

IN-CAMERA PROCEEDINGS BEFORE¹

**JOINT SELECT COMMITTEE ON THE ROYAL NORTH
SHORE HOSPITAL**

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

At Sydney on Thursday 22 November 2007

The Committee met at 9.00 a.m.

PRESENT

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

Legislative Council

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

Legislative Assembly

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

¹ Published by resolution of the Committee 22 November 2007.

ALICIA JACKSON, Registered Nurse, Royal North Shore Hospital, and

SAMANTHA FLEW, Nursing Unit Manager, Emergency Department, Royal North Shore Hospital, and

MICHELLE BEETS, Nurse Manager, Emergency Department, Royal North Shore Hospital, affirmed and examined:

CHAIR: Thank you for agreeing to give evidence today. We appreciate your attendance. I ask each of you in what capacity are you appearing before the Committee?

Ms JACKSON: I am a registered nurse at Royal North Shore Hospital.

Ms FLEW: Nursing Unit Manager of the Emergency Department.

Ms BEETS: Nurse Manager of the Emergency Department, Royal North Shore Hospital.

CHAIR: We are pleased to have Susan Pearce present as a support person, not as a witness. Do any of you want to make an opening statement?

Ms BEETS: Yes, I would like to. I have handouts for the Committee of things I am going to discuss today. If you wish to have copies they are available. I wanted to thank you for giving us the opportunity to present today and to give you a nursing perspective on our positions at the hospital. Although I have to say I was a bit disappointed that we were not asked at the outset to appear and there did not appear to be much of a nursing presence at this Committee. The issues that we wish to discuss today are related to the nursing workforce, nursing education, overcrowding in the emergency department, lack of acute mental health beds and bullying and harassment. Basically I wanted to get the message over today that the nursing workforce we have today—which has been supplied at the back of my statement as a graph of our skill mix and our nursing base at the hospital—has shifted over the years from an experienced R8 nurse down to a second year nurse who is virtually one year out of the university. We have lost a lot of our senior skill cover due to some of the conditions that we have to work with in the emergency department, which is overcrowding and it is very stressful. A lot of our senior workforce has now gone part-time or has left the profession totally. It is a huge concern to all of us.

In relation to nursing education, because these nurses who have come out of the university are fairly inexperienced—and it is no-fault of their own—they do not have the skills or the knowledge base to look after critically ill people. We require a few more clinical nurse educators to support them in their role to allow them to fulfil their career and to attract some personnel because this has an impact on the nursing care they are able to give. Currently we have only two full-time clinical nurse educators for a staff base of 86.46 full-time equivalents nursing staff. One of those positions has been vacant for the best part of this year. So literally we have had one clinical nurse educator trying to teach the nurses the basic skills of how to look after critically ill people. Therefore, obviously, I would not mind some increased resources for a clinical nurse educator, a system with their professional development. The increasing levels of overcrowding in the emergency department [ED], which I am sure you have heard about during this process,

results in increased adverse events towards patients, increased sick leave amongst staff, poor morale and increased length of stay for patients in the ED. It is also vital that this overcrowding is reduced, otherwise we will not have any more nurses left in the system.

The other issue that I want to talk about is the triage nurse, which is quite vital to our role in the emergency department. Often the triage nurse is the first point of contact for anyone entering an emergency department. The triage nurse is often the target of much abuse, sometimes physical. The triage nurse has an enormous workload in assessing patients, competing with multiple priorities, many interruptions and pressures to offload ambulances when people can often walk in off the street with a high clinical need to be prioritised in the system. The pressure for us to offload ambulances is phenomenal because of the KPIs that we are requested to meet. It becomes very difficult for us to be able to do that when we do not have any beds in the ED. The triage nurse is often the target of abuse due to patients presenting because the ones in the wait room are very irate, sick and injured. I noticed some of the comments made earlier in the processes that the nurses were cold, uncaring and mechanical. But nurses are under extreme pressure and working in triage is very difficult.

Another huge issue that we have is lack of mental health beds for acute mentally ill patients. Our presentations have increased. I have put some figures on the second page of my statement. For the first six months of 2006 we saw 888 patients presenting with mental health issues. For the same period this year we have seen over 1,000. The delay for mental health patient separation from the ED is primarily due to the unavailability of acute mental health beds, not due to the delay in treatment processes. These patients are very disruptive. They increase the workload for the clinicians and their length of stay in the ED is not uncommon from three to five days. Often we request individual patient specials for these patients, and they are not always supplied. We have a high level of nursing vacancies. I have attached a graph on a page at the back comparing last year to this year. Our recruitment and retention factor has been pretty poor at Royal North Shore over the last year and the bad press that we have been receiving has not been very helpful.

Then we go on to harassment and bullying of the staff, which is a systemic problem by senior nursing administration at Royal North Shore. This is due to the constant demands and pressures to meet key performance indicators. These key performance indicators have been set down to monitor and achieve quality outcomes for patients. They have been mostly unachievable for 2007. These are very clearly out of the control of the ED. When the patient occupancy is greater than 85 per cent, which I know you have heard about, the hospital becomes very inefficient, elective surgery is cancelled and emergency patients build up in the ED, which results in increased stress for the staff. I think there is very much a lack of professional recognition for nurses, who are undervalued, especially by the general public and their peers. Childcare facilities in the hospital workplace for nursing staff who wish to return to the workforce are not available. Parking, of course, is difficult for staff and we need reduced parking rates. That is a minor thing in the scheme of things. That is roughly what I had to talk about.

CHAIR: Thank you, Ms Beets, for sharing that with us. We appreciate it. Do any of the other nurses wish to make a statement?

Ms JACKSON: I would like to make a statement. I do not think it is just isolated to the emergency department. It is throughout the whole hospital that nurses are

constantly under pressure to move patients to accommodate emergency patients coming up to the wards. So they are quite stressed as well. They are getting burnout. A lot of people are leaving and positions are being filled with agency staff or enrolled nurses or assistant in nursing positions who do not have the expertise in the areas of high dependency, orthopaedic wards and spinal units. So they are feeling the pressure as well. It is throughout the whole hospital, unfortunately.

Ms FLEW: I would just like to add that I think the hospital has lost focus on the one reason why we all take oaths to be nurses and to work in hospitals, and it is patients. There seems to be no direct focus on patient safety and there is a lot of patient compromise in order to meet benchmarks to get people up to the wards. It is clearly simple, you know. The emergency department can process patients and get the best treatment we can give with the resources that are available to us, if we can get the patients out of the emergency department. It is simple maths but no-one seems to be listening to us.

Every day we are under enormous stress to give the best care we can to the patients who come in to the Royal North Shore Hospital emergency department, who believe and want to get the best care that they believe, and truly they do, deserve. But every day we struggle to meet the benchmarks. I think the pressure to move the patients to the wards when they are not well enough to go and the pressure to get people off ambulance trolleys because the matrix system that has been brought in clearly is not working really affect the staff because they are asking us to make decisions and to cut corners when clearly we will not do them. I think there needs to be a focus on patient safety and the stresses that the staff are having to undertake to, you know, meet benchmarks.

CHAIR: Thank you very much for sharing that. We will have some questions, now if you do not mind answering those from the Committee members.

Mrs JILLIAN SKINNER: Thank you very, very much indeed, all of you, for coming in. Can I say that we value enormously your contribution here, but also your work in the hospital. I would like to ask you about the question of morale, which you have touched upon, perhaps, Michelle.

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: This has been an ongoing problem for some time.

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: Has it not?

Ms BEETS: I think so. I think this year has to be decidedly the worst year. I have actually been 22 years working at the Royal North Shore Hospital. I have been a nurse for 37—way too long, but anyway—and it is actually a great job. Nursing is fantastic, but the conditions that we have been meeting over the years are declining, and I think personally we are at rock bottom at the moment.

Mrs JILLIAN SKINNER: While the recent media publicity has not helped at all—

Ms BEETS: No, not at all.

Mrs JILLIAN SKINNER: —would you say that there is some hope that at least bringing this out now and having this inquiry actually can provide some answers.

Ms BEETS: Yes. We are looking to you for the hope.

Mrs JILLIAN SKINNER: Would it not surprise you to know that I have been approached by many, many of your colleagues who are saying, "This is our hope, and we want this inquiry because we have to have some resolution"?

Ms BEETS: Yes. I am sure that some good will come out of this. If we can even just get the hospital back to 85 per cent occupancy, then everybody's daily life will be so much easier to manage and things will work and processes will happen, and the pressure will not be there, and the morale will lift, and everybody will be able to do a great job.

Mrs JILLIAN SKINNER: When you talk about the focus on achieving the benchmarks—

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: —I am taking it that none of you has a problem per se with the benchmarks, but it is that you do not have the resources to meet them. I see nods all round.

Ms BEETS: Yes. It is hard to meet the benchmarks when the hospital is at greater than 85 per cent occupancy. There is no way we can offload an ambulance in 30 minutes, especially when six or eight arrive simultaneously, and then we also have people walking in off the street who might have chest pain and who are also considered a high priority. So you are trying to balance. We are under pressure to get the ambulance patients in so we can meet the target, but then the person who is waiting out the front with their chest pain, or potential infarct, they might have to wait that bit longer because of these pressures. So we try to balance it. We would rather get the person in with the chest pain, which we probably would do, therefore the ambulance gets to wait, and not every ambulance needs to be offloaded immediately.

Ms FLEW: Can I just add that puts extra stress on the triage nurse because they are experienced clinicians who recognise when a patient needs to be seen by a doctor or needs to be in a bed, and we do not have the resources. When we do not have the resources to provide that service because there is the expectation to offload an ambulance beforehand, again it lowers morale. We have nurses—our emergency nurses do not want to triage. It is the most important position in our department and our senior nurses do not want to go out there. It is very difficult. That is how bad the morale is at the moment. We need to look to this inquiry to find some solutions. We can offer some and hopefully it will be better.

Mrs JILLIAN SKINNER: Just about every clinician who has given evidence here has talked about beds.

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: And nurses to look after patients in those beds.

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: Because it is not just a matter of going and finding the beds: they are all there, are they not?

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: It is a matter of addressing this nursing shortage.

Ms BEETS: Yes.

Ms FLEW: Yes.

Ms JACKSON: Yes, and also, you know, when the patients are sorted out in emergency and packaged up and are ready to go to the ward area, most of the time there are no beds available because those wards are shut.

Mrs JILLIAN SKINNER: I was astonished at the number of wards that have been closed—

Ms BEETS: Yes.

Mrs JILLIAN SKINNER: —over recent years. Is that something that needs to be addressed?

Ms BEETS: I think years ago they reduced a lot of hospital-length-of-stay for patients, so they did need to cut back some beds. But I think perhaps five years ago, we might have been just a tiny bit more ruthless in the cutting back of the beds and that is coming now, we can see that happening now.

Mrs JILLIAN SKINNER: So it is like a pendulum has swung the other way.

Ms BEETS: Yes. I mean, obviously opening more beds will be a solution, but we also need the workforce to mind these patients.

Mr MICHAEL DALEY: That is right.

Ms BEETS: And, you know, to balance these books, nurses, I have to say, will not want to come back to the workforce if we have to keep up with these conditions that we are working under. I think we need adequate remuneration as well because I do not think that in general we are a valued workforce. Also for most of our nursing staff, the average age of the nurse is in their mid-40s. Give them another five years and they will have left the system. The girls who are coming or the people who are coming out of university now, there are two second-year nurses who are very motivated, decidedly keen, but do not always have the knowledge base and that is not their fault. They are tired of it already and they have only been out of university one year. They travel, go abroad or take another degree from a different university, so we are not retaining the workforce.

Mrs JILLIAN SKINNER: Earlier I think it was Matthew Daly who gave evidence about the numbers of nurse educators. It was commended by this Committee, one member in particular. It is a very commendable initiative, but if you say you have only one—

Ms BEETS: We have one at the moment.

Mrs JILLIAN SKINNER: How many do you need?

Ms BEETS: I would like three or four because you need to be able to work them after hours and do a rotating roster so they are there on the weekend or they are there at 10 o'clock at night to support the nurses. Everyone works office hours and goes home, but the workload is generally in the evening and the support mechanism is not there. So I really do need an increase, only because the nursing staff, if you look at my graph, is very free down this end of the scale. There is a lot of people here, but they are mostly part time. They do about two days per week and they are the R8 senior workforce. There is not much in the middle and then we are looking at the people just coming out of university, first and second years. They do not have the knowledge base. It comes with experience. They will get it, but they need help to get it.

Dr ANDREW McDONALD: Referring to this graph, which shows that the 18.48 full-time equivalents [FTEs] are R8s.

Ms BEETS: Yes.

Dr ANDREW McDONALD: And you have a lot more R1s to R4s.

Ms BEETS: Yes.

Dr ANDREW McDONALD: When is a nurse able to require minimal supervision?

Ms BEETS: I think personally, from my years of experience, around the sort of year 4, year 5, mark because they have got a bit of solid grounding and they have built on some of their skills. I think around about R4 you expect a bit more of them and they are usually good at coping at that, but R2s, they really are very limited in their knowledge base. They are good nurses, but they just do not have it yet. They will get it, if they get the support and the experience.

Ms FLEW: I think most R2s have only just finished their year graduate rotations so their experience is extremely limited.

Dr ANDREW McDONALD: The Committee has been told that professional practice units are being set up in the area and headed by Mary Dowling—

Ms BEETS: Yes.

Dr ANDREW McDONALD: —to investigate patient complaints and staff grievances such as your own. Have you had any contact with the Professional Practice Unit [PPU] as yet, Michelle?

Ms BEETS: Well, unfortunately when all this happened, this incident that has brought us to this inquiry, I was actually on seven weeks leave. So about that time they did a bit of an investigation at the hospital to do with bullying and harassment, but I was not actually there and never got to speak to any of the people involved. The bullying and harassment is just generally a systemic problem across the whole hospital. It sort of starts at the top and it filters down to the people at the coalface and it is due to the pressures that everybody is under. It is no specific issue. It is just a general, everyday workload, and it still happened this week but in a different way. They are still asked questions, "Why have you not offloaded the ambulances?"

This week we have come very unstuck with beds. Nothing really has improved since I have been back. I have been back five weeks now from my holiday. Leading into my holiday, it was a complete nightmare and it has been consistently bad since about April. We are talking November and not much has changed despite what happened several months ago with the incident that has brought us here. We had a little bit of a lull initially but I think it is that patients did not present to the hospital because of the bad press. Now it is starting to pick up again, and again there are very few beds available. Earlier this week we had hardly any beds left in the hospital.

Ms JACKSON: Plus the acuity of the patients that do present is quite high. It is not that you can treat them and send them home. They need lots of work, lots of investigation and admission to hospital, basically. So they are not people that you can send back to see their general practitioner [GP]. That is another problem too.

The Hon. AMANDA FAZIO: I have a couple of issues. One is just in relation to bullying and harassment. I wonder whether Ms Flew or Ms Jackson have any comments to make about the recent reports into bullying and harassment at Royal North Shore?

Ms JACKSON: I feel that there is bullying and harassment evident but it does come from the senior management in nursing at the Royal North Shore. But these people are under constant pressure themselves, like Michelle mentioned, to meet key performance indicators [KPIs] that are totally impossible to keep to, due to the high acuity of patients and no access to beds, wards being closed and no nursing staff to look after these patients. I guess they are very frustrated in their positions and that impacts on everybody else. It just brings everybody down and it fractures right down the line to the coalface.

Ms FLEW: I think, unfortunately with those pressures, sometimes the direct clinical staff on the floor also receive that—

Ms JACKSON: We are the ones that cop it, basically.

Ms FLEW: —harassment, basically. As managers, we try to sort of take the brunt of it for them, but it is very hard when you have got junior staff trying to do their job and they are being harassed by people they do not even know to get patients to wards when it is not safe to do so. And it is rampant in the hospital, unfortunately.

The Hon. AMANDA FAZIO: We hear a lot about access block and we have heard a little bit about exit block, which is getting people out of the hospital who should

not be there. Have you any comments to make on how that contributes to the problems that you face in your day-to-day work?

Ms BEETS: I think that there is a bit of exit block obviously happening because there is a reduction in the rehabilitation beds. Alicia has been very much involved in trauma patients. They have a lot of patients that need rehabilitation post their injuries. There is a lack of access to those kinds of beds. I am sure that nursing homes are a bit of a problem. I do not know how big a problem that is because I am more in the emergency department, so even though we are responsible for the whole hospital, I do not always have enough facts to contribute on that, I am sorry.

Ms JACKSON: I can comment a little or speak to that question on exit block. I am seeing trauma patients right around the whole hospital at Royal North Shore and that includes aged care trauma patients. It might be decided that this patient is not safe to go home any more or that they need a nursing home placement. That becomes a huge issue. There are no beds, or funding means that we may not be financially viable to get these patients into nursing homes, so they tend to stay in hospital for extended periods of time.

Trying to get people with severe brain injury to a brain injury unit is difficult. There are not enough rehabilitation beds in New South Wales, especially brain injury rehabilitation beds. We are a major spinal injury hospital, as you know, and severe burns unit, as well as a trauma centre, and trying to get these patients through rehabilitation is very, very difficult. Therefore they stay in acute care beds or in an acute care hospital for extended periods because there are no beds available.

CHAIR: Following up on your report, Ms Beets—which is very good—you mentioned that you were at Royal North Shore Hospital for 23 years.

Ms BEETS: Yes.

CHAIR: We have been trying to work out what went wrong with Royal North Shore Hospital when it was so high in its standards and reputation. Did you notice at some point this occupancy issue or overcrowding at the hospital?

Ms BEETS: I think in the last five years it has generally deteriorated, but this year has to be the worst year. I do not think it has helped in some ways having changes in general managers as frequently as we did many years ago. We have gone to about eight of them within 10 years because things have not been fixed, so the solution is to dismiss that person and bring in another person. Quite frankly, I do not think it is their fault. Constantly changing these people is not going to make the system right. You need to keep someone there, even though it is bad, and let them work through the issues and make it better again. If it is bad, you are out, next one in, sort of thing. I think that has not helped.

The changes in management structure within the hospital have been very ad hoc. We had an unsettling period last year with the divisional nurse manager structure. I think that started to begin the decline, to be honest. I cannot pinpoint anything. Whether our patients are more acute and over the years they have decreased a few more beds so you did not notice another five missing, or another 10 missing. When I started at Royal North Shore it was possibly 900 and possibly 99 beds, and now it is just under the 500 mark, if not just above 400. We are not really sure exactly how many beds are there. They

talk about lots of beds, but I think if reality came to it and you actually counted them there are probably 400 and something. So the hospital has technically halved since I started, which is significant considering we are a big tertiary hospital and we take referrals from everywhere.

CHAIR: A couple of you spoke about the key performance indicators [KPIs] and said they are unachievable. What actually happens? If you have to get someone in an ambulance in half an hour, does someone question you, or do you note it down? How does anyone know how long it took?

Ms BEETS: I do not feel that we should earn that KPI personally, because the ambulance service has the jurisdiction of pushing the off-stretcher button to put the KPI in place. They might stop and have a chat to somebody, go around to the local coffee shop and buy a coffee, then go back to the car and push the button. So the information is decidedly inaccurate. We do not have control over the button. They go back to their ambulance and they are ready for the next job.

CHAIR: The ambulance people are the ones who make that record?

Ms BEETS: That is right.

CHAIR: Which evaluates you?

Ms BEETS: Yes, exactly, and it is very inaccurate. We have asked to have control over it but for some reason it has not happened. At the moment we have been a little bit more meeting of the benchmark, but I think for a good seven months this year we were the worst hospital in the State, I am led to believe. Everything was: You are the worst at this, you are the worst at that—you are the worst at everything. But to be honest, we actually provide a very good service. And I could not do it without the rest of the nursing staff or the medical staff.

CHAIR: Do you think those key performance indicators are unrealistic?

Ms BEETS: Certainly not the off-stretcher button. Getting the patients out of the department within eight hours to a ward bed should be very feasible, but at times that is not met either because we cannot move the patients to the wards due to there being no beds in the hospital or we are waiting on people to be discharged. Even this week we have had mental health patients in our department, probably five at a time. We have had two of them there for three days and one person there for five days, already this week.

Mr MICHAEL DALEY: In the emergency department?

Ms BEETS: Yes, in the emergency department, which is a noisy environment, the lights are on 24/7, and they are not really getting any mental health support. They are getting their medications, and hopefully we are looking after them. But they are there for a reason, because their mental health is unstable, but they do not have that input because they are in the emergency department, visited once or twice a day by the registrars or the consultant.

Ms FLEW: And taking up beds for acute patients that are queuing out the front.

Ms BEETS: On Monday there were five of them there. We have had a huge increase in mental health patients.

Mr MICHAEL DALEY: Are they people with mental health problems, or are they people with drug-related problems?

Ms BEETS: A bit of both. Some of them have personality disorders that are hard to treat anyway. But some people stop taking the medication because they think they feel better and then you have to get them back on track again. There are lots of reasons.

Ms JACKSON: They can be quite disruptive patients, obviously through no fault of their own. If you have a patient in the bed next to them who is having a stroke, it is not very pleasant for that patient and their relatives. These people are uninhibited; they go running around, some of them naked, and cursing and swearing. It is terrible for everybody.

CHAIR: They are not really a patient in the sense that they need to be in a bed, are they?

Ms BEETS: No. But it is not good to leave them there for five days; they do need a bed.

CHAIR: Do you strap them down?

Ms BEETS: No, we do not strap them down. We might use increased sedation on these patients—which is not always ideal in these patients either but it is only to make it easier to manage them within the emergency department. We do not tie patients down any more. We use chemical restraints; it is easier.

Mr PETER DRAPER: We really appreciate your attendance today. During the hearing there has been a lot talk about attracting the experienced nurses back. Do you think we can? How are we going to make it attractive to get people who have chosen to leave to come back?

Ms BEETS: I have quite a few mothers working with me at the moment who are in the R8 zone. They would pick up extra shifts but they cannot always work after hours because the child care at the hospital closes at 5 o'clock. If the child care could be extended to at least 10 or 11 o'clock at night, if one of the family members or some single parents do not have the backup, there would be an opportunity to perhaps get some of those people back into the workforce. I think we need to be recognised professionally. Nurses are nurses, but nurses are really important people in the scheme of things, and I think we need to be financially remunerated. I am managing a workforce of more than 100 people and I think my counterparts in the public-private sector probably earn twice the wage that I get, for less hassle.

Mr PETER DRAPER: There has also been a lot of faith put in the Committee to come up with recommendations. We are due to report before Christmas. If that reporting were to be delayed, would that have an impact on morale, do you think?

Ms BEETS: No, I do not think so. We need some very quick wins and then some long-term gains. So if it is going to make it better in the end, I would rather wait another two or three weeks. Have your nice Christmas holiday, come back, and give us something to look forward to. I want to get the message out that overcrowding is the hugest problem. Occupancy greater than 85 per cent is really the challenge, I know, but it will make a difference. Also, we really do a good job.

CHAIR: Your submission is very valuable. The Committee would like to include it in the evidence but we need to have you agree to put your names to it.

Ms BEETS: I am happy to put it out there.

CHAIR: There is no name on the submission. It could be done confidentially. However, we would like to publish it.

Ms BEETS: I will put my name to it. I have been a nurse for a long time, and I guess it is time to retire.

Ms FLEW: I am happy to put my name to it also.

Ms JACKSON: I am happy to put my name to it as well.

CHAIR: Are you happy for the evidence you have given this morning to be published?

Ms BEETS: I have no problem with that, if it is going to help. I know the nurses have had a very small voice in the scheme of things. I think it is important that we speak up for our profession.

CHAIR: You have certainly done that today.

Ms BEETS: Thank you very much.

CHAIR: The three of you are happy for your evidence to be published?

Ms BEETS: Yes.

Ms FLEW: Yes.

Ms JACKSON: Yes. Getting back to your question about where it all went wrong, we are very passionate about our profession but we are also very passionate about our patients and their families. We feel like Royal North Shore is slowly haemorrhaging to death at the moment, and we want to stop that haemorrhaging and make it better. Hopefully this inquiry will do that.

Motion agreed to:

That the evidence and submission of the witnesses be published.

(The witnesses withdrew)

(Conclusion of evidence in camera)

(Public hearing resumed)

PROCEEDINGS BEFORE

**JOINT SELECT COMMITTEE ON THE ROYAL
NORTH SHORE HOSPITAL**

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At Sydney on Thursday 22 November 2007

The Committee met at 10.10 a.m.

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
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Mrs J. G. Skinner
Ms C. M. Tebbutt

CHAIR: Welcome to the third 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 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 the room.

What you say to this Committee today is covered by parliamentary privilege. This means that no the 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 contempt of the Parliament. This protection does not, however, cover anything you may say after the hearing or outside 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 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 ask also 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 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 hearing 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 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 the guidelines governing the broadcast of proceedings are available from the table by the door. I point out that in accordance with these guidelines, members of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee the media must take responsibility for what it publishes or what interpretation is placed on anything that is said before the Committee.

Witnesses, members and their staff are advised any messages should be delivered through the attendant on duty or through the Committee clerks. I ask that all those present please turn off any mobile telephones during the proceedings. I am very pleased to welcome our first witness today, Ms Helen Ganley.

HELEN ELIZABETH GANLEY, Employee, Northern Sydney Central Coast Area Health Service, affirmed and examined:

CHAIR: In what capacity do you appear before the Committee today?

Ms GANLEY: As a private person. I also work for Northern Sydney Central Coast Area Health Service.

CHAIR: If you should you 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. Do you wish to make an opening statement?

Ms GANLEY: Yes. I have come today for three reasons: Firstly, to tell you that I have been bullied over a long period of time, and to tell you that bullying destroys your health, home life and your ability to work effectively and efficiently. Secondly, to make public just a few of the dreadful things that happened to me once I did complain. In some respects the organisational bullying was far worse than that done by my line manager because I trusted those at the top. Finally, I urge you to make wide-ranging recommendations to ensure that bullying is eradicated from Royal North Shore Hospital and, indeed, other sectors in the area health service where I have been made aware bullying is just as bad, as is the treatment of complainants.

Previous investigations into bullying have achieved nothing and have told no-one anything they did not already know. I was subjected to bullying, intimidation, and victimisation at three levels: by my Line Manager, the Manager of the Quality and Risk Management Unit—not the current one—who also happened to be a member of the Royal North Shore Hospital executive. I have been bullied by the Royal North Shore Hospital executive, including the General Manager, the Director of Operations and the HR manager—again, not the current ones. I have also been bullied by Area HR. The examples I will provide are what I believe amount to bullying, corrupt conduct, collusion and the denial of natural justice.

As a registered nurse and certified midwife I worked at Royal North Shore Hospital for 25 years and I have neither complained about anyone nor been complained about. Following the Duncan Stewart report, the Quality and Risk Management Unit was set up in February 2004 with a new boss; that is where I first experienced bullying. I complained, knowing that it was professional suicide. The sequence of events is important because the practice of investigating claims of workplace bullying and harassment very slowly and reluctantly is used to placate a complainant with false assurance.

After being bullied by my boss for seven months, I submitted a grievance. It took almost three months to begin the process. It took more than eight months to finalise the process in a feedback meeting resulting in "no bullying identified". I was then forced to undertake freedom of information to get relevant documentation. Instead of this taking three weeks, it took six months and was incomplete, so I applied for an internal FOI review, which the area refused to undertake. Then I went to the Ombudsman, who conducted an external FOI review and provided me additional documentation. I was then in a position to appeal the "no bullying identified" decision. At that time I also made a complaint about the mismanagement of the grievance process by hospital executives. That was over two years ago and still there is no outcome.

The bully-tolerant culture at Royal North Shore Hospital is longstanding and well known. Meppem/Dalton said that the recommendations from the 2003 Kilkeary-Stowe review were not implemented. In 2003 an area-wide climate survey was conducted by Best Practice Australia. I am sure the Committee will have that report, which said a very large percentage of Royal North Shore Hospital staff reported bullying. I also mention that the statement made by Deb Latta to this Committee, that there were focus groups in each division and an action plan, is misleading. This certainly did not occur in the executive division where I worked and was later bullied

So, what was done as a result of the Best Practice Australia report? Nothing, according to the Royal North Shore Hospital Risk Register dated November 2004, and I have provided a copy this morning to the Committee secretariat. Item 3.1.12 identifies a new risk for Royal North Shore Hospital, related to the 2003 climate survey, being "lack of progress against recommendations". This

was risk assessed as three, which is a substantial risk. Clearly, when management knows there is active bullying and does nothing to stop it this then is the signal for others who are not bullies to come to the conclusion that they too must behave in a bullying manner in order to be taken seriously as managers.

The following are examples of bullying by my boss. On day one Andrea Taylor threatened her brand new staff that she would get a wooden spoon if we brought up the past. She attempted to bring—through the back door—downgrading, changes in our awards and the fact that we would have to reapply for our jobs, sent in a plan that was hidden in an email. Frequently, she made derogatory, intimidatory and coercive statements. She harassed me endlessly about my nine-day fortnight. There was discrimination in work allocation: 12- to 15-hour days, resulting in a workplace injury, where others did almost no overtime. They are just a few. She gave a number of false and misleading statements to the grievance investigator. One example was she said she knew nothing about my health issue until she reviewed the WorkCover certificate. Yet I provided eight emails where over a period of time I informed my boss of my worsening back injury; and, indeed, she did reply to some of these.

Bullying by Royal North Shore Hospital executives: I wish to give some examples of how the grievance against my boss was mismanaged by Andrew Bott, the then Director of Operations. Area policy requires interviewing the complainant and the respondent within a week. It took 11 weeks for this to happen. The whole process took 33 weeks to finalise and, meantime, I was sitting next to the bully.

CHAIR: Ms Ganley, would you just state the position of the person rather the person's name?

Ms GANLEY: Sorry, yes. He organised conciliation and when I declined to participate they brought in the big guns: a person from Pacific Consulting and OSA Group, who was an industrial relations lawyer flown in especially from Melbourne to interview me. Her investigation was fatally flawed—a complete denial of natural justice, but that is another issue. I made a number of requests for a copy of the investigation report before the feedback meeting and the requests were declined. The feedback meeting was very intimidatory. It was chaired by the then General Manager, who made a number of false and misleading statements. I will give you one example: Deb said the grievance process was thorough. However, I was given an email later on by the Ombudsman where Deb wrote to area HR saying, "I agree there needs to be an independent review of this process, which I think has significant flaws"—that was not a thorough process to me—"my concerns about which I have raised at the Area exec."

When I asked her if she thought I had been bullied, she said, "It gets to point of bullying: and it would have been daunting." So it has to be daunting; one has to be fearful to come to work? I think not. Yet the final decision remained that there was no bullying. This is an extremely worrying example I give you: The Ombudsman provided me a lot of documents, some of which I asked for and some of which I did not. This was an email from the then Royal North Shore Hospital HR Manager to Deb saying, "Don't want to table anything in writing that encourages HG or gives her ammunition. Thought some of the points were better left as talking points." Why did I need to be stopped seeing documents that I was going to use as ammunition? I think this is at best collusion and at worst a conspiracy to pervert the course of justice.

A common form of bullying is a refusal to take minutes of meetings or attempts to deny the opportunity to take minutes of meetings or producing minutes that are inaccurate and one-sided, especially in matters of grievance and discipline. I made 12 requests to get the minutes of the grievance meeting and I eventually had to get them under freedom of information. They bore no resemblance whatsoever to the truth, so I asked for a copy of the contemporaneous notes, but was told they had been destroyed. Fortunately, I had someone very senior with me at that meeting, who I told, "Put your head down, start writing and don't stop until I tell you." Therefore, I am able to refute many of the things that are said. In fact, all of these allegations, and the ones in my submission I put forward to you, for 99 per cent of them I have documented hard-copy evidence of what I say.

The Director of Operations told me to use freedom of information when he repeatedly refused my requests for grievance-related documentation to which I was entitled. This was despite the area's policy and the terms of reference of the grievance, which I presume he wrote, specifically

stating I was to be given a copy of the respondent statement. I was refused that repeatedly and told to get it under freedom of information. Under FOI I did receive the respondent statement, but Royal North Shore Hospital had altered it. When asked to explain, they said the last paragraph was blacked out "as the statement made, whilst it may be true, amounted to hearsay and served no purpose in releasing except to damage relations within the organisation. Based upon that fact, it was agreed that it should be removed". Altering documents in grievance situations is considered spoliation and is illegal. There was also a failure to search for FOI documents at Royal North Shore Hospital and a failure to surrender FOI documents. False certifications were made under the FOI Act. As you know, failure to search or preserve the communications of the people and things identified as having relevant information constitutes a sanctionable breach of discovery duties.

Victimisation is real. The majority of bullied people leave. I chose not to, but in 2005 I was forced into taking a secondment out of Royal North Shore Hospital. When I was due to return, Royal North Shore Hospital gave me the following options: Please stay in the area long term, i.e. do not return to Royal North Shore Hospital; or stay in the area short term and return to Royal North Shore Hospital when the new manager arrives in some weeks or a month's time; or take annual leave—I am not sure if they were going to pay for it—and not return to the Royal North Shore Hospital until the new manager arrives. As well, the private office I had was taken away and given to the receptionist, and the nine-day fortnight that I had had in place legally for three or four years was also to be taken away. Victimisation is real.

Now I will address the area HR behaviour. In response to inquiries by the Ombudsman, the area HR provided inaccurate, incomplete and/or misleading information under the signature of Stephen Christley. I give just one example: the area said, "I believe these documents have now been provided to your office"—the Ombudsman. The Ombudsman disagreed, saying, "There is no doubt that some documents appear to be missing". There were certainly other misleading statements made. Another example: In 2005, Stephen Christley directed area HR to conduct a review of my initial grievance investigation and that of another person. As far as I know, this did not happen.

The current area HR manager continually discouraged me from insisting that others be interviewed in the appeal process. Bullying is about habit and it is important that the habit or pattern of the person is brought into context. He stated things like it would be a fishing expedition. Well, he well knew it was a fishing expedition; there were people out there who had grievances against my manager and yet he refused to have these brought in. Unbelievably, Craig repeatedly refused to allow the evidence provided by the Ombudsman to be included in the current investigation. I said to him, "Do you think I went to the Ombudsman for the fun of it through FOI for a year and a half?" When I tried to go external to get his decision overturned to have that evidence included he and the Director of Workforce failed to reply to repeated requests for information that I asked for because I asked for information to be sure that I did not breach the code of conduct. Once they knew I was very serious about going external, they did reverse that decision.

Regarding the internal FOI review, this was supposed to have been undertaken by the Director of Workforce, within the FOI Act the requirement being two weeks—seven months before I went to the Ombudsman, who determined it a deemed refusal by the area health service. There were broken promises, deleted emails without reply and false statements made to me about the review being finalised or there being working notes, which turned out to never have existed. HR is adept at stonewalling. This manifested in delay and obstruction, for example, months to get a meeting with the HR manager. I had to phone him to alert him there was an email sitting on his desk. I eventually resorted to ringing or emailing his secretary saying, "Please tell Craig to open his emails." Partial and no responses to request for information.

There are allegations of horror stories elsewhere. Dr Christley appeared to be powerless to intervene to reverse these HR decisions. They were unto them own. Staff were bullied into resigning rather than taking a flexible workplace sort of arrangement doing less hours, and this is in a context of there being very few nursing staff. There were false allegations made about one whistleblower that submitted concerns to senior management. Following those concerns, they were forcibly escorted by the HR manager out of the premises and given a letter not to set foot on the hospital premises again. They cut long-term casual hours of this complainant until she agreed to sign a gagging clause. This was done under duress to avoid having her home repossessed.

An independent review of the hospital grievance process was ignored by the area and the process concluded that an inappropriate process was followed by the Director of Medical Services and HR. Obviously, there were long-term, serious and ongoing impacts on that person's health. Restructuring in any of the hospitals is a common tactic because when a bullying victim does not subjugate, the ultimate goal is to get rid of them. HR has told people risk being disciplined or being sued if they go to grievance. Another common one is, if there is one complainant about a particular person, there is insufficient evidence; but if there are two complainants, then that is collusion.

On a positive note, other colleagues and I have set up a support group, which can be contacted at *nscchsbullybusters@hotmail.com*. I currently work in the area executive office and am hoping to see out my 40-year service. My manager and her manager are the best bosses I have ever come across: people are absolutely lining up to work in our department. There is no bullying, only support, encouragement, hard work and fun. Finally, the unions told Meppem-Dalton that bullying was endemic in the area and begged the remit to be widened. I do too. That concludes my evidence.

CHAIR: Thank you. We will proceed with questions with the few minutes we have remaining.

Mrs JILLIAN SKINNER: Thank you very much for coming forward with that very thorough piece of evidence. I have a couple of questions because we have run out of time. You talk about some of the discriminatory practices if you come forward making a grievance. Do you know how many other nurses and staff are in the same position as you that have put in a grievance and really have had to leave working in the hospital?

Ms GANLEY: Well, the grapevine is that there are a lot of nurses and other people that this happens to. I mean, the research is replete that something like 90 per cent of people rather leave. As I said, this is professional suicide. I mean, look what happened to me when I complained, all right? Other people who are not so stoic would have collapsed at the end. I almost did. It was just fortunate that I had the ability to move forward. Certainly when I was a quality manager at North Shore and I actually coordinated all the equip service, I was never aware over a very period of about eight years or so of any statistics kept by HR and presented as part of our performance results for equip survey that related to bullying or harassment or terminations or anything like that. I was a member of the corporate executive for a period of time there and this kind of thing was never, ever, ever discussed. It was swept under the carpet.

Mrs JILLIAN SKINNER: So there would be no documentation, no trail, that could lead us—

Ms GANLEY: Absolutely.

Mrs JILLIAN SKINNER: —to find out how many people have been in this sort of situation?

Ms GANLEY: Absolutely. Have they provided the Committee with any?

Mrs JILLIAN SKINNER: Would the Meppem-Dalton review have looked at some of this, do you think?

Ms GANLEY: Well, it did say that they looked at all of the grievances. That, of course, is if they were there and available for them. I mean, documentation seemed to go missing, what the Ombudsman came up with. The HR manager at North Shore was terminated and when they were cleaning out her office they came across this box of documents that seemed to be related to the grievance. Well, I mean, that was where I got a lot of stuff for which I can make these allegations. So, this was just hidden there.

Dr ANDREW McDONALD: Just clarifying one thing: What was your position in the quality assurance unit?

Ms GANLEY: Oh, I was a quality and risk management consultant. There were about five or six of us, and we were brought together from the divisions into the quality and risk management unit and a new boss brought in.

Dr ANDREW McDONALD: And that was for retrospective patient file audit, that sort of stuff?

Ms GANLEY: Not so much that quality assurance nowadays. Continuous quality improvement projects, a lot of the good work, occupation health and safety, those kinds of things, root cause analysis.

Dr ANDREW McDONALD: The Committee has been told that a professional practice unit had been established to investigate patient complaints and staff grievances at Royal North Shore?

Ms GANLEY: Yes.

Dr ANDREW McDONALD: What difference do you think a PPU would have made to your situation?

Ms GANLEY: Oh, I think a lot. They would have been neutral for a start. I certainly have spoken to Mary Dowling and she seems very skilled and knowledgeable. That was one thing I did find about the area HR staff: even at a very senior level, they do not seem to even understand what bullying is about, the insidious and the vindictive nature of it. They do not understand that it is a pattern and not single to events. They do not understand a lot. They do not understand that when you are working next to the person you have made a complaint about for 33 weeks in the office next door how terrifying that is. They did not understand all of this. So you need someone neutral, somebody who understands the law, understands natural justice and is willing to work for you and is not aligned to the managers. You know, HR people get bullied too.

Dr ANDREW McDONALD: What would be the most useful area for a PPU to focus on?

Ms GANLEY: In regards to professional groups?

Dr ANDREW McDONALD: Well, just the whole job? What would they best focus on in the organisation?

Ms GANLEY: Well, you know, I have heard people saying the problem is with the process and the policy's a joke. I do not necessarily agree. It is how the policy is implemented that is a joke. So, sure, revise the policy, but then people need to be willing to go through a proper process and make it an important part of what they do, not something that is, you know, just a bugbear to them.

CHAIR: Thank you very much for coming in today. We appreciate all the information you have given to us. Are you happy for us to table your document?

Ms GANLEY: Yes.

CHAIR: Thank you very much. You have given us very detailed information. We appreciate it.

(The witness withdrew)

KERRY JOY RUSSELL, Director of Nursing and Midwifery Services, Sydney South-West Area Health Service, sworn and examined:

CHAIR: Do you wish to make an opening statement?

Professor RUSSELL: I would like perhaps to just give a bit of background. I have been a registered nurse for 30 years. My background largely in the management area has been around nursing and midwifery workforce areas. I have done a number of reviews relating to the nurse staffing levels and staffing configurations across this State and interstate, and was the primary author for the program that implements the reasonable workload for nurses in New South Wales.

CHAIR: Thank you. We will proceed now to questions.

Mrs JILLIAN SKINNER: We have had evidence from nurses of similar lengths of experience talking about workforce issues at North Shore, in particular the nursing mix, worrying about the inexperience of some of the nurses that are asked to do the more difficult tasks. Would you care to comment about what would be the best sort of mix in, let us say, an emergency department?

Professor RUSSELL: I might just start by saying Matthew Daley, the chief executive, asked me to have a look at the staffing levels and the mix at North Shore just to give him a fairly quick review of whether or not it was appropriate and whether the staffing levels and mix were appropriate to the beds that were open. I shall preface it by saying it was a very quick look. I had a look at one month's data. I was able to get only one month because there were issues with being able to obtain the data. It was a tabletop exercise, so I did not walk around any wards. What I found was, well, in my experience, there was a fairly good level of support in all of the wards. In each ward there was provision for a clinical nurse educator, which was very good. There was also 3.4 full-time equivalent ward assistants, which are staff that provide support to the ward, including some of the work that would otherwise be done by nurses, such as ordering and replenishing of stock. The 3.4 would allow for two shifts a day, seven days a week in a ward, and that is a very good level of infrastructure to have.

There is a reasonable workload methodology in New South Wales that has now been in for over 12 months and it is based on the acuity of the patients. When I looked at the inpatient wards and what they used in the months of October and November, all but four wards had achieved that level required for the acuity of the patients, and in all but four cases they had exceeded it. In terms of the skill mix, I think on the contrary, there was quite a senior level of experience: 11 per cent of the staff at North Shore are clinical nurse specialists. Within the registered nurse group, which is around 900 full-time equivalent staff, 51.8 per cent of those staff are 8-year registered nurses or thereafter. So, they had experience of over 8 years.

The level of first-year registered nurses was 11 per cent, and that is fairly comparable. If I look at somewhere like Royal Prince Alfred, the level of first-year registered nurses is close to 14 per cent. Between 11 per cent and 14 per cent is probably fairly average across the State with some slight variation. The other category of staff that constitute "junior" in the skill-mix area is trainee enrolled nurses. Again Royal North Shore was fairly comparable to other hospitals. In terms of the enrolled nurse ratio, it is about 11 per cent and that is quite low compared to what the State recommendation would be at 20 per cent. I am sorry but the emergency department I did not specifically look at.

Mrs JILLIAN SKINNER: That is what I was particularly interested in. You didn't?

Professor RUSSELL: I didn't because the reasonable workload tool was not applied to the emergency department and it requires a bit more of an in-depth look than I was able to do.

Mrs JILLIAN SKINNER: Did you look, when you were looking at the nursing workforce, at the nurses who work part-time and to the extent that they work part-time? For example, if you had a number of year eight nurses, it looked as though it was a substantial number but they only worked two days a week compared to the EN's or the less experienced nurses that were on full-time. Would you have taken that sort of thing into account?

Professor RUSSELL: I was not provided with that data but it is a trend that more and more nurses work part-time for a whole range of reasons. I was not specifically given the data.

Mrs JILLIAN SKINNER: So you could not comment about any suggestion by nurses that they were top-heavy with the experienced nurses only working part-time so on the surface it looked as though they had a lot more of those nurses than in reality was the case, in terms of access to their support in the ward?

Professor RUSSELL: No, I did not specifically look at it. Would be around 30 per cent of the nursing workforce is generally part-time. I do know that they use around 70 full-time equivalent casual staff and my view was perhaps there was a bit of capacity to increase that. That is an intentional strategy to replace unplanned leave generally.

Mrs JILLIAN SKINNER: Have you read the evidence of the other doctors that have appeared in this inquiry?

Professor RUSSELL: Yes, I have read some of it.

Mrs JILLIAN SKINNER: So the suggestion by many, if not all, of the clinicians that are at the coalface, so to speak, that there is a shortage of nurses, you do not believe that is the case?

Professor RUSSELL: Based on the agreement across New South Wales for the reasonable workload I did not see any evidence. In fact they used 91 full-time equivalents more in October this year than they used in October 2006. When I looked at the nursing hours across the inpatient wards over and above what usually you would provide under the reasonable workload there was 32 full-time equivalents over and above those nursing hours. Of that 32, 12 full-time equivalents were related to "specials". That left around 20 full-time equivalent over and above the nursing hours and that would represent around 15 beds.

Mrs JILLIAN SKINNER: Can I touch again on your "specials". So that people understand "specials"—I hope I am right—are nurses who are engaged to look after one-on-one?

Professor RUSSELL: Yes.

Mrs JILLIAN SKINNER: Particularly troubled patients, maybe people with dementia or other situations?

Professor RUSSELL: That is correct.

Mrs JILLIAN SKINNER: We heard evidence from the union that in fact they were negotiated away or the department tried to negotiate those away as part of this workload's study. Can you comment about that?

Professor RUSSELL: It would be something I have never heard of before and I would be very surprised if it were correct because a "special" is based on a clinical need rather than any resource issues.

Mrs JILLIAN SKINNER: But if it were true—I mean this was evidence given under oath before this inquiry. If let's say, take it for a moment that it were true, would that then impact upon the clinician-nurse's opinion, the clinical opinion on the ward about having to place a patient in a treatment room so that they could keep an eye on them because there were not enough of these nurses that were able to be dedicated to doing one-on-one nursing care?

Professor RUSSELL: I did not see any shift in one month that I thought there was an issue with staffing numbers on a shift. But it would not be the role of the Government and I have never heard that they would attempt to influence the need for a "special".

Mrs JILLIAN SKINNER: I refer you to the evidence by Mr Brett Holmes to this inquiry. It is in *Hansard*.

The Hon. JENNIFER GARDINER: With respect to clinical nurse educators, one part of the hospital has told us that they have got about 86 full-time equivalent staff but only two clinical nurse educators and one of them is on leave or the position is vacant. Does that gel with your studies at the hospital?

Professor RUSSELL: The profiles I looked at for all of the inpatient wards had the provision for a clinical educator and I think if I recall correctly there were about 44 clinical educators used in September-October. Now whether some wards may have a vacant position because of a whole range of reasons I am not able to answer that but, certainly, there is provision in every ward for a clinical educator and that is a very good thing.

The Hon. AMANDA FAZIO: I would just like to ask you a question in relation to your experience in looking at bed management practices, including the rostering of nurses. Can you tell the committee a bit about your analysis of bed management practices at North Shore? Any suggestions you have got about how they might improve their bed management? Do you have an idea in mind as to how many extra beds the hospital could open using the existing resources they have got at the moment?

Professor RUSSELL: As I said before I only had a very quick look but I did look at the number of staff assigned to a ward in comparison to the number of beds that were available. Certainly on the desktop data exercise that I did there was an appropriate number but what it did do was paint a bit of a picture, in that I think certainly in my view there was a problem with the structure and the ability to get nursing systems organised. Within nursing particularly it is an issue because the nurses do not report directly through nursing to the Director of Nursing. I think there is a fragmentation of systems related to staffing. There were some wards when empty beds appeared to have been staffed and when agency staff was brought in to other wards. That suggests to me that there needs to be an improvement in the internal systems of managing the beds.

On a purely desktop view there was probably in October-November staff to open around 15 beds but that would be subject to, someone would need to have a look at that because some of those staff were from a paediatric ward where the occupancy was quite low and the staffing levels did not change. So you would have to look at whether those nurses are just paediatric experienced or whether they were able to be not replaced if a vacancy came up and the position put elsewhere to open up an additional bed. But certainly based on the numbers there was some capacity.

Ms CARMEL TEBBUTT: You raised just then the issue of nurses and how they report. We heard in some previous evidence that the support that is there for nurses needs to be strengthened and that part of that might be because there is a divisional structure and nurses, to a certain extent, have lost their reporting relationship with the Director of Nursing. Is that something unique to Royal North Shore Hospital? Is it done differently in other hospitals, do you know? And have you got any ideas about strategies that could be put in place to better support nurses?

Professor RUSSELL: I think with some better support, in terms of structural support. North Shore has got—the staffing levels, in my view, seemed to be reasonable and the skill mix, I thought there was a bit of capacity in terms of enrolled nurses. I think that they have got the foundation to have a wonderful nursing service if the structural matters were sorted so that some of the nursing systems could be put into place. The nurses need to be able to function as a team. They need to function as one nursing-midwifery service in North Shore to make them an employer for which people wish to come and work. It is my view that they will not achieve that whilst ever they are functioning as separate divisions without somebody overseeing nursing as a whole.

Ms CARMEL TEBBUTT: Within the hospital are you talking about or within the area?

Professor RUSSELL: I think you have got to do it at two levels. It has got to be within a hospital, because ultimately people see their identity as working for a hospital, but it needs to be across the area health service. I believe you can maintain a hospital identity and that you can be part of a bigger team.

Ms CARMEL TEBBUTT: So the structural issue you are saying is the reporting lines for nurses? That there needs to be a more direct reporting line to the Director of Nursing across the divisions?

Professor RUSSELL: Yes, I think with reporting lines comes the leadership, the sense of identity, the performance management, you know, the proper systems to manage bullying and harassment. I believe that you obviously want to deal with the bullying and harassment but at the end of the day you want to stop it happening. And I think you have got to have good systems in place and people feeling a sense of teamwork to make that happen.

CHAIR: Professor Russell, just on the question about bullying. You have obviously heard some of the reports from Royal North Shore Hospital?

Professor RUSSELL: Yes, I have sir.

CHAIR: Does that worry you? As if it is a problem there but not in your area? Is it a problem in other hospitals or unique to the Royal North Shore Hospital?

Professor RUSSELL: I think there are probably elements of it across-the-board but I do not think there are as big problems across-the-board as there seems to be in this matter at the moment. I think that, certainly my experience in Sydney South-West is that I do not have any indication that there would be a widespread problem; there may be individual cases that we deal with. But there has got to be systems. Wherever you work there has got to be a system that addresses the culture as to why it happens, and policies and procedures to make sure that if it does happen it is dealt with.

CHAIR: Do you have a document in your area that deals with that?

Professor RUSSELL: We certainly have the policies that provide the framework to deal with it, yes.

CHAIR: Could you supply us with a copy of that then?

Professor RUSSELL: Yes, I would be happy to do that.

CHAIR: That could be useful in looking at the Royal North Shore Hospital?

Professor RUSSELL: Yes, but if I could just add. I think the policy is there to give people the guidance and tell them what is required to be done but the policy is only as good as the people who implement it.

CHAIR: We have heard evidence that the key performance indicators could be unrealistic. Do you have a role in devising those? Where do the key performance indicators originate? About how rapidly you move a patient from the emergency department out of it or how quickly from the ambulance into the emergency department?

Professor RUSSELL: They are indicators that come from the Department of Health. So, no, they are not locally determined.

CHAIR: Do you do any assessment as to whether they are practical or achievable? Or do you have any views on them?

Professor RUSSELL: We do as an area health service, and certainly they are something that need to be worked on constantly. I think they are achievable but I think it takes good systems, good teamwork and a commitment. Sorry, what I am trying to say is I think when you have got some sort of case management model I think it is easier to achieve the indicators when there is somebody coordinating the activities in the emergency department. But I think they are achievable and people achieve them to varying degrees.

CHAIR: So in your area are they being achieved say 90 per cent of the time?

Professor RUSSELL: I am not exactly sure of the per cent. I would have to go back and have a look at our reports. We are certainly not the best performer consistently but we generally meet most of the targets. But it needs to be worked on. I think we need to meet the indicators but the bottom line is we do not want people lying around in emergency departments on trolleys, so we need to continue to look at better ways of working.

CHAIR: It is whether those KPIs create the stress on the nurses if there are difficult circumstances, maybe creating that pressure and creating some problems.

Professor RUSSELL: I think there is no doubt that there is pressure but I think it is pressure that we need to learn how to deal with and work smarter. Rather than change the indicator, we need to work smarter to be able to achieve it.

Mr PETER DRAPER: One of the submissions I read made an allegation that the director of nursing was setting up what they called a bogus ward staff with nurses from a casual pool with an aim to reallocate them wherever there is sick leave. Can you comment on that?

Professor RUSSELL: I am sorry, I have never heard of such an initiative. I am not aware of a ward.

Mr PETER DRAPER: They also mentioned the "workload tool". What is your opinion of the workload tool?

Professor RUSSELL: The workload tool is what has been agreed to in New South Wales and I am in favour of it if at the end of the day there is a professional judgement that needs to be made because there is no scientific base on which to say what staffing is required. I think the way New South Wales went along looking at it in terms of the acuity of the patient was the right way to go. The easy way to go is to just devise a patient ratio, one to four or one to five—that is the easiest thing to do, but in my view it is not the right thing to do because we know that patients in each ward are not exactly the same and a ward is not a ward is not a ward. If you look at the intensity across the hospital, there will be variations between the intensity of a colorectal patient as opposed to a cardiology or a dermatology patient. So in terms of the way New South Wales did it, I think it was the right way. Whether everybody was happy with it, I guess everybody will not always be happy but I think it was the fairest way to do it.

CHAIR: Thank you for coming in. We appreciate your evidence and your professionalism.

(The witness withdrew)

GREGORY RONALD FULCHER, Director, Department of Diabetes, Endocrinology and Metabolism, Royal North Shore Hospital, affirmed and examined, and

BRUNO MARIO GUIFFRE, Senior Staff Specialist, Royal North Shore Hospital, sworn and examined:

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

Dr FULCHER: I am a senior staff specialist at Royal North Shore Hospital, head of the department of endocrinology. I am also a clinical professor of medicine at the University of Sydney, a member of the Area Health Advisory Council, a member of the Greater Metropolitan Clinical Task Force, former chair of the Medical Staff Council from 2004 to 2006, and also former chairman of a committee that was set up by the former Director General of Health, Robyn Kruk, and Minister Hatzistergos to address issues of concern about North Shore Hospital that arose in 2004 and 2005.

Dr GUIFFRE: I am a senior staff specialist in diagnostic radiology at Royal North Shore Hospital, and have been for the past 20 years. I am also a clinical and associate professor at the University of Sydney but my main capacity today is as part of the clinical reference group with regard to clinical informatics. Medical informatics is the dealing with information within the health care system, and I have been involved with that since approximately 2000. My presence here today is largely as a result of that. I truly appreciate the fact that I have been allowed to come and make a submission. I am a somewhat reluctant attendee at this meeting. My reluctance is partly because I have been making these sorts of submissions, not to the parliamentary Committee but to the representatives within the area for about the past five years, and there has been almost no response.

I am part of a group of clinical people who for various reasons as you have no doubt heard through this inquiry are feeling very disenchanted. We are on the point of disengaging from any sort of interaction with administrators of any sort. The reason I am here is because last Tuesday night was the medical staff council meeting and it became clear in discussion with my colleagues that the message that the IT situation at Royal North Shore Hospital and in the northern Sydney area—and for that matter in the Northern Sydney Central Coast Area Health Service—is desperately bad. Because I have been involved in that and can speak passionately and perhaps with some knowledge of that, they wanted me to come and I accepted on the hope that I could express to you that this is actually something that is very important and that we really need some help.

Last night I wrote a letter, which you probably have now. That is a brief summary of the substance of what I needed to say, but I am happy to talk in more detail of anything in particular to do with it. The fact is that though that as far as the issues are concerned it is very important, and I do not necessarily think that if you are not involved in day-to-day health care you would understand that in 2007 having a functional information management and technology, an IT system, is no longer an option. It is basically essential. Aside from its generating data, we have heard a lot even this morning in the brief time that Dr Fulcher and I were sitting in there has been data bandied about. That data comes from, lot of times, statistical tools that are generated electronically nowadays. Because the IT situation at North Shore is so incredibly poor, some of that data may be inaccurate, inadequate, and the conclusions therefore reached are often misleading.

That is important but what is also very important is from the clinical point of view. I am a radiologist; I am a medico, and I deal with my clinical colleagues day in, day out. The fact is that you need to have clinical data in order to optimally manage health care, and the clinical data includes what in times of old used to be the medical chart. In that medical chart is the history, the examination, the progress notes, the operation notes, the consultations, the day-to-day from the nurses, the results from the laboratories or biopsies or endoscopies, colonoscopies and the like, the imaging results. That is the file; that is the medical record. That is essential for the day-to-day management. The tendency nowadays is for that to be available electronically—an electronic medical record.

The Northern Sydney Central Coast Area Health Service—or even, for example, the northern Sydney or for that matter Royal North Shore campus—is too large to have the single file that used to be in the small cottage hospital available to the doctor, the nurse, the physio to look at. In fact, if a patient presents to the emergency department at Hornsby, for example, their notes, their detail from

their admission to North Shore cannot be available if it is not available electronically. In fact, even if they present to the Royal North Shore emergency department out of hours or on a day when they have come to another clinic it is effectively impossible for that single file to be available to the doctors who are treating the patient. That is a situation which has become almost—it is making care very difficult. That situation is not the case elsewhere, as I detailed in my letter.

Every other area health service moved to an electronic health record in approximately 2000. Not only are we not at that point yet but we have been told that we will be delayed to an indeterminate date for the future. It was not even going to occur when we hoped it was going to occur, either late this year or early next year. It is not even set yet. The situation as far as patient care is difficult. I can speak if you want more on medical imaging issues. They have been detailed in part by the submission by the director of radiology, Stephen Bloom. As for PACS—the picture archiving communication system, which is the electronic generation, storage and dealing with medical images—we have been trying for eight years unsuccessfully to get PACS at our hospital. We still do not have it. It is not only embarrassing; it is a disgrace.

CHAIR: Do you want to allow some time for Dr Fulcher? Do you want to make an opening statement?

Dr FULCHER: I would like to make some statements about some of the work we did in 2004, 2005 and 2006 around issues at North Shore Hospital because I think the impression that somehow appears is that all of this started with a miscarriage in the waiting room at North Shore Hospital, and I think we have had issues that have gone back for a long period of time that we have tried very desperately to address. Some of those have been covered by others. I will not go into issues of funding, bed numbers and all those other things because that has been dealt with by people who know a lot more about it. We were concerned at the time, 2004-05, about the complete lack of a process at North Shore hospital for capital equipment replacement. A lot of the adverse publicity that the area received at that time was around cardiothoracic surgery being postponed, neurosurgery not being able to be performed because there was no money to pay for drill bit sharpening and so on and so forth.

We discussed this at some length and we still, as far as I am aware, do not have an adequate process for capital equipment replacement. At that stage we had something like \$20 million of capital that was required at North Shore hospital for which there was no source of funding identified. We discussed issues around the trust funds, particularly the governance of the trust funds, allegations of inappropriate use of trust funds, the accounting practices around the trust funds within the hospital and in fact the general accounting practices within the hospital that meant that individual heads of department had no budget, had no real capacity to manage their own affairs because the accounting system was so inaccurate that the data we got and looked at was meaningless. Tens of thousands of other people's bills were on our accounts on a very regular basis, not even aware that members of staff were appropriately assigned to the correct cost centres. It was simply a mess.

Dr Guiffre talked about the chronic underfunding of IT, and we talked about the costs of North Shore hospital, and this has come up in this inquiry. It has been stated over and over again about how expensive we are. Not once since we started raising this issue has anybody demonstrated any initiative either at department level, a hospital level, to try to look into the issues around that to ask the obvious question: why is it the way it is, if that is really the case? And therefore have some targeted approach to do very constructive things to try to improve the budget situation if they can be done. I think the question we have asked is: why is there no real requirement for the CEO to demonstrate that they have developed an effective capital replacement because in this day and age we cannot deliver health care without having adequate equipment such as radiology equipment and all the other things you would imagine that you use to do it. It is an integral part of providing health care for patients, yet there is no real requirement for them to have any clear strategy in place that demonstrates that they will be able to meet capital equipment needs over the next few years.

We have regular accrediting of hospitals but to the best of my knowledge no-one comes in and accredits all of the processes that frustrate clinicians on a daily basis—things like the efficiency of accounting practice that takes hours of our time to try to sort out when we should be doing other things; a streamlined process for purchasing and position of placement. It is a problem in all the area health services. We hear that at the Medical Staff Executive Council all the time. I know that they are

just setting up now a red tape committee to look at the red tape processes that people have to go through in order to get what should be very simple things done very quickly and processes such as trust fund management. We still do not have a management committee that sits on our major trust fund that has something like \$6 million to \$10 million in it. It has been sitting there now for three or four years with no management or trustees in place.

It took people like Carol Pollack, I think it was, who brought Deborah Latta in as an external consultant to go through the hospital trust funds and work out where they were, who were the trustees. People were looking after these funds that no longer belonged to the organisation. The whole accountancy system around that was inappropriate. There is no requirement that people understand, as Dr Bruno Guiffre has been saying, that IT is an essential part of the delivery of health care in the twenty-first century and the way in which it has actually been cut back and people have been taken out of it at North Shore has been a major scandal.

People have said that we are very ungrateful for the fact that we have not appreciated the capital development at North Shore, which is not the case. The issue we have had all the way through is that they embarked on a capital program of this magnitude with no clinical services plan in place. We have now been going around in circles for two years trying to argue about things like how many operating theatres should we have; what work is going to be done at North Shore; what is going to be done at Ryde; what is going to be done at the beaches; and all of that relates to the development of the campus and to have it so back to front seems such an obvious thing to have corrected. Yet, that is not something that is put in place.

As I said, throughout 2004-05 we met with the director general on multiple occasions. We met with Bob McGregor on many occasions. We met with the Minister on many occasions. Everyone has been aware of all of these issues at the Royal North Shore Hospital for several years and the frustrating thing for the clinical services staff is that it has taken a miscarriage in a toilet for people to understand that the health service, at least in terms of our area, is in crisis. It raises issues around the clinicians and the voice that they have, and what tools we have to get messages through.

I am not going to be an advocate for hospital boards, but I know we have area health councils that have very little power at present to do anything other than advise. We really do not have a strategy for anybody to look at the red flags that are waving. I am hopeful that at least some issues about requirements of CEOs to meet these obligations and processes that can be put in place to elect clinician feedback have an impact on the delivery of health care, might be something that comes out of this inquiry.

Mrs JILLIAN SKINNER: I am extremely pleased that you have raised the whole issue of information technology [IT], because some of the earlier questions the Committee asked were based on the acceptance that there were flaws in the IT system, but then the assertion that North Shore was more expensive than any other, how could you validate that assertion when you already said that data collection was flawed. You have clarified that. I would like to focus on the patient impact. For example, you cannot check imaging of a patient who might have attended Hornsby emergency department and later Royal North Shore. What is the potential impact of that?

Dr GUIFFRE: As you are probably aware, there have been incidents as a result of that. Nowadays images are generated generally electronically and they can be transmitted electronically and stored electronically. That is the whole point about PACS, picture archiving, storing and communications sending systems. Human nature is such that people who are trying to do their job work around, and we in radiology at North Shore and certainly throughout the area, people who have been involved in this have tried to create workarounds. For example, at radiology at North Shore we do not have PACS. We realise that our clinical colleagues have a problem in that they need to see images on wards, in emergency, in ICU, and elsewhere.

We have slowly created, and often by means that are not supported by the hospital nor the administration—by cancer institutes, the trust funds of the hospital, the pink lady volunteers, a donor—a web of images that is available to the clinicians within the intranet of the hospital. Similarly at Hornsby, the radiology department has created an intranet. On occasion, in a very ad hoc way, it is possible to view the images from Hornsby at, for example, North Shore. That means that on occasion a patient can have been transferred from Wyong for a complex orthopaedic injury to North Shore

inappropriately, because it probably could be dealt with at Wyong, but if the images are sent the orthopaedic surgeon who is on call may review the images, talk with the clinician and say that no, it would be better dealt with either at Wyong or Gosford, costing several hundreds of dollars to transfer such a patient.

The workarounds include, because we do not necessarily have those communications across the area, things that are to my mind dysfunctional, such as using your phone to take a photograph and emailing the image. Images in CD form have been put in taxis and sent to North Shore for various specialists to look at. To my mind that is a disgrace, it is a disgrace across the State but is certainly a disgrace in our area health system. Frankly, we have been pointing this out as forcefully as possible, but it is not in our ambit to fix the problems.

Mrs JILLIAN SKINNER: I have seen a digital pen that is available for doctors to use to write out a patient's record that is capable of being stored digitally and read by nurses. Is that what you are talking about?

Dr GUIFFRE: There are many potential problems. It has to be done in a coordinated way and in a way that is robust and reproducible and that fits in with the corporate system. The people who are at present acting as the information technology and management administrators at northern Sydney are very aware of that, and trying their hardest, but they are completely underresourced, as I indicated in my letter.

Mrs JILLIAN SKINNER: You talk about the budget at North Shore for this technology is 1.7 per cent and the international benchmark is 4 per cent.

Dr GUIFFRE: Yes, it is approximately 1.9 per cent this year. We have had about 10 years of gross underinvestment and that has created a very big hole.

Mrs JILLIAN SKINNER: Dr Fulcher, in the management of trust funds I find it astonishing that there is not a proper process to handle, to manage, trust funds. What do you think should happen?

Dr FULCHER: We made a start with Deborah Latta coming in and identifying the trust funds. We need to get very clear statements of those and they need to go out to every department on a regular basis so that people can look at the balances and check that things are there and even just know that there is money to do things with. We had a situation with 10 dialysis machines that were considered to be unserviceable and unsafe. We got to the point of having an urgent appeal to raise money to replace those machines. Following the order we found that there was a trust fund that had been specifically set up to replace those dialysis machines, but no-one had a record that it had even existed.

We need to get a management team around the major trust fund immediately so that we can make appropriate allocations of funds from that. The staff specialists had agreed, because we were so desperate about the IT issue, to contribute \$1.5 million from staff specialist money to give to the Department of Health to contribute to the cost of delivering a better PACS system. That money has never been used, and this was 2½ years ago.

Mrs JILLIAN SKINNER: What has happened to that money?

Dr FULCHER: It is sitting in an account.

Dr GUIFFRE: I think the process is that the Department of Health, not unreasonably, are trying to make a coordinated approach to the delivery of PACS across the State. The problem that we are suffering under is that it has been so long that he is still waiting in that account to be committed.

Mr MICHAEL DALEY: Dr Fulcher, the new CEO of the area health service has said that preparing a clinical services plan would be one of his priorities, which is good. What involvement would you like to see clinicians have in the development of that plan and what outcomes would you like to see coming out of that plan?

Dr FULCHER: When we are talking, a lot of it is historical. Certainly in the last few weeks since the inquiry was announced and all of the issues came up at North Shore there has been a lot of action and movement. We met with Reba Meagher on a few occasions. She gave Matthew Daley six months to come up with a clinical services plan. If we could have had a clinical services plan two years ago that took six months we would have saved an enormous amount of angst around the development of the new hospital and we would be a lot further advanced in knowing how services were going to be delivered.

Having said that, it is a very positive thing that she has asked him to do that. I think Matthew Daley is very keen that that is set up and running as soon as he can. He has made it very clear that this has to be a plan developed by clinicians and we support that, obviously. We do not want to be so negative all the time. There is an enormous will at North Shore because most of us have been working in the area health service for 30 years. We are committed to the place and to public health, and we are committed to making that institution the best we can make it. We need to get administration that matches the capacity of the clinicians.

We are looking forward to working with Matthew Daley and we will do everything we can to help him get that clinical services plan on the board in six months. Hopefully, that can guide the design of the new campus. It will require a team approach. We need surgeons to develop their plan, we need stroke people to develop their plan, we need to link in with the Greater Metropolitan Clinical Task Force in terms of the networking of services across the State so that it is an integrated plan. There is no shortage of willing people to do it. It will get done, and hopefully some of these issues will start to turn around.

The Hon. AMANDA FAZIO: Dr Guiffre, you have outlined your concerns with the current status of the IT systems at Royal North Shore Hospital. I am aware that some time ago the former CEO put out an email about the need to keep within budget because of the impact that budget overruns were having on updating the IT system. I focus specifically on how IT can be used in tracking bed usage, because of the different ways that beds are counted. That has come up on a number of occasions in the evidence that the Committee has heard. What do you think are the best ways to address this and see a real improvement? For example, would installing an electronic bed board or an equipment program be used? What else might the hospital need for a new IT package?

Dr GUIFFRE: Basically, that is beyond my expertise. I know that those issues are being looked at at the State and Department of Health level and locally. The problem is resourcing. You cannot do this in isolation. You cannot suddenly put up an electronic bed. It is like giving a TV to someone in a village in the Congo. It does not work that way, it has to be coordinated. The lack of investment in infrastructure has had many different adverse effects. However, people work around it, and they try very hard. For example, the fact that there is no enterprise scheduling available within North Shore, means that some people have exercise books in the clinics. When the exercise book goes missing everyone goes into meltdown while they try to find it.

There are XL and Access spreadsheets throughout the hospital, which must be such a frustration for any data manager in trying to pull data because often they are not quite as robust as the tools that would normally be part of the electronic roll-out. People have to actually fill a gap, they have to do something about it. You have to understand, though, that this all sounds black in a sense, but the truth is if you, your friends or your relatives came to North Shore, you will still get excellent care. You get excellent care because people make superhuman efforts and fill the gaps. But is that reasonable? Is it reasonable that only by superhuman effort, despite everything, you can get excellent care?

Ms CARMEL TEBBUTT: I understand what you are saying with regards to both management information systems and clinical information systems. This is obviously an issue that confronts all area health services, but it does seem from some of the evidence we have had presented that it is more of a problem in Royal North Shore Hospital and in the Central Coast Northern Area Health Service. Is it your understanding that there has been less investment in information technology in the area and can you comment on why that might be?

Dr GUIFFRE: I think you are asking the wrong people as to why. It certainly is the case.

Ms CARMEL TEBBUTT: It is.

Dr GUIFFRE: And the fact, as per my letter there, it has been frequent, until the present administration, that the IT budget, regarded as somehow a non-clinical dispensable budget, was pillaged.

Dr FULCHER: I think that was the issue. When there was this push on to reduce non-clinical services and then direct funding into clinical services, it was not appreciated how much IT is an integral part of clinical service and also how much IT is an integral part to managing a hospital efficiently. It was thought that you could take all these people out of IT—you could not spend money there—and somehow, by meeting the bottom line, that would still be okay and it was an error of judgment.

Ms CARMEL TEBBUTT: And more so in your area than in some other areas?

Dr GUIFFRE: We started from behind. There are also other geographic reasons. Part of the rationalisation—I am not going to enter into that; I am not competent to decide whether joining Central Coast and Northern Sydney was a good idea or not, but it has geographically created a very large area. In the process of that, I think there were 45 positions taken from the IT staff because there was an amalgamation of areas. But that is not actually necessarily such a good thing because a lot of time is spent travelling between Gosford and Macquarie or Sydney, Royal North Shore. This has created real problems for employment, OH&S issues of stress and physically trying to organise a meeting. You cannot always organise a meeting via videoconferencing, so it has actually been quite a big problem for our area in particular, leave aside the deficit we started with.

CHAIR: You indicated in your letter this gap of only 1.7 per cent of direct funding when the average should be 4 per cent. Can you put that into money terms? Can you say that Royal North Shore Hospital now needs \$1 million, \$2 million, \$5 million to be spent to upgrade its IT programs?

Dr GUIFFRE: I think that is a question for Matthew Daly and Annemarie Hadley, the Acting Director of the INT of the area as to what actually would be needed to try to sort that out. I do not know an exact figure. I can tell you that it is actually much more than suddenly just making 4 per cent of the budget available this year. It would not fix it. Because there has been such a long period of underinvestment, it would require much more than that.

CHAIR: None of those trust funds are applicable to IT?

Dr FULCHER: As I said, the staff specialist did vote to contribute \$1.5 million towards improving IT, which was almost the entire amount of money we had available to us, but that was the only source of funds in all of that that we could contribute.

CHAIR: That has not been spent?

Dr FULCHER: It has not been spent to the best of my knowledge. It is still in the fund, but that was the only money we had that we could contribute to IT.

Mr PETER DRAPER: I am still in shock about the red tape committee. It is a very alarming development from my perspective. Am I missing something? If there is an IT system that is operating in other health services that is working, why on earth is it not just transferred across?

Dr GUIFFRE: Any sort of IT system, you have to have it locally as well. But the underinvestment goes across the board in terms of hardware, the network, the PC fleet. Until fairly recently there were 386 machines—machines that you would probably find in the Powerhouse Museum, running what were basically pre-Win 98 operating systems, which were making it almost impossible. A lot of the IT effort is still going into crisis management, fixing broken things. Because there has been some time, they have slowly improved some of those hardware issues, but some of these things are well beyond their capabilities in terms of resourcing. It is very good to see that in Central Sydney or Western Sydney they have actually proven that this product will work—fine, that is good—but we actually need to put it in place. It needs to be done locally and you actually have to reproduce it locally.

Mr PETER DRAPER: But a basic framework could possibly be used to assist the current situation?

Dr GUIFFRE: The idea of what needs to be done is fairly clear. It is the money.

Mr PETER DRAPER: One of the submissions I was reading says that there has been a big investment in financial reporting and commented that it is a shame that the same investment had not been applied to clinical reporting. Do you have a comment on that?

Dr GUIFFRE: I do not have the knowledge on that. I would not be at all surprised because that is regarded as an important thing and I am not saying it is not. It is just that it should not be at the exclusion of the clinical.

CHAIR: Thank you very much for coming in today and sharing your knowledge with us. We appreciate it.

(The witnesses withdrew)

(Short adjournment)

PHILIP MATTHEW HOYLE, Director, Clinical Governance, Northern Sydney Central Coast Area Health Service, affirmed and examined:

CHAIR: Do you want to make an opening statement?

Dr HOYLE: A very brief one, if I may. We have heard some—and no doubt this afternoon we will continue hear—very sad, upsetting and distressing things about care and care at the hospital. As a person who has responsibility for quality, safety and improvement in the area health service, I want to say that we hear those concerns, that we take them seriously and we are committed to dealing with them. Although a lot of very good things happen within the health service—and I believe our various papers we submitted and submissions have made the case for that—I do not believe that they take away the responsibility for dealing with what goes wrong, so just to reaffirm our commitment to dealing with those issues.

Of course, as Dr Wilson's testimony last week indicated, all health systems have things that go wrong. That does not mean we should for a moment accept that they do, and reaffirm our commitment to try to stop that happening. If I may extend a moment longer, there has unfortunately also been a slight tendency for some people to, in a sense, get short-term psychological relief, or whatever, from blaming other people. I do not intend blaming anybody. But I do believe that the time has come for people from top to bottom of the system to take responsibility. As a member of the Northern Sydney Central Coast Area Health Service executive and a person who works closely with clinicians and managers at Royal North Shore Hospital, I am confident we have the intention and capability to take responsibility and to take it forward.

CHAIR: We will move on to questions.

The Hon. JENNIFER GARDINER: Dr Hoyle, it is all very well to say the time has come to take responsibility. What has been done to take responsibility, given that we have had witness after witness saying that these problems did not suddenly emerge at Royal North Shore Hospital? We have heard more evidence today of systemic and very long-running problems. Firstly, how long have you been in your current position?

Dr HOYLE: Since 2005.

The Hon. JENNIFER GARDINER: Can you tell the Committee what has been done to address the many issues that have been raised by clinicians over a period of years?

Dr HOYLE: Yes. What has been done, it is very complex and it may take me some time to answer your question. If I could talk about clinical governance, clinical governance is partly a structure but it is, above all, a practice—a practice of trying to improve issues and matters systematically. It needs to be informed by knowledge of what goes wrong. We have various ways of knowing that. There has been extensive discussion on reading the proceedings of the Committee about the incident information management system [IIMS]. There is also what comes out of Quality Assurance Royal North Shore [QARNS], the systematic record audit, which I believe Dr Wilson explained in some detail.

As has been made clear, those identified different types of issues, overlapping but quite distinct. There is also information from indicators—for example, infection rates, medication error rates—that come into it. There is information from safety alerts that may come to our attention, for example, that there is an issue with intrapartum monitoring of foetal heart rates or nasogastric tubes. It can come to our attention from the literature. Dr Nelson and the cardiology team, for example, drew our attention to the benefits of having much earlier diagnosis of myocardial infarction. So we have been able to reduce our cardiac mortality rate from 8 per cent to a world's best 2 per cent.

The point I am making is that there are multiple inputs. Having had those multiple inputs, what do we do about it? In a sense, in quality and its improvement and in listening to clinicians, the perfect can be the enemy of the good. You cannot attend to every small thing that happens. Every small thing that happens has to be attended to by somebody, but at an organisational level we have to say, What is the underlying lesson? Perhaps I could give you an example. You would be familiar with

root cause analysis, which is a very detailed analysis of when a serious adverse event happens. By the way, I should say that the causal statements and the recommendations that come out of root cause analysis are informed by the wisdom of the clinical staff. So they are not driven by managers; they are driven by clinicians. It is bottom-up wisdom, if you will forgive the language, on what can and cannot and should and should not be done and what led to the tragedy that is the subject of the review.

The individual incidents carry with them particular things that need to be done to stop that happening again. But they are at the very extreme end of the distribution of adverse events. In other words, you would require a quite unusual and statistically unlikely-to-recur combination of a place, a person, various elements lining up for that to happen. You could say that we have addressed that, we have stopped each of those little things happening, and that will not happen again. But that is not the case. You have to go back upstream and say, If that is the particular, what is the general? So what we have done on two occasions now, and we do it every six months, is what we call a root cause analysis meta-analysis. Forgive the terrible tautologous language regarding it. What we do is we get the over 350 causal statements from the root cause analyses and using a categorisation method developed by an expert group that includes clinicians we say, What sort of problem is this? If we were going to try to deal at the very centre of the organisation or at a hospital level as opposed to an individual clinical department on a Sunday level, what would we do to fix that?

Some of the issues that come out are the classic one but nonetheless an extremely important one, communication—communication with patients, communication between clinicians, communication between sectors, for example, when someone goes home or comes back. Others relate to policy, procedures and guidelines. Do we or do we not have a guideline? The very important thing about that is that the guidelines, policies and procedures are not a bureaucratic thing. They are, How do clinicians believe this care should be delivered? They are developed, for example, in consultation with the clinicians and signed off by the clinicians. I can go on for a while, but the point here is that we try to gather the wisdom, brought together, so that we can have a strategy around it. A submission from Northern Sydney Central Coast Area Health Service to this Committee includes as an attachment the area's quality and safety plan. I draw to the attention of the members of the Committee that quality and safety plan, which is an attempt to map in the various issues that have been drawn to our attention with the specific action, the specific accountability and the specific deliverable amount of them.

Mrs JILLIAN SKINNER: It has been suggested to me by some doctors that they do not have access to a computer to enter the IIMS data, they have never been trained to enter IIMS data. Therefore, there may be incidents that are not being collected in your quality assurance system. What would you say to that?

Dr HOYLE: I am absolutely certain there are incidents not being collected, first. It may be useful, if the Committee wished, to provide a copy afterwards of a paper by Vincent and another one by Sari, I think his name was, in the British Medical Journal, 17 January this year, which is an attempt to scientifically explore the issue of how accurate is an incident reporting system in finding error.

Mrs JILLIAN SKINNER: If they do not have access to a computer—

Dr HOYLE: I appreciate that. That is part one. I went to part three first. As to part one, it is a little beyond my port folio to have the fine detail on this, so forgive me please. I understand as part of the rollout of the new patient administration system, which is currently occurring I think—do not hold me to it—and scheduled for Royal North Shore in March or so, there are going to be many more computers in place. I will say this: extensive training has been offered. I would not be the first person in a position like mine to find it very difficult to get doctors to be trained in such things.

Mrs JILLIAN SKINNER: What percentage of the doctors at Royal North Shore would be trained?

Dr HOYLE: I am sorry, I do not know the answer to that.

CHAIR: Did you say March next year?

Dr HOYLE: I think, but please do not hold me to that. It is not my portfolio.

Mrs JILLIAN SKINNER: Would there be someone who does know how many doctors have done the training?

Dr HOYLE: Yes, we could find that out, absolutely.

Mrs JILLIAN SKINNER: Would you let the Committee know?

Dr HOYLE: Yes, certainly, it would be a pleasure. About 3 per cent of our incidents are notified by doctors which, at a guess, is about 10 per cent of the workforce. I totally agree they do not report to the same extent. However, it is important to understand that is entirely consistent with the international literature. I am not saying it is acceptable but equally it is not anomalous either.

The Hon. JENNIFER GARDINER: Dr Hoyle, how do you explain the extraordinary amount of evidence from clinicians that there is a disengagement process continuing right to this day? How are you addressing that?

Dr HOYLE: I explain it by saying it is true.

The Hon. JENNIFER GARDINER: What are you doing about it?

Dr HOYLE: There are a number of things to be done about it. Perhaps I can give you very briefly an example of my own journey towards it, and it is very short. I was charged with writing a quality and safety plan as part of my portfolio. I sat in my office last Christmas, actually at home, and I wrote one. Then I looked at it and thought, "Hold on, this is saying to people, 'Please stop trying to hurt and harm people.'" I thought that is absurd, clinicians do not go any more than I do to the workplace with the intention of doing a bad job. After this sort of Demazin moment, I thought, "We need to find a positive way of articulating what is good and what needs improving, an improvement-based approach to things."

Some examples of the practical ways of taking that forward are to do an analysis and an understanding of the types of care we deliver and who is involved in the care, and to get protocols, pathways and an explicit understanding of the way this care should be done. Traditionally, clinicians have been reluctant to accept that. But it does have a huge advantage in that it requires a coming together of those who fund, those who deliver and those who plan on what will be done with what resources with what expected believe. That is precisely the way we are going at the moment.

The Hon. AMANDA FAZIO: I understand that you spent some time as acting general manager at Royal North Shore Hospital?

Dr HOYLE: I did.

The Hon. AMANDA FAZIO: Could you tell the Committee a little about the issues you identified during that period? Given that experience, do you have any recommendations for addressing those concerns and others already identified for this Committee, such as improving the relationship between clinicians and management and addressing tensions within the workforce?

Dr HOYLE: I would be delighted to.

CHAIR: What years were you acting general manager?

Dr HOYLE: I have a slight mental block but I think it was 2002. The organisation that I came in to manage in an acting capacity—and it was always going to be in an acting capacity—was one that was basically in pretty good shape but for various reasons had got into difficulty with accreditation. I understand that the Committee has been advised that it had a \$20 million deficit. In fact, it was about \$8 million, which is unacceptable—not quite an ordinate magnitude but significantly less. It was an organisation that had already major innovations. For example, it had achieved the State's best in access block under the leadership of Professor Robinson and Dr Hammett. It had introduced some superb ambulatory care models for medicine.

What did I find? I found an organisation that, particularly after the accreditation issue, was feeling somewhat bleeding and hurt. There was indeed a degree of schism, for want of a better word, between the clinical staff and management largely because I think they saw management, as we have heard since, letting the organisation down. What did I do? The first thing I did was I broaden the basis of the divisional membership. The executive was me, the director of operations, the finance people and three divisional heads, but we brought the divisional nurse managers and we brought the finance people and business managers for support into the executive, the purpose being to try to have a coming together about what we do.

I can give you an example of how we worked things for the finance meeting. Finance meetings typically were clinicians who were kind enough to cry what were probably crocodile tears about my problem with the budget. After a while I said to them, " Well, I understand that this isn't really something—I know you care but it is not something you feel that you can do something about. Let's turn this into a finance and performance meeting." At that time the word performance did not have quite the antiseptic sting that it does these days. It was more about how well are we doing things. We got the processes of care, the diagnostic related groups [DRGs]—the way we do things—firmly on the agenda, and we finished each finance meeting with, "Is there anything that we have done today or decided today or resolved today that is contrary or offensive to anyone's clinical values?" Occasionally the answer was yes, and we dealt with it.

So it was a matter of a very simple bringing people together. The place where we all link is in the care. I would say that the contribution of management to that is to work with clinicians on the process of care, the way we deliver care, the resources we bring to it, the expectations we have of it, the assessment of it, and the systematic improvement, which has to be a whole-of-organisation effort. I am not sure that answered your question, but hopefully—

The Hon. AMANDA FAZIO: It was an interesting answer, thank you.

Dr ANDREW McDONALD: The Committee has heard that the quality assurance system [QARNS] used at Royal North Shore is different from the one used in the rest of the State, the incident medicines management system [IMMs]. Can you tell us a bit about the differences?

Dr HOYLE: There is in fact no relationship between the two, other than that the Royal North Shore quality assurance system [QARNS] does assist us with identifying instances that have been missed in the incident medicines management system [IMMs]. Very briefly, the incident medicines management system is about staff, or consumers also via staff, notifying something that has gone wrong. The Royal North Shore quality assurance system is about reviewing the record for things that have gone wrong that somebody might not have noticed—that quite often is the case. It is the old legend—boil a frog slowly enough, it will not be recognised. Alternatively, and very rarely, people have actually hoped to get away with things. So it is an entirely different process.

The Royal North Shore quality assurance system is a fantastic asset but I would strongly recommend for the rest of the State that they are not mutually exclusive. It allows us to say on oath or, having given the affirmation, that every death and every serious adverse event in the Royal North Shore Hospital is reviewed by disinterested people who include managers and who include clinicians without a vested interest in the outcome. The lessons are learned and an attempt, usually successful, is made to drive improvement as a consequence. There would be very few hospitals that can say they have been doing that for 17 years.

Dr ANDREW McDONALD: What has the Royal North Shore quality assurance system data showed about the quality of care at North Shore?

Dr HOYLE: It shows that we have an adverse event rate of about 9 per cent, which is probably true. We do not think it is an understatement compared to, for example, the study that I cited earlier by Sari, which gave a 22 per cent rate for major hospitals in England, and the international literature is around 16 per cent. What does all this tell us? I would not want that to be interpreted as me saying, "Oh, that's all right." I think it is dreadful and I think everybody in the community should be concerned that in the Western World health systems continue to be unreliable. What else have we learned from the Royal North Shore quality assurance system? We have learnt to some extent similar

issues, such as communication, protocols, care, but also some very specific issues such as the use of anticoagulants.

We at some stage or at one stage identified issues with transfer of patients between specialty investigative units and the ward and who is in charge of the care. Those issues have now largely disappeared. We no longer have cardiac arrests, touch wood, in people being transferred for computed tomography [CT] scans, which used to happen. There are very subtle changes. One of the problems with the Royal North Shore quality assurance system, and one of the reasons it seems to sometimes attract unwarranted attack, is showing the disappearance of a small number from the radar screen—in other words, if a rate is already low, to show its disappearance is a bit of a challenge.

Ms CARMEL TEBBUTT: I want to ask about the clinical services plan because we have heard from any number of witnesses about the importance of having a clinical services plan. The chief executive officer has indicated that it would be a priority for him. We have also heard about the need to better engage clinicians. What role would you see clinicians playing in developing that plan? What do you think should come out of it? How can clinicians be better engaged in a process?

Dr HOYLE: I must say I am a little bit of a radical here. I actually believe clinicians' involvement is crucial but I think community involvement is even more important. I would not leave the decision on what cardiology services should be delivered and where to cardiologists. For example, the clinical services plan may say that we should invest more in prevention. It so happens that cardiologists I work with strongly believe that, but what if they did not? And a lot do not. So I believe that it needs to be a partnership. I actually think managers have a role—or they have two roles: one is in coordinating and the second is in trying to be sure that the resource allocation that flows from it and the resource use that flows from it is consistent with the area and the public expectation of health services so that nobody loses because somebody is more powerful at the table, to put it in the vernacular.

I think clinical wisdom on what should and should not be done is very important. I think the work done by the Greater Metropolitan Clinical Task Force is a classic sample of how the partnership between clinicians and in this case the Department of Health, who are the system managers, has made some fantastic changes: improvement in cardiac care, the improvement in stroke, for which Royal North Shore has documentary proof of being among the best in the world, is outstanding. That is because there was a coming together, a sensible service plan. I note that Dr Cregan is talking later and I am sure that he can talk at greater length about that. But the clinical involvement is crucial. It is like an ingredient of a cake: You cannot have the cake without it, but also, like the ingredient of a cake, it cannot be the only one.

CHAIR: Thank you very much for what you have been sharing with us. You mentioned you were there in 2002. Did you indicate the accreditation was in trouble in that year?

Dr HOYLE: It was at that time, yes.

CHAIR: What was the reason to that?

Dr HOYLE: The reason—I want to be careful not to get into blame, if you will forgive me, so I will describe the issue rather than say whose fault it was.

CHAIR: Yes.

Dr HOYLE: There were issues with the infrastructure, the built infrastructure. There were issues with the safety of the building, which have since been thoroughly rectified, by the way—I feel safe walking into the building now—due to storage of heavy records on the top floor. Ultimately they come down to housekeeping issues. It is important to say—and I can provide, if the Committee wishes, documentary evidence of this—that the survey, as it is, stated that the clinical care was very good. These were issues to do with the relationship ultimately between corporate services and the hospital. They were terrible. They were wrong. They should not have happened. But they were fixed.

CHAIR: So it was not really a failure on the clinical side—

Dr HOYLE: Oh, no—absolutely not.

CHAIR: —the nursing side, or patient care?

Dr HOYLE: Absolutely not. We did get reaccredited again in six months, which, for those who have ever been involved in such things, is a very, very rapid turnaround. I put it on my curriculum vitae [CV]!

CHAIR: But now we have a situation where apparently the accreditation is only probationary.

Dr HOYLE: Oh, no—not at all. Thank you, Mr Nile: I am very pleased to clarify that. It is not provisional at all. The Royal North Shore Hospital is fully accredited. It had a survey which is called a periodic review where I think it was six, and I may be slightly wrong on that number, people went over the whole hospital for a week looking at the various systems. They found two items that concerned them that were in breach of the new standards, or did not fully meet, I should say, the new standards by the Australian Council of Health Care Standards. I should say by the way that I am a surveyor of the Australian Council of Health Care Standards. I am also a member of the standards committee, so I am actually very familiar with these standards.

CHAIR: Very good. I have been trying to find you to get this information.

Dr HOYLE: Basically the survey team found two things that concerned them. One was with respect to the credentialing and performance management of medical staff. I will talk about that in a moment, if I may. The second was with respect to the audit of medical records. I am not referring here to a Royal North Shore quality assurance system audit where you go through and see what was wrong. It is more about the audit: Was it complete? Was the record signed? What is it timed, et cetera? They commented with respect to the latter about the medical record. I am relying on my memory here. Records were generally of a good standard. There were no concerns about what they saw in the record. But they were concerned that there was a new standard that requires audit of the record so that, if there is an issue found, it gets fed back to the relevant department to lean on the relevant staff to fix it up. That system was not them in place.

They quite rightly and correctly pointed out that that system is not in place. It has now been put in place, ironically leveraging the Royal North Shore quality assurance system, which of course reviews lots of records and all you have got to do is add a screening part to that about that. It is very important to note that there was no condemnation of the content of the record. Once again, if the Committee wishes, I can provide documentary evidence of this statement. Going back to the first part about credentialing and performance management of staff, it should be said that the hospital complied with the earlier standard, and this was an upgrading of the standard. I think it was an absolutely fair call by the Australian Council of Health Care Standards to say that we did not do that properly. In other words, there were significant numbers of senior medical staff that had not had an annual performance review, which they should, and therefore it is absolutely right that that needed to be fixed.

In terms of credentialing—and of course everybody around the table is probably saying, "Oh my goodness, Bundaberg!"—it was all staff at Royal North Shore Hospital. Indeed all of the Northern Sydney Central Coast Area Health Service hospitals are credentialled in terms of the intensity being verified, the standing with the relevant colleges is identified, their training is verified, and their scope of practice is defined. There is nobody who practices for whom that is not the case. What they were referring to was more, "Okay, so you have said you can do general surgery, but does that mean calicectomy, gall bladders? Does it mean large bowel, does it mean small bowel, does it mean you are going to do gastric bypass surgery, et cetera?" It does not define down to that level.

I do not believe that at that point we are different to the vast majority of hospitals in Australia, but the standard had changed. We were one of the first hospitals to be surveyed with the new standard. We have since put in systems to ensure that all departments have agreed on what framework they will have for developing the credentialing and specifying who can do what where, and have now scheduled performance review for everyone. In other words, I think it was a fair hit, a fair criticism. We have taken it on the chin and put the systems into place, once again, I should say, in

detailed collaboration with the department heads. It was not like the director of medical services sat in an office and said, "You'll do it this way." Instead, it was developed in collaboration.

Finally, if I may—I appreciate that I am taking a long time and I apologise—one in six hospitals has advanced completion 60 [AC60] from the Australian Council of Health Care Standards from their last annual report. An advanced completion 60 means you have 60 days to fix it. If you do not fix it, your accreditation is in jeopardy. Ours was signed off well within 60 days and we remain fully accredited until our next routine accreditation, which is October 2008.

CHAIR: I am pleased to know that.

Dr HOYLE: Thank you.

CHAIR: Is it possible to get copies of those accreditation surveys? Are they public documents?

Dr HOYLE: I am absolutely—they may not be, but perhaps if they could be given to the Committee only, until we can clarify that? They may actually belong to the Australian Council of Health Care Standards rather than us. That would be the thing I would wish to clarify.

CHAIR: You will take that on notice, then, will you?

Dr HOYLE: I am absolutely confident that the Australian Council of Health Care Standards would be happy for us to share it with the Committee.

CHAIR: You will advise us whether they must be kept within the Committee and not made public?

Dr HOYLE: That is correct.

Mr PETER DRAPER: We have heard that everybody in the system at Royal North Shore is striving for clinical excellence, and that it is a fine institution. I firmly believe that. A survey back in 2005 identified some \$30 million shortfall in funding for capital investment. Can we achieve clinical excellence without a substantial amount of money being put into the system?

Dr HOYLE: If I could start with change, my response would be to say that I think that money must be directed towards capital to improve the standard of care at the Royal North Shore Hospital—absolutely. I am not convinced that we are sufficiently efficient yet that we should be going out and saying, "Give us more money! Give us more money!" I am not convinced we are underfunded. I do however believe that we have underfunded capital, yes—absolutely.

Mr PETER DRAPER: One of the submissions I read had an interesting part in it which said: "Freedom of speech by employees has been stifled. Citizen involvement in hospitals and health wards has been dissolved. Amateur managers are now running the system and clinicians have become an enemy of the State." Would you care to comment on that?

Dr HOYLE: Yes. If I am an amateur, I am a hell of an amateur. I spent 15 years in clinical practice; I have worked as a senior manager in the United Kingdom in the fourth largest trust as director of clinical services strategic review; I have worked in Melbourne as deputy director at the Alfred; and I have been director of clinical services and an executive director of Royal Prince Alfred Hospital. If I am an amateur, I would like to know who is a professional. I should say that my colleague the area director of clinical operations, Julie Hartley-Jones, has a CBE for services to nursing in the United Kingdom. She has been a senior manager to Oxford Radcliffe hospitals. Mary Bonner was the area director for Waikato, in New Zealand, and has very extensive and distinguished experience as a manager. I do not believe it is an issue of competence.

Mr MICHAEL DALEY: You have just said, "I am not convinced we are underfunded." Does that statement apply to the investment in IT services over the last few years?

Dr HOYLE: I believe we have not directed sufficient funds towards it. I am referring to the area health service. I do not believe the area health service is underfunded.

(The witness withdrew)

ADAM CHUI FAT CHAN, Director, Emergency Department, St George Hospital, and

PATRICK CHARLES CREGAN, Chair, Clinical Services Taskforce, Nepean Hospital, sworn and examined:

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

Dr CHAN: I have been a medical practitioner for the past 25 years and an emergency physician for the last 18 years. I am currently the director of the emergency department at St George Hospital, in Kogarah, a position I have held now for almost 18 years. Since my graduation I have been working all my life in the public health system, so I have kind of lived and breathed the changes over the last 20-odd years since my graduation. I have been involved in quite a number of task force committees, both in the hospital area as well as in the Department of Health. I am currently a member of the ministerial task force on emergency care in New South Wales.

Dr CREGAN: I am the senior surgeon at Nepean Hospital. I chair the surgical services task force in the New South Wales Department of Health. I am a member of the board of the New South Wales Cancer Institute, I am a program director of surgery for Sydney West Area Health Service, and I have a number of previous appointments. I was on the board of directors of the Wentworth Area Health Service in days gone by, I have chaired the Nepean Medical Staff Council, I have been a member of the New South Wales Department of Health Clinical Council and the Greater Metropolitan Transition Taskforce, and I have chaired its metropolitan hospital subcommittee. I have been on the board of directors of the Institute of Medical Education and Training. I would add that I was a student intern and resident at Royal North Shore, as was my wife, and that my mother and sister both have Royal North Shore as their local hospital, so I have some vested interest.

Mrs JILLIAN SKINNER: I am particularly interested in the report into surgical services that was done by you, Dr Cregan, at Royal North Shore and Ryde back in 2004. Could you give us an outline of what that report found and what has been done since, particularly in light of the evidence already given to this Committee? For example, Dr Malcolm Fisher said that he was unable to admit 150 emergency patients to Royal North Shore and that ICU patients were sent to the ward or home too soon. Evidence has also been given in submissions that surgeons have had to go to the car park to assess patients in ambulances. How does this fit with the reviews that you have done at the hospital in the past?

Dr CREGAN: I was involved in the 2004 review. I had understood that Denis King was coming to this meeting. Denis had conducted a review into Royal North Shore probably 18 months before the 2005 review. I did not actually conduct the review; I was just an observer from the Department of Health. I think there was another review before that.

Mrs JILLIAN SKINNER: There have been lots of reviews?

Dr CREGAN: I think this is the fourth or fifth review into Royal North Shore in the past few years. I cannot comment specifically—I can read you some of the performance indicators—

Mrs JILLIAN SKINNER: Would you allow the Committee to have a copy of the report?

Dr CREGAN: Yes, we can get you a copy of that report. What I could comment on that is perhaps more recent is the key performance indicators. Royal North Shore is probably one of the worst performing institutions with regard to key performance indicators that was set up by the Surgical Services Taskforce. They range across a number of areas, from day of surgery cancellations, which are particularly stressful for patients, through to waiting lists, waiting list management, et cetera. However, I think there are a number of reasons why that may be so, and I would be quite happy to lead to those. As I said, this is about the fifth inquiry into Royal North Shore. I think there have been more inquiries into Royal North Shore than the rest of the principal referral hospitals in Sydney over that same period. I think it is reasonable to ask why.

The view from the outside is this. Royal North Shore gets a very large budget—probably bigger than most other equivalent hospitals—but they are always saying they have not got enough

money, that they have not got enough resources, et cetera. No-one is ever going to have enough money or enough resources. I would be so cautious to suggest that in a hospital the senior clinicians are largely the powerbase of that hospital. Managers come and go, Ministers come and go, and bureaucrats come and go. The senior clinicians are there for 20, 30 or whatever number of years. If the senior clinicians do not become part of the solution, then they remain part of the problem.

To paraphrase Thomas Jefferson, a manager can only manage with the consent of the managed. I think that a significant problem is, in fact, in the senior clinical people at Royal North Shore and their failure to engage. By way of example, at this inquiry I found myself in a rather incongruous position. There were about 10 people at the particular setting one afternoon. There was only one surgeon in the room, and that was me. I cancelled my private list to come down to Royal North Shore. I attended the meeting, but no-one from the surgical department at Royal North Shore turned up until towards the end of the meeting. If you are not prepared to put the time and effort into being involved in fixing your hospital, then you cannot whinge that you have not got enough resources.

Mrs JILLIAN SKINNER: Do you think that they have been given the opportunity to have a meaningful role in fixing the problem?

Dr CREGAN: In that inquiry, absolutely. It was chaired by Professor Carol Pollock, a professor of renal medicine at Royal North Shore. Carol is a very approachable person who is very skilled at conducting those sorts of things.

Mrs JILLIAN SKINNER: She has already given evidence here, saying there is a disconnect between management and the clinicians.

Dr CREGAN: I would agree that there is a disconnect. As I said, a disconnect can occur, because both sides have to connect and have to want to connect. There is a range of places that that then takes you. I will give you some examples. Royal North Shore pioneered the 23-hour model of care. That has been picked up and run statewide. It is a very effective method of improving access to elective surgical services. Part of it, though, revolves around patients being discharged according to a protocol, sometimes called nurse-initiated discharge. I encountered a surgeon from Royal North Shore not so long ago who said, "He couldn't do that, because he was a doctor and a nurse could not discharge a patient." There is that sort of prevailing attitude.

With regard to day of stay admissions, the Mayo clinic is virtually 100 per cent. Most rural centres in New South Wales are virtually 100 per cent day of stay admissions, and there are surgeons at Royal North Shore who say, "I could not possibly have left my patients on the day of stay." Rather than getting involved in developing a good process so that there is a good pre-admission process, a good assessment process, and good linkage to records so you can have day of this stay admissions, they would rather say, "Just give us more money."

Mrs JILLIAN SKINNER: These were some of the things in the recommendations?

Dr CREGAN: No, these are other observations. I am not alone. Reviewers from the College of Surgeons have said similar sorts of things.

Mrs JILLIAN SKINNER: But they have never been taken up at the hospital, are you suggesting?

Dr CREGAN: I am sorry?

Mrs JILLIAN SKINNER: There have been recommendations from all these other reviews. Why have they not worked?

Dr CREGAN: I think that is a fair question, and I cannot answer it. But, as I said, people have to want things to happen. For example, orthopaedic surgeons at Liverpool were having a problem. They did not have enough resources, they did not have enough beds, they had problems with infection and so on. They solved it. They said, "We will do our elective operations at Fairfield, we will do our emergencies at Liverpool, we will have a clean hospital at Fairfield, and so on." The

surgeons at Auburn were concerned about what was happening. They developed their own model. They developed the model, took it to management, and said, "This is what we want to do."

Mrs JILLIAN SKINNER: Professor Sears gave evidence earlier. He talked about having surgery cancelled or postponed because there were not enough ICU beds. He had already indicated that he had organised the staff to go into the operating theatre, and so on. I note that in the *Medical Journal* you make a comment that there should very rarely be cancelled surgery.

Dr CREGAN: Correct.

Mrs JILLIAN SKINNER: Yet, doctors are giving evidence before the Committee that they had to cancel surgery because there were not enough ICU beds, the operating theatre was closed to them, they were told there were not enough nursing staff, and so on. Here was a clinician who wanted to take some initiative. Do you have a comment to make about that?

Dr CREGAN: As regards the cancellations, the key performance indicator that the task force I chaired has instituted has said "We want that 2 per cent." Two per cent might not be achievable, but certainly it has to be less than 5 per cent. That revolves around effective management, rather than resources. Westmead published a monograph in the *Medical Journal of Australia* where they were getting up towards 30 per cent cancellations, some of which were for lack of intensive care beds. They undertook a process of reform of their systems and so on, and they are getting down. Yes, from time to time you will get caught short. We had a similar problem at Nepean—perhaps not as bad as Royal North Shore's. By simple processes of bed management, and of the intensive care specialists working with the bed management people, I do not think we have had a cancellation for lack of intensive care beds for months, winter notwithstanding.

Mrs JILLIAN SKINNER: A way forward for us would be some kind of recommendation about making sure the clinicians are engaged in playing their part in freeing up beds and so on?

Dr CREGAN: Absolutely. What has been instructive when we were introducing the predictable surgery program was travelling around the State, more particularly the Sydney region, talking to various clinicians. Sometimes there is a problem: people do have things that they want to do that are good and they have to somehow or other find a way past management to get it done. But very often you see great things happening. At Bankstown, for example, the medical administration is working with Bankstown surgeons. Bankstown did not have a waiting list, whereas everyone else had a waiting list and terrible waiting times. Bankstown had a little bit of this and a little bit of that. Just those little bits of cooperation make it all work. You do not need a zillion dollars; you need cooperation.

Mr MICHAEL DALEY: Dr Cregan, the \$64,000 question for this Committee is how to get clinicians re-engaged, and you have spoken a lot about that this morning and I will not go back over what you have said. But we get one view from the administrators and a diametrically opposed view from the clinicians. They need to be re-engaged; how does a management do that at Royal North Shore Hospital? What strategies do they put in place to re-engage clinicians?

Dr CREGAN: I do not think it is a management strategy alone. Management has to be keen, willing and able to engage, but equally the clinicians have to take the leave.

Mr MICHAEL DALEY: They have said to us that they have tried to take leave and they have tried to do things like that; they have put suggestions up and put models up and for 20 years they have been ignored. Is that not true? Or if it is true, what do we do to move forward?

Dr CREGAN: I would have to say I am uncertain about what models have been put forward. There have been people though who have been trying to do those sorts of things who, in fact, have been, to put it bluntly, shafted by their clinical colleagues. I think that that has been, certainly in the surgical sense, a significant problem. It is a very easy place to be to say, "It is not our fault. It is not our problem. It is because you did not give us enough money"; it is a much harder place to be to say, "We have a problem; we are going to solve it. We will go back to this inquiry and, yes, I will cancel my rooms; I will stop seeing patients; I will go to these mindless, endless, boring meetings until we get things sorted out". But it has to be a two-way street. They have had a lot of good managers at

North Shore; people who I would be happy to have manage my hospital. But somehow or other it has not happened. It is easy to blame management, but I really think that everyone in the institution is to blame if the institution is falling over.

Ms CARMEL Tebbutt: I have a question for Dr Chan. You have been involved in work with emergency departments and new innovations like the clinical initiative nurses and the emergency medical unit. Can you tell us a bit about those and what the benefits of those innovations are? I assume you have got a bit of a view across hospitals. We hear from some of the witnesses that the data that allows comparability between peer hospitals is not as robust as it should be for Royal North Shore Hospital. I assume there is a bit of that issue for all hospitals. Are you able to comment on how you can readily compare peer hospitals, for example with emergency department performances?

Dr Chan: If I can start with the emergency medical unit, which is pioneered in other States and also in some other overseas countries, it has been shown to be very successful in terms of providing a short-stay facility accompanied by senior medical and nursing input to basically turn patients around quickly so that they can have a short stay in the hospital but not suffer any kind of reduction in the level of care or safety. We have had a unit at St George since 2002 and that subsequently has been a model of care. A number of hospitals were funded to introduce a similar sort of unit and it has been working extremely well, but it has to be given the caveat that it needs to be staffed properly. You cannot just dump a patient in there and expect something to happen overnight; it needs to be staffed by appropriate nursing as well as senior doctors to review them the next day to make sure that nothing was missed by the doctor or nursing staff that were involved with their care.

So, that has been a difficult one to sell in the sense that a lot of the time people think they can just put aside five or ten beds and call that then an emergency medical unit, but really they do not actually have the protocol or the staffing to support that kind of function. You find out a lot of the hospitals then turned that into a holding ward: a patient was sent there because there were no beds in the hospital so basically it is nothing more than a transit area other than a unit which actively treats and also manages the patients. When that happens you really cannot compare because a patient is going there and then is subsequently admitted to the ward, whereas in my area only between 10 and 15 per cent of patients end up admitted to the ward. The majority of them would be discharged within 24 hours. That is the difference when you actually compare the number of patients going to the emergency medical unit. You really cannot compare them just by looking at the number, you have to look at whether they were discharged subsequently, how long could they stay for, did they come back afterwards and so on.

That is a difficult one to measure sometimes. Then I think there is also the issue of the pressure of access block. Everyone is focusing on the length of stay in the emergency department so why not build ways to do it to try and get people out of the emergency department so that their length of stay will be seen as short, but in fact they are really only half-baked and they have not been fully managed. So, as a result, the figures may look good but they end up being somewhere like a holding ward or an emergency medical unit or whatever they call them for a much longer period of time, so that it looks as if they are very efficient. Again, while we are just looking at the clock without looking at the quality that is at the end of the process it can be quite misleading.

So that is from the point of view of the short-stay unit. From the point of view of nurse initiative therapy, I think we have again been one of the first hospitals that have initiated that and since the nurse initiative role we have also introduced the role of nurse practitioner on a much bigger scale than any other hospital in New South Wales. Currently, I have got a nurse practitioner working in my department almost 16 hours, seven days a week. It is a model that has been resisted quite fiercely by a number of my colleagues, but also by nursing staff themselves as well. I think part of the problem is you need to be able to have a very co-operative mentality in introducing something like that. The question is not so much demarcation of professional boundaries: "This is a nurse's job; this is a doctor's job, we can't do that", which Patrick has outlined in a similar sort of scenario in the surgical arena, we have seen those sorts of problems in the emergency medicine arena as well.

Until we actually sat together and said, "How do we collectively make the patient journey better?" then we came up with something like: the doctors are limited in terms of numbers, they are often sick of patients, yet these patients are sitting around just waiting for doctors; would it not be a good idea to at least initiate part of their journey by doing some appropriate investigation such as x-

rays, such as blood tests, so that by the time the doctors are free to see them the test will be available so you can actually then make some decision simultaneously rather than sequentially? So, that was introduced initially and we have very strict protocols in terms of what the nursing staff can and cannot do to make sure that we do not just have a nursing a patient but without really doing anything useful or, worse still, doing things that are out of their capability.

As a result of that, we have improved the time seen by clinicians in our department as well. But, unfortunately, I think the pressure has been brought to bear that because of the increasing activity we are not able to meet the target, so there is pressure then to bring the nursing staff forward to basically deal with a patient in a manner that may not really be meaningful and then constitute it as time seen in order to meet the key performance indicators. The one regret I have is that that process has not been monitored enough so that I really cannot tell when I look in other hospitals where they have waiting time meeting all their benchmarks, as to whether this is a genuine performance or it is just a matter of the nurse taking some blood tests or doing an x-ray without necessarily indicating whether those tests are appropriate or necessary. That is the question that I think is underlying what you are asking me.

I have difficulty at the moment looking at any other hospital and saying, "Is this good quality or is this poor quality?" Because the pressure coming from the Department of Health, coming from the area, coming from my hospital executive is just unbearable, trying to meet the key performance indicators irrespective of your workload, irrespective of your starting level. That is what I resent most. I think those practices are good but they have been hijacked by some of the well-meaning administrators that want to make sure that they can be seen as managing their hospital well.

CHAIR: Dr Cregan, you have mentioned there were a number of reviews and you did one in 2004?

Dr CREGAN: It was 2004. I was actually the Department of Health, as it were, observer. Carol Pollack was the chair and conducted it.

CHAIR: Because of the way you are speaking, do you feel there is a sort of a power struggle going on at the Royal North Shore Hospital between the surgeons and the management as to who really runs the hospital?

Dr CREGAN: I think that would be a not unfair suggestion, yes. I would broaden it beyond the surgeons.

CHAIR: The clinical—

Dr CREGAN: The senior clinical group. As I said, in any hospital that group has been around for 20 or 30 years. It is the group that sets the culture of the hospital. If that group will not work with management or will not accept the strictures that are placed on everyone—of budget, of the key performance indicators et cetera, of the need to be accountable to some of those things—if that group does not do it then no manager is going to be able to run a hospital. And if you get offside with that group you are gone.

CHAIR: You mentioned that situation has been there for 20 or 30 years. The hospital was the number one hospital, apparently, in the country and those clinicians were there. What then has changed the environment?

Dr CREGAN: Many of them were there. North Shore has changed a lot, but other external things have changed. The area health services, which were introduced by Peter Anderson and subsequently straightened up a bit by Peter Collins, and the opportunities that they presented I do not think North Shore ever embraced. I think the Northern Sydney Area Health Service ran five silos after it became the North Sydney Central Coast, and now there are nine or 10 silos, whereas the rest of the health system got on with using the opportunities that that areaisation and the networks created. I mentioned the Liverpool-Fairfield association. By using those you free up your abilities in the central hospital.

The Westmead orthopaedic surgeons do most of their joint replacements at Mount Druitt. That frees up their ability to run Westmead orthopaedic and the emergencies and the trauma and stuff much more effectively. There are endless models around the system of taking up that sort of process. Yes, it puts a burden on the individual practitioner: the Westmead surgeons have to drive out to Mount Druitt to do their operations, see their patients, et cetera; similarly, the people at Liverpool, the people at Fairfield, and so it goes on. Those surgeons—I will stick to orthopaedics—those orthopaedic surgeons, who can be an occasionally difficult group, have made that commitment and done it because that is the best way, they believe, to provide services. I do not think there is any strong equivalent in northern Sydney.

CHAIR: There may be even a resistance to that whole approach?

Dr CREGAN: I think there is some resistance to that sort of process.

CHAIR: And perhaps even a resistance to the areas that have been set up?

Dr CREGAN: I think that is right. As I said, there are other things. The opening of the private hospital—a lot of people have spoken to me about that. North Shore used to be, effectively, the largest private hospital in Australia. When they opened a private hospital next door the texture of North Shore inevitably had to change—things like staff specialist trust funds that could generate a lot of income, a lot of funding; those things may have dried up a lot as a consequence of that sort of juxtaposition. So, there have been a lot of other changes going on at the same time which have impacted upon North Shore.

CHAIR: We got the impression from some of the evidence that some of the people at Royal North Shore Hospital would like to go back to a hospital board—reverse the whole process, and so on.

Dr CREGAN: Apart from firing all the nurses, if I could do one thing to destroy the health system what would I do? I would institute individual hospital boards. Hospitals are part of a system: they have to be part of a system; they have to be part of a network, and an individual hospital board is a terrible thing to do. I will not say that the current areas as they are arranged are appropriate—they are not. They need to be smaller and they need to be answerable to a genuine community rather than lines on the map. So that yes, we need to do something about the area health services to bring them back to smaller, more manageable area health services, I completely agree with that, but not an individual hospital board.

Mr PETER DRAPER: We received a submission from the Department of Anaesthetics and they state in it that 70 per cent of their total caseload is now classified as an emergency case, and of course that leads to cancellations of elective surgery. They also state that 50 per cent of the cases are done after five o'clock in the afternoon or on the weekends. Is that just peculiar to this hospital or is that symptomatic across the system?

Dr CREGAN: No. The delivery of health services generally, but I will stick to surgery since it is more my area of expertise, that is pretty consistent—68.2 per cent in July for Nepean was emergency surgery, added to which there is the extra burden of things like caesarean sections. The caesarean section rate for a whole range of reasons is going up, particularly in the large institutions like, well, Nepean, North Shore, Westmead, whatever. So that places a huge burden on surgical services in the operating room. But that is not in any sense unique. It is being driven by a range of things. A lot of it is people voting with their feet. They go to the place for emergency care where they can get pretty much everything delivered. The smaller hospitals, their emergency workload is slowly shrinking away. As to the out-of-hours thing, that is a management issue. That needs to be sorted out. When I say management, management includes the clinical leaders at the hospital.

At Nepean we have had a process where everyone has, not always happily, given up some of their elective time to provide emergency operating time in hours. The same has happened to a varying level around the State. People have to give up that elective time to be able to cope with the emergency load that has been presented to the larger hospitals. The way you solve that though is that you then go and do your elective cases somewhere else. You take your cases down to Mount Druitt or you go to Auburn or, in our case, you go to Blue Mountains—we would like to go to Hawkesbury once that contractual issue gets sorted out with them. You have to take some of that elective stuff out, and when

you do that you do several things. First of all, you improve the quality of what you are doing. You reduce the cost. The Auburn hospital process has demonstrated that and published it; it is all out there that you get reduced waiting times and, indeed, eliminate waiting lists.

Mr PETER DRAPER: Can we get a copy of that?

Dr CREGAN: The Auburn one, yes, I can certainly get that to you. It appears in various versions, but the Australian-New Zealand journal surgery reports probably is the best. By doing those things, taking those cases out of those big hospitals and putting them into the smaller hospitals where they actually do it better—that is back to the area and the network stuff—that is how you solve a lot of those problems.

CHAIR: The Royal North Shore Hospital has used as a reason for a lot of its problems the high occupancy level of over 95 per cent or higher. What are the levels in your two hospitals?

Dr CREGAN: We have had 105 per cent on occasion. It is in that sort of region. All of the principal referral hospitals have occupancies in that level.

CHAIR: The number is 85 per cent.

Dr CREGAN: Eighty-five used to be used certainly as the indicator. Whether that is still relevant, I am not sure. Eighty-five gives you a really easy-to-use buffer, but if you are not managing your resources properly, you can have an 85 per cent occupancy rate and still have emergency departments full of patients. You have to be acutely managing. Adam could probably comment on that even better.

CHAIR: Is your hospital occupancy rate 85 per cent?

Dr CHAN: I think in my understanding and certainly in my hospital, the occupancy rate is always over 90 per cent and in the winter can be 95 per cent, 98 per cent. That is a very difficult situation, particularly from the perspective of the emergency department because our workload is reasonably predictable, even though people think that we are unpredictable. In fact, if you look at our statistics, I can predict on an average day that I will looking at 50, 60 emergency admissions through the department, and the hospital has to provide that number of beds for that particular day.

I think it is the issue about balancing between the elective workload as well as the emergency workload. Often because there are just not enough beds in the system to be able to cater for both, or in the case of elective surgery they tend to overbook it and then if there is a bed, come in, if not, they get cancelled. I am a strong believer that we need to have an adequate bed base by adding the predictable emergency workload and whatever else is left behind, then you actually schedule the elective workload. Otherwise you are always competing and the patients are the ones that suffer. They are actually being stranded in the emergency department.

Mrs JILLIAN SKINNER: When you were talking about the role for Auburn with Westmead, what you are really talking about is the need for a clinical service plan that engages the clinicians that looks at the role of the outlying hospital—so, Royal North Shore, Ryde, Hornsby et cetera. The clinicians have said they have not been engaged in that process. We understand there is now one to be done within the next six months. Does that provide us with some hope for the future?

Dr CREGAN: Yes. Clinicians need to be involved in the formulation of the services plan, but also they have to, as I say, be prepared to make it work. They have to do the hard yards; they have to move their surgery elsewhere.

Mrs JILLIAN SKINNER: The first step is involving them though?

Dr CREGAN: Yes, but as I said, you have to do it. It is disruptive. It is a pity Dennis King is not here. South Eastern Sydney, by way of example, are adjusting the process of redesigning how they do all of their major work, including renal transplants and things like that. That is going to be very disruptive for a lot of individuals to move their practices from one hospital in effect to another

hospital. So, it is going to be quite disruptive. They will come together and have said this is the right way to do it and they are going to do it.

CHAIR: Thank you very much for appearing as witnesses today. We appreciate your expert knowledge in this area. It is very helpful to us.

(The witnesses withdrew)

(Luncheon adjournment)

VERNON JOHN DALTON, Management and Dispute Resolution Consultant, sworn and examined:

CHAIR: Do you wish to make any opening statement?

Mr DALTON: Only to firstly apologise for Judith Meppem who would have liked to be here but for medical reasons she is not able to be here and she has asked specifically that I apologise. So far as your question is concerned, may I ask whether the members of the committee have received a copy of our report?

CHAIR: Yes.

Mr DALTON: Do you want me to summarise that or otherwise I was simply going to say I would be available for any questions?

CHAIR: We might just proceed with questions. We will start with Mrs Skinner.

Mrs JILLIAN SKINNER: Thank you very much indeed for coming. I think this is a very important report from the point of view of our terms of reference and some of the evidence that we have heard from some of the staff at the hospital. Without quoting from the actual place in it, the comment that you were surprised that there was no nurse union involvement at the hospital. Would you care to elaborate on that? It strikes me that this is one of the organisations that are there purportedly to support and represent the nurses' views?

Mr DALTON: Yes. I think the interesting thing was that North Shore had a healthy reputation for an active branch and it was certainly a good mechanism between management and the broader nursing fraternity to deal with issues as they arose. There were two major points made to us about it. Firstly, it was difficult to find people who were prepared to be committed and to provide the time to run the association. The second one was reservations about whether it would be held against them if they were members of the union. More importantly for us, also we approached the Nurses Federation and they said that there were no issues whereas as we did our review, of course, there were a number of issues that emerged.

Mrs JILLIAN SKINNER: And the Health Services Union actually made a submission, wanted to come and talk to you?

Mr DALTON: The Health Services Union had an organiser and two delegates who came to talk to us as well.

Mrs JILLIAN SKINNER: How confident are you, given the terms of reference you had and the time frame you had, that you really got to the bottom of the bullying and harassment at the hospital and came up with solutions for the longer term?

Mr DALTON: I think the recommendations for the longer term are good recommendations. I certainly think that the theme that was recurring all the time across all disciplines in the hospital made it very clear that there was an issue about bullying and harassment. It was certainly to the credit of the area management and the hospital management at the conclusion of our review when we briefed them that they seemed to adopt the recommendations and some other fairly blunt comments we made very appropriately.

I think they were surprised at the extent to which there were concerns expressed but we were wondering why it had occurred and why it was happening and one of the issues was that there had been, I think it was, 10 changes of general manager in 15 years. So in terms of continuity, leadership, tackling these issues, having somebody on the ground was a worry but I am quite sure it was a very positive response to the report and to the recommendations even though it was a fairly, I suppose, hostile report but one we tried to do in a very neutral, constructive fashion to assist management to bring about some change.

Mrs JILLIAN SKINNER: A couple of questions out of that. You would be aware that there had been a review done in 2001, 2003 and then there had been I think it was called the Best Practice

Australia Report in 2003-04, then some workshops for all of the staff to help them understand their obligations in terms of workplace behaviour. Why it was still a problem that required your involvement in 2007?

Mr DALTON: Well I do not think that had been tackled very seriously. As we said in the report those recommendations, when we just simply plagiarised but acknowledged that the recommendations in the Kilkeary-Stowe report of 2003 from our perspective remained valid. I think the other situation that complicated us, and we did not explain it very clearly in the report is, we saw quite a number of people. In addition to those people we saw others informally. Judith particularly had informal contact with clinicians, we both did but she knew clinicians. That helped reinforce some of our views and also helped guide us about how clear the recommendations needed to be. But one of the of the other emerging issues was that of the people who, if you like, came to us with grievances and concerns, 12 of them had long-standing grievances.

Mrs JILLIAN SKINNER: That was my next question.

Mr DALTON: That was probably of great concern to us. But it is interesting that in the health system generally there seems to be a facile view that if you somehow or other extract staff from the support services or administration and re-direct those resources to front-line nurses and clinicians there are sufficient of those resources to do that. What has happened at Royal North Shore, and it was certainly true of the Human Resources Department, is there were two people to manage I think there are about 3,600-odd staff, something like 2,500 full-time equivalents, so you had this group of people who had been trying for some time to have grievances resolved. The other issue was that some managers, whether it was through the workload and work pressures, did not see themselves as having a responsibility to deal with that and that is why we recommended that be overturned because I think there was a tendency for them simply to refer those people to the HR people and the HR resources were simply not there.

Mrs JILLIAN SKINNER: The HR people came in for some criticism in your report as well?

Mr DALTON: Yes, but to be fair to them, sorry if it has come across another way, they were working under extreme pressures. I mean they were up to their backside in alligators and trying to do their best.

Mrs JILLIAN SKINNER: We have heard evidence here that it started at the top and it sort of came down partly because of the pressures to meet the KPIs, benchmarks, whatever you will, without the resources and it was frustrating people at all levels. Would you say that was something that you found?

Mr DALTON: Well that is generally the message that came through except that is a bit too convenient. That was an issue. I mean there is bed access, bed blockages, constant pressures to manage the budget without the level of communication there might have been from management to staff was a problem. But it is also true that there were VMOs and senior clinicians who simply did not want to change, who treated people abominably and it was not because of those sorts of pressures.

Mrs JILLIAN SKINNER: What do we do about that?

Mr DALTON: Confront them first of all.

Mrs JILLIAN SKINNER: And get them into some re-education program?

Mr DALTON: Yes. As I understand it there has already been some very good work done by the Vice Chancellor of Newcastle University—I can't recall his name—he has run quite a number of sessions with people there. But there has been a reluctance I think to actually confront the known offenders.

CHAIR: Did you say he has run courses at Royal North Shore Hospital?

Mr DALTON: As I understand it he has.

CHAIR: With those particular—

Mr DALTON: I do not know, with a whole range of people, Mr Chairman. You would have to check with the hospital about that.

Mrs JILLIAN SKINNER: Do you think there is a case for coming back and having a look in six months, 12 months, or whatever it might be to see whether in fact things have improved and whether some of these people have changed their ways?

Mr DALTON: Well we did make a recommendation to do a review that the general manger put in place within four to six months to see whether there have been any changes.

Mrs JILLIAN SKINNER: Because otherwise we are hearing about report after report, review after review not just about bullying but other things at the hospital, and some of the clinicians are saying "Oh, we have heard it all before." I am very keen that this committee does not have that kind of response.

Mr DALTON: Sure. I have a great respect for what North Shore does I would have to say. They do a tremendous job and I think it is a pity that they have been so badly demeaned and that is not to make any comment about any other issue because there are some fantastic things that are done in and I get angry with some of those clinicians who are not prepared to change, who cause some problems themselves and who in that process are demeaning the whole place and their colleagues. I think that is a very sad state of affairs.

Mrs JILLIAN SKINNER: Everyone is hoping, certainly those that have given evidence, that this committee and some of the things we might recommend can actually provide them with a way forward.

Mr DALTON: I am sure that would be so. I am also sure they would be surprised—I mean that was the thing we struck repeatedly with people coming to see us, how could they be assured that anything would happen as a result of it? Which was one of the reasons I suppose why Judith and I were so forthright in what we had to say, because it was certainly time for management and the area management to be alerted to the issues at Royal North Shore Hospital and I would only guess, I do not know, but I would guess that there has at least been plenty of evidence to show that the report is well known and did see the light of day.

Mrs JILLIAN SKINNER: Were you surprised that it was not circulated amongst the staff at the hospital?

Mr DALTON: I understood that it went on to the website.

Mrs JILLIAN SKINNER: I think that was after it was on mine.

Mr DALTON: Oh, was it?

Mrs JILLIAN SKINNER: Yes.

Mr DALTON: And I understand, I have not had a chance to have a look at it, but some of the things that have happened are also on the website. But I cannot help further than that.

The Hon. JENNIFER GARDINER: Mr Dalton, in your capacity as a Dispute Resolution Consultant have you had to look at this issue in any other hospitals in New South Wales?

Mr DALTON: Yes.

The Hon. JENNIFER GARDINER: Are you able to make any comparison as to the gravity of the situation that you encountered at Royal North Shore compared to others and in general how you might rate the gravity of the situation you studied at Royal North Shore?

Mr DALTON: Probably the issues are different. I am not trying to dodge the question but the other ones I have done were as a direct consequence of the major restructure of the Department of Health and particularly in country areas, people being under threat of losing their job. I do not think anybody did lose their job ultimately but there was a lot of concern and a lot of hostility about the area wide restructure. I think though that the situation at North Shore was probably more serious than I had struck elsewhere. I thought the people that came to see us were very courageous because they were obviously under a lot of pressure. We were given a room that was out of the way. I mean the hospital and people did try to let us act as neutrally as we could but even then people were very apprehensive about whether they would be seen coming to see us.

That is why we did a number of interviews by phone and we did offer to see people in other places. Leaving aside those people who have had grievances of longstanding about workplace issues, the other issues did concern us. I was frankly surprised that amongst nurse unit managers that some of those had established a pecking order and some very good people who attended regular meetings were reluctant to have much to say. They were critical about what had happened but they themselves were not prepared in those open forums to make any real contribution. So it is a chicken and egg thing, unless they are prepared to have a go it perpetuates itself.

The Hon. JENNIFER GARDINER: So it comes back partly to leadership?

Mr DALTON: Yes. I certainly reiterate I think from our discussions with the current executive they are far more committed than I might have anticipated and they are really looking to do something about the grievances that have arisen.

Mr MICHAEL DALEY: Is this the executive of the hospital or the area?

Mr DALTON: Both I think but certainly the hospital people. Mary Bonner was—we saw Mary at the beginning of our review and she was then off for the rest of the review and sometime afterwards. Bernadette Luffman, who was the acting general manager, and Julie Hartley-Jones, who came over from the United Kingdom, were tremendous people who I think are quite committed to bringing about some change.

Mrs JILLIAN SKINNER: One of the witnesses we have had before us indicated there may well be a leadership role in nursing, say, a director of nursing, taking more of a role in the pastoral care of nurses and also keeping a check that they are doing the right thing but also be there for them should they need support. Is that something that you have considered?

Mr DALTON: We could not agree with you more, and one of our recommendations was the review of the director of nursing position.

Mrs JILLIAN SKINNER: So it is back to the old, like a matron's role.

Mr DALTON: Both Judith and I are pretty old fashioned. One of the problems—I cannot make any considered comment about the divisional structure but I can say that having a director of nursing without any true operational effectiveness and having the authority to do what the old directors of nursing fundamentally were required to do is an issue. It is up to the Committee to get advice from somewhere else, but I understand that that particular issue has been enacted. But you are dead right.

Mrs JILLIAN SKINNER: And there are very senior now retired nurses who have been directors of nursing at the hospital previously who have indicated to me that they think that is a sorely needed measure, the pastoral care, the leadership role, instead of relying upon the clinician at that level, which is really split.

Mr DALTON: We spoke to some of those and, without in any way demeaning them, they had been demoralised through the restructuring arrangements and individually affected by that. So far as the director of nursing position is concerned, I could not agree with them more.

The Hon. AMANDA FAZIO: I was wondering if you could tell the Committee how the investigation and report was undertaken. I also want to get your comments—you said there were only

two people in the human resource section—on the way in which you think that staff were managed in general.

Mr DALTON: The first part of your question was that we were asked by the acting chief executive, Terry Clout, I think as a result of an article in the *Daily Telegraph*, to have a look at the issue of bullying and harassment, particularly about previous reports and what had become of them. There was a circular issued by the general manager, Mary Bonner, notifying people of that and inviting them to contact us. When we started a few days later there was a fairly poor response so we then sent our own email out giving my private mobile telephone number and making it easier for people in a sense to access it. That is how it then accelerated.

The terms of reference for us and also the notice that Mary sent out indicated that it was to deal with nurse management and nursing. That was not clearly understood by a lot of people and as a consequence there were people from all areas and disciplines who then approached us and we did not feel that we had the capacity to deny them an opportunity. So that is how it happened and that proceeded.

The Hon. AMANDA FAZIO: And their complaints when they approached you were all to do with bullying and harassment?

Mr DALTON: No, not all of them. We gave a guarantee that we would not—it was important for us to let them know that we would retain absolute confidentiality about who they were and what they told us, what individual people told us, unless those—and they were the 12 people I talked about—wanted us to follow up issues on their behalf, they could be named to the others would not be. The interesting thing is that there was some very experienced long-term senior nurses who came to talk to us about what they had observed in terms of bullying and harassment. They had not been bullied or harassed themselves but they were the people who spoke to us about visiting medical officers, about senior nurses in some departments.

We had concerns expressed particularly by clinical nurse educators that they were devalued on the floor—in other words, because they were not hands on and they were in fact trying to do a very good job in bringing about changes. So there were a number of people who approached us about what they had seen, what they observed, and they then constructively tried to give us some idea about the extent to which there were changes that were needed. The second part of your question, I have forgotten.

The Hon. AMANDA FAZIO: That is all right.

Ms CARMEL TEBBUTT: I was wondering if you could tell the Committee a bit more about some of the concerns that were being raised with you by nurses as part of the review. In particular, I notice that in one part of your report you indicate that some have claimed that management at all levels was not aware when they were actually bullying staff. There seemed to be some issues around people being aware of what impact their behaviour was having. Did you see a lot of that?

Mr DALTON: That was a fairly strong feature. What people were saying was that—again without targeting particular groups—the people who were mentioned to us particularly were some senior nurses and some visiting medical officers who historically did not realise how badly they were treating people. That was why we made the recommendation about those people, the need for them to both be confronted and involved in education—not education but those discussion groups—to let them know that. So what we were trying to say was that we believe there were a number of people who do not even realise that their behaviour constituted bullying.

We had to say to some people—there is again another theory that because of the pressures on the place and because people did their job thoroughly and would not brook anything inferior to that, that that was an excuse for the way in which they treated people. That was again one of the reasons there was a recommendation to identify that as a feature but it is inexcusable, in other words, to simply use the argument that because you have high standards and you are an expert in the way you work that that should allow you then to treat people inappropriately.

Mr MICHAEL DALEY: There have been claims made in respect of your investigation that there were staff who would like to have participated and to have spoken to you but who were too scared to have done so. Is it your impression that that was the case? Secondly, what measures did you put in place to try to ensure some anonymity for staff who did get involved with your investigations?

Mr DALTON: One thing you need to be very careful about with these sorts of reviews is the extent to which there might be collusion. I am quite satisfied that in one group of staff there was a level of collusion, but it was not our role to highlight that but we did through staff encourage them to get other people to come forward. I spoke to a lot of people by phone to reassure them that we would look after their anonymity and what they had to say to us. But I was certainly not aware, I would have to say, that there was anybody who wanted to talk to us who did not get that opportunity. But it was interesting that a lot of people told us about others who were reluctant to come forward and we were aware of that because of our assurances through them those people did come forward. But that is not to say that we got all of them.

Mr MICHAEL DALEY: Because there have been similar claims made about this inquiry as well.

Dr ANDREW McDONALD: How do you think your previous experience contributed to your being able to deliver this report?

Mr DALTON: I think that is for the Committee to decide. I think the previous experience of both Judith and I was that we were able to go into the review in an open-minded way. We believe that we had some credibility with management as well as the people, and we believed even though it is always a tough thing to do that in the end we were able to report the situation honestly and transparently as we saw at. Certainly, as I said in the briefing with the area executive and the hospital executive, we had some blunt things to say and provided a lot more detail about some issues that were in the report. So I suppose it was simply the wisdom and maturity of being able to respect that people would be under pressure to talk to us. We had to work out how we would best do that but during our interview of those people we had to give them lots of confidence and reassurance because many of them were very tearful and upset about what had happened.

Dr ANDREW McDONALD: Having read your recommendations, the senior visiting medical officer—I did not read a specific advice to the area health service about how to deal with the bullying senior consultant.

Mr DALTON: We spoke certainly to the hospital executive and to the area executive about the need to confront those people. I am only talking about a couple of people. So we did identify who they were and suggested—I think we referred—I should not say any more than that. But we did express concern that there were a couple of pockets in the hospital which they ought to and must have known about involving individual people that they should have or should do something about.

The Hon. AMANDA FAZIO: You mentioned that there were a lot of recommendations made in the Kilkeary-Stowe report of June 2003 which was basically into the same issues. When you were doing your review where you able to find out from anybody why those recommendations had not been acted on?

Mr DALTON: Only that it had never been released, and of course the management had changed a couple of times since then but no, I could not. That was what caused some apprehension amongst staff, that there had been those reviews before and nothing had occurred.

The Hon. AMANDA FAZIO: Do you think that that was a contributing factor in basically you having to tease out more staff to come forward and give you their views?

Mr DALTON: Not necessarily. I think the more important issue for me was that there is a real difficulty—and I am hesitant to deal with it too extensively but one of the problems, if there is a senior management or an executive manager you ask for a review and you get a warts and all review and then that is used mischievously, whether it be by politicians or the media. That in a sense is self-defeating. Why would you want to expose yourself to adverse criticism when what you are trying to do is fix the thing up? That is not an explanation; that is a personal view. But it is a pity that those

recommendations had not been acted on because as we said they were just as current when we did our review as when they were first made.

The Hon. AMANDA FAZIO: And you were quite happy with the substance of the report that led to their recommendations, I presume, because you have included most of them either in the original form or in a modified form as recommendations in your report.

Mr DALTON: I hope we did not modify them too much because what we tried to do with the first series of recommendations, I thought were a direct take from the Kilkeary-Stowe report and we acknowledge that.

Mrs JILLIAN SKINNER: How many people did you interview in this report?

Mr DALTON: Face to face, 88.

Mrs JILLIAN SKINNER: Would it surprise you that we have had only three or four nurses coming to us?

Mr DALTON: No. They probably thought we did such a good job. There were 44 nurses of those.

Mrs JILLIAN SKINNER: So it is a fairly substantial number.

Mr DALTON: They were also people who wanted to tell us what they had observed and where some of the unrest was. In addition to that, as I have said, Judith, through her contacts particularly with clinicians and a couple that I knew, we just sort of tried to test whether the stuff we were hearing was as we believed it to be. We tried genuinely to test what we had been told.

Dr ANDREW McDONALD: Are you willing or able to speculate—it appears to have been a problem for some time—how long you think it will take to change the culture of the workplace?

Mr DALTON: Two or three years at least I would think. There are things that can happen now and I do not want to sound negative about that but it will be an evolutionary thing. In the same way as it has been allowed to deteriorate there will have to be a concerted effort over a fairly long period of time to bring it back to what it ought to be. I guess that also depends on the outcome of this Committee's recommendations and the extent to which some of the resource pressures are overcome but there are certainly behaviours by staff—and that is a range of staff—that are being addressed now and should be able to be remediated.

I think we made clear in our report that people should be the subject of disciplinary action if they either see bullying and harassment and do nothing about it or if they themselves are involved. That will involve, again, an escalation of the HR people to have the resources and capacity to do that. I think some other things that I have touched on, like requiring managers to take responsibility for managing issues, for managing staff differences within their unit, for managing performance of individual staff, should have, as I said to Mrs Skinner, some obvious changes within four to six months, but overall longer than that.

Ms CARMEL TEBBUTT: In regard to the recommendation about the cross-discipline task force that should be established across the hospital as a whole, involving a range of different staff, is the idea of that to model behaviour, to oversee the implementation of all the recommendations? Would you expect that members of the task force would not be engaged in bullying behaviour themselves?

Mr DALTON: I would hope so. Again, I am sorry, Mr Chair, I understand that that group has been set up. We tried to suggest that there be representatives from the industrial associations and a good cross-sectional representation in the hospital so that it picked up nurses, VMOs, ancillary staff and support staff and the respective industrial representatives to make sure that whatever plans and procedures were developed to overcome and deal with the issue of bullying and harassment, evolutionarily proceeded.

Dr ANDREW McDONALD: Recommendation 1.3 is for an in-service workshop on bullying and harassment to be arranged for managers at all levels. About how long would such a workshop take to change behaviour in management?

Mr DALTON: Probably I am being a bit obtuse. I am sure that Trevor Waring, the Vice Chancellor of the University of New South Wales, who has already been involved in dealing with many groups of people, will of course have been very successful in raising awareness, creating confidence that something has been done about it. Although you need to perpetuate it and monitor it so you keep repeating it, if necessary.

CHAIR: Did you establish why the earlier report in 2003 appeared to have lapsed, and not really be implemented?

Mr DALTON: No.

CHAIR: Who was responsible for not implementing it?

Mr DALTON: Whoever the general manager was, we did not investigate who that was at that time.

CHAIR: You did not follow that up?

Mr DALTON: No.

CHAIR: Was that because you had no way of following it up?

Mr DALTON: I suppose we could have, but we did not.

CHAIR: For your own report did you have any mechanism to follow up whether your recommendations were being implemented?

Mr DALTON: Not unless the management of North Shore invited us in four to six months to look at that, but we were careful not to create consultancy work for ourselves, Mr Chairman.

CHAIR: A permanent, ongoing role.

Mr DALTON: I am certainly optimistic. I do not think I can be any more sincere in saying that it was probably surprised at the positive reaction of the area management and the hospital executives. If it had been me I would have been very hostile for someone to teach me how to suck eggs to the extent that we were doing. I was certainly very impressed by their willingness to accept seriously the report and the recommendations. It is up to the department within four to six months to decide how they want to test whether there has been any change within the place.

CHAIR: I got the impression from one of your earlier remarks that you had spoken to some of the surgeons, at least one?

Mr DALTON: Informally, people that we knew.

CHAIR: You indicated that there had been some complaints about his behaviour?

Mr DALTON: No, we did not approach anybody, we did not confront anybody, being named. We spoke to those people who were eminent physicians and surgeons in the hospital who could tell us what they had observed in terms of the incidence of bullying and harassment. They confirmed for us that there were real issues about that in the hospital.

CHAIR: You did not firstly speak to anyone who was named as a source of the bullying?

Mr DALTON: No, not at all.

CHAIR: Was there any reason for that? Or was it outside your terms of reference?

Mr DALTON: It certainly was not within the terms of reference. However, we were aware that there was also another inquiry of some sort going on, specifically to address at least one hot spot in the hospital.

CHAIR: One of the concerns was whether the people who were engaged in bullying were aware that they were engaged in bullying.

Mr DALTON: The executive of the hospital are now aware as to who the primary people are, certainly in the VMO ranks anyway, and also in terms of the nurse unit managers.

CHAIR: And they have been spoken to?

Mr DALTON: I would hope so.

CHAIR: To try to improve their behaviour?

Mr DALTON: I would hope they have taken that up seriously. Some of those long-term VMOs and others are going to be more difficult to change, in answer to an earlier question. It can be done. Some behaviours just simply should not be tolerated.

CHAIR: Some companies and organisations use conflict resolution groups, a focus group, a group of people who come together, in which there may be one or two people with a bullying problem. As they discuss the issue it dawns on them that perhaps they have been using inappropriate behaviour. Has that been tried at the Royal North Shore Hospital?

Mr DALTON: Not to the degree that they would like. Certainly through the HR they have used external people and I think they have accelerated that as well to deal with some of those. It has been more related to those situations where there have been specific grievances by staff against individuals. They are doing that reasonably well. Certainly, I was impressed to hear that Trevor Waring, who I know by reputation, has been very active in the broader educational programs and accessing a very large number of staff.

CHAIR: One of the concerns, after talking to nurses today, seems to be that bullying is still current.

Mr DALTON: Yes, I do not think it will disappear overnight. I think they deserve an opportunity to persist in whatever it is they have introduced to counter it. It will not change immediately, that was one of the points I was making, but there are lots of things they can do in the interim to start to make some inroads.

CHAIR: Were you surprised that some of the nurses are still reluctant to speak, or even come to the inquiry, which some have done now?

Mr DALTON: No, I am not. They are no different from any other employees I suppose; most of them badly need to work. I suppose I should not say this on the record, but a nurse who has to work somewhere else will still be in the health system, and the networks are such that they really have to be careful to not expose themselves, I suppose. That is why it is so difficult to really get anything from them, and was one of the issues we raised about setting up a system to follow-up nurses who had left, at least a few months after they had gone, to see if we could establish why it was that they had left North Shore. You are certainly not going to get them to tell you that when they exit, because they may well want to find a job still in the profession. They do not want to run the risk of somehow that informal network catching up with them if they had made some criticism, no matter how legitimate it is.

CHAIR: Although there is, on paper, whistleblower legislation and other protections, individuals still feel threatened if they speak up?

Mr DALTON: Yes, I think that is true, except that, again, the thing at North Shore was more that those who did speak up, who had real grievances, and the process of dealing with those

grievances was of greater concern. One thing that people were told was that they were not to talk to anybody else about a matter. If you are a victim and you are embroiled in some sort of conflict with your direct supervisor, or somebody else, and somehow that is turned around as an issue to damage you, they found it very hard to accept, and I find it very hard to accept, and now the hospital agrees that you cannot say to people if they are under some sort of notification through the HR people that they cannot talk to anybody about it. That is just nonsense.

Some of those changes will have some effect. I also have to say that on the other side of the coin, and I do not mean this mischievously either, I think the processes for whistleblowers and people to bring matters to attention offer quite considerable rejections. It is a bit fallacious for some people to say that there is any evidence that the confidentiality in that process somehow or other is not observed. The interesting thing in the workplace and in North Shore is that there are people whom deliberately and wilfully use some of those processes to counteract legitimate performance issues that are raised by managers and their supervisors.

I hope that makes sense. There are two sides to it. I certainly believe that the processes, protected disclosure, the opportunity for those to be dealt with and the process for that, are well entrenched. I would be reluctant to believe that people were not aware of that. We certainly did not get any evidence of any breaches of confidentiality in that process. We had lots of concerns about the lack of resolution, but nothing about any breach of confidence.

Mr PETER DRAPER: Mr Dalton, you have answered most of my queries, thank you. Earlier you touched on the turnover of management at the hospital, and that there have been eight in the past 10 years. Prior to that, Roger Vanderfield was the CEO for well over 20 years. Do you think that stability is important in preventing and then addressing these issues of concern?

Mr DALTON: Yes, I am sure stability and effective leadership are very important. My answer is yes. The question is how do you find those people and whether they are able to stay there. The other problem at North Shore—and I was not going to say some of these things, because they are outside my terms of reference—but there is a long history associated with North Shore. I am sure that some of the changes over time that have been attempted to be introduced by management, not just to do with budgeting but clinical practice and other things, have met a degree of resistance. Again, that is a separate area altogether of the extent to which experienced senior people, both nurses and clinicians, are willing to see some changes introduced. It does not take me away from the need to have people such as the director of nursing and others provide leadership, direction and authority to be able to overcome some of those.

CHAIR: Thank you for giving your time to the Committee again, we appreciate the service you have given to the people of this State over many years.

(The witness withdrew)

CHRISTOPHER KEVIN ARTHUR, Haematologist, Staff Specialist, Head of the Department of Haematology, Royal North Shore Hospital, and Area Director of Cancer Services for Northern Sydney and Central Coast,

GREGORY MALCOLM BRIGGS, Staff Specialist in Radiology, Royal North Shore Hospital, and

LESLIE BURNETT, Director, Pacific Laboratory Medical Services [PLMS] Pathology, Royal North Shore Hospital, currently on secondment as Cluster Director, Northern Pathology Cluster; affirmed and examined, and

JENNIFER MARGARET DONOVAN, Senior Staff Specialist, Radiation Oncology, Royal North Shore Hospital, sworn and examined:

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

Dr ARTHUR: Yes. Thank you very much for inviting me and giving me the opportunity to present to this inquiry. There are a number of problems detailed in my submission, which hopefully you have received, but I wish to highlight a few. Firstly, concerning the role of clinician managers and specialty department and wards, the specialty departments are the building blocks of the hospital and if the building blocks are weak, then the house will be weak.

Departments are led by clinician managers, for example, doctors like me who one minute can be treating a patient with acute leukaemia and the next minute embroiled in a battle to reappoint secretarial position during one of the regular job freezes. It is a rare day when I go home feeling like I have accomplished something worthwhile. The administrative demands, combined with the heavy clinical workload, cripple productivity, yet clinician managers are essential and if supported better, then many issues could be resolved by local department and ward solutions rather than edicts from above.

Concerning information technology, good IT improves safety and efficiency. I have personally investigated electronic medical records for the last two years and there are several excellent solutions now available, including state-of-the-art Australian products, complete with accurate diagnostic coding capability so we can finally get the real data and chemotherapy prescribing capability for safety. If we were given the authority and some comparatively minor funding we could have a comprehensive IT solution for cancer patients up and running within 12 months.

Regarding workforce, there is a crisis in cancer specialist workforce. Patients are waiting too long for treatment, supervision of junior medical staff is not ideal, the workload has increased substantially, oncologists and haematologists are burning out, so while waiting for the increase in medical graduates, we want to implement some interim solutions, including the appointment of things like physician assistants and support personnel, and other innovations like hospitalists for ambulatory cancer care. We have developed some proposals but require funding,

On the loss of specialty wards, we once had a specialty ward where all of the nurses and doctors were focused on one thing. In my specialty this was haematology and they were the best in the world but now we have moved to mixed, and we have mixed many specialties into generic wards, in other words, a no-specialty ward, and we call the nurses multiskilled. However, it has been shown—in fact, the Health Department has its own data that patients treated outside of specialty or home wards have increased length of stay, increased morbidity and even increased mortality.

With my colleagues in the oncology and renal departments who are one of the ones who have been mixed together, we have recently submitted a draft proposal to move back to specialty wards, a move which would cost very little but could ease bed block, improve efficiency and even reduce mortality. As if this was not even enough of a benefit, nurses have encouraged me to do this because there is evidence that this will help nursing recruitment and retention. So we could solve at least partly many problems in one move with this strategy, with very little cost and without opening a single new bed.

But probably my gravest concern is for the new hospital development. The new RNSH will not have enough beds to treat cancer patients. We currently use between 35 and 50 beds and we have been told that the cancer ward in the new hospital will have just 30 beds, yet there will be a 30 per cent increase in new cases of cancer in the next 10 years. How is it that the planners did not know this? Yet worse than this is the fact that the new hospital, we believe, will have dysfunctional cancer services. The wards, the doctors, the clinics are all separated.

We had a fantastic vision for comprehensive, tertiary cancer services for Northern Sydney that would serve patients all the way to the Queensland border in our tertiary capacity but some faceless planning committee thought they, the planners, knew better on how to design a modern cancer service. North Shore clinicians want genuine change-making input into the fundamental plan. We are talking about having a hospital that would be more productive, more efficient and provide rapid access to care.

Regarding the gross capital expenditure underfunding, Professor Fisher tabled figures, I understand, the other day showing that over 10 years Northern Sydney has received only 10 per cent of the capital funding per capita received by other areas, meaning for \$100 spent on people in other areas, if you lived in Northern Sydney you only got \$10. Coupling this with what I have seen in some of the submissions, the \$250 million a year that our area loses courtesy of the disputed resource distribution formula, it is little wonder that we are in trouble. We have been starved to death.

In my submission I have also discussed the potential errors and fallacies in the costing figures and the funding models, which you can see and I now have evidence to demonstrate this. Finally, I have discussed the futility of the business planning processes. You can see in the appendices that I have submitted, over several plans over many years that the only plans that eventuate are the ones that by the grace of God occur with funding from generous donors, like our wards have been refurbished with hundreds of thousands raised by donations from bequests and the guy who swam from Parramatta to Manly and raised \$200,000.

I have grave concerns also for our cancer plan, which we are about to submit. We could not even get a half-time secretary replaced, and there are several millions of dollars that we will need to provide a comprehensive cancer service, which I think is perhaps a hopeless task with the way things are. Anyway, thank you for your attention.

CHAIR: Does anyone else have an opening statement?

Dr DONOVAN: I have a very brief opening statement. If I had to sum it up in one word it would be "inertia". The hospital seems to be in the grip of terminal inertia when it comes to replacement of equipment. Machines that break down are replaced with the speed of a glacier. For example, in radiation oncology we had a superficial machine to treat skin cancer. It was 43 years old and it was originally donated by the local lions club. It broke down beyond repair in November 2003. The \$300,000 needed to replace it came from a patient bequest.

A new superficial machine was purchased, shipped in and then left in a crate for two years waiting to be installed, to the great frustration of patients who had to travel out of the area to be treated or face unacceptable delays. It took until November 2005 before the machine was ready for use and this is just not good enough. For staff, it is like working in quicksand. The harder you try to go forward, the less progress you make. Something has to be done about the system failure.

Professor BURNETT: I am a pathologist and as a pathologist we tend to provide the information on which other doctors treat their patients. In a modern health care environment about 70 per cent of medical decisions and management decisions are based on the results of pathology. In America where a lot of experience in information technology looks at pathology data, about 90 per cent of all the information accessed from the IT systems is pathology related. So if you get pathology right, you will get a large number of the rest of the system right.

Because of this we tend to be very much systems thinkers. So, with your permission, I have discussed with colleagues and we have tried to tease out just two issues that we can see may be of help to the Committee in perhaps identifying where there are some key logjams that may need to be addressed. One of them relates to the disconnect between the planning process and the budget

allocation process. Perhaps if I could give an example from our own service, PLMS Pathology has been very successful and we pride ourselves on providing work of national and international standard. We have been successful in the public and private sector and have grown very strongly and we are gratified by that support.

Internally, we develop a business planning process. We are rich in information and we have multiple measures on how we perform. Each year, some time towards the end of the calendar year, about October-November we begin the planning process for the next year. We identify all the gaps that are in the service; we review the adverse incidents that have occurred, we review the customer feedback and the complaints. We identify where we have to grow the service and from that we begin to develop a plan for how pathology ought to be performing next year. We interview all the general managers of the hospital, we find out where activities are changing, what new services will be coming, where pathology may need to support or not support and be ready for it.

By about May or June of the year we are ready to submit our case as to what is required to provide the services to the hospital and to indicate what sort of resources are required to allow that to be put in place. At that point the disconnect occurs because we are then handed our budget, which usually is completely unrelated to the services required of us and is usually just last year's budget, adjusted up or down by a per cent or two. We try to engage in dialogue in which we indicate that the budgetary planning process is a form of resource allocation; we have certain tasks to do and we require certain resources to do it. Once it is in place the budget is used to control or monitor how well we track towards that solution.

But our experience has been that the budget allocation process is an arbitrary one; it is not connected to the activity or clinical services we have to provide and it is used more as a way of the financial primacy of the service that sometimes gets in the way of clinical care and when we try to point this out, it is usually the financial indicators that we are asked to table rather than the other indicators.

In the case of pathology, there are very clear directives issued by the Department of Health as to how this should be done. For at least seven or eight of the last 10 years we have each year gone through and pointed out that the area health service has not been following the Department of Health guidelines and it is only been in the last 12 or 18 months that there has been acknowledgment of this fact and only in the last few days, I am pleased to acknowledge that there is now a commitment by the new administration to attempt to implement the Department of Health guidelines. And what we are seeing probably is echoed in many of the other submissions that you have.

The other area in which we hope to be able to assist the Committee and make a contribution would be the issue of facility planning already referred to by my colleague but perhaps pathology could illustrate this better than any other. About three years ago when the planning for the new Royal North Shore facility was being put forward we had a number of presentations on the master plan and were assured that there would be a clinical master plan and we would all have an opportunity to contribute to it and assist the planning team. You can imagine our surprise when we were shown the first drafts and there was no pathology service in the hospital.

We tried to bring this to the attention of the planners and they were surprised because it was on their plans, but their plans were out of date—almost 15 years out of date—and where they had pathology, those buildings no longer existed and where pathology actually was, there were areas that were being demolished. Through two or three variations of the master plan bizarre things happened. The blood bank was demolished and not replaced. You cannot have operating theatres without a blood bank. The anatomical pathology department was cut in half and the pathologists and their microscopes were separated from where the specimens were being cut, so they could not report the specimens. The specimen reception area, where the specimens are delivered, receive specimens by pneumatic tube.

The pneumatic tube system was demolished. It could arrive there by lift but the lift well was demolished. It could arrive there by corridor but the corridors were demolished. In fact, the only way to get the specimen properly was to throw them in a plastic bag from the ground floor through to the second-floor window. We would point this out and in each case the error would be acknowledged, genuine efforts were made to try to address these and eventually they would return to us and say, "I am sorry. It is too late. A mistake has been made but we can't fix it. Don't worry, just stay where you

are. The oversight is so great that at some point someone will realise and I am sure more money will be coming will coming."

The current building, where most of Pathology is, was built in the 1960s and modified in the 1970s. Pathology is the cutting edge of medicine. It is full of high-tech equipment, probably more expensive per square metre than intensive care, yet it has been completely omitted from the planning process. We are told it is too late to put it into the planning process. I can provide more examples if you would like, but perhaps those two would be illustrative of the sort of problems that my colleagues and I are aware of. It seems that there is a disengagement of the clinical community from the planning community. We see it most directly in terms of how the budget process does not support good clinical practice. The concern that we have with the facility redevelopment is that we are making plans for the next 30 or 40 years, yet we may have left out key building blocks.

Dr BRIGGS: I would like to make a short statement. I am a radiologist in the medical imaging department. When I joined the hospital almost 25 years ago, the medical imaging department was recognised around the country as one of the best departments in the country. That was supported by the fact that we were awarded the first MR [magnetic resonance] machine in New South Wales, in fact the country, back in the mid 1980s. Since that time the department is no longer recognised as the best in the country because there is a stressed staff and also the high technology and capital demand in high technology is no longer within the department.

Submissions and business plans for a third CT [computerised tomography] scanner and a second MR scanner have been rejected. The director of my department, Dr Stephen Blome, has given you a comprehensive submission. The outstanding thing is the lack of investment in MR. In fact, there was a Department of Health guideline that a certain amount of money had to be put aside for every patient to get ready for the next MR—in other words, put money aside for capital investment. That \$1.7 million has disappeared.

The second thing I would like to say is when I was chairman of the Medical Staff Council at Royal North Shore Hospital in the three-year period between 1999 and 2001 I was well aware that standards were dropping. I could not get adequate answers from either the hospital administrators or perhaps the Department of Health. I put my energies behind supporting Professor Dwyer from the Prince of Wales Hospital, Professor Goulston and also Professor Graeme Stewart from Westmead Hospital to set up the Greater Metropolitan Task Force. At that time there was a health Minister, Craig Knowles, who was receptive to advice.

Mrs JILLIAN SKINNER: Thank you very much, gentlemen, and Dr Donovan for your attendance. Your evidence has been compelling. Dr Arthur, thank you very much for your thorough submission. Dr Arthur, focusing on a couple of issues in your submission, you comment at page two that "about five years ago the hospital stopped sending me printed monthly budget reports". Is that an important tool in the department's planning? Is it something you would recommend to this Committee to try to restore?

Dr ARTHUR: I do not know if you have the appendix I have submitted. It had lines all over it from one of our budget reports.

Mrs JILLIAN SKINNER: Yes, the navigation screen.

Dr ARTHUR: Yes. Basically the point is I am responsible for a \$2 million-plus budget for the haematology department. They come to me and say, "You are over budget. You cannot have this piece of equipment." For me to even manage the budget—it was bad enough when I had the paper records—now I have to go to a computer and there are probably 50, 60 steps, probably more than 1,000 potential pathways. If I were a good manager, a good accountant, I would have a firm handle on all of the data of the budget and the items that we are spending money on. Maybe if I had a better way to monitor and manage I could see that we could save a little bit of money here and we could use that more efficiently. If you want departmental managers to manage their budget and finances properly, we need to have the data and information in a readily digestible format. We are doctors, not accountants. But we understand a few things, and we could do it if we had reasonable information.

Mrs JILLIAN SKINNER: Appendix 1, which is dated September 1999, is a much simpler budget statement. That is very similar, almost identical, to a document that was leaked to me some time ago that I have supplied to all the members of this Committee. It is a year to date budget for the whole of the Northern Sydney Central Coast Area Health Service broken down by health services, so North Shore and Ryde. It suggests to me that the budget statement is still being produced but the unit managers are not involved or are not being given copies. Is that as you understand it?

Dr ARTHUR: It is interesting because I had asked my own department's business managers if I could go back to these. They said that it is on the website now and I can go through this process here. Even this is unsatisfactory for a manager.

Mrs JILLIAN SKINNER: As to the whole question of patient records, you say it is now a quality and safety issue. We have also heard evidence this morning on this issue. The fact that you are way behind other hospitals and other area health services must have a dramatic impact on your patients.

Dr ARTHUR: Electronic medical records?

Mrs JILLIAN SKINNER: Yes.

Dr ARTHUR: Exactly. My focus is on cancer treatment. We provide chemotherapy; we believe we do it safely. But, for example, if a patient comes into the casualty department who has had some chemotherapy one or two weeks ago, they would not be able to find that out, they would not be able to find the doses of the drugs. I have been up in the wards sometimes on Friday evening when all of the staff has gone home trying to find out what treatment the person was given. The patients usually know something about what they are given, but the precise details are critical in managing these people.

Fifteen to 20 years ago, when I came back from overseas, I was part of a committee with Dr David Moore. We were about to sign on the dotted line of a contract for a comprehensive clinical system that would do results, get results back, order pathology and have a clinical record with intelligence to tell us if we are having drug interactions. Unfortunately, the Health Department said, "No, we will solve this." That was 15 years ago. That is why in the last couple of years I have dedicated as much time as I can to making our own solutions.

Mrs JILLIAN SKINNER: I have questions of all if you but there is not much time. Professor Burnett, as to this business about no Pathology in the new hospital, the budget for the Pacific Laboratories Medicine Services [PaLMS] is astonishing. I do not understand how you are able to provide quality service for patients and support very dedicated clinicians with that kind of attitude.

Professor BURNETT: I think many others have made the same statement to the Committee that we have outstanding staff—clinical, scientific, managerial and administrative staff—who are very dedicated. But the system is not supportive. It seems not to identify the issues that allow us to contribute. The issue of the disconnect between the planning process and the budgeting and finance allocation process affects us all. It prevents good managers, I think Dr Arthur was describing, trying to do what they wanted to. If one has a budget that one knows does not reflect the workload, it becomes difficult to deliver the required outcome.

Mrs JILLIAN SKINNER: Where are the details of your budget reported? Is there auditing or anything like that done of your budget? I have not seen any details of the PaLMS budget.

Professor BURNETT: The PaLMS budget, like our sister services in the other area health services, is a business unit within the area health service. It is an unincorporated entity, which means that the accounts would be separately maintained but reported as part of the area health service. There is a transition process to be completed by the end of this financial year. But the quality services will be grouped together and reported separately under a host service. We are in that transition process. That is not relevant to what I was discussing.

Dr ANDREW McDONALD: I ask the same question to all four of you: You have all talked about disengagement between the clinicians and management. Could I have suggestions about how interaction and communication between clinicians and management can be improved?

Dr ARTHUR: We both have problems, we have all been too busy. I try to meet with my managers but they are always busy. Perhaps the area structure is one of the problems. They have tried to engage clinicians. I cannot give you a one-minute answer how to do this. Both sides could meet together and have some authority, particularly at the local hospital level. Mary Bonner, the General Manager of Royal North Shore, I have met with many times. She says, "I would like to help you but it will go up to area and it will get stuck up there." Give her some more authority to solve things locally and to help us at our local department to solve things. Give us the authority and we can do something.

Dr BRIGGS: It is my personal opinion that the doctors have been disenfranchised from any decision making about how the hospital should be run. For instance, the medical staff councils were once an independent strong body within the hospitals that gave some direction about what needed to be done. There was a change in the structure of the hospitals and the management of the different teams in that there are now divisions. The divisional heads, the doctors in charge of those divisions, became part of the executive. My personal opinion as well is that there is a complete Yes Minister situation with the whole Department of Health. Everyone is saying yes to the person above. The communication would be easy between the managers and the clinicians if the management team turned up to the medical staff council meetings, if not divisional meetings. Each of the specialists you see before you here today and in the other sessions, we all can do our own job, we know what to do. We just need a proper framework in which to do it and proper funding.

Dr DONOVAN: In my opinion there needs to be more accountability among senior clinical staff and the area. Their activities are not really supervised. There is a lot of independent decision-making and activities that need to be policed.

Dr ANDREW McDONALD: Does that mean financial, clinical or both?

Dr DONOVAN: Both.

Professor BURNETT: I think I can answer your question at two levels. In terms of communication, the dialogue and the personal relationships are excellent; they are very strong. The problem comes that as the key decisions are being made, as we saw in the example provided for the planning process or the facilities, when the time comes for the decision-making it is often already made or may be made by a distant party who has relaxed the knowledge and is not willing to then engage in the dialogue or the consultation to see whether their initial impression is correct or tested in the light of reality. So we end up with a planning process that is not so much real as unreal, surreal. It lacks a connection with the clinical realities.

Dr ANDREW McDONALD: I ask all of you a question about workforce shortages. Are they a problem or going to be a problem?

Dr ARTHUR: It is a critical problem. It is one of the reasons that contribute to efficiency. I liken it to a car running in first gear all the time. We are flat out. We have the hospital suffering from 100 per cent occupancy. Our time is 100 per cent-plus occupancy. That makes us less efficient. If I had one or two more haematologists and we had one or two more oncologists, it would make a dramatic difference. When we ask them that they say there is no funding. It comes back to the same old problem.

Professor BURNETT: In the case of pathology, the workforce shortage is international as well as national. There are moves to look at workforce substitution, particularly substitution of capital in robotic and automated machines. These again require incorporation within the planning process. Unless one makes the plans now though, one will end up with very acute shortages within the next couple of years.

CHAIR: You have given us alarming information about the absence of a pathology department. Who is responsible for leaving it out of the planning process? At what level has that decision been made?

Professor BURNETT: The architects tell us that it was not put within their brief when they were given the instructions by the then management of the area. On each occasion that we would return to draw to their attention that they have been given incorrect plans or the incorrect brief, they would go away and come back to say that their instructions are that there are insufficient funds within the current scope of project.

CHAIR: So it is at the area level, not the Department of Health level?

Professor BURNETT: That was my interpretation of what I was told, yes.

CHAIR: One of you mentioned the Medical Staff Council. We had earlier reports that it did not meet. Do you say that is because it lost its authority and had no role to play?

Dr BRIGGS: That is right, and the poor attendance was because of that. At times when there was a crisis the numbers would boom again, as is currently happening. At the last two or three Medical Staff Council meetings there has been a large attendance because people are concerned. They are trying to get feedback from each other and support each other and also see which direction we should go.

CHAIR: Are you able, from that Medical Staff Council, to send views anywhere—to the general manager? What actually happens to your concerns when you do meet?

Dr BRIGGS: At the moment, Dr Charles Fisher is Chairman of the Medical Staff Council. I think he gave evidence here recently. He should be at the forefront of the hospital's decision making.

Mr PETER DRAPER: Dr Arthur, congratulations on your submission. I thought it was outstanding and it really does open eyes. It was very well put together and very thoughtful. One of the things that I found in there makes me want to know about the effect on morale, not only of the managers but on the people working with them, when you go to the time and trouble of putting together a case for either additional employment or an investment in infrastructure, only to have "It's not in the budget" thrown back at you. How does that affect everybody?

Dr ARTHUR: Well, it is demoralising. I finished this at about 4.00 a.m. the other morning and it is just that—I am sorry. It is difficult because I can go home at night-time and know that I have so many things to do that I just cannot get it all done. On the weekends, I would like to spend time having a relax, you know, just to spend a few hours—having a beer in the backyard is something I look forward to. I wonder what has life come to when you cannot actually look forward to having some leisure time. I see my colleagues here: they snap at you. They are angry. They are frustrated. But one of my colleagues is regularly there until 7, 8 or 9 o'clock at night, and he gets angry at me. Morale is really at rock bottom.

It is many of these things I have mentioned. We are losing our wards. You know, we had the social structure of the unique ward where the nurses and doctors could work together to attend to and look after someone in a real crisis, like leukaemia. We had a fantastic thing. About 10 years ago, that was all destroyed. We had very good, secure nursing. We had very few people leave. We had full employment numbers and that has been lost, so it has had a very destructive effect on us.

CHAIR: Who made the decision to destroy that process?

Dr ARTHUR: Each year we were told, and for the 25 years I have been there, they say, "We're over budget." The reason, they said, was because our clinical activity was too high. In other words, we were treating too many patients. They needed treatment. But they said that the clinical activity is too high and we have to come in on budget, hence the conflict with the general manager's performance agreements. So they would cut wards. We were told, "You have to join your ward with the renal ward." But we said, "No, look, that's not going to work." So they made this amalgamation of wards for financial reasons, despite us saying, "Look, we don't think it's the best way to treat patients." We lived with it and we try to make it work, but it is not the best model.

CHAIR: Is it only happening at the Royal North Shore Hospital? Would other teaching hospitals get pushed around the same way?

Dr ARTHUR: That is not my impression. Say, for example, at—I am sorry?

CHAIR: Was about to say that I doubt that they would treat the Prince of Wales or some of those hospitals in the same way.

Dr ARTHUR: We just dream. I have been to the Westmead Hospital. They have a brand new haematology ward, which I have detailed in my submission. I went to the Prince Alfred Hospital. They have a beautiful new cancer block, which we had a vision of doing as well, but that does not look like happening. My impression is that it does not happen and that it is the funding crisis and we are contracting wards.

Ms CARMEL TEBBUTT: I have one question which relates to that. It is based on evidence that we have already had presented to us. In some other hospitals, sometimes the clinicians have embraced the changes more readily than what has happened at Royal North Shore. Do you have a view about that?

Dr ARTHUR: Well, I think the evidence speaks for itself. They have started with \$500 million plus for places like central Sydney and a new cancer building or a new cancer ward, a new haematology TransiNet ward. What changes are they embracing? They are embracing the beneficial changes, great new changes, new wards, new buildings. What we are embracing is contraction and a loss of being able to have some clinical input into what we think is best patient care.

Professor BURNETT: Mr Chairman, I have an example that may also help in answering Mr Draper's question, if that would be of help. You ask how our staff morale is. On my way here this morning—I had hoped to attend the morning session but I was delayed because one of our staff wanted to tell me an account of something he did Monday last. A pipe burst in the ceiling of the building—the same building we are talking about, the one that is falling down—and he threw himself on top of the machine that is underneath. It is one of only two machines in the country valued at about half a million dollars each, and he tried to deflect the water that was coming from the ceiling and with a garbage bin, stood on top of the machine. He protected it and gathered some 50 litres of water, he tells me, before the emergency services arrived. The morale? You have very professional and dedicated staff who are really trying to deliver the best, but under very difficult circumstances.

CHAIR: Thank you very much attending our hearing. We appreciate all that you have given to us and all that you are doing. Continue to do your good work.

(The witnesses withdrew)

JOHN GUTHRIE VANDERVORD, Clinical Director of the Division of Surgery and Anaesthetics and Program Director of Surgery for the Northern Sydney Central Coast Area Health Service, and

THOMAS JONATHON HUGH, Head, Department of Gastro Intestinal Surgery, Royal North Shore Hospital, sworn and examined:

CHAIR: Thank you for agreeing to appear before our inquiry. We appreciate the time you have given to us. It is very important. Does either of you wish to make an opening statement?

Dr VANDERVORD: Yes. I think we would both like to.

CHAIR: Good.

Dr VANDERVORD: Mr Chairman and members of the Committee, I would like to thank you for inviting us to discuss the surgical issues at the Royal North Shore Hospital. I am presenting with Dr Tom Hugh. What I plan to do is talk about the present situation at Royal North Shore Hospital and he will discuss the surgical issues in terms of the redevelopment of Royal North Shore. I will try to be as brief as I can to give some time for questions. There are really three main issues relating to surgery at Royal North Shore Hospital. The first one is the number of theatres related to the workload and the efficiency in these theatres. The second is the problem of a lack of beds at Royal North Shore and the implication of this on the availability of, particularly, intensive care beds. The third issue is to do with funding of the hospital and also the lack of capital investment in the hospital over the last 10 to 15 years.

It may surprise you to know that we in the area do not have a surgical services plan for the northern area-Central Coast. This means that we do not have a plan to coordinate the nine hospitals in the area, nor to coordinate surgery that is carried out in the area, in the numerous theatres which exist in these sites. For two years we have been meeting with the clinicians in the area, including Gosford-Wyong, with representatives of area, and also with the area planners. Finally in 2006 we received a draft document which bore no resemblance to what we had been discussing in our meetings and really did not reflect the clear input to those meetings. We met with area and we said that what we would like to do is to submit submissions from all the departments within the division of surgery and anaesthesia and from some other groups who are obviously affected by surgical planning—for example, radiology, cancer services and breast services.

This was done. We tabled a submission from every department. Since this, which was at the end of 2006 and straight after the draft came out, we have heard nothing, despite numerous requests to reconvene the group and to try to sort out a surgical services network plan, which is obviously what we need to plan surgery in the various hospitals. The response that we have had is that the problems with Ryde hospital and decisions about what was happening with Ryde hospital need to be sorted out before we could move forward. So, without the surgical plan and reorganisation of the situation at Royal North Shore Hospital, the situation at the Royal North Shore Hospital is that the current operating room capacity is insufficient to meet the demands of elective and emergency surgery, despite clinical redesign.

I am sure Pat Cregan, although I was not here this morning, will have talked about, trying to make sure that we are efficient—starting our lists at 8 o'clock, finishing lists on time, not cancelling patients on the day of surgery, planning elective and emergency surgery—and he was very adamant that it is possible to plan emergency surgery. I think he probably is able to do that better than most other people. An internal report done in 2005 showed that the theatres were running at an unsustainable 95 per cent activity and that 37 per cent of the elective and subacute cases are being done after business hours—that means at night and early in the morning. That is all right for emergency cases but not for elective and subacute cases.

This is bad for patient outcomes. It is not good to wait all day to have your elective surgery done late at night or early in the morning when medical staff have worked all day and are due to do full lists the next day. It is also unacceptable for nursing staff and medical staff, as this constitutes unsafe working conditions and it is not conducive to recruitment and retention of nursing staff. The

lack of elective theatre time means that several young surgeons who perform major elective and emergency work have limited operating time or no regular operating time at all.

The second issue is the number of beds that we have at Royal North Shore Hospital. I am not going to get into arguments with the numbers stated by the Department of Health, which include beds in the community, bassinets, et cetera. We have 405 acute beds that we can use for acute cases. Frequent cancellation of elective operations occurs because of access block particularly, but not the full-time intensive care cases that need to go to intensive care, and they are, particularly, the neurosurgical and cardiac cases. Patients cannot be transferred to the intensive care unit [ICU] in a timely fashion because there are not enough beds and therefore patients cannot be admitted to the intensive care unit.

The third point that I wanted to make was to talk briefly about the funding. We are told there is no money and that this is the same situation in every teaching hospital in Sydney. We are told to stop whingeing, pull up our socks, and become more efficient. I am not going to get into the argument of whether we are expensive and therefore are underfunded. The point I would like to make about funding is that we provide at Royal North Shore Hospital two statewide surgical services—spinal injuries and burns. Until recently, most of the interventional radiology was done at Royal North Shore Hospital. I have a document, which I will table. It suggests that each year for spinal injuries we carry a cost of \$5 million a year that is borne by the hospital and not reimbursed by statewide services. Although we do have funding for burns, it falls well short of what we need to cover burns. So there are two statewide services which North Shore provides that are not funded.

I think Professor Malcolm Fisher last Thursday mentioned that Royal North Shore was doing all the interventional radiology coiling for cerebral aneurysms for the first three or four years that this new technology was available. North Shore did it all. We covered the weekends, we covered the nights, and we had a deficit of about \$1.5 million per year. When it was recognised that this was happening, there were other centres set up, and that was great. Governor Macquarie Tower [GMT] had a lot to do with that, but what did not happen was that there was no backfill for that \$1.5 million and that \$1.5 million multiplied by four came out of funds that should have been put into information technology [IT].

Finally, I would like to talk about capital investment, which has been lacking for the last 10 to 15 years at Royal North Shore Hospital. Professor Fisher tabled a document—and I see that Chris Arthur has mentioned it again—highlighting that per capita we are 10 times worse off than comparative hospitals in terms of what has been put in for capital investment. For surgery, this has meant a lack of appropriate and functional equipment within the operating rooms, and it has led to dangerous work practices and reduced patient care. One example of this is the flexible cystoscope equipment in urology. It has now been recognised by the Royal Australian College of Surgeons and they have threatened to take away our accreditation for urology training. This was a memorandum that came out from the health department, and it said that all teaching hospitals had to institute this. We still have not instituted it; we still do not have flexible cystoscopes, and yet they have them at Gosford.

Another example is the outdated and inadequate laparoscopic and thoracoscopic equipment which frequently does not work properly and which threatens patients' safety. An indication of just how outdated this equipment is is the fact that the laparoscopic and arthroscopic equipment which is used in the Northern Clinical Skills Training Centre—and that is used on synthetic models and animal tissue—is, in fact, of a much higher quality than the current equipment being used on patients in Royal North Shore theatres.

I have a folder of what we need in terms of equipment which is urgently required at Royal North Shore, and it adds up to about \$8 million for surgery. It is a tribute to the surgical staff, and in fact to all the clinicians at Royal North Shore who are struggling with inadequate or dysfunctional equipment, that such good clinical outcomes that you heard about from Ross Wilson last Friday can be achieved for patients despite these adverse conditions. The inadequate equipment is not only bad for patients but it is bad for the morale of the nursing staff and the medical staff, which you were asking about previously. When you are working with old, inadequate equipment you are not working well; you do not feel confident.

The greatest asset that Royal North Shore has is the allied health nursing staff and medical staff. That is our best asset; that is the health department's best asset. Once these clinicians start to leave in protest over the difficult conditions at Royal North Shore, my experience is that they will never return to the public system. We have a new chief executive officer, we have a new director general of health, and we are committed to working with them to try to sort this out. We realise they are new in their positions and we are hoping that these problems will be sorted out.

I have had the privilege to work with Professor Picone, the new director general, as she was in great part responsible for the creation of the world-class New South Wales severe burns service which I know you visited a couple of weeks ago at Royal North Shore. That is a centre of excellence; it is something that the health department has done well, and very well. We hope that Professor Picone's vision and enthusiasm will extend to working with us to sort out our problems at Royal North Shore. I will now ask Tom to speak about the redevelopment.

Dr HUGH: Mr Chairman and the Committee, thank you for the invitation. This Committee has listened to many individuals and has received many submissions from staff outlining the problems that exist at Royal North Shore and within the large area health service in which we work. With regard to Royal North Shore, it is an unprecedented inquiry that we are having here into what was once a flagship teaching hospital in New South Wales. Despite the counterclaims to the contrary, that this hospital is no different from any other public teaching hospital, it is a sad fact that the working conditions for the staff and consequently, I believe, the treatment outcomes for the patients, are way below what we should expect in 2007.

There is no need to go into any detail about how unacceptable the state of Royal North Shore has become; we have all heard about that. We should not blame middle management particularly—as John said, the middle management that currently exists there. It is not their fault that there is not a cleaning budget regularly for the wards. I have a number of testimonials from my patients which suggest that they had to clean the toilets in the mixed gender wards before they use the toilets. It is an unacceptable level of care. I do not believe this is acceptable in any hospital, let alone a teaching hospital. I certainly do not think it would be acceptable in Nepean Hospital or Royal Prince Alfred Hospital.

You have heard plenty of submissions from a number of people that the clinical staff at Royal North Shore Hospital have not tried hard enough to resolve some of the managerial or financial issues that seem to plague our hospital. I categorically deny this, and I can produce hundreds of documents from staff members written over the past 10 years that detail the frustrations of trying to work with inappropriate clinical restructuring proposals proposed by various administrative bodies, the inadequate or absent financial and inpatient data, the political impediments to restructuring emergency care, for instance, in our area, and the values to deliver leadership in clinical networking over many years. John went over those issues.

Unless you are working at the clinical coalface at Royal North Shore Hospital you really cannot understand how difficult these problems have been. On a daily basis, it is hard to do business at Royal North Shore. Like many public hospitals, there has been a loss of focus of the purpose of why we are there. It is no longer solely about patient care, but it revolves around a number of administrative services, and they are supported by too many layers of bureaucracy. Patient care and good clinical outcomes are only the by-products of this system.

In this regard I would like to acknowledge, as John said, and support my medical and nursing and allied health colleagues across the whole of our area health service. Many have provided information to this Committee, and they continue to deliver high-quality care in most cases, despite the difficult working conditions. It is only these committed people who have both the clinical skills and the corporate knowledge to be able to deliver the best care to patients. As John said, in this regard they are the most valuable asset of Royal North Shore Hospital. I think their skills and talents have been undervalued.

There have been distracting arguments about bullying at Royal North Shore Hospital. The closest thing I have ever seen to bullying in the nurses or medical staff has been staff fighting with each other. I have witnessed doctors arguing with other doctors about limited funds for junior staff within the department. I have seen doctors arguing with nurses about prioritising urgent cases when

there is not enough emergency operating time, and I have seen nurses arguing with other nurses about inappropriately low patient-nurse ratios. It is not about bullying; it is about providing appropriate resources for a hospital so that the staff can get on with the job of treating patients.

I am not surprised by the number of complaints from the staff and from patients at Royal North Shore. This is supposed to be the quaternary and tertiary referral hospital for a large population of approximately one million people. The clinical staff welcome this inquiry and hope that it might result in an open and rational debate about how to resolve these issues. We keep hearing about how this is a great hospital. Quite frankly, I am embarrassed to bring any of my interstate colleagues or my overseas colleagues to see my own hospital, which I have been a part of for more than 23 years, since I was a medical student.

All public hospitals need better resources—there is no disputing that—but this is about the specific problems at Royal North Shore. The adverse publicity and the subsequent inquiry have been traumatic for the patients and staff at Royal North Shore. Earlier it was asked about the morale. There is no question that morale has been affected. I think until now this process has been far more destructive than it has been constructive. Clinicians have felt the effects in our consulting rooms, and the emergency rooms have never been as quiet as they have been over the last few weeks. For things to have deteriorated this far, I think it is pretty obvious that the people of our large area health service have been seriously let down by those who control the purse strings. Clinicians, nursing staff and allied health staff are committed to working with the current management, to help turn around the fortunes of our hospital.

I mention that I have been a member of the Royal North Shore Hospital Redevelopment Clinical Advisory Committee. It is a group of clinicians who have spent hundreds of hours over the years providing advice about how to build this new, great hospital that we keep hearing about. Suffice it to say that this has been an extremely frustrating process, and the minutes of these committee meetings record the concerns that our advice has essentially not been acted upon. It is incredible that we heard today, and recently from other speakers who do not work at Royal North Shore, that clinicians have not done enough to change the situation, particularly with regard to this new hospital. Again I deny that we have not tried incredibly hard.

Today I would like to table the brief that was written in June 2007 by a number of members of the Royal North Shore Hospital Redevelopment Clinical Advisory Committee. This document was a last-ditch attempt by us to address many of the issues related to the capacity and design of the new hospital that had previously been raised by us. Most of these concerns were dismissed. We certainly raised concerns about the public-private partnership plans and what that meant for the redevelopment and how it might impact in future on patient care. Specifically, we expressed serious concern and highlighted the risks to the people in our area health service in relation to the planned number of in-patient beds, the number of operating rooms, and the number of intensive care beds.

We have achieved some minor changes with the new project team, there is no question about that, but they have been working within a very limited scope. Members of this advisory committee have repeatedly warned that the adverse working environment that currently exists at Royal North Shore Hospital should not be entrenched in the new hospital development, and that is how we have been seeing the plans. We think this is going to negatively impact even more than it has on not only clinical outcomes but, more importantly, the retention of staff—nursing, allied health and medical.

The nurses and the doctors will continue to drain from our hospital into other public hospitals within the area or, more importantly, into some of the private institutions that have sprung up around our area. I would also like to table today the official response from New South Wales Health and the project team, the two-hour brief that was written. We believe that the brief that we wrote was a thoughtful and carefully reasoned document about the issues, but unfortunately the response, in our opinion, simply did not engage with most of the issues raised and essentially the prevailing dogma that there would be no expansion on the proposed scope.

I am also responsible for the consultant urgent surgical on-call roster for what used to be called general surgery and is now gastrointestinal surgery. Many of the surgeons within my department are on two hospitals within our area and have to man two different urgent rosters. It is increasingly becoming more difficult for them to do the on-call roster, particularly when they are

expected to do the urgent work only and cannot get access to the operating rooms because there just are not enough of them. Again I reiterate that unless we resource the hospital properly, particularly with adequate operating rooms—and again we table all that information in this brief about what we think as clinicians, as an advisory group, should be in the new hospital—these surgeons will simply walk because it is an acceptable working condition within which they work.

Royal North Shore Hospital can be a world-class facility again, but it really is only the advice from the people who are working at the coalface that needs to be listened to and that can make a change. Thank you very much.

The Hon. JENNIFER GARDINER: I would like to give you the opportunity to respond to some comments that were made to the Committee earlier today by Dr Cregan, the Chair of the Clinical Services Taskforce. Dr Cregan pointed to the fact that Royal North Shore seems to have had more inquiries into it than just about any other tertiary hospital. He referred to the long-serving senior clinicians at the hospital and a culture which he believed means that the senior clinicians do not take sufficiently a leadership role in engaging in dealing with a lot of the problems that have been put before the inquiry and other inquiries. Dr Cregan said that if the senior clinicians are not part of the solution, then they are part of the ongoing problem, or words to that effect. Would you like to respond to that suggestion that there is a cultural problem at Royal North Shore Hospital that distinguishes it in some respects from other tertiary hospitals?

Dr VANDERVORD: I do not quite know who he is talking about in terms of senior clinicians. That is a very vague—I am a senior clinician. We had one of our reviews—

The Hon. JENNIFER GARDINER: Dr Cregan was not being very specific, but he did refer to people who had been there for 20 or 30 years, for example.

Dr VANDERVORD: I have been there for 42 years. Perhaps he was referring to me. But I have only been doing this job for two years, since the academic head of the Division of Surgery resigned in protest of one of the reviews that had been done and he felt very unfairly treated by it. I have been doing it for two years, so it is not as though I have been in it for a long time. So I do not quite know who he is talking about.

Dr HUGH: With all due respect to Pat, I am not sure what he is talking about either. John is the head of the Division of Surgery, I am the head of gastrointestinal surgery, and there are several orthopaedic surgeons involved who are going to speak after us this afternoon. Charles Fisher is the surgeon who is head of the Medical Staff Council. As I discussed in my talk just then, and as we have indicated clearly in the brief and in the minutes of the Clinical Advisory Committee meeting with regard to the new development, there has been an enormous amount of clinical input and effort—not just from medical clinicians but also from surgical clinicians.

Again with all due respect to Pat, I do not recall Pat working at the hospital in the last 20 years, so I am not sure that he understands what it is like to work in the hospital. He may be talking about a teaching hospital that is relatively small compared with our hospital and certainly does not have the large number of surgeons that are involved. But we have had many, many meetings—and many active meetings—where there has been significant input from our surgeons into bureaucratic processes that have attempted to change clinical practice over the last 10 years and, much more importantly, with regard to the new hospital. We simply have not been able to get anywhere, and that has been the problem. So I deny that strongly, and I believe we have supporting evidence to back that up.

Dr VANDERVORD: If Pat is still here, I would be happy for him to come back and explain to us exactly what he is talking about. I think it is a pretty nebulous sort of thing to say. I would think I am committed to Royal North Shore Hospital. I have been there for a long time, and I am very keen to see it regain its former glory and to go into this redevelopment without the disaster that is going to happen if we continue with the plans that are there at the moment. That is why I am re-engaged in this for two years; I have been doing it for two years. I do not know whether that is what he is talking about.

Dr HUGH: Again, in the last couple of years we have had a number of external, well-respected clinicians giving advice in the redevelopment committee with regard to the redevelopment of the hospital. It was interesting that one of these clinicians came along two years ago, at a meeting which many on the committee will recall, and expressed his alarm at the early, disastrous planning process, and was quite frank in telling New South Wales Health representatives and the project team how disastrous this planning project was. He told that to the committee and he was greatly supportive of our efforts, and we have tried over the last two years—I am not sure whether he still feels the same way, but we have faced these problems for a long time.

The Hon. JENNIFER GARDINER: Dr Vandervord, you referred to the lack of a surgical services network plan—since the end of 2006 there has been nothing—and you are told that Ryde has to be sorted out first. Is there any time line for the sorting out of Ryde?

Dr VANDERVORD: I think you have got to understand that the last CEO was trying to follow a different path with Ryde: he was trying to move Ryde to Macquarie. This was something new he was trying. It took quite a long time to actually get reports done to see if it was feasible, to see whether the money could be raised. Obviously, if Ryde was going to move to the Macquarie site then that was going to change the interaction between North Shore and Ryde. The problem with North Shore and Ryde at the moment if we are going to move surgery to Ryde is that it is not readily accessible, it is not quick. To get to Macquarie would have been 10 minutes.

The other problem with Ryde is that apart from the theatres, which are great, and the peri operative area, the rest of the buildings could be demolished—should be demolished. So, either you rebuild Ryde at Ryde or you rebuild a new hospital at Macquarie or you keep Ryde as a four-day surgery. It is complex. I can understand why they wanted to sort out Ryde before they went ahead with a lower North Shore plan with Hornsby, Ryde, North Shore and the beaches. The other issue, I presume, for planning for surgery in the area is we do not really know what is going to happen with the beaches hospital. We do not even know how many beds are going to be in the beaches hospital. We do not know if the beaches is going to be a combined public-private enterprise. If it is such a good idea for North Shore to be a PPP, then surely we would be embracing the beaches to be a PPP too.

Mrs JILLIAN SKINNER: They have announced that though, have they not?

Dr VANDERVORD: We do not know. When we asked the previous CEO whether he knew, as the CEO of that area, whether the beaches hospital was also going to be a public-private partnership, he does not know. I do not know whether any of you know.

Mrs JILLIAN SKINNER: It has been released by press release, yes.

Mr MICHAEL DALEY: Thank you for coming, gentlemen. You say one thing; Pat Cregan and others say another thing. Regardless of who is right or who is wrong, or combinations thereof that exist, somewhere we have to talk about tomorrow. That is all history. What recommendations would you gentlemen like to see come out of this inquiry to help clinicians and managers meet somewhere in the middle and have a talk to each other—going forward in a meaningful way?

Dr VANDERVORD: I think the clinicians need to be involved in the decision-making. Instead of having a draft proposal given to us, which has obviously got agendas in it that we do not know about—perhaps from the health department, perhaps from the area—it would be better to sit down with the CEO and say, "What do we do with surgery? What do we do with day surgery? What do we do with eyes? Why don't we talk about that instead of it being handed down to us?" and since the time I have been doing it, I have never sat down with the previous CEO and talked about what is happening in surgery in the northern area with a couple of other surgeons.

We need to be involved in that, and I think that may happen now because the history of the people there now is they have been in other areas where they have done that. I know the other directors of surgery in the other areas—Michael Moody in the Prince of Wales, Cregan and McCaughan and Dennis King. Those clinicians were involved intimately in what was done in those areas, and I have never been invited to sit down and talk to the CEO.

Dr HUGH: I support that. I think it has to be clinically led. Clinicians have to have the ability and the authority to make the decisions, and that has not occurred. With regard to the redevelopment, we were told what scope was going to happen, how the hospital was going to be built and what the functional relationships were, and there was no negotiation. It took us two years to get minor changes on that, and essentially we kept getting told—and, again, it is in the brief—repeatedly we were told from NSW Health and from the area administration that there was no room for negotiation in this issue. We made some minor changes only, but it was because it was not clinically led, it was led by NSW Health and administration. I think that needs to significantly change, and when it does we will have a better hospital.

Dr ANDREW McDONALD: I know the Ryde issue is a problem but I think we need to go back to it. What is the attitude of the Department of Surgery to decanting large amounts of elective surgery to Ryde on the Ryde site, as they have in Western Sydney and south-western Sydney?

Dr VANDERVORD: In the submissions, which are in this envelope, from every department, I asked them to see how they could use Ryde. Dr Hugh goes to Ryde and does laparoscopic surgery there; there is the possibility to do day surgery there—sure, all those things can be worked out, if that is what the role of Ryde is. If they tell us that that is the role of Ryde we can do that, and that is what it says in these submissions. That is why we wanted it looked at.

Dr ANDREW McDONALD: So you need a plan?

Dr VANDERVORD: We need to plan it; we need to plan what we are going to put there. They brought eyes to Royal North Shore. That was a decision that, again, I had nothing to do with; I think it was before I even took on the job. But eyes—ophthalmology—in the whole of the northern area came to Royal North Shore. I am not saying it should go there, I am just saying that that would have been a possibility. But there are all sorts of other things that could be done there. If we are given the chance we can sort out Ryde, but we need to know what the Government's plan is for Ryde and the northern beaches.

CHAIR: Thank you very much for giving us your evidence; we appreciate it very much. We know there is some frustration and we hope our report will help to clear all that up.

Documents tabled.

(The witnesses withdrew)

(Short adjournment)

WARREN HENRY ANDERSON, relative of former patient, sworn and examined:

CHAIR: Thank you for coming in. We appreciate you sharing your information with this inquiry. In what capacity are you appearing before the Committee?

Mr ANDERSON: I am appearing as the father of a patient at Royal North Shore Hospital.

CHAIR: The Committee has agreed for a legal adviser to be present to assist you without actually giving evidence to the Committee. You can freely seek advice at any time.

Mr ANDERSON: Be rest assured, Melanie will kick me in the shins if I say anything wrong.

CHAIR: Would you like to make an opening statement?

Mr ANDERSON: I would, if I could. Mr Chairman, Committee members, thank you for giving us the opportunity to address this Committee today. Can I begin by saying what a great thing hindsight is. If we knew on 6 November 2005 what we know about Royal North Shore today, we would never have allowed our 16-year-old daughter to have entered its doors. In hindsight, if only we had known that the doctor who first saw Vanessa in emergency was one overworked and over tired—too tired it appears to inform the specialist neurosurgeon that our daughter was in the hospital. And he was too tired to prescribe an anti-fitting medication, as he was instructed to do by the specialist neurosurgeon. In fact, he was too tired to properly supervise the care of our daughter in the neurosurgery ward.

In hindsight it would have been nice to know that two of the most senior neurosurgeons were both away in conferences in Melbourne. If only we had known that the doctor left in charge of the board had only two weeks' experience in neurosurgery. If only we knew that 50 per cent of the scans go missing in the hospital at Royal North Shore, as was the case in fact with Vanessa's. If only we had known that the resident anaesthetist, who overprescribed drugs for our daughter, has been involved in two previous near-critical incidents in that hospital. In fact, if only we had known that my daughter had called the very busy, overtired night nurse and told her that she had lost feeling in her arms and legs, if only that nurse had called the doctor. And if only we knew that one of the other nurses working on that night was working a second straight shift.

If only we knew that just a few months prior to Vanessa's death a senior neurosurgeon had written to the then health Minister, Mr John Hatzistergos, alerting him to major problems at Royal North Shore Hospital. If only Mr Hatzistergos had taken that letter seriously. Instead, he did not reply to that letter until a fortnight after Vanessa's death. The letter was written a month and a half prior to Vanessa's death. If only we had known about the facility for administering oxygen present in Vanessa's room that just two doors along the corridor there were two empty high-dependency beds, with oxygen that could have saved her life. If only we knew that the cost of manning those beds was seen as a greater value than our daughter's safety.

If only we had known that after being a member of private health insurance on family top cover since 1984 that the privilege and the peace of mind that we thought we had was not possible with a waiting list of three over in the private hospital. If only we had known any of these things, then maybe our daughter would be with her friends this week celebrating schoolies up on the Gold Coast, perhaps, because that is where she should be today. The reason Vanessa is not is because she was taken to a public hospital that was so badly resourced, so run-down, that it could not provide the duty of care that it was legally and morally bound to do. The systemic failures of the public hospital system killed our 16-year-old daughter and we are here today to plead with every single one of you not to regard this inquiry as a political exercise only.

We are pleading with you to recognise there is a major problem here. In the past two years since Vanessa died my wife and I have been disgusted at what we have discovered in relation to Royal North Shore Hospital and the health system it has been part of. There is so much information that we would love to read to this Committee, information that we believe would be valuable that it needs to be publicly discussed. But we cannot breathe a word due to being required to give an understanding to enter into an agreement at the Coroner's that requires us to remain confidential in return for being

made privy to that information. The omission of this information from the inquiry in our eyes will trivialise Vanessa's death. Because of this, I implore you not to close this inquiry on 15 December because it will compromise the findings of the inquiry.

If you are genuinely interested in playing a role to bring about change, you must take into account the final evidence and the findings of that Coroner's inquiry into the death of our daughter. Vanessa did not die from one person's mistake. She died because many people made mistakes at every level in that hospital. She died because the public hospital system was not safe. She died because budgets are prioritised over patient safety. Two years later, has anything changed? We suspect not. Evidence presented to the Coroner's Court so far as not given any confidence that this hospital has really learnt anything from the loss of our daughter's life. From our perspective, the focus in the last two years has been one of cover-up rather than learning from the mistakes that were made.

I stated nearly two years ago that the physical condition of the Royal North Shore Hospital was a disgrace. I actually have some photos here that I will table in a minute. They were taken shortly after Vanessa's death. There are pictures of the men's toilets in the public area. They are absolutely filthy. There are things you would not see in your normal everyday use of a public toilet in any other institution. I personally witnessed in the short time in the hospital a fellow coming out of those toilets, as filthy as they were, in a hospital gown. Was he a patient, nurse, doctor? Who knows but, irrespective, the health risk to them and other people in the hospital was obvious. It is nothing to witness patients in various conditions being wheeled on beds through the paying public lobby area of the main tower in that hospital. Aside from the risk of the spread of germs, it is extremely humiliating for the patients to be on display for everyone to see.

Many of you I know have children. As parents we want you to put yourselves in our shoes. Try to understand what it is like to live with the unnecessary death of a child. Imagine the anger you feel if your child died in the same circumstances. We want you to feel that anger, our anger, our grief, our shocking emptiness and then ask yourselves is this inquiry a genuine attempt to bring about much change—much-needed change? This will be the third Christmas without Ness and for our family it does not get any easier, especially when we hear the horror stories continue to happen at Royal North Shore Hospital. There are many stark reminders to the reality and, indeed, a finality of losing a child, especially at this time of year. Our family and friends have shared our grief over the past two years. They have been very special people.

I know they agonise over the sorrow brought about by the tragic loss of Vanessa. For the past 16 years they have been part of her happy and joyous life. It would be devastating to think any of the special people who have been as so supportive of us suffer a similar fate because there has been no change. If you are genuine, then we thank you from the bottom of our hearts because our daughter's death will have some purpose and a legacy that results in recreating a safe environment in Royal North Shore Hospital for the very people that continue to mourn her passing. However, if this is just a political exercise, another inquiry, well we sincerely hope that none of your children ends up in the poorly resourced, dysfunctional public hospital that it is today.

It is not acceptable for a healthy 16-year-old girl to die as a result of treatment or lack of received in a public hospital. It must change. We did not have the priceless benefit of hindsight to save our beautiful girl. This Committee does have that benefit many times over from the various evidence that has been heard. We were not able to change a terrible outcome, but this Committee can change the outcome of people who attend Royal North Shore Hospital in the future. How fortunate will these people be to have the priceless benefit of our hindsight to save them the experience of unbearable grief for a child that should be with us today. The chronic situation cannot be resolved within a three-day inquiry, but it must be resolved. We need to ensure the inquiry is not politically compromised at the expense of achieving all the changes that are required at Royal North Shore Hospital to save the public hospital system.

Mr Chairman, prior to the commencement of this inquiry you shared that you felt if it was justified you would consider to extend this inquiry. From the evidence that we have heard today, and certainly today, surely this is now a foregone conclusion that the problems at Royal North Shore Hospital cannot be sorted out simply by taking evidence over a mere three days. Thank you.

CHAIR: We thank you very much, Mr Anderson, for coming in to give evidence. Our Committee has resolved to continue to meet after today. There is a meeting on Monday, and based on your evidence, will be any further decisions we make.

Mrs JILLIAN SKINNER: Thank you very much. Can I say on a personal level to you, Warren, and Michelle, I promise you that I will do everything in my power to make sure that your wishes in relation to this inquiry and improvements at North Shore are met. I have noticed that you have sat in the body of the room for most of the evidence given so far. You have heard the doctors and others talk about the lack of resources, the lack of beds, and in your submission you talk about systemic problems. So, it is not, you expect, going to be just a misdiagnosis. There are a whole lot of issues that you are concerned about. Would that be right?

Mr ANDERSON: That is correct. One of the doctors previously mentioned Dr Lali Sekhon. In fact, I think he took over from Dr Lali Sekhon. I came across Dr Lali Sekhon when he actually was involved in the hospital and had left the hospital. Of all things, I was trying to find out for myself why he left the hospital. I wanted to find out why. I was told that they did not know why because he had left and gone overseas before they had a chance to find out. I thought I will do a bit of homework and I found out he had in fact gone to Nevada, to actually practice over in Nevada. There is a letter here that in fact you might already be privy to but it is a letter from Dr Lali Sekhon to the then Minister John Hatzistergos—the one I referred to in my submission—in which he makes some very pointed points in relation to what these doctors have already done. It echoes what the evidence has been here today by the other doctors.

In doing so he saw fit to actually send a couple of e-mails to me just expressing how sorry he was that he had to leave the system. But he was not getting anywhere in trying to fix the system. He wanted to fix the system, like all these doctors. The clinicians want to do their job better and they need the resources to do it. That is what is coming out loud and clear in this inquiry. The other issue he brought about was the nursing issue. The nurses, we are short of nurses, yes we are—it is obvious that we are short of nurses. But let me tell you Vanessa, for instance, would have been the doing year 12. The people that she had as classmates were all finishing year 12 looking for a career. One of the careers obviously would be health—be nice. Why would a child come out of year 12 and think of going into nursing with the current situation the way it is. Why would they have a situation whereby they are confronted with \$30,000 HECS fees and they are confronted with 24-hour roster services when they can go and work in IT for twice the money and work for five hours? These are the things that really need to be looked at to make the job more attractive. We do not need to go overseas.

Mrs JILLIAN SKINNER: I know you have made a plea for the Committee to continue deliberating. Can I ask you—and I know you are constrained in what you can say but—

CHAIR: To interrupt you, Mrs Skinner. Can we just get that letter tabled that he has referred to?

Mr ANDERSON: Yes, sure.

CHAIR: If you can separate that, we will have it added to your evidence.

Mr ANDERSON: Thank you.

Mrs JILLIAN SKINNER: I know you have made a plea to the Committee to extend the reporting time and I know that you are constrained in what you can say but can I ask you in general terms to advise us as to whether you believe that there will be matters that come out of the coronial inquest, not necessarily just relating to Vanessa's death but other matters, that will be fundamental for us to consider as part of our terms of reference to fix the problems at North Shore?

Mr ANDERSON: From the evidence that I have heard in this forum here, I am 100 per cent sure that what that information contains is very, very relevant to what we are talking about here.

Mrs JILLIAN SKINNER: And it is new information perhaps or can you not say that?

Mr ANDERSON: I am sorry.

Mrs JILLIAN SKINNER: You cannot say that.

Mr ANDERSON: I got kicked in the shins.

The Hon. JENNIFER GARDINER: Mr Anderson, are you able to advise the Committee as to the estimated date on which the Coroner's report is expected? Do you know that?

Mr ANDERSON: First or second week of February I am told. I think we sit on 21 January and then early February I would imagine.

The Hon. JENNIFER GARDINER: You were saying and I guess the letter you have now given us from Professor Lali Sekhon indicates that the Government was not unaware of a lot of the issues that have been raised in this Committee's inquiry and in relation to your situation?

Mr ANDERSON: From my perspective when I read that letter and I thought in the role I am in, I am in a management role where I am and I know from my perspective that if I had received a letter as a manager from the an employee of mine alerting me to the sort of things that were happening in the workplace and I did not respond to that, I can tell you I would be in jail. It is as simple as that. One of the most frustrating things for a parent, Michelle and I, is that there is no accountability. That is very, very frustrating.

Dr ANDREW McDONALD: Mr Anderson you have been through a terrible experience and thank you so much for coming.

Mr ANDERSON: Thank you.

Dr ANDREW McDONALD: I only have one question. What changes in the way the hospital system works in general, and North Shore in particular, would you like to see come out of this inquiry?

Mr ANDERSON: Just before coming up here we were discussing if I was asked that question and I guess from when this inquiry started to now, after I have heard the evidence that I have now heard, I am gob smacked quite frankly in what changes are needed to be made. But one real change that I think needs to be done is that from the nursing perspective, and this is one of the areas that I think needs to be sold out there, is we talked about, they were talking about the flow with the disputes resolution and those sort of things. We have not got a shortage of nurses in Australia. The nurses have left the system.

Like me, when I have got a turnover of employees I look at why am I getting a turnover of employees? It cannot be 20 employees go through in the last six months. Maybe the problem is here and I have got to look at that. That has come out loud and clear here today and for the last two days. The reality is the nursing staff needs to be encouraged back into the system and at the moment there is no reason for them. Look, to be honest with you, in the coroners the nurse that was the last possibly to see Vanessa, the last to talk to Vanessa, was put in a terrible situation because of the system. In fact after she gave evidence and she came off the stand absolutely devastated I saw fit to go up and embrace her and say, "Darling I am sorry. It is the system. It is not an individual that is causing this problem. It is the whole system that needs to be looked at."

What do I see to improve that? Staff morale is just at rock bottom in that hospital and from our point of view; from the people going into that hospital it was very, very evident that the morale is rock bottom. The nurses are run off their feet. Route cause analysis is set—I now know what a root cause analysis is, I know it real well. You have a look at the different procedures that are going to be put into place; i.e. four-hourly obs are going to be two-hourly obs. Well, is that not a bigger impost on the already busy nurse? So how have we compensated for that? Has there been extra staffing? Well, no. It is all right to put all these different, new things into place but, again, it is going back on to the nurses and the staff, the clinicians. That is what I see as being the starting point with this but gee I am only a plumber.

CHAIR: One thought that occurred to me in regard to that letter you were referring to, to the Minister. Of course we do not know what response the Minister did give to it—we may be able to find out.

The Hon. AMANDA FAZIO: I think he tabled that as well.

Mr ANDERSON: Sorry, yes.

CHAIR: You spoke as if he made no response.

Mr ANDERSON: Yes, I did. I think the response is—

CHAIR: I am just saying you spoke as if the Minister made no response to the letter. He may have responded to the letter, to the complaints.

Mr PETER DRAPER: It is in the tabled documents.

CHAIR: I mean his response to fixing up the problems.

Mr ANDERSON: Right.

CHAIR: He may have made some decisions that you are not aware of.

Mr ANDERSON: Okay. Yes, for sure. That is fine. I just found—

CHAIR: I do not think he would get the letter and not do anything but what he has done we will have to try to find out.

Mr ANDERSON: Yes, that would be good.

Mrs JILLIAN SKINNER: Have the photos been tabled?

The Hon. AMANDA FAZIO: Yes, they have been tabled as well.

CHAIR: Thank you very much for coming in. Again from such an innocent activity to have such a tragedy develop, we express our sorrow to you in the loss of your daughter.

Mr ANDERSON: Thank you. Thank you for your time.

CHAIR: Thank you for your time. We appreciate it.

(The witness withdrew)

LINDY JANE BATTERHAM, daughter of Joyce Batterham, affirmed and examined:

CHAIR: Thank you for agreeing to come to assist our inquiry. We appreciate your cooperation. As with each of the relatives, I know it does bring some sad memories back to you when you discuss these events. But we do appreciate you coming in. In what capacity are you appearing before the Committee.

Ms BATTERHAM: I am the daughter of the patient Joyce Batterham.

CHAIR: Would you like to say something before we ask you questions?

Ms BATTERHAM: Yes, I would like to read a statement that I have prepared. Thank you for the opportunity to address the Committee today. I would like to draw from my experiences at the Royal North Shore Hospital in the hope that ways can be found to improve people's treatment, healing and caring. I have had many years experience with the hospital as an outpatient, as the mother, daughter and sister of patients in the hospital. Firstly I would like to comment on recent media reports regarding my mother's death. It was reported in *The Australian* that my mother waited nine hours before she was seen in emergency and I understand this statement was repeated here on the first day of the inquiry. The evening news on TV also reported that my mother died on the operating table. Neither of those statements were correct and I would like to remind the media that they have a responsibility to the public to get the stories right.

We definitely had to wait too long in emergency. It was about three or four hours before first being seen and about 10 hours before my mother was admitted to the aged-care ward. However it is what I consider to be unsafe handling procedures for amputees that was exposed in my mother's case which I would like to highlight because it was this that started the downward spiral for my mother and to my knowledge has not yet been addressed by the hospital and why I appear before you today in the hope that things can be fixed.

In fact, in a meeting arranged by Nick Rich, the patient representative from Royal North Shore Hospital, after my mother's death, I was told by the nursing unit manager of 11D and the divisional nursing manager that it had been assessed as being safe for one nurse to help transfer my 90-year-old mother, who had only one leg, from her wheelchair to a bed that had no rail or anything for her to hold on to. I still cannot understand how she was expected to be secure without a rail to help transfer her weight and adjust her position on the bed. I reject any notion that that procedure was safe.

When my mother became an amputee six years ago I was not able to bring her home until all the necessary rails were in our home and I had been trained by an occupational therapist in how to help the transfer, and I expected that the same standards would have been in place at the hospital. I have detailed the events that followed in my submission. One can only despair at what could have happened had I not arrived about an hour after her fall and started to insist she received the care and medical attention she clearly needed but was not getting. A doctor had not even been called despite the witness to the dropping of my mother suggesting this occur. The witness being an employee at the hospital declined to make a statement through fear of losing her job.

A 44-hour wait for the high-risk surgery after the drop which fractured her hip was not acceptable. The lack of communication between theatre and the ward was inhumane. Again, it was not until I insisted they ring surgery at midnight on the Sunday night, 12 hours after her scheduled operation time, that we were told theatre had closed for the night, yet they had not rung the ward to cancel. The nurse could not say when my mother's surgery would take place. The last meal she had had at that time was 36 hours prior and she was extremely parched and uncomfortable. The breakdown in communication continued the next morning when I rang the ward, about 8.00 a.m., to be told that my mother had gone down to surgery. I was very upset because I had wanted to be there to support her because the surgery was classified as high risk.

Was anyone going to ring me, I inquired. "We don't have your contact details", I was told. I said I was next of kin and my details were on the front of the file. I was told by the nursing unit manager that the file had gone with my mother to surgery. Is it true that in the twenty-first century

these details cannot be accessed by a computer database in the ward? I waited most of that day at the hospital hoping my mother would come out of surgery alive. Whilst waiting I decided to knock on the door that said "patient representative", thinking I could make an appointment for another time to talk about the breakdown of systems I was experiencing. Nick Rich invited me in immediately and encouraged me to talk to him about my concerns.

That day and in the ensuing three days he was a great support to me, and I am very grateful that that position exists at the hospital. There is no doubt that the nursing staff worked very hard. There never seems to be enough of them, and at meal times I found myself not only feeding my mother but all the other people in the room because the staff were just too busy for them. However, the defensive nature I experienced among the staff and the covering up of the failure to correctly assess and treat my mother after being dropped needs to be addressed. My mother was a hard working, highly respected and dignified woman. Her last six days at the hospital, which ended in her death, were a nightmare because of what I believe to be the hospital's negligence, sloppy work practices, not enough staff and system and communication breakdown. I really hope that the hospital will learn from this.

CHAIR: Thank you very much. We appreciate you sharing that with us.

The Hon. JENNIFER GARDINER: Your submission and your evidence, I think everyone would agree, is particularly distressing. So I for one offer my condolences. You have asked that the Committee particularly look at the question of the transfer of patients such as your mother, particularly amputees, from a wheelchair to a bed, and you have mentioned the occupational health and safety guidelines. You understand that the hospital is saying that what happened to your mother was within the guidelines in that a student nurse, a solo nurse, undertook that transfer or tried to. It seems to me that normally commonsense would tell you that such an attempt would be extremely dangerous, that you do not need occupational health and safety guidelines. Frankly, I cannot understand how that would come to pass.

Ms BATTERHAM: I find it difficult to understand and that is why I had to have a meeting afterwards to try to understand. To be told that it was all according to procedure still rocks me and it is something I just cannot accept.

The Hon. JENNIFER GARDINER: So there is no suggestion that the guidelines should be changed—

Ms BATTERHAM: No suggestion.

The Hon. JENNIFER GARDINER: —in light of this tragedy.

Ms BATTERHAM: No, not that I was told of.

The Hon. JENNIFER GARDINER: As far as you know. At the conclusion of your written submission you have said that the Coroner is still awaiting an autopsy report before making a decision whether there should be an inquest. Is that still the case?

Ms BATTERHAM: I just had word from the Coroner's office this morning that they have now received the report from the department of forensic medicine and the Coroner is at this time assessing what to do.

The Hon. JENNIFER GARDINER: Are you aware if it is normal for such a long time to pass in the transmission—

Ms BATTERHAM: I do not think it is normal. The contact I had with the Coroner's office expressed concern that it was taking that long.

The Hon. JENNIFER GARDINER: Is that right?

Ms BATTERHAM: Yes.

The Hon. JENNIFER GARDINER: When your mother first went to the hospital she was suffering respiratory difficulties and needed some alteration to her medication. Did she get any oxygen in the long wait?

Ms BATTERHAM: Yes. She had oxygen in the ambulance and then while she was waiting she also had oxygen.

The Hon. JENNIFER GARDINER: But then there was the wait where you believe, before she went to surgery, which turned out to be a very long time, that she was not even given a sip of water or any food at all.

Ms BATTERHAM: Yes, but just to clarify there are gaps there because she was in emergency for 10 or so hours, then went up to the aged care ward where she was going to be assessed by a doctor for her medication and hopefully allowed to go home. That was the Saturday morning. Then early Saturday afternoon was when she was dropped and she would have had her last meal, she had the lunch on the Saturday but did not eat after that.

The Hon. JENNIFER GARDINER: That was a very long time.

Ms BATTERHAM: Yes, and it was the next day, because she was supposed to have surgery on the Sunday she had nil by mouth from the Saturday evening and nothing at all during that Sunday, which was a very hot November day.

The Hon. JENNIFER GARDINER: I guess the general question that arises from your submission, for me at least, is: What happens to the many patients who do not have an advocate, an immediate family member such as yourself who spent so many hours at her bedside? What happens to those people when there is no way to keep an eye out for them if things tend to go wrong?

Ms BATTERHAM: That is a very real concern. I just could not imagine not being there for her because she needed me all that time for a whole multitude of things, and it is very distressing to think that people are not getting that care.

Mrs JILLIAN SKINNER: You said that you had to help with other patients in the ward. I presume that is a follow on from what the Hon. Jennifer Gardiner has just asked you.

Ms BATTERHAM: That is right. The meals would come and then patients, for whatever reason, could not open their juice or they could not get the knife and fork out or they needed help in some way so I was helping them as well because otherwise I have seen people have their dinner delivered and then before anyone could get to them it is taken away and they do not get their dinner.

Mrs JILLIAN SKINNER: There has been research that shows that people can be malnourished in hospital if they cannot open the gladwrap or use the foam cup because it is a hot drink. Was that the sort of thing you observed?

Ms BATTERHAM: That sort of thing, yes, definitely.

Mrs JILLIAN SKINNER: I would like to touch upon your evidence that despite you identifying yourself as next of kin you were not informed and the hospital seemed to have no record of that. Did you ask them about that?

Ms BATTERHAM: They had the record on her file. They all have a big file, and my mother was 90 years old so she had a really big, thick file. My details were on the front of that but, as I said, apparently that file went down with her to surgery and when I rang after she had gone to surgery they told me they had no way of knowing who I was or my details.

Ms CARMEL TEBBUTT: Thank you for coming in and sharing your experience with the Committee. It sounds so tragic and it must have been very difficult, so we appreciate you doing that. I want to ask about your concerns particularly with the hospital's communications with you and what you would like this Committee to recommend with regards to improving communication between the hospital and relatives in circumstances like you experienced.

Ms BATTERHAM: One of the most important communication issues that I found was this business where the theatre was not communicating with the ward and that when we were waiting for her to have the surgery—it was scheduled for midday on Sunday and still nothing at about 7.00 p.m. and I asked them to ring surgery to see whether it was still happening. There was some reticence it seemed to actually make that call, as if they seemed a little bit intimidated to do that. Maybe that was because they were agency staff or I am not quite sure why but there was some reticence to ring the theatre. I stuck at it and they finally did ring about 8 o'clock and they were told that surgery was still going and that they would let us know when it was to happen. Like I said, then we waited until midnight, still no word, and again I insisted that they ring, only to be found that the surgery had gone home for the night.

Ms CARMEL TEBBUTT: And they could give you no explanation of that.

Ms BATTERHAM: That was a very big breakdown. Originally with the deferment of the surgery it was because there had been an emergency or something, somebody else had come in, but that is no excuse for not communicating and I think that that is a very big flaw. When I had the meeting with the staff afterwards they did acknowledge that and they said they were looking at ways to improve that so I am hoping that that has happened. Then in terms of communicating with me because it had happened on the weekend and then the Monday morning is when the regular staff came back and the nursing manager had not been there all weekend, had not known what had gone on at all but still the fact that they did not ring me when she was going down to surgery I think it is abominable.

The Hon. AMANDA FAZIO: I want to ask you about your submission; in it you said that you had previously had a number of negative experiences at Royal North Shore Hospital and that you had actually asked the ambulance driver to take you and your mother to Sydney Hospital. Can you elaborate on that for us and tell us a little bit about why you had those concerns?

Ms BATTERHAM: The concerns around going to emergency were mostly about time, about how long we had to wait. In the past with children with broken bones and myself, after a car accident, there were always very long waits at North Shore emergency. Once we got the treatment I was always very happy, I was never faulting the staff, the medical expertise or any of those issues; it was more about what we talked about, the blockage that happens in emergency and the long waits. I could only compare that to Sydney Hospital where I had been with my mother a couple of times. That was nothing like that. We were seen within an hour, treated, up in the ward, a totally different story. Naturally I was advocating to go to Sydney Hospital.

CHAIR: In your comments you said that the six days that your mother was in the ward was a nightmare. You mentioned the food problems. Were there any other issues that occurred in those six days in care?

Ms BATTERHAM: There were issues constantly. Things were happening right down to even after my mother died and the whole business to do with the Coroner, there was no talk about the Coroner to start with, and it was 24 hours after my mother died that I got a phone call from the doctor to say that my mother's case had to go before the Coroner because she died as a result of a fall in hospital, and that the police would ring me and I would need to go to the hospital to answer some questions. That was 24 hours after my mother died. The police did ring me on that Friday afternoon and asked me could I go into the hospital to talk to them. It was about 2.30, and I said no, I could not, I did not have a car at the time. I said I could go in later in the evening, about 6 o'clock. As it turned out, that was exactly one week after we went there with my mother in the first place.

The two young police officers who interviewed me took me into a little room and asked for a history of my mother's medical record. It was only 24 hours after my mother had died. My mother was 92 years old, so she had a very long medical history. What relevance was that to her body being identified for the Coroner? A social worker from the hospital was supposed to liaise between myself and the police, but I had spoken with one social worker a couple of days beforehand, on the day of my mother's death. There seemed to be no record. The police had to find another social worker who was called in, who knew nothing about my case. So I had to brief the social worker about the case as well as those young police.

I think the whole management of that was not very humane for relatives of patients who have to go through that. I do not know whether that is something to do with North Shore or whether it is to do with those processes that happen everywhere. It is very important that that aspect is looked at too. What other dramas? I have highlighted quite a few of them in my report.

CHAIR: Were you happy with the level of care of your mother during the six days? You have mentioned the problems with the food, but were there any problems with the nursing staff?

Ms BATTERHAM: There were communication issues. When my mother came out of surgery, they first told me that her slurred speech was probably just because of the anaesthetic and that the surgery was a great success. That just did not happen. She did not regain her speech and it was then decided that she must have had a stroke in surgery, because she could not move her arms very well either and had restrictions.

CHAIR: Do you have any comment about the level of care by nurses after the operation?

Ms BATTERHAM: At that point, that night, she was transferred from the aged-care ward down to the orthopaedic ward. I was there and helped with the transfer. The wards men took her down to the next floor and she was just coming out of her grogginess and was thirsty. I asked the nurse when we got down there that she would really love a cup of tea, and could I get her a cup of tea. The nurse said, "Sure", and showed me where the kitchen was. I got her a cup of tea, came back, gave her a couple of sips and then the other sister came in and said, "Oh, she can't have anything, she is nil by mouth". I thought what is going on here? The communication again was not happening. Generally the care was okay, but there were things happening all the time and I felt, again, if I had not been there who knows what would have happened?

CHAIR: Thank you for coming in. The Committee appreciates you sharing your story, which brings back all your sad memories. What you experienced during those days was very traumatic for you.

(The witness withdrew)

PETER ALEXANDER ROBERTS, Emergency Physician, Royal North Shore Hospital, sworn and examined:

CLARE ALICE SKINNER, Emergency Registrar, Royal North Shore Hospital, and

PAUL ALEXANDER CUNNINGHAM, Emergency Physician, Ryde Hospital, affirmed and examined:

CHAIR: In what capacity do you appear today?

Dr ROBERTS: As an emergency physician and the Area Network Chair for Emergency Medicine for the Northern Sydney Central Coast Area Health Service.

Dr CUNNINGHAM: I am an emergency physician working in Sydney public hospitals and currently employed at Ryde, which is co-administered with Royal North Shore Hospital.

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

Dr ROBERTS: Yes. The key issues at Royal North Shore and more broadly are beds per thousand population, work force, and emergency departments admission decision. Australia-wide there is not enough beds per thousand population and peculiarities of the Australian health system make this worse for emergency patients. The funding formula takes into account private beds and this makes it worse in the area around Royal North Shore. It is expensive and harmful looking after patients on ambulance trolleys and in emergency departments when what they need is a ward or mental health unit.

The work force problem is related to that, no other part of the health system accepts patients' entire episodes of care being dealt with by someone who is acting beyond their training. There are not enough emergency specialists in New South Wales. We cannot get doctors to choose to train in emergency medicine. We cannot train a new generation of CMOs or middle grades. It is hard to get nurses to choose the work environment where they do not have the time to show the compassion that they feel. The reasons are the lack of beds and the work force shortage itself, producing a vicious cycle.

For emergency departments, there is an issue related to the bed shortage and work force shortage, which is the admission decision issue. We need a system that accepts the admission decision made in the emergency department; it will not happen without a bed to put the patient into and someone who knows what they are doing to see the patient in the emergency department. We need to urgently do three things: access an extra 0.5 to 1.0 beds per thousand population, recruit an expert work force, and then develop systems that put the admission decision in the emergency department. The key performance indicator to introduce is occupancy at 85 per cent.

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

Dr SKINNER: I do. I have worked as an emergency registrar at Royal North Shore since 2005. That means that I am in training to become a specialist emergency physician. I am also a health work force researcher. The problems I will raise today are by no means confined to Royal North Shore and it is fair to say that if staffing problems are now entrenched at Royal North Shore, most other hospitals are doing it tougher. I want to extend my sympathies to Jana Horska and Mark Dreyer and other patients and their families who have been disappointed in the care they received at my hospital. I assure you that clinicians in the emergency department do our job because we like to help people. We take failures very seriously and we feel them very deeply.

I thank the Committee for the opportunity to speak with you today, and hope that we can effect some positive change for patients and clinicians. You have heard from my colleagues Dr Day and Dr Joseph that New South Wales has the lowest ratio of emergency specialists to population in Australia and that no emergency department in New South Wales, including North Shore, meets current AMWAC medical staffing guidelines. It has been estimated that New South Wales needs to

train over 100 extra emergency physicians to meet the shortfall, yet in the last year only 20 doctors have begun specialist practice in New South Wales.

A study conducted by the University of Sydney Workplace Research Centre in May this year found that only 42 per cent of accredited training positions in emergency medicine in New South Wales were filled by local graduates. The remaining jobs are filled with overseas doctors, locums or are left vacant. This has dire implications for the future of emergency medicine in New South Wales. Being an emergency registrar is very hard work. We see large numbers of critically ill patients, we supervise junior staff, we work antisocial hours and we need to maintain skills across the full range of medical specialties. The workload has been steadily increasing; an extra 4,000 ambulances per year are coming to North Shore, yet staffing and resources have not increased.

The work is intellectually and emotionally intense. Breaks are few and far between. To put this in context, the workplace survey found that two-thirds of emergency doctors rarely or never take a meal break on a 10- or 12-hour shift and less than one-quarter of emergency doctors are able to take a toilet break as soon as they need to. Registrars on my level supervise the department on night shift and after hours. AMWAC guidelines stipulate that we have on-site specialist cover for 16 hours per day, yet we do not have enough emergency physicians to provide this support. This means that registrars are working unsupervised on busy shifts, which can leave registrars who are trainees feeling exposed to medical and legal risk.

Registrars provide direct supervision for junior staff in the department yet we often work short, so we are unable to give adequate support to them in turn. Recently my department has employed large numbers of overseas doctors and locums to fill vacancies. While some locum doctors are fantastic, as a group they have variable skills and experience and they are not orientated so they require increased supervision. They are also paid in the order of \$100 to \$130 per hour, which compares to the registrar rate of around \$40.

Overseas doctors are also variable. For some doctors in our department language and clinical skills are problematic. In coming years we have almost doubled the number of the interns graduating from medical schools yet there is no plan for how to supervise their training given the shortage of registrars and specialists in the system. Access block is a source of stress. It is not uncommon for the entire department to be full of admitted patients waiting for a ward bed. It means that emergency doctors are not only seeing new patients often in the waiting room or in the corridor, but they are caring for admitted patients.

Mental health patients can spend days in emergency waiting for a psychiatric bed, which is inappropriate and may be distressing for staff, for the patient and for other patients in the department. We also see many frail elderly patients referred from residential care with limited handover of information. Discussions about resuscitation and invasive treatment are often had in the busy emergency environment for the first time, which is emotionally distressing for the patient and the doctor. Burnout is a major issue facing emergency trainees. It is difficult to feel valued or to see hope for the future.

Over one-third of emergency specialists and registrars have stated that they do not anticipate a long-term career in emergency medicine in New South Wales. We need to turn that around because our patients deserve high-quality, specialist-led emergency care. A good start would be providing enough beds to solve access block, which would allow clinicians to feel that they have some chance of doing their job properly. I am also concerned that the new hospital has been raised as a solution to all these problems but we are yet to see a brick laid, because these problems need to start being solved now. Thanks.

CHAIR: Dr Cunningham, did you wish to make a statement?

Dr CUNNINGHAM: My name is Paul Cunningham. I am an emergency physician. I have a simple message: That there are inadequate beds in New South Wales public hospitals and that this and other factors have decimated the workforce in emergency departments. These are the emergency departments that you and your constituents and your families need, and may desperately need urgently. I have spent 35 years in New South Wales' hospitals. I know a thing or two about them. I commenced in 1973 as an electronics technician at the cardiac unit at Prince Henry Hospital. I

subsequently studied medicine at Sydney University and for the last 20 years have been practising as a specialist in emergency medicine. I was director of the first private emergency department in New South Wales at Ashfield Masonic in 1995 and also opened the fourth private department at Kareena, Sutherland, in 1999.

I have been on both sides of the public and private fence. For the last eight years I have been at Ryde Hospital co-administered with Royal North Shore. I was a member of the Emergency College National Council for four years in the 1990s and was chairman of the New South Wales faculty several years in the 1990s, a position now held by Dr Tony Joseph, who has spoken to you already, I believe. The reason we are all here today and the reason that Ms Horska was allowed to miscarry in a public toilet at Royal North Shore Hospital is quite simply because there are inadequate acute beds in the public hospital system. This is simply demonstrable in two ways: First, access block developed simultaneously with the closure of beds in the 1980s. This is a simple fact. I saw it happen on a daily basis with my own eyes.

In 1980 there were 6.8 beds per 1,000 population in New South Wales. By 2000 there were 3.8. If you do not believe these figures or you do not believe me, then I suggest we look at a second piece of evidence—international comparison. The average number of acute hospital beds per 1,000 population—a very simple figure that I would like to stress again; the number of beds per 1,000 population—is four per 1,000 throughout OECD nations. In Northern Sydney the number of acute public beds is under two. Even adding the number of private beds in Northern Sydney the total is well under the United Kingdom number and the OECD average and is half the number in Germany.

The shortfall in Northern Sydney, by these figures, is the least 500 beds, not 12. The simple fact is we are commonly turning our emergency departments into disaster areas. This is why far too few people with competence and commitment are now prepared to train or work there. I will finish by asking you: How has this been allowed to occur? I will answer the question: By a combination, I feel, of incompetence by somewhat amateurish head-in-the-sand bureaucrats and a more sinister but not entirely conscious conspiracy.

The two key groups who report to our own elected representatives on health are essentially doctors and nurses and I feel that many of them have given bad advice or ignored the problem because of somewhat perverse incentives in the system. The most influential doctors have become overly focused on short stay procedural admissions for advanced technical clinical work. Some of those people have presented to you over the last week or two, so they have become focused on moving patients in and out of hospitals as quickly as possible and that has become their technical focus and also, if I may coin a phrase, because that is where the money is. The other major medical lobby—the community focus purveyors of prevention would have us believe prevention will stop people becoming seriously ill at all. This is nonsense. Prevention is extremely important but it cannot control people's ill health throughout their lifetime.

Just to conclude, I feel that nurses, the other major group that has been advising our politicians and bureaucrats over the last 20 to 30 years, have somewhat ceased to esteem in themselves the principles of bedside care and they want to do other things. A lot of the other things they want to do are very worthwhile but first things must come first. We need bedside care and we need beds available. This is a looming disaster and it has been somewhat hidden by bed closures, but it is hidden no longer. Thank you.

CHAIR: Thank you Dr Cunningham. Mrs Skinner?

Mrs JILLIAN SKINNER: Dr Skinner, I have read much of your writing on this issue. I want to ask you particularly about training enough emergency specialists—and all of you would have a view about this—to meet the AMWAC staffing formula. It is not generally understood that this trend happens in the emergency department; it is a State Government responsibility, it is a responsibility not only to provide those training places but the experienced doctors in the emergency department the time and the wherewithal to make that training happen? Could you comment on that?

Dr SKINNER: I think that is right. People do not understand that the training job is not just a job. It also is a matter of working in a department where you see an inappropriate case-mix, so you see a number of patients with different presentations and you are adequately and appropriately

supervised during your time. I think as workloads have got busier in emergency departments the other role of emergency departments, which is training—and that is not only of future emergency specialists but also of all of the interns and residents who pass through the New South Wales system occurs in that department and that has been allowed to fall by the wayside as we struggle to meet clinical targets.

Mrs JILLIAN SKINNER: Dr Cunningham, do you have a view about how we encourage people when we get more people trained up as emergency specialists?

Dr CUNNINGHAM: If I understand your question, I think it is true to say that in various specialties there is often a difficulty between training and service. The service is provided by the doctor who is training. Somehow mysteriously in days gone by that seemed to be somehow balanced but it is no longer balanced and we are forced to look at providing service to the community somewhat separately from training and the two things are really separate issues. I am concerned that the environment in the emergency department is driving away good people who are either discouraged from training or leave to pursue other things, having trained.

Mrs JILLIAN SKINNER: Are we going to get to the point where we just do not have enough senior specialists to do that training to get the next generation of doctors into our workforce?

Dr SKINNER: Yes.

Dr CUNNINGHAM: Yes.

Mrs JILLIAN SKINNER: This is something that the AMA and other professional groups have been speaking about. I understand that there are something like 100 interns for next year but that until quite recently it was not known whether training places could be found for them in our public hospital system. Are you aware of that?

Dr SKINNER: I understand that was the case and I also think that in terms of the Department of Health, they consider an intern a doctor and we all know that an intern is not a doctor. An intern will become a doctor but they only do that if they are nurtured properly.

Mrs JILLIAN SKINNER: And the nurturing that needs to be done needs time away from clinical looking after patients, does it not?

Dr ROBERTS: Yes, there is that tension between service and learning to be able to recruit the people. To train in emergency medicine and to train them properly there has to be enough quarantined time and teaching to make that possible but as well as that, you have to get people to put their hand up to train in the speciality, and in the environment without enough beds and with the inadequate workforce, it produces a vicious cycle where they will not agree to do that training. They will choose something else. The way of breaking that cycle seems to be improving the environment by having enough beds.

Mrs JILLIAN SKINNER: Your submission makes the point that a bed is not a bed, if you like. A lot has been said earlier in the evidence that a bed might be something out in the community, it might be a bassinet, it might be a dialysis chair. From the point of view of emergency, a bed is an acute bed where you can put sick patients who need to be admitted?

Dr ROBERTS: Yes, that is right, and it refers to beds in the wards or outside of the emergency department rather than keeping them indefinitely in the emergency department.

Mrs JILLIAN SKINNER: Could you explain, please, what is meant by beds in the community? I think people are unaware of this.

Dr ROBERTS: This concept seems to have arisen where in counting beds there has been the term "virtual beds" where instead of opening, say, two beds in a hospital, there would be what someone thought was equivalent to two beds in the hospital, having a nurse go and see the patient in the patient's home and give them intravenous antibiotics and someone made a judgment that that was equivalent to two beds in the hospital. It is a very important thing; it does help to reduce the number of

admissions but they are not beds and in the calculation of occupancy, which is the average length of stay times the number of admissions divided by the beds, you are counting those in two places. It mucks up the arithmetic if virtual beds are counted. I have also heard of a CT scanner being counted as two beds, taking the view that introducing an extra CT would reduce the length of stay, which is true, but it is not beds.

Mrs JILLIAN SKINNER: Dr Skinner, you talked about locums and overseas trained doctors. We need both.

Dr SKINNER: We do need them.

Mrs JILLIAN SKINNER: Can you please comment more on the practice of increasing numbers of overseas trained doctors and concerns that have been expressed about the level of skill, their training and where they go to from there?

Dr SKINNER: It is very hard to do this in a sensitive manner.

Mrs JILLIAN SKINNER: I understand that.

Dr SKINNER: It is very hard also to tar all the overseas trained doctors with the same brush. There are a number of doctors in our department who come from the United Kingdom and Ireland and are trained in universities on which Sydney University was based and they are not the issue. We are increasingly seeing doctors who have come from environments outside of Western medicine or outside of the developed world and their credentials are largely unknown. There are a number of issues there, so there are issues of communication, cultural appropriacy and clinical skills. For instance, many of the doctors who come from the subcontinent come from a medical culture where they do not perform their own procedures. So if they are suddenly working unsupervised in an emergency department where you need to be able to put in a set of stitches or you need to be able to do some bloods for yourself, or be able to set a fracture by yourself, they do not have the appropriate skills.

Mrs JILLIAN SKINNER: So what does this mean? You have to spend time training them and supervising them?

Dr SKINNER: I am aware of how difficult it would be. I would find it immensely difficult to work overseas. Ideally you would have the time to supervise them and to teach them up to our system but unfortunately our patient load is so much that we do not have that time. So often you find tasks for people to do to try to keep them away from the patients where they will take up more of your time than they would had they not been there at all, which is a very sad thing to say, and I do not mean it in a hurtful fashion.

Mrs JILLIAN SKINNER: I understand that. Is there a prior step that we should consider, maybe training them up before they go into the emergency department?

Dr SKINNER: There is a process through the Australian Medical Council where doctors coming from overseas must be credentialled in Australia. It used to get used a lot. As we have got more desperate, people have been put on the floor without that process. That process has fallen by the wayside. We need to do that.

Mrs JILLIAN SKINNER: To resurrect that.

The Hon. AMANDA FAZIO: Dr Skinner, you may have touched on this area already, but I would like further comment from you. We understand that you have been very involved in trying to improve conditions for young doctors, particularly as the system manages with an increasing reliance on locum medical officers. Given the worldwide medical workforce shortages, what can be done to boost the number of graduates coming through the system? How can we make it more appealing?

Dr SKINNER: We can deal with the number of graduates by increasing medical school places, although I would have some reservations about fully fee paid places. I think it has been demonstrated from the HECS [Higher Education Contribution Scheme] generation that people who

pay through the nose for their medical education do not really feel the same love of working in the public system or the same sense of duty as those who do not. So I think we can deal with the graduates. The problem is the next step. There is good evidence that 5 to 10 per cent of any graduating medical year will drop out. But they drop out to do other things, often health-related things.

What we need to do is to make sure that training experiences are good. So you walk into a job, you know that you will have the job, you have got tenure, you know that someone is responsible for your training, that training will be tailored to what you need and it will be done in a reasonable amount of time. At the moment the dead space in training, the costs of training and the fact that quite often the job you thought you were applying for is not supervised as you thought, all of these are disincentives for training at the moment.

The Hon. AMANDA FAZIO: Would you see that done by way of an extra allocation of resources or time for teaching within hospitals as distinct from treating patients?

Dr SKINNER: We need to learn from our nursing colleagues who have a nurse educator system in place in the hospital. We do not have the equivalent in medicine where people are rewarded for their teaching roles as opposed to the clinical or research role.

Mr MICHAEL DALEY: I pose this question to all of you: What role would you like to see clinicians play in developing creative solutions for the pressure our system is facing, particularly in respect of the growth of or pressure on emergency departments?

Dr ROBERTS: Clearly, I would like to see the involvement of clinicians or clinicians by representatives involved in the decision process and the generation of creative solutions and for that process to be transparent. So that really just means involving them.

Dr CUNNINGHAM: There has been a fair bit mentioned in the transcripts I have seen about the lack of clinician involvement, which is true. Unfortunately, clinicians commonly do not aspire to administration, certainly not medical clinicians. It is not something that is top of the heap. That is a real problem because leadership, ambition and planning are really the problems we are talking about here today. We have to find some way of getting around that. If you look at North Shore and some of the things that have been raised with you that I have seen in the transcripts, it is sometimes an issue of the squeakiest wheel getting the oil. Sometimes there is empire building. Sometimes there is an imbalance in the clinical input into management, which I think we can only overcome by strong professional management but also a formula for allocation of resources that is fair. I am coming back again to the beds per thousand-type concept: that we make sure it is not who is in the media most that is getting the money but who needs the money via an appropriate formula.

Dr SKINNER: I would also like to raise the point that we currently have very few training programs that include some training in management or administration. That should be part of all medical education. Clinicians should be encouraged to participate. There is a strong evidence base around how to run a health service, and we should use that as well.

Mr MICHAEL DALEY: One of the solutions that has been put to this Committee in evidence is that it may be appropriate to upskill your nurses to do an increased number of tasks. What do you say about that?

Dr ROBERTS: There is some advantage in some workforce redesign, and we are behind in this country. There has been a tendency to use the very best nurses and then take them away and give them a role that substitutes some of the tasks of a doctor. Effectively, the emergency department that loses its best nurses to that role substitution is not ahead. It is some of the least trained and even non-medically trained tasks that need to be taken over. There certainly is room for workforce redesign. There has been lots of work done on it, and it just needs to be implemented. The evidence is that it is cost-neutral or saves money and improves the workplace. But all of these are secondary concerns to the paralysis that is induced by having to look after yesterday's patients while you are trying to see today's.

Dr ANDREW McDONALD: The OECD figures are from 2003, is that right?

Dr ROBERTS: Yes.

Dr ANDREW McDONALD: Do you have any updated figures for New South Wales and the OECD?

Dr CUNNINGHAM: The figures are available. The latest OECD summary is always two or three years out of date, unfortunately. They are the latest ones that I could find.

Dr ROBERTS: The Health at a Glance figures, the OECD ones, are from 2003 and the AHHW report, which has some of the figures, is from 2006.

Dr ANDREW McDONALD: Would you comment on the support from outside the emergency department, such as the medical and surgical teams?

Dr ROBERTS: This is where the admission decision issue comes in. There are some delays and problems induced by not having beds and not having a well-trained workforce that leads the departments outside the emergency department not to necessarily trust the decision that has been made and be prepared to move forward with it. There has to be a competent, trained workforce in the emergency department to make that trust happen. Once that occurs there has to be some change so that the admission decision, the unit that the patient is going to be going to, occurs in the emergency department and in a timely way.

CHAIR: As a registrar of the emergency department, do you have any views on how Mrs Hoska was handled with her miscarriage?

Dr SKINNER: Yes, I do, but I was not working on the night so I am reluctant to comment. I generally say that I would hope all patients presenting to the emergency department are treated with dignity and respect and have the opportunity to be treated in a timely fashion. That was not the case that night and that embarrasses me.

CHAIR: Would that time delay be unexpected?

Dr SKINNER: Unfortunately it is relatively normal in emergency departments across New South Wales that there are not beds for new patients who present to the front door.

CHAIR: Do you find any problems with the priority listing system? Do you think it is satisfactory or adequate? Does it need to be revised?

Dr SKINNER: I think it is good for what it does, which is to prioritise the life-threatening nature of disease. But I agree with comments made particularly by Dr Matthews that miscarriage does not sit easily within that scale because it is something that is emotionally distressing whilst not being life threatening. In emergency we try to see people where it is emotionally distressing early if we can if we are aware of it—we are human beings. But if we are busy, unfortunately those triage categories hold and miscarriage does not sit well.

CHAIR: In your role as a registrar, how would Mrs Hoska have eventually seen a doctor in the normal process?

Dr SKINNER: Quite often if the nurses are very concerned about someone they will come and find a doctor immediately to see the person, if they have the opportunity. Normally what would happen is that she would be picked up in a matter of course in terms of her priority. So the doctors, as they become available, go and pick up the next patient from the triage area.

CHAIR: You do not roster them; it is automatically to the next one that is available?

Dr SKINNER: If you are the in charge registrar in the department you have some role in keeping an eye on who is waiting, making sure that patients are seen in a timely manner and managing your junior staff. That is hard because it is different on every shift.

CHAIR: Normally she would go to the first junior doctor that is available?

Dr SKINNER: She would, unless I particularly thought that someone else would be better. I have to admit as a thirty-something woman who works in emergency, I would see a lot of miscarriages. The nurses try to choose someone who is female, relatively not young, not pregnant and relatively sensible.

Dr CUNNINGHAM: If I could make a comment on the comments that have been made about the apparent unfeeling, uncaring attitude of some of the nursing staff in the triage process. It comes back again to the single major point we have been trying to make, that those people are on the front line of a dysfunctional process. To show extensive warmth and compassion is virtually impossible when you are trying to restrict and delay. The people who are self-selected to keep on doing that job day in and day out are the ones who can cope with that. Once the system is freed up and we open our doors appropriately to provide basic linen and a mattress for a person who requires that in a bed, then the staff's natural compassionate nature can be let come through. It is a sign of dysfunction in the system.

Mr PETER DRAPER: Dr Skinner, thanks for giving us a better understanding of the stresses and pressures in emergency, especially the challenges of training. Earlier you mentioned KPIs. Given the environment you are working in, are the KPIs realistic and achievable?

Dr SKINNER: I think Peter actually mentioned the KPIs. The major KPIs that we are encouraged to meet are the triage category benchmarks, which I am sure you have seen. For each category there is an acceptable waiting time. Those are the ones that we try to meet. Although, if you are in a busy department, you are much better off spending the time you have seeing the person in front of you properly than you are to be constantly worrying about the waiting lists. I think we are aware of the two.

Dr ROBERTS: They are reasonable but they are not achievable. The best emergency brains around the State cannot make them be achieved.

Dr SKINNER: You need beds and doctors and nurses.

Mr PETER DRAPER: Yesterday we heard from Dr Hoyle that he thought the budget for the area was more than adequate. Do you have any thoughts on that?

Dr CUNNINGHAM: I know little enough about statistics apart from that money becomes quite difficult. I do not know whether it is a total net shortfall or a misallocation. I am suspicious that there is substantial misallocation. I go far enough back to remember Gough Whitlam opening the federal community health centres, which were then taken over by the area administrations, as far as I understand. The area administrations have a huge responsibility. They are providing funding and management for community-based services as well as for multiple hospital-based services. It is almost impossible to know where the money is going. I was involved in clinical redesign last year. We had tremendous difficulty finding out what the functions of the area were and who the staff were. It is of immense complexity.

Mr PETER DRAPER: For the Northern area?

Dr CUNNINGHAM: We looked at Northern. I do not know the answer to that question, whether it is a net shortfall or a misallocation.

Ms CARMEL TEBBUTT: Dr Skinner, and the other two doctors as well, I think you mentioned in your introductory comments the fact that locums can earn much more money, which I assume can make it difficult to recruit permanent doctors. Do you have any ideas about how we could better recruit and retain emergency positions?

Dr SKINNER: The trouble is at the moment we effectively have a black market in the emergency medical workforce. We are of low status. That is a problem with registrars. Our training conditions have slipped and we see a lot of patients in pretty nasty conditions. There is a black market to do easier jobs for more money. There is a certain cracking point where that is where people head. The only answer is to make the mainstream workforce and the mainstream working environment

much more attractive by managing workloads and managing training. I do not think it is about money, I think it is about the working environment.

Dr ROBERTS: I ditto that. It is the same recruitment task that any employer has. Remuneration is one thing but the conditions, the ability to do your job in a non-frustrating way, to enjoy your work, to get education and all the side benefits, they are all important too. It is a matter of recruitment like in any other industry.

Dr SKINNER: Just to illustrate, though, we have difficulty, actually, employing locums to do the registrar shifts at Royal North Shore because they are recognised in the locum market has being really, really hard. So that becomes really illustrative when you cannot even recruit a locum to fill a vacancy and you think, "Hang on, in the mainstream, surely there is something that needs to be done to help us, too."

The Hon. AMANDA FAZIO: In general, do you think that the career paths are career defined and are rewarding enough for people who specialise in emergency medicine?

Dr ROBERTS: Emergency medicine is unique in that there is very little private component. There is very little that is Federally funded through Medicare. Doctors choosing a specialty, if money is a factor, would not choose emergency medicine.

Mrs JILLIAN SKINNER: We have heard of the need for clinical service plans, particularly with the roles of all the various hospitals—Ryde, North Shore, Hornsby and so on and so forth—and that there is a commitment to have one done in the next six months. But many of the doctors giving evidence have said that they have never been involved. They know that it happened before, but they have never been involved. Can you make comments about that, and how important it is?

Dr CUNNINGHAM: This is the redevelopment plan for North Shore?

Mrs JILLIAN SKINNER: The clinical services plan for the area and particularly the role of the various hospitals.

Dr CUNNINGHAM: What I know about North Shore is that I was simply appalled to see the land was being sold off, which cannot be regained.

Mrs JILLIAN SKINNER: I am talking about the plans as to what services will be available in what hospital.

Dr CUNNINGHAM: The Royal North Shore Hospital tries to be all things to all people. Clinical services move to North Shore Hospital like moths to a flame or iron filings to a magnet. There could be a decentralisation which could foster and give lifeblood to the smaller hospitals but maintain the spoke and wheel set-up.

Mrs JILLIAN SKINNER: So, more services to Ryde, for example?

Dr CUNNINGHAM: Well, you would either give more services to Ryde and nurture the hospital so that it can provide a local service to 200,000 people in its drainage area, or you close it down.

Dr SKINNER: I would have to say that when we did the locum report we interviewed a large number of doctors and nurses for that report. The major thing they said about attractiveness of their nursing department is critical mass. They feel that they have the right staff and the right equipment to treat people in the manner they would choose.

Dr ROBERTS: This issue of Ryde, and it is there on the northern beaches—my experience is that it has been too political to be discussed. For as long as I can remember around the North Shore Hospital there have been questions over whether, say, Ryde should continue as an independent hospital or be closed, and not having clarity on that always makes it difficult—the same with the northern beaches. The economies of scale by merging two hospitals are apparent in emergency medicine, certainly. Only needing one anaesthetist, surgeon, emergency physician and so on on-call

for the two places would be an advantage and having a critical mass. That planning process has been sort of held up for fear of saying something politically unacceptable.

Mrs JILLIAN SKINNER: It will happen now with a promise to have, within six months, a clinical service plan, do you think?

Dr ROBERTS: I am sure if they have promised, there will be a plan written within six months.

Mr MICHAEL DALEY: We have traversed State and Federal issues here today. I have to say, as a State member of Parliament, one of the things that concerns me about the Health portfolio is just that it seems to have a burgeoning demand. We have had people filling the witness chairs for days and days saying, "We need more resources. We need more money." Health currently takes up 30 per cent of the State budget. In less than 25 years it will take up 100 per cent on current trends. I think the Federal Government needs to do something—the Federal Government of the day. What do you see as the role that the Federal level will play in terms of Health resources in the future?

Dr ROBERTS: I would like to see access for emergency patients to private hospitals.

Mrs JILLIAN SKINNER: Hear, hear!

Dr ROBERTS: Because a significant component of our national Health budget goes to the private sector. The way our health system is arranged, emergency patients cannot really access that, except at a few. Now in Sydney it is only three private hospitals that have emergency departments. Even those who might bypass an emergency department with a medical illness, and that represents 70 per cent of our admissions, they are just not catered for in the private sector. There is no requirement for the private sector to look after them and they are less lucrative for the private sector. One thing that could help is ensuring access for emergency patients to the private hospitals.

Mr MICHAEL DALEY: Is there any literature that you would be able to provide to this Committee?

CHAIR: We have to wrap it up, Mr Daley.

Mr MICHAEL DALEY: I am just asking if there is any literature that would be available to the Committee on that.

Dr ROBERTS: I would have to think about it and get back to you.

CHAIR: Thank you very much for living your evidence at our inquiry. We appreciate all that you do. It is very important to know about staffing matters of emergency departments.

(The witnesses withdrew)

ANDREW MACLEAN ELLIS, Visiting Medical Officer—Orthopaedic Surgery, Royal North Shore Hospital, sworn and examined.

DAVID HARRY SONNABEND, Chairman, Department of Orthopaedics, Royal North Shore Hospital, and

JEFFREY SLEYE HUGHES, Former Senior Orthopaedic Consultant-Visiting Medical Officer, Royal North Shore Hospital, affirmed and examined:

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

Professor SONNABEND: Yes, sir. I would like to, if I may, on behalf of both Dr Ellis and me, and then Dr Ellis wishes to add just a short rider to that. Mr Chairman and members of the Committee, we thank you for the opportunity to present these observations. I speak as the Chairman of the Department of Orthopaedics. It is a department with a long proud history. It is the busiest surgical department in the Royal North Shore Hospital. It is a department with numerous members having international reputations. Fellowships in that department are sought on a regular basis by surgeons from around the world. It is the department that, with Sydney University, has the greatest surgical scientific output. Importantly, it has the highest consultant involvement in registrar supervision in the State of New South Wales.

North Shore is a level one trauma centre. It caters not only for the 1.2 million people of the Northern Sydney Central Coast Area Health Service but also for tertiary referrals, particularly spinal and poly trauma from around the State. Dr Ellis is one of our most active and most experienced trauma surgeons. He in his own right handles approximately 20 per cent of that trauma. Dr Ellis and I would like to list a series of observations to which we would be happy to speak, if you wish. North Shore is a once-great hospital which has been driven into decay by years of cynical, secretive and unsympathetic administration.

Within the Department of Orthopaedics there is universal commitment to the public good. All of our current consultants could retreat comfortably to full-time private practice and lead easier lives. Instead, together with their nursing and allied health colleagues, they continue to endure multiple frustrations. These include inadequate emergency theatre sessions; steadily reduced and obstructed access to in-hours theatre time, often with prejudicial effect on their patients; failure of theatre administration to recognise the clinical importance of early intervention in the treatment of skeletal trauma; unpredictable elective admissions, often cancelled without notice; frequent cancellations or curtailments of theatre lists; and, importantly, major shortages of essential equipment which makes procedures either difficult or dangerous.

I would like to acknowledge that this is despite the appreciated strenuous efforts of our most recent general manager, the latest in a long line of general managers. Some surgical and nursing colleagues have already voted with their feet, including my colleague Dr Hughes. The patience of the remainder is not endless. We have repeatedly been fobbed off by senior administration who have avoided any significant engagement with us and have not responded to our requests for help or our letters, repeatedly, of concern and complaint. The enforced virtual irrelevance of the Medical Staff Council of our hospital reflects the increasing lack of consultative involvement of that council.

With the current expensive redevelopment of the Royal North Shore Hospital, we had hoped that the universal consultant recommendation for an institute-based design, already proven in numerous other hospitals, might have been heeded. Instead, without any engagement, without any significant consultation, a pre-doomed patient-centred model has been chosen. It is the doctors and the patients, not the bureaucrats, who have to live with the inevitable failure of that model. Like the rest of the hospital staff, we are demoralised by the gross uncertainty which surrounds future plans. Despite numerous inquiries, and I can describe them if you wish, and multiple reviews and although 70 per cent or more of our work is emergency and trauma related, the orthopaedic surgeons continue to hear rumours regarding possible transfer of orthopaedics to Ryde or to Hornsby hospital on a regular and an irregular basis.

Especially with regard to Ryde hospital, the department feels that we are pawns in a political game in which patient welfare is merely a minor consideration. Gratuitous ill-informed criticism from various medical spokesmen from the Department of Health has further lowered our morale and our concentration. There has been a lack of transparency in budgetary management. Efforts at cost reduction by excessive Christmas closures and so-called rotating theatre closures impede good medicine. Our commitment to spinal injuries, in particular, further harms our budget. I know others have said that our budget is adequate, but when we look at what is lacking and what we cannot obtain, clearly it is not—at least from our department's point of view.

While our budget is largely based on area population, we provide a very extensive statewide spinal service. The Spinal Injuries Unit, an important part of the hospital, alone costs over \$5 million annually. It is not supported by significant specific funding. Numerous other tertiary spinal referrals, which do not make it to the Spinal Injuries Unit and are treated outside that unit, place additional and greater strain on our budget. Despite the numerous committees, inquiries and so on over the last five years, led by an administration based off campus, we still have no real plan to the future—or, if there is a plan, it has been kept secret. Dr Ellis and I would welcome questions regarding this.

Dr ELLIS: The short statement that I would like to make, which may help inform the Committee as to the questions that I can answer, includes that I was the inaugural surgical director of trauma at North Shore; that I have been involved as the director of training or supervisor of advanced training in orthopaedics for a period of time; deputy head of orthopaedics for 10 years; a member of the Royal North Shore Ryde Surgical Services Review Committee of which you have heard some evidence, and the Redevelopment Clinical Advisory Committee. In other words, I have come to you with a background both in constructive dialogue to try to overcome problems but a good understanding of what happens in a hospital with respect to trauma, after hours particularly.

CHAIR: Thank you. Dr Hughes, do you wish to make any comment?

Dr HUGHES: If I may, thank you. Thank you for your invitation. Many of you would have read my submission. I have nothing more to say regarding that other than that I am more than happy to take further questions. I have worked at Royal North Shore on and off since 1981, so I have some corporate memory of this hospital. It trained me, it provided me with mentors, endowed me to work with highly skilled colleagues, and imbued in me that doctors owe patients a duty of care. This is unable to be exercised under the current regime. We also have a duty of care towards the generations of doctors and allied health care professionals who require teaching. Again, if you drive us from the system we are unable to provide this.

The basic message I want to get across is not about the cockroach on the table. I am sorry you mentioned it. Royal North Shore has become a dysfunctional organisation which is process driven and not mission driven. We have forgotten that the patient is at the top of the pyramid. Who have the patients got if their own doctor is ignored and cannot advocate for their quality of care? And we have not been listened to for a long time.

My submission also provided over 80 pages of complaints to the hospital over many years, which were essentially ignored. I could go on and on. But it is only by sheer good luck, and not planning, that there has not been more harm done to our patients. All this is made all the harder due to the fact that the people responsible for the demise of Royal North Shore are often intelligent people who choose not to care or who have too much to gain by doing otherwise, such as the senior theatre managers, who bring in multiple policies despite being told of the consequences and are later demonstrated by an independent audit to only exacerbate the problems. Cases are allowed to be cancelled by non-surgeons—and still that is the case—without consultation with the surgical team.

Patients are not getting their surgery when medically indicated; they are transferred to the next list the next day, the next day, and the next day. There has never been allocation during the daytime for those patients, so in fact what ends up being an indication for the operation is that the patient has been cancelled three times—not that he needed his operation three days ago. Even worse, the apathy sets in. But you know in your own heart that if this was your relative, this is not what you would want for them. You only hope that if you stay within the system, your presence may result in more good than harm. When things do get done for your patient, it is to their detriment, and when you

are not present there is the frustration that you feel, as the administrator physically laughs down the telephone line at you as you complain yet again.

Royal North Shore has been cut to 390 beds and cannot, with its current resources, be everything to everyone, as has previously been stated. There have been decades of inadequate capital expenditure in resources, radiology and information systems. Try to get some good information from Royal North Shore and you will see exactly what I mean. The more extensive demands of increased complex trauma, the cessation of paediatric trauma in our peripheries, and the ongoing tertiary referral stage produced huge demands that are not included in the provision of our funding.

We see our valuable nursing staff leaving one after the other due to untenable clinical situations and appalling behaviour, which goes unchecked. Although I have witnessed the daily endeavours of Royal North Shore's medical and nursing staff providing flashes of world-class expertise, I also see the disdain and indifference to a patient's misfortune, and also a lack of recognition at the sacrifices that many of our staff make over a lifetime and, by definition, their families as well.

At Royal North Shore we have been exposed to a rotating door of poorly supported and duplicitous middle managers. When there is an audit, the face of the person who effected these changes is reinstated as another guise in another regional health centre. Their impact is still ongoing: they still function on a number of different committees, and they continue to be an impediment to progress. Bureaucratic negligence borders on criminal negligence in my opinion. The result is a dysfunctional, dirty and too often dangerous hospital that will require generational change and increased resources reluctantly. Thank you.

Mrs JILLIAN SKINNER: Thank you, gentlemen. It is hard to know what to say, except thank you for continuing to work in our hospital. Many doctors, nurses and others have said that the hospital is only held up by the clinicians who are working in it. I think that has been fairly clearly demonstrated here. One of the things that really worries me about the duty of care you talk about is that it must be extremely frustrating for all of you to know that you are not really providing the duty of care, as you would see it, to your patients, because of the lack of beds, and the lack of staff, resources and support. Is that how you would see it?

Dr ELLIS: There are good people who work in the hospital in all disciplines: our nurses, our allied healthcare workers, and our managers. I am not as derogatory of our middle management. People work hard to give an effective outcome. But, yes, it is frustrating, and the current reality is that we are having about two cases per day cancelled from the orthopaedic emergency list, remembering that about 2½ theatre equivalents a day are being added as emergency cases. There are cases being rolled 24, 48 and 72 hours on a regular basis. In fact, all of us who are on call really spend the 48 hours afterwards doing the casework that should be done. So, yes, it is frustrating, and there are solutions that other hospitals have been able to implement.

Mrs JILLIAN SKINNER: What are they? What do you see as being the solutions?

Dr ELLIS: The first solution—and this is a solution that is present in most teaching hospitals in New South Wales and many other hospitals—is to have an orthopaedic trauma list, to bring all those cases that are done after hours. A 90-year-old who has fasted for one day, fasted for the next day, and fasted for another day—there is plenty of evidence to show that that is dangerous to their health. Outcomes are improved by timely operative intervention. So bringing that stuff within hours—the planners know of this—is a critical issue about being able to do it in a new hospital, whether there will be enough theatres for this. It has been looked at; there is lots of data on it. This is the first solution that needs to be brought in as a priority.

Mrs JILLIAN SKINNER: Professor Sonnabend, I think you are the person who referred to the gratuitous and informed comments from Department of Health spokesmen. Can you explain what you mean by that? Is that an impediment to the clinicians doing their work at the coalface?

Professor SONNABEND: I do not want to single out individuals. But in general terms what happens is that the department chooses the advisers that suit it, and those advisers have ready-made solutions. The solutions are often ill-considered. For example, solutions that apply when two hospitals

are within 100 metres of each other are not relevant when two hospitals are three-quarters of an hour apart. So we are told with critical ear that we should adopt the mode, for example, that Royal Prince Alfred has adopted, where they have the Institute of Rheumatology and Orthopaedics across the road from Royal Prince Alfred.

It is very easy for people to provide predictable elective care across the road from where they work, but it is very difficult for people to provide the same care when they are three-quarters of an hour away. Yet we are told that we are being stubborn and ignorant and ill-considered by not adopting a model which has worked for another hospital. It is not only that the advice is given, but it is also the way it is given, from on high. It is never discussed, it is never considered; it is always thrown at us. I think that, given the low morale of the entire medical staff at Royal North Shore, this only adds to our frustration and disappointment.

Mrs JILLIAN SKINNER: One of the advantages of the institute you just referred to is that it has a clean operating theatre environment that contains infection spread. Is that sort of thing being looked at in the plans for the new hospital?

Dr ELLIS: Not on campus, no. Just by the way, I have no evidence that the infection rate at Royal North Shore Hospital is any different to that in the private hospital. In other words, my understanding is that the theatre infection rate is not, as the community perception is, a high infection rate. I would agree with all the evidence that the place is dirty outside of the operating theatre and that the toilets are filthy. Much of the evidence I have listened to today—I accept that evidence. But with regard to the operating theatre, I have no evidence that infection rates are higher. I think that is an important public perception that needs to be addressed.

Secondly, with respect to an institute approach, no, they are not going to do that. We have strong objections to an institute approach if it is off campus. We have the highest rate of consultant-led trauma supervision of any of the teaching hospitals in the State, by a factor of 50 per cent. Our consultant attendance at open cases sits at about 90 per cent. The State average sits at around 33 per cent. I am talking about after-hours, complex surgery. We know that consultant attendance drives positive outcomes for patients. It also drives reductions in the cost of complications. We know that it is a good system. It is known internationally that consultant attendance is a good system.

The systems that have elective hospitals off campus have very low consultant attendance at after-hours surgery. Although they are touted as good models, they sequester or separate consultant attendance from their teaching hospitals. I can tell you that on many occasions—on public holidays, even on Christmas day—I have seen two or three of our consultants working collaboratively in the interests of patients—I am talking about multi-trauma, where a lot of complex surgery needs to be performed in the interests of patients.

The Hon. AMANDA FAZIO: Dr Hughes, it is obvious from your submission and also from what you told us in your opening remarks that you have significant concerns about the way complaints about medical staff have been responded to. What would you like to see done to improve these systems? Are you aware of any systems in other jurisdictions, either elsewhere in Australia or overseas, that you could suggest would be appropriate to put in place in the New South Wales health system and in Royal North Shore?

Dr HUGHES: The main criticism I had of the complaints system was that the complainant was perceived as the guilty person, the person with the problem. In fact, the person with the problem was the patient. If there was a mechanism whereby the source of the problem was discussed with either the person involved, their department head, me and, say, David Sonnabend, if I had a problem, where the goal was in fact an outcome, what is it that we are going to do so this does not happen to your patient again, most consultants would pull back; they would not be walking around angry and frustrated. If they actually saw a result for their patient that something like that was not going to happen again, I think it could be solved very simply without setting up a huge bureaucracy. It is the culture in which that complaint is being delivered—not necessarily setting up a framework or a judicial system. It really is a mindset that has to be changed. It is the difference between saying "we can't" and "we can". We can do this better.

That is the thing that frustrated me most about Royal North Shore—that they have these wonderful resources, they have consultants that are trained in Exeter, New York, or the Mayo Clinic, but they do not use it. They do not make us so that we are the best. They perceive this as being expensive or dangerous, because we might suggest ideas that may cost more money, when in fact if we could produce a better system it is going to cost less. The real issue is: Are that person's concerns being addressed?

The Hon. AMANDA FAZIO: Is the QARN system supposed to pick up those sorts of issues?

Dr HUGHES: It picks up mistakes and discusses the issues. But you can have those repeated time and again, and there is no good mechanism that ensures—

The Hon. AMANDA FAZIO: There is no in-built quality assurance overall in the hospital?

Dr HUGHES: It is discussed within the department and policy is changed. I will give you an example. Between 1998 and when I finally resigned in 2007 I treated a number of infections involving compound fractures and joint sepsises, and I went back and reviewed them all. The best practice is to get that patient to theatre and wash out the joint within six hours. The shortest patient I could find was 12 hours, and the longest was four days. That happens time and time again. My resignation was on the basis of that problem not being addressed at any stage, despite reams of letters being written, despite the letters going to QARNS and despite the letters going to medical directors. No-one in that hospital said, "We had a problem and this cannot be allowed to happen again."

Dr ANDREW McDONALD: Dr Ellis and Professor Sonnabend, I want to ask about the Ryde-Royal North Shore model. We know it works at Southwest Sydney with Fairfield-Liverpool, and we know it works with Mount Druitt-Penrith. Why can it not work with Ryde-Royal North Shore?

Professor SONNABEND: It depends on what you mean when you say it "works".

Dr ANDREW McDONALD: The elective surgery being done at one hospital to free beds for the emergency surgery at the other hospital.

Professor SONNABEND: It is a fair question. One of the advantages at Royal North Shore is that the consultants are on site. If they are not at Royal North Shore, they are often at North Shore private, which is 100 metres away. On a busy afternoon, Ryde is three-quarters of an hour away. If you get caught on the expressway, it can be longer. So it is not an easy nexus to make. If you are on call at one you effectively cannot work at the other. One of the beauties of the strengths of our department has been that we have allowed people to sub-specialise; so we have world famous shoulder surgeons working on shoulders, world-famous elbows surgeons working on elbows, people with international reputations, knee surgeons working on knees and the best-known spinal unit in the country working on spines. By subdividing the body to that extent we have allowed that level of expertise that is second to none. That means that it is convenient for all the people to be reasonably close by.

It could work if there were some guarantee of access, if there were some guarantee of numbers, but this has been touted on at least four occasions since I went back to North Shore in 2002. In the space of five years we have had four discussions, investigations, whatever you want to call them, all about this. Each time the thrust is different: once it was Ryde; once it was Hornsby; once it was sending hand surgery to Ryde; once it was sending fractures to Hornsby. There is a total lack of consistency, and the model in itself is not as good as you might think. The model is good because the quality of acute care in those other hospitals is not what it is at North Shore. I can elaborate on that if you like, but they are not quite compatible.

Dr ELLIS: Of course it could work. The question is whether it is a better model of operation than not. If the choice is between having emergent beds, if you like, and operating time on campus at Royal North Shore Hospital and having cases delayed on that campus because we are doing an elective load, yes it would be better to go to Ryde. But the best option is to have both on campus where there is a critical mass of supervision and collaboration in terms of the outcome of the patient. An example of a very poor decision has been given to you today when area ophthalmology, which is

suiting for day surgery outpatient treatment, was brought to the emergency campus, if you like—the urgent campus at Royal North Shore Hospital—and displaced some other surgical service. So to bring that onto campus and then tell the orthopaedic service, which is running a great trauma service, that you should now go off and take away what we think is an advantage—the answer is yes, it would work.

CHAIR: Was there any consultation with anyone at the hospital about bringing that other service to Royal North Shore Hospital? It seems to be very impractical.

Dr ELLIS: Yes, but you have heard the evidence: the hospital has been a churning mass of administrative change, not only the number of general managers of the hospital but also directors of finance—people at that next tier down of position—director of operations. It is hard to engage a churn and, as a result, it is hard to argue rationally about anything. It is hard enough to get an answer when a clinician writes to the director of medical services and says that he has significant concern about safety of any surgery being performed at the hospital and you do not get an answer. It is hard for clinicians to engage a moving target.

Professor SONNABEND: If I could just say, the consultation was with the administration of the hospital and with the ophthalmologists, but the clinicians and other specialties did not know it existed until it was a fait accompli.

Dr ELLIS: We were told it was going to happen.

CHAIR: Can it be reversed?

Dr ELLIS: Yes, all decisions can be reversed, absolutely. There are options and I think that people want to engage in the options. We as clinicians realise that for our community—our people—that is what we are there for. We have to stop and bring up the hospital: everyone has to do that, all of us, and we cannot do that except by engaging with it and decisions can be made again and we can look at things again—the surgical services review, which you have heard about, or the plan, that is underway, but these things are behind time.

Dr HUGHES: Can I just make one point? What is a stream of this is that the bureaucracy has been perceived as part of the problem, not part of the solution. The first time I experienced a positive bureaucrat was in fact Mary Bonner ringing me up, having heard I was going to resign, and made the whole afternoon free and said, "Sit down and tell me about North Shore". I was gobsmacked. That had never happened before.

CHAIR: That should have happened five years ago.

Dr HUGHES: It should have happened five years ago—not just to me but it should have happened to the consultant when they had a problem. I remember a few years ago where we made all these representations to various operating theatre bodies and we found out a year later, thinking that these were going to the medical board, that they had not actually been taken to the board. If we could engage a group of bureaucrats who had the mission of saying, "No more patients get harmed. How do we set this up to work?" everything is on the table; I think you would find a reversal of the lack of goodwill. There are people who have put their lives into this hospital and it is no small thing that they leave, and, given half a chance, I think the next generation would kick in.

Mr PETER DRAPER: Dr Hughes, you mentioned one of the things that did really disillusion you was the fact that surgery was being cancelled by non-clinicians. Is that still occurring and what input do surgeons have into determining the lists for the day surgery?

Dr HUGHES: At the present time the director of theatres is an anaesthetist and they are clinicians, but it is not uncommon to find cases being cancelled or bumped without any discussion with you. In fact, the last case that I left on was this patient who had had sepsis diagnosed four days previously in casualty but no one had bothered to look up the results. He then represented in extremis four days later and I rang theatres myself and told them that they needed to have an operation within the next two hours. They said yes; I rang back four hours later, when I still had not got the call to come to theatre, to find that the supervising nurse had discussed it with the resident and because she

thought it had been around four days she cancelled the case and put it on my elective list, which did not have enough time for that case the following day—that was 19 hours later.

That is an extreme case but the consultation process for the surgeons in terms of which cases are done is really only done if the surgeon sits in theatres and has that consultation. If you have got 10 surgeons joining the queue because you have got so much trauma backing up, how do you have 10 consultants having a rational discussion with somebody who is trying to run theatres? I think you would agree with that, Andrew?

Dr ELLIS: Currently, the situation is a lot better than it has been. People are trying to improve the situation and although I am still cancelling about a third of my elective cases because of trauma load, the system is managing better, but it is managing better at some cost. The cost is that the complexity and our ability to do things that once constituted our throughput, if you like—our outcome, our efficiency, as we are so often told, we are now an inefficient hospital. Whereas before we used to set the pace on the bed stays and all the key performance indicators and we used to be held up as an example, our health roundtable—I have got lots of data on that—where we sat five or 10 years ago we sit poorly now because we are choked in the operating room.

It rarely happens now: people are sensitive and discuss, and the floor management system is better than it was and the nurses on the floor are better. Very rarely will a patient get cancelled without discussion currently. But patients are being cancelled because of the shortage. We are not doing our efficient workload that we once were able to do. We are not doing our complex workload because of intensive care bed shortages with some more complicated work.

Mr PETER DRAPER: So is the answer more theatre time to reduce the number of out-of-hours operations and weekend operations?

Dr ELLIS: That is accepted clearly as the international standard to bring within hours a lot of these 30 extra cases a day that are added of urgent and emergent surgical operations.

CHAIR: Thank you very much your attendance today and for sharing your concerns. We will certainly take those on board.

(The witnesses withdrew)

PATRICIA ANNE HEATON, Senior Orthopaedic Physiotherapist, Royal North Shore Hospital, sworn and examined:

BARBARA RUTH LUCAS, Senior Paediatric Physiotherapist, Royal North Shore Hospital, affirmed and examined:

CHAIR: Thank you for your attendance. We appreciate the time you are giving to this Committee's inquiry. Do you wish to make an opening statement?

Mrs HEATON: If we may, yes. We would like to share that opening statement. We just want to give you a little bit of background first. We are both very proud members of the Royal North Shore physiotherapy department, which has a team of dedicated staff who work strongly under the leadership of the excellent heads of departments we have had and a deputy head. We are a highly esteemed department both within Royal North Shore Hospital and other New South Wales health regions. This regard is based on our high staff retention rates, our clinical excellence development through professional development programs and research and quality improvement initiatives.

Our department operates with the goal of providing excellent clinical services amongst our patients, which in turn provide the best quality outcomes we can and not just outputs. These quality outcomes enable patients to be discharged from Royal North Shore Hospital in a timely and appropriate manner and to receive ongoing outpatient services until clinical objectives are met. Our department's ability to do this saves the health dollar in the immediate sense by appropriate discharge times but also in the long term by investing in the future wellbeing of the community through the restoration of patients to their optimal function abilities.

We are confident of this service we provide as it has received recognition through various quality, scientific and community awards. The physiotherapy department is also regularly put forward to represent Royal North Shore accreditation processes because of its high operational standards. Our ability to do this, despite the ongoing demise in working conditions and resources as well as the continued change in governance at Royal North Shore Hospital has been the consequence of a dedicated staff working as a team and strong and accessible leadership provided by our head of department and deputy. However, our ability to continue to provide clinical excellence today and into the future is slowly being eroded.

There are four key factors that we would like to speak to today. First, we would like to talk about the restructure of the division of allied health. I call it the destruction of the division of allied health. This was a whimsy—I call it a whimsy; they call it a policy—of our area health service, which was brought upon us without any reasonable reason for the changes. Until 2006 the physio department was represented under the division of allied health. This was collapsed last year under yet another restructure and we now fall under the division of surgery. This restructure largely represents the medical and nursing voice, but has limited allegiance and identification with the concerns of allied health. Despite an enormous amount of research done by allied health with evidence-based advice forward and discussed with administration, our concerns for clinical governance were dismissed. It is difficult to continue to provide excellence in clinical services when we no longer have a strong representation and communication in operational management systems at Royal North Shore Hospital.

The second thing I would like to talk to you about is the proposed restructure of Royal North Shore and Ryde physiotherapy departments. The proposed amalgamation of both Royal North Shore Hospital and Ryde physiotherapy departments has been planned despite any rational evidence-based practice. Amalgamations have not worked in other health regions, and this is evidenced in the United Kingdom and at Royal Prince Alfred, Concord and Westmead hospitals and, indeed, some of these areas of the amalgamations are in the process of being withdrawn or have been reversed. If our department is restructured to amalgamate with Ryde, it will do so, we understand, on a cost-neutral basis, which will require increased input from Royal North Shore into management hours over two sites. These management hours will be pulled from Royal North Shore clinical services, which will have the effect of reducing the hours available for clinical intervention without any backfill.

The other cost to our department will be an inaccessible head of department due to their increased responsibilities over to hospital services. A department with 56 staff providing services in

numerous clinical specialities requires an on-site and accessible manager. Both Royal North Shore and Ryde hospitals recognise that restructures can be difficult, and I just want to emphasise this. At every point of these restructures through the last few years we have really tried hard to come up with an evidence base to try to make this move forward a positive one. That is something I really want to get across, and we have been knocked at all corners. We do not have any voice whatsoever. We have tried to embrace the process constructively and by consulting other departments that have undergone this process and taken on board lessons already learnt.

An enormous amount of time and effort has been put into providing administration with evidence-based information regarding both restructures, and we have enclosed letters in this submission we are giving to you during that consultation period outlining our concerns. None of this information or these concerns has been addressed or adopted in the final proposed models. One of these letters was addressed to Mary Bonner, the only response being an acknowledgement of receipt of our correspondence. This is another example of a restructure driven by operational management at area health without any justification for change. This proposed restructure will remove accessible leadership, which is vital if we are to continue to provide excellence in clinical service under the demised conditions that Royal North Shore operates. It begs the question, why are we changing a structure that is operating well? My little comment at the end of that is, do not throw the baby out with the bathwater.

CHAIR: Would you like to add anything, Ms Lucas?

Ms LUCAS: I would like to continue on with two further points to finish our submission. I would like, firstly, to speak to the lack of funding for equipment and utilities. The physiotherapy department has no capacities within its budget for the maintenance and upkeep of utilities for the purchase of clinical equipment. Basic clinical equipment, which is used on a daily basis, such as forearm support frames to safely mobilise patients, is purchased through fundraising such as physiotherapy department cake stalls or the floral and voluntary services. All other clinical equipment is similarly accessed this way, such as plinths to treat patients on CPMs, which are machines that we use to mobilise knees after surgery; and interferential and ultrasound machines, again basic equipment that we use in our outpatient services.

There are numerous other shortages in basic requirements for clinical services. Other examples are chairs for patients and staff, and computer equipment. We have some areas with more than 10 staff working with just 2 computers. None of these is addressed by the aforementioned funds. You only need to go down to the plaster room and you will see that every single chair is probably third-hand loved down there and anything that has upholstery on it has also got leucoplast tape just to hold it back together again. As a department we either do without or just continue to make do with old and outdated fixtures and equipment. Most of the equipment we have both in the in-patient and outpatient areas is about 10 years old. As a profession compared to our other colleagues that have been presenting, we need so little, but even this is difficult to procure.

The physiotherapy outpatients department is located in a building that was built in the early 1900s. The upper floors contain services to necks, backs and hands, whilst the lower floor houses the physiotherapy gym, paediatrics and hydrotherapy. There can be up to 20 staff working there at various times during the day. There are numerous areas of disrepair within this building based on its age that have required attention over the past years, but the hospital's system for addressing these have failed to do so, citing lack of funds. One example of this has been the paediatric physiotherapy room in which preterm babies are seen as outpatients after discharge. Many of them are oxygen dependent for the first few months and treated on their oxygen. This room had large areas of paint peeling from the ceiling and the walls. Not only was the peeling paint unsightly, but it was an occupational risk to small babies with respiratory conditions.

After more than two years of lobbying, the \$4,000 required to fund the repair of the paintwork was supplied from administration, but not because it obviously needed repair—only due to concern that letters we had sent seeking funding from our charity Humpty Dumpty Foundation might raise media attention. All clinical areas in this building lack air conditioning and lobbying by our department has continued for 20 years to rectify this. There has been ongoing documentation of episodes of fainting in hot conditions for elderly and antenatal patients over the past two years. There have been approximately 30 heat-related episodes during this time. Occupational health and safety

systems have again failed to address this ongoing issue stating that nobody ever died of heat. We have remedied the situation by calling fragile patients to reschedule their appointments on days when the temperature gets beyond the high thirties. These are all examples of how management systems have failed to respond to basic clinical requirements nor fund our basic clinical needs.

The last point that we would like to address is the lack of consultation in future hospital services and the removal of the hydrotherapy pool in the new hospital plan. The Royal North Shore Hospital hydrotherapy pool currently services 1,000 patients per month. The patients who attend the pool have a wide variety of conditions, which hydrotherapy has evidence-based documentation of benefit. Many of these patients would struggle to maintain their independence in the community without these services. So, examples of this would be back pain or rheumatoid arthritis. Others would just lack access to other pools. So an example of that would be spinal cord injured patients, in which our hospital specialises.

Our hydrotherapy services are well recognised and were acknowledged this year by the Willoughby City Council 2007 Award for Commended Health and Community Services, yet there is no provision for a hydrotherapy pool in the new hospital plan. A recent patient wrote a letter to Bryce Clare, Director of Operations, outlining her concerns about the lack of future hydrotherapy services. His reply states, and I am quoting now, "There is currently no site identified in the Royal North Shore concept plan for a hydrotherapy pool in the long term. However, suitable alternatives are being explored in the local area."

This reply implies that if a hydrotherapy pool is built, there is a possibility that it will be built off site. Consultation by Mr Bryce with our department and other clinical specialties such as rheumatology or orthopaedics would quickly clarify that a replacement hydrotherapy pool is useless off site where it is not located within clinical specialties and accessed by the physiotherapists required to staff it. This is an example of where operational management has failed to understand the clinical requirements surrounding a hydrotherapy pool and failed to consult our department in future service provisions. It again underlines our concerns regarding the quality of physiotherapy services we may be able to offer the community of Royal North Shore in the future.

In conclusion, the excellent clinical services offered by the Royal North Shore physiotherapy department reflect the strong clinical leadership provided by our current head of department plus the immense good will of staff working under increasingly difficult conditions. Our submission to the joint select committee addresses four key areas of concern. It is our hope that our contribution to this parliamentary inquiry, along with the many other submissions by our colleagues at Royal North Shore, will rebuild Royal North Shore to the internationally renowned centre of excellence it once was and provide the community with health services it deserves. Thank you.

CHAIR: Thank you very much for this very full and detailed submission.

Mrs JILLIAN SKINNER: Can I too thank you. This is a very comprehensive and well thought out submission. I am so pleased that the physios representing allied health had an opportunity to appear before us. You are an extraordinarily important component of the clinical workforce at the hospital. Can I just touch on a couple of things. In regard to the hydrotherapy pool, I believe the 1,000 people that come to you every month have all written to me about the lack of planning for a hydrotherapy pool in the new hospital. Earlier the professor who worked in pathology was telling us there is no plan to have pathology in the hospital either. This is a farce, is it not? I just cannot understand. Are the surgeons and other staff supporting you in your plea to put a hydrotherapy pool in the hospital?

Ms LUCAS: It is a fairly basic clinical requirement for the services we offer and there are many patients we see, whether it is children with juvenile rheumatoid arthritis or other conditions that just cannot be treated in an effective way to get them back into the community without a pool.

Mrs JILLIAN SKINNER: There is evidence-based proof that actually providing physio this way spreads your load and you can actually treat 20 patients at one time whereas it would take hours to see that number of patients with your workforce. Am I right?

Ms LUCAS: Yes.

Mrs HEATON: Can I make a comment to that also? It is also the complexity of the cases that we see. I work in orthopaedics and patients with fractured pelvises, for instance, can actually get out of bed a little bit earlier and taken to the pool and start to mobilise a little bit more quickly. So, that is just an example—and certainly keeping those with rheumatoid arthritis moving and keeping them in their own homes.

Mrs JILLIAN SKINNER: Clearly there is evidence that this is beneficial?

Mrs HEATON: Absolutely. The point being that we have the expertise of the staff to manage that broad range of patients. If it was sent off site, you would have maybe exercise therapists or something in the pool who would not be aware of all the ramifications of the complexities of the patients.

Mrs JILLIAN SKINNER: I want to touch on the restructure and the fact you have lost the division of allied health. When that happened I received a lot of representations from your colleagues. Has there been much support from others working in the hospital system for the restoration of that structure?

Mrs HEATON: Not at this current time, no. I think across allied health I have to say that we are all feeling it is not nice being called a grain of rice in a silo, quite frankly.

Mrs JILLIAN SKINNER: Perhaps you could explain who comprises the allied health workforce?

Mrs HEATON: Well, the allied health workforce comprises all occupational therapists, physiotherapists, speech therapists, social workers, orthotists, radiologists. There are a few other groups that come in there and we fought for many years for equal recognition as being a key component of the workforce, especially within a tertiary referral teaching hospital. It has always been a question of doctors and nurses come first and, oh, who were the others? It has been a constant battle to try to make administration understand that we have a huge amount to offer. We have an enormous amount to offer and it is frustrating, because we are a small group, that we do not have a voice that is heard.

Mrs JILLIAN SKINNER: Earlier we heard from a relative of a patient—but it has been presented to us as well—talking about patients not being able to eat because the food presented to them may be wrapped or in foam cups, whatever. Do you see that and could you comment about the duty of care that is required there?

Mrs HEATON: Well, just on that very one point. Physiotherapists are not responsible for food at all in any sense or form.

Mrs JILLIAN SKINNER: No, I know that.

Mrs HEATON: I work in orthopaedics, critical care, and today I had a one-armed man who was struggling to take a piece of bread out of a plastic bag. So, of course, I was there and I sorted it out. So, yes, that happens on a regular basis.

Mrs JILLIAN SKINNER: I would ask a nurse if they were here, but could you tell me are these issues reported? Is there any action taken to make sure it is corrected and does not continue?

Mrs HEATON: I think the overwhelming feeling amongst staff on the floor—we are representing staff on the floor, if you like—is, well, what is the point?

Mrs JILLIAN SKINNER: Which is tragic.

Mrs HEATON: What is the point, because it never, ever gets addressed. Yes, we can keep on putting in these reports. We put in these reports all the time, but in my experience, over many years within the hospital it is finding the key moment to actually nail somebody—usually when there are

visiting dignitaries around works well. But it is very frustrating. I think "frustration" is the word that you could actually put in capital letters over the heads of most of us.

Mrs JILLIAN SKINNER: Is there a mechanism involving a clinician advisory group that you can be involved in to have a say in the future hospital but also in correcting some of the issues for you now? Is there a mechanism that you can see that you could be involved with about which we could make a recommendation?

Mrs HEATON: Well our division of Allied Health has been disbanded.

Mrs JILLIAN SKINNER: We could recommend that it be put back?

Mrs HEATON: Yes.

Mrs JILLIAN SKINNER: Are there some clinical groups that you think you should have representation on that you do not?

Mrs HEATON: Well we do not have representation on very much at the moment. There was a time up until about five years ago when we got a sort of equal time and we were represented on a number of committees but I think that time has—

Mrs JILLIAN SKINNER: There are no taskforces or anything like that in the hospital where you can have a say or you can have a voice?

Mrs HEATON: Well they have a general meeting once a month that is often cancelled. So that is a voice where we can go and submit questions to the management, yes. I also feel free that I can go directly, I can directly access the different levels of management. I feel quite comfortable with doing that but does it actually achieve anything is my problem.

CHAIR: Is there any process through that division of surgery where you say you are now attached?

Mrs HEATON: Well again I feel I am free to e-mail or send the letter to our manager of surgery and certainly to Mary Bonner if I wanted to. I heard the previous speakers and I have to say that last year I would have called this hospital a rudderless ship. I think the rudder is in place. I am feeling a little bit more confident about the line of management.

Mr MICHAEL DALEY: Thanks for coming in today and your work is valued, let me tell you that. You have spoken about capital investment today. How would you like to see a long-time capital investment plan formulated for perhaps the next decade going forward?

Ms LUCAS: I assume that eventually we will be in a new hospital so a lot of our problems that we have at the moment will be gone in regards to infrastructure but for now the problems that we have spoken to—I work in that paediatric room, I also work in that building that did not have air-conditioning, so the first thing there would just be the timely response to the reports that are put in about failed systems. The second thing would be some sort of budget that our department could access, where we could actually allocate funds towards pieces of equipment that we need. So at the moment we have many pieces of equipment that are probably 10 years old and looking that way. So we basically fall on the goodwill of voluntary services—

Mr MICHAEL DALEY: So when it is budget time you do not be consulted about what you need for next year in terms of equipment?

Ms LUCAS: No.

Mrs HEATON: Our budget is literally taken up with the employment of staff. We really do not have any budget up and above that, other than that the plaster room budget, which is for plasters and crutches and things like that. So they do have a budget for the plaster room but within the department our budget is really more or less taken up with the employment.

Ms LUCAS: So basically there is no budget apart from paying wages.

Dr ANDREW McDONALD: Just quickly, how many full-time equivalent paediatric physios do you have?

Ms LUCAS: One and a half.

Dr ANDREW McDONALD: The lack of investment in IT has been cited as a problem. Has this been a problem for yourselves and what should be done?

Ms LUCAS: We need more computers. Things have considerably changed over the last five years I suppose in the way that we access computers and use them for our day-to-day work. So if you think in the area that I work that we have got two computers that are pretty old, got 10 staff trying to access them, we are trying to write letters, we have got requirements now with putting in statistics so that we can justify what we do with our time, and accessing e-mails as well, research where we need to access the Internet.

So all those things make it very difficult to use time well when you cannot get to basic requirements like that. So it is as simple as we need more computers. We need more printers. The printers that we have are probably about six or seven years old. We use the printers for printing out exercise sheets that we use, you know, basic patient information and again that they are so old that if you take a digital photograph and try and implant it into an exercise sheet they do not read in a way that you can actually read them. So just simple things like that would really make quite a big difference to our working life.

Ms CARMEL TEBBUTT: I want to ask about the issue of networking of services. I have heard what you have said about your concerns with regard to the amalgamation of physiotherapy at Ryde and Royal North Shore, but we have also heard from some of the other witnesses about the benefits of networking of services, particularly when you have some expertise like you would have at Royal North Shore that you would then be able to share perhaps with some other hospitals that do not have that level of expertise. Do you see any benefit in that networking of services? Can you talk a little bit more about what your suggestions are to make the restructure of the two physiotherapy departments actually work?

Mrs HEATON: We already have an informal networking system. I have to say that within Royal North Shore we are very fortunate because our staff retention has been so good. We have a senior member of staff in each speciality area that has a huge amount of experience and we network through the APA, through the study groups associated with the APA, and we meet with people of like interests through those organisations. So we do cross our information over and we do have discussions, we organise conferences, we organise education sessions across the board. As far as Ryde and Royal North Shore are concerned, yes, there could possibly be. It is a question again of distance—you have heard the distance.

For instance, Gosford Physiotherapy Department has a very good program of lectures and information sessions and they send them to us. We send them ours. I look at them and I think oh gosh that would be nice, I would really like to go to that but how am I going to take half a day off a clinical load when I am not covered? And this is one of the big points; we are not backfilled in any way. For instance, at the moment I am working half a physio down and I have been working half a physio down for the last two weeks and that will be ongoing probably now until Christmas. If another member goes off sick maybe tomorrow I will be half a person down plus that person down. There is no backfill for those people.

Ms CARMEL TEBBUTT: Even if they are off for a long time?

Mrs HEATON: If they are off for a long time, if it is a planned holiday, yes, we do have relief for those people. We do have planned relieve for RDOs but not for ADOs. So if someone has an ADO no backfill.

Ms CARMEL TEBBUTT: Sorry, what is the difference?

Mrs HEATON: A rostered day off is when we have worked a weekend, so we have to have a day off. So that is actually managed but if it is an ADO, an adjusted day off when we have worked too many hours and we have to take a day off—

Ms CARMEL TEBBUTT: I understand.

Mrs HEATON: —it is not backfilled. Our department would work at approximately 70 per cent of what our designated numbers are on a daily basis because we do not get backfill for any of those people that are off. For instance today—sorry I have got off the point but I will come back to it—we had three FTEs down today and that was over five areas. So those patients would not have been treated today. I am here this afternoon; some of my patients have not been treated today. There is no backfill. To get back to your point sorry, about Ryde-Royal North Shore. The two hospitals are very different. We have actually been working very closely with Ryde Hospital over this restructure—we do not have any ill feelings between the two departments. We are more than happy to work on a clinical basis, an educational basis together but the people at Ryde are at Ryde because that is the sort of place they want to work. Those are the sorts of patients they want to treat.

The people that come to Royal North Shore Hospital are the sort of people who want to work in a big, teaching tertiary hospital. They want to have the education. They want to have the stimulus. They want to have to work hard because they know if they come to North Shore they have to actually work very hard. The staff on both hospital sites has made it quite clear from the most junior to the most senior that they do not want to work at the other hospital, "This is why we came to this hospital. This is why we want to work here. We do not want to have to cross over to the other hospital." So staffing wise we have had such a good reputation of staff retention and people really wanting to come and work at North Shore but if we are going to tell them, "Oh sorry, half the time you are here you are going to be working at Ryde", then our retention and recruitment rate is going to suffer.

The Hon. AMANDA FAZIO: Can I just ask you a quick question because we are sort of running out of time for this part of the hearing; the new chief executive officer of the area health service has said that he is going to make it a priority to have a clinical services plan within six months and I think that has been welcomed to date by every body who has given evidence. Given that you are now part of the surgical department, are you confident that the voice of the Allied Health professionals will be heard in the input into that plan or would you like to see the old Allied Health department be given a separate voice?

Mrs HEATON: I think we are all familiar with the fact that numbers count. There has been, as we see it, a divide and conquer. It is not so much the reporting upwards, it is just the ability to work as a team and as a whole group. Yes, we would like to see an Allied Health Division again.

The Hon. AMANDA FAZIO: Even if you did not have an Allied Health Division, during the consultation for the clinical services plan would you like to be consulted separately or are you happy to be consulted as part of the surgical department?

Mrs HEATON: I do not think I can answer that one for you. It is not something that I would feel comfortable answering.

CHAIR: Just a quick question, I am just wondering if they forgot to put the hydro pool in the new hospital, have you checked your whole department is in the new hospital with all its facilities?

Mrs HEATON: Well on the first draft we were on the third floor with a hydro pool. That has gone and I have got no idea where we are now. Certainly on each level of the inpatient building what has been mooted is an Allied Health room, which we have fiercely fought against too, not necessarily the physiotherapists, we are quite happy with that, but the social workers are not happy with that at all—they need obviously independent rooms where they can take their clients and speak to them in private. So there are a lot of issues regarding that too. Yes, we will have a physiotherapy department but it will be who knows where.

CHAIR: Sufficiently large to equal what you have now?

Mrs HEATON: Well, the numbers we have put in are what we require. We have actually put in what we require. Having been through—believe it or not I have been there a long time with periods away—the period of setting up for the current hospital I know what happens. They say that you have this amount of space and when you actually move in they say, "Oh no, sorry you cannot have that corner because somebody else is having it. You cannot have that corner because somebody else needs it." It is a real fight. It is a bunfight trying to maintain the space that you have requested.

Ms LUCAS: Can I make a quick comment to that? Just in one of the previous plans they actually wanted our offices sited just in a building that was meant to be an office building and away from clinical areas. I cover children's ward, outpatients, I cover a couple of clinics, so I am all over the hospital and I have to say that you really need to be housed in one place and the closer to the clinical services the better. Working with children, mums are often late. The parking at the hospital—I hope people have spoken about parking—but I often have calls from mums in the multi-storey car park with twins at the top trying to get a park, the lift is broken down and they cannot get there. They have gone to the wrong place.

So in your tightly structured day of half-hour appointments you are losing time all the time. Or sometimes they get it wrong and they turn up at the wrong place so you have to run over because you do not have the pram and you can get there faster. There has not been a great transparency about the plans for the hospital and that is obvious through the hydrotherapy pool. We are not quite sure where things are at the moment. So I guess that is just another example of the way things operate.

CHAIR: Thank you very much again for sharing your information with us and the detailed submission you have given to us is a very big help.

Mrs HEATON: Thank you for the opportunity.

Ms LUCAS: We are very grateful.

CHAIR: In asking that question, we have just learnt that the pathology department apparently has not been allocated a space in the new hospital so we are all getting suspicious now—

Mrs HEATON: Well my understanding is—just to come in on that—that the pathology department was going to be part of the research building because they needed a lot of that sort of equipment too. But I think they wanted to be part of the clinical services and I think possibly someone somewhere in the middle has forgotten. You know, one lot is saying, "Oh they are in there" and the other guy is saying, "They are over there" and actually they are nowhere. I think that is probably true.

CHAIR: Thank you again. I wish you all the best.

(Witnesses withdrew)

The Committee adjourned at 6.15 p.m.