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 Friday 16 November 2007

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The Committee met at 9.00 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. A. Draper
Dr A. McDonald
Ms J. G. Skinner

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

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

What witnesses say to this Committee today is covered by parliamentary privilege. This means that no legal or other action can be taken against you by anyone in relation to what you say in your evidence. Any action taken against you for giving evidence may constitute a contempt of the Parliament. This protection does not, however, cover anything you may say after the hearing, or outside of this room today. Any comments you make to the media once you leave the witness table are not covered by parliamentary privilege. It should also be remembered that the privilege that applies to parliamentary proceedings, including committee hearings, exists so Parliament can properly investigate matters such as this. It is not intended to provide a forum for people to make adverse reflections about others.

The terms of reference refer to failings of systems, not individuals. I therefore ask witnesses to minimise their mention of individual doctors or managers unless it is absolutely essential in their addressing of the terms of reference. Individuals who are subject to adverse comments in this hearing may be invited to respond to the criticisms raised, either in writing or as a witness before the Committee. This is not an automatic right but, rather, a decision of the Committee that will depend on the circumstances of the evidence given.

I would also ask that witnesses be mindful of the ethical and legal implications of disclosing personal information about patients. Doctors and managers should only discuss personal information about a client or a patient if it is specific to the terms of reference and that person has authorised them to do so. I would also ask my fellow Committee members to consider the ethical duties owed by doctors to patients when pursuing lines of questions.

It is likely that some of the matters raised during the hearings may be the subject of legal proceedings elsewhere. The sub judice convention requires the Committee to consider the impact of discussing a matter that is being considered by a court of law. The weight of opinion supports the view that a parliamentary committee may discuss a matter that is being considered by another inquiry. Nevertheless, I remind people today that this inquiry is about systemic issues and not the culpability or otherwise of particular individuals.

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

Witnesses, members and their staff are advised that any messages should be delivered through the attendant on duty or through the Committee clerks. I would ask that everyone please turn off any mobile phones during the proceedings.

JOHN FRANCIS GUNNING, Head of Cardiology, Royal North Shore Hospital, and

STEPHEN NICHOLAS HUNYOR, Chairman of Cardiology, Royal North Shore Hospital, sworn and examined:

CHAIR: If you should consider at any stage that certain evidence you wish to give or documents you may wish to tender should be heard or seen only by the Committee, please indicate that fact and the Committee will consider your request.

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

Dr HUNYOR: My colleague Dr Gunning and I are pleased to have been invited to the Committee. I would like to make the opening statement, and I would have my senior colleague make a three-minute statement towards the end of that. We will be close to 10 minutes. Cardiology is proud to have helped keep North Shore among the top performing departments in terms of clinical care, innovation, training of medical students and staff, and research and development. This group is internationally recognised for several pursuits, notably the groundbreaking acute interventional rescue of heart attack victims in the ETAMI and SALAMI programs. This work has virtually revolutionised medical practice not only in the area but across the country. However, the outcomes have been achieved despite unresponsiveness in high-level management and the strangling and mismanagement of funding. The stress and staff restrictions in cardiology bear comparison with emergency departments.

Cardiology has only achieved success because very senior staff positions have been funded by the charitable North Shore Heart Research Foundation. Royal North Shore Hospital would not foot the bill for this vital service. Yet the cost savings over 10 years amount to $18 million—$6,000 per patient—not to mention the misery and the lives saved. This service has also helped stave off absolute gridlock in the emergency department because, in collaboration with the emergency department, these heart attack patients have literally been moved through the emergency department directly to the life-saving therapy that awaits them in the cardiology catheter laboratory.

This year the Australian Council of Health Care Standards, which is a body that surveys hundreds of hospitals each year, granted North Shore-Ryde only a conditional one of a possible four years accreditation, to October 2008. The council uses "a formal process to assist in the delivery of safe, high-quality health care based on standards and processes devised and developed by health care professionals". The council gave North Shore a mediocre report card, and that put it into the lowest 10 per cent. In management parlance, this is a fail. Hospitals are graded according to five different levels of performance and specific criteria—seven in the clinical domain, three in support services and four corporate criteria.

While other hospitals surveyed achieved a total of 26 outstanding gradings and another 943 extensive achievement ratings—that is a total of 946 superior grades—Royal North Shore snared not one of these better outcomes, not one out of 949. The problems identified by the survey were serious, not minor as mentioned in previous transcripts. They related to medical records used in care delivery, which rated five pages of comments and criticism, and to the provision of quality and safe care through strategic and operational planning and development—these are quotes from the ACHS criteria. This also rated two pages of comments and criticism. Risk management—a crucial thing in a hospital—was found to be flawed.

The model of governance as it relates to Royal North Shore is visibly broken. Bold leadership is required for staff in the institution to shed their disdain and even cynicism and to regain trust and confidence in their leaders. Specifically, it requires a hospital board that is highly competent and involved—not filled with retired health bureaucrats—but one that is truly independent. The current models operating at Westmead Children's Hospital and in the 12 metropolitan and eight regional health facilities in Victoria warrant consideration. The pros of this arrangement are well argued in the 2003 Governance Review Report by Ms Kibble and Mr McKay and Bradley that was fully endorsed and implemented by the Victorian Government. It requires a medical staff council that is fully empowered and representative. It requires a high level executive position at North Shore Hospital that is empowered. Other teaching hospitals in Sydney have such high-level executive positions.

Area leadership is required that is committed to a culture of leadership by example and working in a team structure that is not strictly KPI and statistics driven and not totally pyramidal. The current chasm between the one area CEO and the disempowered general manager at North Shore does not serve its best interests. The strains will only magnify during the next eight years with completion, fit-out and occupation of the $91 million research and education building, building of the $400 million class new acute diseases hospital and the 350-bed Northern Beaches hospital yet to be built at Frenchs Forest.

Another issue relates to the Ryde, North Shore, Macquarie axis. Instead of functioning like major international medical centres, which serve as a fulcrum in the wheel, radiating high-level services and competence along its spokes, North Shore is lumbering along with two dysfunctional appendages, Ryde and Macquarie hospitals. This joining is irrational and not supported by staff in any of these institutions. It blurs the identity of North Shore. It blurs the use of resources purportedly going to it. These institutions need to be separated. North Shore's identity crisis is clear from the area annual reports. This 141-page document in 2006—we could not get this year's version yet—devoted a mere 1½ pages to this centre of excellence, and it lists North Shore as eighth among nine hospitals. Change can be effectively implemented if there is good governance and if the management is transparent, accountable and responsive and if it knows when to get out of the way and not impede but effectively support the initiatives of good staff.

Such an example of case study No. 3 in our submission shows that where a dispirited, rundown service, the so-called northern specialist centre, serving more than 57 staff specialists at North Shore, turned around the practice and increased its revenue by 549 per cent in two years. This has also achieved a remarkable staff harmony and stability, and has spawned a "baby service" at Gosford Hospital. We have outreaches in almost all areas of functioning cardiology. Our submission lists 29 substantial recommendations. We believe they represent a strategic and pragmatic way forward. So what is it that North Shore needs and wants to reclaim? It wants to reclaim its rightful role, at least as seen by its 1.2 million stakeholders, as a tertiary and quaternary referral centre, as a centre of clinical excellence, as a research and development institution which is good for staff, good for patients and good for the economy, a top training ground for aspiring doctors, educating nurses, providing leading edge graduate and vocational training and Australia's most ideally situated hospital for local, regional and international access.

There is a long hard slog ahead to fulfil these aspirations. It requires bold thinking, the best committed staff and well managed but appropriate resources—no more resources than any other institution of similar stature in this wealthy country but clearly defined resources for North Shore Hospital and not dribbled away in a piecemeal fashion. As marvellous as the vision for the oft-mentioned $700 million plus campus redevelopment at North Shore is, that is at least eight years off by any realistic estimate. There are already very visible pitfalls looming in this venture and it is this eight-year plus hiatus that could well be North Shore's nemesis. In closing, this great institution needs massive change, not tinkering. It needs it now and it needs to be ongoing; otherwise it will find itself on life support.

Dr GUNNING: The present administrative structure is not working at Royal North Shore Hospital as far as the department of cardiology is concerned. Dr Hunyor referred to the ETAMI program. This has been going since 1997. In other words, we have been taking people at the catheter laboratory 24 hours a day, seven days a week, and opening up the occluded coronary artery. Despite torturous negotiations with administration, the interventional cardiologists who are doing these procedures on public patients are not getting any remuneration for it. After much negotiation, I believe now a 0.5 of a full-time equivalent is divided between the three interventional cardiologists for their work.

This is really an insult. The second area that the cardiology department finds very difficult is the recent cath lab replacement, which we have detailed in our submission. If you have read that submission it really is a joke. The third area that the cardiology Department has been very concerned about is the cardiac technicians. When the old Northern Sydney Area and the Central Coast Area merged it became apparent that the cardiac technicians at the Royal North Shore Hospital who were in fact doing more detailed technology than the ones that Gosford were getting paid approximately three-quarters of what the people at Gosford were being paid for doing less arduous work. We have an e-

mail bouncing request between the chief executive officer at Gosford and the decision was made at Royal North Shore Hospital by one of the administrators that being the same area the technicians in both areas would be paid the same amount. Then there was a torturous back and forth for months and months with nobody taking responsibility and making a decision. The situation was never resolved. It was finally resolved, however, outside the management of Royal North Shore Hospital by an industrial decision which made all the cardiac technicians come under the one umbrella. The fourth area I wish to address, I did not intend to bring up but it involves the matter that became public yesterday, that was the fact that our senior cardiac surgeon was summarily, his privileges were withdrawn over a matter which we regarded as being fairly trivial. This sort of reaction caused another of the cardiac surgeons to put in his resignation. This immediately had a huge effect on the care of our cardiac patients. The matter has been resolved but this is just an example of how there is a disjoint between administration and the Department of Cardiology in this circumstance.

The solution I believe is four, as Stephen as referred to. Firstly, to give Royal North Shore its unique identity back. Secondly, is to empower the medical staff council and make them a real body. Thirdly, is to empower the general manager at Royal North Shore Hospital to a chief executive officer type level and he or she should then be answerable to a Royal North Shore Hospital board. Fourthly, the chief executive officer in this position must be an advocate for Royal North Shore Hospital and not just a person to do the bidding of the department of health. They are the four solutions we would like to see emerge from this inquiry.

Mrs JILLIAN SKINNER: Can I start by saying if I ever have a heart attack I hope I get to be treated, particularly through the ETARMI and SALMI Program that I know is world class and I congratulate you.

Dr GUNNING: Thank you. I just mention, if I may, we recently published the results and with the ETARMI program, which is the ambulance triage, the hospital mortality was two per cent. That mortality has never ever have been published anywhere else in the world on an unselected group of heart attack victims.

Mrs JILLIAN SKINNER: It really is something to be very proud of and I congratulate you. The things that I am particularly interested in—and it comes not only from your submissions but others in evidence given to us the other day—particularly the disconnect between the bureaucratic governance arrangements and the clinicians. I note that you have both said a restoration of the medical staff council would help. That used to be the case, did it not? Did not the medical staff council have a fairly substantial role in the past?

Dr HUNYOR: It had a very substantial role. Things change, that needed to change but not by abolishing it. It needs effective change, effective functional change. We have at times been accused of being in silos. Well the way that the medical staff councils were abolished was to create silos, the so-called divisions which stop surgeons talking to physicians, physicians talking to pneumotologists and emergency doctors were put in three, four, five respective silos. That effectively destroyed the medical staff council with one stroke.

Mr MICHAEL DALEY: When was that abolished?

Dr HUNYOR: The council, well, it was disempowered. It has not had a meeting with meeting with a quorum for three or five years.

Dr ANDREW McDONALD: It has not been abolished:

Dr HUNYOR: Oh, it is there in name only. No one takes any notice of it and the clinical reference group that was established by our new chief executive officer just four weeks ago "forgot" to do invite the chair of our medical staff council to the first two meetings until the physicians urged him to do so. It is there in name only and that is the problem in the system. So much is there, the money is there, the beds are there; we just cannot find them. We cannot find the staff. We do not know what they are doing. We do not know what their job descriptions are. They are disempowered. They are walking across to the private health system.

Mrs JILLIAN SKINNER: Some of these things that have also been raised, particularly in relation to funding, is the suggestion that North Shore is more expensive than its peer hospitals but at the same time there has been a suggestion that the IT, the clinical information systems are not very active accurate—they are flawed, I think. Do you think it is therefore questionable about whether you are really as bad in terms of the cost of your procedures?

Dr HUNYOR: I think some of our colleagues, notably Professor Fisher, may address that in more detail, Dr Fisher. I would just make one comment that as recently as last night we do not know what proportion of the budget is spent on IT at our institution or any other area health service. It may be our current management is not yet up to speed that last night when I suggested that my best information was that other areas where spending five to six per cent on IT and North Shore was spending 1.9 per cent that was disputed but no one could tell me any alternate figures from the management. Now I am told that information-rich industries, such as finance and so on, all right we do not belong in that group, have spent 12 to 14 per cent of their budget on IT. Other smart institutions spend eight to 10 percent. We are told that most areas spend five to six per cent. The figures I have been given for Northern Sydney Health are 1.9 per cent. So we do not even know what we are talking about. You cannot make decisions, wise decisions, good decisions for patients, for staff, for the institution if you do not know what the numbers are.

Mrs JILLIAN SKINNER: So you do not know what the It budget is. Do you know what the budget is for your Department of Cardiology?

Dr GUNNING: No.

Mrs JILLIAN SKINNER: You don't?

Dr GUNNING: No.

Mrs JILLIAN SKINNER: Mr Terry Clout told us that that the cost of running the service is plugged in by every area health service to the Department of Health each month enabling comparisons of cost weighted separations per peer group? You do not have any of that information?

Dr GUNNING: I personally do not have that information and I am the head of the Department.

Mrs JILLIAN SKINNER: If you are the head of the department, how do you come within budget if you don't know what your budget is?

Dr GUNNING: Exactly. If I might make one comment about the cost, the approach of stenting for heart attacks actually saves approximately—the cost with lytic therapy calculated in the late 90s was $22,000 per patient per year. The cost with stenting as a strategy to treat infarcts in 1999 was $14,000 per patient per year. With 3,500 patients being treated in the last 10 years in this way out apartment has saved the health system $18 million in those 10 years.

Mrs JILLIAN SKINNER: In your submission you talk about the transfer of funds to cover bottom line at year's end, the transfer of trust funds, would you care to enlighten us about that?

Dr HUNYOR: I can tell you what is in the submission. Others can refer to this in greater detail. But there is evidence, and I think at the previous days hearings the question of those cancer funds have been discussed. My colleague, Dr Stephen Bland, on whose behalf I think Professor Fisher will present some evidence, also talks about the disappearance of $1.5 million of IT funds from the Department of Radiology and Imaging at North Shore. There are examples—and I am talking not only about disappearance of trust funds, it is about misuse of trust funds and other funds generally. The question of this cath laboratory set up at North Shore that is also one of the case studies, is a sad case in point.

If we multiplied that many times there is such wastage in the system, such irresponsibility. I heard from my head of department this morning that this equipment which was kept in cold storage or whatever at Taren Point for a year because they could not and would not agree on how to install it is now malfunctioning because the temperature requirements for that equipment to be kept in storage

were not totally sufficient. It is that sort of thing that requires micro-management. It is almost like small business versus the large conglomerates. If you are a large conglomerate, like the area is purported to be, you have to act, live and work like a large conglomerate. Otherwise re-empower the people at the coalface and let them do it, hold them to account and see that they are capable.

The Hon. JENNIFER GARDINER: At the time you put in your submission the terms of reference for the clinical reference group were not known to you. Do you now have them and are they satisfactory?

Dr HUNYOR: They were tabled last night.

The Hon. JENNIFER GARDINER: I wonder why!

Dr ANDREW McDONALD: I acknowledge the wonderful cardiology service at Royal North Shore Hospital, which is justifiably world famous. The submission suggests that Royal North Shore should not be part of a network that includes Ryde and Macquarie, it yet previous witnesses, including Tony Salla Sara from the Australian Salaried Medical Officers Federation, said that those networks do create opportunities for an exchange of knowledge and expertise for places like Ryde and Macquarie. How would you see North Shore helping build those hospitals for their populations?

Dr GUNNING: I chair a network, a cardiology committee, involved with all the hospitals in the old Sydney northern area as well as the Central Coast hospitals. We work very hard to try to, and have been successful, in upgrading services such as echocardiography and pacemaker services in other hospitals in the northern Sydney area besides the Royal North Shore Hospital. The submission really wants to give North Shore its rightful identity back again and not have it in some ways not recognised as an entity. Perhaps if the other institutions are not held in such high regard some of that rubs off. This has been the problem.

We have a similar situation with cardiology registrar training. We are arguably the most popular department for trainees to want to come to. There is a networking in place with the laudable aim of having cardiology trainees exposed to rural and non-teaching hospital institutions so that, hopefully, in the future they will see the advantages of this in their practice and they might be drawn to country areas. Obviously rural needs are not being completely met with our present system. So that is a laudable aim.

However, on the other hand, we do not want to have the Royal North Shore Hospital cardiology training program diluted and not be as popular, so we do not get the very best people who can spend time in research while they are doing their clinical training. It is a two-edged sword. My aim is to maintain North Shore hospital as a centre of excellence in cardiology. Anything that detracts from that I would speak against. I do not apologise for that.

Dr ANDREW McDONALD: I will rephrase the question slightly differently for Dr Gunning and then for Dr Hunyor. What would become of Manly, Mona Vale, Ryde, Gosford, Hornsby and Wyong if you were to get your wish and a board were created? How do you see the structure of those hospitals?

Dr GUNNING: If we had a board at North Shore hospital, and answerable just to North Shore hospital, I think that would be advantageous. What happens to Mona Vale, Hornsby and Ryde? I thought the political decision had been made that there would be a new Frenchs Forest hospital, which would be fairly equivalent to the Royal North Shore Hospital. We are working very hard to have cross-appointments in cardiology at all the peripheral hospitals now and Royal North Shore Hospital. In future we would want to see cross-appointments between the new hospital at Frenchs Forest and at the Royal North Shore Hospital.

It would be my view that the myocardial heart attack interventional service is most efficiently done in terms of numbers by having one such unit per population of the present northern area. I would think then that the Frenchs Forest hospital probably should not be doing that, because it would dilute and double up on all the expenses. I do not care if it is as Royal North Shore Hospital or at Frenchs Forest, but I think it should be at only one of them.

Dr ANDREW McDONALD: What about Hornsby, Gosford and Ryde? What would happen to those hospitals?

Dr GUNNING: Gosford Hospital is a freestanding hospital. I believe in a hub and a spoke arrangement, I would regard Gosford as being the hub. It is a fairly artificial connection between Royal North Shore Hospital and Gosford Hospital. Gosford does all, or most, of the things that Royal North Shore Hospital does, and it is the hub to that Central Coast area. Places like Wyong are the spokes, and that is how I see the arrangement.

Mr MICHAEL DALEY: I will ask two questions. First, assuming we are not going back to hospital boards and knowing your four-pronged strategy what other structures would you put in place to go forward in the absence of a hospital board for the Royal North Shore Hospital? Secondly, Dr Hunyor, you referred to the hospital's accreditation status. I understand it is accredited until October 2008. Dr Keegan of the AMA told this inquiry on Monday that the issues identified focused on record keeping rather than critical care. I am interested in your views on how clinicians and management can work together to put in place better systems for record keeping to help both staff and patients?

Dr GUNNING: I prefer to defer to Dr Stephen Hunyor on that. I have actually forgotten the first question, I am sorry.

Mr MICHAEL DALEY: Given your four-pronged strategy in the absence of a hospital board.

Dr HUNYOR: We speak as a unified group of 18 cardiologists. First there is some confusion between identity and networking. North Shore is very strongly committed to networking. Our outreach is to all hospitals and I am just as concerned for the people who live in Gosford, Mona Vale, Manly, Wyong, Long Jetty and Woy Woy as I am for the people who live in the lower and middle north shore. We show that with our programs, with our cardiovascular education centre, which we have also established from private funding. We show it through all our services. We are asking to give us the role that allows us to establish top international standards and diffuse them to some of our centres.

I am told that Gosford is a much more significant physical structure than North Shore; it is in much better shape. Good on it, it deserves it! North Shore needs some other things. To get on to the Council of Health Care standards, I am sorry, if you read their annual reports, which I have done, I used to be a surveyor, I was on the standards committee of the Australian Council of Health Care Standards, when North Shore was rated the best hospital in the country. My colleague who co-surveyed that hospital that year told me that. I am prepared to put you in touch with that person.

This is so-called conditional approval for one year, should have been coming in July of this year but it stuttered and stuttered for another six months before the 60-day critical things that had to be fixed were fixed so it got over the line, it gasped over the line. It is not just record keeping, not that record keeping is not important, if someone comes in with chest pains and there are no records. If patient Anderson comes into the emergency and there are no records—more record keeping is a bit of an oxymoron.

Mr MICHAEL DALEY: How can you get clinicians and management working closer together?

Dr HUNYOR: By having an empowered medical staff council and a board at North Shore. We work on evidence, Mr Daley. So I suggest would could be done is give one hospital a board, not give the other hospital a board, give the third hospital a board and the fourth hospital not. Perhaps give three of the teaching hospitals a board and three teaching hospitals not a board and let us see how they are performing after three years—real, fair dinkum good boards. Victoria has done it, with a government of similar political persuasion. I am told on reliable evidence that Victorian hospitals are performing to about a 30 per cent higher standard than hospitals in New South Wales. There is a message there.

Mr PETER DRAPER: My question is to both gentlemen. Stephen, you were talking about the importance to the hospital of IT and capital investment. One of the submissions stated that the

hospital in May this year established a capital risk register that was designed to identify and manage clinical risks associated with old and broken equipment. Is your area affected by this risk register?

Dr HUNYOR: We are hoping it will be. I was just talking to my colleague—we are not aware that it has had any impact on us that this stage. We are a very technology rich department. I chair a centre on cardiac technology, I ran a cooperative research centre on cardiac technology, I have a Master in technology management. So I am interested in that area. We have yet to hear about its impact, its aims, its resourcing.

Mr PETER DRAPER: Would it surprise you that when neurology were looking for new computers it had some donated second-hand that were two years old at the time and it is still relying on that computer system?

Dr HUNYOR: No, Mr Draper, it would not surprise me. I was talking to the head of the department of neurology last night and she was bemoaning the fact that neurosciences, this very important area handling stroke and neurointerventional radiology is suffering from many of the systemic ills that other technology or purportedly or necessarily technology rich departments are at North Shore.

CHAIR: Both of you have said that you view the medical staff council a very important body. You indicated that the council has not met. Is there a problem about who convenes the council or how it operates? Why is it not functioning?

Dr HUNYOR: Chair, about seven people turned up. It is like a dispirited skeleton that has no use, no say. As I say, the chairman of the council was not invited to the clinical reference group until clinical colleagues said, "What is going on? Why is he not here?" It is an irrelevance. This is the way things are marginalised, in this case by creating the divisions. The divisions are also just sort of bottom-line budget managers. I think you will get evidence in this inquiry from a colleague who has far better insights into the "management" of the division than I have. My colleague will perhaps give you some other insights.

CHAIR: Do you suggest that the area level deliberately made the medical staff council ineffective or does not recognise it? Would that be the general manager's level?

Dr HUNYOR: Chair, I am not in a position to say how deliberate or otherwise it was, but it is a reality. I think despite the protestations of the medics, no note has been taken of their protestations, their requests and their advice to give it some purchase, some leverage, some relevance again. After all, the leadership clinically, which is probably what patients and the community are interested in ultimately, would come from the clinicians and the nurses. The others are meant to be there to help us deliver that. In many cases now, with five, six levels, there have been instances where a request for some equipment just goes into the bottom drawer. You try to fish it out, it has to go through five levels of management. I was told when I was CEO of this cooperative research centre, which had a budget of about $5 million to $6 million a year, that it was peer reviewed against 53 other cooperative research centres in the country. It had an annual report on a $5 million budget. Fifty-three of these reports from these centres went to the department of the Prime Minister and Cabinet each year. That is peer review and you had to account financially management wise, outcomes wise, every other which way. The general manager of the hospital at that time had the authority to sign somewhat less than $1,000—in a hospital that purportedly has a budget of $436 million.

CHAIR: Have you seen the downgrading of the role of the general manager, which I think you said should be a CEO status, as one of the reasons for the hospital being in trouble?

Dr HUNYOR: Yes.

Dr GUNNING: Very much so. It is so tortuous to try to have decisions made. I think the case study of the cardiac technicians is a mind-boggling example. Decisions just do not get taken. It seems to me that it is imperative that there be somebody of CEO status quickly at Royal North Shore Hospital where he or she can be met on a daily basis. Just two days ago Greg Nelson, who runs the interventional cardiology service, spent two weeks trying to make contact with the present CEO, unsuccessfully. He wants to make submissions to have the transmissible ECG in all the ambulances in

the northern area. At present it is in about 50 per cent, less than 50 per cent. In two weeks he has not been able to make contact with the CEO of our hospital.

CHAIR: Of the hospital or the area?

Dr GUNNING: The CEO of the area, I beg your pardon. It is just dysfunctional. We are having difficulty functioning. We have to have a CEO at the hospital who can make decisions and we can talk to on a regular basis.

CHAIR: Thank you very much for appearing as witnesses today. I know that all witnesses would like more time, but we are trying to cover a number of areas in our inquiry. The Committee appreciates your attendance and evidence.

(The witnesses withdrew)

ROBERT JOHN DAY, Director of Emergency Medicine, Royal North Shore Hospital, and

ANTHONY PHILLIP JOSEPH, Director of Trauma (Emergency), Royal North Shore Hospital, and

SUSAN IERACI, Public Hospital Emergency Medicine Specialist, sworn and examined:

CHAIR: Thank you for agreeing to be witnesses and your attendance at our inquiry. Dr Day, in what capacity are you appearing before the Committee?

Dr DAY: I am appearing as the Director of the Emergency Department at Royal North Shore Hospital.

CHAIR: Dr Joseph, in what capacity are you appearing before the Committee?

Dr JOSEPH: I am the Chair of the New South Wales Faculty of the Australasian College for Emergency Medicine and I am a senior staff specialist in the Emergency Department at Royal North Shore Hospital.

CHAIR: Dr Ieraci, in what capacity are you appearing before the Committee?

Dr IERACI: Public hospital emergency medicine specialist.

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

Dr JOSEPH: We would all like to make an opening statement. My statement will go three to five minutes and the others a couple of minutes.

CHAIR: Keep them as brief as possible.

Dr JOSEPH: I would like to thank the Committee for inviting me to speak today in my role as Chair of the New South Wales Faculty of the Australasian College for Emergency Medicine and as an emergency specialist and Director of Trauma at Royal North Shore Hospital. I would like to speak about some of the issues at Royal North Shore, which have brought us here today, and also make some reference to the provision of emergency care at Royal North Shore Hospital and as it applies across New South Wales in general.

First, the recent occurrences at Royal North Shore Hospital have been distressing to all of us who work there as well as the public that we serve. This is unfortunate as the hospital has many world-class and compassionate individuals, not just doctors but also nurses, allied health workers, and many other people who help to run the hospital. There are many excellent clinical departments in the hospital, which I detailed in my submission, and all provide a very high level of care, both to the local community and to the rest of New South Wales in their role as a tertiary referral and teaching hospital.

North Shore is an institution that has a reputation for excellence in teaching, research and clinical care. It is a place that I am proud to take my family, friends and anyone else for care and treatment, but it appears to have lost its way of late. The decline has been subtle, but gradual, over the last 17 years that I have been working there. The recent report of the Australian Council on Healthcare Standards that Dr Hunyor referred to is a telling reflection of the recent decline in overall standards. The statement to this inquiry by the New South Wales Department of Health is, I believe, correct, in that it states:

> The key issues affecting the Northern Sydney Central Coast Area Health Service are poor financial management, patient access and staff morale.

The statement also said:

> There was a failure in the leadership and governance across a range of key areas.

The department goes on to state:

> The new CEO will identify internal problems and take action to resolve them and re-energise clinicians in joint decision making through implementation of clinical management procedures.

That is all very well, but we have heard all that before. We have heard how clinicians have been disengaged from the planning process. There has been no strategic clinical plan for the area and the budgets for basic services, such as cleaning and information technology, have been gradually reduced. Professor Carol Pollock, chair of the Area Health Advisory Council since the amalgamation of the area health service in 2005, has consistently raised a number of issues of concern for clinicians including the redevelopment of Royal North Shore Hospital where the advice of the clinical advisory group regarding the number of beds, operating theatres and intensive care beds has been largely ignored by the area and the department.

The Minister has now stated in this inquiry that there will be 626 beds in the new hospital—this is the first time we have heard that number—including 46 critical care beds and 40 mental health beds. Thus the new hospital will provide a total of 27 more beds than the current total of 599, which is a concern, given the projected population growth for the northern part of Sydney. Professor Pollock has also expressed concerns about the lack of a clinical service plan for the new northern beaches hospital because that would impact on the services provided at the Royal North Shore Hospital. As recently as September 2007, in her report to the Health Advisory Council, she stated:

> Other major challenges for the area are budgetary, operational, including information technology, work force, and high turnover in management.

We await with interest to see how the new chief executive officer of the area will deal with those issues as a matter of urgency. Access to in-patient beds and the capacity to treat in the emergency department at Royal North Shore Hospital are crucial factors that influence the level of care we are able to provide. The distressing events that led to Ms Jana Horska having a miscarriage in the toilets of the emergency department on 25 September 2007 occurred due to the fact that the hospital was full to capacity and no bed was available in the emergency department. On that evening there were 16 admitted patients in the 26-bed emergency department, seven of whom had been there longer than eight hours, and all the beds were occupied. As a result, there was no bed for Ms Horska to provide her with the dignity and privacy she clearly required.

It was not the lack of a specific protocol, as suggested by the subsequent inquiry into this tragic event as all agree there was nothing that could have been done to prevent the miscarriage, but the lack of access to a bed led to a very distressing outcome for the patient, her partner and the staff involved. It is clear that hospitals such as Royal North Shore cannot continue to operate at a 95 per cent occupancy rate or greater. Royal North Shore Hospital currently has 406 acute beds—I counted them—out of a total of 599. These 406 beds are accessible to patients through the emergency department. This is a significant reduction from 700 beds in 1998. I had a walk around the other day and there are 10 out of 24 wards in the main building either closed or used for purposes other than in-patient use. Hospital administrators close beds in order to save money.

We know that hospitals become inefficient once bed occupancy is greater than 85 per cent. So I suggest that bed occupancy less than 85 per cent should be an immediate tangible key performance indicator for hospital administrators at Royal North Shore and at all public hospitals in New South Wales. The Minister's recent announcement of a $30 million funding package to open new beds is a commendable start, but they need to be rolled out further to allow the entire system to operate at a less than 85 per cent occupancy rate. Significantly, the Minister's statement does not mention how the Department of Health proposes to staff these beds with extra nurses.

Doctor Stephen Christley, the previous area chief executive officer, also stated in this inquiry that he believed there was a need for more beds, and that there was a need to increase the capacity of the system. Finally, all patients should be seen or have their care overseen by a trained specialist in emergency medicine, just as I expect this to occur with other specialities. Emergency medicine is no different. This will require enough emergency positions available in the system, which is currently not the case in New South Wales. There is a major shortage of emergency positions in New South Wales. New South Wales has approximately 234 emergency positions, which works out to about 36 per million population, compared to Victoria which has 254, which works out at 52 per million population. These are telling statistics.

Based on those figures, I think that New South Wales needs to increase the numbers of emergency positions by about 104, or less than 50 per cent, to become at least equal to Victorian hospitals. The 22 new positions referred to by the Minister in her statement yesterday is a good start but it is not enough. Also, more significantly, New South Wales has had 50 per cent of all training positions in emergency medicine filled by overseas doctors or locums, or they are unfilled. My department is short three to five registrars for next year. That is in contrast to the Alfred Hospital in Melbourne, which is the busiest trauma centre in Australia. The emergency medicine director tells me that they have to turn away 30 registrars who want to work there every year. That says something about the working environment and the culture in Victoria.

We have also lost a number of excellent young emergency positions to that State. But in my department we have lost in the last few years two of our brightest young emergency positions, including the previous director of my department, to train in intensive care in Professor Fisher's department. Many emergency positions in this State have decreased their working hours, which says something about the working conditions in this State for emergency medicine practitioners, and many doctors and nurses are voting with their feet. New South Wales emergency positions are currently working with the Ministerial Task Force on Emergency Care in New South Wales and the Emergency Department Work Force Reference Committee to determine the numbers of emergency specialists required and how to attract and retain a viable work force.

It is encouraging that the Minister and the department have finally acknowledged that there is a shortage of emergency specialists. We now need to act quickly to redress the problem, but we have not agreed on the numbers. There is also ongoing discussion regarding the provision of a viable emergency nursing work force. In summary, a number of targets must be met as a priority. First, there should be an immediate development of a clinical service plan for the Northern Sydney Central Coast Area Health Service and clinicians should have significant input into that plan.

Second, bed occupancy rates should be less than 85 per cent to allow for a capacity to treat in the emergency department and in the wards. Third, there should be the immediate implementation of a viable work force plan to attract and retain enough emergency positions in New South Wales to meet the current and future needs of the people of New South Wales. We should recruit sufficient numbers of skilled nurses in emergency and other clinical areas. Finally, and probably most importantly, we should keep the hospital clean and abandon the practice of mixed wards.

Dr DAY: I thank the joint select committee for allowing me to appear today. It is a rare shift that I work at the Royal North Shore Hospital emergency department when there are not elderly patients waiting on ambulance trolleys for an emergency department bed to become available, or a number of patients who have been admitted who are waiting for ward beds. They are subjected to the sights and sounds of a noisy and crowded emergency department, and they are looked after by extremely busy emergency department medical and nursing staff that have lots of competing priorities. These patients should be resting in a quieter environment in a ward. There is good evidence that admitted patients who are delayed in Australian emergency departments are more likely to suffer adverse incidents and possibly even increased mortality. My colleagues and I at North Shore emergency department feel strongly that we cannot let this situation continue.

I have been an emergency specialist for 14 years, including the last three years at Royal North Shore Hospital. During that time I have seen two major trends occur in emergency medicine. First, emergency department overcrowding has become endemic. Second, it has become more difficult to attract sufficient doctors and nurses to work in emergency to meet the demand. That has led to an over-reliance on junior, casual and locum staff to try to fill in the gaps. These problems are all system-wide, but I think North Shore provides plenty of evidence of the effects of both those issues. The main reasons for emergency department overcrowding are increased activity and access block, that is, the lack of in-patient beds for admitted patients. Activity at North Shore emergency department has grown considerably in the last two years by 10.4 per cent in 2005-06 and another 6.8 per cent last year. The number of admitted patients has grown by similar numbers. There have been nearly 4,000 extra ambulance attendances over that time.

To cope with this increasing activity the emergency department has made a number of changes internally, including opening a short-stay unit, a fast-track area, opening more emergency department assessment beds, using a communication clerk and intravenous cannulation nurses, to

name a few of the strategies we have tried. However, we still have an unacceptably high rate of admitted patients who are waiting too long to go to a ward bed. This impacts on our ability to see and manage new patients arriving in the emergency department.

The key to reducing access block is to reduce hospital bed occupancy below 85 per cent, the point at which access block is minimised. The Department of Health in its submission gave an occupancy figure for North Shore Hospital of 90 per cent, which I believe is not correct, and it is likely to count beds that are not available to emergency department patients. Northern Sydney Central Coast Area Health Service data in my submission shows that at Royal North Shore for 9 of 12 months in 2006-07 the hospital occupancy was at 95 per cent or above. In emergency we collected figures for two months over winter that showed an average of 16 patients waiting in emergency every morning for a bed.

The only ways to reduce bed occupancy are to reduce the number of admissions, which can end up denying people the care that they need; reduce how long patients stay in hospital, but North Shore already has a relatively short length of stay when measured against its peers; or go ahead and actually increase the bed base of the hospital. The issues of high-bed occupancy at North Shore are not simply going to be solved by a new management team making everyone work more efficiently. They are also not going to be solved by GP polyclinics or super clinics. GP patients are a minimal part of our workload. The real issue is about clearing the emergency department of admitted patients and that means reducing bed occupancy below 85 per cent.

The other big effect of emergency department overcrowding is on our staff. Front-line nursing staff are overloaded with continuous high-intensity work. As a result, the most experienced nursing staff in emergency at North Shore nearly all work part time. The most common full-time nurse is a junior second-year registered nurse. Nurse vacancy rates have been increasing year by year and in April this year we were 20 positions short. The nursing shortage frequently is blamed for the difficulties with nurse recruitment, however, there are many trained nurses who could be attracted back into the system if conditions were better. Unless emergency department overcrowding and workload are fixed, we also risk losing those skilled nursing staff we actually do have at the moment.

Medical staff vacancy rates have led to 50 to 150 shifts per month being filled by locum staff. Two years ago we did not need to use locums at all. The figure of 10.55 emergency specialist staff given by the Department of Health in its submission for Royal North Shore is incorrect. We currently have 9.8 positions, of which 8.8 are filled. We believe the Department of Health should urgently bring the number of emergency specialists up to the AMWAC recommended numbers so that we can provide at least 16-hour-a-day specialist cover.

In conclusion, there can be a lot of talk about differing figures, efficiencies, putting in new management teams and so forth, however, there is no denying that the community is demanding better emergency department services. The public has spoken loudly that the issues of emergency department overcrowding and staffing need to be urgently fixed. They understand that more beds need to be put into the system so that our patients get a fair go.

Dr IERACI: Good morning everyone, it is good to be here and meet you all face to face. I have come with a background of 25 years in New South Wales public hospitals, 17 of those as a specialist in emergency medicine. What I want to share with you this morning is an insider's view of what it is like in emergency departments in New South Wales and what the issues are from a front-line coalface point of view. I will make three main points and then I will make some recommendations. The first thing I want to help you understand is how the role and expectations of emergency departments have changed over the years. What used to be done perhaps 20 years ago in the first few days of a hospital admission is now all compressed into the first few hours of care in an emergency department.

Emergency departments used to be the front door of the hospital. Now the emergency activity drives the activity of the hospital, but the resources and the policies to support these have not kept up with the way the model has changed. In particular, mental health patients are suffering because lots of those are now forced to wait in emergency departments rather than going straight to be assessed in the mental health units, as they used to be. Most mental health wards have stopped taking acute patients

directly, but the equivalent resources were never transferred to the emergency department to allow them to subsume that role.

What is the solution to that? Senior emergency department staff have to have the power to admit patients to the most appropriate team for their care; and having done that, the specialty teams that we refer patients to have to then take responsibility for their care. Specialty units have to provide clinics or assessment units for patients who do not need emergency treatment. There are lots of those out in the community. Typical examples would be elderly nursing-home patients and, I will say again, mental health patients.

The second thing I want to talk about is acute hospital beds. We know the New South Wales Government has recognised that beds need to increase. Yesterday's announcement is certainly welcomed, but a lot more is needed. That is just the beginning of the solution, it is not the entire solution. I have to say here that Federal funds should contribute to rebuilding the hospital bed base. We need enough acute beds as you have heard many times to have 85 per cent occupancy and that allows for safe care in acute hospitals.

The last point I want to make is to help you understand how important it is to have specialist medical and nursing staff working at the front line. As you have heard before, New South Wales actually has been behind the other States in attracting and employing emergency specialists like the three of us. Efforts are starting now and that is important and it is appreciated, but we need to make sure that the task is continued and that it stays on track for many years to come. So, I will just go through the recommendations again to summarise what I have been saying. Firstly, emergency department resources and hospital policy need to reflect the central role of the emergency department in driving hospital activity. The hospital world is new and things have changed.

Secondly, emergency department senior staff have to have the authority to admit patients to the most appropriate hospital unit; and having done that, the specialty units have to take responsibility for their care. Thirdly, specialist units should provide clinics or assessment units for patients who do not need emergency treatment. I particularly include there elderly nursing-home patients and the mentally ill. Fourthly, combined State and Federal funding must bring bed numbers up so that occupancy is kept at 85 per cent to ensure safe care. Lastly, we have to make New South Wales nationally and internationally competitive in recruiting and retaining emergency medicines by specialists. We have to stop the brain drain to the other States. This will need sustained effort and it needs vigilance to keep it all on track for many years. It is good to meet you all. Thank you for giving me the chance to speak.

The Hon. JENNIFER GARDINER: Dr Joseph, in your written submission you said that it is apparent that clinicians lack a voice with management both at a hospital and an area level and recommendations on strategic or clinical matters are not taken into account when critical or strategic decisions are being made about clinical care. This morning you have said to us that you have just found out about the number of beds that would be allocated to the new Royal North Shore Hospital. It would seem from that, even given that we are in this climate where there is an extraordinary focus on your hospital and the area health service, clinicians like you are still voiceless in making those extraordinarily important decisions not just for now but for the future. Would that be fair comment?

Dr JOSEPH: Yes. Talking to members of the advisory committee for the redevelopment, and I spoke to one of the members last night, and that was the first time he had heard the final numbers for the redevelopment of the hospital. As I said, it is of concern that it is only going to produce fractionally more bed numbers than we have at present.

The Hon. JENNIFER GARDINER: Despite a growing population projection?

Dr JOSEPH: That is correct and, as I say, Professor Pollack has made numerous recommendations to the area executive regarding governance and clinical matters since 2005, and they have not been addressed.

The Hon. JENNIFER GARDINER: Dr Joseph, you have made a number of recommendations: first, the need to reduce the average bed occupancy rates to less than 85 per cent.

What do you think would be a reasonable time for that to be implemented? Obviously it is an urgent requirement. What do you think it would be—months, weeks?

Dr JOSEPH: I would think within 12 months that would be achievable. There is bed space at North Shore at the moment. There is a ward they can open tomorrow, with some cleaning, which has got 25 beds.

The Hon. JENNIFER GARDINER: With some cleaning?

Dr JOSEPH: Well, I mean it has not been used for some time. It is a little bit older, but it is vacant. But they have a problem now finding enough nurses to staff it. Part of the problem is actually recruiting the nurses back into the workforce. We know there are lots of nurses out there who actually are not nursing, but you can attract them back into the workforce by appropriate conditions, such as parking, such as child care. I mean, the nurses who worked in my department and who have gone off to have babies say it is not worth their while to come back because half their wage goes in child care. So beds, nurses, and then clinical governance—probably clinical governance first.

The Hon. JENNIFER GARDINER: In terms of recruiting nurses, how quickly do you think that could be done if there was an attractive package, taking into account the basic things that you have referred to, in this day and age, such as child care and access to parking and so on?

Dr JOSEPH: Well, it is hard to tell but I think if the conditions were there, that would attract them; they would come back within months, I would have thought. Obviously they would have to make arrangements but one of the senior nurses in our department who has been the night duty manager for a number of years has recently left because she cannot get child care for her child. Her husband is away working sometimes, so she is concerned for her child and she has to stay home now. She has taken a day job in another place.

The Hon. JENNIFER GARDINER: Dr Day, you challenge the New South Wales Health submission in relation to the bed number figures. What sort of beds would they be counting so as to come to a different figure to yours? I regret to say that we were not able to question New South Wales Health officers on the submission because we did not get their submission until they turned up, and apparently they are not coming back. Would you like to comment on where they get their figures from and why there is that differential?

Dr DAY: Yes. There are a certain number of beds that are counted as hospital beds and often it is very difficult to know exactly how many beds there are in the hospital. Some of those beds are not accessible to emergency patients—for instance, in specialists units like neonatal, intensive care beds, special care nurseries, and paediatric beds that are not available to adult patients. When they are counting the number of beds for bed occupancy, it is very difficult to know which beds are being counted and which beds are not being counted. What really needs to be counted are the beds that are accessible to emergency department patients. When those beds are counted the occupancy figure is much higher. As said, it is 95 per cent or above for nearly the whole year.

Mrs JILLIAN SKINNER: I have a question following on from that because it is one that I picked up as well from the evidence given on Monday. One of the things that Dr Deb Picone, the director general, said was that she had identified the bed equivalents and in fact has said that of the intensive community-based, care-at-home packages, those are counted as hospital beds. Is that right, as you understand it—that a bed that a patient might occupy at home getting nursing from the hospital is actually now counted as a hospital bed?

Dr DAY: I believe that is correct. I think when the total number of beds is counted at North Shore, there is a figure of between 500 and 600. We know that the actual number of beds that are accessible to emergency patients is 379 plus about 36 intensive care beds. So the actual number of beds accessible to emergency patients is far fewer than the total number of beds.

Mrs JILLIAN SKINNER: And this would be of absolutely critical importance when you are looking at access block because you certainly cannot access any of these other beds for a patient that has the kind of condition that you need to be admitting for.

Dr DAY: That is correct.

Dr JOSEPH: Can I make a comment, Chair? There are two things. In the hospital's annual report for 2006, the report says the occupancy rate was 94 per cent. Secondly I have an email from Dr Richard Matthews who has actually counted the number of beds and they give a total of 599 of which 321 were available for medical and surgical, but they also counted maternity, 32, the special care nursery, 25, bassinets, 24, dialysis, day only, 18. That is where the total number of beds comes from. There is a smaller number available for acute patients.

Mrs JILLIAN SKINNER: That is correct. They are all listed on page 10 of the *Hansard* record from Monday, if you want to have a look at them. The other thing we were told on Monday is that there is a midnight bed census done every night that counts the number of beds, but then counts the number of patients in them. Do you know that? Do you get access to that information?

Dr DAY: I did not get direct access to that information. I know from the figures that we collected in emergency over winter that there were 16 patients waiting every morning for beds. I think that is an occupancy closer to 100 per cent when that occurs.

Mr MICHAEL DALEY: I note that Dr Joseph and Dr Ieraci mentioned Federal funding and Federal support. Given the burgeoning Federal surpluses and the election context we are in at the moment, what difference do you think a serious intervention by the Federal Government in terms of funding and support for State health systems could make after 24 November?

Dr JOSEPH: I understand that Federal funding for State hospitals has decreased significantly in the last number of years. I think the funding has decreased by something like $2.5 billion and that has gone back into the Medicare rebate. I would say they really need to inject at least that amount back into the public health system but it will take a lot more money than that to get the public hospital system across the nation up to scratch as far as bed occupancy rates go.

Mr MICHAEL DALEY: Given that even if the beds are made available and the State governments have a bit of success in bringing nurses back into the profession, I understand that the graduation of the doctors and nurses is really a Federal responsibility. How are we going to get more doctors and nurses to graduate so that we can put them into the State health system?

Dr JOSEPH: There are more doctors and nurses coming through. We know we have actually got lots of nurses and that the medical intake is doubling in the next two years with the doctors coming out, but what we are concerned about is the lack of people to train these young doctors and nurses when they do come into the system. Training specialists is actually a State responsibility. This is something the States have dropped the ball in, although Victoria has not, but New South Wales certainly has. We have a lower number of specialists, certainly in our workforce, and we are concerned we are not going to have enough to train young emergency physicians if we can actually manage to attract them back into the training scheme.

Dr IERACI: If I could make just a slightly different comment about the cooperation between State and Federal funding: When funding has been negotiated I think in the past it has been assumed that we are still funding the old-fashioned model, where emergency departments are small places and hospital beds should generally decrease. The world is different and hospital beds need to start to increase again. So really the Federal contribution is an important part of that. When we negotiate with the Federal Government it needs to be negotiated on the new model, not the old model.

Ms CARMEL TEBBUTT: Could I ask a question addressed particularly to Dr Day, but the other doctors might like to comment. In your submission you outlined some solutions to emergency department overcrowding. Obviously beds is one of the solutions that you have spoken about today, but can you talk about how we can achieve perhaps some of the other solutions you identify in your submission, particularly developing appropriate referral patterns and also better patient flow and efficient discharge processes as they relate to older people, and the issue of exit block as it is sometimes described. Can you talk about how we can achieve some of those things?

Dr DAY: Yes. I think there are some particular issues in the Northern Sydney area. We have a number of smaller hospitals surrounding Royal North Shore Hospital. Over the years services in

those hospitals have gradually diminished. A number of different specialties, such as paediatrics, urology, vascular surgery and hand surgery—there is quite a long list of those—are not practised at a number of those smaller hospitals like Ryde, Manly, Mona Vale and Hornsby hospital. What that means is that there has been an inflow of patients to the North Shore Hospital from all those specialties because the other hospitals can no longer take those patients. There has been a lack of planning as to how that should happen and there has been no funding that has flowed with those extra patients that come through. There has been no role definition of what the smaller district hospital should be doing and what function North Shore should have: what it needs to do for its community patients, what it needs to do for its tertiary responsibilities for the area. It also has statewide responsibilities. The entry for most of those patients is through the emergency department. All those patients are competing for the same beds so there needs to be further planning around service delivery and admission processes.

Ms CARMEL TEBBUTT: What about exit block and patient flow? Are there issues there?

Dr DAY: We know that elderly people are disadvantaged, even amongst people in emergency departments. They tend to stay in the emergency department for longer before they get to the ward. There are systems that would allow those patients to be put more speedily through the hospital.

Ms CARMEL TEBBUTT: Is there a shortage of aged care places in the area for older people who perhaps no longer need a hospital bed but who need to be referred to an aged care place outside Royal North Shore Hospital? Is that an issue for the hospital, do you know?

Dr DAY: It has been an issue from time to time. There have been large numbers of patients waiting for rehabilitation beds and nursing home beds. I cannot give you exact figures on that.

Ms CARMEL TEBBUTT: Do you have any ideas about how that might be better addressed?

Dr DAY: It is likely that there is a need for those beds to be provided for patients that are not acutely unwell and do not need acute hospital beds and should be looked after in another setting.

Dr JOSEPH: Can I make a comment on that? This comes down to a clinical services plan for the area. That is something we have not seen since 2005. With regard to North Shore and Ryde hospitals, it has been a very unhappy alliance for both groups. Dr Christley mentioned in his submission that the role of Ryde should be reviewed. We have been saying for a number of years that Ryde probably should not be working as an acute hospital and should be maybe concentrating on some of the aged care patients and less urgent surgery patients. That is something the area could do in a very short time to increase efficiency for those two hospitals.

Dr IERACI: This is one of the arguments against individual hospital boards because one of the solutions to this problem is the ability to access different parts of the health system for different purposes rather than individual hospitals only governing their own purpose.

Mr PETER DRAPER: One of the approaches to resolving some of the issues surrounding access to emergency departments across the State seems to be the collocation of GP clinics. I read in the submission that you do not believe that is an effective way of doing it. Can you elaborate a little on that?

Dr DAY: We strongly believe that adding GP services and putting up polyclinics is really not the answer to the system issues that are facing emergency departments. GP patients make up a very small percentage of patients that come through the emergency department. They are seen rapidly and quickly discharged. Our real issues lie with treating complex patients, a lot of whom require admission to hospital.

Dr IERACI: There is actually extensive evidence about that. It is real-life evidence, looking at places where GP clinics have been instituted and looking at what impact they have on the local emergency department. The impact is either neutral or they send more people to the emergency department. The fact is GPs in clinics are practising like GPs, even if they have out-of-hours X-ray

and so on. It is the complex patients, and particularly elderly patients, who are clogging up the emergency departments. It is obvious that the ones who need to lie down are the ones who are blocking beds. There are a small number of relatively simple cases that come to emergency departments, but they are quick and easy to treat. They do not cost much. They are fun to see on a day when the emergency department is so full. Someone you can see quickly and move out can be a pleasure. Clearly, the split between State and Federal funding of the two systems seems to have more impacts on that proposal than any evidence that it does any good.

Dr JOSEPH: When GPs refer patients to the hospital one-quarter of those patients are admitted to the hospital. So these are a sick group of patients. They cannot be looked after by the GP clinics anyway. The other patients, as Sue has said, can be seen and sorted. They do not take up a hospital bed so they do not affect our access block. They are a very small group of patients.

CHAIR: Dr Day, you mentioned the problem with people who have mental health problems and the aged coming into the emergency department. You indicated that they should somehow go straight to the mental health unit.

Dr IERACI: That was in my statement.

Dr DAY: Dr Ieraci mentioned that.

CHAIR: If that is the case, why is that not done? Can the hospital not make that decision internally?

Dr DAY: I can certainly speak about the Royal North Shore experience. Very frequently there are no mental health beds available for patients, and patients stay in the emergency department for prolonged periods. In fact, mental health patients make up one of our greatest sources of access block. Many of those mental health patients only need 24 to 48 hours before they are discharged. Some of them are then transferred to other facilities. One of the strategies that will be extremely useful is the development of a psychiatric emergency care centre—a PECC—which is a psychiatric short-stay unit that would have some beds so that mental health patients could be looked after for 24 to 48 hours outside the busy emergency department environment.

Having mental health patients in the emergency department is certainly not good for the patients themselves. It is a busy, noisy environment and it is difficult to get any sleep. Often that can exacerbate their condition. It is also sometimes very difficult for other patients and staff in emergency departments who are trying to look after mental health patients in the intense environment of an emergency department. They are a very important group that needs to be dealt with better.

Dr IERACI: Even beyond that, there has been a systematic move away from assessing mental health patients directly in mental health wards. That workload has been displaced to the emergency department. When we were all junior doctors mental health patients did get assessed and admitted directly to mental health units. Over the years, for a range of reasons—including cultural reasons—that workload was displaced to us. Emergency departments are becoming the answer to everything for everyone. That does not result in a better service for the patients. So how can you return that to the way it used to be? It is cultural change. It is not a difficult change to bring about for mental health units to have their own assessment purpose, the way they used to.

CHAIR: How do mental health patients physically get to the emergency department? Does somebody bring them?

Dr IERACI: There is a whole range of ways.

CHAIR: Is it possible for them to be diverted to a mental health unit and not the hospital at all?

Dr IERACI: That is what used to happen, yes. It is possible for that to happen again if the culture changes and the will is there for it to happen.

Mr MICHAEL DALEY: You have a mental health unit at Royal North Shore Hospital, do you not?

Dr JOSEPH: We do, but we do not have a mental health unit within the emergency department. If mental health patients have a medical problem they need to have a medical assessment, which is going to happen in the emergency department. So a lot of mental health patients need to come through the emergency department to have a quick assessment. If there is a bed they will go there but sometimes they spend two or three days in the emergency department because there is no mental health bed. Similarly with patients who have chronic illness and malignancy, when they get sick there is no other avenue for them to access hospital care than through the emergency department. This is where some of the systems of care could be changed, but polyclinics are not the answer. It has to happen within the public hospital system.

CHAIR: Another problem you mentioned is that you have been waiting for the clinical services plan since 2005. Who is holding that up?

Dr JOSEPH: I understand it has not happened. There has been a changeover of the CEO of the area times two, I believe. Professor Pollock has been asking for that since 2005. It would be useful to know how all the hospitals are going to cope with clinical matters, but that has not appeared. This is what we are asking for. We are told by the CEO that this can occur in the next six months. I guess if it did not occur maybe this Committee might need to make that happen.

CHAIR: Is there any point in Royal North Shore Hospital developing its own clinical services plan in the short term?

Dr JOSEPH: North Shore is in the Northern Sydney Central Coast Area Health Service and there are a whole lot of other hospitals in the area. So the plan has to be developed for North Shore, Gosford, Manly, Mona Vale, Ryde and Hornsby. They all had to be included in the plan to work out what they are going to do. We know that a lot of the super specialty stuff gets concentrated at North Shore, such as the spinal injuries, the burns and the hands. But that sort of comes in by default. There is no actual planning to increase the bed base for North Shore to cope with all these patients in the area. Likewise the paediatric services at Ryde and Manly. The paediatric wards were closed and all the paediatric admissions happen at North Shore. But there was no basis to increase the bed base of the paediatric ward at North Shore to cope with these patients. That is why we need a plan.

CHAIR: You mentioned in closing that there were wards that were closed at the hospital. One of the submissions talks about a phantom ward where nurses are rostered and so on, but there are no patients in the ward. Are you aware of that?

Dr DAY: No, I am not aware of that.

Dr JOSEPH: I am not aware.

CHAIR: We might follow that up. We thank you for your attendance today and not only for what you have said here but you have been making many public statements and issuing reports to the media, which I think have helped to create greater community debate, out of which we hope may come some solutions. Thank you for taking that leadership role.

(The witnesses withdrew)

CHARLES MARSHALL FISHER, Chair of Medical Staff Council, Royal North Shore Hospital, and head of Department of Vascular Surgery, affirmed and examined, and

SHARON EILEEN MISKELL, Director of Medical Services, North Shore and Ryde, and Staff Specialist Medical Administrator, sworn and examined:

CHAIR: Do you wish to make an opening statement?

Dr FISHER: Yes, we both do, and I was going to make mine first. The first thing I want to do is pay compliments to the clinicians at North Shore who are committed to providing quality clinical care. They have been, they remain so and they look to doing that in the future. They are also committed to providing that care in the best environment and being involved in that environment. The issue has been that they have been frustrated from doing that. You heard this morning that the attendance at the medical staff council meetings has in the past been relatively low. I have only been in the role as the chair for a relatively short time. But when clinicians have perceived the opportunity to be involved and have communication with the administration they have been there in great numbers, and certainly at the last two meetings, which were convened to talk about the new hospital and also to meet the new chief executive officer, there was standing room only; the meetings went way over time and there was certainly an attendance of 100 to 150. So clinicians do want to be involved and they want to participate in this process.

I also accept that some changes have occurred at the hospital. As you know, there is a new chief executive officer, but the new chief executive officer has only been there for six weeks. So it is very hard for clinicians to see any hard changes. There have been some things put in place. We heard this morning about the risk assessment for purchasing of capital equipment. We have not seen yet how that process actually works and how equipment has been obtained using that process. We also have an undertaking from the chief executive to have the area strategic plan for clinical services given to us within six months. We are less clear how that process will occur and what the involvement of clinicians will be.

We certainly have a clinical reference group and in the corporate governance rules or bi-laws the chief executive is clearly able to establish various committees as they choose to provide advice. One of the groups that he does have to consult with is the medical staff council. The medical staff council is the only group there that is representative of the medical staff. All the other groups that we are talking about are by appointment only. You heard mention this morning that I initially was not invited to be on that committee and I think that is an issue because there would have been no process for a process of communication from that group to the rest of the clinical staff and vice versa for the rest of the clinical staff to provide input in some form other than just by corridor conversations.

You have my submission already and I wanted to speak to some of it very briefly. I have just mentioned how frustrated clinicians are that they have not been involved with management. Certainly there has been an involvement on paper, but this has not happened in fact since specific examples of the new hospital. I was only recently involved in the clinical group involved in that, but I know that clinicians who were extremely frustrated that their objections were not even being minuted and, on the other hand, it was then assumed that because they had been to these committees they had approval of the whole process. I have mentioned the area strategic plan. That is coming, but clearly without that plan you do not have a process to determine the workforce you need to deliver the services, the resources you need to deliver the services and then appropriately allocate them. So in the meantime clinicians will be doing the best job that they can within the environment they are allowed to work in.

I have mentioned the capital equipment. The RDF, which has been referred to, refers to money that you allocate to the areas to provide care. It does not have anything to do with the equipment. The RDF recognises the high quality of health and a simple example is the survival of patients. Patients in the northern area live longer and are older than anywhere else and the RDF recognises that. Certainly what is not the case at North Shore is the equipment that we have to provide that care. It is terrible. It is ageing, there is no asset register of what we have, and we certainly do not describe the quality. The equipment is outdated. So whilst we might have a surfeit of longevity of life on the North Shore, we do not have a surfeit in any way of quality equipment. We have a major deficit and that certainly contributes to the clinicians' ability to provide quality of care. What we are

particularly lacking is any sort of strategic plan to determine what equipment we need and what we are going to get. Clinicians have provided that information and it is still sitting in a drawer somewhere.

We have mentioned information technology. There is some information technology infrastructure, but it is certainly not clinically focused in any way. Clinicians do not receive routine information as simple as how many admissions came in under your unit last month; what was their length of stay; what operations did they have? It makes it very hard for clinicians to benchmark their care. Different departments have their own databases and their own data managers, but by and large they have been set up completely separate from any facilities provided by the hospital. So those departments that are fortunate enough to have that are able to do it, but not all departments provide care in things that are necessarily as easy as others to raise money through donations and through the public.

I have mentioned the engagement of clinicians and I want to emphasise again how involved they want to be, but they have been extremely frustrated. Data for clinicians I have mentioned. We want to do the right thing, but we do not know how we are going. The solution is obviously more involvement of clinicians.

Dr MISKELL: I would like to thank the Committee for inviting me here today to enable me to provide evidence. I am a specialist medical administrator with dual degrees in medicine and law. I am a Fellow of the Royal Australian College of Medical Administrators and also a Fellow of the Australian College of Legal Medicine. In my submission to the Committee I have highlighted key areas which I believe are needing to be addressed as urgent priorities at North Shore. These include clinical services planning and workforce planning, information systems and information technology infrastructure, capital planning and the capital budget, peer reference costing, strategic clinical services planning framework, organisational structure and management expertise of the North Shore and Ryde health service executive, and also capacity and demand management. In my submission I have identified in some detail further information about those areas.

I believe that capital planning and capital budget is the urgent priority that needs to be addressed. There are instances across the hospital where we do not have appropriate equipment. It is broken; it is not working or unable to perform surgery. We are delaying surgery and I believe it is because of the clinical expertise and competence of our surgeons that we are not having the adverse outcomes that we could be having for patient care. To provide examples of that, in the past 12 to 18 months we have been able to perform ENT laryngeal surgery because the old laser equipment is breaking down and parts are no longer being manufactured. This situation has existed for 12 to 18 months. Using money fundraised by the pink ladies, who are volunteers working in a small area in the foyer of the hospital, that equipment has now been ordered, costing $160,000.

Cases have had to be cancelled or patients sent to other facilities to have the surgery done. NT drill bits were breaking during surgery in 2006. This occurred for approximately six months. These patients could not be transferred elsewhere for surgery because the proceduralist at North Shore doing that work is only one of two trained proceduralists to do that complex surgery in Sydney. That equipment was purchased in December 2006. The cardiovascular operating table is broken and needs to be replaced, at a cost of $300,000. This has been on the capital replacement register for two years. There is no identified funding for replacement at this stage. The cost is $300,000, as I mentioned.

Nerve integrity monitoring equipment used for neurosurgery and ENT surgery has been breaking down in the past 12 months. This is basic standard equipment used for acoustic neuroma and parotic surgery to enable nerve monitoring and to prevent nerve injury. This equipment has recently been ordered using area funds. Interventional bronchoscopy equipment, which is standard equipment for a tertiary facility providing treatment for advanced cancer and respiratory assessment and treatment, is not available. Equipment is currently being borrowed from another department. The approximate cost of that equipment is $150,000.

Mrs JILLIAN SKINNER: I am astonished that this is a teaching hospital treating patients with very serious conditions and you do not have basic equipment. How long has this been going on?

Dr MISKELL: I have been at the facility since September 2005 and I understand it has been the situation for 10 years.

Mrs JILLIAN SKINNER: Dr Fisher, this must be extremely frustrating for the doctors that you represent across the whole of the hospital.

Dr FISHER: I can add to the list gastroscopes, colonoscopes, light tails for laparoscopic equipment. In my own department we have vascular ultrasound equipment. You would have walked past that when you visited the treatment room on ward 10B. That was manufactured in 1996 and generally people regard that it has about a five-year working life. We did put in a capital equipment plan in about 1999 and I anticipated that equipment would have been replaced twice. That equipment is no longer supported by the company. My situation is no different to any other department around the hospital, plus equipment in theatres. So we are working generally with old and outdated equipment. In anaesthetics they need a transit oesophageal ultrasound machine, 20 ventilators, and the list goes on.

Mrs JILLIAN SKINNER: One witness, Dr Salla Sara, who represents one of the peak medical groups, suggested that other hospitals like St George, Wollongong, Westmead Children's Hospital and planning underway at Prince of Wales for digital x-rays but not North Shore. Do you know if digital x-rays are proposed for the new hospital?

Dr FISHER: I am aware that there is a plan for it to be in at North Shore.

Mrs JILLIAN SKINNER: The new hospital?

Dr FISHER: No, the current North Shore. I was involved in discussions in my departmental role about 18 months ago but I am not aware of where we are now, so I think the process has stalled.

Mrs JILLIAN SKINNER: The medical staff council that you chair, we have heard that previously it was a body with some status. It reported to the Minister on occasions. When did that change?

Dr FISHER: I have only been in the role very recently. I think it has been a gradual decline and it is probably a barometer of the power or the involvement that the clinicians had in the hospital.

Mrs JILLIAN SKINNER: If I suggested to you there had been evidence that it was tied up with when the area health service boards were abolished, when the new amalgamation came in—that is when the medical staff councils lost their empowerment? Would that surprise you?

Dr FISHER: I think when the areas were amalgamated suddenly the area was a lot bigger and the relevance of any particular hospital diminished, and it is therefore very much harder for one to stand out.

Mrs JILLIAN SKINNER: I would like to touch on a different area. We heard from Professor Cliff Hughes from the Clinical Excellence Commission yesterday about some of the work they are doing but we also talked briefly about local incident reporting systems particularly led by Dr Ross Wilson, who has had a substantial reputation for a long time. That particularly looked at what was happening at the hospital level. Can you tell me about the incident information management system. How often are doctors reporting IIMS from North Shore to the CEC?

Dr FISHER: I do not know but I would comment that although there is that process you clearly need to have a local process as well and you do not want your local process to diminish in favour of reporting somewhere else.

Mrs JILLIAN SKINNER: Professor Hughes said that.

Dr FISHER: You need both processes in place. The number of reports, no, I do not know that.

Mrs JILLIAN SKINNER: How many doctors have been trained in using the web-based form entry system to submit IIMS to the CEC?

Dr FISHER: I think that might also go back to the process of how information is communicated to doctors.

Mrs JILLIAN SKINNER: You would be perhaps not able to tell me whether there are any submitted by the doctors at North Shore?

Dr FISHER: I have done some.

Mrs JILLIAN SKINNER: What sort of feedback do you get? How do you then act on your feedback?

Dr FISHER: I just fill them in.

Mrs JILLIAN SKINNER: If there is an adverse event how do you act to make sure it does not happen again? What actions are taken at the hospital level? Perhaps Dr Miskell might be able to answer that as well.

Dr MISKELL: In terms of IIMS completion by medical staff, yes, that does occur. Those IIMS go on to a database. Depending on the level of severity, there may be what is called a reportable incident brief also generated, and then that reportable incident brief is given a severity assessment code which is according to the level of risk. The action that is then taken is determined by that severity assessment code, so it may be a formal analysis or it may be a local investigation.

Mrs JILLIAN SKINNER: Would it be Dr Wilson we would ask these questions perhaps, or is it somebody else?

Dr MISKELL: Absolutely. Dr Wilson, in his position as manager of the northern centre for health care improvement, oversees a program called QARNS, which is Quality Assurance Royal North Shore based on retrospective chart audit.

Mrs JILLIAN SKINNER: Would you have a role in working with the families of patients when there has been an adverse event?

Dr MISKELL: I do, depending on the level of that incident. If it is a high-level incident I may well be involved.

Mrs JILLIAN SKINNER: The Anderson family, for example?

Dr MISKELL: Yes, I was involved with that matter.

Mrs JILLIAN SKINNER: Did you insist they come to the hospital for interviews rather than go and speak to them somewhere outside which was less stressful?

Dr MISKELL: The family had requested that we meet off site and I identified Macquarie as an appropriate venue and suggested to them that we might meet there, which was what was planned. Unfortunately, one of our neurosurgeons was not able to get to Macquarie in that time frame so I suggested to Mr and Mrs Anderson that that being the case were they happy that we meet at North Shore hospital, not in the clinical building but in a building outside the clinical building, which they agreed to.

Dr ANDREW McDONALD: Is digitisation of the X-ray planned?

Dr MISKELL: My understanding is that will occur at North Shore hospital before the end of this financial year.

Dr ANDREW McDONALD: Dr Fisher, what is the current role of the Medical Staff Council at Royal North Shore, knowing the changes that have happened in the area?

Dr FISHER: There is the role that is outlined in the corporate government structure and the other group involved was the medical staff executive council, which comprises representatives of the various hospital medical staff councils. It is usually the Chairs and one or two others who will meet as a group with the chief executive. Again, that process has probably been in abeyance. I am aware that the CEO wants to reinvigorate that process as well. Most of the clinicians are waiting and seeing, as a whole. I try to communicate with them as best I can. You cannot have too many meetings, because people cannot get to them. We want to try to get the opinions of all the staff, so we have regular meetings and I anticipate that that will be a much stronger forum. Perhaps that can be reflected in the fact that management now want to come to those meetings, to be seen.

CHAIR: Do you have weekly or monthly meetings, or when needed?

Dr FISHER: Currently we have scheduled second-monthly meetings. In addition we have had two extra meetings. The first one, which I mentioned, was to talk about the hospital redevelopment. We had a meeting with the new CEO shortly after he arrived, about three or four weeks after he arrived. He is planning to be in attendance for at least part of the next meeting, which is next week.

The Hon. AMANDA FAZIO: Dr Fisher, last Monday the Committee heard from the new chief executive officer, Matthew Daly, that he is committed to developing a clinical service plan. What do you see as the key elements of such a plan?

Dr FISHER: As people have mentioned already this morning, it is not just a plan for North Shore. It has to be a plan for across the area, because we have to know what we are doing but it also has to fit in with what everywhere else is doing. Clearly it will involve clinicians from other hospitals. We have to define what services we will provide and we have to have clinician involvement in that. The proof will be in the detail, exactly what we are allowed to provide or how we organise that. We have talked about the possible role of Ryde hospital. If there is a political directive or imperative that a particular role has to be maintained, clinicians may feel that that will not be the most efficient or best clinical plan. Obviously changes would have to be made. Yes, clinicians would be involved. There have been meetings in the past and draft plans have been developed and never been taken back to those various groups and they certainly have not been ratified.

Ms CARMEL TEBBUTT: Dr Miskell, in your evidence and in your submission you raised a number of concerns about how things operate at Royal North Shore. I guess in your position as director of medical services you are in a position to be able to address some of those issues. What do you think is the support or resources that you need to do that? How does the process work? Do you raise these issues with the general manager or the area executive? How do you try to get these things resolved?

Dr MISKELL: The issues I have identified are around clinical services planning, workforce planning, strategic planning framework which, for our area health service, is a network framework. They are in the mandate of the area, not of the health service executive. The health service executive is dependent on the area executive to complete those service plans, workforce plans, and also the roll-out of the clinical networks, as a strategic planning framework. The executive is well aware of the absence of those planning frameworks and the urgent need to have those plans completed.

Ms CARMEL TEBBUTT: The capital asset register you spoke about, is that within the remit of the hospital?

Dr MISKELL: Yes, that register was put together in May. It was identified that there are a number of significant risks that we were trying to manage, so that was put together at health service executive level and made available to the area executive. Yes, those issues have been managed up to the area executive.

Dr FISHER: I will make a further comment on how we do the plan. The other day comments were made about North Shore having a silo mentality. There are some elements of that, because that is the way we are organised. We are organised in divisions, departments and whatever. When we say we have a network plan, everything we do is within our own little box; that is all we are

allowed to do. If we want to buy equipment, it is for our department. We had to justify the purchase within our department, within our division. If we do have a plan or perspective across the area we do not currently have that mechanism to do that. It is a bit chicken and the egg. You have to have the network first to have that plan. We do not have those networks. Some do but a lot do not. So when we sit around and have this area plan, we have to now start talking across because currently all we can do is talk up and down. We do not go across.

Mr PETER DRAPER: In many submissions the term "clinician frustration " came through loud and clear, especially in relation to a lack of consultation about the new hospital with bed numbers, theatres and other issues. Do you have an opinion on how this new facility will deliver patient care without considering the clinicians' import?

Dr FISHER: I think it will be very hard. There are certain assumptions being made with the new hospital. There will always be some risk in making those assumptions, but clinicians are the ones doing the work. They can see what developments are involved. I have been involved in only some of these committees, I went to one and was never told of any further committee. I was involved in another committee on diagnostic studies. We had one meeting of that. We outlined a whole lot of issues of concern and again there were no further committees.

By and large the clinicians wanted an institute-based model along the types of care, particular diseases would tend to be treated in the right place, and the model of care proposed was a patient-based level of care. Ambulatory care would be on one level, wards on another. That does not really fit. If you are a patient and you walk in and turn out to be a bit sicker than you thought, you then have to go from outpatients to somewhere else. My own department provides care in four separate places across the hospital. So I do not know how I am meant to provide a functional department. Clinicians are aware of how changes in practice will occur in five or ten years time. That advice does not seem to be followed.

Mr PETER DRAPER: It was put to me that the current management structure looks more at budget than at patient outcomes. Would you comment on that?

Dr FISHER: That has certainly been the history. Again, if we are talking about equipment, the frustration has been of no money this year, rather than as there is no money this year what are we going to do about getting equipment? The other frustration is when there are changes in care that you can provide. They have never been prepared to spend a little to save a lot. It has always been that there is no money to spend. So there has been no investment.

CHAIR: Dr Fisher, you indicated that a lot of equipment is old and some is broken. Previously the Committee heard that an operating table collapsed during an operation a few years ago. Is there any evidence that some of the lack of modern equipment could endanger patient safety or care?

Dr FISHER: I do not have details of the IIMS reports. At a more simple level, there are questions of efficiency of care. Things are slower and you just have to wait that little bit longer for the extra bit of equipment. Occasionally cases are delayed or postponed. Time, energy and money are lost. The opportunity to operate on another patient at that time is lost, so there certainly are inefficiencies at the most basic level. If you look at quality and safety there is a pyramid, and presumably for a proportion of those events more dangerous events will occur. I do not know of any specific examples.

CHAIR: Dr Miskell, do you have any information in that regard?

Dr MISKELL: I am aware of an incident in 2006 when, as I mentioned, ENT laryngeal laser equipment was not functioning, so an ENT shaver was used instead. Subsequently, a patient suffered a puncture of the oesophagus as a result of using that equipment rather than the laser equipment. As I said in my opening statement, I believe it is because of the expertise and confidence of our surgeons that we have not been getting into difficulty with adverse outcomes. But I cannot say categorically that those incidents have not occurred.

CHAIR: There has been some criticism about trying to treat Royal North Shore Hospital and Ryde Hospital as one unit. Do you find that it is working, or is it not working? What do you suggest should occur?

Dr MISKELL: What is needed is clear role delineation between the facilities. That requires a clinical services plan that will configure services across that area health service appropriately. That has not been done. The two facilities are basically functioning as they were prior to the restructure, the only difference being that we now have cross-appointments of the executive. So I am now involved with the management of Ryde Hospital in addition to the Royal North Shore Hospital, and members of the divisional structure also are now managing across to Ryde Hospital. There was mention previously of a role delineation that would focus more on Ryde having a primary focus with minor risk surgery, short-stay day surgery, and cold surgery, as it is otherwise known.

As Royal North Shore Hospital is a major trauma centre with a focus on hot surgery that would enable us efficiently and effectively to provide services across the sector with what has been demonstrated in other area health services that have implemented that model, that is, significant reductions in length of stay and in delays to surgery. We have a significant problem at Royal North Shore Hospital with access to theatres. Currently, we have 14 theatres and 25 per cent of our activity is done out of hours. That is at a time when there is reduced infrastructure both in relation to staffing and in relation to diagnostic. There is not the senior level of staffing available in those out-of-hour periods. It represents unsafe working hours for medical staff and it also contributes to access block and to problems with capacity and demand management.

CHAIR: Thank you very much for appearing before the inquiry. The information that you have supplied is important to us.

(**The witnesses withdrew**)

(**Short adjournment**)

RAYMOND FRANCIS RAPER, Director, Intensive Care Unit, Royal North Shore Hospital,

MALCOLM McDOUGAL FISHER, Director, Intensive Care and Critical Care, Royal North Shore Hospital, and

WILLIAM ROBERT SEARS, Visiting Medical Officer, Royal North Shore Hospital, sworn and examined:

CHAIR: Thank you for agreeing to come and share your knowledge with the inquiry. Dr Raper, in what capacity are you appearing before the Committee?

Dr RAPER: As Director of the Intensive Care Unit at Royal North Shore Hospital.

CHAIR: Professor Fisher, in what capacity are you appearing before the inquiry?

Professor FISHER: I am not sure. I am one of the longest serving specialists at Royal North Shore Hospital and I am also the area director of critical care and intensive care.

CHAIR: Dr Sears, in what capacity are you appearing before the inquiry?

Professor SEARS: As a visiting medical officer at Royal North Shore Hospital.

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

Professor FISHER: I think we all do.

CHAIR: I would ask if you could keep them brief so that Committee members will have the chance to ask questions in the time available.

Professor SEARS: Thank you, Mr Chairman and Committee members. My name is William Robert Sears and I am a specialist spinal neurosurgeon registered in the State of New South Wales and a visiting medical officer at Royal North Shore Hospital. With the exception of a four-year hiatus from 2001 to 2005 when my colleague and previous student Lali Sekhon took over from me, I have been neurosurgeon to the spinal injuries unit of Royal North Shore since 1988. I thank you for the opportunity to appear before this important inquiry. Before speaking about the problems that concern me deeply at Royal North Shore and in particular affect my capacity to care as a specialist spinal surgeon for patients with complex spinal disorders from across the State of New South Wales, I think it would be helpful for me to provide you with a brief summary of my training and experience as a specialist spinal surgeon.

I studied medicine at Sydney Hospital prior to an internship at Royal Prince Alfred. I did my initial surgical and neurosurgical training at Guise Hospital in London and returned to Australia in 1983 to Royal North Shore Hospital where I took up advanced training in neurosurgery. Since I watched my first spinal surgical operation 37 years ago at the age of 15 years I had wanted to be a spine surgeon and was fortunate to find a position, which included training at the then world-famous spinal unit of the Royal North Shore Hospital under the renowned Dr John Grant, who had founded the unit in 1957. Subsequently, and following a 12-month neuro-trauma fellowship in Toronto, Canada, at Sunnybrook Medical Centre, one of the busiest blunt trauma and spinal injury units in North America, I return to Australia in 1987 where I took over from Dr Grant on his retirement.

For a number of years while I shared the on-called roster with Professor Taylor and Dr John Yeo I was on surgical call for two out of every three weeks 24 hours a day, seven days a week. I have now cared for over 10,000 patients and for approximately the last 10 years I have practised exclusively in the field of spinal neurosurgery. I have recently been appointed Associate Professor and Director of Spinal Surgery at the newly established Macquarie University School of Advanced Medicine. Sadly, I have witnessed a gradual decay of a once world-class hospital. Over the last 20 years it has become increasingly difficult for me to admit patients to the hospital or to operate on patients who had been admitted.

The morale of the medical and nursing staff with whom I work has got worse and worse. The stress under which these dedicated staff operate has driven many to leave. As a result of my own frustration and concerns over my inability to adequately and safely care for my patients I resigned in 2001 and went solely into private practice. I was truly sad to do this, but I had trained a young spinal surgeon, associate professor Lali Sekhon. He took over my workload at the hospital. In 2005 I think he had finally had enough: he resigned and went overseas. My understanding from him was that the situation at Royal North Shore had further deteriorated since I had left.

My friends, the head of the Division of Surgery, Dr John Vandervord, and the previous director of the spinal unit, associate professor John Yeo, urged me to return as they feared the spinal unit would otherwise fold. I had felt guilty ever since leaving the hospital believing I had a duty to teach young surgeons and to care for those who genuinely cannot afford private medicine. I had admired my colleagues who had continued to work at the hospital and so, in spite of the advice I was receiving from many colleagues that I would be mad to return, I did.

Ladies and gentlemen, Royal North Shore is a sad reflection of the once great hospital I first knew. It is gridlocked with patients cared for by overstressed staff who function in an adversarial environment with their colleagues, both nursing and medical, as they try to find beds and push patients around the hospital. I find myself frequently sitting around on a Friday morning, my day to operate at Royal North Shore, waiting till 9 o'clock, 10 o'clock or 11 o'clock in the morning for an intensive care unit bed to be found so that we can start operating. Often the cases are cancelled.

When issues about Royal North Shore appeared in the media I finally felt that I may have an avenue to ventilate my concerns. These were issues that I had raised with various people in management over time, but it was clear that there was a limit to the way that they could respond. A case discussed in the media recently is one of many and indicative of my concerns. The time I sit around waiting for intensive care unit beds is wasteful of precious resources and cruel to already anxious patients. I was once proud of Royal North Shore Hospital, and I am still proud to serve with the staff of Royal North Shore. I have the greatest respect and admiration for their resilience and their dedication. I do hope that you can help them and me to help our patients.

CHAIR: Dr Raper?

Dr RAPER: Mr Chairman, ladies and gentlemen, it is nice to see you all again after the recent tour when I think I met most of you. Thank you for the opportunity to speak to you. I had a pre-prepared statement, but I wrote that a few days ago and things have changed since then. I am really pretty angry about the situation that we are encountering for many reasons that I will try to let you know. I thought probably the best way of starting was to read to you an excerpt from a letter I received yesterday as the Director of the Intensive Care Unit:

> Although dad died in your hospital after a lengthy operation and even longer intensive care all the members of the family were impressed by the high level of medical and pastoral care which your department afforded him and us. While our loss was devastating, we were so impressed with your care and compassion that when the recent news items broke about the hospital I felt compelled to write to you and express our thanks in this form. However, it was also very clear to us that in physical terms your hospital is extremely compromised.
>
> The wonder to our family was that given your working conditions and coupled with the intense nature of your roles and service that any of you had the morale to come to work day after day. We all observed the dilapidated and untidy state of your surroundings, the makeshift waiting areas, the corridors used as storage areas and the poorly maintained common areas—our lasting memories of great kindness and amazing medical skills even when dad didn't live to have the benefits of that against a background of near third world squalor. Our only complaint was that when dad was moved upstairs to floor 9 the physical situation was even worse.

I do not think you could say it any more eloquently than that. My colleagues have been telling me for a long time that they are embarrassed at the condition of the hospital, the physical state of the hospital and the intensive care unit. I have been telling them they are exaggerating. Well, I am wrong. I am embarrassed. I am embarrassed to receive that letter. I need to make a few points on behalf of my colleagues. Many of them have been very forthcoming with things that I need to bring to this Committee's attention and I will try to relay some of those points and try not to use the sort of colourful language with which these issues were expressed to me.

The physical state of the unit and the hospital in general, is it new? No, it is not new. I have been to many, many committees and I have sat on many tables and banged the table with Stephen

Christley and we have been to the director general. I was reminded during the week—although it was rumour, I think it was fairly well confirmed—that when Andrew Refshauge was the Minister for Health, and how long ago was that, he refused to be filmed or photographed at North Shore because it looked so bad. Just yesterday my nurse unit manager was saying, "Yes, it is a bit rough and whenever someone rings up for a job we have to tell them, look, don't worry about the physical condition when you come to see us. It's a really good place to work, but don't look too closely at the physical facilities that you have to work with."

We have heard something about North Shore's resources. Let me tell you that two or three or four years ago we took all of Westmead's discarded ventilators to prop up our ageing fleet because this is a ventilator that is no longer supported by the manufacturer. In fact, it is the model after the one that Wollongong discarded as being obsolete about five or six or seven years ago. On Wednesday, and this is part of the reason why I guess I have become so upset, I was at a series of conferences at Prince Alfred Hospital. Amidst the opulence of Prince Alfred the squalor of North Shore is even more apparent. But also, there were some fantastic presentations from my colleagues at Westmead and Prince Alfred that day. It made me realise how much we have lost the lead in so many areas that the North Shore intensive care used to hold.

One of the areas where we have lost the lead is in organ donation. We used to be certainly the leading donor hospital and we also led a lot of the philosophical and thoughtful thinking about the way organ donation should proceed. We have not had an organ donation coordinator now I think for 18 months or thereabouts. Two reasons for that. One is money. There is not any. We have to find $40,000 or $50,000 to employ such a person in the area, and that is money that is nearly impossible to get. The second thing is that I did not want to lose another nurse from the floor because we have been so busy and running at such a high level of occupancy that to take a critical care nurse off the floor I thought would be bad.

One of the hardest jobs that we do in intensive care from day to day is try to manage—you have heard from Professor Sears—the demand compared to the resources we have. We spend hours in the mornings trying to sort out: trying to get people in and get people out and work out what we can take and what we cannot take. One of the most demoralising things for us is to have to turn down a patient who should be coming to intensive care while we are keeping patients in the unit that are ready to be discharged to the ward. We now have a reasonable prospective data collection system that we put in place ourselves and for this year and a little bit longer 25 per cent of patients discharged from the unit have their discharge delayed more than 24 hours. That is a waste of that bed usage in the intensive care unit. Why is that? Because the wards are full. If that does not mean we need more beds, I do not know what does. If the figures that are in Peter Roberts' submission to this inquiry are anything like true, then this is a public planning disgrace in terms of the number of beds that are available to us in the North Shore.

We are constantly told that we are all wall very expensive. Well, I cannot see how. We have the oldest equipment that we marshal very carefully. I am not really complaining so much about the ventilators because they are still good ventilators and we are managing very well with them, but to buy anything new is nearly impossible. Visitors or doctors who come to work with us from other hospitals cannot believe how extraordinarily parsimonious we are with medications and with the way we manage our equipment and so on in. The data—whenever data gets fronted out to us and it is said, "Here, you are expensive", as soon as you scratch the surface, the data is rubbish. It is unreliable. I have sat with the accountants trying to go through our costs and I cannot make any sense of it and they cannot make me make any sense of it, so I do not have any faith in any of the data at all. There are lots of examples where we have been compared with unreasonable comparators as well.

As a manager, I have taken over the unit over the last three or four years from Professor Fisher, and I feel I have dropped the ball in the way that we have stopped being one of the leading intensive care units around, but the thing that is most frustrating to me are the bureaucratic administrative processes. Getting anything done is just about impossible. Someone said to me the other day about administrative support and I thought, "Now, there's an oxymoron if ever there was one. It is administrative impediment." All the people in the system are great. Wherever you scratch the surface and find someone, they say, "Oh yeah, I can do that.", "I can fix that.", "I want to help that.", but it does not change anything. The system is inept. The people are great, but the system is terrible.

I finish by saying that in spite of this I want to say that I am very proud to be associated with North Shore and have been for 30 years and with the intensive care unit where I have been a specialist after 21 years. I have the privilege of working with a fantastic group of men and women who work very hard to provide critical care services to the people of this State. At our recent annual ball, several of the nurses went out of their way to let me know how proud they also felt to be associated with the Royal North Shore intensive care unit. This is a world-class unit with world-class outcomes based on objective data. We have an international reputation for clinical excellence and for high-quality training and research and we attract doctors who wish to train in intensive care from all over the world. Among our current senior trainees are doctors from the United Kingdom, from Ireland, from Sweden, from Denmark and from Switzerland.

Royal North Shore, I think, has been very badly let down by the department and by a series of administrations. The wonderful people who work at the hospital and the patients it serves deserve better than this. I hope that Royal North Shore can be restored to its rightful and needful place in the New South Wales health delivery system and can again enjoy the confidence of the public for whom it exists. Thank you very much.

Professor FISHER: Mr Chairman, have you received my written submission? I have not received an acknowledgement of that. I did send it in within the appropriate time. I will try not to dwell on that. It just came to me today: I remember some years ago, when they announced the new hospital development, saying to Alan Jones that we know in this place that we produce outcomes that are better than many places in the world. Imagine what we can do if we have a decent plan from which to work. We have been waiting a long time.

North Shore has been my professional life for 32 years. I have worked with some of the best doctors and best nurses I have ever met and, without question, the best allied health people I have ever met in our unit. I have had children there, I have had operations there, and my family have had operations there. I have always had confidence in this hospital. I am going to have my first grandchild there in February—and thanks be to God, my first grandchild will be born in the clean part.

For 20 years I was in charge of intensive care. I received eight written complaints: four of them were about me. I gather the incidence and the ratio have been the same under the new director. But the one thing I did learn about complaints is that there are two sides. When we go in for the hospital bashing in the papers, we cannot get the other side across and that is when our nurses are bullied, harassed, and spat at on stations, and I find this offensive. They do not deserve it. May I present a little bit of the other side:

> To all at the intensive care unit:
>
> Without your Help,
> without your Care,
> Your support & love
> my dear friends –
> I would never have made it.
>
> THANK YOU FOR
> BRINGING ME BACK
> I LOVE YOU ALL
> MILOS

I took these off the wall yesterday:

> To All the Staff
> In ICU
>
> Thank you for looking
> after my brother, …
> and my whole family.
>
> I can't find the words
> to express my gratitude.
>
> I am comforted to know
> that he was given
> dignity and comfort

in his final moments …

A letter that the *Sydney Morning Herald* refused to publish, dated 11 October:

I was released from the Intensive Care Unit at the Royal North Shore Hospital this weekend after two weeks. I had been taken to Royal North Shore with life threatening injuries resulting from a car accident.

Including avulsing one of the main vessels from his heart—

To awake from a coma after a week and a half and to read the criticisms expressed about the hospital in your newspaper were therefore of … interest to me.

The coordinated team approach from the helicopter and paramedics to the senior surgeons, operating staff, nurses, administrators [even] and support staff that I experienced was a different place. Not only did they save my life, but throughout I was treated with sensitivity and support by all members of the team … it was this sense of kindness and dedication … as well as their technical prowess, which makes the difference between life and death.

Dear Mrs Fisher—

I cannot do that one, I am sorry. Do you want to have a go?

Dr RAPER: Yes, give it to me:

Dear Mrs Fisher

No-one at the Royal North Shore Intensive Care Unit knew what a great kid our son was. He was so proud when he bought his first car and set off. To a mother it gave the same sinking—

I am not sure I can do this either—

feeling as when he first rode his tricycle out the gate. Our fears were realised, we were summoned to the Royal North Shore and met your husband who told us our son was almost certainly going to die. For the next seventy-four hours he tried to stop him dying.

Every hour or two he came and told us how he was going. He didn't need to speak after a while. We could tell from the way he walked, and when he was winning and when he was losing. We lost.

We send you these flowers to thank you for lending us your husband last weekend. We are sorry he wasn't home.

Professor FISHER: Sometimes it is a bit hard to get upset about cockroaches, Mr Chairman. We are told we are inefficient—wow! We run a hospital that is over 30 years old. We run it with a constant turnover of administrators and managers who could fix those problems. We run it at 96 per cent occupancy. We fear that they will blame it on efficiency and ignore some of the other things that go with it. We do not know what Deborah Latta said this morning but we do know why she left. I think that maybe in my submission I have said it is not just five general managers, it is directors of finance, and it is executives right across the board who go. They are going because they are put in a situation where they are told the bottom line, the budget, is their major responsibility and they have people like us banging on the door saying, "Our equipment is broken. Our wards are dirty. We need resources." I believe many of these people go because they have been put in a situation for years where they are in a no-win situation and can only fail. Without resources, they cannot solve the problems.

Can we be more efficient? Of course we can be more efficient. When you cannot do something better, it is time to move on. We are told we are expensive. Richard Matthews said on Monday we are $400 per procedure greater than Liverpool and Prince Alfred. Last year in meetings we ran with the administration to try to resolve problems. We begged them to tell us where we are expensive so we can solve those problems. The first thing we were told was that there is only benchmarking in Prince of Wales because of the various accounting systems, and then we receive various information about expensive areas.

The first was endoscopy: "This is what it cost, and that is what it cost for the 1,500 patients we did endoscopy on. You are way outside the benchmark." "Just a moment.", said the director, "We did 3,000 patients." The hospital did not appear to have information about them. In haematology, for example, and marrow transplants, the other hospitals that are involved in that, St Vincent's and Westmead, receive special funding, possibly from statewide services, but we do that within budget.

We are the only place that could to neuroradiology. We had a deficit of $1.5 million a year. The accounting systems are so bad within the Department of Health and our place that the only reliable system is the one we built ourselves.

I do not believe someone can justify saying we are expensive with data. We may be; tell us where we are, and we will try our very best to fix it. If we are expensive, there may be some reasons. There may be things like haematology funded within budget. It may be things like the drain on us from neuroradiology. It may be that we take more emergencies and more out-of-area critically ill complex patients than any other place. It may also be that we do not, as other hospitals do, coerce public patients into becoming private patients so that they become revenue and so their prostheses and pacemakers are paid for by private health funds.

There are a number of very good reasons for that. When we are given finance information to clinicians finance information and numbers are not enough, particularly in huge profusion. We want them related to outcomes. We have information on outcomes and in most of the places we can look at this we are very proud of them. Are we sufficiently well funded? I would like to table the document entitled, "Capital spending per capita in area health services between 1989-90 to 2000-01". This was worked out by a person in our administration, who is no longer with us, to look at capital spending comparisons. Between those times the spending per capita in the Northern Sydney Area Health Service was $93. The average across the State was $919. The second worst was the Central Coast Area Health Service, which is now in our network, with $644. Do not tell me we get enough.

If you look at Peter Roberts' submission you will see that we have 1.7 beds per thousand, which I believe is lower than anywhere else in Australia. This has complications for us. As for our operating theatres—we are a big surgical hospital and we have a lot of absolutely outstanding young surgeons who provide statewide services—50 per cent of the time we run the same number of operating theatres as Dubbo hospital, with 90 beds. One of our senior surgeons has operated on Saturday morning for the last 41 weeks to clear the backlog of patients that came in on Thursday night. He has been complained about to the HCCC for delaying surgery. This is not his fault; he would like to do it now. Delaying surgery involves a complex set of events: we have got to get the patient in, we have got to get them into theatre and we have got to get them to ICU. Those blocks occur. Access block is killing our hospital and so is exit block. If we cannot get the patients out of intensive care we cannot take the patients in. We tend to take patients in intensive care as a priority if they are not safe. The elective surgical patients are safe in the wards.

One of our outstanding young surgeons is a pancreatic surgeon. He gets one operating list a month and he does his elective cases, which are very serious and complex and often come from out of the area, anywhere he can fit them in—Sunday afternoon, Saturday night; anywhere he can get a place. I think the thing that concerns us most about the future is the new hospital development. We learned for the first time on Monday how many beds will be in that hospital development—this includes clinicians who have been involved in this process for years. I have not been on the committee that dealt with this but earlier this year I became engaged when the clinicians wanted to go to the press to say that public money was being wasted because the planning of the hospital was inappropriate. Six hundred and twenty-six beds—Dr Matthews says we have 599 now. Fourteen of those beds are intensive care beds. They are telling us that we are going to get a new hospital in five years—which is probably a generous estimate—and we are going to have, what, 13 more acute beds to put patients in. If it is anything like the building we have got now—although they say there will be room for expansion—in the absence of capital works and support, that might be what this State and our area get for the next 30-odd years.

If you drive down the Pacific Highway and look at the Meritonisation of the railway corridor and the Pacific Highway, you read the State Plan, which says we want to increase the population of Ku-ring-gai by 33 per cent and the population of Hornsby by a similar amount, and you look at these concrete bunkers—which give a new definition to the word "Sartorial"—you will see why we are fearful of the increase in population and the load that it will put on when we increase from 7 per cent to 10 per cent. We are getting two more theatres. We have not got enough theatres now. But there will be room for expansion—yeah. The findings of this Committee—and, more importantly, the response of the health department and the Government to those findings—are crucial to the future of our hospital, particularly our young surgeons, who are likely to leave in frustration. Certainly the result of those findings will determine the future of many people like me. They will decide whether we give it

one go or we walk. To me, a drink with an umbrella in it is looking particularly appealing at this moment in time. Thank you for listening to me.

CHAIR: Thank you, Professor Fisher.

Mrs JILLIAN SKINNER: First, I say to all you doctors that I think you are all fabulous—and so are the clinicians at the hospital, doctors, nurses and allied health professionals. Every single person who has given evidence here today has said, "It is the clinicians who are holding Royal North Shore Hospital together." I am sure I speak for all members of this Committee when I say that we acknowledge that. The work you are doing is absolutely phenomenal. The reason for this inquiry is to give you an opportunity to address and highlight some of the concerns that prevent you from having the environment to do the work you would like to do. There seem to be common threads about access, lack of acute care beds in the hospital, a lack of management structure involving clinicians, and poor IT.

One of the things that has emerged from the discussion with you this morning is the focus on the ICU and the fact that there is an intensive care unit block that is just as serious as that which is affecting the emergency department. I am particularly concerned about the delays in getting patients in for operations for what may well be life-threatening conditions because you cannot get an intensive care bed. Professor Fisher, you make the comment in your submission that patients are discharged from the ICU, particularly after six o'clock. You say there is a well-recognised risk factor leading to increased morbidity, mortality and so on. Can you tell me what we need to do in order to stop this problem with ICU? Is it about opening more ICU beds or does the whole hospital need increased capacity?

Professor FISHER: There are two issues: the State issue, which is my hat; and the North Shore issue, which is Dr Raper's. I would prefer to address the State issue. There is absolutely no question that we have been since 1998 as a specialty in intensive care very well resourced and supported in terms of extra beds. We have a very good working relationship with the health department in terms of allocating those beds. There is a problem that some of the units in which we would like to put more beds are now geographically full. There is nowhere to put them, and we may have to convert high-dependency beds. When I had some say over where the beds went I was resourcing Hornsby to try to keep patients away from us—or advocating the resourcing of Hornsby. We had more neurosurgical beds. So I think the statewide plan is effective and there is data that we have had major improvements in no bed transfers from other hospitals and various other parameters. But it is still an issue and a lot of our time is spent finding beds. In terms of North Shore, I defer to my lord and master on my right.

Dr RAPER: There is not any point in opening up more intensive care beds if they are going to be used as glorified ward beds, because that is extraordinarily expensive. Nursing ratios and so on in intensive care are much higher than in the ward. If our exit block for more than 24 hours goes from 25 per cent, as it is at the moment, to 50 per cent, then all we have done is add cost. So it is better off to put the beds in the wards, where they are really needed. We have had some expansion of our high-dependency capacity, which for us means intensive care—it is just a question of how many beds we end up opening. We are struggling to get the nurses to open them all, but we are getting there. All of this adverse publicity and the general view of North Shore in the public at the moment is making it very hard for us to recruit. But it has also resulted in a drop-off in demand in the last several weeks. We think that is because of all the adverse publicity. So that has been the balancer to that problem.

Mrs JILLIAN SKINNER: Dr Raper, when I visited the hospital a number of years ago you showed me around the intensive care unit. It has always stuck in my mind that you said to me, "You need to speak to the most important person here", and that was the nurse unit manager. No nurse unit managers have appeared before the Committee and none have made submissions to the Committee. I have heard rumours—and people have approached me to say this—that they are too scared; there is bullying and harassment going on and they do not want to come forward. Would that surprise you?

Dr RAPER: It would. The nurse unit managers that I work with currently are a fantastic group of people. We have just got three or four out of the box. They are wonderful human beings. I must say that all the things I have been talking about have been discussed with them. I consider

myself as being their representative. I do not recognise the bullying and harassment. I do not understand it; I do not recognise it; I do not see it. It is not part of the unit that I work in.

Mrs JILLIAN SKINNER: Professor Fisher, your concerns about the new hospital have been expressed by Professor Pollock and the others who have come here. I find it extraordinary that you had to find out from *Hansard* that there are only going to be some 626 beds in the new hospital. Do you think that there is a real risk of doing a terrible disservice to the future population unless that can be reviewed with the clinical involvement that you would want?

Professor FISHER: First of all, I should say I have not been involved in the regular meeting in development and planning. I only became involved when my colleagues said, "No one is listening to us, we need to go public", and I suggested an alternative strategy which actually worked and a lot of things were changed, although it did lead to me having to talk to probity lawyers and people like that I did not know existed and having to sign secrecy documents and various other things. I do think that things have changed.

Also it is fair to say that the new Director General of Health, Debora Picone, has been involved in the building of hospitals and I have had some conversations with her since I got back from overseas, which encourage me to think that someone who knows something about it is listening and there may be changes. However, we have heard it before. It is like our new chief executive officer. We have heard it all, but without resources and without support he is unlikely to pull people who have beaten themselves against the wall for many years with him.

Mrs JILLIAN SKINNER: Professor Sears, in relation to your account of the delay in getting your patients into the operating theatre because of the lack of an intensive care unit bed, can you explain what impact that has on the patients and also on the doctors and nurses charged with looking after them?

Professor SEARS: Well, it is obviously immensely frustrating to the staff. It is very wasteful of valuable resources to see these people sitting around in a tearoom drinking cups of Lipton tea instead of being in the operating room.

Professor FISHER: You have tea!

Professor SEARS: Yellow label. The saddest part is patients being repeatedly delayed or even cancelled and I can think of one example in particular where a chap has been in hospital, he has been cancelled twice, and he is having serious problems just earning a living now because he has resigned his job to come and have a major spinal operation. We have patients who come down and they are on, then they are off, then they are on, then they are off. I understand why. It is because my colleagues here and the nursing staff one or two floors higher are trying to clear a bed for the patient, because you cannot start an operation unless you have a safe place for them to go afterwards, but they cannot get the patients out into the ward and we are supposed to start at 8 o'clock in the morning. I can think of times when I have sat in the tearoom for three hours. There was a day recently where I went to my office and worked until 2 p.m., until I got the call to come down to the hospital. I can think of one day where I was rung up, "Do you mind cancelling your whole list because there just are not any beds", so I took the day off. It is just so wasteful of a resource.

Mr MICHAEL DALEY: You can take it from everybody around this table that we all appreciate your care and expertise. This morning and on other days that we have had public hearings we have heard that the number of beds in the hospital system is an issue. What has been made clear is that there is a chronic workforce shortage. Can you suggest any creative ways we can address the problem? It is no use putting an unlimited amount of beds in the system if we do not have doctors and nurses to staff them.

Professor FISHER: We have no trouble getting doctors. As Dr Raper said, we train people from all over the world. With nurses we enjoy very much better things, very much better staff ratios, in intensive care unit than other places, and there are two things apart from making sure that there are meetings with the nurses where problems can be discussed, our quality thing, for example, is run by the nurses, involving them in the process particularly with end of life care, letting them talk to families and taking them to family meetings.

There are two things I would put to you, which will probably horrify you, but for many years any nurse at Royal North Shore Hospital in the intensive care unit who wished to undertake some form of post-graduate training—we funded that. We found that nurses living on the North Shore, still paying back their HECS, who had reached the time in life where if something did not happen to allow them to expand or develop they would move out, wanted to do post-graduate training but could not afford it, and we have paid for that for I think 62 nurses over the last period. When we have to attract staff we are not allowed to put that in the ads because they have to be in a strict format and that would make us a little bit competitive.

The second thing we have is a budget for nurses to attend post-graduate conferences. Nurses, if they want any sort of leave, have to fight for it. I should add that Craig Knowles did put aside some recurring money for post-graduate nursing in intensive care and we fund the difference between what they get from the department, but certainly treating them like professionals who enjoy some of the things that we enjoy, the ability to attend conferences, the ability to expand—if one of our nurses presents a paper at a conference anywhere in the world we will fund that travel for her. Other people do not do this. In fact when we started doing this people complained to the health department that we were getting unfair advantages, but certainly encouraging nurses to do post-graduate training and supporting them financially I think would be a very encouraging thing to attract nurses in this State.

Dr RAPER: Could I point out that that is not out of the ICU budget; it is separate funding.

Ms CARMEL TEBBUTT: Could I ask a question of Professor Fisher, although others may also want to comment, which is about networking of services. We have heard quite a bit from various witnesses this morning about the importance of networking of services. Can you tell us a bit about what is happening with the networking of critical services, how this is working, and perhaps what needs to change to make it work more effectively?

Professor FISHER: The first thing that we have done in our area, which I do not believe anyone else has done, is in places we identify where patients are in harm's way when we are there, like Ryde and Mona Vale, or patients who have genuine tertiary problems in our immediate area, we have stopped people having to go through the rituals of lots of phone calls and things. We say all we want to know is that the patient is on the way. That unfortunately puts a further load on our emergency department where they will often have to go first for various tests, but that is one of our internal local networks.

We have responsibilities that our area network meets. It is very frustrating because the three things that have been our targets are, firstly, to sort out the peninsula and have one intensive care unit there, which we have not been allowed to do for political reasons; secondly, make the unit at Ryde safe or close it, and that has had political problems too—I think there were seven reports on the high dependency-intensive care unit at Ryde; and, thirdly, try to get some sort of decent information system so that we can look at what we do and get access to IMS data, to the data collected on infection, so we can benchmark against each other and look more critically at what we do. As to all of these well-funded places on other levels that have this information, we have to prise it out of them with a crowbar, and usually we do not get it. So that is really the function of our network.

Then we have our default responsibilities to the Queensland border and to other hospitals within and out of the area. We take more patients from out-of-area than anyone else. We also have a network out-of-area, but most of those are patients going home. That is a problem for us. One of the wonderful things about the North Shore hospital of which I am particularly proud is that there is a culture of consultants in there at night, looking after people, and we find that patients from other places are often talking to the resident, the boss or the surgeon, and they may live 30 miles away. You sometimes have to take those patients just because you have not got a clue what is going on. Sometimes even the English at the other end of the phone is not very good.

We had a patient sent to us recently for the wrong reasons from the north coast who did not really need intensive care, but we could not get the patient back, and when we inquired they said the nurses did not like him. This man was going to die and his wife was in Coffs Harbour, and we were unable to get her down to be with him. There are lots of funny things. John Hunter is a trauma unit like us. A few weeks ago a patient was sent down; it was a critically ill patient, a risky transport,

because they had no plastic surgeons to debride the patient's wounds. So the network is a bit of a two-edged sword as far as I am concerned in terms of the area and the State.

Dr ANDREW McDONALD: There was an interesting comment about doctors coming in in the evening and that has been probably North Shore's greatest contribution to the rest of New South Wales, the culture of the senior staff on site. I acknowledge that it was a major influence in my own practice. This is for Dr Raper. I understand that North Shore accepts intensive care patients from outside the area and even outside the State. How do you balance the needs of the local people with the people from outside the area?

Dr RAPER: A lot of the patients we take from out of the area fit into the categories of spinal or trauma spinal injuries and burns, so that is part of the statewide services. We rarely take people from out of State unless there is a particular reason. Recently we accepted a patient from Darwin who had a spinal cord injury sustained in a truck accident in Katherine because his wife lived in Sydney and the alternate was for him to go to Adelaide. So there are things like that that are obviously important that we do. How do we balance that? With great difficulty but the resources do not belong to me, they do not belong to only the people who live on the North Shore. It is a State resource. It belongs to the people of this State. We cannot leave someone who is desperately ill out there in the community somewhere without proper attention while we are continuing to do surgery which can be put off for a day or so. We do not like doing that. We would much rather we could do both but we have to balance the priorities.

CHAIR: Just to clarify one point that has been raised—and you raised it here today—about an operation being prepared and then being stopped. There was a statement as if this has been just a bureaucratic decision or a decision by a clerk to stop the operation, but you have been making it clear that it is a decision on the lack of beds, where to put the patient after they have had the operation; there is nowhere for them to go. Is it a combination of both?

Professor SEARS: I am sure it is a combination of both. The frustration I face almost every Friday is the bed block of getting a patient who requires a major spinal operation, requiring intensive care and trying to get them into a chronically full intensive care unit. I operate on Friday. It is the end of the week. I guess it is bad every day but for me that is a real problem. The clerk issue, I cannot really speak to that.

CHAIR: So it is not really just a bureaucratic decision; it is a decision forced on you by the lack of beds in the intensive care unit.

Professor SEARS: Correct. Can I just say something about the issue of networking and bed availability? One of the major concerns I have in my capacity of looking after people throughout New South Wales with spinal cord injuries is not just the need to care for the acutely injured patient. Once you have cared for such a patient their physiology is different. Going forward, I hear from time to time of serious problems occurring when established paraplegics or tetraplegics in the community suffer complications of their paralysis and cannot get back into Royal North Shore. I heard from my colleague John Yeo just the other day of one patient who he was asked by the Coroner to comment on—a patient who was not given appropriate care not because the person looking after him was sort of your worse than average doctor. It is just that not working at a spinal unit they do not understand a patient's physiology. For me it is vital that there is some funding to establish beds that are available for the chronically injured to come back in when they suffer serious and life-threatening complications.

Professor FISHER: Another reason we may look expensive is that burns and spinal injuries are funded from statewide services but only for the first admission. So when they come back for further grafting or problems or other things like that, that cuts into our annual budget.

CHAIR: Thank you. It has been important for us to hear from the three of you, and we appreciate greatly, as we saw you on our visit, what you are achieving in the hospital in difficult circumstances with old equipment in a rundown hospital. We hope that from our inquiry we can get Royal North Shore Hospital back into the top 10 per cent in Australia.

The Hon. AMANDA FAZIO: When we did our site visit one thing I saw in the intensive care unit was a noticeboard full of thank you letters and cards that patients had sent in. While only a

few submissions have come in from people who have had what they described as excellent treatment at Royal North Shore Hospital, we should not lose sight of the fact that these inquiries inevitably and unfortunately only focus on adverse events in the hospital and that the majority of people who are treated at Royal North Shore receive excellent care.

Professor FISHER: We would like the public to know that for every one of those complaints I can bring you a suitcase full of those letters you saw on the noticeboard.

(The witnesses withdrew)

ROSS McLAREN WILSON, Direction, Northern Centre for Healthcare Improvement, affirmed and examined:

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

Dr WILSON: I am the Director of the Northern Centre for Healthcare Improvement, and one of its activities is a program called QARNS, which surveys the quality of care at Royal North Shore.

CHAIR: Do you wish to make an opening statement?

Dr WILSON: Thank you for the opportunity to address this very important inquiry from the point of view of Royal North Shore Hospital. I shall briefly cover a few points. I started in 1973 as an intern at Royal North Shore so I am, as far as my children are concerned, in the dinosaur group and have probably been around too long. I was clinical superintendent in 1978 and 1979 at Royal North Shore when there were 900 and something beds. There are currently—I do not want to get into the argument about how many beds because there seems to be a lot of discussion about it. There are just not enough beds but there are currently many more fewer than 900 plus beds.

I have been on the consultant staff of Royal North Shore since 1981, after I spent a few years working in the United States. With my colleagues Professor Fisher and Dr Raper, I was a senior specialist in the intensive care unit for many years. I also was involved in improving the quality of health care, and we started a program called QARNS, which I will touch on in a moment. Part of those activities led us to learn to measure and report on adverse events not just in Royal North Shore and not just in New South Wales but nationally. In 1995 we published a landmark paper called the "Quality of Australian Health Care Study", which was the study that put patients' safety on the map in Australia. It led to the formation eventually of the Australian Council for Quality and Safety in Health Care, and my colleagues Bruce Barrowclough and Cliff Hughes spoke with the Committee earlier this week.

Because of the ability to get anything done federally, New South Wales set up a ministerial advisory committee prior to that time, in 1997, and I chaired that Ministerial Advisory Committee for Quality and Health Care in New South Wales from 1997 until 2002-03. I stopped practising clinical medicine two years ago and have been fully occupied in improving the quality of health care not only at Royal North Shore but nationally and internationally, and I am part of the expert advisory group for the World Health Organisation on the World Alliance for Patient Safety. We work in a number of places; we are currently the World Health Organisation research centre for patient safety. Interestingly, we are researching patient safety in developing and transitional countries such as Yemen, Egypt, Morocco, Tunisia and Kenya. In my experience, sometimes there is not a big gap when I come back to the Royal North Shore Hospital having been to Yemen. I do no say that in any disparaging manner, there just is not a big difference in how health care is delivered.

I would like to touch on QARNS, which has been mentioned earlier in the inquiry. Some people would remember in the 1980s there was a legal inquiry into the Chelmsford events, around deep-sleep therapy and unexpected and unannounced mortality associated with that care. The public record is very clear about the outcomes of that. At that time the Department of Health was looking to find out other ways to prevent, if there were something like a Chelmsford, how would we know about it, how would we find out about it? We were the recipients of seed funding in 1988-89 to look at whether some of the newer American programs would be applicable in Australia. We did a pilot study for one year, funded by the Department of Health looking at all of the discharges from Royal North Shore Hospital through the examination of their medical records.

That was a very expensive undertaking, and turned out to be unsustainable because of cost and time. From that our program grew. Since 1989 that program has reviewed every patient who has died at Royal North Shore, every patient who has had an unplanned transfer or return to the operating room, every patient who has had an unplanned transfer to the intensive care unit, major obstetric and other events. We are probably the only hospital in New South Wales, probably one of the few in Australia, that can say that there has been a careful and systematic examination in an objective and structured way of all of those events. So we can be quite clear that there is not a Bundaberg or a Chelmsford, or some other event going on. I have been able to reassure our management about that.

The second part of the QARNS process that is important is that it is actually owned by the clinical staff. It works, because it works directly with the clinicians who are providing the care, through the mechanism of peer review. The medical record is examined objectively, the clinicians meet and have a peer review discussion and they decide what needs to be done. If it is within their purview, within their department, to fix it they do—promptly. If it is a bigger problem that they cannot fix within their department, that is more difficult and I will touch on that later. They do not get fixed with quite the same speed.

The peak committee is the Clinical Review Committee, which reviews every major adverse event in the hospital. It meets weekly and it has broad membership across management, senior clinician leaders and includes nursing managers, ward nurses, junior doctors and the consumer. We are the only committee in New South Wales that routinely examines adverse events where there is consumer involvement. We have been greatly assisted by that—the multidisciplinary nature of the committee—and it has been quite a challenge. That committee also integrates the outcome of all the root cause analyses that occur. The IIMS reporting system also functions as a trigger for cases to go into this system.

The system has been in place, continuously improved, for 17 or 18 years. As the Department of Health has rolled out new initiatives, such as the incident monitoring system, et cetera, we have integrated them and collated them. But we have not been prepared to dismantle what we had that was working very well and working better than those systems can provide. An example of our summary position is that when we published the national figures about adverse event rates in Australia in 1995, our figure was 16.6 per cent, which meant that 16 per cent of patients admitted to hospital suffered some sort of adverse event. Half of those were preventable. That is an awful lot of patients having adverse events.

Now we know that if we get the measurement systems right, across the world that rate is between 10 and 20 per cent. In fact, we have results from 12 countries, using similar methodology, that tell us that Australian health care is no better and no worse that most others. It certainly is not the best in the world in terms of patient safety at a national level. At the same time as the national figures were 16.6 per cent, I can share with you information that says that the Royal North Shore Hospital adverse event rate was half of that, only 8 per cent. We have continued to monitor that every two to three years, and at the last measurement, nearly 24 months old, the adverse event rate is still just on 9 per cent. Over that 10 or 12 years, patients are now older and sicker and more complicated and more likely to have adverse events.

Our summary position is that although every adverse event is intensely regrettable, the preventable ones, that we should prevent, and the unpreventable ones, that we should at least alleviate, the rate of adverse events at Royal North Shore is lower than anywhere that we know. More importantly, we know what it is. We do not have those figures from other centres, they are not available. An example of an adverse event rate of 9 per cent for a hospital like North Shore, which has 50,000 admissions a year, means that about 1,800 patients have an adverse event in a year. That is about 35 patients a week. It means that about two patients a week will suffer permanent disability or even death as a result of an adverse event.

If all those were picked up by IIMS or other reporting systems, we would expect to have potentially 50 events as so-called SAC1 events, a year, having to have 50 root cause analyses. That is from a hospital that has a very good performance in this area. My point is two-fold: first, the QARNS process is far more sensitive and finds many more things that need to be fixed; and, secondly, we are trying to integrate it with the newer systems, but they are not as good at picking up these sorts of major clinical events. If you look at them, they pick up different things. In the United Kingdom, the National Patient Safety Agency has just undergone a thorough review.

In fact the parliamentary inquiry, not dissimilar from this, during which the chief executive was dismissed because its reporting system, like IIMS, on a national basis in England seemed not to be working to improve the quality of health care in the United Kingdom. Despite the fact that they had one million reports in their system, there did not seem to be one million improvement activities that following in terms of manage response. The things that were being reported were falls and medication errors, not some of the many other things that effect patients.

In summary, from my point of view, I make the point that the clinicians at Royal North Shore do a fantastic job. As someone who is one of them, and being one of them, and someone who has also been involved in assessing their care broadly, the clinical results are outstanding. We have very good measurement to support that. My second point is that the clinicians work in a seriously substandard environment. The infrastructure is inadequate, it is not just the building, which is inadequate, but even the colour schemes are inadequate, but the maintenance of the building is more worrying. The capacity to have adequate infrastructure for computer networks, for sterilisation, for fire alarm systems, for signage is very hard in that building. When there is not much money maintenance of infrastructure is one of the first things to go. Maintenance and capital are the areas where money is not spent when budgets are tight.

Thirdly, in terms of the capacity or environment in which the clinicians work, the management has failed them. The management has failed in terms of helping them to live a good clinical care. It is almost as if we have had, up until the last year or so, two parallel systems. I acknowledge that there are improvements going on at the present time and I am optimistic for them to be successful. My comments reflect the last 20-plus years. When I look at the Health Services Act and at the functions of area health services I find that the first one is generally to promote, protect and maintain the health of the residents of the area. That is the first responsibility. The second one is to conduct and manage public hospitals that are under its control. The fourth one is to achieve and maintain adequate standards of patient care and services. So these are very broad things that we have to do. What we have had is clinicians desperately trying to manage the care while the parallel stream has been managing the buildings and the budget, and those two streams of activity have not always been well connected.

Again let me acknowledge that the changes in structure and activities of recent times hold out hope for improvement, but the legacy of the past will take a long time to change. The hospital of excellence will take a long time to get there. With the culture of the involvement of loyalty and of committed clinicians it is very hard to get back trust. If the culture has been like that for 10 years, the experts would say that it would take us another 10 years to turn it around. You cannot turn around hearts and minds overnight.

I guess that my last plea to the Committee is that whatever comes out of this inquiry, please let it be substantial and over a long period. It will take that length of time to get the hearts and minds of the people right, not just the buildings, not just the budget, and not just enough money. It is the dedicated and professional work force that is providing the care that is helping the residents in the Northern Sydney Central Coast Area Health Service.

CHAIR: Thank you for that overview.

Mrs JILLIAN SKINNER: Thank you, Dr Wilson. Your groundbreaking study has been acknowledged by this Committee and also much more broadly.

Dr WILSON: Thank you.

Mrs JILLIAN SKINNER: I wish to commence with the issue that you referred to last. Everyone has put forward the notion that there are fantastic clinicians at Royal North Shore Hospital. I do not think anyone in this Committee would have another view. It stuns me then why management, the Government and the area health service do not make use of you. There is a disconnect between management and the capacity of clinicians to have a say and to make an improvement. That seems to me to be the logical way forward. Would you agree with that?

Dr WILSON: There is no question that the integration of managing the care—and that is the clinicians' role—and managing the infrastructure and the budget is the key way around. In fact, my view is that the core business we are in is delivering health services, and the organisation exists to help that happen rather than the other way around.

Mrs JILLIAN SKINNER: It has been put to me that that is what we should be looking at. The main business of a hospital is to look after patients, the clinicians' role is to look after patients,

and management's role is to support the clinicians in that task. That is simplistic but would that be an unreasonable view?

Dr WILSON: That is a reasonable proposition. There is accountability in both directions for their actions. I think accountability is a very important issue.

Mrs JILLIAN SKINNER: It is difficult for clinicians to be accountable if they do not know what is their budget, if they do not have proper access to management information tools, and so on. Would that be right?

Dr WILSON: Correct.

Mrs JILLIAN SKINNER: If we are to make recommendations about where we go from here, we must come up with some recommendations about a structure that engages clinicians but that gives them the tools to do that properly. Because of your emphasis on trust and rebuilding it over time, we need some timelines and some monitoring to ensure that it really happens; that it is not just another promise that goes nowhere.

Dr WILSON: Correct.

Mrs JILLIAN SKINNER: I go back to some of the quality issues that you talked about earlier. I think you were in the room when Professor Malcolm Fisher talked about having to use a crowbar to prise out Incident Information Management System information. I presume he was talking about the Clinical Excellence Commission and not your group?

Dr WILSON: No, I do not think he was talking about our group. We send the information openly to all those who are involved in a case. So even if the issue might be with the anaesthesia part of the case, the surgical team and any other team involved in the care will get a copy of the summary. They will know what questions are being asked of which group and which issues are being raised.

Mrs JILLIAN SKINNER: Your referred to the successful reduction rate of adverse events at Royal North Shore Hospital. The number you gave would tend to indicate that the serious adverse events reported by CEC are seriously undercounted?

Dr WILSON: Undercounted broadly, but certainly undercounted at Royal North Shore Hospital. But that methodology does undercount; we know that is what it does.

Mrs JILLIAN SKINNER: Perhaps because the hospital does not include all adverse events. When the report on the quality of Australian health care safety was published, some fairly large figures were referred to relating to adverse events throughout the system. Can you give us an insight as to what they were believed to be?

Dr WILSON: The estimates were extrapolated nationally. I put some caveats around this, but the estimates for Australia were between 12,000 and 18,000 deaths a year as a result of preventable complications in hospital. Two weeks ago I was involved in a meeting with the health Ministers of seven countries—Australia, New Zealand, Canada, the United States of America, the United Kingdom, Netherlands and Germany. We pooled all our figures at that meeting and the measurement for the collective countries involved was between 150,000 and 180,000 preventable deaths across all those countries.

The difference in the performance between the countries was not very big. It was not as though one country stood out. I want to emphasise that this issue about adverse events and patient safety is an international problem. It is not a problem only for North Shore or New South Wales; it is an international problem. Therefore, our responsibility is to build responses so we know what is going on and we have a management structure that will fix it. Ultimately, if you do not have the clinicians engaged, you cannot solve that problem. Fixing these adverse events involves the hearts and minds of the people providing the care.

Dr ANDREW McDONALD: I agree that your 1995 study was groundbreaking and I pay tribute to you. It has certainly modified the practice of any clinician in New South Wales. Since then, how much better have we got?

Dr WILSON: We do not know beyond North Shore.

Dr ANDREW McDONALD: Tell us what has happened at Royal North Shore Hospital.

Dr WILSON: At Royal North Shore Hospital we have managed to keep the adverse event rate at the same level as it was 14 years ago. We have measured it regularly using the methodology. Professor Bob Gibberd, a statistician from Newcastle who models this work and a lot of other work for NSW Health, predicts that our adverse event rate should have gone up about 60 per cent to 70 per cent in that time, based on the increasing complexity of patients and the increasing age of patients. As patients age their risk of adverse events goes up dramatically after the age of 60. As you see, we are now doing major work on patients who are in their eighties so the risk of adverse events goes up. So this issue about patient safety for all of us is another of the manifestations of the ageing of our population.

Dr ANDREW McDONALD: How does safety at Royal North Shore Hospital compare to safety at other hospitals?

Dr WILSON: I do not know any other hospital that is measuring their adverse event rate. I think, without proper measurement, it is hard to answer the question. I can say that in the last 10 years a number of initiatives have come out of NSW Health to address patient safety, so it is not as though it is not on the horizon. A lot of initiatives broadly have come out of NSW Health to help to address this issue. The question I have is: Are they working and how would we know? Again, this is not just a question for New South Wales; it is a national and an international question. At some point we will have to address that question. It is not easy. We have addressed it at North Shore and we know. I would encourage others to work in the area and to try to do the same sorts of things.

The Hon. AMANDA FAZIO: Dr Wilson, what do you think about the idea of up-skilling our existing medical work force to help to address the shortages? What role do you think nurses and career medical officers could play?

Dr WILSON: There is no question that the work force is a major issue that threatens all our health systems. The nursing work force is the biggest issue, and the distribution of the medical work force and the allied work force are other similar sorts of issues. I think this is an approach that cannot be local. We need a systematic approach to understand the work force requirements and then up-skill or change skills, or change roles. We need a much more flexible approach to role design for career medical officers and for advanced nurse practitioners. In the United Kingdom there are pilot projects in which pharmacists are doing the prescribing for repeat prescriptions for patients in the community without involving general practitioners. I think we are moving forward into an era where we need to be far more flexible and prepared to up-skill, change roles, et cetera, for all of us in the work force. I also know that there are probably a number of people in the workforce who do complicated clinical work who would like to do less clerical work.

CHAIR: You are measuring these adverse events. Is it possible to calculate what the effect would be if you have poor morale of the staff, frustration with the doctors, poor equipment, old equipment? Could not that increase the danger of adverse events?

Dr WILSON: Poor morale leading to lower commitment or fatigue or failure of communication can contribute. Poor equipment is potentially a major issue in contributing to adverse events. Our clinicians are very good at working around things; they are very good at making do. If we were in a jumbo jet and we were going to take off, the pilot and the first officer would go through a checklist and everything would have to be checked to be right. But if we are going to start an operation and we do not quite have all the equipment or it is not all quite working properly, but there is such pressure to get this done urgently, it is possible that people will work around.

I think we have got used to a can-do mentality that means that sometimes we deliberately and knowingly cut corners. We protect patients by our experience. I think it is a very major issue. As we

push people harder there will be greater causes. I do not have precise data for you. The last point I would make though is that the morale issue affects people's wish to improve. So if I send a case to a department that says there is a shortcoming in care and they agree but their response to me will be, "Yes, but why bother trying to ask for more staff?" or "Why bother trying to get new equipment because we can't" So that the engagement in trying to fix things—the engagement of participation improvement programs, the willingness to sit on committees, the preparedness to move your 12-hour day to a 14-hour day—goes. That is a major thing you lose with the loyalty: this commitment to the organisation to spend time over and above to make things better.

CHAIR: It is a compliment to Royal North Shore Hospital in spite of some of those aspects that their adverse events level has remained so low.

Dr WILSON: I think it is a compliment to all of the clinical staff—medical staff, nursing staff, allied health staff—that they have done so well in being able to achieve this. That is not very good comfort to the few patients who have adverse events, and I would not want us to ignore the patients who have adverse events, and their families as a result of it, because they happen and no hospital is perfect. But they do not happen as often at North Shore as the media would suggest and they do not happen as often at North Shore as many other hospitals in Australia from the data that we have.

CHAIR: Thank you very much for appearing as a witness and for the very valuable material you have collated over the years.

(The witness withdrew)

DANIEL STIEL, Clinical Director of the Division of Medicine and Aged Care, Royal North Shore and Ryde hospitals, sworn and examined:

CHAIR: Do you have an opening statement?

Dr STIEL: I do. I am a physician and a gastroenterologist by training, so for me verbal diarrhoea is an occupational hazard and I hope you forgive me if I go on a little. I will be repeating some of the things I am sure you have heard before, but repetition may not necessarily be a bad thing.

CHAIR: I think politicians have the same problem.

Dr STIEL: I am sure that is not true.

CHAIR: Just to be fair to you.

Dr STIEL: For the past 15 months, as I mentioned, I also held the position of Clinical Director of the Division of Medicine and Aged Care at both Royal North Shore and Ryde hospitals. This division sits alongside the other two major clinical divisions: surgery and anaesthesia—my colleague John Vandervord, who is the clinical director of that, is here today—and also the Division of Women' and Children's Family Health.

The Division of Medicine is the largest in terms of personnel, with approximately 1,200 FTEs, and spans 25 clinical departments across both hospitals. As you will hear in the next few minutes, I feel very passionately about the place, but I also hope that I am a realist and a pragmatist. I see an extremely bright future for the hospital but only if—if and only if—it is given the support and resources it needs to serve the citizens of both northern Sydney and beyond.

With the Committee's indulgence I would like to add a personal note, if I may. My family's connection to the hospital goes back to the 1950s. I share a Royal North Shore Clinical School medical education with my sister and brother before me and with my daughter, who graduates at the end of this year; my wife is a nursing graduate of another hospital in the northern area. In all, my own professional association with the hospital spans 37 years, and in that time I have watched it grow from a cottage hospital with the old Florence Nightingale wards, nurses in huge veils and starched uniforms, to a sophisticated centre of education and research and clinical practice second to none.

I have also watched it go through enormous stress over the past decade as we have struggled to maintain even a semblance of what we had in the eighties and early nineties. Some areas of the hospital, it has to be said, have survived and some have even excelled—and I think you have heard some of that earlier today—but most have become demoralised. There is a real sense of neglect, of frustration, of being let down, of becoming disenfranchised. Some of this has emanated from lack of visionary and bold leadership. Some management practices and processes have left a lot to be desired. It should also be acknowledged that we clinicians also need to constantly adapt to an ever-changing and increasingly challenging health environment.

One aspect of this is that the decision-making processes seem to have become more and more distant as the years have gone by. People at the coalface no longer seem to matter any more. I wonder if I could table what might seem a trivial set of documents here. I have just gathered together four letterheads which the hospital have had over the last decade or so, beginning with Royal North Shore Hospital and the crest, which Roger Vanderfield commissioned when he was General Medical Superintendent; following on to Northern Sydney Health with North Shore listed below; then Northern Sydney Central Coast NSW Health, with a rather pale crest and North Shore writing at the bottom; and the most recent iteration, Northern Sydney Central Coast NSW Health, and if you want to put something about North Shore in it you put it in yourself on your word processor.

That is a metaphor to me. You could say: Does it matter? We need to have a more collegiate approach to health; we should not live in silos—I have heard those expressions used many times. But for the people who live in the northern area, for the doctors and nurses who work there, for the patients, it is their hospital and it seems they are going to be looking somewhere to find out where their hospital fits into their care. So, I think it is just a small but important symbol of what has been happening.

You have heard many points of view from all sides over the last few days and you will be hearing more, with arguments regarding the adequacy or otherwise of funding, bed numbers, redistribution formulas, public-private mix, access block, exit block, the new hospital development and particularly the mistakes of the past. This afternoon I have no doubt you will be hearing some stories from patients and relatives who have had unfortunate experiences at Royal North Shore, and I share their distress. However, rather than dwelling on the past, I would like to offer some thoughts on what I think are four key issues which require urgent attention to help resolve the problems we have.

The first, and you have heard it already, is meaningful—and I stress meaningful—re-engagement by management; and that is from the Minister's office and the department right down with all Royal North Shore staff: medical, nursing, allied health. We have not heard much about non-clinical staff: The orderlies, the PSAs, the clerks, the cleaners—they are as important as anybody else in this organisation. And this has to be done in an atmosphere of honesty and mutual respect. In that regard, and we heard it earlier today as well, I believe the current executive and senior management at both area and Royal North Shore level—some of whom have only been recently appointed, it must be said—do have a genuine desire to achieve this. We have also had personal assurances from both the Minister and the director general that this type of dialogue will be followed through from the highest level—and we have to take that on trust.

Without being able to really speak for all of my colleagues, I think it is fair to say that there is a broad groundswell of opinion that the current executive can and will make a positive difference. But for this to happen two things need to occur. Firstly, we need serious and ongoing financial and logistical support from government and the health department. We also have to have individual clinicians and other staff members re-empowered to have a voice in the running of the hospital. A mechanism to achieve this has to be found. Whether it is through invigorating the rather emasculated medical staff council or some other mechanism, other forum for dialogue remains to be seen. That is up to us to organise. With respect comes trust. I can promise the Committee that the corporate engagement this will generate within the hospital staff will repay the investment many times over.

The second aspect is clinical redesign. This is an initiative of the department headed by Catherine McGrath, and I am a proponent of it. It must, however, be clinician led in partnership with management. We need to look constantly at what we do and find ways of doing it better. There are a number of initiatives at North Shore currently underway in the planning stage. Sometimes I feel rather miffed to think that we are dinosaurs, we are living in an old age where we are not moderning up our hospital, but here are a few things that we are currently doing or planning to do. Coordinating sophisticated patient-flow systems, giving nurses meaningful handover and management tools in the wards, implementing estimated date of discharge practices, examining long-stay patients and why they are there and doing something about it, enlarging the transit lounge, setting up a medical assessment unit for the increasingly complex and elderly patients that occupy now 70 per cent to 80 per cent of our emergency rooms, creating a hospital avoidance clinic. People are better at not being in hospital if we can keep them out, than being in hospital. To that extent, enhancing some out-of-hospital measures such as APAC, which does a fantastic job but also needs more resources; reconfiguring palliative care services; and setting up a rehabilitation unit across Royal North Shore and Ryde hospitals—it is currently very fragmented.

They are just a few instances, but there are others. The clinicians are doing their bit for the cause. More needs to be done, obviously. Many of these initiatives, not all, involve significant financial investment. This is very difficult for clinicians to argue successfully with management when we are constantly told from on high, at the highest level, including the department, that we are over budget, we are too expensive, and terms like "basket case" really do not help, especially when despite numerous requests we are not provided with sound data to support these assertions. We clinicians always need to submit the proverbial business case to management to have any hope of getting anything up to, let alone over, the line. In contrast, if I can be provocative, I have not seen too many business cases coming down from above to support what we often think are arbitrary decisions that we then have to abide by. It is too often one-way traffic.

The third proposal—and you will be pleased, I am almost coming to the end—is adequate resourcing of the hospital, which we may regard now as a broken record. I cannot imagine any clinician here who has not requested this today. Funding not only of beds, personnel, capital

expenditure for equipment and maintenance, but also implementation of some of these clinical redesign processes that we are asked to do by the department, and which we do willingly. I believe Royal North Shore has been seriously underfunded and underbedded for many years, though I am sure New South Wales Health—I know they have—will continue to argue to the contrary. We have been disadvantaged financially by the high private bed numbers in our area. This fact was privately acknowledged to us by at least one previous health Minister, although it has been denied by others. Bed shortages become critical in winter, particularly when respiratory tract infections amongst older people take hold. Without a minimum critical bed mass, gridlock will occur inevitably despite the best clinical redesign processes in place.

So, no matter what we do, if there are not enough beds when the crunch comes in the middle of winter, we cannot hope. It is a little like the streets of Sydney. We know that during school holidays traffic seems to flow quite smoothly. Once the traffic comes back, it needs only a few per cent extra and the city becomes gridlocked. That is what bed block is. In that context, we all welcome the Minister's global announcement in terms of beds, which was brought before the public a few days ago, but I have not seen any detail regarding the numbers, particularly at North Shore. So, it is hard to make a judgment whether or not this is going to make a difference. Another very important principle is that capital and maintenance budgets and the budgets in relevant trust funds must be quarantined and not swallowed up in the bottom line. I suspect this is a more global phenomenon, but it has been particularly prevalent at North Shore. The resultant crumbling infrastructure creates a substandard environment in which to work and be treated, and we have heard what effect that can have. Properly resourced and maintained information systems and a workable human resource department, both of which have been totally decimated, are central priorities.

Not that I believe necessarily that there is a culture of bullying and harassment but if there are issues, they cannot be allowed to fester. I agree with Ray Raper, I have not seen this. It may occur, but not in the departments with which I have been associated. You cannot resolve this problem with a human resources department that has only a couple of people there and, hopefully, if you knock on the door, you might be lucky enough to find a secretary or someone—working frantically hard, do not get me wrong—totally underresourced. These are essential priorities. Finally, and more on a philosophical note, we need reaffirmation of Royal North Shore as a major centre of excellence in clinical care, medical research and education. The campus redevelopment will be a vital yardstick against which this will be measured. We should be proud, I believe, of the emerging research and education building and, naturally, of the outstanding researchers and clinically skilled personnel that will work in it. But I have to be honest, regarding the main hospital redevelopment the omens to date have not been good. In closing, let me say to Committee members, you would gather that physicians talk a lot, we have a lot to say, but we mean well. I hope that at least some of what I have said will be useful in your deliberations.

The Hon. JENNIFER GARDINER: If I could start perhaps with one of your later points, the point about the problems in winter. It seems to me, as a lay person, that that is not a new problem and has been exposed for many years, particularly with the larger hospitals in Sydney. Surely, such resourcing should be built into the normal clinical services plans of a major place like Royal North Shore. Do you agree with that? Is it built in? If not, why not? How can that be changed for the better?

Dr STIEL: I think I am not unfair in saying that clinical services plans have been thin on the ground both at Royal North Shore and in the northern area in general. I echo the sentiments expressed by Malcolm Fisher and others that that is changing. We do have confidence in the new administration and they cannot do things overnight. And we have not had a winter yet to demonstrate that. You cannot run a complex organisation like that with major shifting dynamics firstly without data. That has been our major problem. To have a clinical services plan you need information about which patients are coming in, how long they are staying, which wards they are in, how many outliers are there because outliers do less well outcomewise and stay longer than patients in their own home ward. Also redesigning the bed configurations: there are many things that need to be done, but you need information. We are just now beginning to accumulate some of that.

With that information and with the clinician involvement, yes, we can achieve things, but I would make the point that no matter how carefully that is done, if you are below a critical bed mass, nothing you can do in that regard will totally solve the problem. We can argue about the redistribution formula and whether we have been harshly done by, but the number of beds in northern Sydney has

been cut dramatically. I have not been to these hearings before, but we forget that it is not that long ago the mater public hospital was also open. We had the mater public, Royal North Shore with over 900 beds, Chatswood Community Hospital, and Princess Julianna, which was our rehab hospital in Turramurra.

There were many facilities and the flexibility was enormous. Whereas we have a lot of beds in the lower north of Sydney, many are in the private sector and doing great work, but it is elective surgical work largely, cherry picking—they are a business and good on them, and they do it superbly well—but they do not look after the people who need it most, in the middle of winter particularly. You can have a total bed mass that is adequate, but the distribution is not right. We have no control over those beds; we only have control over the tiny number of beds we have. If we added the total number of beds together and had them under the control of one area health authority, we could do tremendous redesign. However, when we have only 400-odd beds in that catchment, going up all the time, we struggle. Yes, we need to redesign and we need data, but we need more beds—properly managed, not just to soak up people. They have to be targeted.

The Hon. JENNIFER GARDINER: You mentioned that the enormous stresses started within the past 10 years or so. Can you identify the turning point? Were there any factors that caused things to go downhill?

Dr STIEL: I was probably being a little liberal with terminology when I said the past decade. I would not put it as defined as that. It has been a gradual process. It has probably been longer than a decade. I still remember under a previous administration our having a protest on Gore Hill oval about the number of beds we had lost under a government of a different political persuasion to this Government. This is not necessarily a political issue; it has been a gradual and progressive process. Of course, health care costs are increasing everywhere. We have international, national, and peculiarly Australian, peculiarly New South Wales and peculiarly northern problems to deal with. We cannot solve the national or international problems; we can solve only the northern problems. We believe that there has been a divergence of the curve where everyone is struggling, but we believe we are struggling more for a range of reasons, not the least of which is the fact that we have lost so many beds, compensated for by the private sector, that we have reached the point at which we cannot function.

The Hon. JENNIFER GARDINER: You mentioned aged care. How many people are in the aged care assessment team at Royal North Shore Hospital?

Dr STIEL: I cannot answer that question. I am happy to get back to you on that.

The Hon. JENNIFER GARDINER: Is it very substantially underresourced? I ask because one submission to the Committee states that there is only one team member.

Dr STIEL: I would not isolate the aged care assessment team in that process. The team is obviously very important in assessing patients who need placement after discharge. That is one aspect of the so-called exit block. However, it is far more complicated than that. Some of these patients' assessments may relate to their rehabilitation status; they may relate to the ability of their general practitioner to look after them in the home with the support, for example, of the aged care assessment team. A range of other things interdigitate. It is a very complicated process. I would be happy to get back to the Committee about the aged care assessment team. All those areas need better resources and, more importantly, integrated planning in the hospital and in the out-of-hospital network. A lot of good work is being done, but we need more resources.

The Hon. JENNIFER GARDINER: In respect of the new building that is in the offing, I think you said that the omens are not good at this stage about design, capacity and so on. What omens were you referring to?

Dr STIEL: I do not like dwelling on history because I am not sure it is helpful. However, the process through which we have achieved the current development status—and I am not exaggerating—was appalling. There were very good clinician-led committees and planners and managers who looked at the model of care for the new hospital. We must be progressive; we cannot use the same models of care that we have been using. Halfway through that process, without warning,

we were given a directive from the department that the type of models we were looking at were not acceptable and that we had to go down a particular path. I think it is fair to say that I do not know of a single clinician in the hospital—medical, nursing or allied health—who believes that was the right model to use. When I discussed this at forums I am on—such as the Department of Health physicians' task force—and mentioned to my colleagues in other hospitals that they were asking us to do this they were gobsmacked.

We have made inroads with the current planning. Hopefully, with the new administration at both the departmental and hospital levels, improvements will be made. The process by which we have reached this has led to so much anger and frustration that people have left the committee in disgust. A few of us have stayed on. This is not a criticism of the planners—they are doing a fantastic job in difficult circumstances. It is a cultural thing. They seem to think that if we clinicians want something it is probably because we are in for ourselves; that the model of care we want is good for doctors but not necessarily for patients. I would argue that hopefully it is good for both. Clearly, we never get everything we want. At Concord, Liverpool, Prince of Wales and Prince Alfred hospitals the process was quite different.

We visited a unit in Brisbane a couple of weeks ago and I spoke to the nursing unit manager who led the redevelopment team. Royal Brisbane and Women's Hospital was redeveloped about six years ago. I asked the manager where the outpatient clinics were located. She told me that they went to each department and asked what they wanted and, where possible, they concurred because they thought the units knew best how to run their outpatient clinics. They might be close to the ward, in a generic area, near the physiotherapy unit or wherever. It depended on the clinicians' expertise. That did not happen here. We were told we would have a generic outpatient floor and where it would be. We would not have outpatient facilities or offices near our wards.

But surely we want the outpatients' facilities near the ward, the clinicians, the registrar and the nurses. Surely we want an integrated approach to care. No, we were told we were going down a certain path. We have made inroads. Malcolm Fisher alluded to intervening in the process, which has made a difference and we are better than we were, without question. But how much better would it have been to have achieved this point six years ago? I think the hospital would already be under construction, not only the research building, which looks great. They are the frustrations that we have been dealing with. We are dealing with past frustrations, and I do not want to dwell on that any longer than necessary. That is the background against which we have been working over the past few years, but I must acknowledge that it is changing.

Ms CARMEL TEBBUTT: I also want to touch on the issue of improving engagement between clinical staff and management. I heard that you do not want to dwell on the past and that there have been some signs of things moving forward. What are the strategies that you would like to see in place at the Royal North Shore Hospital to continue to improve the opportunity for clinical staff to have input into management decisions?

Dr STIEL: I would like to see people at the coalface having direct contact with decision makers.

Ms CARMEL TEBBUTT: What is the process?

Dr STIEL: That will vary. We used to have a thing called the medical board. This is not a hospital board. Individual clinicians of any persuasion would come to a meeting once a month with the chairman. The administration would be in the room to hear the concerns and gripes. Afterwards they would even have a drink and cheese and biscuits while they informally chatted.

CHAIR: Was that the medical staff council?

Dr STIEL: It then became known as the medical staff council, but it was called a medical board. We then implemented a divisional structure. There are some things that a medical staff council, being too amorphous, cannot deal with. As I said, we have a budget of $122 million just in the medicine division. We cannot deal with those complex issues with someone who may not have an interest; for example, someone in mental health may not be interested in what we are doing. We have lost that direct stakeholder involvement.

Ms CARMEL TEBBUTT: Does it happen at a divisional level?

Dr STIEL: It does, but it is layered. We have divisional executives who answer to the general manager. That is fine. There is a great working relationship. We relate to the heads of departments, and again there is a great relationship. We meet once a month and our doors are open at any time. They then convey information to their constituent members. However, there is not the feeling that the average person in the hospital can directly knock on the general manager's door. She is very available and approachable; if they could knock on anyone's door it would be hers, but it is just not possible.

Ms CARMEL TEBBUTT: Why is it not possible?

Dr STIEL: I guess we have been discouraged from that sort of behaviour over many years. There has been a gradual removal of the decision-making process. Honestly, the feeling has been that even if you do knock on the general manager's door, unless the chief executive of the area—and possibly not even that, it could be the department—sanctions even a trivial request it will not be granted. The level of discretionary spending and decision making has moved further and further away from the coalface.

It is up to us to re-establish some of those structures, and nursing will do it differently to medical, and whatever, but the reason the medical staff council has not been an articulate voice is because it does not have teeth. It is simply a group of people having a chat. It does not have the ability to influence things and there are too many layers. That is not to say that the divisional structure is flawed: it needs to be there. It is not unique to the Royal North Shore Hospital. You will find in the smaller hospitals that do not have divisional structures medical staff councils are very strong and individuals do have a voice there. But in the larger hospitals, and ours is a classic example, it has been lost. Part of that responsibility is ours: I accept that. But it has been discouraged.

Mr MICHAEL DALEY: Putting your aged care hat on, can you tell us what strategies you would like to see to improve exit block?

Dr STIEL: You are not implying that I have an aged care hat myself, are you?

Mr MICHAEL DALEY: I am just reading your title.

Dr STIEL: Yes. These strategies to improve exit block include some of the things that have been mentioned—better aged care assessment team assessment. Probably the major thing for us is rehabilitation. There is currently a very fragmented rehabilitation process. We have people who do a bit of rehabilitation at North Shore, we have Royal Rehabilitation at Ryde, and we have the Greenwich hospital run by Hope Healthcare. There is not good coordination between them. The Poulos report—Chris Poulos is a rehabilitation physician who suggested in April or May that we get a rehabilitation department with a clinical leader and really get moving on coordinating and getting things running.

Mr MICHAEL DALEY: In a hospital, or in the locality?

Dr STIEL: It was an area-wide decision, but it would probably be based at Royal North Shore-Ryde. It was the lower North Shore he was talking about predominantly, not the upper North Shore and not Gosford.

Mr MICHAEL DALEY: Yes.

Dr STIEL: That submission was put in in May. We put in our recommendations as a division as to how we thought which one should be accepted and which ones perhaps were unrealistic. To date there has not been a response. There is a financial cost in doing this but enormous rewards at the end. That is one example where a report is being commissioned, generated, recommendations have been made, reviewed, and, admittedly under a different administration to the one that is there now, not a lot of action, probably because they looked at it and said, "This is going to cost a bit of money. We are over budget. How can we achieve this?"

Matthew Daley has assured us that that will not happen any more; that if a good case can be made, it will be funded. We will be held accountable, and should be, that it succeeds. We have to repay it over time. That is one example of what could be done and there are several others in terms of patient flow issues, but that is probably the most critical one in terms of, hopefully, getting people who are currently in hospital and who might be going to nursing homes actually not going to nursing homes—getting them home, with some rehabilitation, under the care of their loved ones and their general practitioners. That is just one example. There are several others along those lines that we can look at. Most involve some financial injection. Some are just changing practices.

CHAIR: You mentioned the new hospital is not really having much input, if any input, from the staff at the Royal North Shore Hospital. It must be based on some plan or model. Is it based on some American model, is it? You sound like it is not going to be very practical or workable.

Dr STIEL: I would have to say it is not that we have not had any input. We have had years of input, countless committee meetings. It is that the input has not been heard, in my view.

CHAIR: That is what I am saying.

Dr STIEL: Others can speak about the number of operating theatres, and my surgical colleagues are much more articulate at this than I am, but it is basically the difference between what is very commonly called—and I hate these terms because they are very proscriptive—an institute model versus a patient-centred model, one being where you make as much generic as you can and keep the individual groups out there somewhere, or alternatively try to integrate a particular service, such as age care, neurosciences, mental health or whatever in one area and have the inpatient, outpatient, research and offices as much as possible coordinated because that is where those people work and patient drift from one part to another.

That is the type of model we wanted. Most hospitals in Sydney have gone down that path—not all: John Hunter Hospital has gone down a patient-centred model. But no-one in our hospital wanted the model that has been put to us and so we have a situation where something was, we felt, being forced upon us. There have been changes. I do not want to sound churlish about this but it began with an entrenched position and it has been clawing back, inch by inch, to the position that we are now in, which is more satisfactory. But, hopefully with Deb Picone's affirmation that she is interested in this area, and I believe her, we may be able to even improve further from where we are.

CHAIR: Thank you, Dr Stiel, for sharing with us your expertise. We appreciate it.

(The witness withdrew)

[Luncheon adjournment]

JANA HORSKA, former patient of Royal North Shore Hospital, and

MARK GLEN DREYER, husband of a former patient of Royal North Shore Hospital, sworn and examined:

CHAIR: Thank you for agreeing to appear before our inquiry. I appreciate your coming in. I realise, too, that it brings back many sad memories for you. Hopefully your appearance will help us to find some solutions to the problems at the hospital and prevent them reoccurring with other patients. I understand, Mark, you want to make an opening statement?

Mr DREYER: Yes, on behalf of Jana.

CHAIR: It is on behalf of both of you?

Mr DREYER: Yes, but it is written as Jana's statement. My full name is Jana Horska. I was born on 6 November 1974 and am 33 years of age. Mark Dreyer is my husband. Mark and I were married on 9 December 2006. We have no children. Mark is employed as a waterfront foreman and I am currently employed as a shop assistant. I have been asked to provide a statement surrounding the events of my miscarriage, which occurred in a public toilet of the Royal North Shore Hospital casualty department on Tuesday 25 September 2007. In the period leading up to 25 September 2007 I was under the care of Dr Hamilton, general practitioner. On 20 September 2007 I attended the Mater Hospital where I underwent an ultrasound and blood tests to confirm the status of my pregnancy and in particular the health of the foetus. On Monday 24 September 2007 I returned to the Mater Hospital and collected the results of my tests. I was assured by the staff at the Mater Hospital that everything was okay and I should make contact with the ante-natal clinic at the Royal North Shore Hospital so that the progress of my pregnancy could be monitored. I was advised that at that time that I was 14 weeks pregnant.

On Tuesday 25 September 2007 I attended my work. In the morning I noticed that a discharge of dark fluid. I immediately contacted my general practitioner, Dr Hamilton, at the Cremorne Medical Centre. Dr Hamilton directed me undergo a repeat ultrasound which I did at approximately 1.00 p.m. that day. I re-attended Dr Hamilton's surgery with the results of the ultrasound as advised. At 4.00 p.m. I was advised by Dr Hamilton that the uterus was fine. Once again I was told everything was okay. She recommended that in time I see a gynaecologist to monitor the progress of my pregnancy. At about 6.30 p.m., when I was at home, I again noticed a discharge of brown tissue and blood. I was extremely distressed by this. I was concerned as to the safety of the foetus and worried as to my general health and wellbeing. I immediately rang Mark, who was at work. It was agreed that it would be quicker for me to attend Royal North Shore Hospital emergency department by taxi rather than for Mark to leave work and come to our home then drive me to the hospital. I immediately travelled to the emergency department at Royal North Shore Hospital.

I believe I arrived there at approximately 7.10 p.m. I attended the counter at the emergency department and spoke to the woman behind the desk. I told her that I was 14 weeks pregnant and I showed her the results of the ultrasound performed that day. I advised her that I had had a brown tissue and blood discharge, that I was suffering cramps, and that I was concerned about the foetus. I was very concerned that there was a possibility that I may miscarry and I wanted urgent medical treatment to do whatever was necessary to prevent this. I also told her that in April 2007 I had a previous miscarriage. I impressed upon her that I was suffering from cramps and that I was bleeding. The woman behind the desk simply told me to take a seat in the emergency department and gave me a leaflet about miscarriage in early pregnancy. I was extremely distressed, in a great deal of pain and anxious for medical treatment. I was in no state to read a leaflet or to concentrate on any documentation.

I remained sitting in the casualty department immediately in front of the woman on the front desk for almost an hour. I was seated on a hard seat for most of the waiting time. My hands were buried in my knees and I was in a huddled position as the pain was quite extreme. Approximately 15 minutes after I arrived a nurse who was walking around the public waiting area attended on me and took my temperature and blood pressure. She also asked me I was wearing a sanitary pad and I

responded that I was. I was not provided with any medical treatment at this time. At approximately 8 o'clock Mark arrived. By the time he arrived I was more distressed and in even more pain. Mark attended upon another nurse who was in the public area of the waiting room. He said the following:

> My wife is fourteen weeks pregnant. She is sitting here with all the symptoms of early miscarriage. She is bleeding and in pain. She has been here for an hour. We need help. We need to see a doctor straight away.

The nurse responded as follows:

> If she is going to miscarry, she is going to miscarry. There's nothing that can be done.

Mark responded:

> We are not here to miscarry. We have been told that she should be treated straight away. She requires immediate treatment. Surely something can be done.
>
> Why has she been made to wait in a waiting room in this condition?

Mark again pleaded with the nurse for me to be seen by a doctor as a matter of emergency. Mark made a further comment to the nurse:

> I understand that time is important. Isn't there anything that can be done?

The nurse simply responded:

> Sit over there and wait.

Over the next hour my condition continued to deteriorate. Mark was sitting beside me attempting to comfort me. I was in serious pain and I was becoming more upset about my deteriorating condition. During this hour I was sitting in front of the front desk of the emergency department. I was crouched over in pain and Mark was making gestures to the staff behind the counter but nobody provided assistance. At all times during this ordeal we were in full vision of the people behind the admission counter. During this hour from 8.00 p.m. to 9.00 p.m. we were both concerned that if we made any more requests for help that we would have been placed to the end of the waiting list. Whilst we were waiting in front of the admission counter for the hour from 8.00 p.m. to 9.00 p.m., I attended the toilet in the emergency department and whilst there I experienced a contraction and noticed a pink discharge and then a further contraction. I returned to the waiting room area where Mark was seated immediately in front of the admission counter. I was in so much pain was squatting on the floor.

At approximately 9.00 p.m. I went to the toilet again. I experienced a further contraction, and with that there was a rush of blood and the baby came out. When the baby came out his heart was beating. His limbs were moving and he opened his mouth as if to breathe. I was extremely distressed, almost hysterical. I was desperate for the baby to be seen by a doctor. I was desperate for any medical treatment that might have been able to save the baby. I cried out to my husband "Mark! Mark! Mark!" Mark could not hear me at the time. I threw a "Wet Floor" sign out against the toilet door. Shortly after that Mark came into the toilet. Both Mark and I were very distraught. Mark attempted to comfort me; we were both in a state of shock and distress. He then summoned the triage nurse who had earlier been in the public area. Mark repeatedly said to her, "I told you this was urgent." There was no response.

The triage nurse and Mark helped me take my pants and shoes off and placed me in a wheelchair. She provided me with a blanket. I was then taken into the emergency area and I was placed on a bed. There was blood all over the lower part of my body and the foetus was still in between my legs. I was left unattended in the emergency area for some time. The contractions kept coming whilst I was awaiting medical attention. Apart from being given Panadol, I was given no medical assistance or advice despite the fact that I was continuing to experience contractions. I was left in a bed for approximately one hour. Nobody noticed that the foetus was still in between my legs and I was bleeding. About 45 minutes after being taken to the emergency ward a gynaecologist attended on me. At the same time the nurse came up to me and said the following words:

> Don't worry. My mother has had heaps of miscarriages.

The gynaecologist examined me. When he lifted the covers of the bedding he discovered that the foetus was still there. I could see that he was quite shocked. I was then attended to. Following this, we did not know if I was to be admitted overnight or simply discharged later that evening. It was eventually decided that I should be admitted overnight. For almost three hours I remained in the emergency area. There was constant confusion over whether or not a bed could be found for me. At approximately midnight I was taken to a ward. The ward contained five beds, all of which were empty, and I was placed in one of those beds in the ward all on my own. I remained in the hospital until about 3.00 p.m. on 26 September 2007, when I was discharged.

The events of 25 September 2007 and the loss of our son have had a devastating effect on both of us. Having reached 14 weeks in the term of the pregnancy and having been advised that the pregnancy was progressing well, we had an expectation that our child would reach full term and would be born in March 2008. We cannot understand or accept that our pleas for help over a period of some two hours at the emergency department of Royal North Shore Hospital went unanswered. We were fearful that if we continued to complain about the lack of treatment and attention, we would have been further neglected and ignored.

The loss of our child in the public toilet of a hospital has caused both of us terrible grief. We will always be left wondering whether the outcome would have been different had we been treated with priority. Regardless of what might have been done to save our child, something could have been done to spare us from this ordeal. There have been a number of inquiries into this matter, each with strict deadlines. There is no deadline that applies to our ongoing grief and suffering.

CHAIR: Thank you, Mark and Jana. We realise how difficult this is for both of you—and for you, Mark, especially in reading the statement. We appreciate your helping our inquiry by making the statement to us and by being available to answer some questions. Would you like to proceed with questions now?

Mr DREYER: Yes.

Mrs JILLIAN SKINNER: Thank you very much, Jana and Mark. When this occurred the media was advised that the Minister's office had said that you were happy with your treatment at Royal North Shore Hospital. Could you comment on that statement?

Ms HORSKA: I never said anything like that.

Mrs JILLIAN SKINNER: So that was an incorrect statement?

Ms HORSKA: Yes.

Mrs JILLIAN SKINNER: The Minister then established an inquiry into your miscarriage, in particular, but also into other miscarriages. When the report was released it was indicated that you had not been interviewed. Would you care to comment about that and what happened?

Mr DREYER: That is the real sore point with me: for the inquiry to say that we declined to be interviewed. We never at any point declined to be interviewed. We sought early legal advice at that stage after I was given advice by a friend of mine. We left it in the hands of that particular legal guy at that time. There was a bit of toing and froing with emails between the solicitor and Professor Walters. To go forward, the last email that virtually said there was a deadline, which our solicitor received a week earlier, was sent to us and, through a chain of events, we did not read it. It might sound like I am telling a story here but the truth is we had problems with our computer at home and we could not access our email. I was on night shift that week and I was not contactable. We basically found out about this deadline—I found out that the actual report was coming out when a journalist woke me up after night shift on the Friday afternoon. I was quite amazed that the inquiry had been completed without us having any input.

I cannot understand this deadline. What is this deadline business? That is my problem. Jana was not in a fit state that week to be sitting down and cross-examined about anything. We had just received the pathology results that week regarding the baby and we found out it was a boy. Jana was

absolutely devastated; she was back to square one. There is no way I would have put her through meeting with these guys at all and having any sort of questioning.

Mrs JILLIAN SKINNER: So you felt it was unreasonable for the public to have been told through the media that you did not want to participate in the inquiry.

Mr DREYER: It is very hurtful. I think people realise—we have been very open with everybody in telling what has happened. It defies belief that we would not be willing to participate and contribute to our own inquiry into our miscarriage. It is unacceptable. You would not believe that we would be like that.

Mrs JILLIAN SKINNER: Do you have any comments about the recommendations or the outcomes of the inquiry?

Mr DREYER: For me, it is not worth the paper it is written on for the simple fact that we have not had an input. There are inaccuracies through there.

Mrs JILLIAN SKINNER: What are the inaccuracies, Mark?

Mr DREYER: Times. All it says in there about what I said to the triage nurse was that I walked up and complained about the time that Jana had been waiting in the waiting room. I begged and pleaded with the woman. Time was just one aspect. It just skims over things. I signalled her to come in to treat us—to tend to us—in the toilet. There is nothing after that. Absolutely nothing. She lay on that emergency bed for a good hour with the baby between her legs. Everyone is generalising about the miscarriage and the problems with the hospital but no-one is dealing with the actual immediate problem of our baby between her legs, and bleeding.

Mrs JILLIAN SKINNER: You said the day after this happened that you were concerned about the "lack of care and comfort"—I think they were your words. Will you go into that now? Was that something that was particularly in your mind at the time?

Mr DREYER: It is still in my mind. We can talk all we want about lack of funding and how the hospital has got systematic problems and the health system has problems and all the rest of it, but the basic nursing qualities of care, comfort and reassurance to patients just were not there. My experiences with the nurses—the nurse that I dealt with and the other one there—were that they were cold and very robotic. Even at the time they came into the toilet there was no care, no comfort, no hug—nothing. It was just business. It was all business. It was robotic, it was mechanical and it was very cold. Even in the toilet I was saying, "I told you, I told you, I told you this was urgent. I told you it was a priority. I told you. You didn't listen to me." She did not respond to me at all.

Mrs JILLIAN SKINNER: Do you think that the review that was done and then the recommendations that have come out that are going to make any difference at all?

Mr DREYER: In the inquiry?

Mrs JILLIAN SKINNER: Yes. If someone else presents having a miscarriage, are you confident that they will be treated differently?

Mr DREYER: I have no confidence in the Government whatsoever. Absolutely none, and the sheer fact that a recommendation is put here in our inquiry to say that there should be proper procedures, policies and protocols put in place in emergency departments to cater for women presenting with early pregnancy difficulties, it defies belief. What, are we the first ones to ever go to a hospital with early pregnancy problems? I cannot believe that there was not already something in place. Even on the night I said to Jana, "You'll go straight in. Don't worry. You're a pregnant woman in difficulty. You'll go straight in. You won't have to be in a waiting room." That is why I was just completely shocked that she was made to wait.

CHAIR: Dr McDonald?

Dr ANDREW McDONALD: Thank you so much for coming. We are incredibly grateful that you have both come. Thanks very much for your statement, which is incredibly eloquent. It is an enormous thing that you have done. I am very impressed.

Mr DREYER: Thank you.

Dr ANDREW McDONALD: I have simple question for both of you that you can answer individually. What would you like to see come out of this inquiry?

Mr DREYER: I will speak on behalf of both of us. That is our local hospital. We live there. Obviously, like everyone else, we want a reliable hospital, somewhere where you can go and be confident that you are going to get the proper care that is required. It is just a basic thing that people expect in a city like Sydney, in our country. That is what we want to come out of it. We do not want a hospital that is a basket case.

Dr ANDREW McDONALD: You are saying that the most important thing for yourself is reliability?

Mr DREYER: Yes, and proper treatment and care for people who present with—early pregnancy difficulties is one and that obviously has to be addressed but there are numerous other conditions that people can present with. You just want to be confident that the hospital can cater for that and people do not suffer and lose life.

Dr ANDREW McDONALD: So reliability, correct treatment and caring, is that a reasonable summary?

Mr DREYER: It is basic stuff, I think.

Ms HORSKA: Yes.

Dr ANDREW McDONALD: Do you agree with that, Jana? Do you have anything to add?

Ms HORSKA: When I go to hospital next time I want to be treated. I do not want to be sitting in a waiting room.

Dr ANDREW McDONALD: Moving on to reliability, correct treatment and caring, what changes to the way emergency departments work would you like to see?

Ms HORSKA: When you go to the emergency room you should at least be given information how long you have to wait for. Someone should attend you during the waiting period and check on you, which I did not. The nurses were overlooking me all the time and I wish that changed because they were very cold.

Dr ANDREW McDONALD: So you did not feel like you were kept informed of what was going on?

Ms HORSKA: No, I had no information. I had no idea how long I had to wait for. I did not know what was happening. They did not tell me. If they told me I had to wait there for two hours I would probably go home and make myself comfortable, but I was given no information whatsoever.

Dr ANDREW McDONALD: Mark, would you like to add to that?

Mr DREYER: Yes, I agree 100 per cent with what she said. We were given no indication whatsoever. That was very frustrating. The thing that I cannot get past is I feel I should have approached the nurse more but I felt if I had I would have been—because they get people coming up all the time, "How long, how long". We were just another person trying to jump queue. That is the way we were treated. That has got to improve. There are a whole range of things have to improve down there.

Emergency departments are notorious. They just have such a bad name so something has to be done. I am no expert in this area but surely the waiting time is a major problem and people cannot just be all thrown in as numbers. There has to be some division of what category they are in.

Dr ANDREW McDONALD: Do you know what category you were?

Ms HORSKA: Four.

Mr DREYER: We were triaged.

Dr ANDREW McDONALD: At that time did you know?

Ms HORSKA: No.

Mr DREYER: No, we did not know. We found that out earlier. Basically in hearing that, everything that we said was just muzzled; just been talking to the wall. It also fell on deaf ears. It was urgent to us but not to them.

Dr ANDREW McDONALD: What about the way in hospitals work? We have talked a bit about emergencies. Would you have suggestions about improvements to the way hospitals work?

Mr DREYER: Get rid of the bureaucrats.

Dr ANDREW McDONALD: Jana?

Ms HORSKA: Yes, I think the same because the first person I see in the morning was some kind of manager, a lady, and I only wanted to see the gynaecologist, which was the last person I got to see.

Mr DREYER: Yes, we saw the bureaucrats in damage control. We did not see the gynaecologist, who we wanted to see straightaway. The people at the coalface of the hospitals, they are the people who should be running these hospitals. To get a little bit political—

Dr ANDREW McDONALD: Go on. This is your chance?

Mr DREYER: I think people, the general public would have had a lot more respect, or would have had respect for Morris Iemma to come out and take the politics out of it, take away the political spin, which has been very hurtful for us—the insensitivity has just been unbelievable—they do not realise that the pain they cause with this rubbish that they peddle. It is just inconceivable that they can sit there in front of cameras and say it in print and in press releases. It is unbelievable. Take the politics out of it; sit down with people at the coalface of these hospitals, get every public hospital across the State, get representatives of the hospitals who are at the coalface who know the systemic problems, sit down with them, sit down with both sides of politics, bring the Federal Government into it as well obviously. I would look across the world and see who has got the best system operating at this present time in the world and I would take that model to the table and say, "Right, let's sit down and nut this out and see what can be done."

I believe money from Federal—it is one thing to just give money to States but money has to go to the area where you want it to go. That is what I believe. What is the use of giving a whole heap of money from Federal funding and that money is not going to the area where you want it to go. This is a major problem for me. There is no accountability of that money where it goes.

Dr ANDREW McDONALD: You are great experts on the system.

CHAIR: Mark or Jana, when you came to the emergency department, the report of that inquiry that you did not get the opportunity to give evidence to, had some excuses that it was very busy and crowded at the time. Can you recollect what it was like that night?

Ms HORSKA: When I walked in, I just kind of thought, okay, it did not look that busy. The waiting room was not full, there was about 15 people waiting, and I felt quite optimistic about getting

attention straightaway. I had no idea what was happening behind the doors, if they had any ambulances or how busy it was behind there. No-one told me anything. I am saying if they told me I had to wait that long, I would go home; I would not be waiting that long being in pain.

CHAIR: Mark, you have used the word "robotic" in describing the attitude of the nurse or nurses.

Mr DREYER: I had dealings with one particular nurse that I spoke to.

CHAIR: Was that the triage nurse?

Mr DREYER: Yes.

CHAIR: Was she the one behind the glass wall?

Mr DREYER: She was outside the glass when I arrived. I spoke to her outside the glass. Now I spoke to her then, and then she was the lady I flagged down to come and help us. She just happened to be out the front again when Jana was in the toilet. She came in with a wheelchair with another nurse at that time. But yes, I am talking about her particularly. Once we went in, everything was fine except for the mass confusion, but her treatment of us was very robotic. It was very cold; it was very mechanical. There was no care, there was no comfort; there was no reassurance to either of us. Even at the darkest hour of this ordeal, there was nothing, except for the wheelchair. I helped her undress Jana, get her onto that wheelchair and get her out of the toilet and into the emergency bed. Yes, when I am talking about that, I am talking about her particularly. The other girl there at that time was like a bit of a junior, I thought. She was just assisting. She just stayed in the background, but it was particularly that nurse.

CHAIR: You would expect nurses to show compassion and care because that is their role?

Ms HORSKA: Of course.

CHAIR: But obviously you did not see that?

Mr DREYER: No, it was certainly lacking, and it is a basic element of nursing that I expected anyway and I think most people do.

CHAIR: We thank you for coming in. We know it is difficult for you to do this, but I think it has helped our inquiry to hear from you first-hand.

Mr DREYER: I appreciate the opportunity. As I said, we feel robbed of the inquiry into the miscarriage that took place.

CHAIR: Is there anything you would like to add? Is there anything you would like to suggest that we should recommend as a committee?

Mr DREYER: To you personally, Fred, I hope you give this inquiry the necessary time it needs and not be pressured to finish it by the recommended time of December because I think it needs longer than that and I think a report that is done without the proper input from everybody that wants to have input is not going to deal with all the problems that are plaguing this system. That is what I would like to say to you personally. You are a man in the community of high moral standards, so I have some trust in you to hopefully carry out what is required.

CHAIR: We certainly will not fail you.

(The witnesses withdrew)

SHARON ANNE HOOPER, relative of former patient of Royal North Shore Hospital, sworn and examined:

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

Ms HOOPER: A relative.

CHAIR: Could you name the patient, please?

Ms HOOPER: Mrs Edith King.

CHAIR: Do you wish to tell your story?

Ms HOOPER: I am here on behalf of my grandmother, who is 92 and losing both legs at the moment—we are fighting to save them—with blood clots. I was not happy when they transferred her to Royal North Shore. They transported her at 11 p.m. from Hornsby hospital because the vascular surgeon was on vacation and they thought she would be in the best possible place at North Shore. I went to see her at 1 o'clock the following day and she was still in Accident and Emergency and to my knowledge no one had been to see her. So then I sat with her for a while. The nurses were running frantic. No doctors came, so I went to have a coffee break and when I came back she was gone and they said, "We've sent her up to a ward", and they said, "Are you a relative?" I said, "Yes, I am", and they said, "Well, here's some medications—they got left behind. Could you please take them up with you?"

I was a bit concerned about that. Firstly, they did not really know who I was and they did not ask for any identification to pass on drugs of whatever sort. When I got up to the ward I asked had a doctor seen her and they said "No", they were in surgery and would be there as soon as they could. I saw no doctors while we were there. She went up to the ward on the Friday and it was not until the following Tuesday night after the media had contacted me that I actually got in touch with a doctor. Up until that time we had seen no doctors. It was as if they were babysitting her. She is quite demented right now, I think because of all the change and what she has been through with the pain that she has been in, so to keep her in her bed they put the rails up on the bed all the time. Therefore she kept trying to climb out of the bed and she tore both her legs, which has now brought on massive skin ulcers that will take months and months to heal, if she survives.

It was not until the story broke, the media rang me at work on my private mobile to tell me that they had a photo of my grandmother and asked me was I aware that she had spent the night in what they call the cupboard the previous night, and I said, "No, I don't believe you", and they said, "We have a photo to show you". They sent it to me at my work via email, and I fell apart. I really fell apart. Up until then I had no knowledge of what had gone on, and everything snowballed from there.

Once that story hit the media, from then on, I had every conceivable specialist, physio, everybody ringing me every day to check how she was. The actual specialist rang me every day. I was not really impressed with some of the staff on the ward. They did not really speak a lot of English. I know they are very run off their feet and I do not take it out on the nurses at all because, watching them with their workload, it is just ridiculous, it really is ridiculous. One morning I phoned to see if she had had a good night and I do not know who I spoke to—I suppose it was a nurse—and she just said, "Look, I haven't got time for this phone call", and hung up on me, which I thought was a bit rude. All I wanted was some information to see how she was coping. Because we live at Hornsby I could not be there every day with work commitments. Trying to get down to see her was a big thing, so it quite stressed her out.

After the incident in the treatment room they put her in another ward with three men. I know there is now in the public system a shared ward sort of thing, but they had her shoved in a corner and the gentleman who was in the bed next to her had the curtains around him the whole time, so she could not see whether it was daylight, dark or whatever, and every now and again the nurses would just run past her and see if she was all right, and the gentleman next to her also had security guards at the bottom of his bed. I do not know what he was there for, but that was not very comforting either. So I was quite happy when they said they were transferring her back to Hornsby.

Mrs JILLIAN SKINNER: Thank you very much for coming forward to give evidence today. I have a question about the policy of using the storage room or treatment room. There are some doctors who have said that this has been going on for some time; there are others who have said that they do not think it is appropriate. Dr Keegan, who is the President of the Australian Medical Association, told this inquiry on Monday that it might have been that there was not much of a clinical choice. I would like your comment about that, particularly since Mr Brett Holmes who is the general secretary of the nurses' union told this inquiry that in fact there had been a negotiated position some time ago, when they were trying to save money, about reducing the number of individual patient specials. He explained that that is where they took away nurses who were able to provide one-on-one care for patients who might be confused or whose condition warranted a single nurse—he talked about older people and disorientation—to prevent injury. Do you think it is possible that that is why your grandmother was put in that treatment room, because there were not enough nurses to look after patients in the ward?

Ms HOOPER: Possibly, yes. They said that that was the best place for her at the time. But when I went back in the next day, they had not even put her back into the same room; they had put her into another room. And her space was still vacant in that room. That is what I could not understand.

Mrs JILLIAN SKINNER: It was not that there was not a bed available?

Ms HOOPER: No. She was in a bed.

Mrs JILLIAN SKINNER: But, quite likely, as Mr Holmes had explained, there were not enough nurses available to look after her?

Ms HOOPER: Yes.

Mrs JILLIAN SKINNER: You said earlier that your grandmother is back in Hornsby hospital. Why is she in Hornsby hospital and not Royal North Shore?

Ms HOOPER: Now the vascular surgeon is back from holidays, she is in rehabilitation in Geraghty Ward at Hornsby hospital, still under the vascular team and under aged care. They have done a fantastic job. They have done dopplers on her, and they have done surgery and put five stents in her left leg, which is now giving her blood supply to that leg. They are still not 100 per cent sure if she will walk again, but they have done everything since we have been back there. Even the nurses at Hornsby are run off their feet, but for some reason in Geraghty Ward they just have that time to spend with a patient. Even if it is just passing, they will stop and say, "How are you?" or whatever.

Mrs JILLIAN SKINNER: You are reported in the *Daily Telegraph* of 16 October as saying, following a meeting with Minister Reba Meagher, that her main concern was not with the ordeal your grandmother had endured but with the fact that the story had got out. Would you care to elaborate on that?

Ms HOOPER: I felt that she was really only concerned that the breach of confidentiality had been broken, that someone within the hospital had given them my mobile phone number, and that someone had let the media in to take that photograph of her in that treatment room. That is what I felt she was mostly concerned about.

Mrs JILLIAN SKINNER: Did the media take the photograph, do you know?

Ms HOOPER: Yes. They said that somebody let them in.

Mrs JILLIAN SKINNER: Do you think it was a staff member who let them in?

Ms HOOPER: Well, someone must have let them in. The photograph would have been taken between 9 o'clock and 10 o'clock at night, and the doors of Royal North Shore are locked well before that. So somebody had to have access to let them in to take that photograph.

Mrs JILLIAN SKINNER: You did not, and none of your family did?

Ms HOOPER: No. I only found out the next morning, when the media phoned me and said, "Are you aware that this is where she spent the night?"

Mrs JILLIAN SKINNER: To this day, do you do not know who did that?

Ms HOOPER: No, I have no idea.

The Hon. JENNIFER GARDINER: You said at the beginning that you were very anxious about your grandmother being transferred from Hornsby in the first place.

Ms HOOPER: Yes.

The Hon. JENNIFER GARDINER: Was there any particular reason for that, apart from the fact that she was going away from the locality?

Ms HOOPER: I knew that with the dementia she has—and you see it more and more every day—I knew she would not cope with a lot of change. Apparently, that night at Hornsby they spent quite a bit of time on the phone with Royal North Shore arguing over "Would you take this patient or would you not?" It was more like they were babysitting her until the vascular surgeon returned to Hornsby. I just did not feel comfortable with it.

The Hon. JENNIFER GARDINER: When you were first with her at Royal North Shore, did anyone approach you to find out who you were?

Ms HOOPER: No. I was walking around in accident and emergency. They have volunteers working there, and I was just walking around trying to see even where she was. A volunteer came up to me and said, "You look lost. Can I help you?" I was asking where she was and that, and she guided me to my grandmother.

The Hon. JENNIFER GARDINER: It was a volunteer who helped you?

Ms HOOPER: Yes. No-one came to say, "This is what is happening" or "This is what we plan to do."

The Hon. JENNIFER GARDINER: The other day the Clinical Excellence Commission gave evidence to this Committee. One of its recommendations is that this communication problem between patients and their families and the hospital should be improved. Do you think that that is very important in this case?

Ms HOOPER: Definitely. At Hornsby I have noticed that every time a decision has to be made or there is a change, they take you into a meeting room, you have the surgical team with you and a social worker, and you all sit down and they discuss what is happening or what they want to do, or what they feel you want. Yes, definitely.

Mrs JILLIAN SKINNER: We have all seen photographs of the treatment room. It had some equipment in it, including oxygen bottles and so on. Were you happy with that, or would you like to make a comment about that?

Ms HOOPER: No. I just could not understand why they had put her in there. It was like she was not important; she did not have feelings. I know that that day she was in a lot of pain so they gave her a strong medication and that would have knocked her around. I do not know. Would they like their relative put in there?

The Hon. AMANDA FAZIO: We have been advised that the nurses who placed your grandmother in the treatment room have stated they did so because it allowed them to observe her during the night. They were concerned. She had tried to climb out of bed, and they were concerned that the drip might come out and she would hurt herself.

Ms HOOPER: Yes.

The Hon. AMANDA FAZIO: We have also been advised that that has been the practice at the hospital for quite some time because of the way it was designed: from the nurses station, that is the only room where they can pop in all the time to check on the welfare of the patient. Can you tell us what your main concerns were about the decision to put your grandmother in the treatment room?

Ms HOOPER: Well, a phone call would have been nice. When I left the hospital I always made sure they had all my phone numbers, in case they needed to contact me about anything. Just to be told by the hospital why they did it, before the media got hold of it, would have been a good thing.

The Hon. AMANDA FAZIO: As I said, from what we can gather the hospital has been using the treatment room for these observational purposes for quite some time and it has been confused with a store room. Would you be happier if the treatment rooms were not used as store rooms, if they were available for patient care only?

Ms HOOPER: Yes, definitely.

Ms CARMEL TEBBUTT: I want to ask about confidentiality. If I understand what you are saying correctly, the photograph of your grandmother was taken without your knowledge or involvement.

Ms HOOPER: Yes.

Ms CARMEL TEBBUTT: That seems to be quite a serious breach of confidentiality. Also, your phone number was provided to the media without your being aware of that?

Ms HOOPER: Yes.

Ms CARMEL TEBBUTT: Do you have any concerns that those things could have happened?

Ms HOOPER: Definitely, yes.

Ms CARMEL TEBBUTT: Do you regard that as quite a serious issue?

Ms HOOPER: Yes. I work in the medical profession, and that is a definite no-no.

Mr MICHAEL DALEY: Have you been able to see the treatment room?

Ms HOOPER: I did view it after all this broke free. Actually, that day I went down after the media had rung, and they had another man in there. I was quite surprised. The nurse said, "Yes, we do it all the time."

Mr MICHAEL DALEY: The Committee went on a tour of the hospital and spoke to the nurse who made the decision to put your grandmother in there. She said she did it because it was in her direct line of sight, that at night there were people talking and laughing, and that there are people around to stop them getting disorientated. You work in the medical profession. Can you tell us about experiences in other hospitals that you or your family may have had over the years compared with the experience you have spoken about today?

Ms HOOPER: I do not think we have ever had an experience like what we have been through.

Mr MICHAEL DALEY: It has generally been good?

Ms HOOPER: Yes.

Mr PETER DRAPER: You have said that after the media coverage you received a lot of follow-up from the hospital and regular updates, and so on.

Ms HOOPER: Yes.

Mr PETER DRAPER: Did that result from the media pressure, do you believe?

Ms HOOPER: I think so, yes, definitely.

Mr PETER DRAPER: As we heard from the previous witnesses, communication seems to be a big issue with patients.

Ms HOOPER: Yes, definitely.

Mr PETER DRAPER: How do you think we could improve that information flow between medical staff and patients' families?

Ms HOOPER: I think they should follow what they do at Hornsby: take them to boardroom or a private room and sit down with the doctor, the social worker and whoever else they need, and just keep the family up to date—make them feel part of that process, instead of just locking them out and treating them like they are not very important.

CHAIR: Following up on that question, it seems as if the nurses, the people you were relating to, had no policy about doing that, and it seemed to be very different to you as the nearest relative, a granddaughter.

Ms HOOPER: Yes. It did not concern them at all. It was just part of their daily routine.

CHAIR: You mentioned earlier in your testimony about your grandmother tearing her legs. How did that happen again?

Ms HOOPER: On the bed rails. They had the bed rails up to try to contain her in the bed. Because of being disorientated she kept trying to get out. The skin on her legs is like tissue paper, so even putting paper tape on her legs at the moment just tears the skin off. It would not have taken much.

CHAIR: Was she in the treatment room when she was doing that?

Ms HOOPER: No, she was in the ward.

CHAIR: She had no injuries while she was in the treatment room that you know of?

Ms HOOPER: No, and she had none when she went down there because I was with her the night they transferred her. They went over her with a fine tooth comb and there were no injuries on her legs when she left Hornsby hospital.

CHAIR: You mentioned that you were very disappointed that your grandmother was put into a ward with three men.

Ms HOOPER: Yes.

CHAIR: And one of those, you said, had a security guard or a policeman?

Ms HOOPER: A security guard, yes.

CHAIR: So he may have been apprehended for some crime perhaps.

Ms HOOPER: Yes.

CHAIR: So you do not feel that was a very good environment for your grandmother.

Ms HOOPER: No, I do not. I mean, she had no-one to talk to. She was there day and night. It was no different to her, and it was only when the nurses were passing that they would look at her

and say, "Are you all right?" Then they would wander off again. If you went to the nurses station to try to find somebody you could not distinguish who was a nurse, who was a ward clerk or anything. That to me was a bit confusing also.

CHAIR: Do you think that a patient should have a right to indicate that they are happy to be with men if it is a female?

Ms HOOPER: Yes, definitely.

CHAIR: That they should be consulted or just simply wheeled into that ward?

Ms HOOPER: No. Especially for her era, it was never the done thing, and they must find it terribly hard to accept being thrown into a room with three men. For my era it would not be such a big deal but someone of her age it is quite confronting for her.

CHAIR: Would it even have an impact on her recovery, perhaps her mental state. She would certainly be a bit agitated, you would think.

Ms HOOPER: Yes, and they did not communicate, whereas if she had been in a ward with some women they would have a bit of a natter and whatever, but the men kept the curtains closed and that was it.

The Hon. AMANDA FAZIO: How long was your mother in Hornsby hospital before she was transferred to Royal North Shore?

Ms HOOPER: I took her up on the Thursday afternoon, and they transferred her at 11 that night.

The Hon. AMANDA FAZIO: Because the cardiovascular team was away.

Ms HOOPER: Yes.

The Hon. AMANDA FAZIO: How long was she at Royal North Shore before she went back to Hornsby?

Ms HOOPER: I think it was two weeks.

The Hon. AMANDA FAZIO: And she has been in Hornsby hospital since?

Ms HOOPER: Yes.

The Hon. AMANDA FAZIO: I was just trying to work out the time frames. Had she been in and out of Hornsby hospital before?

Ms HOOPER: Yes, over the years.

The Hon. AMANDA FAZIO: Do you think that might have helped in terms of your family establishing a rapport with the staff there?

Ms HOOPER: No because she has been in different wards. It has never been the same ward. Geraghty ward has a lot of aged care people.

Mr MICHAEL DALEY: Was your mother living at home looking after herself or with a relative or in a nursing home?

Ms HOOPER: She was living with me.

CHAIR: And because of your grandmother's clotting problems, there must be no vascular specialist at the Royal North Shore Hospital. Is that the case?

Ms HOOPER: Yes, they were there but I never saw him. To this date I have never seen him. I have only even seen his offsiders.

CHAIR: There was a specialist at Royal North Shore Hospital.

Ms HOOPER: Yes.

(The witness withdrew)

WEI DENG GAO, Former Patient, Royal North Shore Hospital, sworn and examined:

CHAIR: What is your full name?

Ms GAO: Wei Deng Gao. My English name is Wendy.

CHAIR: And you are appearing as a former patient?

Ms GAO: I am the patient, yes.

CHAIR: Can you tell us your story?

Ms GAO: Yes. On Sunday 18 March I feel abdominal pain frequently. My own GP was not available on Sunday so I went to this medical centre to see the GP. The female doctor, she think it is appendix problem. She said, "You better go to Royal North Shore Hospital emergency, otherwise getting serious, your life in danger." So she wrote the letter I carry with me. I was preparing to stay in the hospital. I carry everything. I went there, it was afternoon, just after 2.00 p.m. I been waiting, waiting five hours. Of course, during waiting and nurse come and take my blood sample to check but I been waiting until 7 o'clock. I get in see the doctor. After doctor check she say, "You are definitely not appendix. You need an ultrasound. We don't have ultrasound on Sunday. You have to go back tomorrow to GP, local, to get an ultrasound." All she gave me is painkiller.

So what can I do? She said, "Here's emergency. We can't keep you here. Emergency only, taking patient life threatened." So I go back and Monday I went to medical centre again, get an ultrasound and ultrasound show nothing, no sign, nothing, cannot see anything. On Tuesday evening at 11.00 p.m. I suddenly feel terrible pain. This pain I never experienced. It is just wish I could die; the pain is unbelievable. So I rush to the hospital again. That was 11.00 p.m. Again, painkiller, sit there, painkiller. Nurse of course every now and then gave me check temperature, blood pressure, this sort of thing, until morning three o'clock I get in see the doctor in the emergency. The doctor told me, say "This time we can't let you go home. You have to stay, need a CT scan because ultrasound can't see. We have to wait until morning." So again painkiller and stay inside until the morning they get me ready for the CT scan.

Until 11 o'clock I went to get CT scan room, to get CT scan, after that they put me in the room on my own and nobody come and talk to me. Of course nurse come in every now and again to check, temperature, blood pressure, this and this, but no-one come talk to me. I ask a nurse, "What happened with me? What is my problem? Where is the doctor?" She said, "Today we have been very, very busy. Doctor will come and talk to you soon." Okay, until 5 o'clock still nobody come and talk to me. No communication. So I can't wait any more so I saw a doctor pass around, I just call her in. I say, "What's the problem with me? What does CT scan show?" She said, "Oh, we have been very, very busy today. CT scan show you have fluid on your appendix." She did not tell me I was burst. Actually later I know I actually burst on the Tuesday night, 11 o'clock, but she didn't me "You burst" she used "You have fluid on your appendix". "Now", she said, "You need to go to surgery. We are waiting for the surgeon to come and talk to you. We have been very busy." Okay, so she left. Then someone come in and ask me whether I want Medicare or whether I want private. Why they not talk to me earlier? Then an hour later a surgeon come in. He said to me, "You have very nasty appendix." I am sure they all know I was burst. So an hour later I was sent to theatre. Before getting to theatre the guy told me "Now we put you on the priority but if someone have accident, car accident, lost blood, you still have to wait." Fortunately nobody accident so I get in to theatre, get the surgeon. That was the story.

CHAIR: They removed the appendix then, did they?

Ms GAO: I don't know until two day later doctor, surgeon come and check me. Every doctor, almost young doctor, old doctor come in, almost everyone say, "You had very nasty appendix". When the surgeon come and talk to me, check, I said, "Oh, I was lucky. I almost burst." He said, "You already burst."

CHAIR: Yes. On the Tuesday?

Ms GAO: On the Tuesday night actually. So after burst I have been waiting to how many hours? From midnight, 11 o'clock to next morning—afternoon, 6 o'clock, 8.30 o'clock, 7.o'clock to get a surgeon. So my local GP told me I be very lucky to alive.

Mrs JILLIAN SKINNER: I think you are.

Ms GAO: Yes.

Mrs JILLIAN SKINNER: You first went to the hospital on the Sunday?

Ms GAO: Yes.

Mrs JILLIAN SKINNER: It was the—am I right—Tuesday that you came back?

Ms GAO: Yes.

Mrs JILLIAN SKINNER: At 11 in the morning and it was 11 p.m. the next night that you were finally in the theatre with an appendix that had ruptured?

Ms GAO: Yes. 11—Tuesday 11 p.m. I feel terribly pain burst until Wednesday later around 7 or 8 o'clock I get in the theatre.

Mrs JILLIAN SKINNER: You have said that many doctors have said to you—

Ms GAO: Very nasty.

Mrs JILLIAN SKINNER: Very nasty?

Ms GAO: Yes. Because they know how serious I was.

Mrs JILLIAN SKINNER: Listening to your story one of the things that comes across, quite apart from the lack of treatment in a timely fashion, is no information.

Ms GAO: No information. No communication.

Mrs JILLIAN SKINNER: At any stage of your treatment not really any proper information about your condition or how long you had to wait?

Ms GAO: No. After CT scan they all know what is happening. Why doctor not come and talk to me just for two minutes, let me know what happened to me?

Mrs JILLIAN SKINNER: They said they were very busy.

Ms GAO: Yes, very busy.

Mrs JILLIAN SKINNER: Were they? Did you see that? You saw it?

Ms GAO: I just see people running around outside. I am in the room on my own.

Mrs JILLIAN SKINNER: There has been evidence given to this inquiry that there is a real problem with blockages in the emergency department.

Ms GAO: Oh yes.

Mrs JILLIAN SKINNER: So it is quite likely that was the case?

Ms GAO: Yes. On Sunday I was waiting. I say, "Why I waiting so long? What's the emergency meaning? It lose the true meaning emergency. Five hours? People can die in five hours." I am lucky, you know, I am probably strong enough to be alive. I ask a nurse, I say, "Why I have to wait so long?" She said, "Oh, today it has been very good. Yesterday even busier."

Mrs JILLIAN SKINNER: You have seen other GPs and so on since you have had this. Have they said anything to you about this?

Ms GAO: My own GP—later back to my own GP, he said, "You are lucky to be alive."

Mrs JILLIAN SKINNER: So your complaint is not with the medical treatment. You were treated well by the doctors when you finally got treatment?

Ms GAO: I think the surgeon did good job and the nurses terrific.

Mrs JILLIAN SKINNER: So the surgeons and the nurses are terrific but the system—

Ms GAO: Yes.

Mrs JILLIAN SKINNER: The lack of information?

Ms GAO: Yes.

Mrs JILLIAN SKINNER: That would be your main concern?

Ms GAO: Yes. And why they don't have this necessary facility, like the CT scan, ultrasound on Sunday? People can get sick anytime, every day, any day, anytime, you know.

Mrs JILLIAN SKINNER: So a lack of equipment available 24 hours a day really, seven days a week.

Ms GAO: Should, in the emergency department.

Ms CARMEL TEBBUTT: Ms Gao, thank you for coming along and sharing with us your experiences because it does help us better understand what is happening and inform our processes as a committee. Can you perhaps tell us a little bit about what changes you would like to see come out of this inquiry? What changes you would like to see at the hospital in how it deals with patients and what could be done better?

Ms GAO: I think this hospital problem is not just black, white, that simple. It is quite complicated, you know. I think—

Ms CARMEL TEBBUTT: But just in your experience?

Ms GAO: Management definitely need a change to make the hospital system better and the procedure better. Should put more staff working in the emergency. Because obviously emergency can't follow the demand. My impression is the hospital is seriously understaffed.

Dr ANDREW McDONALD: How are you know, Ms Gao?

Ms GAO: Okay, but I am remedial masseur and I am working with my physical. When I working too much always reminding me something, pain, little, slight pain, always can remind me.

Dr ANDREW McDONALD: From what I under the diagnosis of appendicitis in you was actually quite difficult because of the normal ultrasound. Is that your understanding as well?

Ms GAO: Yes.

Dr ANDREW McDONALD: Can you think of any way of improving that, other than what you have already said?

Ms GAO: I think doctor is simply inexperienced in the emergency department because I am not the only one with no typical appendix symptoms. I heard so many people happen same. They don't have this high fever or nausea, or white blood cells rise very high, they don't have and they burst. So

doctors should know. I am not the first case to, like this. Doctors should know by now because so many people got pain and no typical symptoms but they are appendix, they eventually burst. So to avoid this, how to avoid this happen? People have pain must have problem otherwise they don't have pain. I went to first time in the emergency, they should not have let me go, send me home. Should keep me in the hospital for further check. Imagine if I burst on Friday night should I wait to Saturday, Sunday, to Monday to get CT scan to find out what is wrong? If doctor can't diagnose with just experience, they need to use a machine to diagnose, then this machine should be available 24 hours.

CHAIR: You have given us the impression that even though your appendix did burst, that the doctors were concealing that from you. They were pretending that you only had a pain in the appendix. Is that what you feel?

Ms GAO: No, my first local lady GP was concerned about appendix, but emergency doctor definitely not appendix.

CHAIR: Before you had the operation, you were given the impression that you had not had a burst appendix, is that right?

Ms GAO: No, they were just not sure. They have to wait for CT scan. They cannot say anything.

CHAIR: Did they tell you it was burst before the operation?

Ms GAO: No, nobody told me what is wrong. I thought appendix need operation. Nobody tell me it was burst until two days later. Then I learned it was burst long time ago, Tuesday night, otherwise it would not be paid like that. Before it burst the pain was bearable without painkiller. But after it burst, I have to take painkiller.

CHAIR: Do you think the doctor or doctors may have been embarrassed that it had burst after you had been to the hospital?

Ms GAO: They should be embarrassed.

CHAIR: So, they were not telling you the truth?

Ms GAO: I am not sure why they do not tell me the truth. They try to hide something or they worry if they told me I might panic. Of course, if they told me I would panic. I would bring in outsider to help, if I had to wait that long. I have private health fund. If they told me earlier I would go to private hospitals straight away, but no communication, nobody come talk to me.

CHAIR: Thank you for telling the Committee your story. All this information helps the Committee to make its report and recommendations to make sure the system works better for people like you in the future.

(The witnesses withdrew)

THERESE MACKAY, relative of former patient, sworn and examined:

CHAIR: You are appearing as a relative of a former patient, your husband?

Mrs MACKAY: Yes, with my daughter Melissa.

CHAIR: Would you now tell the Committee your story?

Mrs MACKAY: Yes, I have written it down, because he was in Royal North Shore Hospital for 5½ weeks, so I wanted to make sure I did not forget anything. I hope you have read my submission.

CHAIR: Yes, and it assists the Committee.

Mrs MACKAY: It is lengthy, but it was needed. No matter what happens here our family will not give up on setting to right the appalling cruelty my husband and our children's father, Don, endured with so much dignity. I will follow through all the avenues I am able to take, some of which I have already begun. My husband, Don, went to Royal North Shore we thought to have a simple lung drain and biopsy. It was not an emergency operation. Dr Mathur performed a lung drain and biopsy, but also an operation called pleurodesis. We had never heard of pleurodesis. We now know that you never do a pleurodesis at the same time you do a biopsy; a high does of talc is always suspect, you should never do it on someone who cannot fully expand their lungs.

Don had been unable to fully expand his lungs since 1982 because of quadriplegia. You should not do it whilst there is any fluid in the lungs. Don would still have had fluid in his lungs as it was still draining after that surgery. These were all ignored. He had such marginal respiratory reserves and his state of health along with his quadriplegia meant that he was already quite debilitated before the unnecessary and dangerous surgery was done on him, so bizarrely soon after he arrived from Port Macquarie, as I was still driving down.

I will tell you next of what I and the family feel is criminal neglect he suffered in the almost three days after his operation for which the cardiothoracic and the spinal deserve censure. They all missed the very visible signs of don's impending respiratory arrest from the failed pleurodesis. He was struggling to breathe and began to hallucinate, because, as I now know, there was a build-up of carbon dioxide in his system. His shoulders were going up and down and his tongue was moving in and out of his mouth as he tried to breathe. The cardiothoracic team's Dr Hemley said, "They were unconcerned", which I find amazing, and I have the notes. They did not seem to understand quadriplegia breathing, which makes it harder to breathe if you are sitting upright—the opposite of what it like for us. They should have.

They ordered him to be sat up in his wheelchair, he quickly got worse. About 2.00 p.m. I begged them to help me get him back into bed. I was told to wait till the lift round at 3.30. The lift round turned up at 4.30. He was treated like an annoyance. I still see all this in my head. Every half hour I would go to whomever I could find to get help for my husband. Finally I had to go home. I was staying at the Greenwich, which is Rotary, close to the hospital. It had been a very long day and I wanted to be there to catch the doctors the next day. I said to call me at any time, I was only five minutes away. Anyway, we were fobbed off.

He then had the first respiratory arrest early in the morning. I had actually mentioned to them to ring me if anything went wrong, like in the middle of the night if he called me I could be there in five minutes. I was told the next day by Norman, the man who was in the bed next to Don, that Don had called my name for three hours, but they did not call me. They had my number and my daughter Melissa's number. After that respiratory arrest, Don was aware that he had no chance of survival because with quadriplegic lungs that is a really bad event. They never in spinal, and soon in intensive care, noted their failures to act. They do not appear in any notes. The lack of observations and notes by spinal nurses is a disgrace.

He would spend five weeks in intensive care, where they tried to get him to breathe again by extubating and reintubating him several times allowing him to come very close to further respiratory

arrests before they would reintubate him. Shocking treatment for him to suffer and for us to have to watch. One time when they extubated him no-one took any notice of me when I told them that he was looking the same as he had in spinal pre-arrest. They just ignored me, apart from physio, who recorded this. Physio were always wonderful. Don went up to 50 breaths per minute, not written down anywhere of course.

We saw it on the monitor and the nurse got angry with us and said, "What are you worrying about?" and either turned the screen away or switched it off. She said that his tongue going in and out rapidly, and I have never seen anything like this, was that he was trying to talk. In intensive care there was one nurse for one patient. Then all hell broke loose and we were hustled out again and he was reintubated yet again. One time when a nurse was suctioning don, a part of the equipment fell onto the floor. I think Melissa saw this. We saw that nurse pick up that bit and put it back in my husband's mouth: bold as brass. This was only days before golden staph and Klebsiella pneumonia invaded his lungs so disastrously.

My lovely husband laid in intensive care for five weeks with his arms tied to the bed, both lungs now filling up with fluid constantly, body full of infection, sepsis they called it. He was full of excess fluid. He caught MRSA, that is golden staph, first in the arterial line then in his lungs and Klebsiella pneumonia in his lungs, candida albicans all throughout his mouth, in his urine and no doubt in his whole system. The place was filthy beyond words. There was no continuity of care with staff and much of doctors' and nurses' notes are illegible, which made this lack of continuity dangerously worse. The lack of hygiene in intensive care was shameful. Infection control is almost non-existent. In isolation they use a throwaway plastic bib type of apron, which covers only about a third of your body and clothing. Apparently the staph and other dangerous germs do not go on the arms, sides and back of the body.

My sister, a renal dialysis nurse from Brisbane, was horrified. This was towards the end, when she noticed they had turned off all his fluids but still had Don on a large amount of Lasix. Lasix drains fluid from the body. Anyone who has any medical knowledge would find this shocking. If she had not picked up on this, his last days would have been even worse torture than they were and he may also have endured the sickness that goes with full renal collapse. The nurse was reluctant to act on this and we had to go hunting for a doctor to have this rectified. It was hours before this was done and was not mentioned in the notes. Another time our eldest daughter, Melissa, was with us and we noticed that he was very nauseous from something. We saw that a loss of clear fluid was coming out of his mouth and running down to his beard. We called his nurse over so she could suction him so he did not choke. She was quite begrudging and on her way over complained she had just suctioned him. So she suctioned him and then walked off. We tried to clean him up as best we could. Then it began again and we had to call her over. He was her only patient. She was quite angry.

We told her he was really sick and could she give him some Maxalon in the drip, as this worked well on nausea for him. By this time the fluid was behind his neck, down behind his head and underneath his shoulders. He was cold and shivering and feeling really ill. Because he had so many tubes—I cannot remember how many; he seemed to have tubes and wires coming from everywhere—we asked her to help us clean him up because we were afraid of disconnecting something. She told us he would have to wait for the lift round. That was that. We cleaned him up and got under him as best we could and he watched our faces with the saddest eyes. How could she do this to him? These incidents are not just odd ones out of the ordinary. Every day things like this happened. Occasionally you would have a really good nurse, and they deserve huge praise for having to endure the bad nursing of the others. You see, none of the nurses had name tags, so you could never remember the names the next day. It was one-on-one nursing, but if you are there long enough you might see three different nurses a day looking after him. We were there for five weeks.

I have never seen such suffering like that. I am 53 years old and I have seen some terrible things—three months with his sister as she died from cervical cancer horribly. I watched my own mother struggle with end stage cardiomyopathy and other things wrong. I was present during all of Don's original hospitalisation for seven months when he broke his neck in 1982. In between I have seen and experienced the worst of human cruelty towards him at times. His last 5½ weeks spent in Royal North Shore Hospital were just horrible torture to extreme, all of which should have been avoided had that doctor not done the original dangerous and unnecessary pleurodesis. But once done he should have been treated with compassion in intensive care. Royal North Shore caused the damage,

but when he was overloaded on carbon dioxide and their hotchpotch of ever-changing medication and was hallucinating, many of them treated him as if he was an imbecile and with cruelty.

There were a few nurses and doctors who understood what was going on, and I wish I could remember who they were. They have my eternal gratitude. They should all have been like that to any ill and suffering human being. On the days when the real nurses were on, Don would be so different. It made me wonder what happened to him when we were not there. He was unable to talk because of the ventilation tubes and eventually the trachea. Sometimes when I came in I could sense that something was terribly wrong and he tried to not allow some nurses to touch him when I was there. Others, the good ones, he would do his best to be co-operative when he was able. We live now—Melissa and Alison, our other daughter, and one of my sisters—with five weeks of a horror movie inside our heads which plays over and over. Even as you talk to people the images seem to be playing in your inner vision. How much worse must it have been for my husband and my children's dad to have to, without choice, experience the dreadful suffering which was inflicted upon him, his arms tied to the bed for five weeks and mouth gagged by tubes?

Once he was diagnosed with golden staph Don was to spend the rest of his life, about 4½ weeks, in an internal pod-like room. This room had no natural lighting. I would turn the lights off to give his eyes a break from the bright fluoro light above his head. There was no halfway with this light; it did not turn down. The whole environment in this room was as if it was cut off from the outside. Only sometimes could we see a small patch of sky, and that was when we would ask if the curtain next door could be pulled back a little. On his last day there my sister was with him when a nurse came into the room and totally cut that room off by pulling the curtains right round his cubicle and across the door. She then sprayed right around the doorframe with some strong smelling chemical, as if he was already dead. He just shrugged at this. This was shocking and the nurse offered no explanation.

By 14 May Don's lungs were drowning in infection, apart from all the fluid, which was building up and being drained from the right and left pleural areas of his lungs. He was grossly oedematous—his body full of fluid. He had a pressure area, which he had never had in his life. He had sepsis in his body from all the infections. He had developed a condition called hypoalbuminaemia. He was unable to be weaned from the ventilator as a result of the damage done by the failed pleurodesis operation. They finally admitted that Don was dying, something he had accepted since those first days in intensive care. The intensive care and cardiothoracic doctors, because he was under both, should have given Don and us, his family, full disclosure of what they knew early on, as we discovered later in their notes. Five weeks of dreadful suffering would have been avoided. They lied to Don and us. To admit the truth was to admit the failed pleurodesis, and they all bear responsibility for this.

In all the time since Don had been in Royal North Shore and with all that was going on, I think that up until this time I had come across a social worker once. But we can find no notation about the meeting. Now when they decided he was dying, we were about to be drowned, almost assaulted in a sea of concern. When it was explained to Don by a doctor that he was dying, her notes record, "He looked at me as if to say, 'It took you that long to notice?' and expressed excitement at being able to go home to die." I had a bit of an ace card, I wanted to get him home and I think they wanted him out too. I asked was there any way we could get him to our home to die. He had always hated being in Royal North Shore and did not want to die there. It is unheard of what happened next. He was flown home by air ambulance to Port Macquarie on a ventilator, which would be removed, we were initially told, some time after Don arrived. Palliative care and others in Port Macquarie have never come across the likes of this in their whole careers. Royal North Shore said they would try to organise a ventilator from Port Macquarie for home so that Don could have some time there and then choose when to turn it off. He was told that it was likely he would die a couple of hours after turning off the ventilator. That never happened.

Just before we left we were told they could not find one home ventilator in the whole of Port Macquarie. Don just wanted to go home to die so that he could die in the place he loved, not Royal North Shore. He would have agreed to anything at this stage. So within minutes of Don arriving home, the ambulance began asking for the ventilator. His doctor allowed a small amount of time and disconnected it. Don put his arm out to hold it a bit longer. He was home with his loved ones. The doctor took his hand off the machine and firmly tucked it under the blanket. Don died a couple of hours later. So even that choice, the most sacred of human rights, was taken away from him by the

orders of Royal North Shore and his own GP. I question the legality of that whole event. The girls and I were just like robots by this time. I remember my face felt prickly and numb. The last four days of the time between 11 April and 17 May were bizarre. On reflection, it felt as if we were a part of an orchestrated event, and we are still puzzled by this time. Although Don wanted to be let die, the day he came home the girls and my sisters and I agreed that it felt like an execution.

I got a phone call a week or two later from Royal North Shore asking me how Don was going after his discharge. I am now in touch with the Coroner's office, as it appears there should have been a Coroner's report done because Don died directly of the failed surgery. Royal North Shore would have known that, but his discharge got them out of that mess. This GP should have known that also. Once in intensive care Melissa and I heard Don state clearly something that still haunted us both. He had wanted the tubes out. Clearly he wanted to die. That was expressed all through the five weeks. Don wanted those tubes out. He knew he was dying. So he chewed through a tube—he did that a couple of times—when we were there one day. On the out-rush of the released air he looked at us and said clearly, "Help me." We both have to live on with that desperate whisper in our heads for the rest of our lives. That was a shocking thing for a mother to see her daughter go through.

I think the poor patients and their loved ones need to be considered first as a priority and those good nurses and good doctors be supported when they want to whistle blow. I do not know how a new hospital or even cleaning up a hospital, especially just before the inquiry, will stop what happened to Don. He was killed not just by filth; he was killed by bad attitude and gross negligence. God help us all. I just also want to mention a feeling I have. They put Don on a study called the NICE study. It is to do with insulin in intensive care. We started to be concerned that there was an element of research in the treatment of Don because of his disability. We cannot prove that. I only just recently got flowcharts from that.

I have one other thing. This photograph shows our family at Christmas. Don is in the centre of his family. Even with all his disabilities he was the foundation of our family. Although he had fluid in his lungs he was not an emergency. This is a picture of Don taken with Melissa and I about three days before he went to hospital, and this is a picture of Don about six days after he went to Royal North Shore Hospital. This is a picture of Don in the early stages of Royal North Shore Hospital, before infection and before he was in that horrible room. I only just found that photograph on my sister's CD. She had taken it for a reason. I thank Committee members for their time and patience.

CHAIR: Thank you for giving us such a detailed and efficient report.

The Hon. JENNIFER GARDINER: Thank you, Mrs Mackay. I am sure that all members of the Committee understand how harrowing it would have been for you, first, to write the submission and, second, to come here today. You came from Port Macquarie to help us with our inquiry.

Mrs MACKAY: Yes, that is right.

The Hon. JENNIFER GARDINER: Thanks go also to Melissa for being here. With respect to the specific allegations of possible negligence in the treatment of your husband, have you referred those matters to the Health Care Complaints Commission?

Mrs MACKAY: Yes I have, some time ago actually.

The Hon. JENNIFER GARDINER: Is it following up on that?

Mrs MACKAY: Yes. The doctors just received my statement in the last couple of weeks and so has Royal North Shore Hospital.

The Hon. JENNIFER GARDINER: I do not want to distress you any further.

Mrs MACKAY: I think I am beyond that.

The Hon. JENNIFER GARDINER: You did say, alarmingly, that in the intensive care unit there was filth beyond words. Can you describe what you saw?

Mrs MACKAY: Okay. In the little isolation room—Melissa would remember that room—when the nurses took off their little throwaway aprons they would throw them and they would either land in the garbage or they would not. The wards men who did the cleaning of all the wards—they would go from ward to ward cleaning them—would pick up those throwaway aprons. They would go around and pick up the aprons and put them in the garbage. The next moment they would put on the same silly little aprons and they would go from bed to bed where there were people who did not have golden staph and people who did, or people who had other bugs, and they would do the lifting and the turning. They would lean over patients wearing these throwaway aprons, but the whole sides of their bodies and their arms were bare.

Do you remember that in the old days you had to wear a cloth that covered you from your top almost to the bottom of your feet if there was an infection? Now they wear something you would not wear to a barbeque. That was one instance. There was also blood on the floor, dirty sinks, dirty toilets and dirty windows. That does not make any difference, but the windows at Royal North Shore Hospital were just unbelievable. The windows in Parliament House are much cleaner. You could not see out of them, which just added to the bad feeling. There was a dreadful bad feeling in that hospital. It felt dark. Basically, it was just filthy.

Let me give you another example. My husband was a very clean man and he always looked after himself. We had nurses, but he was always careful with his hair and everything else. Once every 5½ weeks he got his hair washed. Finally it got so bad that we asked a nurse to help. We tried to mop it with washers and stuff, but you have to understand the amount of tubing that Don had around him and the ventilation. We just did not want to cut anything off. One day when Melissa was with me we asked the nurse whether she could help us to wash his hair. The nurses had a little instrument that you could put under the head, like a hairdresser, that channels the water down.

The nurse said, I do not know where the thing is", even though we had seen it and we knew it was there. The next moment we turned around and looked at her and she was looking at winter coats on the Internet. She noted in her notes on that day, which I have at home, "Relatives asked for hair washing, but it did not get attended to." That is the sort of filth. Don went for 5½ weeks and had just one hair wash. It is good to have your hair washed just for your own good feeling.

The Hon. JENNIFER GARDINER: Absolutely.

Mrs MACKAY: It was shocking.

The Hon. JENNIFER GARDINER: Did he have to have the lung drained and the biopsy at Royal North Shore Hospital because of his quadriplegia?

Mrs MACKAY: No, it was done at home quickly in March, in radiology, but they could only do a quick lung drain. They were afraid to drain it all because they did not want to collapse the lung. Our pulmonary doctor in Port Macquarie who could have done it—and Don would still be alive—decided to go into research and only does sleep apnoea now, so we have no pulmonary expert at Port Macquarie. If you have read the notes you will know that Don's GPs kept going on holidays, so there was a terrible lack of continuity. But when he came down to Sydney it was not an emergency, because I had had him at home.

The Hon. JENNIFER GARDINER: I know it was not an emergency but, because of the lack of a doctor at Royal North Shore Hospital—

Mrs MACKAY: They could have done it at Port Macquarie but we did not have a proper pulmonary specialist that was still practising.

The Hon. JENNIFER GARDINER: You said in your submission that your husband was terrified of going back to Royal North Shore Hospital and that he swore he never would. You then stated:

> He said to me many times that he probably would not survive if he did. Every time he went there he ended up with MRSA in isolation and needed to be there much longer than expected.

Was it a primary fear that he had that he would get the infection again if he went back there, or were there other factors?

Mrs MACKAY: He had his original accident in 1982 and the spinal unit was beautiful. It was active and vibrant, if you could call it that, and there were doctors everywhere and the best of equipment. They nursed the new spinal patients in the spinal ward, not in intensive care. He did not go back until 1994 because he managed to stay well for so long. When he went back in 1994 you could see the deterioration; it was beginning to become filthy. He got the golden staph then.

He went back in 1999 or 2000—I am not sure which year—and the same thing happened. Instead of going down for two weeks he was there for seven weeks, which is a long time out of your life, and he went again another time a year later. That was the last time. As got older his health was not that good and he knew every hit was going to hurt. He did not want to go down, but we could not avoid it. He could not get enough air into his lungs. Because of a lack of oxygen he was going to sleep at the breakfast table trying to have breakfast.

The Hon. AMANDA FAZIO: Could you please tell the Committee what kind of advice you were given about any formal complaint mechanisms that were available to you, because you obviously had concerns about the care your husband was receiving? What was your experience with that process?

Mrs MACKAY: When Donald was in the spinal ward for three days before intensive care, I was really concerned about the lack of treatment he was getting. I could see what was going on. I heard the lady before me state that, if you complained too much they ignored you, or somebody said that earlier. We used to say that they blanked you out. If you started to be too needy you got blanked out. That was the term that we used. I am sorry; I have forgotten the question.

The Hon. AMANDA FAZIO: What was your experience?

Mrs MACKAY: I went to the patient's advocate downstairs whose name is Mr Rich. He took my notes, which was fairly good, because I had them later and that helped a lot. I did not go to talk to the nurses because Don had a respiratory arrest, so he advised me to go and talk to the nursing unit manager in spinal on the day of Don's respiratory arrest, which was a pretty horrible day. I had to go downstairs and go through his mattress and everything, because they just left all his stuff strewn everywhere, and you do not leave behind a $2,000 mattress.

I went back to see the nursing unit manager and she was quite arrogant. I complained about the lack of observation notes and the lack of everything. She said, "This is spinal ward. He came in under cardiothoracic. We are doing you a favour for having him." That was her response after my husband's respiratory arrest. She did not look into it. So I gave up on the patient's advocate and stuff like that. I just needed to be upstairs.

The Hon. AMANDA FAZIO: Can you tell us what you think could be done in the future handling of concerns and complaints that might help patients and their families so that they do not have the same experiences that you did?

Mrs MACKAY: It was such a disaster that I do not know where to start. There is no explanation for what happened to Don. It is a systemic problem. I have to be honest: I have noticed a change in people's attitudes towards disabled people. There has been a big change and we are going backwards. In the 1980s people were much more open-minded and he was treated like a human being. But finally he was treated like an idiot. Because he could not get enough breath he was not making sense. He should have been treated. It was their fault; they mucked up the operation. They had missed the signs of respiratory arrest, so they punished him. We had a term at home. We used to call them the punishment nurses. That is a big problem with the nursing. I know they are busy but there is a big problem with their attitudes to compassion.

The Hon. AMANDA FAZIO: What about in terms of your interaction with the patient advocate? How would you like to see that sort of service improved?

Mrs MACKAY: I would have liked to have seen him offer to come up with me when I went to see the nursing unit manager. It was basically, "You go up there and do it yourself", sort of thing. Other than that, he seemed to be ineffectual. I had the feeling that he was working more for the hospital than for the patients and their relatives. There was one person—and I cannot remember names; I wish I could because she was the only one person who I could say was wonderful—she was the chaplain on the floor of the intensive care. She would track you down every single day and she actually cared; she followed you up. But she had no other powers other than that. If they were all a bit more like her we would have good hospitals.

Dr ANDREW McDONALD: That was an excellent submission I read, thank you very much, and you spoke very well. Your husband's medical condition appears to have been a very complex one.

Mrs MACKAY: He was a quadriplegic. As the doctor who was here before said, you have basically got to forget everything you know about your physiology and go back the other way. They breathe differently—there are a whole lot of things that are different; so it is specialised.

Dr ANDREW McDONALD: What sort of changes would you like to see made to the way people like your husband are looked after, medically?

Mrs MACKAY: The observation notes in spinal—I cannot remember the exact times—there is a huge distance in-between the observations. When Don was up in the chair it was not so bad; he was okay. When a quadriplegic is in bed they are totally helpless; they cannot press a buzzer; they cannot get a drink of water; they cannot read a book. Yet when Don was stuck in bed one time for six months I nursed him by myself, with a little bit of help from some nurses in the morning. If I went out to the clothesline I would run back in or I would hang them on the veranda line so I could hear: I never got outside his hearing because at any time he could have an event happen.

I did that, and I am not patting myself on the back—all carers do this. We call it a hospital of one 24 hours a day, seven days a week, and most of us survive. I am sorry; I get a bit fed up hearing about the poor nurses and the poor doctors. It would be more important to think about the poor patients first as a priority, and that is not what I heard this morning. A few of us relatives are a bit upset about that, because the patients seem to be not as important as the staff. That is my attitude anyway.

CHAIR: We thank you very much for coming in and sharing your story with us. We sympathise with you and your daughter over the loss of your husband who you loved very much.

Mrs MACKAY: I have not lost him; he is still there.

(The witness withdrew)

(Short adjournment)

CHRISTINE ELIZABETH RIJKS, Relative of former patient of Royal North Shore Hospital, sworn and examined:

CHAIR: Thank you very much for coming in to our inquiry. Thank you for your help.

Ms RIJKS: Thank you for the opportunity.

CHAIR: You are appearing as a relative of a former patient of Royal North Shore Hospital?

Ms RIJKS: The daughter of Philip Singleton Lindsay.

CHAIR: Would you like to tell us your story?

Ms RIJKS: I have already prepared something. Do you mind if I read this?

CHAIR: No, we are very happy for you to read it. We know it is a lot easier for you to do that when you have some sad memories.

Ms RIJKS: My father, Philip Singleton Lindsay, date of birth 15 March 1918, died on Thursday 7 July 2005 from renal failure at the Royal North Shore Public Hospital. He was the holder of a Veteran Affairs gold card. Following the closure of the Repatriation Hospital at Concord, my father, like all returned servicemen, received a letter stating that the gold card would provide the best level of hospital treatment in Australia and he and my mother truly believed that his gold card would provide this level of care. The evidence that I wish to present to this inquiry implies no criticism of the staff at the hospital. I have the greatest admiration for the nursing and medical staff. I have no criticism of any individual nurse or doctor. If I criticise the standard of nursing, it is due to what appeared to me to be the low staffing levels created by the health system and management of this hospital. It is also criticism of the treatment of returned servicemen holding gold Veteran Affairs health cards.

My father was admitted to the Royal North Shore Hospital on five separate occasions from September 2003 due to problems relating to kidney failure. On the fifth occasion he was admitted on or around Sunday 26 June 2005 following severe reactions to his first treatment of chemotherapy for prostate cancer. His symptoms included severe nausea, vomiting, diarrhoea and dehydration. On Sunday evening 3 July, one week later, my mother phoned me to say that my father was not getting good nursing care at hospital. She felt she could not leave him because it appeared that no-one was looking after him in her absence. He was not well enough to be taken home. He could not feed himself he was so ill. He was not being washed.

That day when she arrived at the hospital she found him slumped in a chair in a hospital gown, not covered with a blanket or in a warmer dressing gown, and no slippers on his feet. He was cold and miserable. My mother called on the nursing staff for assistance to put him back into bed. She was very distressed to see my father like this; so was he. They both had a terrible weekend. My mother, also in her eighties, was absolutely exhausted. My mother felt that a privately employed nurses would improve the quality of care for my father and to allow her to go home and get some sleep. My mother asked the nursing staff if it was possible for her to engage a private nurse, and the response was that it was not usual. Thirty minutes after this phone call from my mother I was on a flight from Ballina to Sydney while my husband phoned the Royal North Shore Hospital to obtain a list of nursing agencies from which a private nurse could be employed with the hospital approval.

To give you an idea of my father's normal everyday activities, he was still working. Retirement even at 87 years of age was not part of his philosophy. He was still driving himself to and from work from Mosman to Leichhardt, travelling interstate on business, and driving long-distance country trips. For the long weekend in June he drove to Grenfell and back again. So, he was leading a very full, active life in spite of his recent health problems with his prostate and kidneys. My father was in a four-bed ward, bed number 24 in ward 10B. He had been transferred from the twelfth floor ward and this move appeared to cause his condition to deteriorate. He became very distressed after the move. He believed that his hospitalisation on this occasion was caused by an extreme reaction to chemotherapy. He told me he was not going to have any more treatments. His second appointment

was scheduled for 14 July 2005. He said to me, "I should never have listened to Doctor." I have in brackets "Professor Levy."

On the Sunday night, the night I flew down from Ballina, I arrived at the Royal North Shore Hospital. Ms Manuela Pitaga from Allied Medical Staff arrived at the hospital that same night at 9.45 p.m. as our privately employed nurse. Our family employed Ms Pitaga from Sunday 3 July to Thursday 7 July. My mother was informed recently by Veteran Affairs that the Royal North Shore Hospital records said that we only employed our private nurse for one night. This is incorrect. Ms Pitaga was an experienced nurse and familiar with the Royal North Shore Hospital. She was to stay with my father all through the night and take observations, and attend to his personal comfort and safety though she was not authorised to administer medications or injections et cetera.

She had mobile phone number for any reason she wished to contact me through the night and I arranged to be back at the hospital before 7.30 a.m. Monday, the next morning, before she finished her overnight shift. The following morning at 6.00 a.m., Monday 4 July 2005, I was back at the hospitals and our private nurse gave me a report of my father's night. She had recorded all the usual observations, including blood pressure and his temperature, and she had swabbed out his mouth with water and helped him to get more comfortable.

Dad had a cannular in his left elbow—he is left handed—and whenever he moved his arm the buzzer on the saline drip started to beep, waking everybody in the room. This happened every few minutes all through the night. I asked Peter, the helpful male nurse on duty, if a new cannular could be put into his right hand instead and in the meantime if a splint could be put onto Dad's elbow. Peter made a splint from a role of newspaper and two crepe bandages to provide a temporary solution. My father's breakfast of liquid foods consisted of a cup of black tea, a plastic container of orange juice and a plastic cup of orange jelly. This was plonked down by an indifferent food trolley man. I had to spoon feed my father. He kept spitting out bits of vomit. I am sorry this is so graphic, but I have notes from when I was there.

My father was distressed and very unwell. He had oxygen through his nose plus a saline drip, which was replaced with a new bag as soon as it emptied. Ms Pitaga left and agreed to return to that night. Dad said to me, "Who's paying for my nurse?" I told him he was. Dad said, "But I've got a gold health card from the Government." I told Dad that his other gold cards would be of more use. That morning Dad told me he was feeling so ill that he did not think he could go on, but hoped the chemotherapy drugs would soon be out of his system. I noticed that he was feeling very cold. I asked the staff to bring him more blankets; I asked if they had any warm blankets in a hot box, as they do in surgical theatre wards. No, there were not any hot blankets.

Two medical oncologists from Professor Levy's team arrived at around 8.00 a.m. that same morning. I learnt that Professor Levy was in fact now overseas and had said goodbye to Dad on Friday. Dad's war-related deafness often meant that the failed to comprehend things that doctors told him. Two medical oncologists—one was Catherine Thoo or Toon—told me that his kidney function was deteriorating but that the liver function was improved after the chemotherapy. I ask what my father's prognosis was like and I expected the oncologist to say that once the chemotherapy drugs were out of his system that he would start feeling well again and he probably had one or two years of life. However, they told me that kidney failure was a quick death and that Dad had at most several days. They confirmed that I should gather the family together as quickly as I could.

Dr Catherine Toon and her male colleague oncologist were very kind but factual. They told me that they would arrange an ultrasound during the day to see whether it was possible to change the stents in his kidney area, which could possibly improve the kidney function. She asked Dad if they had this operation if he wanted to be resuscitated. This was the actual conversation that I wrote: "Mr Lindsay, you are in a hospital, and if anything goes wrong lots of doctors will rush to revive and resuscitate you. Do you want to be resuscitated?" Dr Toon had to shout this question again to my father, who could not hear it the first time. It had to be shared in the room where three other anonymous patients lay in their beds divided only by a cotton curtain. Dad said he did not wish to be resuscitated.

My mother arrived at the hospital and we booked her into the accommodation at Rotary House within the hospital grounds so that she could stay close to my father. My parents' adult

children, grandchildren and great grandchildren also arrived and stayed with my mother at Rotary House and in other accommodation adjacent to the hospital. To be able to stay in accommodation within the hospital made a huge difference to our family. But I was informed recently that to Rotary House accommodation no longer exists.

Meanwhile the staff at Royal North Shore Hospital informed me that he could not die in the hospital, that there were other places for dying, and suggested he be moved to Greenwich Private Hospital. My father was very distressed at the suggestion of a hospital relocation. He had not entered the hospital with any ideas he would be dying. We requested he be given a private room. Dad moved to a private bed in room 10, but we were informed that it was just a temporary solution as they might need the room. There was constant pressure for beds in the hospital.

The next day, Tuesday, my father was facing the realization that he would be dying very soon. At the end of Ms Pitaga's shift, Dad had taken her face into his hands. He was showing his appreciation of her gentleness and caring through the night. Again on Tuesday the hospital staff reacted by informing us that he could not die in the Royal North Shore Hospital, that we need to find somewhere else, and Greenwich Private Hospital was again brought to our attention. As a family we refused to have my father moved from the hospital or from room 10.

The anaesthetist visited and confirmed that he was not prepared to give Dad an anaesthetic. He said, "No operation for a start. His kidney's too far gone. Not in a fit state to cope with anaesthetic." All that day Dad kept asking for food. The nurses at the hospital would not allow any food because they were worried that if it went down the wrong way he could develop pneumonia. He had visitors all morning—friends and family saying goodbye. Dad became agitated if he smelt food. "Why are you refusing to let me eat?", he asked us quite accusingly. Dad clearly still had his sense of taste and smell and was hungry for food but unable to feed himself. He kept pleading with us to bring him food. The hospital staff were adamant, no food. Our privately employed nurse had shown us how to swab out his mouth with cool water to keep him more comfortable. She had also shown us how to massage his legs, feet and hands. So we swabbed out his mouth with cool water and also with warm pumpkin soup. That is how we satisfied his taste buds—with pumpkin soup and cotton buds. We also massaged his legs, feet and hands, which brought some calmness to his situation.

By Wednesday afternoon, the following day, my father was very distressed. We felt he needed morphine pain relief on demand. I talked again to the oncology team and requested that he be permitted to have morphine. The two doctors looked at me and said they had already written in his notes that he could have morphine every hour. But when the oncology doctors looked, they found that the morphine drip to my father had been disconnected, that the cannular had been removed and he had been given morphine only once every six hours, which was grossly insufficient.

Dad had indicated that he was now ready to go but he said it was not happening fast enough for him. The oxygen tube in his nose was irritating him and he kept pulling it out. I knew that Dad was getting closer to death; he was no longer showing any signs of response when I massaged his feet and legs. He complained earlier that he had lost all feeling in his legs.

Our private nurse phoned me at 2.00 a.m., Thursday 7 July 2005 to say that Dad had died at 1.55 a.m. My husband, sister and I walked quickly to the hospital. Our private nurse had already washed him and put on fresh sheets. My father was still warm and looked more peaceful. He had really laboured silently towards death in the final steps. She told us he just took one final breath and that was it. At 3.29 a.m. the hospital doctor—a young woman—arrived to check Dad's body. She listened to his heart, took pulse and shone a torch into both of Dad's eyes. She pronounced him dead and asked me to step outside. She asked me now long he had had prostate cancer. I said that he had been admitted to Royal North Shore Hospital with kidney failure in September 2003. She said there had been five hospital admissions.

Our private nurse told us that Dad's body could stay at the hospital for quite a few hours. In my notes at the time I wrote that we could stay with Dad for 12 hours from the time the hospital doctor gave official pronouncement of his death. But, no, the hospital was not going to allow this. He had to be taken out of the room as soon as possible so they could put someone else in that room. My brother immediately made arrangements to have his body transferred to the morgue.

My father received an extraordinary level of care during his passage of death due to our privately employed night nurse and his caring family. It is hoped that the hospital continues with the policy of allowing privately employed nurses into the hospital to work alongside the hospital staff. We were very grateful for that. What did I learn about Royal North Shore Hospital through my father's death? I will not make an issue of the poor quality of hospital food—I was not impressed with that either; it was very poor quality. I wish to focus on the low level of nursing for a dying man incapable of caring for himself—a returned serviceman from World War Two promised the best in health care that Australia could provide.

The three main issues were that a gold Veteran Affairs card appeared to provide a lower level of physical care—for example, type of hospital room, public hospital versus private—than a private health insurance plan. My father let his private health insurance go when he was given a gold card by the Government. The second point is that there were too few staff on the ward, and those staff had too high a workload. The third point is a constant pressure for bed availability. There were some other issues. Four, not a high level of human hands-on nursing care, especially for someone in my father's situation. Dying is one of life's passages, just like birth. I would be surprised if birthing conditions at Royal North Shore Hospital are as low as dying conditions.

There was no time for special consideration for an elderly patient, such as putting the cannula into the left elbow of a left-handed person, although I do recognise how difficult it is to insert the cannula and perhaps my father's dehydrated veins did not offer any options; not placing a splint on his arm to prevent ongoing problems with the drip not functioning and waking everyone else in the room all through the night; not washing patients, not assisting with feeding, not keeping patients warm; not creating a caring, loving atmosphere to promote healing or comfort; creating unnecessary suffering, for example, not connecting the morphine when it was approved and written in the notes by the oncologist, and clearly required by the patient.

Six, complete disregard for the comfort of a dying person. Why did they keep trying to have him relocated to another hospital, or move him within the hospital? Seven, what special care services are available for the dying? If there are people available for spiritual needs, why not for physical needs? He was offered prayers, but this was not what he wanted. Where were the physiotherapists or massage therapists to do gentle massage for my dying father? Where are the hot blankets for the elderly? Where is the happy, helpful staff? This is not a factory. It should be a centre for healing. There was not a good atmosphere at this hospital.

CHAIR: Thank you very much again for a very detailed and clear submission. We appreciate that very much.

Ms RIJKS: Thank you.

Mrs JILLIAN SKINNER: And a very thoughtful one as well, so thank you. You have summarised a number of issues that say it all. Can I ask about a follow-up from this? What has happened since? Have you been asked to provide any advice to the hospital about the complaints mechanism? Have they come back to you? Has it been followed up?

Ms RIJKS: No. I did not want to make a complaint. I was really—and my mother who is here today and my husband—so grateful that we were able to bring in our own private nurse. It is something that I would encourage anybody to do because I recognise that somebody dying does need very special care. Like, we did extra things as a family; we took music in and we sang to my father. We did a lot of things that I have not gone into now that probably are not relevant, but I do not know why a hospital could not be a place like this.

I understood when the staff kept saying, "Well, this is not somewhere for dying." I know that hospitals are places for healing, but my father did not actually enter there with any idea that he was going to die. None of us had any idea at all. It came as an absolute shock on that Monday morning when, instead of being told that he had months or a couple of years, I am presented with a few days. And it came as a big shock to my father too.

I guess why I am here is I was reacting to the Horska case of the miscarriage. I read that in the paper and I was so appalled I thought, "It's time that other people spoke out about what has been

happening." So I wrote a letter to the *Sydney Morning Herald* and I did not really even expect it to be acknowledged or published, and the next thing it was front-page news because of the timing.

Mrs JILLIAN SKINNER: And because you were lucky enough to be able to afford a private nurse, but some families might not be. What would happen to them?

Ms RIJKS: Funerals cost a lot of money, too.

Mrs JILLIAN SKINNER: And the private nurse, the care she provided that you have described?

Ms RIJKS: It was absolutely extraordinary. I mean, I have been in a lot of hospitals and had a lot of surgery and if somebody, if your mouth is dry and you are not well, swabs it out with cold water and a cotton bud, it can be just such a comfort—just little things like that.

Mrs JILLIAN SKINNER: Yes.

Ms RIJKS: And to stay with my father all night to make sure that the trip was not stopping and so on.

Mrs JILLIAN SKINNER: Did she say anything to you about the conditions in the hospital, the cleanliness?

Ms RIJKS: She did not criticise it at all. We did not criticise any of the staff at all. There were lots of little things I could go into. Perhaps it was not appropriate to tell my father the way he learned he was dying in a shared room like that, and not having consideration for his deafness and not having consideration for the other people in the hospital too. They were eating their cornflakes when this conversation was going on. The man across from him became quite distressed. It is just lots of little things. They are not things that I really want to criticise at all.

Mrs JILLIAN SKINNER: No.

Ms RIJKS: I would like to see a hospital that had more staff, that had a happy atmosphere, and that had more hands-on. It just seemed to be too busy to be caring for people, particularly if you were someone who, like my father, needed a very high level of care.

Mrs JILLIAN SKINNER: That is something that has come through the evidence from other people here. Many people say that there is no criticism of the staff, although there are obvious exceptions to that, but it is usually that they are run off their feet, there is not enough of them, there is obvious constant pressure for beds, which you have described here as well. Those are the sorts of things that you would want fixed, if you had your way?

Ms RIJKS: Definitely. I just do not think there is enough funding into hospitals. You do not go to hospital unless you need to be there. My father would have much preferred to have been at home, but we could not cope at home. We had no proper way of looking after him in the house and he was not well enough by this stage to even move again in an ambulance.

The Hon. JENNIFER GARDINER: Ms Rijks, you have said there was a discrepancy between the records of the Department of Veterans Affairs and the Royal North Shore as to how many nights the agency nurse was there.

Ms RIJKS: That has been reported to me by my mother.

The Hon. JENNIFER GARDINER: Has that been sorted now?

Ms RIJKS: No, I am not interested in worrying about details like that. It does not really help anybody.

The Hon. JENNIFER GARDINER: But it does—

Ms RIJKS: It indicates that, yes, there were problems in the recording, but I have not followed that through personally. That was reported to me. I have not gone back to the hospital and asked if they could check through those records to see if that is true, but is I think my mother knows. Mother, that is correct?

Dr LINDSAY: That is right.

Ms RIJKS: That is right.

CHAIR: Your mother cannot give evidence.

Ms RIJKS: No, she cannot. I am repeating. I do not have this firsthand but I did state in here that that was the information I was given.

The Hon. JENNIFER GARDINER: Okay.

Ms RIJKS: Because I thought that if this went any further, the hospital might say, "Well, they only had a nurse for one night", but that was not true at all. If my father had stayed in hospital for six weeks, we would have kept employing Ms Pitaga for that entire time. It was open-ended when she came. She had no idea how long we would be employing her.

The Hon. JENNIFER GARDINER: You have said that there were such basic shortcomings—not washing, not feeding, not keeping the patient warm, lack of privacy and dignity.

Ms RIJKS: Yes.

The Hon. JENNIFER GARDINER: They reinforce other messages from other patients and, indeed, clinicians have acknowledged that those are shortcomings. Hopefully there may be some recommendations out of the inquiry—that they get back to basics, if you like. Is that the direction that we should be headed in?

Ms RIJKS: I would be very pleased to see that.

Ms CARMEL TEBBUTT: Thanks, Ms Rijks, for coming and sharing what must have been an absolutely terrible time but also having to relive it through your evidence to this Committee. But I think it does help our processes to understand patients' experiences. I was going to ask what is it that you would like to see come out of this inquiry. I think you have really outlined that, but is there anything further you think we should be aware of that you would like to see reflected in our inquiry recommendations?

Ms RIJKS: I do not know. I would like to see what your recommendations are going to be. I have got no idea what they are.

Ms CARMEL TEBBUTT: We have not come up with them yet. I am sorry, I was just asking was there anything particularly that you would like to see come out of this inquiry that you have not yet had a chance to articulate?

Ms RIJKS: Only that the hospital should be there for the patients. It does not exist for any other reason. That is their reason for being. They have to go back and look at what patients need, the people that they are caring for.

Dr ANDREW McDONALD: Just clarifying one thing, the palliative care team—

Ms RIJKS: Pardon?

Dr ANDREW McDONALD: The palliative care team from North Shore. Was your husband offered a consultation with the palliative care?

Ms RIJKS: My father.

Dr ANDREW McDONALD: I am sorry, your father. Was he offered a consultation with the palliative care team?

Ms RIJKS: I cannot comment on that. I do not know.

Dr ANDREW McDONALD: Right. You know what I am talking about, palliative care?

Ms RIJKS: I do, I do. I have no idea. I just lived through the Sunday that I told you about. What date was it? Sunday 3 July until Thursday 7 July at the hospital. I do not live in Sydney. I came down as soon as I knew that he was really unwell.

Dr ANDREW McDONALD: While he was in the hospital, in those four days he was in the hospital?

Ms RIJKS: Not that I can remember.

Dr ANDREW McDONALD: What about the formal complaint mechanisms? Were you told about how to make a complaint?

Ms RIJKS: We were not wanting to make a complaint. It was not part of our agenda. We decided we would avoid ever going back to the hospital. If my mother was ill that is not a place I would be in a hurry to take her. I was born in the Royal North Shore Hospital, so our family has a long history with that hospital.

The Hon. AMANDA FAZIO: You said your father had a Veterans Affairs gold card for medical treatment. Do you feel he was let down because there are no special repatriation hospitals any more?

Ms RIJKS: Definitely. I do not know if you need a special repatriation hospital but you need to really look after people. When you make a promise—I am going to give you, as a government, a gold card—I had my father saying, "I do not need to keep my HCF payments up any more." I would have been happier to see my father keep his HCF payments up and ignore the gold card and know that we could get the level of care for him that we wanted, because I felt this gold card he had was like a card to nowhere. I just did not think it was giving him the level of service, yet people are under the impression that if you have a Veterans Affairs gold card you are going to get the very best level of treatment, but that was not what I experienced with my father with a gold card. I thought he was getting a very poor level of treatment.

The Hon. AMANDA FAZIO: My father has a Veterans Affairs gold card. I think I am probably under the same assumption that you were, that it meant the very good level of care they got in the repatriation hospital would be replicated for them if they went into an ordinary hospital.

Ms RIJKS: That has not been the experience with this particular hospital. I cannot comment on other hospitals.

CHAIR: Just following up that question, obviously when the Concord Repatriation Hospital was operating it would have given VIP treatment to all the ex-servicemen?

Ms RIJKS: I believe so.

CHAIR: And, according to reports, they did. The question is whether the nurses or staff at the Royal North Shore Hospital understand the significance or importance of that card?

Ms RIJKS: That is quite a possibility. I do not know how many permanent members of staff are at the hospital or whether a lot of people are brought in from agencies who really do not know. I do not know what the situation is, but I appreciate that comment and I think that is very relevant.

CHAIR: With the private nurse, were there any problems with the other nurses or any tensions with the other nurses?

Ms RIJKS: Not at all. It was fantastic. The particular nurse we got was very experienced in palliative care. She was just the most gentle, caring person. If anybody's parents were needing special attention, they were dying, I would happily recommend her.

CHAIR: I understand she was very good, but was there any resentment from the other nurses?

Ms RIJKS: Not at all. They were working in, absolutely. The hospital still had its regime, its treatment, whatever it was, it just continued on. She was not replacing any of the things that they would normally have done. She was just providing this extraordinary one-on-one overnight special care so my mother, my brothers and sisters and I came in through the daytime. We would get there about 7 o'clock and have a crossover period and she would leave at 7.30. She would come back in the evening and stay all night so we could go home and have some rest—we were staying in the hospital grounds—knowing he was being cared for.

CHAIR: Some people have said that the care by the nurses should be of such a high standard that it is not necessary to hire a private nurse to go into a public hospital. I know you did the right thing, but do you feel that is setting a bad precedent, that patients will feel they need to have their own nurse?

Ms RIJKS: I think it should be an option that individuals can take advantage of. I think it should be there. We were so grateful it was available and it is something I would recommend to anybody who had somebody in a family that was dying. It just gives the most marvellous support to the family and the patient.

(The witness withdrew)

(Short adjournment)

JENNY LANGMAID, Former patient, Royal North Shore Hospital, sworn and examined:

CHAIR: Thank you very much for coming today. We appreciate your support. It is quite okay to have your friend support you.

Mrs LANGMAID: Thank you.

CHAIR: Would you like to make a statement to the Committee?

Mrs LANGMAID: I have a statement. Perhaps I will not read it verbatim. I might start with it.

CHAIR: You can quote from it; that is quite okay.

Mrs LANGMAID: I apologise; I am quite weepy. My friend is having a baby but I am the emotional one. I presented to the Royal North Shore Hospital on 16 June 2005 at 9.30 p.m., along with a close friend—who is here with me today—because my husband was overseas on business travel. I was 14 weeks pregnant. I briefed the triage nurse on my condition and my medical history and explained that I believed I was in labour. Half an hour later, at approximately 10 o'clock, I inquired as to how long I would have to wait. I was advised up to one hour. I reiterated that I had had two previous miscarriages at 15 and 17 weeks and that, with identical symptoms, I believed I was in the process of losing my baby. I was told to take a seat and somebody would see me as soon as they became available.

My pain rapidly worsened over the one hour and my contractions were between three and five minutes apart. Again, this was communicated to the triage nurse. I remained in the waiting area whilst trying to breathe through my contractions in a state of disbelief as to what was unfolding. At this stage I felt the outcome was imminent and knew that I did not want this to happen in front of a room of strangers, including another pregnant woman sitting opposite me. At 11.00 p.m.—some one and a half hours from when I first presented to the triage nurse—I insisted that if a bed was not available I at least sit on a chair on the other side of the emergency doors, out of view of everybody in the waiting area. I was eventually allowed to sit on a chair just on the other side of the doors. My pain was witnessed by the triage nurse and another nurse who walked by. Neither showed any sense of empathy, understanding or concern and nor did they make any attempt to ensure that I had medical support.

My contractions and pain continued in the chair for the following 20 minutes. I felt a huge gush of blood and at 11.20 p.m., along with my friend, looked for a toilet. Once I was in the toilet my baby son expelled at approximately 11.30 p.m. My friend located the nurse and when she came to the toilet I told her that my baby was in the toilet bowl and that she would need to get a pan so that I could retrieve him. Shock, and perhaps her lack of familiarity with the department, reflected in her slow, inattentive response. I was finally taken to a cubicle within the emergency department to try to stop the haemorrhaging, whilst another nurse tried to deal with the bleeding and removal of clots. I was asked to change rooms twice—walking from room to room and visible to others in the emergency department, covered in blood and completely distressed—as the instruments they required were not in both the previous rooms.

Some 45 minutes later the nursing unit manager introduced herself to me. She then met with the attending OB registrar, who finally took me to the theatre to conduct a D and C at approximately 12.30 a.m., as the bleeding would not subside. I came away from the Royal North Shore Hospital feeling that there was a lack of empathy before, during and after miscarrying, a complete lack of any level of care and ignorance of my medical history, and absolute disregard for my basic needs upon presenting to the emergency department and my subsequent cries for help throughout those two hours. Whilst the outcome may not have been different, the indignity of losing my baby in an emergency department toilet could have been prevented, and will stay with me every day of my life. I live with the fact that the events of that night play on my mind constantly. Should I have gone to the maternity section of the hospital or perhaps another hospital? I thought I made the right choice in going to an emergency department as I thought it was an emergency and I was not yet participating in a maternity

program at any hospital. I also thought I would be in good hands at Royal North Shore Hospital, supposedly being a teaching hospital and a major research facility. Thank you.

CHAIR: Thank you very much. We sympathise with you in your loss.

Mrs JILLIAN SKINNER: Thank you very much for coming and telling us your story. It is important that we hear from patients about what it means to them. We have heard from doctors and nurses but I think your stories are very important as well. One of the things that has really struck me just this afternoon while listening to patients is that you have all talked about a lack of empathy—as though the care and comfort that you would expect from caring professions were no longer there. Yet many times people have said that the doctors and nurses are fantastic. It worries me. Do we need to make some recommendations about giving caring staff more time to be caring, training them more or emphasising this more in training? What do you think is needed? Do you have any ideas?

Mrs LANGMAID: I think that is a very good question. But Alison and I come from banking and finance backgrounds and human resources fields and we deal with people all the time. Depending on the situation that you are presented with, I think you have to have a certain amount of regard for exactly what you are dealing with—if that is somebody grieving, bereft or what-have-you, you need to deal with that appropriately. I think there is no brush you can use to paint the one picture. I think it is very difficult to say, "Okay, we will install empathy into the medical staff" because I think sometimes it has to be within you. It is like a behaviour; I do not know whether you can teach that. I have had a positive experience there with my daughter. I do not think the hospital is in complete disarray but I think, unfortunately, the emergency department seems to have been.

I wrote down some of the things that I personally would have liked to see. I know that there is a triage performance benchmark and they have categories one to five. In reading that, I felt that I was obviously allocated a category five. Perhaps I was not there dying but my baby was, and I think they need to consider that. I think an increase in their training and development and the retention of the nursing and medical staff, I think an increase in the number of nursing staff available to support these high-volume areas. I know that is getting a little bit away from the question.

Mrs JILLIAN SKINNER: I think that is important. I guess what you are saying is that you were pretty well aware of the inevitability of what was happening to you.

Mrs LANGMAID: Absolutely.

Mrs JILLIAN SKINNER: But it was about the dignity and getting beyond that very public open space to somewhere where you had privacy and a caring environment.

Mrs LANGMAID: I really think I would have got more support if I was in the local McDonald's. I really do.

Mrs JILLIAN SKINNER: Because Jana Horska's miscarriage got so much publicity, some protocols have now been put in place. Was there discussion of any protocols after your miscarriage?

Mrs LANGMAID: No. That is another very good question and it is one that has been asked previously. I am struggling now to talk about it. Two years ago I could not string any sentences together. Everybody is different as well. We all grieve differently, but I think because my husband was overseas, that was again difficult. He did not get back until the following morning and trying to deal with that and process that—perhaps you just hope it is a one-off; you hope it will not happen again but I must admit when I heard it had happened to Jana Horska, it felt like it was an absolute replication of what had happened to me.

Mrs JILLIAN SKINNER: And hearing about her is what brought you forward to speak about this?

Mrs LANGMAID: Absolutely.

Mrs JILLIAN SKINNER: What do you hope to achieve out of this? You have made some suggestions for how we should change things. Is there anything else that you would like to see changed?

Mrs LANGMAID: I think the hospital is a place that you would expect delivers a standard level of care. That is why you go to a hospital and you have that minimum expectation. I think as an absolute basic minimum you do expect to receive that as a patient. That is one expectation I would have. This is not enjoyable for me; I am not trying to point fingers at anybody. I do not think it was one particular person that dropped the ball. I think it was a group of people.

Mrs JILLIAN SKINNER: A culture, climate?

Mrs LANGMAID: Perhaps the culture, perhaps the processes, perhaps they were outdated, perhaps there is a lack of any sort of incentive to be in an environment like that; there is no reward, there is no recognition. If you look at private enterprise, it is a very different approach to the way they deal with people because it is a happy place to be.

Mrs JILLIAN SKINNER: Yet we have heard many patients, not in the emergency department, talk about the nursing staff and doctors and how grateful they are. Do you think it could be because the emergency department is so frantic and so busy and they have too few beds? Could that have been a problem?

Mrs LANGMAID: I think so. The emergency department is a unique department in itself. It is obviously an incredibly stressful environment and I think perhaps that is one area that they need to perhaps focus on having larger volumes of staff being able to support the unit overall, but I think the communication that comes out of an area like that is not transparent and you sit there as a patient waiting in a waiting room being told that you might be waiting for half an hour or an hour, but clearly that is not really the case. I think it does need to be transparent for the standard citizen sitting there waiting. We are all equal; we are all people and you all have wives and children and you would not want that to happen to them.

Mrs JILLIAN SKINNER: The physical shape of the waiting room with the outside part then the barrier to go inside, is that problematic for a patient, do you think?

Mrs LANGMAID: I just think the process of the triage. I do not think that the division between the two for me personally was an issue but I just think personally the fact that they are very busy; they have not got the number of people to support the number of people sitting in the waiting room. It extends to a number of other problems.

The Hon. JENNIFER GARDINER: As you said, a patient should be entitled to expect a minimum standard of care and when you are confronted with the fact that that does not exist and you are already in a shocking situation, it adds to the shock and the grief, does it not?

Mrs LANGMAID: Absolutely. You have gone through the process of a tragedy happening, unfolding, and then you are marched around the actual area with blood everywhere whilst other people can visibly see you. It is just horrendous.

The Hon. JENNIFER GARDINER: It is terrible. Can you tell us did the emergency department seem busy at the time?

Mrs LANGMAID: I think they certainly seemed busy but they did not seem frantic.

The Hon. JENNIFER GARDINER: They were not frantic?

Mrs LANGMAID: I think I have presented to the emergency department with my family before and it did not seem anything out of the ordinary to me, but there are lots going on behind the scenes that you do not see.

Mr MICHAEL DALEY: Thank you for coming in today and taking the time to help us out. After you went through what you will unfortunately did, did the hospital or anybody else contact you

and give you any information about avenues for complaint or to take the matter further in any way? Was any information given to you?

Mrs LANGMAID: No. There was no follow-up. In fact, that is one of the things that I have actually pointed out here; that I think post-miscarriage treatment is really important and it impacts on the reputation of the hospital because whilst I certainly was not out there vocally speaking badly of the hospital, people who knew me and knew of our circumstances as a family obviously were very disgruntled with the hospital overall because of the situation that I was in and the lack of care that I received.

CHAIR: You mentioned a moment ago that they grade patients. You thought you were graded number 4 or 5. Did they indicate how long you would have to wait? Did you receive any advice that you would have to wait two hours or four hours?

Mrs LANGMAID: No. Initially when I first presented at 9.30 it was suggested that it could be up to an hour and through that first half an hour, that is when I went back continually between Alice and myself and said, "Look, I know what's happening here. It's happened before. And it's going to be quite distressing for the people who are sitting out here as well as myself, for them to see this" trying to protect them as well. There was another pregnant woman sitting there, it would not have been a nice thing for her to see a foetus on the floor.

Whilst it is very hard to make a call, "Okay, this lady needs to be seen straightaway. She's as important as someone who has been brought in by an ambulance", I know that is a very hard call, but quite often when medical staff are assessing patients we, as patients, give all the information—"This is where my pain is, this is the severity of the pain". You listen to us and make an assessment based on the fact that "Okay, these are the symptoms. We need to get her in straightaway." I was saying to the triage nurse that "I know what is happening, I am in quite a bit of pain and we do not have that much time", but still I was told to sit back down and wait. I understand that is a really difficult call but I think there needs to be some sort of shift in the way they assess what category is allocated.

CHAIR: It would appear that whoever designed those protocols originally—and they have been changed—made an error, to say that a person who may be having a miscarriage is a low priority person.

Mrs LANGMAID: Absolutely.

CHAIR: That decision was the wrong decision.

Mrs LANGMAID: Absolutely.

CHAIR: And the nurses are following that system.

Mrs LANGMAID: I know that a positive thing has come out of that in that now obviously all women presenting to emergency will be sent to maternity, but I did have that conversation with the NUM two years and I did actually make that suggestion myself and it is a shame that it fell on deaf ears.

CHAIR: The other point that is fairly obvious is that the staff who man the emergency department should be specially selected who can show some empathy towards patients. They are the front door of the hospital.

Mrs LANGMAID: Absolutely.

CHAIR: It seems that you are not the only person giving this sort of evidence. There seems to be a lack of care in the nurses working in that department. Whether they become hardened or something is affecting them but it seems to be a pattern that is not very positive?

Mrs LANGMAID: Reverend Nile, you are absolutely 100 per cent correct and it is so difficult for the medical profession to attract talented, skilled workers within that field. They need to

retain them and they need to give incentivise them and reward and encourage them. There are lots of things that they can be doing for them to be there and to be happy about being there.

The Hon. AMANDA FAZIO: You are aware that a special report was commissioned to look into ways to improve the treatment of women presenting with miscarriage to emergency departments conducted by Professors Hughes and Walters. There has been a bit of media coverage about their recommendations. Have you any comments to make about their recommendations? Are you aware of them?

Mrs LANGMAID: No, I am not.

Mr PETER DRAPER: I very much appreciate you coming in and telling us your story. You are very brave.

Mrs LANGMAID: Thank you.

CHAIR: We appreciate you giving us your time and for Alison coming in to give you moral support. Apparently she has been supporting you for some time?

Mrs LANGMAID: Yes, she has.

Mrs JILLIAN SKINNER: And you have a daughter?

Mrs LANGMAID: Yes, a seven-year-old. She unfortunately said, "How come you've come back from the hospital without a baby", because that is what children expect to happen.

(The witness withdrew)

STEVE ERNEST CROSBY, relative of former patient of Royal North Shore Hospital, sworn and examined:

CHAIR: We appreciate your help, Mr Crosby. You are representing Ms Leng Liu, a former patient, who does not wish to give evidence today?

Mr CROSBY: We started reliving the experience this morning and she just broke down, so she would prefer not to.

CHAIR: I am sure you can convey her thoughts to us. You are a relative?

Mr CROSBY: I am her de facto partner, yes.

CHAIR: Have you a statement that you want to make or do you just want to answer questions? We are happy for you to make a statement or tell your story or her story; we would appreciate that.

Mr CROSBY: Meaning you would like to hear my version of events?

CHAIR: Yes.

Mr CROSBY: Leng was eight weeks pregnant and we were aware that we had a complication. We were advised by our general practitioner to, if anything happened, race up to Royal North Shore Hospital and go to emergency. The evening in question was actually the same evening that Jana turned up at the hospital. If I can quickly say that what led me to be here was that, the morning after, I heard Jana's husband on the radio talking to Alan Jones and I was thinking the timing when he was there was just uncanny, they must have been virtually mopping the place up as we walked in the door, so it was directly after. I did not actually see Jana and her husband, so they were out by the time we moved in. I just could not believe that that had happened and they were prepared to let it happen again, half an hour afterwards.

Anyway, we got to the hospital, filled the form in and the nurse came out within about five minutes, which was great. She took Leng's blood pressure and we thought, right, everything is going well. But then we proceeded to wait. I cannot remember exact times, but we probably got there at about 9.30 and we would have waited until close to 11 o'clock and then I decided that I needed to know what was happening. People that came in after us started going through the door and I thought maybe they have missed us out, so I went to talk with the nurse and she said, "Right, you're on the list, you're on the list", and I pushed her a bit more, I kept asking her questions, and she got a bit agitated and then started going through her list and she said, "Well, you're actually nine people down the list." I said to her at that stage, "When we came in here there were only three couples in the place"—three that we could see anyway—and I said, "There's people going through the door that came after us", and she said, "Well, we considered your wife to be stable and we do it in order of priority."

I thought, well, okay, but in the meantime my wife was in a lot of pain. She had been to the toilet at that stage I think about three or four times, just mopping up blood running down her legs. We had our three-year-old son there trying to keep him under control as well. It just wasn't a comfortable situation. I went back and talked with Leng and we sat there for probably about another 20 minutes. I went back up and said, "Look, I really need to have a time. My wife is in a lot of pain; there's a lot of bleeding happening"—and by the time we left she had been to the toilet five times. She had brought some period pads with her, and they were soaking up and there was a lot of blood after that. She could not give me an answer and I said, "Look, I've really, really got to have some sort of timeframe here", and then she looked up at me and she said, "Well, look, we're not going to be able to do anything until we have an ultrasound and we're not going to be able to do that until the morning", and I looked at her and I just—sorry.

I was in total disbelief at that stage and I said, "Well, what am I doing here?" She was prepared to let me sit there right through the night, without even telling us, and I thought, well okay, and I said, "Look, I'm going to take my wife home where she can at least lay down", and she said to me, "Well, okay"—this is my words, I don't remember her exact words—"We can't tell you what to

do. If you go home, that is your decision". I thought: well, that's it. I'm going. So we went home. We had been home for about five minutes and she miscarried in the toilet.

CHAIR: What did you do after that? Did you go back to the hospital or to a doctor?

Mr CROSBY: No, we just stayed home. We went to the doctor first thing in the morning.

CHAIR: I am sorry to hear that story, especially, as you said, given that it happened just after Jana's case.

Mr CROSBY: When I heard that the next morning, it totally rocked me. I could not believe that two would happen in a row. They just did not seem to care at all.

Mrs JILLIAN SKINNER: The next morning when you heard Mark Dreyer speak out, you must have wondered how the same staff who had gone through such a trauma with Jana could not react to your situation. Is that what you were thinking?

Mr CROSBY: Yes. There was nothing. It was as though we had gone in there with a cut on our hands—like it was no big deal and we could wait.

Mrs JILLIAN SKINNER: Sitting here listening to you, it strikes me that there are several issues here: first, the total apparent indifference or lack of empathy, and second, the fact that you were not given any information?

Mr CROSBY: That was the worst part. She was prepared to let us sit there the whole night, right through to the next day, before we had the ultrasound. They were her words—that we needed an ultrasound before they could do anything.

Mrs JILLIAN SKINNER: If you had been told upfront, "It looks like it is not a high priority. You are going to be triage 4 or 5. You are going to have to wait a couple of hours. You are going to need an ultrasound anyway", what would you have done?

Mr CROSBY: We would not have stayed there all night. It was very, very uncomfortable for her. If they could have given her a bed, it would have been great. But just sitting in a chair and bleeding profusely, it was not a good situation.

Mrs JILLIAN SKINNER: They are pretty hard plastic chairs too; they are not comfortable?

Mr CROSBY: No, not exactly.

Mrs JILLIAN SKINNER: What has happened since? Have you heard about the results of the review and that they now have new policies? Do you think it will make any difference? Or have you not heard about what they have said about that?

Mr CROSBY: I have been following it. I think a lot needs to happen at that place. The next day when I was relating it to my GP, he said to me—I will not use any names—he works with a group of doctors. He said that every time he personally wants to contact someone at Royal North Shore Hospital, it is the worst place he rings to get information from. He said he gets a real run-around—people just do not care; they are not really helpful at all. I think there is a whole culture there. It has been happening for a long time, I think.

Mrs JILLIAN SKINNER: Do you think that the fact that the triage nurse did not come straight out and say, "It is going to take a while" was part of a fear of taking responsibility for telling you that you could go home? Did you feel that at all?

Mr CROSBY: She did not want to use the words—I felt at that stage that she did not want to take liability at all. Yes, that is right.

Mrs JILLIAN SKINNER: Did they say to you at any time that they are really busy, or that there are lots of people with more urgent conditions? Did they say anything like that?

Mr CROSBY: She did not say that, but when I asked her how long the first time, she did say we were nine down on the list.

CHAIR: The first time you arrived, there were only three other couples there, he said?

Mr CROSBY: Yes, when we walked in the door. That is not to say that there may have been others walking around, but in the actual waiting room there were only three couples.

Mrs JILLIAN SKINNER: Did the staff examine your wife at any time to, for example, have a look at the blood loss to determine—?

Mr CROSBY: Not at all. The only time we had contact with the nurse was when she took the blood pressure when we first got there. I guess that was just to assess her condition. But it was only blood pressure, that was it.

Mrs JILLIAN SKINNER: So really, there was no examination—not even any questioning about the blood loss?

Mr CROSBY: No, nothing.

Mrs JILLIAN SKINNER: When you went to your GP the next day, your wife did not need follow-up treatment?

Mr CROSBY: She had an ultrasound. That still went on for another week; she was passing blood clots. A GP was talking about the little operation for a clean-out. I am not sure what they call that.

Mrs JILLIAN SKINNER: A curette.

Mr CROSBY: Yes, that is right. As it turned out, we did not need that, so it was okay.

Mrs JILLIAN SKINNER: Was there any follow-up from the hospital to find out how your wife was?

Mr CROSBY: No. Funnily enough, the only time I heard from the hospital—I got rung up about this inquiry last week; I cannot remember which day it was. The day after that, the hospital rang up and they wanted us to go down. The day after we got rung up for this inquiry, we got contact from the hospital.

Mrs JILLIAN SKINNER: You mean, the day after the Committee Secretariat called you, the hospital called you?

Mr CROSBY: Yes.

Mrs JILLIAN SKINNER: I hope your wife has now fully recovered and is fine.

Mr CROSBY: Yes.

Mrs JILLIAN SKINNER: Apart from the emotional aspect, which takes time?

Mr CROSBY: Yes.

CHAIR: When you arrived at the hospital, they did take your name and address and particulars so they could contact you?

Mr CROSBY: When we arrived, at the start?

CHAIR: Yes.

Mr CROSBY: Yes. They have what I believe is probably a standard form. All our details went on that.

Dr ANDREW McDONALD: You have mostly answered the questions but I want to see if you have anything to add to what you have already said. You said that a lot needs to happen. What suggestions do you have about what could have been done differently? You have already suggested a bed.

Mr CROSBY: Thinking back on the situation, the nurse was not like a nurse. She was not like a nurse as I remember nurses, as I picture nurses. There was no empathy. She was very cold—may as well have been a prison officer. Even that, even just a little bit of empathy. More questions of what is going on. Even when I mentioned the blood loss and the pain, still nothing happened. They did not even come and have a look at her. We were just sitting out in the waiting room, still waiting. When I had that conversation with the nurse, that was probably another 20-minute period after that before I went and saw her again. So there was no follow-up anywhere there at all. I do not know what needs to happen.

Dr ANDREW McDONALD: They are two very good suggestions.

Mr MICHAEL DALEY: You said part of the negativity of the ordeal for you was sitting in the waiting room not knowing what was going to happen and not getting any information, and one example you used was that you would like to have known how long you had to wait and what follows, such as the ultrasound. Is there any other information, looking back as you are sitting there, you would like to have known that the hospital could have given you and did not?

Mr CROSBY: We did not get anything at all so it would have been nice to know at least what they were going to do, what the procedure was: Were they going to take her in for the night or just have a look at her? I do not know. There was nothing there. We were running blind.

Ms CARMEL TEBBUTT: Thank you for coming and sharing your experiences with us. After Jana Horska's experience and your own experience but not informed by that, there was an inquiry by Professor Hughes and Professor Waters which Mrs Skinner referred to. One recommendation that came out of that was that women with early pregnancy present at the maternity unit rather than going through emergency. I think the rationale behind that is that they would be in a better position to understand what is happening and also to appreciate the need for empathy and perhaps be more in a position to offer that because they do not have all the other stresses that are going on in an emergency department. In your experience would that be a better process? Do you think that is a useful change to be made?

Mr CROSBY: I am definitely for change to be made. As far as that idea goes, I think it is the worst idea I have ever heard.

Ms CARMEL TEBBUTT: Why is that?

Mr CROSBY: In my partner's situation, she was losing the baby, and if we are going to be in a maternity ward with other babies around, I think that would be hugely traumatic. I cannot see that working.

Ms CARMEL TEBBUTT: My understanding of the process was that it would be in such a way as to try to provide a separate area.

Mr CROSBY: Okay, if it is something totally away—when you say maternity ward I am picturing—

Mr MICHAEL DALEY: A specialised maternity area staffed with maternity nurses and clinicians in a separate area.

Mr CROSBY: In that respect it is a good idea if they have all the right sort of people there.

Ms CARMEL TEBBUTT: Sorry, that is my fault for not explaining it as clearly as I could have.

Mr CROSBY: Yes, it is probably a very good idea. If it is somewhere totally different, totally separate, they would have all the right professional carers there. That is the reason they are there in the first place. It is probably a very good idea.

CHAIR: Thank you again for coming in. The triage system seems to put a lot of responsibility on that particular nurse, almost acting like a de facto doctor. Do you think the point where your wife was really in a serious state and bleeding she should have said, "I'll get a doctor to come and look at your wife. Forget the ultrasound"?

Mr CROSBY: Yes.

CHAIR: Talk a doctor who can then make a decision about what should be done.

Mr CROSBY: Yes. I totally agree with that.

CHAIR: This is a hospital with doctors. There seemed to be great trouble trying to find a doctor.

Mr CROSBY: I do not know what was going on behind the scenes but that would have been—I guess I kind of expected someone to come out when I was explaining it to her but nothing happened.

CHAIR: It is possible that the doctors never knew, no doctor knew all this was happening.

Mr CROSBY: He probably did not go past the front desk.

CHAIR: Thank you for coming in, and please convey our sympathy to your wife.

(The witness withdrew)

(The Committee adjourned at 4.55 p.m.)

IN-CAMERA **REPORT OF PROCEEDINGS BEFORE**[1]

JOINT SELECT COMMITTEE ON THE ROYAL NORTH SHORE HOSPITAL

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

———

At Sydney on Friday 16 November 2007

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The Committee met in camera at 8.30 a.m.

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PRESENT

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

Legislative Council
The Hon. A. Fazio
The Hon. J. A. Gardiner
Ms J. G. Skinner
Ms C. M. Tebbutt

Legislative Assembly
Mr M. J. Daley
Mr P. R. Draper
Dr A. McDonald

[1] Published by resolution of the Committee, Friday 16 November 2007.

DEBORAH JANINE LATTA, Private Citizen, Former General Manager, Royal North Shore Hospital, sworn and examined:

CHAIR: Thank you for coming today to assist us in our inquiry. We appreciate your attendance. In what capacity are you appearing before the Committee?

Ms LATTA: I am appearing as a private citizen and as past General Manager of Royal North Shore and Ryde Health Service.

CHAIR: The Committee has agreed to hear your evidence in camera. At the end of your evidence we will ask you whether we should publish it. We will resolve that issue when you finish your evidence.

Ms LATTA: Thank you.

CHAIR: Would you like to begin by making a brief statement?

Ms LATTA: Yes, I would. Thank you for the opportunity to appear before the Committee. I was the General Manager of Royal North Shore and Ryde Health Service, responsible for both hospitals and with shared responsibility for 35 community health facilities from February 2003. I left the health service in August 2005. I have had the benefit of reading the transcript from Monday's hearing made available on the parliamentary website and note that there have been many statements made about the excellent and committed staff, the hospital's reputation as a major provider of high-quality health care and the admirable track record in research and in obtaining grants. I certainly concur with all such statements. I would add that there is a major commitment and significant achievement by highly skilled professionals in the areas of training and education of all clinical groups, some programs for which are leading edge.

In accordance with the terms of reference, I note that there has been a focus on the issues of bullying and harassment, both through this inquiry and in the recent media. As such, I would like to provide information about this to the Committee from my perspective. Soon after I was appointed to the position of general manager I was provided with a number of written complaints about bullying and harassment allegations that related to a senior nursing member of the Royal North Shore Hospital executive, which were up to a year old. My brief was to action these complaints. The area executive and I determined the approach to be taken, which included the investigation culminating in the September 2003 report that has been mentioned in recent times.

The person of interest was informed of the issues and of the investigation, and relevant senior nursing managers and those who were invited to participate in the investigation were informed of the investigator's focus. Those who submitted the original complaints were asked to participate. I met regularly with the person of interest during the period of the investigation regarding performance and progress of the findings from the investigation. My recollection is that this person resigned from the hospital prior to the report being received to take up an alternative position. Following her resignation and the subsequent receipt of the report, each of the divisional nurse managers were informed of the outcomes and of the need to provide leadership regarding not tolerating bullying and harassment and actioning any such behaviour.

Soon after this the area executive decided that a staff climate survey would be conducted for all staff across the area. This was undertaken a couple of months after the report was received. As such, I felt that the survey was an appropriate next step in determining the extent of the problem since the major contributor was no longer in the organisation. The survey demonstrated that bullying and harassment was still evident and that this was the case throughout a number of services in the area health service. Such surveys are often difficult to interpret and, as such, focus groups were conducted with staff within the departments of each of the divisions of Royal North Shore Hospital and Ryde Hospital to determine the most important aspect to be acted upon from the information received in the survey report. Action plans were developed and implemented in conjunction with the staff to address the issues.

I requested that the human resource manager allocated to Royal North Shore and Ryde Health Service from the area HR service undertake research into approaches for best addressing bullying and harassment. This is not an easy thing to address and, as such, I felt it worthwhile to gain some evidence in approaches that may have worked in regard to bullying and harassment—and may have worked well. Bullying and harassment is one of those types of behaviours that you could liken to addiction: people need to first understand that they actually have a problem. From my experience, most people do not understand that they have a problem, no matter what education or awareness raising they participate in. I was informed that the area HR service would be dealing with it across the area and, as such, individual hospital programs were not to be developed.

From the very early days of my appointment it was evident that there were many other areas of priority, including the major work that I needed to undertake as a result of changes in the area health service. This was to merge Royal North Shore and Ryde hospitals into one management structure, financial management, quality systems, clinician engagement, data management and reporting, and capital and equipment replacement. All of these were additional priorities apart from managing bullying and harassment. I am certainly happy to answer any questions.

Mrs JILLIAN SKINNER: Thank you very much. That is very enlightening. I am very pleased that you have addressed some of those issues, particularly around bullying. The Minister told this inquiry that former management at Royal North Shore had not immediately addressed bullying. I had assumed that she was probably referring to you, which would appear from your evidence not to be the case.

Ms LATTA: I am assuming that it was me. That is why I felt it was important to clear the record.

Mrs JILLIAN SKINNER: Much has been said about the latest bullying review—the 2007 review—conducted by Vern Dalton and Judith Meppem. The 2003 review that you commissioned is now in the public domain and the media has reported on it. The staff climate survey led in 2004, did it not, to a lot of staff briefings, including power point presentations?

Ms LATTA: That is correct.

Mrs JILLIAN SKINNER: Why do we still have in 2007 bullying and can we be confident, do you think, about the most recent claims that this will be a thing of the past?

Ms LATTA: I am not sure that we can be confident that this is the case. It is a very difficult thing to deal with and I think a lot of it has to be people, like senior people, actually modelling appropriate behaviour and I do not know that we always see that, unfortunately. It is not an easy thing to deal with, in that it is not a matter of saying, "Well, you are a bully and we are going to sack you" or whatever. You actually have to go through a proper process.

The other issue in regard to bullying and harassment is that people have to want to come forward to tell you that there is a specific issue. As a general manager I could not deal with issues of a specific nature unless people came to me and said, "I have an issue" and then I would take it up. In fact, I took up a number of those sorts of things personally when they were raised with me and dealt with them. That is one of the issues that means it continues to possibly bubble underneath the surface, if people do not feel that they can come forward.

Mrs JILLIAN SKINNER: One of the things that the Meppem-Dalton report has highlighted is the fact that the human resources area itself seems to be an area where there are some concerns. Was that the case in your day?

Ms LATTA: Absolutely.

Mrs JILLIAN SKINNER: That may be something we can focus on when Mr Dalton gives evidence.

Ms LATTA: Yes. And can I just add to that?

Mrs JILLIAN SKINNER: Yes.

Ms LATTA: I think one of the issues—and I raised it when I was within the organisation—was that often the bullying, harassment and grievance processes go hand-in-hand and the grievance process is actually very cumbersome and difficult to navigate. I think those sorts of processes need to be easy for staff to navigate so that things can be addressed.

Mrs JILLIAN SKINNER: Thank you, because that is my next question. I have had a number of nurses in particular—but not only them—say that there are still outstanding grievances that are a couple of years old, if not older, that have not been dealt with. Would you find that hard to believe or believable?

Ms LATTA: I think it is believable and it really depends on how much those grievances have escalated and who is actually dealing with them.

Mrs JILLIAN SKINNER: If there were suggestions that some staff, particularly nurses, were afraid or unwilling to come forward to this Committee because they need continuing bullying, harassment or behaviour that would lead to further grievances or make their lives more difficult, would that surprise you?

Ms LATTA: It would actually. I do not know that that is throughout the organisation. I have not seen any evidence particularly.

Mrs JILLIAN SKINNER: But if there were any that would say that?

Ms LATTA: I would expect there would be some people that would say that, yes.

Mrs JILLIAN SKINNER: I turn to page 4 of the Minister's evidence from the transcript the other day. She said that one of the areas that concerned her was management of Royal North Shore, particularly poor financial management. The context for her saying this was past practice was no longer the case. Do you think she was referring to you?

Ms LATTA: I do not know, to be honest. Throughout the transcript there are lots of things referring to management and it can be confusing as to who is talking about whom. I guess I have some views on how things were managed financially.

Mrs JILLIAN SKINNER: What was the financial position of Royal North Shore Hospital when you are general manager?

Ms LATTA: Royal North Shore Hospital had had a very longstanding financial issue, so it was not new when I came into the role and during the time I was there, there was an approximately $20 million budget problem.

CHAIR: A deficit problem?

Ms LATTA: A deficit yes, on an annual basis.

Mrs JILLIAN SKINNER: You mean that every year it was $20 million in the red?

Ms LATTA: Yes, pretty much. It was different from year to year but generally that was the amount. When I first started in the organisation, a couple of months after I started I was asked to present to the board at the time what I had found in regard to financial issues in Royal North Shore in particular because they were concerned that things were still not in a good state and what I had found as a new person coming into the organisation. So I presented to them—it was two or three months, I cannot remember exactly now, after I started in the role and I had found a number of issues that had developed over a period of time that assisted in them being in that position. So I presented all of those to them. They were things like new services being approved, additional appointments being made without any funding actually being put to any of those, and some of those were worth quite a number of millions of dollars.

Mrs JILLIAN SKINNER: Mr Barker said there was a review of the Royal North Shore budget allocation process in 2005. Were you there during that time?

Ms LATTA: That started just as I was leaving.

Mrs JILLIAN SKINNER: So you do not know the outcome of that review?

Ms LATTA: No.

Mrs JILLIAN SKINNER: Dr Matthews told us that there were significant performance issues at Royal North Shore, particularly about the cost per DRG compared to peer hospitals. He reckoned it was about $400 per cost-weighted separation more expensive at Royal North Shore. Would you agree with that figure?

Ms LATTA: There were some parts of service provision that were more expensive, for sure. Also in those transcripts it talks about how some things cannot be compared quite so easily. If you look at orthopaedics, one of the major differences that I would see, having had experience in other hospitals, is that the senior medical staff in orthopaedics all attend for all of the trauma that happens, which does not happen in lots of other hospitals, so obviously that is an additional cost but it is also something that I think is very positive.

Mrs JILLIAN SKINNER: So it is a good practice but it adds costs; it has financial implications?

Ms LATTA: Yes.

Mrs JILLIAN SKINNER: The suggestion in one submission about a shift of trust funds at the end of the financial year to cover the bottom line, would you be aware of that?

Ms LATTA: I was. I believe something like that happened prior to me being there but it also happened during my time there and after much argument it still actually occurred. That trust fund has since been reimbursed with the funds that were taken out of it.

Mrs JILLIAN SKINNER: Was any action taken against the individual who shifted the funds?

Ms LATTA: No.

Mrs JILLIAN SKINNER: Do you think that was appropriate?

Ms LATTA: I do not believe so.

CHAIR: We will move on to Mrs Tebbutt.

Ms CARMEL TEBBUTT: You have identified in your evidence some of the priorities that were there when you first got to the position and you continued to work on. What were some of the challenges in addressing those priorities? You talked about bullying and the report, you talked about the challenge of merging Royal North Shore and Ryde. What were the challenges, in your experience, in the time that you were there in dealing with and addressing those priorities?

Ms LATTA: The Royal North Shore and Ryde merge actually went quite smoothly considering it was such a major change. It was really a matter of engaging clinicians, as well as managers to make that happen smoothly and for it to be effective at the end of the day. It was a situation of a small hospital thinking a big hospital is taking it over and a big hospital thinking, "Well, what has a small hospital got to offer? We all worked very hard on addressing that, so I think while that was a challenge it actually worked well and we all worked together in making it happen and further work has happened in order to make that even more streamlined. We have talked about bullying and harassment. Financial management I found particularly challenging. One of the reasons for that was that I guess I felt I did not have a lot of control over what was happening with the financial situation. I would find that cash flows had been altered without me knowing, so that money

had perhaps been brought forward to cover the costs of a month-by-month situation, which meant we would have less money towards the end of the financial year, and I found out that that had happened after the event.

Ms CARMEL TEBBUTT: Who would be responsible for that then?

Ms LATTA: Well, people within the area had made those decisions. So those sorts of things happening without any transparency made it extremely difficult for me to be able to manage the financial situation, and I did bring this to the attention of the area on numerous occasions and in fact actually at one point said to them, "If this approach to managing finances is going to continue, I don't believe I can be held responsible for the outcome of the financial situation." With the clinicians and the managers in the organisation I spent considerable time developing strategies to improve the situation, including setting up a clinical services group, which involved lots of clinicians, and we spent a lot of time—we met every week and we had subgroups that went and looked at every single service.

From that we developed a plan for what we saw the future of every service being. It was very detailed, it was all the FTEs, it was the finances, it was what clinics they had, it was all of that, and we put a report together as to what we felt as a group each service's future was and also recommendations for what we thought could happen that also related to financial management. None of those recommendations was approved, despite the fact that clinicians were involved in making the decisions, and I felt that those sorts of recommendations would have actually assisted with the $20 million financial problem or deficit. So those sorts of things, like doing all of that work, no outcomes happening from it, became very frustrating, and with financial management being a focus—and you could not get over that hurdle I felt, you know, after all the work you just could not get past it—that meant that other work that I felt was important to get on with, like making sure that we focused on patient care, was sort of I guess satisfied to some extent because of the financial focus.

Dr ANDREW McDONALD: A number of submissions and witnesses have raised a concern about the relationship between management and clinicians, saying it was not very good. Were you aware of this?

Ms LATTA: Well, in fact I would dispute that. I do not know what timeframe they are talking about. In fact when I put in my resignation the medical staff in particular went to the director general at the time and said that she needed to fix the problems because they did not want me to leave, and I have lots of emails and so forth that support that, so I would dispute that it was during my time.

Dr ANDREW McDONALD: Were there any initiatives you tried to put in place to address the relationship? You have already talked about the clinical services group. Any other ideas as to what can be done to improve the situation?

Ms LATTA: I think the main relationship issue is actually between the hospital and the area health service, and that is not necessarily unusual with other area health services as well, but I think it was a particular issue at Northern Sydney. I believe that there needs to be more than lip service paid to the fact that we want to work together. I would hope that a positive outcome from this process is that one of the things is people do need to give more than lip service to the fact that we are supposed to be working together, we are supposed to be working to the same aim, you would hope, and that is excellent quality care for patients as well as looking after our staff, but that is not always evident and I honestly think at times we are actually at loggerheads with each other. I think that there really needs to be a very serious look at that.

The Hon. AMANDA FAZIO: I understand that before you went to North Shore you were the general manager at Sutherland hospital?

Ms LATTA: That is right.

The Hon. AMANDA FAZIO: What were the major differences you found in the way the two hospitals operated?

Ms LATTA: They are quite different hospitals, as you can appreciate. However, when I was at Sutherland a lot of the financial, for example, human resource, all of those sorts of support services

that helped us do what we had to do were the responsibility of the hospital, so they were under my responsibility, whereas at Northern Sydney they were at an area level. So I had no authority over those sorts of people whereas at Sutherland I did, which meant that strategically we could move forward together, I could help direct and they could be part of the team in moving forward.

For example, on the financial side of things, when I first went to Sutherland hospital—that was in February—they were expecting that they would be $600,000 over budget by the end of that financial year. We put a lot of strategies in place, which I was actually able to work with the staff and the managers to do in an autonomous way, and we ended up coming $600,000 under budget without cutting any services, and that was things like increasing revenue, looking at streamlining things, and we made an additional $3 million revenue within the first year of me taking up that role and continued to develop that. I think it is that autonomy that is really important within a hospital and also I guess respecting the role of the general manager in being able to do the job that they are appointed to do and paid reasonably for.

Mr PETER DRAPER: There seems to be a lot of instability in the executive management of the hospital. I think there have been eight general managers in 10 years and 29 senior resignations. Can you let us know what contributes to that instability?

Ms LATTA: I think the financial part of it being the focus—and you will have seen that in a number of submissions I think, that that has become the focus—and, whilst it is obviously extremely important, it has to be balanced with ensuring that we are providing good patient care. I think that has upset a number of people and that is one of the reasons why there has been some instability. I guess I cannot talk on behalf of other people, but it is once again that relationship between the hospital and the area and while there are individuals that have worked really hard on that, both at the area level and the hospital level, to try to improve that, it has not been consistently applied and it has peaks and troughs and I think that is a difficult environment to work in.

Mr PETER DRAPER: Going through the submissions there was a report in I think 2004-05 that identified the capital needs of the hospital at about $30 million, and I think the estimate now is $50 million.

Ms LATTA: Yes.

Mr PETER DRAPER: Is it satisfactory that a hospital of Royal North Shore's standing seems to be so reliant on donations and charities to replace equipment? You mentioned that you were developing a plan for that. Was that actually put in place?

Ms LATTA: As to that 2004-05 document that you referred to, we generated that while I was there. There was no capital or asset replacement plan for the organisation when I started, so we actually developed that 10-year plan. The staff and managers within the organisation were not used to ever doing something like that, so what they used to do is put up what they called wish lists and they were not necessarily even the things that were really required because there had not been a proper planning process for it, and they were also called wish lists because they often did not get them. Anyway, I wanted to change that culture so that we actually did have a plan, that they knew that if we bought a piece of equipment now it may have a five-year lifetime, therefore we will put it on the plan for five years' replacement, and at least so that we could understand what the magnitude of the problem was. I think the capital expenditure is the first thing that goes when there are budgetary problems and the delegations for that sort of thing really sit at an area level now because those sorts of things need to be approved through that process.

What I tried to do is put a risk management process around it, given that the magnitude of the problem was so large. So it was asking that question: if we do not purchase this piece of equipment now, what is the outcome of that? How does it affect patient care? Then I was able to get things approved. But obviously there was a big backlog of those things. So, no, I do not think it is appropriate that a hospital like that mostly relies on donations. It certainly is part of how we run our health services and lots of hospitals do rely on it, but it should not be the main form of providing replacement equipment.

We did go down the track through the health system at one stage of leasing equipment, which did not always work in favour of the organisations but for some things, and particularly very expensive pieces of equipment, it did prove to be helpful. Throughout the system, Royal North Shore is not the only place that is like this, and I think that once again there needs to be a serious look at how we do this across the system.

CHAIR: You have indicated the way the area health service interfered with the running of Royal North Shore Hospital but they did not do it with Sutherland hospital. Is there any reason why they wanted an on-hands role with regard to Royal North Shore Hospital?

Ms LATTA: They were in two different area health services—

CHAIR: It was simply different policies?

Ms LATTA: Yes, different management approaches really. Plus, the other thing that was different was that in South Eastern Sydney not all of those support services were across the area; as I said, they were at hospitals. Whereas, Northern Sydney had moved to the approach some time ago of having all those services provided from an area level, which brought all of those resources together into the area. I think there are pluses and minuses for taking that approach.

CHAIR: It is hard to say whether it was more efficient or less efficient?

Ms LATTA: Yes. There is a potential for it to be more efficient, but I think the thing that then occurs is that there is no loyalty or real drive to want to work within the hospital to make that particular hospital function better. There are so many other competing priorities when they are sitting at the area level, so I think the dedication to particular facilities or hospitals is somewhat diluted.

CHAIR: Thank you for appearing before the Committee today and sharing with us your views as a former general manager of the hospital.

The Hon. AMANDA FAZIO: Would you be happy if we published the evidence you gave today?

Ms LATTA: Yes.

CHAIR: No names are mentioned.

Ms LATTA: No names are mentioned, and I think that from the way we have talked about the initial bit it is probably okay.

CHAIR: You would be happy for us to publish your evidence?

Ms LATTA: Yes.

Motion agreed to:

That the evidence of the witness be published.

(Conclusion of evidence in camera)

(Public hearing resumed)