery to what is a very small number, not zero as is the target set by the department—

Mrs JILLIAN SKINNER: That is not the question.

Mr DALY: —but certainly dramatically reduced from what it was just a few short years ago. I guess the other issue in terms of looking at procedures from as far back as 2002 is the way that Health generally has moved some procedures out of operating theatres altogether into treatment rooms so they are not counted as operating procedures. Other work is moved into private settings where we might enter into agreements with proceduralists to lease space and to fund it through private revenue streams. To count the figures in that way is probably a little bit of a guess.

Mrs JILLIAN SKINNER: And some of it goes in as emergency department procedures because they cannot get in electively.

Mr DALY: Yes. There are all those things. It is very difficult—

Mrs JILLIAN SKINNER: So that could account for the increase in presentations in the emergency department.

Mr DALY: It may contribute.

Mr MICHAEL DALEY: You have been the chief executive for a relatively short period of time. Can you tell the Committee what problems you have identified at the hospital since taking up the position and what actions you have taken to address them?

Mr DALY: I guess I would put them into three categories. One is something I covered in part in the opening statement—the lack of engagement with clinicians. I have come from working in two previous area health services where the basis both of structure and operation of those area health services was very much a hand-in-glove partnership with the hospital and the area health service's clinical leaders. I have heard a lot of clinicians being quite disaffected about their capacity to contribute and they are willing to. As a result many have withdrawn. It is pleasing to see that those that appear to have withdrawn in recent years are now coming forward and willingly wishing to participate, whether it is through the clinical reference group that has been established. This support I am receiving to broaden clinical networks, there application across the area health service, and also with the development of a clinical services plan that will be clinician lead and clinician owned—there is no point it being my plan, there is no point in being the planners plan. It has to be the clinician's plan. I am getting very strong support from clinicians right across the area health service, but particularly Royal North Shore, to be key leaders in that regard.

The second area is in relation to complaints handling, which I did not speak to any further in the submission. They are complaints handling in the sense of complaints from patients, complaints from relatives and complaints even from our staff where the corporate governance systems of the area health service have been insufficient to ensure we are adequately responding to all of those. Many are being handled very, very well but all too often it is the most difficult ones that tend not to be closed off, tend not to be able to satisfy all parties to a complaint and that is why an important step in that escalation process to resolve what can be very, very complex complaints or grievances sees the role of the Professional Practice Unit and Mary Dowling's leadership of that.

The third problem clearly is the information available, to both managers and clinicians, in managing a very large and complex budget and the fact that we do have financial problems—we would not be the first hospital that has had financial problems but like each of the other hospitals over the many decades of health that I have been working in it, a financial plan will be worked up and will be implemented and we will get it back on track.

Ms CARMEL TEBBUTT: Mr Daly, you have spoken a bit about some of the action you have taken since you have been in place to address issues you have identified, can you tell us also about some of the initiatives that have been funded by the Department to improve clinical service delivery at the hospital and across the area?

Mr DALY: I guess, looking back over the last couple of financial years; the big contributors have been the opening of the additional 53 beds on the Royal North Shore campus. There is no doubt that has assisted with its access improvement with that capacity. But also the clinical redesign work that clinicians across the campus are undertaking to improve their throughput. We have also had quite

significant enhancement funding for elective surgery and that has facilitated a reduction in long wait non-urgent elective surgery. We still have a way to go there. I do not believe any patient should be waiting more than 12 months for a procedure. You would have to genuinely question the necessity for a procedure to be frank if it can wait 12 months. So I am committed to getting all of the hospitals in the area health service down to a zero long wait. There have been enhancements for intensive care, neonatal cot, severe burns service procedural enhancements. So there has been some quite targeted enhancement funding to Royal North Shore aimed at the key access points and aimed at key clinical services, whether it is for the local community it serves or as part of its statewide responsibilities.

The Hon. AMANDA FAZIO: Mr Daly, a number of concerning incidents have been identified at Royal North Shore since you took over. From your position do you think these are indicative of a hospital that is in crisis, which is what we have been told is the case, and what do you plan to do to respond to these incidents?

Mr DALY: My personal view is I do not believe that Royal North Shore hospital is in crisis. Certainly many of those incidents can be tied back to a failure of our complaints management systems to fully embrace the concerns of patients or their next of kin, for us to feed back in a speedy but open and transparent way what the outcomes of, what poor clinical outcomes may have been and why that occurred and embracing patients or their next of kin in the process to review those incidents and the way forward to ensure they do not happen again.

Dr ANDREW McDONALD: Given the allegations of bullying at Royal North Shore, how do you think your experience in dealing with similar claims at Campbelltown and Camden will assist you in dealing with these?

Mr DALY: Certainly my experience with Campbelltown and Camden hospitals was again a failure of the complaints management systems to appropriately respond, a willingness of management to accept a problem and act upon it. I guess it is the failure to act on problems that are brought to management's attention, regardless of where we are talking about, is what drives frustration. Frustration not only with patients and relatives but also clinicians where if a problem is raised time and time again and seemingly no action is taken it would drive me over the edge so I can totally understand why it would drive others. That, in turn, fuels an absolute disconnect with the hospital. That is what led to the establishment of the Professional Practice Unit in southwest Sydney, as it was at the time, and was enormously successful in handling very, very difficult complaints very sensitively, given the nature and topic, and was able to actually bring those complaints to a resolution where it had not been able to in the past. That model has worked very well I believe in south-west Sydney. It is a model we adopted in south-east Sydney Illawarra and I am very confident that it will work within Northern Sydney Central Coast.

Ms CARMEL TEBBUTT: I would like to ask a question of Professor Pollock. With regards to the Area Health Advisory Council do you have views about what you would like to see happen to make sure that that can operate more effectively to make a better contribution to Royal North Shore hospital and the area as a whole, I guess?

Professor POLLOCK: Obviously we have area-wide considerations but North Shore has been particularly an issue that the Area Health Advisory Council has concerned itself with. We had actually raised many of these issues prior to this blowing up with the particular unfortunate incident of the Horska's. I draw your attention to the submissions I make to the, my committee makes to the Health Advisory Council and in particular the last one dated 12 September, which was obviously prior to all these issues being raised. The key issues I had noted was the engagement of clinicians in particular required to achieve short and long-term budgetary savings. The northern beaches hospital redevelopment was a key issue, in trying to sort out the clinical services planning—because until we are sure as to what is going there we cannot really look at a network situation as Matthew was detailing.

Stabilisation of government structures was an issue, unambiguous information given to the clinicians, clearer articulation as to how community rates of private insurance impact on each of the programs within the funds allocated through the RDF, which was an issue that Ms Fazio raised. It was something we did actually have a report back to the Area Health Advisory Council on at the last meeting because we considered this an issue. That has been a recurrent consideration of the Health

Advisory Council. In a report that I gave to the Health Advisory Council, the statewide group, I raised issues regarding major issues out of the redevelopment at North Shore, which was disengagement of clinicians, retention and retraction of skilled workforce, network development and various other things, reconfiguration of services to support the provision of quality services within budgetary and workforce constraints, implementation of future planning etcetera.

We have actually considered these things at great length. That report was actually given to the Health Advisory Council in April of this year. I could detail the report that I actually gave to the Health Advisory Council in November of last year, which actually highlights the issues that the Area Health Advisory Council have with respect to accountability. We do only have an advisory role so that does place some limitations on what we can actually expect in responses from the Chief Executive. Matthew has indicated to me that he will be responsive to the Area Health Advisory Council's concerns.

I do not think that a lot of these issues are specific to North Shore. I refer to my chair-in-review document that was submitted with my recent submission on behalf of the council that highlighted the activities of the Health Advisory Council. My opening statement was that the area health service as a whole has faced challenges in 2006-07 that can be clustered into the following areas: budgetary; operational, including information technology; workforce; turnover in management; and planning for North Shore and northern beaches redevelopment. They are not things that have escaped our attention. We have certainly been bringing them to the attention of the Health Advisory Council, the chief executive and various people around the table. We are very much engaged and we are very willing to help. We have a fantastic group.

I should also add that Matthew mentioned the clinical reference group that has been constituted. It is largely made up of the core of clinicians that previously contributed positively in other forums. We have also constituted a community reference group, and we had our first meeting of that group last week, I think. It is a fantastic group and I am looking to the community also to support the redevelopment of North Shore back to the state that it should have in the perception of the public. My view is that we do a fantastic job and the clinicians should be congratulated for working under difficult circumstances. I think the community at large recognises that we have had lots of positive comments back but unfortunately that does not make it into the press. I am grateful for this group of community leaders that going to be very supportive of what we are doing.

The Hon. JENNIFER GARDINER: Would Professor Pollock be good enough to table each of the reports that she has referred to?

Professor POLLOCK: They are public documents that have been submitted to the Health Advisory Council. But I am happy to provide them.

The Hon. JENNIFER GARDINER: Can you table them now?

Professor POLLOCK: I have written all over them. Can I provide them at a later date?

The Hon. JENNIFER GARDINER: Sure.

CHAIR: Thank you. Professor Pollock, you mentioned September prior to the events at Royal North Shore Hospital. When was your report prior to September? Do you do an annual report?

Professor POLLOCK: Yes, we do an annual report. But the report I mentioned on 12 September—the previous one was in July. There tends to be two monthly reporting to the Health Advisory Council from each of the area health advisory councils.

CHAIR: How soon did you point out some of the serious problems at Royal North Shore Hospital, from your point of view, in your reports?

Professor POLLOCK: They are all general issues about clinician engagement, for instance. They are not specific to North Shore. It is just that the issues have been raised that are relevant to North Shore. I could say that the same thing has happened at Gosford Hospital, Manly and Mona Vale. It is really a general issue that I am raising. We have raised clinical services planning. I can

supply you—I probably have the Health Advisory Council reports back to August 2006. In that the recommendation we made was: endorsement from community, clinician, researcher in redevelopment strategies and the budget to support the operational activities of networks. Different issues are raised at different times but they have been constant. The pressures are really cumulative pressures at North Shore. I do not think this has been a critical incident that means it has happened yesterday.

CHAIR: Would you specifically mention Royal North Shore Hospital? You said a moment ago that sometimes problems are happening in many hospitals. Did you specifically mention in your reports that a hospital was having special problems?

Professor POLLOCK: I have mentioned North Shore, particularly in light of the redevelopment. I am also chairman of research and the clinicians are at the stage now that the researchers were at maybe 18 months ago. The researchers have done fantastically well, as Matthew alluded to. We were the most successful research-active institute in Australia in the last National Health and Medical Research Council grant-giving round. I think that is partly because the researchers can look at this new building that is going up and feel really positive about their future. The clinicians are still in that phase where in redevelopment you are not quite sure of where your future is, and it does lead to a degree of uncertainty and people lose confidence in the whole system when they are uncertain about things.

CHAIR: Where do your reports go? Who is supposed to act on them?

Professor POLLOCK: I report directly to Matthew—I do not report to Matthew that we discuss things that are issues. Then my reports are directly sent to the Health Advisory Council, which is chaired by Judy Whitworth and Ian Sinclair. Obviously I had regular discussions with the director general and, on occasion, the Minister.

CHAIR: Were you happy with the response you were getting to your earlier reports? Were you expecting a greater response?

Professor POLLOCK: Some of the issues have been responded to and some of them are referred back through the executive for management. For example, I had been concerned that the northern beaches capital development had not been included in budget papers, and that of course creates issues. The people on the northern beaches have been concerned, for instance, that their hospital might not come to fruition, particularly after The Spit Bridge funding was pulled. Without that security it has been hard for those clinicians to then engage with the North Shore clinicians in terms of network development. One thing leads to another. Because of my continued concern that we had not been on the capital funding papers the director general called me and showed me the papers that articulated that the northern beaches funding was secure.

So in that respect there are circumstances where I can go back and reassure everybody—the community as well as clinicians—that there is movement forward. I think people do not understand the time frames in which things happen. You expect things to be done immediately. When a system has been running down for a period, particularly in things like capital development—information technology is probably one of the key areas—it does not get fixed overnight. Their small changes have to build on larger changes but the morale turnaround does not follow immediately.

CHAIR: Mr Daly, you mentioned in your earlier submission that you knew there were some problems at Royal North Shore Hospital and you had to travel from Gosford to look at the situation. There has been criticism, which I imagine is really a government policy issue, about the fact that you are based in Gosford. The people at Royal North Shore Hospital feel that base is very far away to be concerned with the problems of hospitals in the Sydney area. Do you have any views about that? Should your head office be located in Sydney somewhere rather than in Gosford to enable a more hands-on approach?

Mr DALY: I can say a couple of things. One, I think the decision to amalgamate was probably the best thing in terms of patient care and patient safety. I am not sure that we have delivered on those as yet in northern Sydney and on the Central Coast because I do not believe the area health service is operating as an area health service. I think the savings that came out of amalgamation—I can only speak in detail from my previous appointment at South East Illawarra—were excellent for

the $10-plus million that was freed up from backroom operations that we invested specifically in the Illawarra and Shoalhaven. That was the direction from government and we delivered on it. It also delivered more than 300 jobs that we moved out of Sydney to the Illawarra, where unemployment is somewhat higher than in the eastern suburbs of Sydney. So from that point of view I think a very good regional development decision was taken.

People often ask: Are these area health services too big? When I started, my initial response was: Yes. But having now worked through them over three years I think the economies of scale are there for the taking. I think the capacity for the deposit of clinical expertise that now exists within these larger area health services that can be tapped into by smaller facilities and peripheral facilities in the outer metropolitan areas of Sydney are tremendous. Where should the head office be? I really do not care where it is because the nature of the way I work is that I am very hands-on. I do not sit in an office; I get out there and annoy the life out of people by seeing them in their units, in their wards and in their offices. So the nature of the area executive now is that I have told them that they ought to expect to be travelling a lot and actually be in the facilities because that is where the core business is. So in some respects it actually suits my style, and certainly the team that I am building around me, by nature, will have a similar style—it will need to be because if I see them in their offices too often I will be kicking them out.

Mr PETER DRAPER: Mr Daly, thank you for taking the time to show the Committee the hospital. It was very educational. At the end of the day when we were speaking you gave an undertaking to provide a copy of the 12-point plan that you developed with the nurses but that has not arrived as yet. Can you provide the Committee with a copy of that?

Mr DALY: Certainly. I am sorry if I did not do that.

Mr PETER DRAPER: In a large number of the submissions information and communications technology seems to be identified as an area that was allegedly underfunded, which was creating obstacles and blockages. Do you believe the budget is sufficient for that particular area? If not, are there plans to address that concern?

Mr DALY: I think the two are very closely linked, yes. Over the last couple of years I think there has been a conscious decision to hold back investment simply because as a State we are moving towards an electronic medical record. When it started three years ago, it was just fantastic to see leadership coming at a State level so that as patients move to a State system, not just a single hospital or area system, we will move to the capacity to be able to see where patients have had episodes of care at other hospitals in the system. The information that is contained in those episodes of care at other facilities will be of enormous value to the hospital they are now presenting at. It is a major State investment for the electronic medical record, but it will have enormous clinical benefit. It will take a further few years to roll out all the benefits from it in terms of being able to order tests electronically and schedule patients, so it is a staged approach. Royal North Shore will be going live with the first stage of it early next year.

Mr PETER DRAPER: The Deputy Director General, when he gave evidence previously, identified that it was costing $400 per patient more at Royal North Shore Hospital than at other hospitals. Do you have any idea why there is that variance?

Mr DALY: I think that is one of the frustrations that I have heard in talking to clinicians at Royal North Shore, that this data has been tabled.

Mr PETER DRAPER: It is corrupt data, do you believe?

Mr DALY: I do not know that it is corrupt. I am not entirely confident in its accuracy, certainly not to the point where I could take it to a clinician of a specialty and say, "On this basis why are you $400 more than your peers at Prince of Wales or anywhere else?" I think there have been attempts to confront clinicians about their costs and, hence, their practice in the past. I think it has probably generated a lot of anxiety between the parties. Given the reliability of the data, all parties could not sign off on it. It would be silly of me to replicate that until I can show some integrity to the data, at which point I would like to share it with the senior clinicians. Let us face it, I need their advice

as to how practice should change to deliver a model of care that is going to be good for the patient but also at a similar price to the peer reference hospitals.

Mr PETER DRAPER: In your opinion, will the structural changes you are putting in place address the large number of senior people who have been leaving the hospital?

Mr DALY: I do not think it is so much people are leaving the hospital. I think they continue their clinical practice and what they are fundamentally trained for, that is, providing very good care to patients. I guess where we have missed their input is in the management, strategic direction and service development aspects of not just Royal North Shore but the area health service. That is the wealth of expertise that is there and that I wish to tap into. People are telling me that they are prepared to participate and give me that advice. I go by the mantra that you may not always agree with what I might decide but at the very least you will always understand the rationale for it. I think that is only fair, particularly given the nature of the workforce in Health.

Mr PETER DRAPER: That is very encouraging. Are statistics available that show the breakdown between the number of doctors and nurses in the hospital as opposed to the bureaucracy?

Mr DALY: Yes, they are. I think we have included that in the area health service's submission to the inquiry showing the growth of staff within the hospital and the area health service by those professional break-ups and disciplines.

Mrs JILLIAN SKINNER: I refer again to the complaints handling mechanisms, particularly in relation to bullying. I understand there was a report in 2001 and 2003, and then in 2004 a PowerPoint presentation, which was compulsory for all staff to attend, about how staff should behave. Then there was the Meppem-Dalton review in 2007. Do you understand why many staff members, particularly nurses, feel very cynical and distrustful of the capacity of management to address very serious allegations of bullying?

Mr DALY: I certainly cannot understand that with the nursing task force I am working with. They are 15 of the most frank nurses you would ever come across and they have no hesitation in telling me what they think.

Mrs JILLIAN SKINNER: Perhaps you could share some of their views with us. It is likely to reflect some of the submissions. I would be very interested in knowing what they are saying.

Mr DALY: Certainly the issue of bullying and harassment was on their 11- or 12-point plan. It certainly was not their highest priority. There were a host of nursing issues. I am working through them one by one and I am meeting fortnightly with the group to address them. I am not sure I answered your first question.

Mrs JILLIAN SKINNER: That is fine. The majority of the submissions from the clinical staff—who have my greatest admiration and respect—particularly from doctors, are still very much about finances and, therefore, lack of staffing and beds for patients. It seemed to me there is still confusion about beds. When talking about bed numbers, do you separate out, as is done for staff numbers, Royal North Shore and Ryde or are they now considered a health service altogether?

Mr DALY: They are certainly managed as a health service. When I have provided advice to the department on bed numbers, the bed numbers I have provided are specific and peculiar to Royal North Shore Hospital.

Mrs JILLIAN SKINNER: The head of the emergency department, Dr Day, in the summary at the front of his very long submission talks about:

> Most of the complaints that have come through the media have been caused by a stretched, overloaded workforce and a chronically overcrowded ED [emergency department] due to admitted patients waiting for ward beds.

Why, if there are so many acute beds available in the hospital, does the head of the emergency department make that claim?

Mr DALY: I suspect because his staff work very hard.

Mrs JILLIAN SKINNER: There is no doubt about that.

Mr DALY: Yes. The beds are beds. The Department of Health determines the definition for a "bed" and the whole system is obligated to count according to that.

Mrs JILLIAN SKINNER: We are talking about access block—people blocking the emergency department because they cannot be found an inpatient bed. That really is at the heart of the Horska matter and others, particularly relating to emergency. Do you acknowledge that?

Mr DALY: I acknowledge that access to a bed to decanter patients out of the emergency department and into a ward is a contributor. But there are a host of other major contributors in addition to bed availability, and that comes down to processing time, access to clinical teams, after hours, consults. There are a host of things that contribute to access block. I accept Rob's advice that access to a bed is a key contributor, but it is naive to think it is the only contributor.

Mrs JILLIAN SKINNER: What is the bed occupancy rate at Royal North Shore Hospital?

Mr DALY: I do not have the precise figure. It would be above 90 per cent.

Mrs JILLIAN SKINNER: The suggestion in Dr Day's submission is that bed occupancy urgently needs to be reduced to below 85 per cent by providing sufficient beds in the wards. Would you reject that or you think that is appropriate?

Mr DALY: I am sorry, I did not hear your question.

Mrs JILLIAN SKINNER: Dr Day says in his submission there is unsustainably high bed occupancy and that bed occupancy urgently needs to be reduced to below 85 per cent by providing sufficient beds in the wards. That is his recommendation.

Mr DALY: Of course, we would welcome additional beds at Royal North Shore, but we also have a responsibility to ensure we are operating in the most efficient way. That impacts upon things like length of stay, which comes back to the case-mix data, so that at the very least we are in a position to, and we have started doing this, look at our relative length of stay. That is a very clear indicator and measure to ensure we have an average length of stay that is comparable with other teaching hospitals.

Mrs JILLIAN SKINNER: That goes back to the accuracy of your data systems, because there is dispute about some of them.

Mr DALY: In relation to bed length of stay, the data is pretty sound.

Mrs JILLIAN SKINNER: He then goes on to staffing issues and he says that the current 9.8 full-time equivalent emergency specialist positions at Royal North Shore emergency department should be immediately increased to the AMWAC recommendation of 11 to 16—AMWAC being the Ministerial Council recommendation I understand. Could you comment on that?

Mr DALY: I have spent the last four or five years in Health trying to attract more and more emergency physicians and the reality is in fact that there are far more positions that hospitals are willing and wanting to fund than there are emergency physicians, hence the amount of locums at extraordinary rates that we are obligated to employ in order to provide some emergency physician coverage. I continue to recruit not just for Royal North Shore but other emergency departments in the area. There is a vacancy at present within the emergency department, as I understand, at Royal North Shore and even the peak teaching hospitals are having trouble finding people to work in them.

Mrs JILLIAN SKINNER: Could I go on to the practice of employing registrars using money provided by foreign or outside sources and an amount of money earmarked for training purposes that it has been suggested has not been used that way? Do you know what I am talking about?

Mr DALY: I am not familiar with the arrangement you refer to.

Mrs JILLIAN SKINNER: It was something alleged in a letter presented to the coroner in relation to the Vanessa Anderson inquest where a doctor claimed that another registrar was employed at the hospital and her salary was paid by a foreign government—nothing untoward about that, except that there was a $30,000 stipend intended to be for her training, which was not used for that purpose but was diverted for another use. Do you think that would be, if it is correct, an appropriate thing?

Mr DALY: Training hospitals and teaching hospitals like Royal North Shore receive funding from a host of sources—tertiary institutions on a per student basis is not uncommon and it is a revenue source for the hospital. Certainly the teaching and training requirements of students taken in have to be met first, but if the hospital can actually make some type of margin on that to reinvest in direct clinical services I would call that good management, as long as the training requirements were met of the students.

Mrs JILLIAN SKINNER: As long as the training requirements were met?

Mr DALY: Indeed.

The Hon. JENNIFER GARDINER: Mr Daly, you mentioned that the corporate governance systems of the area health service, you have discovered since your appointment, are not up to scratch. Would you be able to provide the Committee with the set of corporate governance guidelines, noting that Mr Iemma when he was the Minister for Health abolished all the boards of the area health services so it is a bit hard to figure out where the accountability lies now in New South Wales Health, and this seems to be a system-wide problem. Would you be able to do that, perhaps on notice?

Mr DALY: Yes, and I guess they will revolve around a number of legislative obligations in terms of timeframes for responding to certain issues as well as performance indicators that the department places upon us for acknowledging, responding to and resolving complaints, as an example. We could identify a list of those and submit it to the inquiry.

The Hon. JENNIFER GARDINER: Going back to the question of budgets, which I think has been mentioned, clinicians have submitted to the inquiry that they only get summaries of hospital budgets. Why can it not be the case that it is standard procedure that the detail of budgets and actual expenses on a hospital-by-hospital basis is made available to the clinicians and also to the public?

Mr DALY: I totally concur. That is why the work of Rob Wright and Neville Onley is very much focused at present on new and appropriate budgeting reporting arrangements so that not only are hospitals very clear—and I believe they already are—in terms of their budget allocation, but more importantly specific clinical services, so that we can devolve management to the unit level, which is where it should be, but the systems at present struggle to facilitate that, to be fair, or to be kind.

The Hon. JENNIFER GARDINER: From your experience in, for example, Illawarra and elsewhere do you believe that should be state-wide?

Mr DALY: My opinion is that it is good management practice and I think we are all in support of good management practice.

Dr ANDREW McDONALD: I have some questions for Mary Dowling. Can you begin by telling the Committee about North Shore's new professional practice unit; specifically, what are the aims and what do you hope to achieve?

Ms DOWLING: The professional practice unit was developed to manage serious patient complaints, staff grievances, contentious issues and issues around professional practice. The unit was established to be an area-wide unit, but the main focus initially will be on the Royal North Shore Hospital. The unit will investigate complaints and grievances in an open, transparent and frank manner, and the main aim of the unit will obviously be to develop or support a culture that supports unhindered reporting of patient complaints and staff grievances.

Dr ANDREW McDONALD: You have previously set up units in two other area health services. How would you compare the situation at North Shore with other hospitals you have worked at?

Ms DOWLING: As Mr Daly said, the handling of complaints and grievances probably has been somewhat inadequate. I have identified in the other two area health services that managers performing investigations need some training. It is a very difficult task for a manager to investigate staff complaints, grievances and issues around professional practice. In my last area in particular I organised, with the help of human resources, 25 senior people to come to a two-day workshop on managing investigations. In doing that, we have a core of well-trained very senior people to assist with investigations. In fact two of the people that we trained, one was the area director of medical services and another was the mental health director of clinical governance. So you need a very senior buy-in from clinical staff to make this work, and I have already met with learning and development and human resources, I have met with the director of workforce development, I have met with mental health, and we are going to develop workshops doing the same thing.

Ms CARMEL TEBBUTT: I want to ask a question of Jenny Becker about workforce issues. We know that medical workforce shortages are an enormous problem right across the country. Can you tell the Committee a bit about what you are doing both in the area and at Royal North Shore Hospital to address workforce shortages and to attract and retain staff?

Ms BECKER: Workforce shortages as a whole?

Ms CARMEL TEBBUTT: Medical workforce shortages.

Ms BECKER: Clinical?

Ms CARMEL TEBBUTT: Yes.

Ms BECKER: One of the most important areas we have to look at is actually monitoring what is going on within the organisation because you get turnover internally where people move from one unit to another, but there could still be a problem, or people move externally. Part of our brief is actually creating ourselves as an employee of choice because it is one thing to be bringing people into the organisation, attracting them, but if we cannot hang on to them we are wasting our time. So we are looking at a range of things.

Within the various groups, for medical, we are looking at safe working hours as an important issue for us. There is a quality project being run on that at the moment within medical administration. There is also some work being done on ensuring that the junior medical staff are sufficient in particular areas, depending on the workload in the area at the time. Allied health has seen a research project undertaken that actually identifies that, two or three years in, people decide that they may want to leave the organisation, and part of that is the flexibility of wanting to travel overseas, wanting to do things differently. Generations X and Y want different things from their workplace. For nursing there is a range of activities, going to university open days—and that is an attracting issue—but for nursing there is a lot of research that has been done on the sort of things that keep nurses in the organisation.

One of the important ones is to do with the capabilities of the managers who are managing these people and work related to that is an important issue. We have looked at performance review; there is a number of tools across the area that address performance management of staff. However, we are looking at a unified tool, which we are trialling at the moment—one tool across the area. The important part of our performance review is that it often is a point of potential conflict if people are not doing it properly. It is one thing to be doing it and another to be doing it really effectively and having that with really good communication skills. So, support for education—which is another point for nurses—is a really important area that we need to monitor and ensure that it happens.

Within the management capability we have had 40 clinical managers last year go through a clinical leadership program—and that was the highest level in the State—and we have another 40 who are moving into that next year. With the amalgamation a lot of people who have moved into management roles have not been at that level before or it may be new to them, and it is really important for keeping our workforce that the managers understand around their workforce, that they

have good reporting mechanisms and we give them information about what is happening so that their capability is actually increased and they have got an opportunity to then manage the staff effectively, because that is one of the singular issues in maintaining your staff: that relationship with their direct manager.

Dr ANDREW McDONALD: I have a question for Matthew Daly. How many beds has Royal North Shore added since 2004?

Mr DALY: The various round of sustainable access improvement program beds over the last 2½ years has amounted to 53 for Royal North Shore.

Dr ANDREW McDONALD: It is just the emergency department numbers finish in 2004. So since 2004 there have been 53 extra beds, is that right?

Mr DALY: Fifty-three beds, yes.

CHAIR: That brings us to the end of this particular segment. We thank you very much for your attendance, for the information you have supplied and for your submission. We wish you all the best for your area.

(The witnesses withdrew)

MARY BONNER, General Manager, Royal North Shore and Ryde Health Service,

COLIN IAN CRAWFORD MURRAY, Acting Manager, Decision Support Unit, Royal North Shore Hospital, and

LINDA DAVIDSON, Acting Director of Nursing and Midwifery Services, Royal North Shore Hospital, sworn and examined:

CHAIR: Thank you very much your attendance. One of my concerns is that our inquiry does nothing to interfere with the operation of the hospital. We appreciate the fact you are here now and thank you for your help. Ms Bonner, do you want to make an opening statement?

Ms BONNER: Yes, please. I have been the General Manager of Royal North Shore and Ryde Health Service since March 2005. Prior to that I was the General Manager of health services for New Zealand's Waikato District Health Board. Royal North Shore has had a number of changes to the executive team since July 2002, which have been disruptive to staff. I have found the staff and community of Royal North Shore Hospital very supportive and over the years I have worked for Northern Sydney Central Coast Health I have established effective working relationships with clinicians. Their professionalism is of the highest standard.

Research supports the fact that excellence in the delivery of patient care attracts high-quality clinicians across all professional disciplines and, as a consequence, Royal North Shore has an excellent reputation for teaching and education. Royal North Shore, like other health organisations is forecasting continuing shortages within the nursing, allied health and medical workforces. In addition to strategies to improve these staff shortages, specialist reference groups have been established to address staff morale, to manage bullying and harassment issues and to report implementation of actions to solve these concerns back to the clinical reference group, a group of senior clinicians set up to advise the chief executive and general manager on the implementation of recommendations from a number of reviews since 2004.

Royal North Shore has a key leadership role in service development for Northern Sydney Central Coast Health, providing a wide range of high-quality services. It has the challenge of serving its local community in providing tertiary services for the area health service as well as being a major trauma centre and providing statewide services for burns and spinal cord injury services. Consequently, because of its excellent reputation patients for specialist services come to Royal North Shore from the population of northern Sydney, from the wider Northern Sydney Central Coast Health catchment and from around the State and beyond.

The provision of all these services is challenging within the capacity and resources available at Royal North Shore. As a consequence, there is a clear need for an area-wide clinical services plan to be finalised to ensure services are provided where and when appropriate to meet community demands for the area. One of the consequences of Royal North Shore being adverse to budget over the past few years has been a low investment in capital. It has also recognised that the information currently available to support clinicians and managers to improve front-line clinical services needs to be provided in a more timely fashion, be available at award clinical and specialty level and include information about case mix characteristics and costs. This information is required for meaningful benchmarking with like organisations.

Emergency access block over the last few months has been an issue and a 100-day turnaround plan is in place to analyse and rectify the identified issues. Although there has been an increase in the number of beds over the last two years, it is well recognised that from efficient service occupancy should average 80 per cent, and Royal North Shore generally exceeds 90 per cent. Further work is being undertaken through clinical redesign programs to improve the bed utilisation and reduce the number of patients not being cared for on their specialty ward. There is a clear commitment by the nurse unit managers, allied health staff and consultants to improve systems and processes in order to improve the care for patients. An example of this is Royal North Shore Hospital's continuing care project, which commenced in December 2006 and has provided extensive diagnostic scrutiny for each in-patient unit.

The focus of the project is on patient assessment at award levels so that effective, safe and timely care can be provided and constraints to a timely discharge can be addressed. Under the continuing care project length of stay and expected date of discharge data are compared with peer hospital group performance. Patient care is the focus of all clinicians and managers. As a result, patient surveys, advice from the community participation committee, complaints received, clinical redesign projects and audits play a valuable role in the implementation of changes in clinical services to improve patient journeys.

Royal North Shore Hospital and community health services are currently undergoing a $702 million redevelopment to deliver a new main hospital building, new community health facilities and new research and education facilities. The aim behind this massive investment is to deliver quality health care services in purpose-built facilities which will represent good value for money while meeting the future health care needs of a growing and rapidly ageing community. I am confident that the staff of Royal North Shore have the ability, the dedication and the commitment necessary to achieve this objective.

Mrs JILLIAN SKINNER: I start with a comment you made that there have been a large number of changes in the management and this in fact has been drawn to the attention in several of the submissions, the fact that there has been such a rapid and dramatic turnover of positions, particularly yours, and I do not think it is any reference to you and reflection on you. I think seven to nine started off chief executive officer, executive director down to general manager of Royal North Shore. Some clinicians feel that that has devalued the hospital and there has been a loss of corporate memory. How do you respond to that?

Ms BONNER: I agree. It always takes some time to get familiar with an organisation so there is the loss of corporate memory of what has happened before. It is difficult for all staff, when there is a turnover, bringing the new person up to speed.

Mrs JILLIAN SKINNER: There has also been a suggestion that nobody knows exactly how many people are working at Royal North Shore. Can you provide any advice about the number of clinicians, and broken down, medical staff, nursing staff, allied health and then what you would call managers, bureaucrats, who are not involved in the delivery of clinical services?

Ms BONNER: We can provide that information. I do not have it in my head. I will take it on notice.

CHAIR: Take that on notice.

Mrs JILLIAN SKINNER: Thank you. I believe in the annual report you can see the top two tiers of management for the area health service. I think I have been given levels three and four as well. Could you provide that as well for the Committee?

Ms BONNER: Yes.

Mrs JILLIAN SKINNER: So that we can see how many tiers of management it is required for doctors to go through in order to get approvals, because that is one of the other things complained about in the submissions. There is such a big disconnect between what a doctor can actually do, and a nurse and allied health, and the processes they need to go through. So can you provide that?

Ms BONNER: We can provide that. That is the delegation process for the area.

Mrs JILLIAN SKINNER: Can you comment on the suggestion that it is very frustrating for some of the clinical staff?

CHAIR: You will take that on notice.

Mrs JILLIAN SKINNER: You mentioned that the bed occupancy rate is an issue for you. How do you believe you can lower the bed occupancy rate?

Ms BONNER: Certainly, the clinical redesign work at present being undertaken is looking at ways that we can take any of the system processes or delays out of that to improve so that people are not delayed through waiting for a result, diagnostic, et cetera. So there are issues that can be addressed in that. Also, the work that has been done in the clinical redesign is identifying the blockages and providing more information. I guess if everyone was to take all the blockages out then we could create more beds by the day.

Mrs JILLIAN SKINNER: So you think it is perhaps not that you need more beds but you need to free up or manage the beds better.

Ms BONNER: We certainly need to manage the beds better and the clinicians are involved in that and are willing to look at different ways to do that. We then need to do some bed modelling and analyse whether or not we would need that.

Mrs JILLIAN SKINNER: Professor Pollack mentioned that the advisory group had a number of concerns they had been raising for some time and she referred to the redevelopment of the hospital. There has certainly been a lot of discussion with me, and I think publicly, about the clinicians' concern that the number of operating theatres will not be sufficient and the number of beds will not be sufficient—in other words, the capacity of the planned new hospital will not be such to meet future demand. Do you have any comments to make about that?

Ms BONNER: I am certainly aware of the discussion around whether the operating theatres would be adequate or not and also for the beds. The clinicians have expressed a desire for eight additional operating rooms to be incorporated into the plans, and planning has indicated 16 operating rooms and 13 procedure rooms will be sufficient to meet future demand.

Mrs JILLIAN SKINNER: So there is a disconnect there between what the clinicians believe and what the planners are saying. Do the nurses have a particular view on that?

Ms DAVIDSON: I have not looked at that information so I cannot comment.

Mrs JILLIAN SKINNER: So the nurses are not involved in the discussion about the future hospital and how it is structured?

Ms DAVIDSON: Certainly the planning process does pull in nursing at all levels, at high level and at clinician level. At this stage it is not at that level of planning.

Mrs JILLIAN SKINNER: So the fact that the brief is out there for the private tenderers means that they will be missing out on having a say in the new hospital, will they?

Ms DAVIDSON: No. I am also a member of the development committee so I do have some input into that.

Mrs JILLIAN SKINNER: Do you share the views of some of the doctors that have been putting forward the proposals to the redevelopment team?

Ms DAVIDSON: Personally no, I do not.

The Hon. JENNIFER GARDINER: Ms Bonner, you mentioned the different levels of services that Royal North Shore is expected to provide to the local community, tertiary services, et cetera, and you mentioned the burns and spinal cord, where New South Wales acts as the whole catchment area for the hospital. Can you give us an idea of how many patients actually come to Royal North Shore from country and coastal New South Wales?

Ms BONNER: I do not have that information but I will take it on notice.

The Hon. JENNIFER GARDINER: With respect to the burden on the Royal North Shore Hospital and the fact that it is operating, as you say, at 90 per cent or 95 per cent capacity, is that partly because of a reduction in surgery that is available at hospitals like Mona Vale, Hornsby and so on? Is that part of the problem?

Ms BONNER: I cannot comment on the specific point but because of our range of services that we have, tertiary quaternary services, we take the tertiary quaternary from the area, the statewide services from the State and some specialities we take people outside and beyond that, too. But I cannot comment on the services at the other hospitals.

The Hon. JENNIFER GARDINER: Ms Davidson, I think you were nodding when Ms Bonner was talking about the need to manage the beds better. Can you give the Committee any suggestions as to how you think that can happen?

Ms DAVIDSON: In my position as director of nursing and midwifery services I also hold the portfolio brief for access, so I am very well acquainted with how we do things and how we need to do things better. There has been a lot of work at Royal North Shore looking at activity and benchmarks and performance indicators. So there has been a lot of redesign looking at the processes. It is not actually about resources but how the systems actually work that we can manage the processes better and get people through the systems.

The Hon. JENNIFER GARDINER: Is it working? How long has such review been going on and is there any measurable improvement or is it simply getting worse?

Ms DAVIDSON: I can say that there is measurable improvement at the moment. Our indicators are showing that some of the systems are starting to work. We have had a number of strategies. We have been told that perhaps we had too many strategies and maybe we needed to focus on some others. The process mapping is actually—and the clinicians are involved in the process mapping in the emergency department, and that is identifying systems errors that slow down the process and therefore impact on our ability to get finite data to provide the actual performance of that emergency department. So in effect care is being provided in a timely manner but how the process has happened is not being articulated in that way.

The Hon. JENNIFER GARDINER: It has been submitted by a number of our submitters that the area health service is now so big that there is not enough emphasis on those parts of the health service, including yours, south of the Hawkesbury River. Do you have a comment on that?

Ms BONNER: I have not noticed there has been a lack of emphasis on North Shore. It is the major tertiary hospital for the area. Am I missing something in the question?

The Hon. JENNIFER GARDINER: No. Do you have any difficulty accessing senior managers given that the area health service is headquartered on the Central Coast, or do they spend a lot of time on the F3?

Ms BONNER: I have no difficulty accessing the senior managers. They spend up to two days a week at North Shore and recently more because of circumstances. They are very available on the telephone and through teleconferencing facilities if need be. I do not have a problem accessing them.

Mr MICHAEL DALEY: This morning Richard Matthews spoke about the quality of care as opposed to the experience of care. How does management at Royal North Shore Hospital monitor and assess patient experiences? Is that feedback generally good or are there problems? What is done with the feedback to improve care?

Ms BONNER: We get information about patient experiences in a number of ways. Patient surveys are a primary source. We conduct regular surveys. A major patient satisfaction survey was carried out recently across the State with regard to food and environmental services. We do not have the results yet. One was done a couple of years ago about perceptions of nursing care. Quite a few of the units conduct individual surveys. For instance, maternity gets monthly patient satisfaction feedback. Our clinical redesign always gets feedback from people experiencing the service about their patient journey and what can be done. We also have the complaints and audit systems, which give us feedback. A good example of feedback on a patient journey is the recent clinical redesign. People have made complaints about communication, delays and service and that has then been worked through. That is what we are trying to do to make beds more accessible in the wards.

The Hon. AMANDA FAZIO: I have a question for Ms Bonner, but Ms Davidson might like to comment. It relates to allegations made in the media that staff would be too nervous to take part in the recent investigation into bullying among nurses at Royal North Shore Hospital. What was done to ensure anonymity for staff who participated and what are you doing to address the concerns raised?

Ms BONNER: The feedback was anonymous; there was no chance that their identity or their position would be revealed. A coordinator position has been established as a result of the report and an action plan has been developed. A specialist reference group has been established to report to the clinical reference group. There is an undertaking to implement all the recommendations in the report. One recommendation was mandatory training about bullying and harassment. Communication and training packages have also been developed. Timely settlement of grievances is being addressed and training sessions are conducted for staff on how to deal with and escalate grievances.

Ms DAVIDSON: As Ms Becker alluded to earlier, performance management, performance development and managing grievances depends entirely on the skills of the manager concerned. Sometimes they can be perceived as inadequate. Then it becomes a grievance issue. Part of it relates to providing that information and improving managers' skills. That has been undertaken as a proactive move ahead. The report said that none of the behaviour was intentional—it was a skills issue. Implementing mandatory education will certainly help to resolve that deficit.

Ms CARMEL TEBBUTT: My question is to Ms Davidson. We have heard a little about your role in representing the views of nurses in the redevelopment process. Can you tell us about some of the other initiatives in place at Royal North Shore Hospital to involve nurses and to ensure that they are consulted, particularly when we talk about improving patient care and patient experiences?

Ms DAVIDSON: Since I have been at Royal North Shore Hospital I have been the executive sponsor of the continuing care clinical service redesign project. I spent a bit of time walking the wards and observing the patient and nurse experience. I have discussed that information with the project manager for clinical service redesign, who has a lot of diagnostic information available from her discussions with the nursing unit managers and clinical leaders on the wards. We have combined the information we have about the areas we need to focus on and the standard of care Royal North Shore Hospital believes should be provided for each patient.

We have initiated a four-week blitz involving every nurse. Every day for an hour each nurse has a practice partner working alongside them raising consciousness about what they are doing for the patient, why they are doing it and who they need to communicate that to. That sounds very nice and it was not a one-off initiative. We want to sustain that because we found that the patients themselves had extremely positive reactions. There was involvement and the nurses and their partners all gave positive feedback.

Royal North Shore Hospital is in the enviable position of having a clinical nurse educator on every ward. They will be ring fenced and they will touch base with each nurse every day at the bedside to talk about planning, who they need to communicate with about it, what action they are taking and what they expect of that nursing procedure. It is very exciting. The professional practice unit is also very good. It provides nurses with a voice if they have concerns about any clinical issues. The divisional structure provides alignment between the nursing unit managers and their divisional managers through an operational manager. They can communicate any issues through that structure.

Dr ANDREW McDONALD: It is incredible that you have a clinical nurse educator on every ward. It is wonderful.

Ms DAVIDSON: I know. It is wonderful.

Dr ANDREW McDONALD: As clinical director of nursing at Royal North Shore Hospital can you tell us about some of the concerns nurses are raising about its functioning?

Ms DAVIDSON: This is great; it demonstrates transparency and engagement. The nurses feel comfortable coming forward with their concerns. Those concerns relate to vacancies at the hospital, the skills mix on some wards and agency staff. We implement processes to ensure safe

patient care practices when agency staff are employed. However, some of those processes can be a barrier to providing timely care. For example, when an agency nurse starts we have a process regardless of whether they have done that previously in another hospital we need to assess whether they are up to the standard at Royal North Shore Hospital. That is a bit of a time lag, so we have changed those processes. Some of the others are around some practice policies that we have put into place. Once again, out of practice outcomes and reflection on practice, which also have a bit of a barrier to nursing. Some other concerns have been around communication, because we are always learning how to communicate effectively; how to get that from the clinical bedside to management. We are learning from those and reflecting on those.

CHAIR: Ms Davidson, following up some matters regarding nurses, I received some anonymous emails from people claiming to be nurses and saying that they were nervous about giving evidence. How would you account for that, for nurses having that feeling at the Royal North Shore Hospital?

Ms DAVIDSON: As I said earlier, I think perhaps it was from what came out of the bullying and harassment report, that it was not necessarily intentional behaviour but some from a skill level. Under my direction we talk about bullying and harassment behaviours and it certainly is not tolerated.

CHAIR: Is there any particular area where bullying is coming from? Is it from the clinicians, doctors or managerial staff? Is it possible to identify the origin of bullying?

Ms DAVIDSON: No, I cannot say.

CHAIR: Where do you think it is coming from? Apparently it is occurring, whether it is intentional or unintentional.

Ms DAVIDSON: The report was undertaken looking at nursing management, bullying and harassment. From the report outcome my understanding was that there were a number of staff who presented who were not only nursing. So from the nursing outcome it was particular areas of groups of nurses, usually in management. Once again, probably on reflection looking at the skill of those nurses in those management positions.

CHAIR: Is it not so much doctors, is it from the management side?

Ms DAVIDSON: I focus on nursing, so I was looking at the nursing.

CHAIR: Ms Bonner, this inquiry is being held because of some problems that occurred with patients at the hospital. Is there a system where you get a daily report? Today there was a report in the media about Mrs Batterham, who did not get to see a doctor from 6.00 p.m. to 3.00 a.m. Did someone make a note of that? Will you get an occurrence report?

Ms BONNER: Yes. Recently introduced has been a daily report of any incident that has occurred overnight. I will have that first thing in the morning.

CHAIR: What would you do when you see an accident report?

Ms BONNER: They are taken through and discussed with the director of clinical operations, if we are talking about significant events. They are certainly discussed with the director of clinical operations and sometimes the chief executive as well on action to be taken. There is a complaint process that we follow as well. As has been alluded to, we need to improve that at Royal North Shore in the way that we deal with complaints and talk to patients and their relatives and we conclude the complaint process.

CHAIR: After you get the incident reports would you have some regular meeting with the head of the different divisions or departments to discuss this?

Ms BONNER: If the complaint is from a certain department, yes, we immediately involve the head of the department and the appropriate nurse unit manager or clinical director in that

complaint. Where possible, complaints are handled and dealt with at a divisional level or a ward unit level. When they become more serious they are escalated further up.

CHAIR: Earlier you said that you commenced in March 2005 and that there had been some problems prior to you taking up that position. Have you been alarmed at some of the events that have occurred in the past year or so since you arrived, compared to your previous experience?

Ms BONNER: Having worked in a fairly large organisation before, it is unfortunate that all events in a hospital do not go to a patient's expectation; there are some unfortunate outcomes. They are always taken seriously and investigated and there is a root cause analysis of the more serious ones so that we can improve for the future. It is always very sad for the individuals and patients, but it becomes a learning process to try to avoid that in future, if possible. I do not see a great number of these issues happening at Royal North Shore than at any other organisations that I have worked for.

Mr PETER DRAPER: Ms Bonner, Reverend the Hon. Fred Nile asked a question of Ms Davidson about bullying. I could see that you were quite keen to say something. Would you give your views on that issue?

Ms BONNER: I was saying that the report was wider than nursing, and it was across all areas of the hospital.

Mr PETER DRAPER: Are you satisfied that that has been addressed?

Ms BONNER: It has been addressed, it is mandatory training. Every staff member will attend a training session and that is happening as we speak. Some positions are being taken at the moment and it will go through the whole of the hospital.

Mr PETER DRAPER: Earlier the Committee heard about key performance indicators and Ms Davidson referred to those in her contribution. We heard that there are signs of very positive improvement and significant advances in key performance indicators comparing what is happening now to what was happening in September. Why it was so bad in September? Did something extraordinary happen then, that we can see such rapid improvement?

Ms BONNER: Our available data and certainly part of our process mapping is showing us that we do not have effective data. Sometimes we are crawling around in the dark to try to find out the core problem. Some data is showing that some attendances are increasing, not just for Royal North Shore but across the whole health system. The number of ambulance presentations is increasing. Our matrix for ambulance presentations within an hour has increased over what it was at the same time last year: it was five an hour, it is now six an hour. That again demonstrates that we have to work in more efficient ways in order to manage patients.

As we a tertiary facility, the presentations that we are receiving are that very often multiple ambulances come and people walk through the front door, people who have equally high acuity presentations. When we reflected and had a look, because, certainly, experiences in the health system at around September are when the winter activity starts to abate, and that certainly we have not experienced that seasonal decline, as normally we would.

Mr PETER DRAPER: When you were mentioning the KPIs you said the improvement is there at the moment. Does that mean that you are uncertain that once the scrutiny is removed that the framework may not be sufficient to retain that improvement?

Ms BONNER: No, I am very confident that the processes we are putting in place are there for sustainability, and that is what is exciting. I know that sounds funny, but it is.

Mr PETER DRAPER: No, that is good.

Ms BONNER: We are getting data that we are being able to manage our capacity and our demands. We are doing predictive for the next 24 hours, plus at 8.30 in the morning we can have a look and see what our capacity will be like for the afternoon and really plan on how we are going to manage that, or what contingencies we need to put in place so that we can be sure that that is

happening. We have been doing that, but not in a formal way. This gives us documentation and formal processes so we can be confident in the information that we have. That data is trying to be really useful and pure. At the moment we are still working on historical data but we are confident that we will get it. When we have reflected on the day before to see whether the strategies we put in place actually had some outcomes, the predictive and the actual were very close. So, with the decision support unit and the people from the Department of Health clinical service redesign project, it has been quite helpful.

Mr PETER DRAPER: Are your information systems adequate for delivering the information you are looking?

Ms DAVIDSON: I think it has been alluded to in previous submissions that there has not been money put aside for the information infrastructure, so I cannot say they are adequate, but they are developing.

Mrs JILLIAN SKINNER: I would like to go back to the grievance and bullying issue again for a minute or two. Ms Davidson, you said you believe nurses are happy now, et cetera. How many outstanding grievances are there in the hospital? Maybe that is something for Ms Bonner to respond to?

Ms BONNER: I do not have that information but we can take it on notice.

Mrs JILLIAN SKINNER: That would be good, because there are some submissions that I cannot refer to because they are in confidence that lead us to believe there are some quite serious outstanding matters not being dealt with. You also said you were confident there is now an education process. I understand there was one in 2004 as well. Why did that not work?

Ms DAVIDSON: I cannot say, because I was not there. The confidence I have is that I am here.

Mrs JILLIAN SKINNER: The Meppem-Dalton review, as it has now been called, makes a couple of comments that I would like to get your comments about. First of all, it says:

> We were surprised that the local New South Wales Nurses Association branch is inactive and understand that there are current efforts to resurrect the branch.

It said the association said there were no significant issues at the hospital. Were you surprised at that finding from the Meppem-Dalton review?

Ms DAVIDSON: No. Since I came across from Ryde to North Shore in the acting position, as a professional the lack of an industrial branch for the facility was something that I thought we needed because it is a voice professionally.

Mrs JILLIAN SKINNER: But there is somebody there now?

Ms DAVIDSON: The branch has been reconvened.

Mrs JILLIAN SKINNER: There was quite a lot of industrial action by nurses at North Shore about 18 months ago about restructuring. The Meppem-Dalton review also states:

> We were overwhelmed by the people wishing to speak with us and the alleged mistreatment of some.

It goes on further to highlight some of the areas:

> Across all disciplines there were strong concerns expressed about the hospitals bullying and harassment policy which is seen as a joke.

It goes on them to say:

> A number of staff told us that it is a strong perception that human resources is there for the benefit of management and not for victims.

Would that be a fair reflection? These are very respected people—Meppem and Vern Dalton.

Ms DAVIDSON: I cannot comment on that. I can only talk about my experience. I am not sure of the time frame they were alluding to.

Mrs JILLIAN SKINNER: If you provide us with the information about how many outstanding grievances, I think that would be really useful. One of the other things that has been raised in relation to nursing, and particularly you mentioned agency nurses, is a concern about the overlap between an agency nurse starting a shift and the person he or she is relieving. In some cases it is up to an hour and a half, which would require either a third-party handover or a written handover. Is that a concern?

Ms DAVIDSON: It is a concern that was raised by the after-hours nurse manager and has since been changed. I cannot give you the exact date that has changed, but it was raised through them. We have now changed that. The agency will work a full shift, but at all times the agency was able to work a full shift, depending on the request of the nursing unit manager in charge. So we have formalised that.

Mrs JILLIAN SKINNER: I have been advised that the person heading up an investigation into grievances was forced to resign after three to four weeks because there was an outstanding grievance against that person. Can you comment about that perhaps, Ms Bonner?

Ms BONNER: I do not have any knowledge of that.

Mrs JILLIAN SKINNER: Perhaps you could take that on notice and let us know? Earlier, Dr McDonald asked a question about how many beds have been opened since 2004. Can you tell us how many beds were closed between 1995 and 2004? In other words, what was the number? Can you go into the records and give us advice about what were the bed numbers at Royal North Shore at the beginning of the Labor Government? I am talking about comparative definitions, the definitions they use now as compared to then.

Ms BONNER: We will take that on notice.

Mrs JILLIAN SKINNER: You raised the issue earlier about changes in management. Can you tell us when people leave Royal North Shore Hospital or any other facility or service, is an exit interview done, which is normal practice in the private sector? Do you find out why people leave?

Ms BONNER: I guess it could be spasmodic, the exit interviews. I know the new chief executive has introduced that, that exit interviews must be done for everyone.

Mrs JILLIAN SKINNER: You talk about patient surveys. It might surprise you to know that the great bulk of these submissions do not come from patients or families, they come from clinicians. I think it would be very informative to get an understanding of what it is that makes people leave the system. It might be just the grass-greener thing or there might be an unaddressed issue that could be fixed. You would agree with that?

Ms BONNER: I agree.

The Hon. JENNIFER GARDINER: The Australian Medical Association and the salaried medical officers have submitted that the clearest failures in the operation of Royal North Shore Hospital appear to be at the management level. They point out that over the past 10 years the hospital has had no less than seven general managers. The members are unable to recall the exact numbers but most suggest the figure could be as high as 10. They refer to acting positions at the hospital. The Decision Support Manager is acting. The Director of Nursing is acting. The Director of Finance is acting. The Clinical Director (Surgery and Anaesthesia) is vacant. The Divisional Manager (Division of Medicine) is vacant and the Deputy Director of Medical Services is vacant, and there are a number of acting positions in the area health service as well. Ms Bonner, could you give us an indication of the time line for when there will be a stabilisation in the management of the health service?

Ms BONNER: It is something we strive to get at as soon as possible, stabilisation. Some of the acting positions are there—the Divisional Manager of Surgery is acting in that role because the incumbent is on maternity leave, and the Manager of Decisions is acting in that role. Sometimes there is a role-on effect through those positions. If there is a clear resignation we aim to fill the positions as soon as possible and make them stable.

The Hon. JENNIFER GARDINER: When do you think the three mentioned as being vacant will be filled?

Ms BONNER: Would you just remind me of the three?

The Hon. JENNIFER GARDINER: The Clinical Director (Surgery and Anaesthesia), Divisional Manager (Division of Medicine) and the Deputy Director of Medical Services.

Ms BONNER: The Deputy Director of Medical Services has been advertised. I am not sure when the interviews for that will be. The Divisional Manager (Division of Medicine) is a permanent appointment. The Clinical Director (Surgery and Anaesthesia) is a permanent appointment, and we are recruiting for the Deputy Director of Medical Services position.

The Hon. JENNIFER GARDINER: When you say they are permanent, they are vacant. When are you interviewing for those?

Ms BONNER: No, there is a person in as Clinical Director (Surgery and Anaesthesia).

CHAIR: Are you saying they are no longer acting?

Ms BONNER: Those two particular positions were appointed into it. I would have to take on notice what stage the Deputy Director of Medical Services is in the recruitment process.

The Hon. JENNIFER GARDINER: Ms Davidson, a number of these submissions referred to the problem of patients at meal times missing out on their meals. It has been submitted by a doctor who trained at Royal North Shore Hospital years ago that when his father was admitted—it was some years ago but obviously he is still very concerned about it—his father would not have been fed at meal times had his family not being there to assist. This seems to be a pretty widespread problem. Does that concern you as the Acting Director of Nursing? Have you raised that issue with hospital management? What is being done to fix that problem, given it is so basic and that patients should have those basic services at their disposal?

Ms DAVIDSON: We even go beyond the term "basic" and call it essential care. We see it as treatment. Currently, a project that is underway, that is headed by the nutrition department, is doing an observational study of patients, their nutrition and their feeding in hospital. It covers not only assistance to feed; it also looks at the nutritional content and attractiveness of the meals being provided. That blitz around nursing care is part of the essential care that we are focusing on. It is not only a nursing care process; we lead because we are there and we are providing direct care to the patients. We are also trialling in one of the wards the use of specially trained volunteers to assist. As our patient profiles become more frail, more aged and more complex, more and more patients require assistance at mealtimes, which outstrips the number of nursing staff or other staff available to assist them. So we are looking at other alternatives to provide that care.

Dr ANDREW McDONALD: You talked earlier of the concerns of some of the nurses and you said that they were concerned about vacancy levels and the skills mix. Have you put in place any initiatives to address those issues?

Ms DAVIDSON: We have already pulled together a working party to look at recruitment strategies. Royal North Shore Hospital has 100.3 full-time equivalent vacancies. Although that is not terribly high in comparison to other peer facilities we felt that we needed to have some strategies to address those issues. So we have already been doing some advertising and recruitment but we are not getting many responses. That is not something being experienced by Royal North Shore Hospital alone. We sought agreement to get a targeted advertisement going and a large advertisement went in on about 4 October outlining why people should come and work at Royal North Shore Hospital.

That advertisement was to run for four weeks. It came out right at the time the episode in the emergency department occurred, which was not the best time to attract people to come to work at Royal North Shore Hospital. So we took the further step of having a flexible advertisement in which we embraced flexibility for nursing staff in providing a 24-hour service. That advertisement is running at the moment. Earlier Ms Becker said that it is not only about recruiting or attracting people to come to work at Royal North Shore Hospital; it is also about keeping people there. Research shows that it involves things such as clinical nurse educators, clinical nurse consultants, supporting nurses to attend education, and skill development.

We are working with a four-generational work force and we are identifying what it needs. A working party is looking at that. We also have overseas nurses, Reconnect nurses, training enrolled nurses and new graduate nurses. Normally we sit with about 94 new graduate nurses. We have increased that number to 110 for next year so we can demonstrate what is happening at Royal North Shore Hospital and we have a sustainable work force there.

Dr ANDREW McDONALD: You referred earlier to the need for flexibility and education. What other changes would you like to see to make Royal North Shore Hospital a more nurse-friendly environment?

Ms DAVIDSON: We are looking at a valued work force. However, a lot of that value has to come from the nurses themselves. We are looking at a multidisciplinary team and at the role of nurses within that multidisciplinary team so we can empower them and give them some autonomy to make decisions. It is about process mapping and what will come out of that, and skills development to assist in autonomous decision making.

Mr MICHAEL DALEY: How has recent media reporting on events at Royal North Shore Hospital affected staff—first, nurses and, second, clinicians and staff generally?

Ms DAVIDSON: I think Professor Pollock said earlier that we are getting a lot of positive reports from patients. We are doing media briefs for the media and we are not getting there. Nursing staff feel that they do not have a voice in the community. It was reported to me that some nursing staff in the community are undergoing similar situations to those being experience by their colleagues at Camden and Campbelltown, that is, abuse in the streets and episodes of spitting. When that comes back morale within that environment tends to wane accordingly. We are trying to gather some of those positive experiences so we can get that information to nurses. The nursing staff that are there are professional and committed and they provide excellent and professional nursing care.

Mr MICHAEL DALEY: There is no doubt about that.

Ms BONNER: I would like to refer to all staff. A number of members of staff who have worked at Royal North Shore Hospital for a long time are skilled and very committed. They find teaching difficult because they provide excellent care and a lot of specialities. As I said before, it is unfortunate to be having this teaching at this point in time.

Mr MICHAEL DALEY: Did you engage someone to boost staff morale generally?

Ms BONNER: Yes. A specialist reference group has been set up to boost staff morale and to support and encourage staff. At this point in time it is focusing on the retention of staff.

The Hon. AMANDA FAZIO: Ms Davidson, you referred to extra care requirements for frail and elderly patients that you are encountering more frequently these days at Royal North Shore Hospital. Are these patients also contributing to access block, whereby people cannot go through the emergency department and into beds in the ward because the frail aged are taking up those beds when they probably would be better placed in a nursing home?

Ms DAVIDSON: I do not have the exact figures. If you like, I will take that question on notice and provide those exact figures. No nursing home or residential care beds available are in the community for some patients to move into. However, I will provide that information on notice.

Ms CARMEL TEBBUTT: We heard earlier from Mary Dowling, head of the Professional Practice Unit. What is your view about the impact that the Professional Practice Unit will have on the hospital?

Ms BONNER: I certainly welcome the Professional Practice Unit. We have issues that have been unresolved and we are about to have a more timely resolution of some of the complaints that, in some cases, are very complex for both staff and patients. It is a good introduction to the Northern Sydney Central Coast Area Health Service.

Mrs JILLIAN SKINNER: I would like my question to be taken on notice. Earlier, in answer to a question asked by Reverend the Hon. Fred Nile, you referred to people being able to speak out and not being fearful. I think a guideline is given to staff about their role and responsibility when speaking out. It would be useful if you could you provide that guideline for the Committee.

Ms DAVIDSON: Yes.

CHAIR: Ms Davidson, you said earlier that you were giving media briefings but that you were not getting much response. Who does those media briefings? Were you doing them or do you have a media person who does them?

Ms DAVIDSON: Yes, but we provide the content.

CHAIR: You provide the content, but you were not happy with the response.

Ms DAVIDSON: The organisation does them and not me personally.

Mr MICHAEL DALEY: What is the nature of the news releases that you put out? Are they good news stories and things like that? Give us an example.

Ms BONNER: One example was the introduction of the single photon emission computed tomography scanner at Royal North Shore Hospital. It was great to have a SPECT scanner.

Mrs JILLIAN SKINNER: Tony Abbott attended that presentation, did he not?

Mr MICHAEL DALEY: And it was not even reported widely.

Ms BONNER: And some really good services provided.

CHAIR: Mr Murray, we have not asked you any questions. Earlier we spoke of another case where a surgeon said he was stopped, allegedly—from all these reports I will say "allegedly"—from pursuing with an operation by someone who said, "You should not proceed with that." Do you know who that was? Was that a factual event—it was a spinal case?

Mr MURRAY: I am not aware of that incident, I am afraid.

CHAIR: Your role is?

Mr MURRAY: Decision support, so, provision of information.

CHAIR: Giving advice to the clinical divisions?

Mr MURRAY: In terms of provision of information data, activity information.

CHAIR: You have no contact with the actual surgeons directly?

Mr MURRAY: Not directly, no.

CHAIR: Our time has concluded. We thank you again for appearing before the inquiry. We wish Royal North Shore Hospital all the best, you have been number one and that you will be number one. We want to help you achieve that.

(The witnesses withdrew)

(Luncheon adjournment)

ANTONY SALLA SARA, President, Australian Salaried Medical Officers Federation,

ANDREW DONALD KEEGAN, President, Australian Medical Association New South Wales, and

SIMEON JONATHAN MEAD, Executive Director, Australian Salaried Medical Officers Federation New South Wales, sworn and examined:

CHAIR: Thank you for agreeing to appear as witnesses before our inquiry into Royal North Shore Hospital. Dr Keegan, in what capacity do you appear before the Committee:

Dr KEEGAN: As the President of the AMA.

CHAIR: Dr Salla Sara, in what capacity do you appear before the Committee?

Dr SALLA SARA: As President of ASMOF.

CHAIR: Mr Mead, in what capacity do you appear before the Committee?

Mr MEAD: As the Executive Director of ASMOF.

Dr ANDREW McDONALD: Mr Chairman, may I declare a vested interest. I am a paid-up member of the Australian Salaried Medical Officers Federation.

CHAIR: Seriously?

Dr ANDREW McDONALD: Yes. I am a paying member of the Australian Salaried Medical Officers Association.

CHAIR: Do any witnesses wish to make an opening statement?

Dr KEEGAN: I think Dr Salla Sara and I shall, starting with myself. Thank you for the opportunity of allowing me to appear before the inquiry. I am the President of the Australian Medical Association New South Wales. I am a gastroenterologist and I hold a visiting medical officer position of appointment at Nepean Hospital where I have been for some many years since 1989. AMA New South Wales has joined with ASMOF New South Wales in making a submission to this inquiry. AMA New South Wales and ASMOF are the peak medical representative groups in the State and we join together to show the seriousness of doctors' concerns about the Royal North Shore Hospital and other hospitals in New South Wales. We are disappointed by the limitations of the inquiry. The short time for submissions has compromised the ability to undertake a comprehensive review of the issues at Royal North Shore. More importantly, limiting the terms of reference of the inquiry has prevented a comprehensive review of the statewide public hospital system.

There is anger and frustration from doctors across New South Wales about the state of the hospitals and it would have been appropriate to provide an opportunity to address those concerns through an appropriately constituted inquiry. With regard to the incident from which the inquiry originated, that is, the care provided to Ms Horska, we would seek to have the terms of inquiry widened to include the way in which the incident was reviewed. In our submission we have noted our disappointment that such a superficial review had occurred. The review conducted into Ms Horska's care shows that the health system still is not able to look beyond individual patient incidents to address systemic factors that lead to unsatisfactory patient care.

With regard to other terms of reference, in our submission we have detailed the frustrations of doctors at Royal North Shore Hospital. Doctors at North Shore are frustrated and saddened by the perceived demise of their hospital. North Shore has gone from being one of the premier hospitals in Australia to last year not being able to achieve ACHS accreditation, and now operating under conditional accreditation. The doctors are frustrated also by the difficulties of having to work under at leased 7 general managers over the last 10 years. We are pleased to see that some of those general managers are appearing before the inquiry today and we hope that they will provide direct evidence of

what we and our members can only assume, that is, the difficulties of running a hospital when there is little or no response or support from above.

We are calling on the inquiry to make a real commitment to improve the problems of managing Royal North Shore Hospital. This commitment cannot simply be a trite statement of the need to ensure stable management; it must, instead, be an examination of the factors that have caused the turnover in management and the institution of strategies to address the problem now and once the spotlight has again faded from Royal North Shore Hospital. We also call on the inquiry to urgently address our members' concerns about widespread failures in consultation associated with the redevelopment process of that hospital. We have provided two specific examples in our submission, in relation to pathology and mental health. However, the concerns about redevelopment were widely expressed across all specialties.

Our members acknowledge that the demise of the management of Royal North Shore Hospital has been a slow process. However, there is a consensus that the problems have worsened considerably since the Government amalgamated the area health services in 2004. The amalgamations removed mechanisms, such as area boards, which allowed doctors to have an oversight of the clinically relevant decisions made by the chief executives and managers. Since amalgamation, authority and responsibility has resided solely with the chief executive, leading to frustrations and delays in decision making. Simple decisions on appointments, resources and equipment are delayed, and the phase—on the chief executive's desk—has become a by-law for a system gone mad on red tape.

The other casualty of area amalgamation is the medical staff councils. Medical staff councils are established committees to which all senior doctors at the hospital are able to belong. Medical staff councils provide a mechanism for doctors to comment upon issues facing their hospital. Since amalgamation, the medical staff councils have become powerless, removing an important source for doctors and a mechanism for patient-centred care. We therefore call on the Committee to reinvigorate the clinical governance process by reinstating the role of medical staff councils and medical staff executive councils and giving those councils direct, mandated access to hospital managers, chief executives and the Minister.

The limited time has prevented us from detailing the issues facing all the specialties at Royal North Shore Hospital. However, we are aware that doctors are making specific submissions relevant to their specialties and we support those submissions. Doctors are interested in looking after patients. They are involved in and consulted about their hospitals; they will be advocates for those patients and those hospitals. They will provide the feedback necessary for the care and wellbeing of the patients.

As a doctor associated with the public hospital system, I know that the story of Royal North Shore Hospital is a story of every public hospital in New South Wales. It is a story of doctors, nurses and allied health staff providing excellent clinical care to their patients but being frozen out of decision making and clinical governance. This Committee has the opportunity to address this frustration and anger, and to implement recommendations to improve the delivery of health care, not only of Royal North Shore Hospital but across New South Wales. Thank you.

CHAIR: Dr Sara, do you wish to make an opening statement?

Dr SALLA SARA: Yes. My background is that I have been a doctor for more than 23 years. I have been a medical manager for about 20 of those years. My last full-time medical management job was at Sydney Hospital. I have been the President of the Australian Salaried Medical Officers Federation for about five years now.

The Australian Salaried Medical Officers Federation is concerned that the risk of highlighting problems at Royal North Shore Hospital is that the public will think that the staff are not doing a good job, and that obviously bothers us because the staff are our members. We are aware that some staff in the emergency department were verbally abused by members of the public following the recent publicity. In response to this, it needs to be emphasised that the medical staff at Royal North Shore Hospital, and in New South Wales public hospitals generally, are world class. Many of them have international reputations in their areas of expertise.

The problem is not with the quality of the doctors, nurses or other health professionals; the problem is the under resourcing of the hospital and the consistent failure to involve the senior clinicians, in our case doctors, in the planning and decision making about the allocation of resources. The under resourcing at Royal North Shore has resulted in a gradual deterioration of the hospital. Our members report that the under resourcing at Royal North Shore has meant that they are not able to do their jobs as well as they want to or as well as they should. As a result, patients are not getting the service and the care they deserve and we owe them.

The key issue in this regard is the lack of adequate bed numbers, as detailed in our submission on pages 14 and 15. Royal North Shore is running at an occupancy rate of about 95 per cent. International research clearly demonstrates that hospitals running at an occupancy rate of more than about 85 per cent cannot cope. The direct result is the access block in the emergency department. Royal North Shore needs about another 70 beds to achieve that 85 per cent occupancy rate. That is what really happened in the emergency department. The emergency department was full, there were no beds in the hospital to get the patients out of the emergency department, and so this woman—who should have been on a trolley, should have been on a bed—was not; she was in a waiting room facility. There were no beds in the emergency department because there were no beds in the hospital. It is very simple.

Another example of under resourcing is the poor clinical information systems. The quote from a doctor at the bottom of page 6 of our submission highlights that patient records are not available in about 30 per cent of cases in outpatient clinics. That is absolutely bizarre. There is another quote from a doctor on page 6 about eight doctors frequently queuing for one personal computer to get laboratory results. It is absolutely incomprehensible. As well, the lack of a meaningful capital budget means that staff rely on broken or outdated equipment. There are some references in our submission to some of the nonsense that has been going on there.

The workforce is, of course, the key resource in any hospital. So they are demoralised, they are frustrated, and they are not able to do their job. We need to continue to try to attract and retain medical staff to hospitals: we have a worldwide shortage of doctors. As far as we can see, the area health service does not appear to have a workforce plan of any sort, so it is not planning to fill the vacancies, to recruit and retain doctors at the hospital. The workload of the clinical staff is steadily increasing and administrative support has been drastically cut. So the doctors are having to do more administrative work, when they should be seeing patients. When we have a shortage of them, it does not make a lot of sense. The staffing establishment is completely unrelated to the number of patients treated, and there is detailed reference to that on page7 of the submission. Thank you.

CHAIR: Mr Mead, do you wish to comment?

Mr MEAD: No thank you, Mr Chairman.

The Hon. JENNIFER GARDINER: Dr Keegan and Dr Sara, you may wish to comment on this. You have expressed concern about the short time frame for this inquiry and about the narrow terms of reference of the inquiry. Do you believe that there should still be, regardless of this inquiry, a comprehensive review of the New South Wales hospitals system? If so, what do you think the nature of the inquiry should be? For example, have we reached the point where we should have a judicial inquiry or a royal commission, for example?

Dr KEEGAN: The judgement as to what form it is in is not ours, obviously, but the information that our members give us is that there is major concern about the function of the public health system in New South Wales. Any process which may improve that and satisfy what is a growing concern about the ability to look after patients, as well as we would like, would have to be a good thing. I guess the simple answer is that it depends on what can come from this inquiry, but any process that initiated an improvement in what seems to be a growing problem would be welcome.

Dr SALLA SARA: Thank you for the question. Yes, the Australian Salaried Medical Officers Federation would support an inquiry. As Dr Keegan has indicated, it is not so much the form but the fact of having one. Politics is the art of the possible, so whether such an inquiry happens I guess is another matter.

The Hon. JENNIFER GARDINER: Gentlemen, you have been at pains to make sure the Committee understands that the problems at Royal North Shore Hospital are also being felt at most hospitals and health services across the State. Could you give us a feel for perhaps a couple of examples of the sorts of crises besetting other hospitals?

Dr KEEGAN: I do not know whether we should be thinking in terms of crises; possibly impending crises, but I do not know about crises as yet. I think we do have to note that the quality of the clinical staff that we have out there is actually preventing a lot of crises from occurring. What we are seeing is it is becoming harder and harder for those clinical staff to actually look after their patients. What we are seeing is that it is becoming more difficult to progress even staffing management.

I am aware that multiple signatures are required. In the Royal North Shore Hospital situation, if you want to expand your senior clinical staff, you need seven signatures on an application. As Dr Sara said, you have to virtually fish for your senior clinical staff. There is a worldwide shortage. Unless you can grab them when they are available, you lose them, so you lose that skill. I am also aware that a similar number of signatures is required in quite a number of other area health services. We get reports from across the State from people not being able to replace staff or not even being able to start recruiting staff when someone is retiring or leaving. From a senior workforce point of view, that is where it stands.

The workforce is going to be a major thing in terms of medicine. We are not aware in New South Wales of any workforce planning across New South Wales of note. We are going to have an increased number of medical graduates, as is mentioned in our submission. We are anxious to see any planning on how those graduates are going to be trained to become specialist and general practitioners. As far as we can see, that is not happening. Certainly there are clinical services plans in most area health services, but I understand that is not the case in the North Shore area. I also understand that it was supposed to be two years ago that a study or an assessment was to be done of how many various specialties were required across the State, and that was to be managed, recorded, and planning made to maintain their workforce and enhance that workforce. We understand that is not happening.

The Hon. JENNIFER GARDINER: And such an analysis was meant to have been funded by the New South Wales Government, as I understand it.

Dr KEEGAN: That is my understanding, yes.

The Hon. JENNIFER GARDINER: And that is pretty fundamental, is it not?

Dr KEEGAN: I would think so.

The Hon. JENNIFER GARDINER: Given the fact that the shortage of medical staff is not a new problem: It has been an emerging one for a very long time now. Just in relation to the restructure of their health services in 2004-05, in your submission you say that a focus on area-wide services at the expense of identifying individual hospitals has not worked. In your opening statement you mention the amalgamations, the abolition of the area health service boards, the elevation of the chief executive officer being the sole person in charge and a system gone mad, and the decreasing significance and power of medical staff councils. Can you point to any benefits of the restructuring? In particular, are there any benefits for patient care?

Dr KEEGAN: I think I can perceive that there are probably benefits and I believe there were in a corporate sense, but my business is looking after patients. I have not really perceived a benefit from that side of the business.

Dr SALLA SARA: My experience is that there have been some benefits. There has certainly been a reduction in administrative costs. There is some argument that that has potentially gone too far, but the amalgamations will have provided expertise in a sense to the second cousin in the merger. For instance, I work for South Eastern Sydney and there has certainly been expertise made available to the Illawarra. I am the part-time director of clinical services there, so in a sense I am living proof that, yes,

there has been a transfer of expertise in the area health services, particularly to the more rural and other parts of it.

Certainly in other area health services I understand that that has occurred, so that is clinical expertise and managerial expertise, and there has been a plus to the ledger, but it has been very difficult on those tier two persons. We are sitting in South Eastern Sydney, which goes from the edge of the harbour just to our north all the way to Milton, so it is certainly very hard on those people. It means that they cannot manage as well as they should, so that is essentially what we mean in our submission. The geography is so big you just cannot devote the time you should to your particular portfolio.

Mrs JILLIAN SKINNER: Thank you, doctors. You might not be surprised to know that the things you have raised today, the under-resourcing, failure to engage clinicians, lack of adequate bed numbers, high occupancy rate, access block from emergency, equipment old and outdated and a demoralised workforce, are reflected in just about every submission that we have received from doctors and others. It certainly has been acknowledged this morning, except for perhaps the lack of access to beds. The bureaucrats and the Minister are suggesting to us that there is not a problem with beds. Can you explain how they could possibly mount such an argument?

Dr SALLA SARA: I could not comment.

Mrs JILLIAN SKINNER: You cannot explain, or what?

Dr SALLA SARA: Do not know, do not understand how you could make the statement; do not know.

Dr KEEGAN: As a physician and I guess as an assigner—I have also done a research-based PhD so I have some handle on how you manage statistics and the literature and evidence base—as I see it, the simple way of approaching the evidence is if you have an occupancy rate of more than 85 per cent, you have not really got a safe hospital and you are relying hugely on your clinical staff to keep that hospital running effectively and safely.

Mrs JILLIAN SKINNER: Yes.

Dr KEEGAN: We have occupancy rates of well over 95 per cent and at least a starting point there logically seemed to be some resources—some beds and staff to operate them.

Mrs JILLIAN SKINNER: Would it not surprise you then that we have concerns expressed by people such as Dr Charles Fisher, the Chair of the Medical Staff Council at the hospital, Dr Paul Cunningham, all of the 18 members of the section in the Department of Cardiology, the head of the emergency department, Dr Day, and many others who are all saying exactly the same thing. Obviously these doctors and their staff are very committed to providing the best possible care, but they feel totally frustrated because they feel they do not have access to beds and the staff that you are talking about. Would you care to comment?

Dr KEEGAN: We are statewide organisations that represent our members. We hear this from across the State.

Mrs JILLIAN SKINNER: The emergency department staffing has been a matter that has been raised in a submission by Dr Day. I do not have the submission in front of me but currently there are about 8 equivalent full-time doctors whereas the recommended level is up to 16. That would surely have a major impact on an emergency department's ability to cope.

Dr SALLA SARA: Oh, yes, that is correct. They end up working more hours or, alternatively, you do not have a staff specialist providing the coverage on some part of the day. You would like coverage by a specialist 16 hours a day, 7 days a week, but clearly they are not going to be able to provide that.

Mrs JILLIAN SKINNER: The report that you have referred to, that followed the review into the miscarriage incident at the hospital, referred to the claims that a lack of beds contributed to

that, but made no recommendations about extra beds. Is this at the heart of the problems in our hospitals—a lack of beds and a lack of staff?

Dr SALLA SARA: In this particular case if there had been a bed in the emergency department this young lady would have been on it. She would have been counselled by the young doctor to say, "I am sorry. The fact that the pregnancy is doing away with itself means it is not viable. You do not need to imagine anything you have done has caused this." Get the social workers involved; ring the VMO—the obstetrician or the staff specialist—so you would be taking care of that person. If you do not have a bed to put her in the end she stays in the waiting room, because you have people with heart attacks and multi-trauma and people going septic that our occupying the beds in the emergency department.

Mrs JILLIAN SKINNER: So it all boils down to beds?

Dr SALLA SARA: It all boils down to beds. I guess one of the problems we have though is there is still—as our submission also points out—this significant ongoing under funding from the Feds. State governments from whatever persuasion have lots of competing priorities, and I do not think it is necessarily Liberal or Labor, because I think there just is not enough money. But the money from the Feds being lacking in the millions is probably an underlying thread in what has happened.

Ms CARMEL TEBBUTT: Just to explore this issue of beds a little further, and I perhaps took a different interpretation from some of the submissions that were made this morning than what Ms Skinner did. What I was hearing was that bed numbers are important but that bed numbers are only one factor. With regard to occupancy rates, the processes that enable patients to be moved through the hospital system and treated effectively is also an important part of the equation? I guess what I would like to hear from you—taking note that your submission very clearly points out a need for more beds—is what do you think some of the other solutions might be that we could look at to take the burden off our hospitals?

Dr KEEGAN: At the moment we have a system running in that hospital, and other hospitals, with occupancies that are too high. The immediate request would be for those beds to allow the occupancy to run at a better level. Dr Salla Sara has already touched on IT solutions. We are a long way behind where we really should be in terms of IT in our hospitals. It provides a huge range of potential, in terms of improving patient care, patient discharge, patient management and reduction in error—particularly with medication delivery. So there is quite a large potential for IT solutions improving the throughput and the outcomes of patients. Noting again, it is the outcome that needs to be the dominant thing rather than the output; which is not effective where you have concern that the Government structures are shifting in the wrong direction—more towards output rather than outcome. Again we are looking after patients not numbers of people moving through.

Also you need to look at where the patient goes out from the hospital. The visit to the hospital is only a small component of their health care. If we are talking about emergency admissions, two-thirds pushing to even three-quarters of emergency admissions are medical, not surgical. So a lot of those people are going to require ongoing medical care. You need to have an improvement in engagement with the people looking after the patients. Quite often the people looking after the patients in the hospital and outside, the continuing thread is the medical staff. So if you are running a system at the moment where you disengaging your medical staff then you are going to make that even harder as well. So I think IT and engaging medical staff is a good starting point to say, "Look fellas, how can we do this better?"

Ms CARMEL TEBBUTT: The IT issues are things that could be improved across the system as a whole or are specific to Royal North Shore?

Dr KEEGAN: Across the whole system.

Dr SALLA SARA: And specifically North Shore. I mean a number of hospitals have already got digital x-ray systems. If you push hard you can nearly do it for the cost of the film budget, which is what has happened at St George. They are planning one for Prince of Wales. There has been one in place in Wollongong for some years and there has been at the Children's Hospital Westmead for probably 10 years. So you do not lose films with those things. You get the information immediately a

report is available; you can see the pictures immediately on a PC in a ward. That means that the junior staff do not have to run round continually to find x-rays. As I understand it, there has been no planning for such a system at North Shore.

Can I, in a sense, just answer your question from a slightly different perspective as well—the first question? At any point in time there is a set of work practices adopted by the staff in hospitals. Some people will say yes, we do not need 70 beds at North Shore. If the medical staff did discharges on the weekend and if we had an extra resident and if we had a digital x-ray system we would only need 50 beds. That is fine, but it is going to need time and energy and effort to get to those revised work practices. So something needs doing in the next month or two—that is the extra beds. The Health department has been running a process of clinical redesign for some years, which has made differences to the throughput of patients through hospitals, but you cannot change an organisation of 5,000 staff members, you know, tonight. It takes time. It takes engagement, as Dr Keegan has said. To engage with the senior medical staff they will not listen to you, so therefore the chances of achieving work practice reform and redesign are very much more difficult. If they get that frustrated, they just will not talk to you or listen to you and do things the old way. So it is important to plan for the future, workplace redesign, engage with doctors, change work practices, look at the IT solutions and the efficiencies and increased care you can get for those but still today the estimate we have is about 70 beds would make a significant difference.

Mr MICHAEL DALEY: Just on the question of engagement that threads through the written and oral submissions. This morning we heard from the chief executive officer of the area health service and he acknowledges that there is a lack of engagement and is moving to address that, such as through a clinical reference group, nursing task force and the like. Is it the case that you would welcome these measures that have been implemented by him?

Dr KEEGAN: I think that any measure looks to engage the staff would have to be welcomed. I think there is a great deal that can be gained with that but I would again go back to the potential role of the medical staff councils. Those structures that you are talking about should sit within line governance—

Mr MICHAEL DALEY: Just examples.

Dr KEEGAN: Medical staff councils sit off to the side and would report to the chief executive officer, the general manager of the hospital and the Minister, if necessary. That is your safety valve. So if something is going down at a lower level and is not filtering up through line management, which we tried hard to think of multiple examples but cannot off the tip of my tongue, you do not have that safety valve off to the side. That was part of the role of the medical staff councils when they were fully functional players and it is a role they could play again. I am frankly a little surprised that our chief executive officers and our leaders have not taken advantage of that more in recent times.

Dr ANDREW McDONALD: Can I get you gentlemen to answer this question separately, as your views may vary. We know there are significant workforce shortages in both nursing and medicine. How should we look at upskilling our current workforce, specifically nurses and career medical officers? You choose who goes first.

Dr SALLA SARA: I guess I should. Role substitution is very difficult. Certainly with nursing staff there has not been an easy fit between the nurse-practitioner processes and systems we have in place in New South Wales with medical staff. There are issues with the HIC in terms of billing—they cannot bill. There are issues in terms of pathology tests that they order—again, you cannot bill for those. Of course in an emergency department you do not bill any way but I am just saying in terms of a broadening of that. The issue of upskilling CMOs is already something the Health department is running with. They unfortunately have given it the word "hospitalist", which has a different meaning in different States and has a quite different meaning in the United States. But that upskilling of CMOs has already occurred and there are a number who specialise in paediatrics, emergency, aged care and so on. The recent advertisement for hospitalists did not bring a single reply to me wearing my hat as Director of Clinical Services at Wollongong hospital. So the shortage of medical staff has meant that yes it is an attractive option, but it is not attractive enough. Generation Y are taking a different view to medicine than I took—

Dr ANDREW McDONALD: We took.

Dr SALLA SARA: Than we did. So yes it is an option. It is certainly there on the table. The Health department, to its credit, has been running with it and it works in some places but it has not worked overall.

Dr ANDREW McDONALD: So if we need 70 beds where will we get the doctors from? I will ask the same question of Andrew Keegan.

Dr SALLA SARA: In terms of the 70 beds, the way I perceive it would work is that we would continue with the current medical teams. If we divide those 70 beds among three or four surgical teams, four or five medical teams—the cardiologists, the respiratory doctors, the aged care doctors and so on—each team would have only a few patients extra. So we would not necessarily need extra medical staff but it would mean that the patients could be got out of the emergency department and that would make the emergency departments function better. Yes, there would be a flow-on effect in the hospital but—I guess we would have to have a detailed knowledge to know the answer—in terms of the rest of the hospital there is not necessarily a guaranteed need for extra medical staff.

Dr ANDREW McDONALD: What about nursing staff?

Dr SALLA SARA: Yes, there would be a need for nursing staff. That is certainly an issue.

Dr ANDREW McDONALD: They have 100 FTE vacancies, as you know, at the moment.

Dr SALLA SARA: Is that the case? Everyone has vacancies; I was not aware as to the quantum of those vacancies.

Dr ANDREW McDONALD: I will ask the same question of Dr Keegan.

Dr KEEGAN: I think the nursing staff are a major concern. Frankly, I think we need to look after our nursing staff better than we do. But as far as the beds, where they should go and how they should be managed, part of having those beds and having your occupancy where it should be is that you have appropriate patients in the right place. That in itself will improve your outcomes and efficiencies. If you have a medical team doing a ward round over a campus that is half a kilometre long as opposed to—

Dr ANDREW McDONALD: As you know, North Shore is not half a kilometre long.

Dr KEEGAN: I am thinking about my own place.

Dr ANDREW McDONALD: This is not about that.

Dr KEEGAN: But, still, if you add in the multiple floors maybe it would be. Does a resident not usually take 5,000 to 6,000 paces each day? We can seek data on that somewhere. That is getting up around that level—it is somewhat longer, actually. But if you have multiple wards and you are spreading your ward round over that and your resident staff have to see them every day as opposed to having sufficient beds to have your unit in your unit, then that will improve efficiencies. I think, again, if you go down to the people who were doing the work and ask them how you can do that. But, no, I have not got a wonderful answer for the nursing staff. That is a hard one.

Dr ANDREW McDONALD: Thanks, Andrew.

CHAIR: I have a general question. Earlier you made some criticism of the inquiry for focusing on Royal North Shore Hospital. Do you see any value on focusing on one hospital that clearly has some major problems and finding solutions that could then be applied to all public hospitals? There are 230 public hospitals in New South Wales and I do not think any committee could conduct an inquiry into 230 hospitals in its lifetime.

Dr KEEGAN: That is a reasonable statement. I have two comments. We were reflecting the concerns expressed to us by our members. Yes, we look forward to some benefits along those lines coming from this inquiry. We would all be pleased to see that.

CHAIR: The terms of reference include the option of making recommendations for all other hospitals in the State, hopefully. That is a challenge for the Committee to do that.

Dr KEEGAN: A large challenge.

Dr SALLA SARA: We hope that you manage to succeed, Mr Chairman.

CHAIR: We inspected the hospital the other day. If it needs 70 beds and apparently we are short of doctors and nurses, are we short on space as well? Is there any problem with locating 70 extra beds in the existing facility at Royal North Shore Hospital?

Dr SALLA SARA: Not as we understand it; there would not be a major problem.

CHAIR: Are there empty wards?

Dr SALLA SARA: We understand that the beds could be found—the majority of those beds would be able to be opened assuming the staff and the funds were provided, yes.

The Hon. AMANDA FAZIO: But you probably would not need 70 beds if you moved out all the people who had been assessed as being suitable for nursing homes.

Dr SALLA SARA: There is still an issue with getting people out the far end into a nursing home. That is correct. The lack of aged care beds in the community is a major problem.

CHAIR: There was an impression when the hospital was using a storage room, which it called a "treatment room", for patients that there was some pressure on rooms and wards for patients. Were you aware of that treatment room being used?

Dr SALLA SARA: Yes.

CHAIR: Do you have any views about that?

Dr SALLA SARA: It is not appropriate. In the main, it is not appropriate.

Dr KEEGAN: My comment was that if the nursing staff felt it was the appropriate thing to watch that patient properly then I have no problems with the nursing staff doing that. But I follow that by asking: Should they not have had another bed designated as a ward bed to do that instead?

CHAIR: It has been alleged that Royal North Shore Hospital has been allowed to run down because of the number of private hospitals and the fact that people on the North Shore have private medical coverage and resources should be shifted to the western suburbs. Do you have any views about that?

Dr KEEGAN: I live and work in the western suburbs. My opinion—I have been working at Nepean for more than the last decade where that has been a battle for us, as you can imagine—and my impression over that period is still that we were just a bit behind everyone else, who was also behind maybe where they should have been. It is a matter of resources: the absolute resources and the resource distribution formula. If you look at the resource distribution formula that is used in New South Wales there is an effort to do the right thing. I do not think we have any problems with what it attempts to do. But a multivariate calculation of the biological system will have some error in it, and with the sums of money we are talking about—we are talking about millions, if not tens of millions, of dollars—with a couple of per cent error, which is what you would expect in that sort of calculation, I suspect that it might be worthwhile looking into that level of error and seeing whether that might explain your cost disparity.

CHAIR: So you see it more as an error rather than a deliberate policy?

Dr KEEGAN: I would be disappointed if it was a deliberate policy.

Mr PETER DRAPER: Dr Keegan, you mentioned the ACHS accreditation earlier. What does "ACHS" stand for? Can you explain a little about the shortcomings that caused Royal North Shore Hospital not to meet that accreditation standard?

Dr KEEGAN: The ACHS is the Australian Council on Healthcare Standards. It is a process whereby there is a set series of administrative, clinical and other hospital hotel-type functions that the hospital is assessed on a regular basis. My understanding is that the problem with North Shore—I have not seen the full detail of that—involved some of the record keeping and the hotel components of its function rather than clinical care.

Mr PETER DRAPER: So it is an administrative shortcoming.

Dr KEEGAN: That is my understanding of where the problem is.

Dr SALLA SARA: Mr Chairman, if I may comment also. As I understand it, one of the issues was the governance—the management—of staff. So, yes, it may be an administrative issue but the net result of those sorts of issues is generally going to be less coordination between the staff. If the staff do not know who the manager of the department is and the department manager does not know who their boss is, those things reflect on the functioning of any organisation. So they are important standards.

Mr PETER DRAPER: We heard from NSW Health people today that with the new management structure and new policies they believe some breakthroughs have been made to take North Shore into the future. Are you satisfied with the direction that it is heading in at the moment?

Dr KEEGAN: I am not sure I have a good handle on just what direction that is. I think time will tell. I know some of the things that have been proposed may look promising. I think we need to see what the people on the ground feel about those in the weeks and months to come.

Mr PETER DRAPER: You mentioned earlier that there have been seven management changes in recent years. It was put to me on the weekend that it appears to be a tool used by the health system whenever a crisis arises to change the management and buy time. Do you have any comment on that?

Dr KEEGAN: It does seem to occur. From my understanding of what has happened when that has occurred both in Australia and in the United Kingdom—I am aware that similar sorts of things are happening there—it has not improved the outcome and it is usually a reflection that there is a fundamental management problem, or even on some occasions budget problems, with the facility or the health service that that is occurring in. To me, it would say that those overseeing the system should step back and ask, "Okay, what is actually going on here?" It is the same as if you are running any sort of business; if you have a high staff turnover something is wrong. If your management is turning over at that sort of rate then something is really wrong.

Mr PETER DRAPER: It does not appear to be a good career choice.

Dr KEEGAN: No. That is actually another concern that needs to be spelled out—if it has not been elsewhere. We need health service and hospital managers with a great deal of skill. We also, through whatever happens here, need to be careful that we do not drive away those people with skills. They have some important work to do and we are very happy to work with them. They do stuff that doctors are hopeless at doing but they need to talk to us.

Mrs JILLIAN SKINNER: Dr Keegan, I have a question I would like you to take on notice. Ms Picone, when giving evidence, said there were problems of finance, access and staff morale at all hospitals but only Royal North Shore was complaining. Is that an accurate statement or is that what has been highlighted in the media? I have certainly heard about it at other hospitals. I ask that you take that question on notice, given that you are at Nepean, and also Mr Mead, because of your experience speaking with doctors across the system.

CHAIR: Thank you for giving us your valuable time. We are very grateful.

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(The witnesses withdrew)

BRETT HOWARD HOLMES, General Secretary, New South Wales Nurses Association, affirmed and examined:

ALISON FRANCES MAYHEW, Nursing Unit Manager, Royal North Shore Hospital, sworn and examined:

CHAIR: Thank you for appearing before our Committee. We appreciate your attendance and cooperation. Mr Holmes, in what capacity do you appear before the Committee?

Mr HOLMES: I appear as the General Secretary of the New South Wales Nursing Association.

CHAIR: Ms Mayhew, in what capacity do you appear before the Committee?

Ms MAYHEW: As the former Branch President of the New South Wales Nurses Association.

CHAIR: Mr Holmes, do you wish to make an opening statement?

Mr HOLMES: Yes, thank you. The Nurses Association has provided the Committee with a submission.

CHAIR: We appreciate that. We have copies.

Mr HOLMES: I would ask that you note there is one typographical error on page three in the third paragraph. It is a transposition of "less with more". It should be "more with less". The Nurses Association has addressed in the submission a number of areas in accordance with the requirements of the Committee. The first one really goes to the clinical management systems at Royal North Shore Hospital. We had identified that we had serious difficulties with the proposed restructure of the area health service and, in fact, the restructure of Royal North Shore-Ryde in early 2006. That was a long process of negotiation and at one point resulted in the Nurses Association and its members at Royal North Shore taking some industrial action and bringing to the attention of the media, the public and that Department of Health our level of unhappiness with the management proposals that were being put in place, first of all, at Royal North Shore and Ryde hospitals.

The nub of that matter was that previously Royal North Shore had a divisional structure of management and nurses played a pivotal role in that divisional management structure. The divisional management position of the nurses included having operational and budget control and responsibility for nursing services within their division. The proposal being put forward by that area management was that that budget and operational responsibility would be removed and that nurses would be put into an advisory role. After nearly nine months of negotiation, including the industrial action, we have settled on a structure where, unfortunately, the divisional nurse manager was still in a position with limited amount of operational control but they ended up with the title "operational nurse manager". However, they were still reporting through to a divisional manager and a clinical director, who was part-time. That clinical director had to be a medical officer.

We believe that has an ongoing impact on the ability of the health service to be properly managed and to respond to the clinical issues that nurses face on a day-by-day basis. The structure placed an inordinate amount of pressure on the nursing unit managers and placed the divisional operational nurse manager in a position largely of advice and professional leadership, without being able to intervene in resource issues between the nursing unit manager and the divisional manager. The critical problem there, of course, is that the divisional manager could have anything up to 30 nursing unit managers trying to get in the door to have their critical resource issues addressed. Whilst the new management at the area health service has now indicated that it will review those job descriptions and the structure, it does take time to do that review. The difficulties that arise on a day-by-day basis of trying to provide patient care at the ward and unit level are limited by the structure which does or does not make it possible for a nursing unit manager to access a real decision maker who can make decisions about where resources will be spent and allocated.

In terms of the utilisation of resources, the Nurses Association became aware in February 2006 of a proposal to save $20 million, as there had been a budget overrun at that point at Royal North Shore, not an uncommon situation, as I recall from previous years. However, the branch and the association took action to try to have that budget overrun addressed. The proposals that would be put in place at that time included reducing the number of individual patient specials. That is where a patient is deemed to require one-to-one supervision or assistance. It might be because they are confused or their condition warrants a single nurse. In the case of Royal North Shore it was often an assistant in nursing who would stay with that patient during their critical period, whether that was because of their delirium or disorientation, to try to prevent injury to that person. That could also include whether that patient was a mental health patient, an aged patient or had a serious illness. Restrictions on those individual patient specials we raised as a concern.

There was also a decision that we were not able to overturn in terms of reducing the number of hours that agency nurses were being engaged. Instead of being engaged for a full shift, in order to save money—and this is not common or not unique to Royal North Shore—the agency nurses are limited to six-hour shifts instead of eight-hour shifts. That obviously puts pressure on the rest of the staff when the agency staff goes home or does not arrive until some time after the commencement of the shift. The nurses' association in frustration undertook industrial action and again tried to bring that to the attention of the department, the Government, the media and the community. I recall that Mrs Skinner was at one of those actions and one of the rallies as well. There was a review of the individual patient specials, but I am informed that it did not solve all of the issues.

There was an agreement to a review of the recruitment process and from my discussions with Ms Mayhew the recruitment process is still a slow and tedious one. There was an agreement at the time that there would be a removal of the restriction on recruitment. All of those issues were supposed to address the additional pressure that budget constraints were placing on the staff. However, at the end of the day, the capacity to resolve those problems lies ultimately with the executive management in the hospital, the area and the department. We believed that we had appropriately raised the issues and tried to address as many of those as we could.

In terms of complaints handling and incident management, the nurses' association does provide assistance to its members in trying to resolve issues and there are grievance processes set down by policy directives from the Department of Health and the area health service. Wherever possible, the nurses' association advises its members to undertake those grievance processes at the lowest possible level because we find that if you escalate them to head office at first point then everyone wants to escalate to a higher level and it ultimately does not always produce a good result because it then becomes who has the best representation, whether it is human resources or the union, and really grievances have to be resolved between the individuals if at all possible.

CHAIR: Mr Holmes, is this some of the material that is in your submission?

Mr HOLMES: It is.

CHAIR: So that we do not miss out on asking you questions—if it is in the submission we will obviously take that into account—is there any final point you want to make before we go to questions?

Mr HOLMES: I would just like to point out that we believe that there are a number of strategies for improving the quality of care. These are in the submission, but I think it is useful to put them on the table. We believe that the disconnect between operational and professional accountability and responsibility and divisional management must be removed; the disempowerment of senior nursing management structures must be addressed as a matter of urgency with full operational control returned to divisional nurse managers, reinvesting the authority to implement action in response to clinical advice; appropriate communication structures between the divisional executive, which must include divisional nurse managers, and nursing unit managers must be implemented; and there needs to be adequate funding to provide appropriate levels of staffing to all services within Royal North Shore and across the rest of the health system.

We believe that at North Shore there is a requirement for management to facilitate the effective functioning of the reasonable workloads committee, which is within the provisions of the

Public Health System Nurses' and Midwives' (State) Award, and we believe that Royal North Shore and Northern Sydney Central Coast should implement the recommendations of the Review of Workplace Culture and Allegations of Bullying and Harassment at Royal North Shore Hospital report.

Mrs JILLIAN SKINNER: That is a good point at which to start my questions. It is the Meppem-Dalton review that has been referred to. Given your indication that there was a level of unhappiness on the part of the union about the restructure at North Shore, Ryde and other places—and, as you have pointed out, I actually appeared with some of the nurses at the hospital at the time—it is surprising to read in this report:

> We were surprised that the local New South Wales Nurses' Association branch is inactive.

Can you tell me when it became inactive, that is the year and the month, and can you fill us in—I understand something has happened now to resurrect it?

Mr HOLMES: Ms Mayhew may be able to tell you the exact date when the branch became ineffective, but it really became largely inactive midway or towards the end of 2006 and it struggled to reform in the annual reformation that occurs before March 2007.

Mrs JILLIAN SKINNER: Can you tell me when you became aware that nursing staff at the hospital were the subject of bullying and harassment and what you did about it? You said you did not want to take it on at a head office level, but did you do anything about it at all?

Mr HOLMES: We can only act on issues that are brought to us. On checking our records we had 23 issues where people were given advice on how to deal with their grievances. In the first instance, as I have said, those people are provided advice as to how to try to resolve it at the local level. When Ms Meppem approached us we checked our records and, from an assessment of those records, we saw no different pattern in the records of Royal North Shore, which we could bring as evidence, from what one would find in any other large hospital. Twenty-three out of 1,400 nursing staff does not necessarily mean that there is a widespread pattern, but that does not mean that there is not a culture of restricting or limiting, or giving people messages not to go to the union.

Mrs JILLIAN SKINNER: That is my concern, because it would seem to me from comments in the press and made by nurses to me, and in fact in some of the submissions here, that it is much wider spread than that, and maybe they were afraid to go to the union or to speak out. Could you contemplate that?

Mr HOLMES: That is quite possible. It is possible that there was a culture that frowned upon utilising the nurses' association.

Mrs JILLIAN SKINNER: Are you aware of any rules or guidelines that would limit nurses speaking to you or speaking out; that may lead them to be afraid about their jobs, or whatever, if they spoke up?

Mr HOLMES: No, there are no rules that prevent people coming to the union.

Mrs JILLIAN SKINNER: Or speaking out publicly?

Mr HOLMES: Well, there are certainly limitations on what people are allowed to say publicly, the code of conduct does provide limitations on that, and we provide advice and protection for people who want to have their matters addressed.

Mrs JILLIAN SKINNER: Do you know how many outstanding grievances there are on the part of nurses that have not been dealt with and have been going on for years and years?

Mr HOLMES: No, I am not aware of that information; that is a matter for the health service.

Mrs JILLIAN SKINNER: How many nurses are there at Royal North Shore and how many of them are members of the nurses' association?

Mr HOLMES: We have just under 1,000 members at Royal North Shore.

Mrs JILLIAN SKINNER: Have you ever written a letter of protest to the management of North Shore, the Minister or even the department about bullying and harassment at the hospital? Given that you did not think it was a major issue, presumably not?

Mr HOLMES: No, I cannot recall.

Mrs JILLIAN SKINNER: There has been media coverage—in July this year, for example, that led to the Dalton-Meppem review being started—about nurses complaining about harassment. Your union representatives at the hospital did not take that on board?

Mr HOLMES: The media contacted us, and I did the same thing that I did for Meppem and Dalton and reviewed our files. I obviously was in no position because of privacy to disclose details to the media about that, but my assessment on the numbers that we had and the types of cases that we had was that we could not justify a call that there was widespread bullying.

Mrs JILLIAN SKINNER: Yet the report says the health services union specifically asked the Meppem-Dalton review if they could speak to them about concerns about bullying. That does not come as a surprise to you?

Mr HOLMES: They must have had a different report from their members about it.

The Hon. AMANDA FAZIO: Mr Holmes, in your experience as General Secretary of the nurses association, how does the situation for nurses at Royal North Shore Hospital differ from the situation at other hospitals?

Mr HOLMES: Clearly, many of the issues that the nurses at Royal North Shore are facing are similar across the State. There are always limitations and restrictions on staffing: there are difficulties recruiting; there is a nurse shortage. Clearly, going back to February, March of 2006, Royal North Shore certainly had a big hole in its budget and the activities that they were publicly trying to address those issues were ones that caused our members at Royal North Shore some grief. That is not to say that situations elsewhere were not similar.

Of all the restructures across the State we had the most difficulty with Northern Sydney Central Coast. Mind you, we have not resolved restructures in Sydney West yet and we are still waiting what the final outcome will be in some of those restructures. But we certainly had the most difficulty with the proposals at Royal North Shore in terms of how their management structure was changing.

Dr ANDREW McDONALD: A number of people, such as the media, have used the media to question the clinical decisions made by nurses in high-profile cases such as the triage of Ms Horska and the placement of Mrs King. As the nurses' representative do you think it is appropriate for people to second-guess the work of nurses this way?

Mr HOLMES: It is certainly not helpful in terms of trying to address issues. We have experienced this before at Campbelltown and Camden where many people in the media think that they know the answers to all the questions on the basis of a 30-second interview with someone. And it is not helpful to ultimately anyone, either the patients affected or the staff. It is very distressing for the staff to hear members of the media—and not all members of the media—calling for the heads of people who make clinical decisions without those media people understanding the clinical situation or the real situation that those nurses face.

Mr MICHAEL DALEY: Brett, what do you see as the greatest barriers to the recruitment and retention of nurses at Royal North Shore Hospital?

Mr HOLMES: Clearly, right at the moment it would be very difficult to be recruiting to Royal North Shore. But there is a practical issue that is occurring: there is a slow process of approvals to get people on to staff at Royal North Shore, and Alison, as a nursing unit manager, was just telling me about the process that is gone through. Even though there is an established position it still needs to go through a committee process, you need an authority to appoint signed off from the general

manager, and until that happens no advertising can occur. If, for instance, the divisional manager is not at that meeting and the authority to appoint is not signed off then you wait another week for that committee to meet again and it delays it.

There is already a significant delay in being able to recruit people because of the requirement to have the advertising and then the interview process and then the criminal records checked. So it can be six to eight weeks before you actually fill a position that becomes vacant. And if a person has only given you two weeks notice, as they are required under the award, that means you are running short for six weeks and you have to fill that with using overtime, casuals or agencies.

CHAIR: Just following up that question, you have referred to agency nurses and the problems with the length of their shift—the six hours, the eight hours and so on. What percentage of agency nurses is working at Royal North Shore Hospital?

Mr HOLMES: If I could ask Ms Mayhew to answer that?

Ms MAYHEW: I would not be able to give you an exact percentage but a lot of agency nurses do not come to Royal North Shore anymore because of the shortened shifts. A lot of other hospitals in the metropolitan area offer longer shifts and, I guess, coming over the bridge for a six-hour shift is really not valuable to them at all.

CHAIR: And the main reason for the agency nurses is because of the shortage of nurses on staff? It is not a financial decision to have agency nurses?

Ms MAYHEW: It was originally a financial position to cut their hours to save money.

CHAIR: But to actually employ agency nurses as against having—

Ms MAYHEW: It is not against it but they are probably more willing to look at pool staff rather than agency staff to fill in the vacancies.

Dr ANDREW McDONALD: Maybe you could explain what pool staff are?

Ms MAYHEW: Casual pool staff.

CHAIR: I mean staff who are actually a part of the hospital staff.

Ms MAYHEW: It is a bank of staff that just works casually but are employed by Royal North Shore Hospital.

CHAIR: Are there any problems with agency nurses working with the nursing staff at the hospital?

Ms MAYHEW: No.

CHAIR: There are no tensions?

Ms MAYHEW: No, we love them—anything to fill a vacancy.

Mr HOLMES: If I could just say, one of the difficulties, of course, is that you have got to orientate an agency staff if they have never been there before. One of the limitations and restrictions that Royal North Shore tried to put on in 2006 was that they would only engage agency nurses who had previously worked there. There is a premium cost for employing agency staff so they are the least desirable, I suppose, before overtime. They come in a bit cheaper than overtime, but not a lot. So they are not readily engaged but they are an essential part of being able to fill the vacancies.

CHAIR: We have received in our submissions a report on Mrs Batterham, an elderly lady—I think she was 90-odd years of age—who one nurse was trying to help and the patient fell over and broke her hip. Would that be an indication of not sufficient nurses on staff: one nurse trying to handle the woman on her own?

Ms MAYHEW: Not knowing the whole clinical situation I would not be able to make a final comment on that. It would depend on the clinical situation. If the patient had been assessed that they were safe with one nurse then one nurse would get them up. Nurses do not tend to put themselves in danger. Not knowing the case properly I would not be able to comment.

CHAIR: So it may not have been related to staffing at all?

Ms MAYHEW: It could have or it may not have been. It depends what else is happening around. I do not know where that particular incident occurred or what their staffing numbers were like for that day or their skill mix. There are a number of factors involved.

Mr PETER DRAPER: When we were at the hospital I heard about how shortages in administrative staff were impacting on nurses in taking quite a lot of time away from their face-to-face duties. The panacea coming from a whole range of areas today has been to put 70 new beds in. If that happened how would they be staffed?

Ms MAYHEW: I honestly do not know. That seems to be the clear-cut solution to what is happening but opening up more beds—we cannot even staff the ones we have got currently at Royal North Shore. We are doing a lot of overtime, which could primarily increase clinical risks in the environments. Another 70 beds—most wards are working down very regularly on a shift-by-shift basis. There are just not enough nurses.

Mr PETER DRAPER: That is the bottom line. Could you also comment on another thing that came out of the visit, and that was the proportion of young, inexperienced nurses in emergency as opposed to experienced people? It seemed that the older nurses were predominantly part-time and that was putting more pressure on young people going into the emergency department?

Ms MAYHEW: I cannot really comment. I do not work down in the emergency department but even in the ward areas there are a lot of younger nurses coming through and taking up more and more responsibilities than ever so before. Once upon a time the older, more experienced nurse would take the in-charge role and the mentorship and the delegation of that shift. Now we are coming down to first-year and second-year registered nurses having to take on that role, as well as being able to delegate and supervise less skilled nurses in that environment, with patient security a lot higher. So I think health has changed considerably but unfortunately we just do not have the nursing staff in our current environment to move with health.

Mr PETER DRAPER: My impression—correct me if I am wrong—is that the support is not necessarily there for those young people who are coming into the profession, not through a lack of intention but just through a lack of people with experience on the ground.

Ms MAYHEW: Definitely it has been noticed in the past 18 months that with the restructure that has happened in the hospital there is not a lot of operational day-to-day support for staff in the ward areas. What tends to happen if there is no ward clerk available it is normally a nurse's responsibility to continuously answer that phone, look after the patient's relatives, our patients, being able to enter their details in computers to make sure they get the meals so on top of that having to talk to their management trying to get patient flow through the hospital.

CHAIR: Mr Holmes, you mentioned about the nurses having to take action and so on. Was there any connection in joining the Royal North Shore Hospital with Ryde Hospital? Did that create greater problems or is that part of the cause?

Mr HOLMES: Not that it brought Ryde Hospital to as much difficulty as Royal North Shore. The whole area took action in terms of the restructure proposals ultimately, and we were able to get some improvement there and Ryde was part of that but from my understanding there were difficulties at Ryde but not to the extent that Royal North Shore suffered.

(The witnesses withdrew)

SALLY McCARTHY, Vice-President, Australasian College for Emergency Medicine, affirmed and examined:

CHAIR: What is your occupation?

Dr McCARTHY: I am a specialist emergency physician.

CHAIR: In what capacity are you appearing before the Committee?

Dr McCARTHY: I am appearing as the Vice-President of the Australasian College for Emergency Medicine.

CHAIR: Do you wish to make an opening statement?

Dr McCARTHY: Yes I do. The college has prepared a submission which unfortunately is being submitted today so you will not have received that yet. Our submission addresses two of the terms of reference for the inquiry. The first is the one regarding the efficiency, effectiveness and appropriateness of resource allocation and utilisation within the hospital and in particular the operation of the emergency department. There are a number of key resources for emergency departments to be able to provide care to patients, and the most important of those is the space to treat patients. Emergency departments are open continuously and can have seriously ill patients presenting any time of the day and night. We have to treat all-comers whenever they present, and in order to do so we require immediately available treatment space or an area where we can commence treatment.

Unfortunately the phenomenon known as access block or delayed transfer of admitted patients from emergency departments to hospital wards has been present in emergency departments across Australia for some years. The college has done a number of surveys on access block across New South Wales—four in the past three years—and each of those has shown that between 30 per cent to 40 per cent of all patients in emergency departments are waiting for a bed in the hospital. The last survey was done in September this year, which showed that in New South Wales or Australian emergency departments 42 per cent of the patient workload was patients waiting for beds in the hospital, and 79 per cent of that group had been in emergency more than eight hours. So one can see that this severely inhibits the capacity of emergency departments to receive and treat new patients as quickly as they need to.

The situation has been present for at least the past decade and has worsened across the system, particularly in New South Wales in the metropolitan and peripheral hospitals, but it is worse in the tertiary mixed emergency departments such as that at Royal North Shore Hospital. Access block is the single most important factor leading to overcrowding of emergency departments and overcrowding itself has a number of adverse consequences. We are all aware of ambulance delays across the system—that has been well publicised—but there has been quite good Australian evidence showing that patients subjected to access block then have disproportionately longer lengths of stay within the hospital system, irrespective of their stay in emergency. By not providing beds for these patients when they need it, the system is actually managing them more inefficiently than it needs to once they get into the hospital.

Patients admitted from emergency departments during times of crowding have been shown by two Australian studies to be at greater risk of dying subsequently in the hospital. This is a significantly increased risk. Patients presenting during periods of crowding in emergency departments have been proven to experience delays in heart attack treatment and pain relief. There was also a documented increased risk of cross-infection among patients in crowded emergency departments. We know that overcrowding in Australian emergency departments is not caused by patients coming to emergency departments who should access the health system elsewhere and specifically it is not caused by GP type patients. Australia has done a lot of research on this topic and we know that patients are very smart in knowing the appropriate method of accessing care. Patients who need a general practitioner do not come to Australian emergency departments. In any case, the small number of patients who we think could be treated by a general practitioner do not occupy beds or treatment space and do not contribute to crowding in the department or our inability to put a patient in a treatment area when we need to.

The second most important factor required for appropriately managing emergency department patients is appropriate staffing. My nursing colleagues have just spoken about staffing generally in the hospital. However, New South Wales has a problem with emergency department doctor staffing, and particularly emergency medicine specialists and trainee emergency medicine specialists. A number of workforce surveys have been conducted by the Commonwealth Department of Health and New South Wales Health bodies and by the college. They clearly show that New South Wales is different from other States in that it has the lowest ratio of specialist emergency physicians to patient presentations in emergency departments of any State or Territory except the Northern Territory. It is significantly lower than the next most populous State—that is, Victoria.

We know from surveys that approximately half of the emergency trainee positions or registrar positions—which is the middle-grade doctor level that provides the backbone of work sorting out patients 24 hours a day seven days a week—are not filled by Australian-trained emergency medicine trainees. Approximately half of the positions are filled by trainees of the college who we know are getting appropriate training and have graded experience and supervision. The others are filled by overseas-trained doctors, often with inadequate orientation to the Australian system, by locum medical staff, with their attendant problems with regard to matching competency with the work required of them, or they are left unfilled.

Emergency departments across New South Wales, particularly those in the tertiary hospitals, frequently run with vacant doctor shifts. That is par for the course. No emergency department in New South Wales meets the Australian Medical Workforce Advisory Committee 2003 recommendations for specialist medical staffing in emergency departments and, in particular, Royal North Shore Hospital emergency department does not meet that guideline.

As I said, the most important component of providing care to emergency patients are space to treat them when they arrive and when they need it and the appropriate staff—both the type and number of staff—to do so. Other support structures are important, such as optimising non-clinical support to clinical staff to free them up to perform clinical duties, appropriate information management, technology and decision-support tools and support such as appropriate human resources and quality processes, and education and other service requirements.

Running an emergency department is a very complex task. Large departments often have around 200 staff. A lot of work needs to go on behind the scenes to deliver consistent quality care 24 hours a day. Unless appropriate senior medical personnel are in place the requirements cannot be met, particularly the training and supervision requirements.

The Australian College for Emergency Medicine would also to like to address the second term of reference that the Committee consider strategies or measures in place or proposed for improving quality of care for patients at the hospital that may also benefit New South Wales' patients generally. As I said, the most important strategy for emergency departments is freeing up space so that new patients can be treated when they need it. This is the overriding concern, even more than staffing at the moment. If we cannot offload a patient into a treatment area, if we must see them in a corridor or leave them in a waiting room, we are unable to provide care.

The second most important improvement is support for increased numbers of senior specialist emergency doctors and trainees in so far as that group provides leadership in education and policy making and delivers the care that the community requires. It is generally accepted in all other areas of practice within the hospital system that the patient has a right to be seen by a specialist. That is not the state of play in emergency departments across New South Wales.

The next most important comment with regard to staff is that we need adequate numbers of all clinical staff—nursing, medical, allied health and other support staff, and non-clinical staff who can free up clinical staff to be available to provide clinical care. There are efficiencies to be gained in support structures within the department to free up clinical staff.

Mrs JILLIAN SKINNER: Thank you very much indeed. I speak for myself, the Coalition and I am sure others when I say that people working in emergency departments do an absolutely incredible job. It is partly as a result of concerns raised by you and others that we are sitting here

today. I am particularly interested in your comments about the number of surveys that have been done, particularly those relating to access block. The college has done a number of surveys, as have the Auditor-General and specialist committees. A taskforce was established by the New South Wales Government all pointing to this. I also note your comment about the greater risk of dying and longer stays in hospital. Is it fair to say that those survey results would all be known to the New South Wales Government?

Dr McCARTHY: Yes.

Mrs JILLIAN SKINNER: And known for some time?

Dr McCARTHY: That is right. These studies have been done over the past 10 years at least.

Mrs JILLIAN SKINNER: Ambulance officers have been speaking ad nauseam about the consequences of delayed access to emergency departments and not being able to respond to other calls.

Dr McCARTHY: That is right. There are available figures across the system about the hours ambulances are delayed before they can offload in emergency departments.

Mrs JILLIAN SKINNER: You said that your need to free up space in the emergency department is therefore linked to a capacity to admit that 30 to 40 per cent of patients who need to be admitted for further treatment. It is about beds.

Dr McCARTHY: It is about beds or bed equivalents. Looking at the ratios of bed closures, we may well need more physical beds, but we undoubtedly need some system efficiencies whereby beds are effectively freer earlier.

Mrs JILLIAN SKINNER: A submission lodged by Dr Robert Day, head of the emergency department at Royal North Shore Hospital, highlights all these concerns. He talks about the AMWAC recommendations. What is "AMWAC" and what are the recommendations?

Dr McCARTHY: AMWAC is the Australian Medical Workforce Advisory Committee, and it is a subcommittee of the Australian Health Ministers' Advisory Council. It was conducting medical work surveys across various specialist groups in the 1990s and the 2000s. The Australian Medical Workforce Advisory Committee has done two surveys on the emergency medicine specialist workforce in Australia—the first in 1997 and the second in 2003. The membership of Australian Medical Workforce Advisory Committee includes jurisdictional representation from State and Commonwealth health departments. It also has representatives from industrial associations and groups. The committee also includes a couple of emergency physicians. It interviewed people across the system to determine its recommendations, including New South Wales Health advisers and workforce advisers within State and Commonwealth departments. It also sought advice from other clinicians in the system, but external to emergency, and from emergency physicians and nurses.

The committee's second report in 2003 noted that large tertiary emergency departments such as the department at Royal North Shore Hospital should have least 12 to 16 emergency physicians per department. These recommendations were made before some of the changes in the model of care we provide were introduced. A lot of large hospital emergency departments now run a 10-bed observation unit in addition to the work they are doing when AMWAC conducted its survey. Those recommendations are probably quite conservative.

Mrs JILLIAN SKINNER: New South Wales was privy to that working party and did not object to the recommendations?

Dr McCARTHY: No, NSW Health was on the working party, part of the group recommending those recommendations.

Mrs JILLIAN SKINNER: When Dr Day said that the current workforce is 9.8 full-time equivalent emergency specialists at Royal North Shore Hospital yet the AMWAC recommendation is 11 to 16, that is far short of the recommendation.

Dr McCARTHY: It is.

Mrs JILLIAN SKINNER: Would that explain some of the problems that have been highlighted?

Dr McCARTHY: Undoubtedly. The lack of senior medical staff in emergency departments is a key factor in explaining problems to patients encountering less than optimal care in emergency departments. The problem with emergency departments is that the specialist doctors are not only delivering care themselves, but are also often supervising many junior staff. As I mentioned in our submission, the junior staff consist of staff who may not be trained at all to provide care in emergency, they may be locums who work there for one shift and we never see them again, or they may be junior doctors at the very beginning of their career who require quite a lot of support.

Patients presenting to emergency departments are very complex, and often they have a quite critical illness. The type of patient presenting to an emergency department now is quite different from those of 15 to 20 years ago, from which most of the staffing structures originate. The type of work is significantly changed. Demand on emergency departments across New South Wales has gone up significantly in the past 10 years, but also in the past three years with approximately 8 per cent increase in demand across the system. Without the appropriate numbers of senior medical staff to make the best decisions for the patient as soon as they present, and thereby most efficiently use resources in delivering best quality decisions, deciding on what investigations might be necessary, whether the patient needs further care in the hospital or should be discharged, without that ability we are delivering a poorer quality care for patients, but also for the system.

Dr ANDREW McDONALD: You talked about two things: mainly space to treat patients and staffing. I would like to go through both of those. First, space to treat patients, about the access block. Previously people have said that Royal North Shore Hospital needs more beds. The nursing staff have said there is not enough nursing staff to go around. What is your comment on that?

Dr McCARTHY: I have a couple of points on that. One is that we know that in Australia we have a lot of nurses who are not working in the health system any more. Probably the absolute number of people trained as nurses within the community may be adequate to staff additional beds. However, the question is: one needs to retain those people in the system and also recruit back into the system those people who have left. That is a key feature of the health system for all clinical groups, not just nurses. One wants to work in an environment that values one's contribution. When somebody feels that they have some control over decisions in their environment and can actually contribute to the quality of care and deliver the care they want to provide. While there is a shortage of nursing staff within the system, undoubtedly there are measures that can be taken to attract nurses back into the system and retain the nurses that we have in the system.

Dr ANDREW McDONALD: You talked about beds. What does the role of ambulatory care services or other alternatives, to in-patients have to do with the bed block issue?

Dr McCARTHY: There has been a lot of initiatives over the past 10 or maybe even 15 years which have addressed getting patients out of hospital earlier, keeping patients out of hospital who do not need care in hospital, things such as post-acute care services, hospital in the home, and many other acronyms which pretty much mean that services can be put into the patient's home in the community or delivered by outpatients at the hospital so that patients who once upon a time might have stayed in hospital for an additional few days or a week can now be looked after at home. One thing concerning emergency departments one needs to remember, is that it has always been in the interests of clinicians in the emergency departments to discharge everybody they possibly can, because the emergency department is where stress is suffered by patients who want the beds. Over the years emergency staff generally utilise those other services extremely highly so that the patients who will be admitted to hospital these days are generally only there for the shortest possible time, and really need to be there.

Dr ANDREW McDONALD: You talked about the AMWAC issue. Currently only 50 per cent of registrar jobs are filled by people who are currently training. How many emergency department staff specialist positions are vacant in New South Wales? How long will it take at the current rate of training until those vacancies are filled?

Dr McCARTHY: There are significant vacancies across New South Wales. Vacancy should be considered in two ways: one is the absolute number of vacant positions we have across the State, which is 44; but we should remember that people such as myself, I am the director of the Prince of Wales emergency department in Sydney, do not ask for enhanced staff, because we know that the current conditions and environment for emergency positions across New South Wales has been conducive to either specialists or, in particular, trainees, moving to other specialties to train because of better working environments and better conditions for them.

Dr ANDREW McDONALD: What about moving people out of the rest of the hospital into emergency, specifically nurses and doctors rotating people through the emergency?

Dr McCARTHY: Andrew you know that emergency medicine is a specialty area and has distinct training and skills for practising emergency departments. If we want to look at the evidence of people who are not trained in emergency medicine, doctors and nurses, we just need to look at problems arising with junior unsupervised staffed and locum staff. I know that one of the findings of the inquiry into the Camden and Campbelltown hospitals was that there were adverse incidents suffered by patients when inadequate specialist supervision and inadequately trained staff were involved. Gone are the days when doctors and nurses were jack-of-all-trades and could work anywhere.

CHAIR: Do you have any comments on the Royal North Shore Hospital triage operation? There was some criticism as to whether it delayed the assessment of patients.

Dr McCARTHY: The college is on record as supporting the decisions made by the nursing staff in emergency at Royal North Shore Hospital with it particular incident of Jana Horska in terms of allocating an appropriate triage category. In general, the Australasian triage scale is a well-validated, internationally recognised scale that has been taken up by other countries and has been shown to be objectively applied. It is just validated for use in emergency departments. The issue in that particular case at Royal North Shore Hospital was not the application of the triage scale, but that there was nowhere to put Ms Horska for treatment. We can triage people all we like, but if we cannot put them in a private space or have a treatment bed or have anywhere to put them, we simply will not be able to provide treatment.

The other factor that goes along with that, given the overcrowding in the Royal North Shore Hospital emergency department that night, and of emergency departments in general, is that when our treatment spaces are fully utilised our staff are also fully utilised. I have already discussed the shortages of appropriate medical staff. We often run with vacancies or inadequately trained staff. I am aware that there are significant problems with agency and overtime for nurses in departments. The staff in emergency departments are fully occupied, seeing patients occupying emergency beds. When we have additional patients either waiting to transfer to the ward or in corridors or in a waiting room or in spaces that are not treatment areas, not only is there no treatment area, generally speaking there are no staff to manage that patient appropriately.

Mr PETER DRAPER: Do any hospitals in New South Wales or other States meet the AMWAC guidelines?

Dr McCARTHY: No New South Wales emergency department meets the AMWAC 2003 guidelines. There are many examples of departments external to New South Wales, particularly in Victoria, Western Australia and Queensland, that do meet those guidelines. Some of the larger hospital emergency departments in those States surpass AMWAC starting guidelines.

CHAIR: When I visited the Royal North Shore Hospital emergency department the triage nurse was in a glassed-off office. Is that really the best way of assessing a patient, a person who has come in for help? Doctors always look at patients and handle patients.

Dr McCARTHY: In emergency we have a very difficult situation. I agree with the thrust of your question, which is that it is difficult to be kind and caring and appropriately assess patients behind a screen. On the other hand, like any other front-line position dealing with the public—and we would deal often with a very stressed public, people with overdoses, who are suffering violence or

mental health disorders—emergency is one of the most violent places in the hospital system in which to work. There are numerous documented instances of attacks on clinical staff and in particular on front-desk staff. Unfortunately, we are forced to provide that barrier so we can ensure our staff are safe. Triage always has a separate area where they can guide a patient through to quickly assess them or perform an ECG or do basic blood pressure, pulse rate, et cetera. So, while they are sitting behind a screen, they have a room off to the side where they can assess people.

(The witness withdrew)

TERRENCE JAMES CLOUT, Chief Executive, South Eastern Sydney Illawarra Area Health Service, sworn and examined:

CHAIR: Do you wish to make an opening statement?

Mr CLOUT: No, I do not.

Mrs JILLIAN SKINNER: Welcome.

Mr CLOUT: Thank you.

Mrs JILLIAN SKINNER: The condition of Royal North Shore Hospital, the cleanliness, we know it has recently been cleaned, but it is the subject of some criticism, particularly in relation to infection control measures and so on. What was the state of it when you were involved in the Northern Sydney Central Coast Area Health Service?

Mr CLOUT: As you would understand, as would members of the inquiry, I was in that role for about nine weeks. In that period of time I would not purport to have been around every part of the facilities, and nor would that be true of Royal North Shore Hospital.

Mrs JILLIAN SKINNER: But you did go to—

Mr CLOUT: I went to some of those, certainly, and the emergency department. I did not observe there being any levels of gross untidiness or dirtiness. It is an old building, there is no question about that, and it shows the signs of many old buildings.

Mrs JILLIAN SKINNER: Were the windows clean?

Mr CLOUT: There were some that were probably not as clean as I would have liked them, to be honest, but I did not notice any that were grossly unclean.

Mrs JILLIAN SKINNER: So a submission by a doctor about cockroaches on operating tables, and so on, would surprise you or not?

Mr CLOUT: Certainly in that period of time those matters were not brought to my attention. I would have expected, with the change in administration and the new acting chief executive, if there were issues of that nature, they would have been brought to my attention. But it is more likely that those issues would have been brought up through the normal processes, for considering those matters through infection control, I would have thought.

Mrs JILLIAN SKINNER: You were the person who instigated the Meppem-Dalton review into bullying, where you not?

Mr CLOUT: As you will be aware, that matter first came to my attention, as it did to most people's, through the media. It was clear that the Minister's response to that was pretty quick and she indicated she wanted that matter investigated. She indicated that to me and I instituted the investigation.

Mrs JILLIAN SKINNER: Up until that point you had not been aware of the grievances and the extent of grievances at the hospital by staff?

Mr CLOUT: That happened very early in the period I was there. It is fair to say that it had been brought to my attention that there were at Royal North Shore some discontent and issues around bullying and harassment. Quite frankly, I had not got my head around those by the time the issues broke in the media, but very quickly I did. It was clear that what needed to happen was that I needed to get some people in independently to have a look and provide some advice.

Mrs JILLIAN SKINNER: You came previously from the Hunter?

Mr CLOUT: Hunter New England. I am sure, with one of the members on this panel, if I did not say Hunter New England I would be in trouble.

Mrs JILLIAN SKINNER: You had a reputation there of being a fairly good financial manager. Could you comment, perhaps, about the budget at North Sydney Central Coast Area Health Service and, in particular, at Royal North Shore Hospital, and its history of being over budget?

Mr CLOUT: Yes, I can, and I am happy to take your comments about our management at Hunter New England. One of the first things I had to have a look at when I came into the role was what the situation was in relation to the budget, because at that time we were in the process of putting together the budget for 2007-08. It was clear, looking at that, that I needed to get briefings, and I did so with the Department of Health and from senior people within the area health service. It was clear there was a significant financial challenge. In health services, in my experience, that is not unusual but clearly what needed to happen was, first, we needed to understand very well exactly what the pressures were and where they were coming from. Secondly, we had to, with the Department of Health, put together a plan that would address those significant challenges. The view I formed over a period of time of looking at all the information, all the data, was that we could not continue with the strategies that had been put in place. Quite a good plan had been put in place some 18 months before that financial year but some of the strategies that were necessary to make that budget work had not been achieved. Therefore, we have to look at other ways of doing it. So we put together that plan. It was really a significant challenge and it was not going to be fixed in one year.

Mrs JILLIAN SKINNER: That plan and the strategies that were looked at—I have some documents that were given to me—the clinicians did not know anything about it. There seemed to have been very little public knowledge or clinician knowledge about the detail of the budget and the plans to cut the overruns back. Would that be right?

Mr CLOUT: In comparison to how I had been used to working those issues through in their detail, the budget issues through in their detail, with senior managers and clinicians, that process was not as robust as I was used to. That is not to say that it had not been looked at and there had not been discussions, but I think it is fair comment that in my view there needed to be greater focus on that. There needed to be greater engagement with clinicians, a greater dialogue around what the issues were, what the plans were, what savings had to be made, where those savings had to be made and where expenditure could be made.

Mrs JILLIAN SKINNER: It must be so difficult for clinicians, and managers for that matter, heads of divisions or departments, to plan the future and come in within budget if they do not know what the budget is in the first place?

Mr CLOUT: The whole issue of meeting the financial imperatives that one must when you are spending public money, delivering safe quality care, meeting the performance indicators and doing all that, is hideously difficult. The reality is you have to have good information and you have to share that information broadly and you have to take the hard decisions and get a commitment from clinicians and senior managers right across the system to implement that plan.

Mrs JILLIAN SKINNER: Share information, in other words?

Mr CLOUT: Yes, you do.

Mrs JILLIAN SKINNER: Some nurses have reported to me and others that the harassment, bullying that they perceive or allege related to pressures to come in under budget or to cut costs, and that goes down to the cost centre that might even be a ward. So, a nurse unit manager might have enormous pressure applied on him or her to cut back on services to cut back on the budget overrun? Would that be a fair thing to say?

Mr CLOUT: I think it is a simplistic view but it has a modicum of truth like all claims do. The facts are that trying to balance all of those issues right across the system is very difficult, number one. Number two, the system is under pressure. There is a significant increase in emergency department presentations, separations, expectations and there is a limited budget to do that with. There is a high expectation from the community, quite rightly.

So it is very difficult to try to get that balance right. I do not know whether I accept that the pressure that is felt from the top of the organisation right through to the clinicians, the managers and right down into the organisation—and it truly is a pressure cooker environment within which everyone works—can rightly be correlated with issues around culture, bullying and harassment. Bullying and harassment in the workplace does not exist in many other places within the system, both in this State and elsewhere, where those pressures exist. You can see cause and effect but you can also see places in which that is managed and balanced so that it does not exist. Bullying and harassment happen because individuals bully and harass. The organisation has to be aware of that first and then act promptly in relation to it and make it clear that it is unacceptable.

Mrs JILLIAN SKINNER: The Coalition, and in the latter part I, sought information under freedom of information from the Northern Sydney Central Coast Area Health Service—I think while you were the chief executive officer there—about the number of elective procedures performed in that hospital. We have data that goes from 2000 up to 2006 that clearly shows that at Royal North Shore Hospital fewer elective procedures were performed in 2006 compared to those performed in 2002. Would that drop in elective surgery partly contribute to the fact that more people are presenting through the emergency department?

Mr CLOUT: It may, but I think it is unlikely to be directly correlated. The real issue around elective surgery is how long do those people who are requiring the procedures have to wait and whether or not they get the procedure.

Mrs JILLIAN SKINNER: True. But the fact that the minister and many others keep asserting that there is increased elective operations is disputed by the freedom of information figures from the area health service. They are likely to be right, would they not? I have not been presented with incorrect information.

Mr CLOUT: You would think so.

The Hon. JENNIFER GARDINER: Mr Clout, for the record, can you explain to the Committee how it was that you transferred from Hunter New England Area Health Service to Northern Sydney Central Coast Area Health Service for that period and you then exited to go south?

Mr CLOUT: Yes. My colleague Dr Stephen Christley resigned his position at Northern Sydney Central Coast Area Health Service. I was approached by the director general on the basis of asking whether or not I would be prepared to act in that position while the position was advertised and filled, and I agreed to do so.

The Hon. JENNIFER GARDINER: Did you agree for a short period?

Mr CLOUT: Yes.

The Hon. JENNIFER GARDINER: Was that the understanding at the time?

Mr CLOUT: Yes. I undertook to fill that position while it was being advertised, which is not an uncommon thing to do in business. While this probably is the most important business to be in, nonetheless, it is a business to run. The most important thing during a transitional period is to ensure, first, that the business keeps getting done and that the systems do not stop. Then there are other things to do, like preparing a budget, putting together a forward plan for the financial position, engaging with clinicians, looking at processes and procedures, and stuff around issues like the Meppem-Dalton report. First, you have to ensure that the business keeps getting done, and I agreed to do that during that period.

The Hon. AMANDA FAZIO: Mr Clout, compare Hunter New England Area Health Service with how you found the Northern Sydney Central Coast Area Health Service. How would you compare them in relation to clinical networks between hospitals in the two regions?

Mr CLOUT: It is a little hard to compare because it is a bit like apples and oranges. Hunter New England Area Health Service has a large metropolitan area but it also has a very extensive rural and even remote and coastal component to it. It has 50 plus hospitals and one major teaching and

referral hospital, that being John Hunter Hospital. It then has other significant acute hospitals—Tamworth, Armidale, et cetera. The development of clinical networks in Hunter New England was following a path and we were somewhat down the path of developing some managed clinical networks across the service.

We had done that with a lot of engagement with senior clinical staff—doctors, nurses and allied health staff—and I think we had made some significant progress in some areas, in particular, in mental health, children's services, cancer services and renal services. There were other areas where we had significant work to do and there is still significant work to do to build those networks. I think there was an acceptance by the clinical councils of the need for that networking and for us to work through the development of clinical streams and clinical networks. I think in Northern Sydney Central Coast work along those lines had already been done and had achieved some success in some areas. Again, I think it was being retarded a little. In other words, what had been worked out was the need to do it. The discussion had taken place as to how it needed to progress.

I was there for a short period so I am giving you my impression here. I think there was somewhat of a view that we had had a lot of consultation but that we had not seen from senior clinicians sufficient action or implementation. Therefore, there was a tendency to say, "We have to deal with other issues of direct clinical care and we think that that is not working to our satisfaction." I am giving you my perception as conveyed to me by some of the meetings I had with some of the senior clinicians across the area. I think it was probably being held back by that but it was clear that people knew what needed to happen and they could see the advantages of that networking across the area. A little more silo maybe but that may be just history and tradition.

Sometimes it takes a bit longer to change things. Royal North Shore Hospital is a hospital of significant history and kudos because of what it has done and what it is doing, and so it should be. So it is a bit harder sometimes to get people to accept that they need to move outside that focus and into a broader area. I saw evidence of that happening, but there was more work to do.

Ms CARMEL TEBBUTT: My question is also a comparative one, so I appreciate that it might be difficult to respond to it. We heard that some of the information systems with regard to Royal North Shore Hospital and the broader Northern Sydney Central Coast area need improvement. In your view, having been at Hunter New England Area Health Service and then having spent a short period at Northern Sydney Central Coast Area Health Service, how different are the management systems, for example, the financial management systems, between the areas? Can you comment on that?

Mr CLOUT: Yes, I can. I think Hunter New England—Hunter before the amalgamation, to the credit of the people who were there before I was—had invested very heavily in information systems, both clinical and non-clinical, et cetera. We continued that since the amalgamation. To do that, of course, we had to make prudent decisions about investing in information technology and clinical information systems. That meant that while we were making that investment we were not spending it on elective surgery or on renal and mental health. Of course, we had to balance that up and have the dialogue and discussion around that. I think that Northern Sydney Central Coast Area Health Service had made less of an investment in that and had balanced it differently. But one has to understand that it is a balance.

For every balance there are implications and there are people who will come to you and say, "You got it wrong." I know that that is hideously difficult to do but I think that that one was and is—it continues to be and will continue to be for the next 10 years—a critical decision in the area of investment. It is a bit like the decision to invest in community based care, care in the home, and prevention and early intervention. Those are things in which we need to invest heavily. If you are investing in that you have to make the decision that you can spend the money only once, so you do not spend in another area for that period. They are hideously difficult decisions to make. In answer to your specific question, I think that the information systems, both corporate and clinical, in Hunter New England were more robust and, therefore, better information was available to clinicians and managers in those information systems at that point in time than I found at Northern Sydney Central Coast.

Mr MICHAEL DALEY: Given that one of our terms of reference includes any suggestions that the Committee might recommend to improve efficiencies at Royal North Shore Hospital, are there

any aspects of good practice from Hunter-New England hospitals, which might be employed at Royal North Shore Hospital?

Mr CLOUT: I think there are lots, and I think there are lots at Royal North Shore Hospital that also would be of benefit to people at John Hunter Hospital and Tamworth Hospital. The name of the game is not about thinking that there is a place you can go that is a repository of all models of care of all best practice. The name of the game is accepting a view that, in a sense, you do not make your own candle brighter by snuffing out other people's but, rather, you go to them and you say, "What are they doing well that we can learn from? Let's get the clinicians involved to come and look at that and talk about it. What are they doing well; what are we doing well?"

In a lot of the redesign stuff that has been done, different hospitals, different groups of clinicians, different areas have come up with models of care that are really good and everyone then has to have a look at those and say, "Okay, how can we apply that? How is that going to give benefit to our group of clinicians providing that service?" That is one area and certainly some of the things that I think we have developed at all of the hospitals across Hunter-New England gave evidence of good practice and changed model care. But I make the point that that is also true at Royal North Shore; it is also true at Gosford, it is also true at Prince of Wales, it is also true at Wollongong.

There is one area, though, that I think some of the work we did at Hunter-New England and some other areas have done around using episode funding as a tool in a kitbag of tools in terms of looking at the cost of providing the same service and saying, "How are we going in terms of cost efficiency in relation to that?"

Mr MICHAEL DALEY: Is that like widget funding?

Mr CLOUT: There are some people who may refer to it as that, but from my point of view it is a very powerful tool. We do all have the information that enables us to know that if we do a cataract operation, this is how much it costs to do it. If we do a hip replacement, this is how much it costs to do it. It should not be the case normally, as at least a first guide, that we can say having a cataract operation done at five different places should be 60 per cent more expensive at one place than it is at another, or a hip replacement or anything else. If we are looking at that data and we are saying compared to our peers—provided we are comparing apples with apples and the context is reasonably similar; and that is why we have peer groups of hospitals—then you would expect to say that the cost of a procedure or a service should be about at the peer group average.

It is not an exact tool or a science but if you look at your data and you say, "I am significantly more expensive to do the same", then as an administrator, as a clinician, as a taxpayer, as government you should be looking at it and saying, "Why is that so?" You then have to look at that cost structure and say, "We need to understand why it is more" and, unless there is a good reason why, we should be driving the cost of that down so that it is at the same rate, provided you are doing apples with apples.

You always get an argument about the data, unquestionably. As soon as you produce that, people say the data is rubbish. The answer to that is, "Well, we will make the assumption that there is a plan and a journey to look at how you make the change from being much more expensive down to being at your peer group average. We will do that progressively. We will work together to ensure the robustness of the data and information so that if we are wrong, we have got time to adjust once the information is much more robust and accepting that the information will never be perfect.

CHAIR: Thank you for the answers you have given. I just have a general question. You mentioned earlier about the Royal North Shore Hospital budget overrun. Is there any simple explanation? Is there one area such as a clinical area, which you seem to be suggesting may be the area that is blowing out the budget?

Mr CLOUT: To be honest, I was not there long enough to be able to answer your question definitively, but what I would say to you is that there is a standard approach that I have used when the data tells me that it is more expensive and how I go about discovery. When you get to the gross figures, you say, "Okay, we need to understand the business better." If you are managing a large corporation of this nature, then you have to understand the business. What you then have to say to your senior staff—and that goes and number of levels down—and engage with the clinicians about

saying is, "We need to get the best information we have got, we need to work it through and try to identify where those additional costs are."

The reason I say that that is important is that in my experience over the last 20-odd years of working with clinicians, they are actually very much able to and prepared to help you reduce the costs if you work with them and can show where their costs are more expensive than others, provided they are satisfied you are comparing apples with apples. The reason for that is that most of the senior clinicians also work in the private sector so they work in both fields and if you have the data with them and have a genuine dialogue with them, then they can say to you, "It is costing much more here to do this. The cost of the prosthetic is much more. We've got to do better than that." And they can help you identify how to drive those costs down; not so much "where" because you can measure where, but they need to be the people who will help you identify.

There is another good reason for having that dialogue and engagement and that is, quite frankly, if you have worked with them to identify where those costs are higher and some strategies to bring them down, there is a much greater chance that you will have their support in implementing that change. If, on the other hand, you do not have that engagement, all the barriers will be up and it will be, "The figures are wrong. It's not apples with apples. We're not more expensive and you shouldn't touch anything", and that does not help you solve the problem.

CHAIR: Is it another factor that the Royal North Shore Hospital was built in 1976, even though there has been some updating and new buildings are going in? Could an old hospital be more expensive than a modern hospital such as Westmead, which has the latest equipment?

Mr CLOUT: Unquestionably that is true. The question is whether or not the extent of the difference in cost is totally explainable by that. That may explain some difference.

CHAIR: It may be a factor?

Mr CLOUT: It may be a factor but in my experience you can have all the structures in the world but if people are not working together effectively, things will not work. You can have all the best buildings in the world but if people are not working together it will not work. While those things are a factor, in my experience they are rarely the most significant factor and if they are a factor, they are mostly a factor in the area of support costs as opposed to clinical costs.

Mrs JILLIAN SKINNER: You talked about episode funding as a tool to make comparisons. With your 20 years experience in the system, you would recall the yellow books that used to be published. For the benefit of the Committee, yellow books were a very comprehensive description of everything that went on in a hospital that enabled you to compare peers, so that you could look at that the cost of episodes, staffing, the emergency department, absolutely everything. Do you think that should be reintroduced as a mechanism to enable a bit of transparency and therefore some solutions?

Mr CLOUT: I do remember the yellow book and I used the yellow book.

Mrs JILLIAN SKINNER: Still?

Mr CLOUT: No, I do not use it anymore.

Mrs JILLIAN SKINNER: I do.

Mr CLOUT: It had advantages and disadvantages. The problem with the yellow book is that the data was too old, so that by the time you got the yellow book out, the information was two, sometimes three years old. But the thinking behind it was absolutely valid, that is, that you needed to be able to look at that information, analyse what it looked like for your own facility, your own service, your own area health service and then across, and ask business-type questions. Do I think we need the yellow book? No, I do not because that information is already available.

Mrs JILLIAN SKINNER: Where is it available?

Mr CLOUT: We have all of that information, in terms of the costs of running the service is plugged in by every area health service to the Department of Health every month.

Mrs JILLIAN SKINNER: Called what? In what? What is the name of the document?

Mr CLOUT: There are numerous documents that it is out on. The most important thing is that every area health service is able to pull out that information and look at it. For example, I was able to, and did, when I was in the acting position, look at the cost per case-weighted separation for the peer groups of every hospital in Northern Sydney Area Health Service compared to its peer group for the year 2006-07. Bear in mind that is 2006-07 and I was there in the very early part of 2007-08, so the importance of it is that while it is not comprehensively brought together in one document, it is there, it is useful and it is pretty current.

Mrs JILLIAN SKINNER: And would there be an argument to make that publicly available or at least more broadly available than it is now, because people keep asking questions and making wrong assertions about this information?

Mr CLOUT: I am not sure about the argument of making it public.

Mrs JILLIAN SKINNER: Or available to clinicians at the very least?

Mr CLOUT: Well, my view is very simple about that, and that is that that information is available to area health services and it does need to be the subject of discussions with senior managers and clinicians. In fact, while I was there I held a meeting of 150 senior managers and clinicians at Gosford, which was the whole area health service, put all of that data up on the day and made it available and talked about the challenges that we had and what the strategy had to be. So, from my point of view, I used that information very openly and always have done. I see no reason why managers should not be doing that and having that dialogue. You will still get the arguments from those people where the data goes up and it says they are more expensive and that the information is not robust, but then you need to go back and have the discussion with them and say, okay, work with us, show us where it is not and we will improve it; then we will be progressively working with more robust data.

Mrs JILLIAN SKINNER: Yes. One more?

CHAIR: We just have one question from this side.

Dr ANDREW McDONALD: You talk about the silo mentality, Terry?

Mr CLOUT: Hi Andrew.

Dr ANDREW McDONALD: Hi. Both inside and outside North Shore—inside North Shore the departments and outside North Shore with the other hospitals—how much of a problem was it?

Mr CLOUT: It is a problem everywhere. Relatively, the more—

Dr ANDREW McDONALD: You are under oath, Terry.

Mr CLOUT: No, no. It is a matter of being balanced in terms of it. The more established a service, a facility, a unit is, the more likely I think that it is to be siloed because of its history. But in those really important health services it is also the area where it is most important to have more concentrated discussions around getting people on board with broader networking as opposed to silo thinking. But that is something that is true right across the system and in business generally. If you have a very, very well-established, highly respected organisation and it has got people in it who have built that, you can understand that it is very difficult to say to them, well, that is fine, but we now want you to step out into something that you are less certain about, you are less in control of. That is a big ask: it is a big ask of you; it would be a big ask of me. But it is important that that happen because you cannot provide services these days and service the whole of the community of this State unless you accept the proposition in terms of equity of access that you need to network those services right across

the State. Both technology and transport now makes it possible for us to do that. We just have to get lots of people to catch up that thinking in their minds.

The Hon. AMANDA FAZIO: Is the nature of the clinical workforce at Royal North Shore—I understand that a lot of the doctors train there and there is not much staff turnover for clinicians—does that make the silo situation perhaps a little more concentrated than in other comparable hospitals?

Mr CLOUT: No, because I think, particularly the traditional, well-established, older establishments, that that is true of them as well. So, I do not think it is anything peculiar or particular to Royal North Shore at all. I think it exists in many places. The referral patterns, some of them are very legitimate referral patterns and what we refer to as natural referrals. Others are ones that do not make a lot of sense in terms of having equitable access to services across the whole of New South Wales. It is those ones, and only those ones, that you want to disturb and get people to see a broader canvas that they can play in and we need them to play in in terms of providing those services in a network way across New South Wales.

CHAIR: Thank you very much for giving us your experience over a wide range of health areas. We appreciate that very much.

(The witness withdrew)

STEPHEN TIMOTHY DENNIS CHRISTLEY, Medical Practitioner, and

PHILLIPA GAY BLAKEY, Medical Practitioner, affirmed and examined:

CHAIR: Thank you very much for appearing before the inquiry. We appreciate your cooperation. Dr Christley, in what capacity are you appearing before the Committee?

Dr CHRISTLEY: I appear as a private citizen. I am the former Chief Executive of Northern Sydney Central Coast Area Health Service.

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

Ms BLAKEY: As a private citizen, but I am the former Director of Clinical Operations, Northern Sydney Central Coast Area Health Service.

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

Dr CHRISTLEY: I did send via e-mail a statement over the weekend. If the Committee has that, I am happy to talk to it, otherwise I can briefly make a few points to kick off.

CHAIR: We will just get copies of your statement. If you could run through it quickly for us.

Dr CHRISTLEY: North Shore, as has been alluded to by others, I think has a long, proud tradition in the provision of very good, high-quality patient care. If you look over the years, it has been seen as a leader in a number of areas: quality systems, a lot of the innovations around patient access, and management of surgery have come from North Shore and have had national and international recognition. But of recent times North Shore has experienced access issues. In my time as chief executive I saw no evidence whatsoever that North Shore had a higher rate of serious incidents—SAC 1s—than any other hospital. My experience of the culture in North Shore and, indeed, with the area health service generally was that it was open to reporting incidents, that there was a willingness to work through issues and put in place improvements. But North Shore obviously is a hospital where there is a degree of discontent.

In many ways I see North Shore as perhaps a bit of a litmus test for the Australian health care system. About 70 per cent plus of elective surgery in Northern Sydney Central Coast takes place in the private sector. The majority of emergency work takes place in the public sector. If you were to compare growth rates in activity in Northern Sydney Central Coast, particularly in the northern Sydney end, to growth in the public sector activity in other area health services, you will find it significantly less because there has been a higher take-up into the private sector. What that means for clinicians at North Shore is that in what was once the largest private hospital in Australia, if you measure that in terms of private inpatients, it now has a very much smaller private load and that private load is transferred to the private sector. So, clinicians are straddling the practice across two places and what they are seeing is an erosion of the relative scale of North Shore versus its previous glory.

I have seen in the papers people making comments about the health system. One of the ones that stuck in my mind was from a surgeon somewhere out west who said that in the public sector it makes up probably 10 per cent of the revenue but 90 per cent of their problems. If you look at it, you have on the one hand an uncapped private hospital system where, from personal experience, if you need to go in, you go in—you almost go in too fast before you decide whether you need the operation at times—versus a system that does operate in a capped way and that has as its first priority emergency care. For clinicians at North Shore I think the balance between emergency care and the elective work has got a little bit out of kilter and I think the demands on them that they meet, I really take my hat off to them—it takes a huge degree of commitment to meet that.

If you look at clinical performance indicators, North Shore performs well on relative lengths of stay case-mix adjusted. The area as a whole performs well in terms of appropriate versus inappropriate admissions to hospital. I was not planning to talk about cost, but there has been a bit of

discussion about the yellow book and costs for North Shore. If you actually go back to the 1998-99 yellow book and look at North Shore compared to other hospitals, what you see is that it is about $40 in that instance, from memory, higher costs than peer average. If you go down through the DRGs you find that it is overcost in the small volume units, maternity being perhaps the highest stand out. So lot of that is about Royal North Shore and its place in the world. I think it is quite obvious that we need to look at efficiency, but also we need to look at an understanding of the balance between public and private sector work.

Comments have been made about structure. I thought I would make some introductory comments about structure to allow people to understand the rationale behind what was happening in Northern Sydney Central Coast Area Health Service. Obviously, what happens from here is a decision for others. What we were doing in Northern Sydney Central Coast Area Health Service regarding structure was to try to break each health service into manageable units and then build networks from the bottom up across the area health service, so that people who had budgetary and clinical accountability for service delivery in a particular discipline or clinical area were then able to work with their colleagues in other health services across the area to work out what was the best way to provide care, what common care models there were, and what staff development needs and workforce issues there were. As Terry said, that was in a degree of variance in terms of its development. But I would point, for example, to do maternity services where, from the bottom up, there was an agreed model of care and there was a range of things happening at a varied level. I can instance paediatrics and a range of other areas, including emergency departments and so on.

Comments have been made about whether the area should have a professionally based management structure. We made a conscious decision to have a management structure that had professional input but was generically based, although most of the people in those roles are clinicians, or are from medical nursing or allied backgrounds. I think perhaps the proof of the pudding, if I might instance one, is at Hornsby Hospital, where they have had very innovative models of care in the emergency department based around small teams, which I think have been breaking down some of the professional barriers between different disciplines. I could go on, but I do not want to take up your time for questions so I will stop at that point.

Mrs JILLIAN SKINNER: Dr Christley, when you left the North Sydney Central Coast Area Health Service it was very fast and unexpected. A lot of people were very surprised. Was it a voluntary resignation?

Dr CHRISTLEY: It was a voluntary resignation. I had been thinking about my future for a while. I was actually on leave when I had a discussion with Deb Picone. Out of seven days leave I had worked for five. I went in, and we had a discussion. I think there is a benefit to change. There are some times—and maybe the Australian political landscape represents it at the moment—when perhaps you are not sure that your messages are being heard. I feel that the area health service would be best served by a change of leadership, and I was happy to move on.

Mrs JILLIAN SKINNER: What were your messages that were not being heard?

Dr CHRISTLEY: I do not think I really want to go into them too much, if you do not mind. Could I come back to something that is relevant to this Committee? There has been a lot of discussion about clinical services planning, and so on. The changes that need to be made in Northern Sydney Central Coast Area Health Service are significant changes. Some of those changes had already been made. We have had the discussion about Manly-Mona Vale hospital and the new roles. Certainly significant discussions need to occur concerning North Shore and Ryde and their respective roles, and other discussions also need to occur.

My sense was that, both working with the clinicians and working with the department and the political process, it was time for somebody else to come in and have a look at what I and my team had done, review that, see whether they believed that was the right way forward, and take that forward from there. In fact, part of the reason for my leaving in a fairly rushed way was that I had planned some sessions talking about future direction; we had already had discussions at clinical council and AHAC about some of the service changes that needed to be made and some of the strategies that needed to be made to improve things, both from—I think clinical quality and budget go hand in hand, so I will say both from a sustainability of clinical quality, because workforce issues are real and unless

we move to address them they will swamp us, and the budget issues are also real. I believed that it was probably better that new leadership take that forward rather than old leadership.

Mrs JILLIAN SKINNER: I notice that in your email, which we have just been given, you talk about the reporting of adverse events and so on. Are you confident that all adverse outcomes are reported to the Clinical Excellence Commission?

Dr CHRISTLEY: All I can do is look at trends and my understanding—and Cliff can probably answer this later on—is that Northern Sydney Central Coast Area Health Service has a high rate of reporting, which I applaud. Our level of SAC 1s looks fairly realistic; it is fairly consistent. In terms of print, it is not going up; if anything, you could use your imagination and say perhaps it is going down, but I suspect that is artefact and does not stand up at all.

I suppose I am also encouraged by the cultural elements. I adopted the practice of regular staff forums. They became less frequent because I believed that the hospital general managers needed to take the lead with staff. But certainly in the early days of the area health service I went out every month for three months and spoke at each of the hospitals. What encouraged me about the culture generally was that people would stand up and say to me, "We do not think patient care in this area is optimum." I would say, "Great; you are actually raising these issues." The other good thing was that the clinician management partnership would take those issues forward and deal with them. I think that people in Northern Sydney Central Coast Area Health Service generally speaking had a good attitude towards reporting patient incidents—

Mrs JILLIAN SKINNER: Did you feel that in relation to the Vanessa Anderson matter, which still has not been resolved by the Coroner?

Dr CHRISTLEY: I do not know whether I should make too many comments.

Mrs JILLIAN SKINNER: In general terms?

Dr CHRISTLEY: In general terms, I do not think the communication with the family in the Vanessa Anderson matter was as good as it should have been, but I should not make any further observations.

Mrs JILLIAN SKINNER: But you are confident that the matters the clinicians and others should raise, in your opinion, will have been brought forward?

Dr CHRISTLEY: I believe so. Certainly I have not heard anything being held back in that regard. I think that is a really sad case for all concerned.

Mrs JILLIAN SKINNER: Reports that might come forward about an investigation into other hospital deaths, from falls for example, not being investigated at the hospital level would surprise you?

Dr CHRISTLEY: There will always be flaws, I guess. I can never claim perfection; it is a dangerous thing to do. But I believe that people notify things when they are encouraged to notify and things are appropriately investigated. I do believe that at times there have been glitches in the way complaints have been handled in terms of the contact with families. Following the case we mentioned earlier, we reviewed the way those matters were drawn to the area health service's attention early, so we could ensure that the appropriate communication did occur.

Mrs JILLIAN SKINNER: You said that you think Royal North Shore performs well in comparison with its peers. Do you mean in budgetary terms?

Dr CHRISTLEY: No. I was referring then to its clinical performance in terms of case mix adjusted to length of stay, and I also referred to inappropriate admissions. The issue of financial performance is a very, very difficult one. About six months ago there was a presentation from Richard Matthews to the senior executive advisory board using neurosurgery as an example. Neurosurgery at Royal North Shore was starting to be expensive. Then they broke that down into the various cost components: medical board, medical supplies, nursing, et cetera. They put across all Royal North

Shore's peers the way people are factored in the costing methodology. I would support the clinicians who would say there was not much you could believe in it at that level because the numbers were composed so differently across the area health service. I think NSW Health is putting a lot of effort into improving that, and one of the benefits of the standardisation of information technology and financial systems across the area health service is that people will use the same methodologies to compare those costs.

Still referring to financial performance, earlier I alluded to the small volumes. It is hard to compare tertiary referral hospitals, but I know that if you look at major metropolitan hospitals—such as Manly, Campbelltown, et cetera—according to a study done about three years ago, the cost performance of those hospitals is pretty directly related to size. The smaller ones, which still have to have an ICU or whatever else they have to have, are more expensive than the larger ones because they distribute a large number of variable costs over the same fixed costs base. We need to really not use those difficulties as an excuse not to look, but we do need to be mindful of the fact that there are complexities that underlie some of the comparisons.

Mrs JILLIAN SKINNER: I wish to ask you a question raised in one of these submissions relating to finance about allegations of shifting trust funds or bequests to the bottom line at the end of the financial year.

Dr CHRISTLEY: There was one instance of which I am aware about three years ago where somebody took money from a trust fund, or used money for an inappropriate purpose. That was discovered and restored. That was not the cancer trust fund you alluded to this morning.

Mrs JILLIAN SKINNER: So it was another one?

Dr CHRISTLEY: It was not of the order of magnitude of $3 million. It was a large sum. I cannot remember now what it was. I am not aware of any other irregularities. What we did over the last couple of years is actually strengthen the Government's process around trusts so that Professor Pollack, who was here before, one of the roles she did not talk to you about was that she is actually a member of a committee that looks at bequests and determines what purposes they can be put to so that there can be no diversion in any way from the intent of the donor in terms of donations.

Trusts are a difficult issue. One of the things that has happened with the move of work from the public sector to the private sector and private work is that there is a significantly reduced component of private practice trust grants at North Shore now available for discretionary distribution by clinicians, and that is certainly one of the challenges that the health service faces in terms of its capital and so on.

The Hon. AMANDA FAZIO: What would you say are the major challenges that you have faced in your time as the chief executive of the Northern Sydney Central Coast Area Health Service?

Dr CHRISTLEY: I was the first person to be appointed across to area health services. At the time in the initial phase there were two boards. I guess the ground rules shifted post my appointment to being mergers across the State. Some of the undertakings I was given when I first went did not come to pass, given the structural changes. I think there was a degree of antagonism perhaps or sibling rivalry between the two area health services. We found though that that diminished significantly once people understood what the population health issues were across the area.

I must say that the clinicians at North Shore who were part of the clinical council and the area health advisory council and other forums where we presented the data, where we presented to a range of clinical and community forums, became aware of the enormous growth of the area health service in the Central Coast area, and particularly around Wyong, and became very useful allies in trying to resolve some of those problems. For instance mental health is one example where Northern Sydney resources helped Central Coast with significant service expansion that would not have been possible, given the shortage of medical staff.

I think changing governments is a challenge. I believe we were probably 70 per cent of the way through changing from old ways of doing things to new ways of doing things, and delivery on the savings that were expected was also a challenge. But as has been said by a number of people, I think

there are significant benefits to be had through clinical interaction across a larger area. Without wanting to go into details, there are some specific examples where I have seen opening up to a broader scrutiny, and there has been significant clinical practice change because people have actually seen that there are other ways of doing things. I think the lasting benefit will be greater clinical cooperation across different groups.

Ms CARMEL TEBBUTT: Dr Christley, I want to ask you about the financial performance of the Royal North Shore Hospital. I know you have already made some comments with regard to that. One of the things we have been hearing from some previous submissions was that particular procedures at Royal North Shore Hospital were more expensive compared to hospitals in its peer group.

Dr CHRISTLEY: Yes.

Ms CARMEL TEBBUTT: Others have said that the data is such that perhaps you cannot easily make that comparison. I guess I was wanting your view on that and also just the financial performance of the hospital.

Dr CHRISTLEY: I will make a couple of quick comments about costs of admissions. I think it is very difficult and you do need to test it, but at the same time you need to develop your hypotheses and go and check them. We did, as part of the management project that Terry referred to, 18 months of two years ago analyse some of the data around where there were cross-variances across the area. It was not just that North Shore was more expensive than others. There was an opportunity to look across the area health service. I will just say why I think it is hard to just use the data without taking a broader perspective. Some of the respiratory diagnoses were much more expensive at North Shore, but if you compare them with another hospital in the area which was cheaper—and I will not name which one—you found people with what appeared to be, on data, similar clinical conditions having been at North Shore that did not come back for a lot longer, or at all, whereas there was more, by result, a revolving door elsewhere.

There may be a range of reasons for that: I mean, there may be better performance at North Shore or it may be better primary care. I think one of the things that this Committee has not heard of yet is what is happening in primary care and the flow-on impact to the acute hospital system. It could be that Northern Sydney at that stage when the data was there had a much better developed acute/post-acute and Hospital in the Home system and better chronic disease systems for that particular condition, not generically or in others where Central Coast was strong. There could be a range of reasons. But you just need to be a little bit cautious in interpreting the data.

One other point I make is that it is very difficult. To do costing, we break it all down and then we try to pretend that the buckets we have broken it down to actually mean something whereas putting it into different programs can give you different answers. Therein lies the "There are … lies, damned lies, and statistics", but just out of interest I did a little analysis of the resource distribution formula and I looked at what the acute care program would indicate that health services might produce in terms of diagnosis related groups for the acute resource distribution formula component they have got.

Mr MICHAEL DALEY: Is that in this submission?

Dr CHRISTLEY: No, it is not. It is a back-of-the-envelope analysis. I suggest that maybe the department should have a look at it because they would be much better having a look at it than me. But if you take the four metropolitan areas because it is done at an area level, Northern Sydney Central Coast was one of the two that produced the most diagnosis related groups if the budget in the acute stream was actually true to the topics that it is allocated in. So there could be efficiency, it could be not spending enough on information technology and doing the things that Terry said, it could be a range of reasons, but the value to the taxpayer of the number of clinical cases treated for the dollars allocated for acute care for Northern Sydney Central Coast stand up to analysis.

Dr ANDREW McDONALD: Steve, we have not heard about the challenge of health care and providing high-quality care while balancing the budget. That is common to all hospitals. What is different about North Shore? What challenges are there at North Shore specific to balancing the budget?

Dr CHRISTLEY: I think I have alluded to some of them. You can always manage better. You always can. Inevitably you can look at controls. In relation to some of the comments that have been made about information systems, believe it or not Northern Sydney Health actually won a public sector finance award for its financial information at out-to-cost-centre level a few years ago. Its human resources data was actually as good as anywhere. But with the standardisation of systems there is a little interim phase now where the information is actually pretty poor. But it will improve with the implementation of the standard Oracles and patient administration systems and so on and so forth. It will then go forward on a whole-of-State basis and be as good as anywhere. I think that is the right direction, that is the way, because we waste a lot of money reinventing the wheel. If we can get a better wheel and give it to everybody, obviously that is the way to go.

If you say that North Shore on the diagnosis related group/adjusted length of stay, which is the primary determinant of cost, is not different to its peers, in fact it is probably reasonable on most of the evidence I have seen. I believe the differences are either that there is some inefficiency in staffing, and I do not see that people are telling me that they have got too many staff too often, or it comes back to relatively small volume units that probably leads off to the private sector and the high emergency load. My belief is that while that does not stop you looking for further efficiencies, and there will be and there are always because that is the nature of health, in the public system we have growing demand, we have an expectation of good quality care, and we need to continue to improve the way we do things. When we have data we will be able to substantiate. In the meantime we need to explore various hypotheses around cost.

My hypothesis is that, while not totally explaining, a lot of it is about volume. And to come back to services planning, I do not believe that five acute hospitals in the old Northern Sydney Area Health Service are sustainable. With the Manly/Mona Vale merger that will come back to four and I believe there is a need for a very good look at how North Shore can focus more on the critical care emergency work and Ryde hospital become a centre of expertise for the community in dealing with the sort of chronic disease-aged care constellation and there needs to be another look at also the role of, perhaps, Greenwich. All those things we were setting in train, I believe they need to continue. I believe until you address some of the fundamentals of the structure of health care, in particularly that North Shore-Ryde sector, you are always going to have budget problems.

The other question is—to save Gillian asking it—is there enough money? I do not know the answer to that. There is an RDF. I mean, my belief is it is probably worth looking at the RDF again and checking that it is right. But you have to have a guide and you have to tailor your services to meet the clinical need of the community and there would be a few suggestions I would make about things that could be looked at in terms of the RDF, in terms of some of the things I have done over the last week just pulling things apart and saying that is interesting.

Mr MICHAEL DALEY: That is increased Federal money you are talking about?

Dr CHRISTLEY: I think if there is one thing that should come out of the Federal election, regardless of which party wins, should be that we do not have a Federal and a State system. It is absolutely ludicrous. North Sydney in that regard is less broke than some other places but if you move to Wyong and you look at why the emergency department is cluttered, it is because there is really no after hours primary care. I mean I have worked in general practice and I have worked in hospitals, the amount of cross blame that goes on between the two sectors is appalling. The quality system in New South Wales health should be extended to general practice or there should be a way found to get the same information because, from personal experience, a hospital can leave you perfectly satisfied and you go to your GP and the hospital never learns about it, or the other way round. Unless we get those things linked we are not actually going to improve healthcare for the community and we need to do that.

CHAIR: In the submission you gave to us you said in one of your paragraphs:

> The demands of the public sector are becoming more focused on 24-hour a day requirements of emergency activity. This is particularly the case for surgeons who have expressed much frustration at the Royal North Shore hospital over recent years.

Is this because it affects their income?

Dr CHRISTLEY: No.

CHAIR: What is the cause of the frustration?

Dr CHRISTLEY: It basically means that by taking an appointment at a public hospital you are committing yourself to a 24-hour day, or a roster that, depending on your speciality, can be quite intense and yet most of your elective surgery is happening in the private sector. So how do you resolve that? That is really hard to resolve. We just need to recognise, I think, that it is an issue and we do depend very much on the goodwill of those people and they get frustrated at times. You go from one system where you have got a bankcard that is bottomless to another one where there are all sorts of constraints and you get frustrated. I understand that and I think engagement of those people is really important but I say that I think we do need to engage them in a structure that has all levels of management and clinicians working together. That was what Northern Sydney Central Coast was trying to put in place. The alternative is a quasi-industrial system where you have got your clinical groups and you have got your management groups and they cannot get together until they get to the top of the organisation and that does not resolve things appropriately at the appropriate level. We need to get it as close to the coalface as we possibly can.

CHAIR: Following your comment, when we were speaking to the specialists in the emergency department they were telling us how nearly all the difficult cases in New South Wales, trauma cases, are brought to Royal North Shore hospital either by ambulance or flown in by helicopter. So that hospital becomes more like an emergency centre and people who want to have elective surgery go then to the private hospitals.

Dr CHRISTLEY: That is parallel to what I believe is the truth. I mean there are other hospitals that also take the severe trauma load but if you look at hand surgery or a range of other disciplines, such as burns, spinal, North Shore is the only trauma centre that will actually do everything. Prince of Wales, which has spinal, is not a trauma centre. Concord, which has burns, is not a trauma centre. So North Shore has a unique role in the provision of trauma care in New South Wales.

CHAIR: In effect the other point you are making is, that private hospitals do not have emergency departments?

Dr CHRISTLEY: With the exception of The Sand in the area, and I think there are one or two others—

CHAIR: But in principle they do not?

Dr CHRISTLEY: In principle they do not and to go to them you have to pay almost $200 up front to walk in the front door. So the burden of emergency care, the burden of care of the injured, the burden of caring for people who cannot afford private hospital care, comes back to the public system. It is interesting; the RDF actually ascribes 75 per cent. The way it works is, you get allocated a number of dollars based on population need, worked out by a complex formula, and from that is taken, it varies from area health service to area health service because it is weighted—so for a cardiac bypass it counts as one, cosmetic surgery counts as zero, delivery one and so on and so forth—the average is about 75 per cent of the activity that happens in the private system is assumed to be a substitution for what happens in the public system under the RDF. So that quantum of dollars is not given to the area health service that has that private activity occurring in. My analysis, for what it is worth—my back of the envelope—is that it is not that substitutable. I think that is again a dilemma at the Commonwealth level that needs to be addressed. I believe that less than 75 per cent of the activity that is happening in the private system is actually taking a burden off the public system. So there are some issues there for policy makers at a national level rather than at a State level that the State level needs to be aware of.

CHAIR: Would it be too radical a proposal to try to have some emergency services provided by private hospitals? To have some method where that could be done?

Dr CHRISTLEY: It probably would not work in a workforce sense. We would all have our own solutions. Mine is that perhaps private insurance ought to pay for what happens in emergency as

well as paying for what happens in the elective. That might reduce what, at the moment, is a huge taxpayer's subsidy into elective surgery for those that can afford it and shift it to being a more balanced subsidy to the health care of the people that can afford private insurance across the spectrum. But everybody will have his or her own solution and I am certainly not claiming to have the wisdom on that.

Mr PETER DRAPER: We have heard from a number of contributors today that the shortage of acute beds is a real issue. Was that the case when you were there?

Dr CHRISTLEY: I said in my introductory statement that North Shore has been a leader in innovative ways of dealing with it. The beds at North Shore have reduced if you go back 10 years I think. I hesitate to say that but I would suggest they probably have. A large amount of that has been North Shore Private and the private system generally and a lot of it has been practise improvement. But it is very hard to say well it is just beds. It is also the way you use those beds. North Shore, for example, treats people that might have been admitted for a week in ambulatory care, they come back every day, they get their antibiotic, they avoid the risk of being in hospital or they get hospital in the home. Some work that we did, probably about 4 or 5 years ago, we modelled how to take the load off North Shore and Hornsby and the results were pretty similar.

If we invested money in better community services, hospital in the home, home care, if we manage to discharge people with complex spinal injuries who needed to have their care organised, we actually could deliver more improvement than if we use those same number of dollars to put in the number of beds. So yes we do need to improve the capacity of the system. We need to either improve systems or make investments to improve the capacity in the system, whether that comes down to beds—and I believe there is a need for some beds. I would have liked to have had a few more beds when I was there. I believe there are probably a few more now so that has probably now been addressed—we just need to keep a broad perspective on all of those opportunities for improvement. Also remembering, if we could stop people needing to come into hospital in the first place with good primary care, then we are doing a lot of good.

Mrs JILLIAN SKINNER: I have a couple of quick questions that came from some comments you just made. You referred to the spinal unit at North Shore. I am sure you are very well aware of Professor Lali Sekhon's resignation letter in which he said there was "more focus on the bottom line than on patient outcomes". Recently Professor Bill Sears, who replaced him, made almost exactly the same suggestion, and said that he almost quit just a few months ago for the same reason. Is that a real problem when this is one of the specialty areas of the hospital?

Dr CHRISTLEY: It is interesting. Going back to about the time just prior to when Lali Sekhon resigned I had some meetings—it got to area level—around capacity issues for neurosurgery. We had actually agreed to increase high-dependency beds. We increased the intensive care beds by two and we agreed to increase the throughput of neurosurgery by an amount. I cannot remember what it was—50 or 100 cases, I cannot remember now. The issues in implementing that were staff recruitment. In the most recent discussion I had with the neurosurgeons, which would be probably nine months ago given that I have been gone for five—it may even be a little bit more—they were not meeting their throughput target. Some of that is to do with intensive care bed access.

Mrs JILLIAN SKINNER: That is what Professor Sears said.

Dr CHRISTLEY: That is an issue, and North Shore and I am sure others will talk about that. North Shore, because of its range of services, takes people from all over the place and sometimes exit block from ICU can be an issue in the same way that exit block from the emergency department can be an issue. It comes back to a common set of problems. But there was a lot of effort put into trying to address capacity issues in neurosurgery going back to that time. I cannot comment on Bill Sears; I was not there.

Mrs JILLIAN SKINNER: You made some comments about Ryde, North Shore, Mona Vale, Manly and so on. Can I read into that that you think in fact a new role for Ryde would not include the emergency department as it is currently structured? What do you see as the future role for Manly, Mona Vale and the new northern beaches hospital? What will it end up as? What should we end up with?

Dr CHRISTLEY: We should end up with in each of those population areas, which are 250,000 to 400,000 people, one fully competent emergency department. But if you go to an emergency department, as I did on a family matter on Friday, nine times out of 10 you do not need an emergency department; you need a place that can assess. I refer to what is being spoken about at the Commonwealth level: super clinics where you have a range of diagnostics and the capacity for GPs to refer or people to present and to be worked up in a way that does not mean that you go somewhere you do not need to go. I believe there may be an opportunity to develop a roll around that. But these things tend to generate controversy. I have no status; my views have no status. But speaking as a health service manager and a clinician, I believe that rather than trying to run two emergency departments and splitting the scarce ED clinician workforce we would be far better off with a generalist assessment and urgent care centre at one place around which there was a centre of excellence in general medical and aged care, because that is what the population needs. If you look at successful health systems that contain their costs they put an emphasis on primary care.

Mrs JILLIAN SKINNER: Dr Day, head of the emergency department at North Shore, says specifically in his submission that it is not the GP-type patients that are the problem at that emergency department.

Dr CHRISTLEY: That is right. It is less of an issue. But I am not talking about GP-type patients. I am sure as you go through this inquiry you will hear a variety of different views from different professional groups and specialty groups and somewhere, synthesising all of that, there lies a truth. But that truth requires listening to all the parties and probably debate between the parties, which needs to be brought back to a resolution and not allowed to drift on.

Mrs JILLIAN SKINNER: We do not have that very often in Health.

CHAIR: We have a question from Mr Daley before we finish.

Mr MICHAEL DALEY: I will have to abridge it, given the time. You were the CEO of one of the area health services at the time of amalgamation. What benefits came from amalgamation and what negatives came from it and how did you deal with those?

Dr CHRISTLEY: I was CEO of the two at the time and I had previously been chief executive of each so I knew them fairly well. The benefits I believe are the corporate services savings—and there were definitely corporate services savings. I believe the clinical networks that have developed have brought enormous benefit to both area health services—there have been learnings for both. I think the disadvantages are where people chose to take the view that they wanted to defend their parochial patch rather than be part of the whole. I think that was really misunderstanding certainly what we were trying to do in Northern Sydney Central Coast Area Health Service. We wanted to build networks from the bottom up and I think people were coming to understand that and participated in those more fulsomely.

Mr MICHAEL DALEY: So it is not true to say that there were no good clinical outcomes from the amalgamations—which has been said here today.

Dr CHRISTLEY: I would say most certainly not.

CHAIR: Thank you very much Dr Christley and Ms Blakey.

The Hon. AMANDA FAZIO: Mr Chair, before Dr Christley leaves can we clarify whether you wish the statement that you emailed to the secretariat, which we have all been given copies of, to be treated as a submission to the inquiry.

Dr CHRISTLEY: I was seeing that as a submission. I was doing it so that it was easier for you and I did not need to speak for 10 minutes to start with today. I think that would be appropriate.

The Hon. AMANDA FAZIO: Thank you.

Document tabled.

CHAIR: Thank you. Sorry, Ms Blakey, we did not cross-examine you.

Ms BLAKEY: That is absolutely fine.

(The witnesses withdrew)

CLIFFORD FREDERICK HUGHES, Chief Executive Officer, Clinical Excellence Commission, and

BRUCE BARRACLOUGH, Chair, Clinical Excellence Commission Board, sworn and examined:

CHAIR: We thank two such esteemed witnesses for appearing before the inquiry. Thank you for your attendance today. In what capacity are you each appearing before the Committee?

Professor HUGHES: I am here as the CEO of the Clinical Excellence Commission. I was also one of the co-investigators into the events around the tragic miscarriage on 25 September at Royal North Shore Hospital.

Professor BARRACLOUGH: I am appearing as Chair of the Clinical Excellence Commission.

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

Professor HUGHES: Thank you, Chair. I make it quite clear that this is a difficult separation of powers for me as the CEO of the Clinical Excellence Commission, whose charter does not normally go to individual cases. The terms of reference of the special inquiry that Professor Walters and I had to do was conducted by me in my own capacity. I was asked to do that by the director general and I carried it out independently of my role as CEO of the CEC. Nevertheless, my experience in systems issues was one of the reasons I believe I was asked to perform that task. From the point of view of the inquiry, the report has been tabled and is there for public comment. We believe that we have addressed the issue of antenatal care effectively. The terms of reference were such that we were not given the opportunity to look into the broader issues of the emergency department, in particular. We did have discussions with some emergency physicians before we commenced our inquiry to make it quite clear. We understood that a task force had been reconvened and that we were not going to trespass onto that territory and make the issues difficult with two different inquiries.

Furthermore, we also had the opportunity to discuss the issues around the particular events of Jana and Mark that night, particularly as they affected what was happening in the waiting room, the so-called triage area and those areas that are outside the main arena of the emergency department. So the report needs to be read, quite clearly, in that context. Finally, with my Clinical Excellence Commission hat on, our view is to try to improve the safety and quality of health care throughout the State. We are not line management, so we have to exercise our leadership by leverage and find ways in which we can work with both management and clinicians to improve outcomes from the point of view of safety and, more importantly, quality of care, which includes access, appropriate care and the quality of care as perceived by each patient coming through the system. It is with those statements that I am here before you.

CHAIR: Professor Barraclough?

Professor BARRACLOUGH: As Chair of the board of the commission, I would like to underline what Cliff has said about the role of the commission. It has been set up to provide support for clinicians to do their work in the very best way they can. It is not part of line management; it is a catalytic organisation that puts programs in place to help people do their work to the very best level. Part of our mission is not only to build confidence in health care by making it better and safer for patients but also to make it a more rewarding workplace. When it is a more rewarding workplace people communicate better. Some of the events of the particular incident that Cliff was asked to investigate may not have happened if people had been communicating in a much better way.

Mrs JILLIAN SKINNER: Welcome both of you. Dr Ross Wilson at North Shore has had a reputation for a long time in relation to quality and dealing with adverse incidents, long before it became almost a sexy thing to talk about. Can you give me some indication as to your knowledge of the current work of Dr Wilson and others at Royal North Shore Hospital?

Professor HUGHES: Certainly. Dr Wilson, Professor Barraclough and I have been compatriots in this field since we all worked at North Shore many, many years ago under the tutelage of Professor Tom Reeve and Dr Graham Copeland, both of whom taught us the principles of safety and quality, even though they were not then yet part of the lexicon. We have worked closely with Ross in a number of areas. Professor Barraclough was chair of the Australian Council for Safety and Quality for its entire duration of six years, and Ross and I were both members of that. Ross chairs the Northern Centre for Health Care Innovation. That group works in partnership with the sort of work that we are doing. It has a different charter. It is a local organisation. Its inner workings are not part of our particular knowledge, but we are playing the same field looking at the ways in which we can improve safety and quality. So we are well aware of his work and we have worked with him on many projects.

Mrs JILLIAN SKINNER: You have touched upon the issue I want to talk about, that is, that it is a different charter and a local organisation. The Clinical Excellence Commission takes a broad brush, an overarching view of what is happening, is that right?

Professor HUGHES: That is right. Our mandate is to advise the Minister.

Mrs JILLIAN SKINNER: Therefore, you rely upon voluntary information from the local area, the hospital, about the incidents that have occurred in that facility.

Professor HUGHES: That is correct. We have developed an incident information management system, which is entirely voluntary. You might ask why not mandate. Human nature is quite perverse at times. That is true in Health as anywhere else. Mandate often means Big Brother is watching you and you may be punished. So we have chosen a different route—to engage people in understanding the value of reporting incidents as they see them. Our program has been extraordinarily successful. I do not wish to frighten the Committee, but we get 13,000 reports per month of incidents across New South Wales. Let me reassure you very quickly by saying that by far and away the bulk of those are either near misses or events that cause trivial or no harm. By near miss, I mean something that could have gone wrong and the staff noticed it because of their protocols and took appropriate action before the event occurred.

Last year we produced our last report on incident management in New South Wales. Of about 88,000 clinical incidents only 500 were very serious ones and they sometimes resulted in death of a patient or severe injury to the patient. So the scale of reporting is truly amazing. That tells us that the staff do want to improve. It also gives us an opportunity to look at the volumes that tell us where the trends really lie. The smaller the volume the harder it is to identify trends. So we do work hand in glove with local hospitals and with North Shore and others to provide that information. It can be done anonymously. Most of the reports received do have a name attached to them, which tells us again the integrity of the staff we are dealing with.

Mrs JILLIAN SKINNER: Would it surprise you then to learn that there is at least one person, maybe more, who have approached me about reports of adverse events in hospitals that have not been dealt with in the way they believe they should have been, in particular, hospital deaths related to falls in hospitals in the North Sydney and Central Coast areas?

Professor HUGHES: I think when you are dealing with a voluntary system we will always recognise that there will be under-reporting. It is one of our concerns, and we try to identify that where we can by having a look at other data if it is available. With respect to North Shore, they do have entry reporting, the organisation we have been talking about, and they do their own local reporting. I cannot tell you what they know because they keep that to themselves and they deal with that locally. That is direct feedback, one would hope. Certainly we would encourage any clinician to report through to the larger bodies so that we can get these trends and put learnings across the whole State so that we break down the silos that I hear have been mentioned already today.

Mrs JILLIAN SKINNER: You do rely upon that voluntarily?

Professor HUGHES: Absolutely.

Mrs JILLIAN SKINNER: Some time ago Dr Ross Wilson indicated a much larger figure than is usually talked about that, in his view, would represent adverse incidents in hospital.

Professor HUGHES: That data is about 15 years old now. It was a landmark study, a Quality in Australian Health Care study. Members would be interested to know that one of the co-authors of that is now our Director of Quality Systems Assessment, Ms Bernie Harrison, who is working intensely on that project and some others as well. That was an audit of some 15,000 cases across the country. It was a case note audit and went down in great detail, looking page by page, line by line, to see if they could identify things that may have been associated with an adverse outcome. That is a different process to people identifying what happens as they walk around the wards as they manage a patient and then go to a computer and report it. So we would expect some difference.

If you have a look at the huge volume of data that we are reporting, particularly in what we call categories 3 and 4, which are the less severe ones, we have a much greater volume. We have not seen over the last three years a significant change in the number of high severity episodes, which we call SAC 1s, severity assessment code 1. That number has varied between 400 and 500 each year. They are the ones that are obvious. We have a bit of a handle on those. You raise the issue of falls. Falls are actually the second highest category of incident that we see across our hospitals, for a number of reasons, not the least of which is that our patients are getting older and frail, they are more confused, they have vision impairment, they may be rigid, all of which are factors that predispose to falls, as well as the number of medications they are on. If you are on more than four medications you are much more likely to have a fall than if you are on less. I think it is not surprising that there are some that are not reported through our system.

Mrs JILLIAN SKINNER: Can you tell us about hospital-acquired infection? That is another issue that has been raised in relation to Royal North Shore.

Professor HUGHES: Infection is one of the problems that we have known about for a very long time. We have also known some of the remedies for a long time. It is 150 years this year since Florence Nightingale told us that hand hygiene was one of the things that we could do to stop infections in the wards of people recovering from amputations. As a result of that information and some surveys that we did, we were aware that busy practitioners across the world were not carrying out hand hygiene programs effectively. A little over a year ago we launched a hand hygiene campaign. We involved consumers right from the word go. We had badges that said, "It's okay to ask". It is okay for a patient to ask the question: Have you washed your hands? That program has been dramatically active across the board.

As it so happens, that program was launched at North Shore by the then Minister, Mr Hatzistergos. This program put it fairly and squarely in the hands of the clinicians. That is where these programs really have their best impact, by getting the clinicians to respond. We doubled the rate of hand washing in our hospitals. It went from about 28 to 30 per cent to about 68 per cent. We are only halfway there but it has had a huge impact. We are now rolling out a new program with the Quality and Safety Branch, to be known as Hand in Glove. It starts off with a sterile hand in a glove for wound management to a cleaning glove, talking about keeping our hospitals clean, to a measurement glove, with a number on it, right through to an enforcement glove that says if you do not do this then you have to accept the consequences of your actions. So we believe that hand hygiene is a major issue and it is one of the programs that we are using our leverage to change.

Mrs JILLIAN SKINNER: Do you report hospital-acquired infections and would you agree with Dr Richard West, the college of surgeons spokesman, on this issue of infection control that where you see a high incidence of hospital-acquired infection it is generally a hospital under stress because the staff are too busy to wash their hands?

Professor HUGHES: There is little doubt that busyness and hand washing do go hand in hand—pardon the pun—and it is like all of us, we do forget to do the basics when we get particularly busy. We are also well aware that hospitals are getting sicker patients, there are more bugs around, so they are more likely to have serious outcomes associated with those infections when they occur, and our job is to try to build up the system, to say to people, "Stop and think" and "wash your hands". That has been effective across the board in all hospitals.

Mrs JILLIAN SKINNER: Are you reporting the outcomes?

Professor HUGHES: The reporting up until now has been through a fairly circuitous route with a contract through the Australian Council on Healthcare Standards. That inevitably led to a delay in time for the information getting back to the local hospitals. We are currently working on a different way of doing that through the Clinical Excellence Commission and the quality and safety branch so that that information gets back to the relevant wards very quickly. We are also doing another program in intensive care units designed specifically at minimising infections around central line infection, and that actually has online reporting. The staff note the procedure, when it is done, the time and any infection that occurs, they fax that through to the CEC, it is entered in the database and that information goes back immediately to the unit. So we are trying to short-circuit that previously long delay.

Dr ANDREW McDONALD: Can you tell the Committee how New South Wales compares to the rest of Australia and the rest of the world in terms of the reporting of adverse events and the rate of adverse events?

Professor HUGHES: The first question is relatively easy. We have one of the world's best reporting systems. If we look at the per capita figures for reporting between ourselves and the UK, we are eight times more prolific in reporting incidents than they are in the United Kingdom. The only other reporting system that is as big as the one we have in New South Wales is the Commonwealth of Pennsylvania, which has about the same numbers with a population that is probably about 50 per cent greater than the State of New South Wales, so in terms of the volume, superbly better. Because there are so few people that are reporting the same sort of way that we are, it is not possible to give you apples with apples measurement, but we believe this is a very highly reliable reporting system that we have, recognising it is the reporting of incidents, not an audit.

Dr ANDREW McDONALD: You talked about 500 SAC 1s and I think most hospitals in the world would probably have some form of recording those. How would we rate compared with other hospitals worldwide?

Professor BARRACLOUGH: As far as we are aware, there is no real difference in terms of those sorts of events. When you look at it in the broad, across populations, with any of the advanced health systems in the world, we have all got very similar sorts of results. You can look right down to individual units and find blips in the chart from time to time, but basically we have a system where there are relatively few high-level events and, while every one of those is a serious event and something that we need to work to avoid, we have more of a handle on this than most organisations. If you look at what happened in New South Wales we introduced a methodology of analysing high-level events called root cause analysis, a simple ex-engineering activity that has been converted to health care.

We took a significant number, maybe 2,500 of the 100,000 employed by New South Wales Health, and taught them the rudiments of root cause analysis. Within a year we have a 30-fold increase in reporting of high-level adverse events. It is not that the events were not there before, it is just that now we have a methodology that leads to a culture change where people understand that it is a systems issue because that is what root cause analysis is about, and when they believe it is a systems issue they also believe that something will be done about it, and that is in fact the case. So when we try to improve the system people get some feedback that says it is okay to keep telling us about these things because they are not inappropriate to blame for things that actually have multitudes of systems issues around them.

Professor HUGHES: If I can add to that very briefly, once a SAC 1 incident has been ratified there is a legislative requirement to do the RCA and to complete that within 75 days.

Professor BARRACLOUGH: Following the 30-fold increase in reporting high-level adverse events we then introduced the incident management system that Cliff has just told you about and because we did it in that way where there was some trust built up we now are very close to the reporting culture that most other health systems aspire to. The airlines found that until you have a reporting culture you do not understand the potential for things that might go wrong. You cannot put the fix in place to improve the system so that it is likely for things to occur. Mind you, modern health

care is probably the most complex thing humans ever attempted to do, not only because of the technology but because of the multiple human-human interactions and the complexity of that. That is not only complex on the floor of Parliament, it is also complex in hospitals. So that multiple human-human interaction activity is what makes health care extraordinarily complex.

We may never get to the stage where we have absolute numbers of adverse events because there is always this assessment process that says how much is due to a disease, how much is due to a missed opportunity, how much is due to a physical error, and what the end result is in relation to each of those things and multiple other things. So one of the aims of your question was to find out some sort of base level. This is a very difficult thing to do and most systems have no idea at all. We have a better handle than most because we have developed a reporting culture where people feel safe to report even the most severe of adverse events.

Mr MICHAEL DALEY: You have covered some of this ground already, but how important is it for clinicians to be encouraged to report incidents and to communicate with patients and families?

Professor HUGHES: I think it is critical. The best way we can improve the system is to identify any potential flaws, and potential flaws are much more numerous than the ultimate adverse events. I am sure if we were to ask the airline industry how many times there was a near miss or there was something that went wrong in the cockpit we probably would not want to fly, but we know because they are reported that it is safe to fly. That is why it is so important to have a robust, preferably voluntary but all-encompassing reporting system, so that we can identify trends long before they become the individual catastrophes that cause so much harm to patients and indeed to staff.

The Hon. AMANDA FAZIO: Could you explain the similarities and the differences between the incident reporting system at Royal North Shore Hospital and the system now used state-wide because I understand they are not quite the same, and can you also tell us if there is any difference in the rates of adverse events between North Shore and a similar hospital?

Professor HUGHES: The short answer to both of those is no, it is very difficult to do that. What Dr Wilson's group does within its confines is subject to his or its own rules and regulations, and we do not have managerial control over those. With respect to the information that we collect, our agreements when we first started this process were at an area level with the various area health services and we provide them with aggregated data for their area and a state-wide benchmark on a six-monthly basis and we report that same information to the public once a year, although we have just moved to a six-month reporting cycle with the public report as well. The management then has the information and the capacity to analyse its own data, institution by institution, and to take the managerial steps that are necessary in dealing with the trends that it identifies from one of its institutions to another. It is interesting to have a look at the data that comes across at an area level. There is a remarkable similarity in the shape of all the curves in the graphs that we produce. The numbers obviously vary because of the slightly different sizes of the area health services, but by and large there is a remarkable similarity across the State.

The Hon. AMANDA FAZIO: I am still at a bit of a loss to understand why one major hospital is allowed to have a different reporting system to everybody else?

Professor HUGHES: They also report via IMS. There is no reason why the staff cannot report via IMS, but they happen to have another group with an expert, Dr Ross Wilson, which has developed its own in-house processes as well. Our aim is not to tear those down because they are obviously local and they have an immediate reporting process of their own. We expect, and we have got no reason to dispute, that they are providing the same sort of reporting through to us on the individual incidents as well.

Professor BARRACLOUGH: And they have been doing it for many years and they are quite capable of doing that. They have been reporting to the local board for many years, when there was a board, and it is not prudent or appropriate for us to try and remove a system that is reporting to the local authorities very effectively about the high level events in that health area but, at the same time, invite everybody in that health area to be a part of the reporting structure of the whole State, which they willingly do.

CHAIR: Professor Hughes, there has been a report—it is in our submissions and it has been in the media today—concerning Joyce Batterham. I was wondering, with the incident reporting you get this cause and effect. You probably know some of the background: whilst a nurse was moving her she fell off the bed and broke her hip. She then had to have surgery, then had a stroke during the surgery and then died six days later. Where would that fit in with incident reporting? You may not even be aware that she died six days after she left the hospital—I assume she was out of the hospital.

Professor HUGHES: I cannot comment on individual cases. I am afraid I do not know the details specifically. The process we have in place allows for the management staff up the chain of reporting to add further information. So if she had a fall in the hospital, and let us say that the fracture was not apparent for the first time, and subsequently had an x-ray that confirmed the fracture, then the nursing unit management would upgrade that form from maybe a SAC 2 to a SAC 1—to the highest level. If she had a death that occurred after a surgical procedure within 30 days—longer than that, actually—it needs to be reported to the Coroner as a normal course of events.

We have also started to roll out across the State a surgical mortality or death-reporting program known as CHASM—Collaborating Hospitals Audit of Surgical Mortality. This is a program that is owned by the surgeons in this State and the CEC as a cooperative venture. The CEC is funding that and putting data managers into each of the areas. We are currently rolling it out in Sydney West and in Hunter New England and early next year into two other areas, and by the middle of next year the whole State will be covered. Any death that occurs after a surgical procedure or under the care of a surgeon within 30 days of that operative procedure will be reported to that committee and the details of that event will be assessed by another surgeon who is anonymous to the person looking after the patient.

If they identify areas of concern or something that needs to be considered further, they will ask for a second-line assessment and then a full chart review will be conducted in detail, and obviously in that case it cannot be anonymous because the details of the patient will be known from the charts. Then the aggregated and identified data will be analysed and reported essentially to the surgeons but also to the CEC and, therefore, to the public. At the same time a report goes back from those surgeons to the operating surgeon explaining where we thought the care was deficient.

A similar program exists in Western Australia at the moment; there is a smaller one in South Australia and Tasmania and the oldest one is in Scotland. Ours is modelled on the Scottish model. Each of those programs has demonstrated that 87 per cent of surgeons will change practice as a result of participating in an audit of what they do. That is the value of reporting and getting the information back to the clinicians as quickly as possible. It enables the leaders to change practice and make it safer for the rest of us.

CHAIR: As you would be aware, your detailed report on Ms Horska's miscarriage received some fierce criticism. How would you reply to that criticism?

Professor HUGHES: We expected people would disagree with some of our comments. There was concern expressed by Professor Walters and myself that we did not have the opportunity to meet with Ms Horska and her partner; we would like to have done that; we had planned to do that; that was not possible. So there was one gap, and that was their particular perspective. But we would still like to hear that. We understand how awful it must have been on that night and since to deal with the events surrounding the miscarriage and the publicity. We understand that and that is why we have allowed them the right to their privacy.

We believe that our focus on antenatal care, however, was correct. We believe that sitting in a waiting room—as I have done, not on this particular occasion but on many occasions in that particular waiting room—we began to understand how patients see things just a little differently from some of our clinicians. Clinicians do not mean to see it differently, they are just very busy carrying out the first rule, which is to be safe, and they were very busy on that particular night—extremely busy; every bed was occupied and some of those beds had been occupied two and three times. So they were busy trying to make life safe for most of their patients. In the meantime another patient's condition deteriorated rapidly and the quality of care that she received was simply appalling—not because anyone wanted it to happen or anything else, it was simply they were too busy with other priorities.

What we have chosen to do in our report is to find some ways to address the antenatal care issues in particular and the events as the patients see them in the waiting room to try and improve the quality of care in that part of the patient's journey. What happens inside the emergency department and as people move from the emergency department into hospital beds is something for the emergency care task force to deliver upon, and we are looking forward to working with them as we can give them some ideas on implementation. They have got to give us the expertise around what they need to do but we can help them with implementation. We have done that with the obstetricians and we will be meeting with them in two days time to put in place some of the recommendations that we have made.

We were pleased to note that the Government has responded positively to virtually every recommendation that we made and we think that that will drive antenatal care in a much more positive way forward, even providing information for women in the first 20 weeks of pregnancy. It is crazy to think that they do not have access to the information. When suddenly the penny dropped that every woman has a pregnancy test, there is a place where we can give them some information that says when this happens you go to the emergency department or when this happens you go to your GP or there is an early pregnancy advisory service or you need to get some support around a completed miscarriage. All of those things are so important to change the quality of life around women who have gone through one of the most common events they are likely to go through: one in four pregnancies will end up in miscarriage. So we have addressed that issue and we believe that the Government's response, the department's response, will enable us to progress those things very well. We would like to see things happening inside the emergency department as well.

CHAIR: And those improvements will now apply to all the hospitals, not just Royal North Shore Hospital?

Professor HUGHES: Absolutely. The benefit of having these issues out in the public arena is that we can break down the silos. Of course, what happens in a smaller hospital or multipurpose centre will look different to what happens at Royal North Shore. What happens at Royal North Shore might look a little different from what happens at Royal Prince Alfred or at the Royal Hospital for Women, but we expect that all women will have access to good information, to early care and the support that they need and that Jana did not get that particular night.

Professor BARRACLOUGH: Can I amplify some of those things? One of the statements that we would very much like to hear is that culture eats strategy for lunch, and to get patients an appropriate experience, irrespective of the terrible things that they are going through in the health sense, we need to have an appropriate culture so that people actually treat patients as they would wish to be treated as human beings and not just in the technical expertise that they might have. A number of the programs that we are working on are designed to try and change the culture so that we are more like the hospitality industry in that context, as well as producing the benefits of the technical health care that people are capable of delivering.

Our clinical leadership program, the communications activities that we are involved in and other activities that we are involved in with some of the new programs around this culture change I think will have a demonstrable effect. We would regard a lot of the issues that come up to committees like this as being about the patient experience, not always about the technical care—in fact, often not about the technical care, but about the experience the patient has had while they have been receiving that care, and we need to improve that. It is about changing the culture so that it is much more like the hospitality industry than it is something where you go purely for what is often a very frightening and sometimes painful technical care.

CHAIR: That culture of care, which I think is very good, would that be something that is now a focus of the university-trained nursing programs?

Professor BARRACLOUGH: I cannot answer for them. I am involved in the new medical school at the University of Western Sydney and I know that the communications issues and the quality and safety issues more generally have been built into that curriculum. I know a number of the other universities are picking up all the issues that might address the safety and quality agenda and one would expect that to flow through to allied health nursing and medical courses as time goes by.

Professor HUGHES: If I could just add to that, it is interesting that we are using hospitality in hospitals. They really go hand in glove. One of the things we have noticed, in coming back to the idea of culture, is that the clinicians have been focussing on outcomes, quite correctly. They want to get the best outcome for their patient. They have also had to deal with a crowded life because of all the other things that happened to them. One of the things that has not been continually pushed effectively is the idea of clinical leadership, of clinicians regaining some sense of leadership.

Management is just one of the specialities in a hospital—a very important one but just one of them. One of the programs that we have developed, the CEC, over the past two years has been a clinical leadership program which we deliver in two separate ways. One is across the State, aimed directly at nursing staff, allied health—a lot of mental health practitioners, including some psychiatrists, are doing that program. It is spread across the State. Some 150 graduates are about to graduate from that program. The second program is a modular program for senior doctors and management, and we have just graduated 31 clinicians, four of whom were managers. One intriguing thing was to see the managers and clinicians coming together and solving problems, and they each had to produce a project together and working as a team.

I think this is one of the important areas for health is to get hold of this team concept, to work together as a team, and we can produce marvellous changes. You will be interested to know that there were three emergency physicians on that program. Each of them produced a stunning report. They were able to learn how to negotiate with their managers to get more money to change emergency departments, to get two star specialists in one emergency department.

Mrs JILLIAN SKINNER: Were they from North Shore? They should have been.

Professor HUGHES: We would be happy to have members from any hospital come and work with us. We have a second program about to start next year, and we are already working on funding for future programs. We are coupling that with a culture of communication. We are actually talking to the hospitality industry about how they see the front-line staff as being crucial in the outcomes for their clients going through a journey in hospital. We need to do exactly the same with our hospitals.

Mr PETER DRAPER: When incidents are reported and you make recommendations flowing on from that, are you satisfied that the recommendations are completely followed through?

Professor HUGHES: I think the short answer to that is no because we do not know how each of them has been followed in every case. Certainly, when we put recommendations out in a special review that the CEC does, we go back after about six months and ask what has happened. Some members may be aware that about 1½ or two years ago there was a series of meningococcal incidents, some in Wyong and some in Shoalhaven. We were asked to do a review of those two deaths, which were also very tragic. Neither of them was preventable as it turned out in the long term, but young lives cut short. We put 47 recommendations up. Six months later we went back to each of those hospitals and to the area health services and we asked to see the outcome of each and every recommendation. There was only one that was not complete, and that was about three weeks off completion. But we do need to go back to ensure that people are acting on the information that we are giving, and that is particularly true of the severe events, the report on incident events from SAC 1.

Mr PETER DRAPER: Given you visit six months after, looking at the number of referrals to your organisation it is quite astronomical. Is it difficult to follow-up on so many referrals?

Professor HUGHES: Of course. What we hope is that when units conduct their review of their own activities they will act on them as they go. Some of you may have heard the expression "M and M". It stands for a morbidity and mortality meeting. It is a fairly common pathway for a unit or a group of clinicians to get together and discuss the adverse events and to act on them. We have systematised that into the IMS. We have also systematised that into the CHASM program. There is an anaesthetic program. There is also a committee that looks at perinatal mortality that also systematises it, and there is a committee around mental health. Each of those provides a local and specialty based area where the recommendations can be thought through, applied locally and the results of changes measured as well.

Professor BARRACLOUGH: We would expect to get every more answers as we go forward with the quality systems assessment. We have a program that has just been rolled out now to look at compliance with the policies, programs and guidelines of the department as they relate to safety and quality at multiple levels of each health area, and we would expect to report on that as we get some detailed information over the next 18 months or so.

Mr PETER DRAPER: That is very encouraging.

Mrs JILLIAN SKINNER: Earlier today we heard Dr Sally McCarthy, Vice President of the Australasian College for Emergency Medicine, who referred to research I am sure you would be aware of, and that is the revelation that there is longer hospital stay, greater morbidity, greater mortality connected to extended stays in emergency department through access block. Do you ever look at things like that, the incidents of that occurring in a practical sense?

Professor HUGHES: We do not have a good handle on access block as such. That is a KPI that is reported by the department. It is not one that people easily identify as an incident so it tends not to come through IMS. We are well aware that some of the incidents occur because patients are being managed in an inappropriate setting. For instance, a person who may have had some heart disease who, if there is no bed in the cardiology ward, goes to a neurology ward where the staff are less practised. That is not new intuitively for all of us. We have always known that that was the risk, and we have tried to minimise that as far as possible. We are doing some work with the SACS Institute, looking at the outcomes of placing people in what we call non-home wards to see if there is anything that is of serious consequence to that. I cannot answer your question except to say we are looking.

Dr ANDREW McDONALD: Every year we have between 400 and 500 SAC1s in New South Wales. Over the past few years this has not decreased or increased much. The number of patients has increased and probably the complexity has increased. Could the fact that they have not changed much be an improvement, knowing that the denominator is much higher even though the numerator has not changed?

Professor HUGHES: I think it is a long bow to draw but it is worth pulling on. A 6.7 per cent increase in patient load through the hospitals in the past year. That is a fairly significant increase. There is no question that the age is increasing and there is absolutely no question that the complexity of the disease is increasing. I come back to Professor Barraclough's comment: each of those represents a tragedy and each of them has to be reduced. So we must try to focus on each of them, and also the potential for the other ones to become as severe as that.

Professor BARRACLOUGH: If you take individual issues such as wrong site procedures, which to my mind are almost a never event and we have put a program in place to help reduce those because they are such a devastating exercise not only for individuals but also for public confidence. We have noticed some early reduction in those particular areas within surgery but we have noticed an increased reporting from radiology where procedures are done which maybe were not being reported in the past so you have a combination of complexity and increased reporting as the reporting culture becomes more evident but at the same time we have been able to show some, we do not know yet whether it is a blip on the right side of the scale but we would hope to know that over the years that follow as we continue to analyse these numbers.

The Hon. JENNIFER GARDINER: Professors, you have pointed to one need, the need to change the culture, which is a pretty profound concept, for me anyway. Can you give the Committee any suggestions as to recommendations that you would like to see us make to the Parliament that would take the whole question of clinical excellence across the State forward, anything that we have not covered to this point?

Professor HUGHES: I think that goes to the heart of what we are trying to achieve. First is to allow staff to be confident in reporting errors without fear of blame. We certainly expect staff to be accountable but if they feel they can discuss things openly in their own quarters and resolve issues and make changes and then tell other people, then I think we will bring the culture change into being. I re-emphasise that it needs leadership. It needs leadership from the clinicians first of all and from management second. I think it needs leadership from the Parliament. I think it needs leadership from the press to allow us to make changes and not to apportion blame in ways which are damaging to staff.

To think of the staff at North Shore who have been ashamed to wear their uniform down the street, that tells us that we have a long way to go in making the culture safe and secure for them but far more importantly we have a long way to go to make it safe and secure for our patients.

Professor HUGHES: This is not only about safety and the more technical aspects of quality; it is really about the patient experience, because this is what people value. They really do value the experience. This is the way you make decisions about how you spend dollars and where you go for care. It is all about the patient's experience. We have programs that we wish to put in place to change the culture so this is the high-level focus and we would like that to be supported throughout the health system. The key performance indicators are about the patient's experience as well as all the technical exercises that one is expected to do.

Mrs JILLIAN SKINNER: One who hope the family's experience in the event of an adverse outcome because at the moment there is lot left to be desired in that regard.

CHAIR: Hopefully when the patients have confidence in the public hospital that will help them in their recovery.

Professor BARRACLOUGH: I think that is true.

CHAIR: Thank you for appearing before the committee.

(The witnesses withdrew)

(The Committee adjourned at 5.30 p.m.)