Joint Select Committee on the Royal North Shore Hospital

The Royal North Shore Hospital

Ordered to be printed 20 December 2007 according to Standing order 231

New South Wales Parliamentary Library cataloguing-in-publication data:

New South Wales. Parliament. Joint Select Committee on the Royal North Shore Hospital.

Report on inquiry into the Royal North Shore Hospital / Joint Select Committee on the Royal North Shore Hospital. [Sydney, N.S.W.] : the Committee, 2007. – 250 p. ; 30 cm. (Report ; no. 1).

Chair: Rev. the Hon. Fred Nile, MLC.
'December 2007'.

ISBN 9781921286193

1. Royal North Shore Hospital of Sydney.
I. Title
II. Nile, Fred.
III. Series: New South Wales. Parliament. Joint Select Committee on the Royal North shore Hospital ; no. ?

362.11 (DDC22)

How to contact the committee

Members of the Joint Select Committee on the Royal North Shore Hospital can be contacted through the Committee Secretariat. Written correspondence and enquiries should be directed to:

The Director

Joint Select Committee on the Royal North Shore Hospital

Legislative Council

Parliament House, Macquarie Street

Sydney New South Wales 2000

Internet www.parliament.nsw.gov.au/royalnorthshorehospital

Email royalnorthshorecommittee@parliament.nsw.gov.au

Telephone (02) 9230 2412

Facsimile (02) 9230 2981

Terms of Reference

1. That a joint select committee be appointed to inquire into and report on the quality of care for patients at the Royal North Shore Hospital, and in particular:
   (a) clinical management systems at the hospital,
   (b) the clinical staffing and organisation structures at the hospital,
   (c) the efficiency, effectiveness and appropriateness of resource allocation and utilisation within the hospital, and in particular the operation of the Emergency Department,
   (d) the effectiveness of complaints handling and incident management at the hospital, and
   (e) operational management of Royal North Shore Hospital in general but in particular, the interaction between area and hospital management as it relates to hospital efficiency, effectiveness and quality of care.

2. That the committee consider any strategies or measures in place or proposed for improving quality of care for patients at the hospital which may also benefit New South Wales' public hospitals.

3. That any individual patient complaints identified in the course of the inquiry be referred by the committee to the Health Care Complaints Commission.

4. That notwithstanding anything contained in the standing orders of either House, the committee consist of eight members, as follows:
   (a) three members of the Legislative Council, of whom:
      (i) one must be a government member,
      (ii) one must be an opposition member, and
      (iii) Revd Mr Nile,
   (b) five members of the Legislative Assembly, of whom:
      (i) three must be government members,
      (ii) one must be an opposition member, and
      (iii) one must be a cross bench member.

5. That the members be nominated in writing to the Clerk of the Parliaments and the Clerk of the Legislative Assembly by the relevant party leaders and the cross bench members respectively within seven days of this resolution being agreed to by both Houses.

6. That Revd Mr Nile be Chair of the committee, and that the committee elect a Deputy Chair at its first meeting.

7. That, notwithstanding anything in the standing orders of either House, at any meeting of the committee, any four members of the committee will constitute a quorum, provided that the committee meets as a joint committee at all times.

8. A member of either House who is not a member of the committee may take part in the public proceedings of the committee and question witnesses but may not vote, move any motion or be counted for the purpose of any quorum or division.

9. That leave be given to members of either House to appear before and give evidence to the committee.

10. That the Committee report by Thursday 20 December 2007.

Committee Membership

Revd Hon Fred Nile MLC	Christian Democratic Party	*Chair*
Mr Peter Draper MP	Independent	*Deputy Chair*
Hon Amanda Fazio MLC	Australian Labor Party	
Hon Jenny Gardiner MLC	The Nationals	
Mr Michael Daley MP	Australian Labor Party	
Dr Andrew McDonald MP	Australian Labor Party	
Mrs Jillian Skinner MP	Liberal Party	
Hon Carmel Tebbutt MP	Australian Labor Party	

Table of Contents

Tables and Figures

Chair's Foreword

> *… whatever comes out of this inquiry, please let it be substantial and over a long period. It will take that length of time to get the hearts and minds of the people right, not just the buildings, not just the budget, and not just enough money.*[1]

I am pleased to present the report of the Committee's inquiry into the Royal North Shore Hospital.

This has been a challenging inquiry. We received disturbing evidence about aspects of patient care and workplace behaviour at one of the State's iconic public hospitals. But the willingness of individual patients and their families to recount their difficult experiences has been an important first step in addressing the concerns expressed by inquiry participants.

The inquiry revealed considerable consensus among Committee members and witnesses regarding many of the reasons for recent problems at the Hospital, including the pressing need for a clinical services plan for both the North Sydney Central Coast Area Health Service and the North Shore Ryde Health Service. Without this 'big picture' view of the Area's current situation and anticipated future needs, it is impossible for the Hospital to know how and where to allocate its resources.

It is imperative that nurses, doctors and allied health professionals actively participate in the development of these plans. The disengagement of clinicians in the governance of the hospital was one of the most important themes revealed by the inquiry. But this is not the responsibility of management alone: clinicians need to demonstrate their preparedness to adapt to new ways of working within a larger, more complex amalgamated Area Health Service. We urge both the Area Health Service and the North Shore Ryde Health Service, to finalise and implement their clinical services plans by April 2008.

A culture of bullying and harassment exists in significant parts of Royal North Shore Hospital. It is also indisputable that inappropriate workplace behaviour has been allowed to thrive for several years. This has had a devastating impact on many staff members, and most likely on patients. NSW Health and the Area executive have stated their firm commitment to addressing this issue. We look forward to a progress report on this matter when we receive the Government response to the recommendations in our report in six months' time.

No one disagrees that there is a national and state-wide shortage of nurses and doctors. We call on the Australian Government to fund more university places for medical and nursing positions and for the NSW Government to fund additional training places for doctors and nurses in clinical settings. In the meantime, we should make the best use of the existing medical workforce. Evidence to the inquiry suggested that the large number of unfilled nursing vacancies at Royal North Shore Hospital stems in part from high workloads and unworkable management structures. We hope that many of our recommendations will lead to an improved working environment for all staff, including nurses, and thereby increase the appeal of Royal North Shore Hospital as a stimulating and positive workplace.

The willingness of patients and their families, such as Ms Jana Horska and her husband, Mr Mark Dreyer, to share their painful experience at Royal North Shore Hospital was instrumental in

[1] Dr Ross Wilson, Director, Clinical Governance, NSCCAHS, Evidence, 16 November, p 40

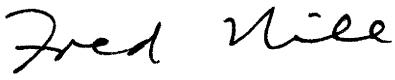
establishing this inquiry. Their accounts contributed to our understanding of the systemic problems confronting the Hospital, many of which are not confined to Royal North Shore Hospital.

For example, the model of care for women such as Ms Horska who present to an Emergency Department with signs of threatened miscarriage is clearly unacceptable, as the Minister for Health has acknowledged. Difficulties with recruiting and retaining clinical staff, 'access block', inadequacies in complaints handling systems and a disconnect between clinicians and management are not confined to Royal North Shore. For this reason, and where appropriate, several of our recommendations are relevant to other Area Health Services across the State.

The Royal North Shore Hospital has a proud place in this State's public health system, with a teaching, research and clinical profile that attracts national and international regard. I am confident that the inquiry will assist the Hospital to reclaim its reputation for excellence. Indeed, one of our recommendations is that by 2010, RNSH be returned to the top echelons of NSW Hospitals as measured by the Australian Council of Healthcare Standards.

I would like to thank all of the participants in this inquiry: clinicians, patients and families, for sharing your knowledge and expertise. I am grateful to my committee colleagues for the work they have undertaken on this inquiry and the constructive approach they have taken throughout. On their behalf I acknowledge the efforts of the Legislative Council's committee staff – Elizabeth Galton, Simon Johnston, Stephen Frappell, Beverly Duffy and Sam Griffith.

I commend this report to the Government.



Revd Hon Fred Nile MLC

Committee Chairman

Summary of Recommendations

Glossary

A number of these definitions have been taken from the Northern Sydney Central Coast Area Health Service *Annual Report 2005-2006*:

Access block — The period of time a patient stays in the Emergency Department after the Emergency Department staff have completed their assessment and treatment prior to being admitted to a ward. Patients waiting to be admitted for longer than eight hours are experiencing access block.

Allied health — Health professionals other than doctors and nurses (for example, physiotherapists, occupational therapists, social workers).

Acute care — Care where the intent is one or more of the following: manage labour or childbirth, treat illness or injury or provide definitive treatment of an illness or injury (excludes palliative care), perform surgery, reduce the severity of and illness or injury, protect against the exacerbation and/or complication of an illness or injury which could threaten life or normal function, and/or perform diagnostic or therapeutic procedures.

Ambulatory care — Any form of care other than as a hospital inpatient; for example, chemotherapy can be administered to cancer patients during a short daytime stay in an Ambulatory Care Ward. An inpatient stay is not required.

Casemix — The range and types of patients (the mix of cases) treated by a hospital or other health service. This provides a way of describing and comparing hospitals and other services for planning and managing health care. Casemix classifications put patients into manageable numbers of groups with similar conditions that use similar healthcare resources, so that the activity and cost-efficiency of different hospitals can be compared.

Clinician — A registered practitioner who spends most of his or her hours in clinical practice.

Enrolled nurse — An Enrolled Nurse (EN) in the NSW Public Health system is an individual who has completed a 12-month enrolled nurse employment and training course. The duties of an EN range from providing physical and emotional support, to more complex care and administering medications.

Patient flow — The way a patient moves through the hospital from admission, into care and then discharge.

Registered nurse — A nurse who is on the register maintained by the state or territory nurses board or nursing council to practise nursing in that state or territory. The minimum educational requirement for a registered nurse is a three-year degree from a tertiary institution or equivalent from a recognised hospital-based program. To maintain registration, it is necessary for a nurse to have practised for a specified minimum period in the field of nursing in the preceding five years.

Triage	A French word meaning 'to sort out'. The Triage System is a way of placing patients into categories of care so that they are seen according to the urgency with which treatment is required.
Triage category	The urgency of a patient's need for medical and nursing care is evaluated using the Australasian Triage Scale, which places patients in one of five categories:

- Category 1: Life-threatening illness or injury, to be treated within 2 minutes (for example, critical injury or trauma, cardiac arrest)
- Category 2: Imminently life-threatening illness or injury, to be treated within 10 minutes (for example, chest pains, difficulty breathing, severe fractures)
- Category 3: Potentially life-threatening illness or injury, to be treated within 30 minutes (for example, major fractures, heavy bleeding, severe illness)
- Category 4: Potentially serious condition, to be treated within one hour (for example, sprained ankle, earache, migraine headache)
- Category 5: Less urgent condition, to be treated within two hours (for example, minor cuts, rashes)

Abbreviations

ACAC	Area Clinical Advisory Council
ACHS EquIP	Australian Council on Healthcare Standards Evaluation and Quality Improvement Program
AHAC	Area Health Advisory Council
AHCA	Australian Health Care Agreement
AHWAC	Australian Health Workforce Advisory Committee
AMA	Australian Medical Association
AMWAC	Australian Medical Workforce Advisory Committee
ASMOF	Australian Salaried Medical Officers Federation
CMO	Career Medical Officer
CT	Computed axial tomography (also CAT) or computed tomography
DRG	Diagnosis related group
eMR	Electronic Medical Record
EN	Enrolled nurse
FTE	Full time equivalent

HCAC	Health Care Advisory Council
ICT	Information and communication technology
IIMS	Incident Information Management System
MRI	Magnetic Resonance Imaging
NCOS	Net Cost of Services
NSCCAHS	Northern Sydney Central Coast Area Health Service (sometimes referred to as North Sydney Central Coast Health or NSCCH)
NSRHS	North Shore Ryde Health Service
NUM	Nurse Unit Manager
PACS	Picture Archive and Communications System
PAS	Patient Administration System
QaRNS	Quality assurance Royal North Shore
RCA	Root Cause Analysis
RDF	Resource Distribution Formula
RIS	Radiology Information Systems
RNSH	Royal North Shore Hospital
SAC	Severity Access Code
VMO	Visiting Medical Officer

Chapter 1 Introduction

This chapter provides an overview of the inquiry establishment, the methods used to invite public participation and a summary of the report contents. It also describes the events precipitating the initiation of the inquiry.

Establishment of the Committee and the inquiry

1.1 On 16 October 2007, Revd the Hon Fred Nile MLC presented a motion in the Legislative Council to appoint a joint select committee to inquire into and report on the quality of care for patients at the Royal North Shore Hospital (RNSH). After debate, the original motion was passed by the Legislative Council on the same day and the resolution was forwarded to the Legislative Assembly for consideration.[2]

1.2 The Legislative Assembly agreed to the Council's resolution, with several amendments pertaining to the Committee membership.[3] These amendments were agreed to by the Council on 23 October 2007.[4] The resolution, which includes the inquiry terms of reference, is reproduced on page iv. As per the resolution, Revd the Hon Fred Nile MLC was appointed Chairman of the Committee. Mr Peter Draper MP was elected to the position of Deputy Chair at the Committee's first meeting on 24 October 2007.

1.3 On 28 November the Legislative Assembly agreed to a resolution of the Legislative Council that the tabling date for the Committee's report be extended from 14 December to 20 December 2007.[5]

Conduct of the inquiry

Submissions and public hearings

1.4 The Committee received a total of 103 submissions. The Committee called for submissions through advertisements in major metropolitan, North Shore and Central Coast newspapers, and by writing to relevant individuals and organisations. Submissions were received from

2 Legislative Council, New South Wales, Minutes of Proceedings, No 19, 1st Session of the 54th Parliament, 16 October 2007, item 18

3 Legislative Assembly, New South Wales, Votes and Proceedings, No 22, 1st Session of the 54th Parliament, 16 October 2007, item 25. The original motion required that four of the eight Committee members be drawn from the Legislative Assembly and the same number from the Legislative Council. The resolution passed by both Houses stipulated that three members of the Committee be drawn from the Legislative Council and five members from the Legislative Assembly.

4 Legislative Council, New South Wales, Minutes of Proceedings, No 22, 1st Session of the 54th Parliament, 23 October 2007, item 14

5 Legislative Council, New South Wales, Minutes of Proceedings, No 33, 1st Session of the 54th Parliament, 29 November 2007, item 2

NSW Health, Northern Sydney Central Coast Area Health Service (NSCCAHS), key stakeholder groups such as the Australian Medical Association and the NSW Nurses' Association, as well as from former patients or their families, current and former nurses and doctors, allied health professionals and former members of the Area and hospital executive. A list of all submissions is contained in Appendix 1.

1.5 A total of four public hearings were conducted at Parliament House involving 78 witnesses. A list of witnesses is provided at Appendix 2 and transcripts of the hearings are on the Committee's website at: www.parliament.nsw.gov.au/royalnorthshorehospital

1.6 The Committee also conducted a site visit to RNSH on 5 November where the Committee met with Area and hospital management and senior clinicians. Details regarding this visit are included at Appendix 5.

1.7 The Committee would like to thank all who participated in the inquiry, whether by making a submission, giving evidence or attending a public hearing. We recognise that many people, including former patients and their families, and clinicians, shared information about sensitive personal and professional issues concerning their experiences at the hospital. We are grateful for your contribution.

Background to the inquiry

1.8 This inquiry has its genesis in the publication of several allegations of poor patient care at RNSH, and in particular, the treatment of Ms Jana Horska in the hospital's Emergency Department on 25 September 2007. Several other cases of alleged poor patient care received extensive media coverage following this incident. Ms Horska and a number of other people who were concerned about aspects of their care at the hospital appeared before the Committee or provided a submission. Their experiences are summarised in Chapter 3 of this report and provide a valuable reference point for discussing the systemic issues confronting the hospital.

1.9 Given the emphasis on 'systemic' issues in the terms of reference, the Committee has not sought to make findings on specific incidents or allegations of inadequate patient care. These are more appropriately examined by the relevant agencies, such as the Health Care Complaints Commission (HCCC) or the newly established Professional Practice Unit (PPU) at NSCCAHS. Where appropriate, the Committee's secretariat staff have referred individual patient complainants to the HCCC or the PPU.

1.10 Restoring staff morale and public trust will be a major challenge for the Area and hospital management. The nurses and doctors at RNSH have been subject to intense media and public scrutiny over the past few months. While several of the instances of patient care raised during the inquiry have been disturbing, the Committee also heard from inquiry participants who expressed their gratitude for the skill and commitment demonstrated by hospital clinicians.

1.11 Some of the problems that beset RNSH identified during this inquiry regarding patient care, complaint handling, workplace behaviour, management structures and resources are not confined to RNSH. For this reason, our recommendations are not confined to RNSH or the NSCCAHS, many are broadly applicable to other public hospitals in New South Wales.

The coronial inquiry into the death of Vanessa Anderson

1.12 Ms Vanessa Anderson died at RNSH on 8 November 2005. Her death is the subject of a coronial inquest and a report from the Deputy Coroner is expected to be finalised by late January 2008. The evidence of her father, Mr Warren Anderson, is discussed in Chapter 3.

1.13 On 22 November, the Committee resolved to deliver its final report on 20 December 2007, and to include in this report a recommendation to the Parliament, that if there are any recommendations from the Coroner's Report into the death of Vanessa Anderson that are within the Committee's terms of reference, that the Parliament consider re-establishing this Committee for inquiry and report into these matters.[6]

Recommendation 1

That if there are any recommendations from the Coroner's Report into the death of Vanessa Anderson that are within the terms of reference, the Parliament should consider re-establishing this Committee for inquiry and report into these matters.

Summary of issues

1.14 The inquiry has found significant problems concerning the management and operation of the Royal North Shore Hospital (RNSH). Some of the issues identified during the inquiry are specifically related to the hospital, while others are relevant to public hospitals across the State. In summary, these issues are:

- The lack of a clinical services plan to inform planning, resource allocation and capital investment
- Frequent changes of General Managers – eight over the last 10 years, leading to lack of continuity and direction in management of the hospital
- A 'disconnect' between hospital management and clinical staff, resulting in disengagement of the clinical staff
- Clinical staff criticism of the 2005 restructure of the health system which merged Northern Sydney and Central Coast Area Health Services to create the larger Northern Sydney Central Coast Area Health Service.
- Resistance by some clinical staff to integration with the wider Area Health Service network
- Failure by management to engage effectively with clinical staff in planning for the redevelopment of RNSH
- Workforce shortages and the inability to fill vacancies, increasing the stress on existing staff
- Lack of authority for senior nursing staff in clinical management structures

6 Joint Select Committee on the Royal North Shore Hospital, Minutes No 7, 22 November 2007, p 7

- Inadequate administrative, Human Resources and Information Technology infrastructure, diverting clinicians' time and energy from leadership
- Failure to invest in Information Technology at the rates common to other Area Health Services, adding to inefficiencies
- Inadequate, poorly understood financial data with considerable confusion over budget responsibilities
- Lack of capital investment resulting in seriously outdated equipment in some departments
- Unhygienic and dilapidated physical environment
- A diversion of a trust fund and diversions of other budgets to cover recurrent budget shortfalls
- High bed occupancy rates and their link to access block
- Impact of access block and understaffing on the Emergency Department
- Inappropriate model of care for women presenting to the Emergency Department with threatened miscarriage
- Impact of stress on the capacity of staff to display empathy
- Failure to ensure incident monitoring leads to system changes
- A culture of bullying, with inadequate Human Resource staffing and management commitment to respond effectively to the problem.

Report structure

1.15 **Chapter 2** provides background information on the New South Wales health system, the Northern Sydney Central Coast Area Health Service and the Royal North Shore Hospital.

1.16 **Chapter 3** includes a series of accounts of peoples' experiences at RNSH, either as patients or as the relatives of patients treated at the hospital.

1.17 **Chapter 4** considers the operation of the RNSH Emergency Department (ED). The performance of the ED is considered in comparison with other major hospital EDs, and an examination of the challenges confronting all EDs is made. The model of care used in the ED and the patient experience of that care are also addressed.

1.18 **Chapter 5** discusses claims of a culture of bullying and harassment at RNSH.

1.19 **Chapter 6** examines the organisational structure of the Northern Sydney Central Coast Area Health Service (NSCCAHS) and RNSH, including the decision to form the amalgamated NSCCAHS in 2005 and concerns about the appropriateness of the senior management structure of the NSCCAHS.

1.20 **Chapter 7** focuses on the need for a clinical services plan for the NSCCAHS and the North Shore Ryde Health Service (NSRHS) to coordinate the provision of health services within the NSCCAHS.

1.21 **Chapter 8** discusses various management issues at RNSH and in the NSCCAHS, including the perceived disconnect between clinical staff and management at RNSH.

1.22 **Chapter 9** examines issues relating to the workforce of RNSH, and the hospital's physical environment.

1.23 **Chapter 10** examines the efficiency, effectiveness and appropriateness of resources allocation and utilisation in RNSH. The financial management arrangements across NSRHS and RNSH are explained and discussed.

1.24 **Chapter 11** examines aspects of the management of healthcare incidents and complaints by patients at RNSH.

Chapter 2 Background

The New South Wales health system

2.1 The New South Wales health system comprises the following:

- The New South Wales Minister for Health, the Hon Reba Meagher MP
- The Minister Assisting the Minister for Health (Cancer), Ms Verity Firth MP, and the Minister Assisting the Minister for Health (Mental Health Services), Mr Paul Lynch MP
- The New South Wales Department of Health
- Public health organisations, including eight Area Health Services, the Ambulance Service of New South Wales, the Children's Hospital at Westmead, Justice Health, the Clinical Excellence Commission and HealthQuest.[7]

2.2 The eight Area Health Services in New South Wales are as follows:

- Northern Sydney/Central Coast
- South Eastern Sydney/Illawarra
- Sydney South West
- Sydney West
- Greater Southern
- Greater Western
- Hunter/New England
- North Coast.

2.3 The organisational structure of the North Sydney Central Coast Area Health Service (NSCCAHS) is discussed in Chapter 6.

The geography of NSCCAHS

2.4 The Royal North Shore Hospital (RNSH) is part of NSCCAHS. The Committee notes that NSCCAHS is also sometimes referred to as Northern Sydney Central Coast Health (NSCCH).

2.5 NSCCAHS came into existence on 1 January 2005 as part of the health reform package of the then Minister for Health, the Hon Morris Iemma. Mr Iemma's package, titled *Planning Better Health*, included a reduction in the number of Area Health Services across New South Wales from 17 down to eight through a series of mergers and boundary changes.

---

7 New South Wales Health, 'About New South Wales Health', cited at www.health.nsw.gov.au/aboutus/index.html (accessed 23 October 2007)

2.6 NSCCAHS was formed as a result of the amalgamation of the former Northern Sydney Area Health Service and Central Coast Area Health Service.[8]

2.7 NSCCAHS extends from Sydney Harbour to the northern reaches of the Central Coast, and incorporates the following regions:

- The Central Coast, including much of the Hawkesbury River
- Sydney's Northern Beaches
- Hornsby & Ku-ring-gai
- Ryde
- Sydney's North Shore.

2.8 NSCCAHS is defined geographically by the 13 local government areas of Gosford, Hornsby, Hunters Hill, Ku-ring-gai, Lane Cove, Manly, Mosman, North Sydney, Pittwater, Ryde, Warringah, Willoughby and Wyong.

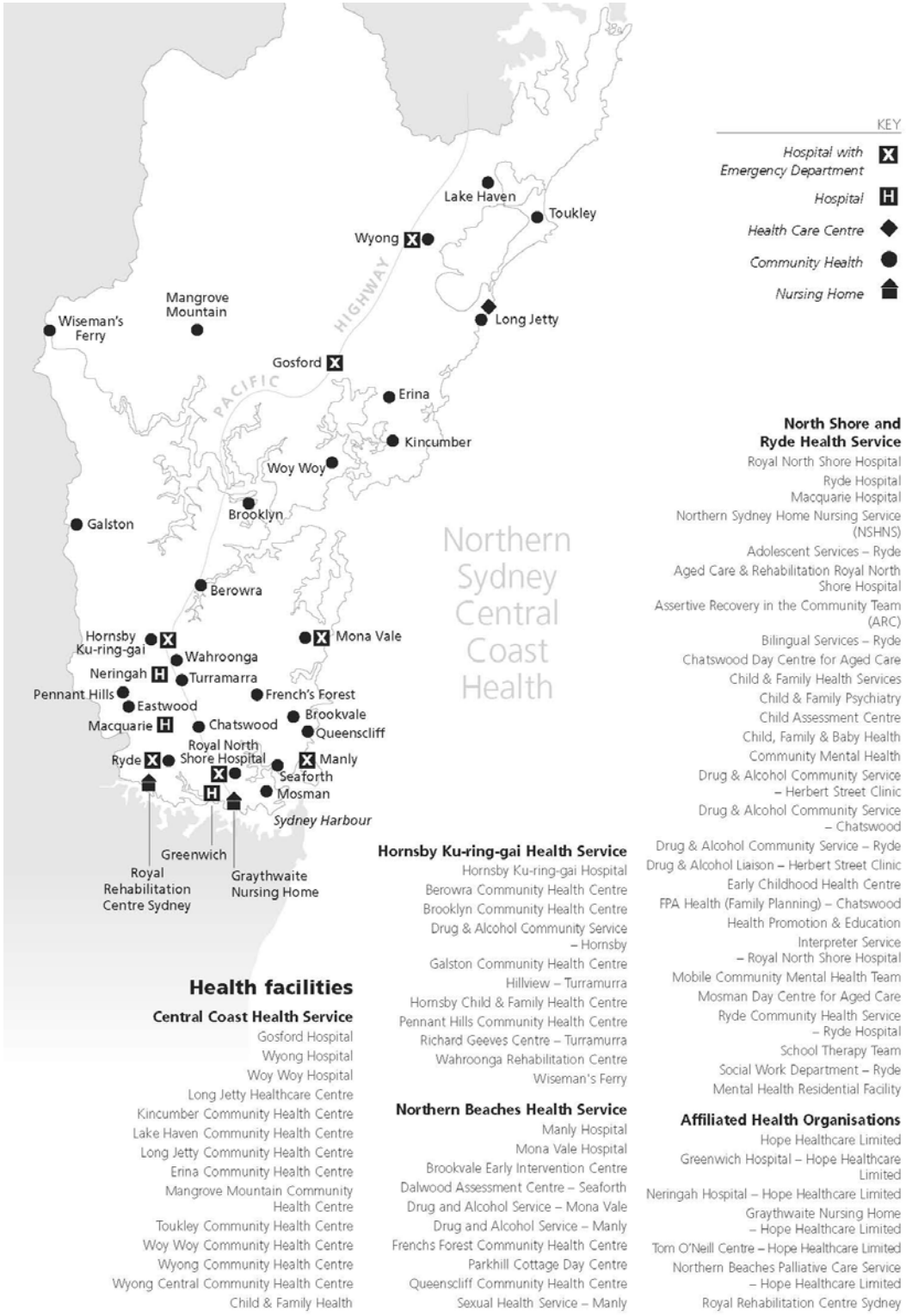
2.9 Health care institutions within NSCCAHS include Gosford Hospital, Wyong Hospital, Woy Woy Hospital, Long Jetty Healthcare Facility, Hornsby Ku-ring-gai Hospital, Manly Hospital, Mona Vale Hospital, Royal North Shore Hospital, Ryde Hospital and Macquarie Hospital. Affiliated organisations include the Royal Rehabilitation Centre, Sydney, Neringah and Greenwich Hospitals, Graythwaite Nursing Home and the Tom O'Neill Day Centre.[9]

2.10 A map of the boundaries of NSCCAHS, together with key hospitals and institutions within NSCCAHS, including RNSH, is shown over the page.

8 Northern Sydney Central Coast Health, *2005/2006 Annual Report*, p iii

9 Submission 34, Northern Sydney Central Coast Area Health Service, pp 6-7

Figure 2.1: The Northern Sydney and Central Coast Area Health Service



Source: Northern Sydney Central Coast Health, *2005/2006 Annual Report*, p ii

2.11 In 2006, an estimated 1,124,250 people lived within the boundaries of NSCCAHS, representing 16.4 per cent of the estimated population of New South Wales and 19.1 per cent of the population aged 75 years or more.

2.12 By the year 2011, it is estimated that this population will have grown to more than 1,162,210, and the 75 years and over population will have grown to more than 20 per cent of the entire New South Wales population. This is significant because older age groups need considerably more health care than the general population.[10]

The Royal North Shore Hospital

2.13 The Royal North Shore Hospital, together with Ryde Hospital, form the North Shore and Ryde Health Service. The hospital is located on the Pacific Highway at St Leonards.

2.14 The hospital services 12 per cent of the New South Wales population, making it one of the State's largest public hospitals. More than one third of all its patients come from the four local government areas of Lane Cove, North Sydney, Willoughby and Mosman.

2.15 Clinical services offered at the hospital include aged and rehabilitation care, surgical services, immunology, dermatology, microbiology, palliative care, cardiology, cardiothoracic surgery, critical care, emergency medicine, endocrine medicine and surgery, haematology, medical imaging, mental health care, neurology, obstetrics and gynaecology, oncology, ophthalmology, orthopaedics, paediatrics, pathology, podiatry, respiratory care, urology and vascular and trauma medicine.

2.16 Community health services offered at the hospital include child, adolescent and family services, drug and alcohol treatment, child protection, sexual health care, carer support, breast screening, mental health services, dental health services and health promotion.

2.17 State-wide services provided by the hospital include neonatal intensive care, severe burn care and reconstructive surgery, pain management and research, spinal cord injury care, interventional neuro-radiology, cerebrovascular embolisation and the services provided by the Sydney Simulation Centre.[11]

2.18 The hospital is also one of the state's major trauma centres and provides local and State-wide trauma services, including a specialist burns unit and a specialist spinal unit. Helicopter ambulance flights deliver patients to RNSH from country centres. This service is complemented by comprehensive intensive care and diagnostic clinical support services.[12]

2.19 The hospital is also the major tertiary referral, research and teaching hospital in NSCCAHS. It is affiliated with the University of Sydney (Northern Clinical School) and the University of Technology, Sydney (nursing education) and many staff hold conjoint appointments.

---

10 Northern Sydney Central Coast Health, *2005/2006 Annual Report*, p 1

11 NSCCH, *2005/2006 Annual Report*, p 40

12 'Royal North Shore Hospital', http://www.nscchealth.nsw.gov.au/services/003700637.shtml (accessed 23 October 2007)

Chapter 3 Patient experiences

These first-hand accounts of patient experiences at RNSH, several of which were crucial to the establishment of this inquiry, have strongly informed the Committee's report. The accounts paint a picture of a hospital under strain, and demonstrate how a demoralised organisation with staffing shortages and a lack of or poor distribution of resources can affect the quality of care that is provided to patients.

The Committee also heard examples of excellent treatment and patient care at Royal North Shore Hospital in spite of the lack of resources, and these also informed the Committee's view of the hospital's environment and performance. Shortcomings of the physical environment of the hospital, including the lack of cleanliness, are also discussed.

Adverse patient experiences at RNSH

Ms Jana Horska, former patient[13]

3.1 Ms Jana Horska miscarried in a public toilet at the Royal North Shore Hospital Emergency Department on Tuesday 25 September 2007. She was 14 weeks pregnant. Both she and her husband, Mr Mark Dreyer, were shocked by the attitude of the staff in the Emergency Department, claiming 'it was very cold; it was very mechanical. There was no care, there was no comfort; there was no reassurance'.[14]

3.2 After noticing symptoms of miscarriage, Ms Horska took a taxi to the Royal North Shore Hospital's Emergency Department. She arrived at approximately 7:10 pm and informed the triage nurse of her condition, stressing the fact that she was suffering from cramps and was bleeding. The triage nurse assessed her as a Category 4 on the Australian Triage Scale of clinical urgency[15] and told Ms Horska to take a seat and read a leaflet about miscarriage. When Ms Horska's husband arrived an hour later he reiterated their concerns to another nurse and received the same response, 'sit over there and wait'.[16]

3.3 Ms Horska's condition worsened over the next hour until she was in so much pain that she was squatting on the floor. At approximately 9:00 pm she went to the toilet for a second time:

> I experienced a further contraction, and with that there was a rush of blood and the baby came out. When the baby came out his heart was beating. His limbs were moving and he opened his mouth as if to breathe.[17]

13 Mr Mark Dreyer and Ms Jana Horska, Evidence, 16 November 2007, pp 51-57

14 Mr Mark Dreyer, Evidence, 16 November 2007, p 57

15 *Report of Inquiry into the care of a patient with threatened miscarriage at Royal North Shore Hospital on 25 September 2007, prepared by* Professor William Walters AM and Professor Cliff Hughes. The Australian Triage Scale has 5 categories, with 1 the highest urgency.

16 Mr Mark Dreyer, Evidence, 16 November 2007, p 52

17 Mr Mark Dreyer, Evidence, 16 November 2007, p 52

3.4 A triage nurse was summoned and Ms Horska was taken into the emergency area and placed on a bed. She had blood all over the lower half of her body and the foetus was still between her legs. Apart from a Panadol, Ms Horska received no medical treatment and remained in this state for an hour. After 45 minutes a nurse came in and told her:

> Don't worry. My mother has had heaps of miscarriages.[18]

3.5 Ms Horska remained in the emergency area for three hours before being taken to a ward at around midnight.

3.6 As a result of their experiences, Mr Dreyer and Ms Horska want the hospital to become more reliable and caring. Ms Horska believes that 'when you go to the emergency room you should at least be given information about how long you have to wait for'.[19] Mr Dreyer believes that nurses should show compassion because 'it was certainly lacking, and it is a basic element of nursing that I expected'.[20]

3.7 Mr Dreyer and Ms Horska say that they will always wonder whether the outcome would have been different had they been treated as a priority. Even if their child could not have been saved, they could have been spared the ordeal they went through and the trauma they have suffered since the incident.

Mrs Jenny Langmaid, former patient[21]

3.8 Mrs Jenny Langmaid miscarried in a public toilet at the Royal North Shore Hospital on 16 June 2005 at 11:30 pm. She was 14 weeks pregnant. Mrs Langmaid said:

> … there was a lack of empathy before, during and after miscarrying, a complete lack of any level of care and ignorance of my medical history, and absolute disregard for my basic needs upon presenting to the Emergency Department and my subsequent cries for help throughout those two hours.[22]

3.9 Mrs Langmaid arrived at the hospital at 9:30 pm and explained to the triage nurse her condition and medical history, which included two previous miscarriages. She told the nurse that her symptoms were identical to her previous miscarriages. The nurse told her to take a seat.

3.10 As Mrs Langmaid waited, her pain increased and her contractions became more frequent. She did not want to miscarry in a room full of strangers, which included another pregnant woman, so at 11:00 pm she insisted that even if a bed was not available, she sit in a chair on the other side of the emergency doors.

---

18 Mr Mark Dreyer, Evidence, 16 November 2007, p 52

19 Ms Jana Horska, Former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 55

20 Mr Mark Dreyer, Evidence, 16 November 2007, p 57

21 Mrs Jenny Langmaid, Former patient of Royal North Shore Hospital, Evidence, 16 November 2007, pp 84-88

22 Mrs Jenny Langmaid, Evidence, 16 November 2007, p 84

3.11 At 11:20 pm, Mrs Langmaid felt a huge gush of blood so she searched for a public toilet. She miscarried her baby son ten minutes later. Mrs Langmaid spoke to a nurse that her friend found:

> I told her that my baby was in the toilet bowl and that she would need to get a pan so that I could retrieve him. Shock, and perhaps her lack of familiarity with the department, reflected in her slow, inattentive response.[23]

3.12 Mrs Langmaid was taken to a cubicle in the Emergency Department in an effort to stop the haemorrhaging. She had to change rooms twice as neither room had the necessary instruments. Mrs Langmaid said she had to walk 'from room to room and [was] visible to others in the Emergency Department, covered in blood and completely distressed'.[24] Forty-five minutes later the nursing unit manager arrived and she was taken to the theatre so a procedure could be performed to stop the bleeding.

3.13 In light of what transpired that night, Mrs Langmaid would like to see nurses display more empathy to patients in her condition. She felt she did not receive even a basic level of care. Mrs Langmaid said to attract and retain skilled and talented workers they must offer incentives, encouragement and rewards. She considers that currently 'there is a lack of any sort of incentive to be in an environment like that; there is no reward, there is no recognition'.[25]

3.14 Mrs Langmaid also believes a change is needed in the categorisation of inpatients. She stated, 'Perhaps I was not the one dying but my baby was, and I think they need to consider that'.[26] She was, however, optimistic about the newly introduced treatment protocols for women presenting to the Emergency Department with symptoms of miscarriage.

Ms Wei Deng (Wendy) Gao, former patient[27]

3.15 On Sunday 18 March 2007, Ms Wendy Gao went to the Royal North Shore Hospital Emergency Department on the advice of a GP, who suspected she had acute appendicitis. If left untreated, a ruptured appendix can be potentially life threatening. Over the course of the next three days, Ms Gao said she was repeatedly told by a number of physicians that she did not have appendicitis, even though she was experiencing terrible abdominal pain.

3.16 After being sent away from the Emergency Department at Royal North Shore Hospital without being admitted on the Sunday night, Ms Gao had an ultrasound at her GP which showed no appendicitis. However, after experiencing a huge surge of pain on Tuesday night, Ms Gao rushed back to the Emergency Department. In agony, she had to wait in the waiting area for four hours to be seen by a doctor. This time, the doctor decided to admit Ms Gao, but the diagnostic service she needed, a CT scan, was not available until the next morning. Ms Gao then had to wait nearly eight hours to get a CT scan, all the while being in terrible pain.

---

23 Mrs Jenny Langmaid, Evidence, 16 November 2007, p 84

24 Mrs Jenny Langmaid, Evidence, 16 November 2007, p 84

25 Mrs Jenny Langmaid, Evidence, 16 November 2007, p 86

26 Mrs Jenny Langmaid, Evidence, 16 November 2007, p 85

27 Ms Wendy Gao, Former patient, Royal North Shore Hospital, Evidence, 16 November 2007, p 65

3.17 After her scan, Ms Gao said was left alone in her room with no information about her condition, despite repeatedly asking what was wrong with her. She would later find out that her appendix had burst when she felt the surge of pain on Tuesday night, before her admission.

3.18 Ms Gao told the Committee that she believes the medical staff knew her appendix had burst and neglected to tell her until after she had surgery to remove her appendix. She said that she could not understand why she had to wait days for a simple diagnostic procedure to be performed because there was no one able to perform the procedure on the weekend, or why a doctor could not come and 'talk to me just for two minutes, let me know what happened to me?'[28]

Ms Vanessa Anderson, former patient[29]

3.19 Ms Vanessa Anderson was a 16-year-old girl who died on 8 November 2005 at the Royal North Shore Hospital. She had a depressed fracture of the skull after having been hit in the head by a golf ball. Her condition was assessed as serious, but not life threatening.

3.20 Ms Anderson's parents believe systemic failures led to their daughter's death. Her father, Mr Warren Anderson, stated that the hospital:

> … 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...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 budgets are prioritised over patient safety.[30]

3.21 The Andersons are primarily concerned about three areas: a lack of staff, resulting in overworked employees; a lack of knowledge among staff of policies and protocols; and an ineffective and insensitive complaints handling system.

3.22 Mr Anderson said that the doctor who first saw Vanessa in the Emergency Department was overworked and tired. Mr Anderson said that the doctor did not inform the specialist neurosurgeon that Vanessa was in the hospital and later did not prescribe the anti-fitting medication as instructed by the neurosurgeon.

3.23 Mr Anderson stated that 'those in control of the Neurosurgery Ward were inexperienced, with a cumulative length of about two weeks experience on that ward.'[31] The medical officer's handbook was locked in a cupboard in a room on the ward, and new staff had not been provided with this orientation handbook.

3.24 Mr Anderson told the inquiry he believed that more needed to be done to encourage nurses back into the system. He said '[w]e have not got a shortage of nurses in Australia. The nurses

---

28 Ms Wendy Gao, Evidence, 16 November 2007, p 66

29 Submission 46, Mr and Mrs Anderson; Mr Warren Anderson, Relative of former patient of Royal North Shore Hospital, Evidence, 22 November 2007, pp 60-64

30 Mr Anderson, Evidence, 22 November 2007, pp 60-61

31 Submission 46, p 1

have left the system.'[32] There were only three nurses working in the almost full Neurosurgery Ward that Vanessa was in. Two doors along from this ward 'there were two empty high-dependency beds with oxygen that would have saved [Vanessa's] life'.[33] These were vacant because there was not enough nursing staff to enable the beds to be filled. During her time in the Neurosurgery Ward, Mr Anderson said that Vanessa informed a busy and overtired nurse that she had lost all feeling in her arms and legs. No doctor was called.

3.25 Following Ms Anderson's death, the family were 'treated with little empathy or consideration by senior management'. Mr Anderson said that verbal disputes between medical staff and management occurred in front of he and his wife.[34] In addition, Mr Anderson said that incorrect and incomplete information was provided to them about what transpired the night their daughter passed away.

3.26 A Coroner's report into Ms Anderson's death is likely to be completed in early 2008.

Mrs Therese Mackay, relative of a former patient[35]

3.27 Mrs Therese Mackay gave evidence to the Committee as the wife of a former patient of the Royal North Shore Hospital, Mr Don Mackay. Mr Mackay was a quadriplegic as a result of a road accident in 1982, and his wife Therese had been his primary carer for the past 25 years. Mr Mackay was admitted to the Royal North Shore Hospital in April 2007 and passed away just over five weeks later in what his wife Therese termed a 'grotesque parody'.[36]

3.28 She described her husband's death as the result a number of factors, such as no continuity of medical care, a lack of accountability amongst staff with no one willing to take responsibility for difficult situations, and incredibly poor clinical hygiene and infection control. The main factor was an operation she vehemently believes was unnecessary for her husband. Don Mackay, she told the Committee, was the victim of a 'diseased and dying hospital which was filthy and chaotic'.[37] Her husband and family received minimal support from nursing and medical staff, and in their five weeks in the hospital they did not see a social worker once.

3.29 In her evidence to the Committee, Mrs Mackay described her husband's nursing care as 'shocking', where her highly dependent husband would see up to three different nurses in one day. This was in a one-on-one nursing environment, and lasted for five weeks.

3.30 After his surgery, Mr Mackay contracted Golden Staph (a blood infection) and pneumonia. His body was full of infection, and Mrs Mackay puts this down to infection control being 'almost non-existent.'[38] Mrs Mackay told the Committee:

---

32 Mr Anderson, Evidence, 22 November 2007, p 63

33 Mr Anderson, Evidence, 22 November 2007, p 60

34 Submission 46, p 3

35 Mrs Therese Mackay, Relative of former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 69

36 Submission 14, Mrs Therese Mackay, p 2

37 Submission 14, p 1 part A

> The place was filthy beyond words…The lack of hygiene in Intensive Care was shameful.. In isolation they use a throwaway plastic bib-type of apron, which covers only about a third of your body and clothing. Apparently the staph and other dangerous germs do not go on the arms, sides and back of the body.[39]

3.31 After contracting these infections, Mr Mackay's condition steadily declined. He was moved to another room, where he would spend the remainder of his life. When he was told that he was dying, Mr Mackay was relieved, as he would be able to leave the hospital and go home to die.

3.32 One of Mrs Mackay's biggest criticisms of her husband's care was lack of full disclosure about her husband's status and prognosis. The lack of continuity of care, with a 'revolving door' of nurses, was evident in the way that staff were unwilling or unable to give information about Mr Mackay's condition to his family.

3.33 Mr Mackay's death has since been referred to the Coroner for inquest, and his treatment has been referred to the Health Care Complaints Commission.

Mrs Christine Rijks, relative of a former patient[40]

3.34 Mrs Christine Rijks' father, Mr Philip Lindsay, was a patient at Royal North Shore Hospital in 2005, where he died of renal failure. Mr Lindsay had on-going kidney problems and prostate cancer, and had been admitted to Royal North Shore Hospital on five separate occasions since 2003.

3.35 On his last admission, in July 2007, Mr Lindsay was suffering from a very bad reaction to the chemotherapy treatment being used to treat his prostate cancer. At 87 years of age, he was significantly weakened by this treatment and was suffering from severe nausea, dehydration and vomiting. He was extremely frail and so ill that he was unable to feed himself. After being told that he only had several days to live, Mr Lindsay was repeatedly asked to move hospitals, as the ward he was in was 'not a place for dying'.[41] This was extremely distressing news for Mr Lindsay to hear, and Mrs Rijks felt that through the constant need for beds, the comfort and well being of her father were being ignored.

3.36 In addition to this, it became apparent that the nursing care Mr Lindsay was receiving was drastically below what Mrs Rijks felt he required. Mrs Rijks was shocked and disappointed by the 'low level of nursing care for a dying man incapable of caring for himself'.[42]

3.37 He could not feed or bathe himself, and yet he was not helped to do these things. Mr Lindsay was also in a great deal of pain, as Mrs Rijks claimed the pain management directions on his chart (for the administration of morphine as needed) were not followed.[43]

---

39 Mrs Therese Mackay, Evidence, 16 November 2007, p 70

40 Ms Christine Rijks, Relative of former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 76

41 Ms Christine Rijks, Evidence, 16 November 2007, p 79

42 Ms Christine Rijks, Evidence, 16 November 2007, p 79

43 Ms Christine Rijks, Evidence, 16 November 2007, p 79

3.38 Mr Lindsay's wife felt she could not leave him because it appeared that no-one was looking after him in her absence.[44]

3.39 Mrs Rijks asked if she could hire a private nurse to attend to her father. Although uncommon, Royal North Shore Hospital agreed to the request. Mrs Rijks, in her evidence told the Committee that she does not mean to criticise individual nurses or doctors, and made it clear that she feels 'the low staffing levels created by the health system and management of this hospital'[45] are to blame for the substandard nursing care her father received. Mrs Rijks also made it clear that she believes her and her family were very fortunate to be able to afford their own private nurse. Other families might not be as lucky, she said. Mrs Rijks strongly stated that the option of employing a private nurse should remain available.

Ms Lindy Batterham, relative of a former patient[46]

3.40 Ms Joyce Batterham was a 90 year old amputee who was admitted to the Royal North Shore Hospital on Friday 10 November 2006. She died in the hospital the following Thursday after a sequence of events that her daughter, Ms Lindy Batterham, believes could have been avoided if there had been better communication between the staff, suitable occupational health and safety procedures in place for handling amputees and higher levels of staffing.

3.41 Ms Joyce Batterham was taken by ambulance to the Royal North Shore Hospital after experiencing breathing difficulties due to her heart condition. She waited three to four hours lying on an ambulance stretcher in great discomfort before gaining entry to the busy Emergency Department. It took a further six hours before she was admitted to the aged-care ward.

3.42 In the aged-care ward Ms Joyce Batterham was dropped to the ground when a nurse working on her own attempted to lift her from her wheelchair to a hospital bed. Ms Lindy Batterham considers this an unsafe handling procedure; she was appalled when she was told that this practice was in adherence with the hospital's occupational health and safety guidelines. After Ms Joyce Batterham was dropped, her daughter arrived and found 'they had put her back in the wheelchair and given her painkillers to address the extreme pain she complained of, and then they left her sitting in her wheelchair, with no access to a buzzer, and without calling a doctor'.[47] An x-ray, conducted at Ms Lindy Batterham's insistence, concluded that her mother had fractured her hip and would need high-risk surgery.

3.43 Ms Joyce Batterham waited 44 hours for her surgery, without any food. There were many instances of miscommunication during this time. Ms Lindy Batterham states, 'that the lack of communication between surgery and the ward was inhumane'.[48] It was only when Ms Lindy Batterham insisted that the ward call the theatre they found it had closed for the day. When

---

44 Ms Christine Rijks, Evidence, 16 November 2007, p 76

45 Ms Christine Rijks, Evidence, 16 November 2007, p 76

46 Submission 47, Ms Lindy Batterham; Ms Lindy Batterham, Relative of former patient of Royal North Shore Hospital Evidence, 22 November 2007, pp 65-69

47 Submission 47, p 2

48 Submission 47, p 3

Ms Lindy Batterham called the hospital the next morning she was told that her mother had already gone down to surgery; she was distressed, as she wanted to be there to support her mother. The nursing unit manager informed her that they did not have her contact details as her mother's file had been taken to surgery.

3.44 Ms Joyce Batterham suffered a stroke in surgery and passed away four days later.

3.45 After her mother's death, Ms Lindy Batterham was supported by the hospital's Patient Representative who organised a meeting with the Ward Manager and the Director of Nursing to discuss her complaints about her mother's treatment. Ms Lindy Batterham believes that the hospital's incident report on her mother's care was inaccurate. She was concerned that no lessons would be learnt from her mother's case.

3.46 The matter is currently with the Coroner. Ms Lindy Batterham takes issue with the fact that she was not told prior to her mother's death that the case would go before the Coroner and that she had to recount the case to the police and a social worker only a day after her mother passed away.

3.47 Ms Lindy Batterham believes that there are systemic problems in the hospital such as a lack of staffing, that she considers can only really be fixed by improved pay and conditions for nurses. She also states that the aged-care ward should have a higher ratio of staff, as the patients on that ward tend to have greater needs.

Mr Steve Crosby, relative of a former patient[49]

3.48 Mr Crosby gave evidence to the Committee on behalf of his partner, Ms Leng Liu.

3.49 Ms Liu was eight weeks pregnant when she presented to the Royal North Shore Hospital Emergency Department on the advice of her GP. She had severe abdominal pain and a lot of bleeding and feared that she was going to miscarry. They arrived at around 9:30 pm on 25 September 2007 and about five minutes later were seen by a triage nurse who assessed Ms Liu's condition.

3.50 Ms Liu and Mr Crosby waited for an hour and a half before Mr Crosby confronted the triage nurse and asked how many patients were before his partner on the admission list. He was told that there were nine people in front of Ms Liu, despite there only being six people in front of her when they arrived. The nurse explained that Ms Liu's condition was stable and that they admit people in order of priority.

3.51 Ms Liu, by that stage, was in tremendous pain and experiencing very heavy bleeding. Mr Crosby was very distressed at seeing his partner in such discomfort and asked the triage nurse how long until his partner would be seen. She was reluctant to answer, but eventually told Mr Crosby:

> Well, look, we're not going to be able to do anything until we have an ultrasound and we're not going to be able to do that until the morning.[50]

---

[49] Mr Steve Crosby, Relative of former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 89

3.52 Mr Crosby was very agitated and distressed by this:

> I was in total disbelief at that stage…She was prepared to let me sit there right through the night, without even telling us, and I said, 'Look, I'm going to take my wife home where she can at least lay down.'[51]

3.53 Mr Crosby and Ms Liu left the hospital shortly after this and went home. After being home for about five minutes, Ms Liu miscarried in the toilet.

3.54 Mr Crosby made the point that this happened on the same evening as Ms Horska's miscarriage:

> I just could not believe that that had happened and they were prepared to let it happen again, half an hour afterwards.[52]

3.55 Mr Crosby told the Committee that he would be very happy to see a change in the way that threatened miscarriages are handled by Emergency Departments, and that he would hate for anyone else to have to experience what he and Ms Liu did in Emergency.

Mrs Sharon Hooper, relative of a former patient[53]

3.56 Mrs Sharon Hooper's grandmother, Mrs Edith King, was a patient at the Royal North Shore Hospital in 2007. Mrs King is 92 and was transferred to RNSH from Hornsby Hospital because of blood clots in her legs. She has very limited mobility and suffers from dementia.

3.57 During her stay, Mrs King kept trying to get out of bed, so the nurses put the rails on her bed up to stop her from falling. Mrs King persisted and climbed over the rails, causing her to fall and cut her legs quite badly. After this fall, the nurses moved Mrs King to a treatment room, which was in sight of the nurses' station. Medical supplies were stored in this room, including oxygen tanks. Mrs Hooper found out about her grandmother's treatment through the media rather than through the hospital, which caused her great distress:

> All I wanted was some information to see how she was coping.[54]

3.58 However, her requests for information went unanswered. Mrs Hooper said she did not blame the nurses:

> …watching them with their workload, it is just ridiculous, it really is ridiculous.[55]

---

50 Mr Steve Crosby, Evidence, 16 November 2007, p 89

51 Mr Steve Crosby, Evidence, 16 November 2007, p 89

52 Mr Steve Crosby, Evidence, 16 November 2007, p 89

53 Ms Sharon Hooper, Relative of former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 58

54 Ms Sharon Hooper, Evidence, 16 November 2007, p 58

55 Ms Sharon Hooper, Evidence, 16 November 2007, p 58

3.59 After the media attention about this incident Mrs Hooper said she was contacted by many hospital representatives, after previously struggling to draw any medical attention to her grandmother. Mrs King was subsequently moved to another ward, before being transferred back to Hornsby Hospital.

3.60 Mrs Hooper told the Committee that she believes there is a communication problem between patients and their families and RNSH. She believes that in comparison to her experience of the patient/family consultation that takes place in Hornsby Hospital, communication between patients and their families and RNSH is poor and needs to be drastically improved.

Positive patient experiences at RNSH

3.61 While the Committee heard from people who were dissatisfied with the care they were afforded at RNSH, or that their relatives were afforded, we also received many positive comments from people who were very happy with the level of care provided at the hospital.

3.62 Mr David Ingman and his wife Jean informed the Committee that they received 'prompt and excellent attention' when Mr Ingman presented to the Emergency Department at RNSH with chest pains on 29 January 2007.[56] They said that Mr Ingman's examination and subsequent treatment were extremely thorough:

> … at every stage the staff were pleasant, informative, considerate and quite frankly very caring. We cannot speak highly enough of all the staff we came into contact with.[57]

3.63 Mrs Jenny Clarke submitted that her family 'will always be deeply grateful for the prompt, sensitive and incredible competence' of all the sections of the hospital she had contact with while her son, Alex, was a patient in August 2007:

> The medical teams responded rapidly to every change in Alex's condition and were very thorough in their investigations… We were overwhelmed by the quality of care since it was patently obvious they were grossly understaffed and under resourced… Unfortunately Alex's condition turned out to be terminal, but Royal North Shore gave him back some of the most important days of his life.[58]

3.64 Mr Raymond Tooby was a patient at RNSH in 2004 when he was admitted for cardiac surgery. He said, 'I received great care and kindness, the staff were very diligent with my care.'[59]

3.65 The Committee also acknowledges that there are many other people who are very grateful for the care and commitment of the staff of RNSH. In his evidence Dr Ray Raper, Director of Intensive Care at RNSH, read the following letter to the Committee, on behalf of Professor Malcolm Fisher AO:

---

56 Submission 26, Mr and Mrs Jean and David Ingram, p 2

57 Submission 26, p 2

58 Submission 67, Mrs Jenny Clarke, p 2

59 Submission 72, Mr Raymond Tooby, p 1

> No-one at the Royal North Shore Intensive Care Unit knew what a great kid our son was. He was so proud when he bought his first car and set off. To a mother it gave the same sinking … feeling as when he first rode his tricycle out the gate. Our fears were realised, we were summoned to the Royal North Shore and met your husband who told us our son was almost certainly going to die. For the next seventy-four hours he tried to stop him dying.
>
> Every hour or two he came and told us how he was going. He didn't need to speak after a while. We could tell from the way he walked, and when he was winning and when he was losing. We lost.
>
> We send you these flowers to thank you for lending us your husband last weekend. We are sorry he wasn't home.[60]

Committee comment

3.66 The Committee wish to express their sympathy and regret to all those who have experienced complications in their treatment or who have lost loved ones at Royal North Shore Hospital. We thank those who were willing to come forward and share their experiences as part of this inquiry in the hope that their evidence may prevent similar cases in the future.

The physical environment

3.67 Throughout the inquiry, the Committee heard complaints about the physical environment of the RNSH. Patients and staff alike complained of the lack of cleanliness of the hospital and the dilapidated nature of some of the wards and operating theatres.

3.68 Chapter 10 addresses issues associated with old and redundant equipment, in the context of the need for improved capital replacement planning. In this section, the Committee considers some of the points relating more generally to the physical condition of the buildings.

Cleanliness

3.69 The RNSH was given a thorough clean shortly before the Committee visited it on 5 November. There was some scepticism expressed in the media that this cleaning had been conducted expressly for the Committee's visit. This suggestion was vigorously denied by the Minister for Health, the Hon Reba Meagher MP:

> The issue of cleaning was first raised by the nurses when they met with the Chief Executive on 25 September. They identified at that meeting that the cleanliness of the hospital was not up to scratch. The new Chief Executive gave a commitment to act on the nurses' concerns. That is an example of good management, responsive management, and a management team that is determined to improve staff morale.[61]

3.70 The former acting Chief Executive, Mr Terry Clout, told the Committee that in his short time as Chief Executive, he had not experienced any particular problems with cleanliness:

---

60 Dr Ray Raper, Director, Intensive Care, RNSH, Evidence, 16 November 2007, p 31

61 Hon Reba Meagher MP, Minister for Health, Evidence, 12 November 2007, p 4

> I did not observe there being any levels of gross untidiness or dirtiness. It is an old building, there is no question about that, and it shows the signs of many old buildings.[62]

3.71 However, Dr Tom Hugh, Head of the RNSH Department of Gastro Intestinal Surgery, commented critically on the general level of cleanliness in the hospital :

> 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.[63]

3.72 A number of parties to the inquiry commented on the lack of cleanliness in the hospital.[64] Mr Warren Anderson said that the physical condition of the hospital was a disgrace. He showed the Committee photos he had taken of the men's toilets in the hospital shortly after his daughter 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.[65]

3.73 Mrs Therese Mackay also commented on the 'filthy' conditions in the intensive care unit, where her husband was being cared for after having had an operation on his lungs. She felt that the conditions in the ICU had resulted in her husband Don contracting infections:

> The lack of hygiene in intensive care was shameful. Infection control is almost non-existent.[66]

3.74 However, Dr Andrew Ellis, an orthopaedic surgeon VMO at RNSH, told the Committee that while the hospital was dirty, the operating theatres were not, and therefore the rate of infection is not high:

> … 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

62 Mr Terence Clout, Chief Executive, South Eastern Sydney Illawarra Area Health Service, Evidence, 12 November 2007, p 68

63 Dr Tom Hugh, Head, Department of Gastro Intestinal Surgery, Royal North Shore Hospital, Evidence, 22 November 2007, p 55

64 See, for example: Submission 10, Ms Maureen Cain, p 2; Submission 13, Dr Jeffrey Hughes, p 1; Submission 20, Mr Donald Martin, p 5; Submission 52, Professor Malcom Fisher AO, p 6.

65 Mr Anderson, Evidence, 22 November 2007, p 61

66 Mrs Mackay, Evidence, 16 November 2007, p 70

> 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.[67]

3.75 Professor Cliff Hughes, CEO of the Clinical Excellence Commission, told the Committee about the CEC's hand hygiene campaign across hospitals in NSW, which had been launched at North Shore Hospital over a year ago. Professor Hughes said that hand hygiene was an important way to control infection and said that the program had been very successful:

> We doubled the rate of hand washing in our hospitals. It went from about 28 to 30 per cent to about 68 per cent.[68]

3.76 The Cardiology Department of RNSH were critical that there had been a major clean of the hospital that they felt did not address the issue of infection:

> The fact that it is still incomplete and patchy in application some weeks following a very expensive 'blitz' by contractors working over week-ends, is worrisome. Also concerning is the fact that cleaning has been confined to 'patient and visitor areas' **This is another slap in the face for staff** and represents a failure to understand the non-aesthetic INFECTION implications of filth in hospitals. Unfortunately, 'bacteria' don't differentiate between patient and staff areas![69]

3.77 The lack of basic maintenance was identified as a problem by Ms Barbara Lucas, a senior physiotherapist at RNSH. Ms Lucas commented that there were 'numerous areas of disrepair' in her workplace:

> 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.[70]

Inappropriate accommodation

3.78 Ms Sharon Hooper, the granddaughter of a patient of RNSH, discovered that her grandmother, Mrs Edith King, had been kept overnight in a treatment room that had also been used to store equipment. [71]

3.79 The treatment room, which the Committee saw on their site visit, is used to store supplies used in the daily activities of the ward. If occupied by a patient, it is possible that staff may

---

67 Dr Andrew Ellis, Orthopaedic Surgeon VMO, Royal North Shore Hospital, Evidence, 22 November 2007, p 83

68 Professor Cliff Hughes, Chief Executive Officer, Clinical Excellence Commission, Evidence, 12 November 2007, p 88

69 Submission 30, Cardiology Department RNSH, p 15

70 Ms Barbara Lucas, Senior Paediatric Physiotherapist, Royal North Shore Hospital, Evidence, 22 November 2007, p 88

71 Ms Hooper, Evidence, 16 November 2007, p 58

disturb the patient when collecting supplies. Ms Hooper was not happy about the accommodation:

> I just could not understand why they had put her in there. It was like she was not important; she did not have feelings.[72]

3.80 Dr Antony Sara, President of the Australian Salaried Medical Officers Federation agreed that it was not appropriate to use the storage room as a treatment room.[73]

3.81 The Minister for Health, the Hon Reba Meagher MP, told the Committee that the treatment room was an appropriate place to use in the clinical management of certain patients, and it would continue to be used:

> The treatment room is used for patient care and has been used for patient care for a long time. It is equipped with oxygen, suction and a patient buzzer. I went on the night with the director general to discuss with the nurses the decisions they had made in relation to the care of a patient. They assured me that they use that room because it affords them a greater line of observation from the nurses' station, and they felt that it was quite important in the appropriate clinical management of this elderly woman. So, the treatment rooms will continue to be used until we redevelop the hospital.[74]

3.82 Dr Andrew Keegan, President of the Australian Medical Association (NSW) commented that while it might have been an appropriate place to monitor a patient under the circumstances, he was surprised that there was not a better alternative:

> … if the nursing staff felt it was the appropriate thing to watch that patient properly then I have no problems with the nursing staff doing that. But I follow that by asking: Should they not have had another bed designated as a ward bed to do that instead?[75]

Shared wards

3.83 It is common practice in public hospitals, including Royal North Shore Hospital, to have wards shared by male and female patients. The Committee heard evidence from a number of inquiry participants who were unhappy with this arrangement.[76]

3.84 For example, Ms Hooper complained about the situation of her grandmother once she had been moved from the treatment room to a shared ward:

> After the incident in the treatment room they put her in another ward with three men. I know there is now in the public system a shared ward sort of thing, but they had her shoved in a corner and the gentleman who was in the bed next to her had the curtains

---

72 Ms Hooper, Evidence, 16 November 2007, p 60

73 Dr Antony Sara, President, Australian Salaried Medical Officers Federation, Evidence, 12 November 2007, p 53

74 Hon Reba Meagher MP, Evidence, 12 November 2007, p 9

75 Dr Andrew Keegan, President, Australian Medical Association (NSW), Evidence, 12 November 2007, p 53

76 See, for example: Submission 75, Dr Michael Kennedy, p 1; Ms Sharon Hooper, Relative of former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 58

> around him the whole time, so she could not see whether it was daylight, dark or whatever, and every now and again the nurses would just run past her and see if she was all right, and the gentleman next to her also had security guards at the bottom of his bed. I do not know what he was there for, but that was not very comforting either.[77]

Committee comment

3.85 The Committee notes that, throughout patient evidence, there were references to:

- overworked clinicians
- a lack of continuity of care
- a lack of information sharing with patients and their families
- inadequate priority given to women threatening or undergoing a miscarriage
- a lack of diagnostic capacity out of hours
- poor complaints handling
- lack of cleanliness in certain areas.

3.86 The Committee also notes community concern about the physical environment and lack of cleanliness of the Royal North Shore Hospital.

3.87 We accept that there is not much that can be done about a dilapidated building, but there is no excuse for not keeping a hospital clean, particularly considering the dangers of infection that exist within hospitals. The 'project clean' that occurred shortly before we conducted our site visit restored the hospital to the level of cleanliness that it should have at all times.

3.88 The Committee notes that the redevelopment project planned for the hospital will result in new buildings and state-of-the-art facilities. It is essential that the level of cleanliness which was introduced shortly before our site visit is maintained in the new hospital with adequate funding and staffing available for that purpose. All areas of the hospital should be cleaned, including those used by clinicians that are not routinely visible to patients or visitors.

[77] Ms Hooper, Evidence, 16 November 2007, p 58

Chapter 4 Operation of the Emergency Department

> The distressing events that led to Ms Jana Horska having a miscarriage in the toilets of the emergency department on 25 September 2007 occurred due to the fact that the hospital was full to capacity and no bed was available in the Emergency Department.[78]

On the night of 25 September 2007, Ms Jana Horska arrived at the Royal North Shore Hospital (RNSH) Emergency Department (ED) with symptoms of miscarriage. Her experience in the ED and subsequent miscarriage in the ED toilet prompted an immediate review of ED procedures on that night resulting in the *Report of Inquiry into the care of a patient with threatened miscarriage at Royal North Shore Hospital on 25 September 2007*.[79] The events of that night also led to the establishment of this Committee to inquire into the structural and organisational issues that affect the quality of patient care at RNSH.

In this chapter the Committee examines the operation, structure and role of the ED at the RNSH. The problems of access and exit block are explained and considered, with an examination of possible solutions. The Committee also examines the triage system in operation within the hospital and the shortcomings of the triage system for the care of patients.

The Royal North Shore Hospital Emergency Department

4.1 The RNSH ED is the access point to the hospital for people presenting with urgent medical needs. On a typical day, ED staff at the RNSH will see anywhere between 120-180 patients, with a wide variety of illness and injuries.

4.2 On arrival in the ED, patients are assessed by a triage nurse and allocated a triage category under the Australian Triage System (ATS) according to the seriousness of their injury or illness. Categories range from 1 to 5, with 1 being the most serious. The ATS scale is outlined in greater detail later in this chapter. Patients are then seen according to their triage category. Depending on the seriousness of the injury and the number of other patients in the ED, there can be considerable waiting periods for treatment.

4.3 Some of those patients, about 35 per cent, will need to be admitted to other parts of the hospital, while the remaining 65 per cent are treated in the ED and discharged to their homes.[80]

---

78 Dr Tony Joseph, Director of Trauma (Emergency), Evidence, 16 November 2007, p 11

79 *Report of Inquiry into the care of a patient with threatened miscarriage at Royal North Shore Hospital on 25 September 2007,* Professor William Walters AM, head of the Royal Hospital for Women at Randwick, and Professor Cliff Hughes, Chief Executive Officer of the Clinical Excellence Commission. Hereafter referred to as the Walters/Hughes Report

80 Submission 27, RNSH ED, p 4

Structure of the Emergency Department

4.4 The current ED of the RNSH opened in 2003 and consists of Adult Emergency and Paediatric Emergency areas, six consultation rooms, three resuscitation beds, a fast track area and an Emergency Medical Unit intended for short stays.[81]

4.5 The Adult Emergency area contains nineteen beds while the Paediatric Emergency area contains seven beds.[82]

4.6 The ED provides a range of services for patients:

- The groundbreaking acute interventional rescue of heart attack victims in the ETAMI and SALAMI programs[83]
- A 24 hour Level 6 Emergency Service, the highest level, seeing both adult and paediatric patients requiring unscheduled treatment.
- A Trauma Centre for the Northern Sydney area guaranteeing immediate transfer of patients requiring tertiary care within the Area Health Service.
- Acute assessment and/or resuscitation of patients with acute burns and spinal injuries, as part of the hospital's State-wide role in those areas.
- A 5 bed Emergency Medical Unit (EMU) where patients can be admitted under an Emergency Specialist for up to 24 hours.
- A fast track Emergency Treatment area allowing rapid treatment of ambulatory patients. [84]

4.7 The ED also fulfils a teaching and training role, promotes a research program and has been actively involved in implementing work practice changes to improve the operation of the ED, including the fast track Emergency Treatment area and the EMU.[85]

4.8 One important point raised by a number of participants to this inquiry relates to the physical location and layout of the ED and the difficulties of accessing it. In his submission, Mr Lindsay Skinner (an architect specialising in hospital planning and design and former patient, visitor of patients and father of a registrar at the RNSH) identified several issues associated with the layout of the ED, including poor signposting, poor positioning of the triage and admission desks and an inability to monitor the public toilet. He suggested that the poor physical layout contributed to other problems within the ED:

> I believe that the poor functional planning creates great inefficiency and inconvenience for staff which wastes a lot of their time, effort and energy, and contributes to poor morale and performance.[86]

---

81 Submission 27, p 2

82 Submission 27, p 2

83 Dr Stephen Hunyor, Director, Cardiac Technology Centre, RNSH, Evidence, 16 November 2007, p 2

84 Submission 27, pp 2-3

85 Submission 27, pp 3, 4

4.9 Two parties to the inquiry noted the difficulty of even locating the ED, citing poor signage from the street and confusing instructions provided over the telephone by ED staff.[87]

Activity, staffing and performance

4.10 In the following sections, the Committee examines key statistics for the ED and draws comparisons with other peer hospitals in NSW. Peer hospitals are those of a similar size with similar functions across the State, and include the John Hunter Hospital in Newcastle, the Liverpool Hospital and the Royal Prince Alfred Hospital.

4.11 It is important to note that while statistics and figures provided by NSW Health for other parts of RNSH were disputed and criticised by clinicians at the hospital (as discussed at length in Chapter 10), these ED statistics were not subjected to the same degree of scepticism.

Attendance and utilisation

4.12 In his submission on behalf of the ED, Dr Robert Day noted that the ED 'has been dealing with steadily increasing demand which has caused increasing pressure on the unit'. He cited an increase from 42,312 presentations[88] in 2004/05 to 49,903 presentations in 2006/07, an increase of 7,591 presentations. From 2000/01 to 2004/05 the figures had been relatively stable at between 42,000 and 43,000 presentations, with a low of 40,948 in 2002/03.[89]

4.13 Dr Day emphasised the impact of changes in 2005 to the ambulance matrix system (the ambulance matrix system determines to which hospitals ambulances take their patients) on presentations to the ED, with an increase from an average 26 per day in 2003/04 to 37 per day in 2006/07.[90]

4.14 However, in its submission, NSW Health provided utilisation figures for the ten hospitals with the greatest volume of ED presentations, including the ED of RNSH, that showed that the RNSH ED 'is not the busiest, and it is not in the top 10 across the State in terms of demand growth'.[91] The figures are provided in Table 4.1.

86 Submission 45, Mr Lindsay Skinner, p 2

87 Submission 5, Mr Timothy Slee, p 1; Submission 11, Ms Suzanne Benson, p 2

88 The event of a person attending the Emergency Department as a patient is referred to as a presentation.

89 Submission 27, p 5

90 Submission 27, p 5

91 Submission 33, NSW Health, p 30

Table 4.1 Presentations to Emergency Departments, 10 NSW hospitals with greatest volume

Hospital	Emergency Department presentations			
	2005/06	2006/07	Growth 05/06 to 06/07	% Growth
John Hunter	55,331	58,117	2,786	5.0%
Liverpool	51,794	57,211	5,417	10.5%
Royal Prince Alfred	49,960	54,962	5,002	10.0%
St George	49,392	53,707	4,315	8.7%
Penrith-Nepean	46,368	50,994	4,626	10.0%
Royal North Shore	**46,696**	**49,900**	**3,204**	**6.9%**
Westmead	45,669	49,779	4,110	9.0%
Children's Hospital (Westmead)	45,822	48,903	3,081	6.7%
Gosford	46,375	48,581	2,206	4.8%
Wollongong	43,359	47,782	4,423	10.2%

Source: Submission 33, NSW Health, pp 28-29

Staffing in the Royal North Shore Hospital Emergency Department

4.15 The ED provided information on their current staffing levels. Key points made were that vacancies among emergency specialists, registrars and nurses were impacting on the effectiveness of the ED. Some of the issues arising from those staff shortages are addressed in this section. However, many of the issues raised in relation to the ED workforce and the challenges the ED faces are applicable across all State EDs, and these broader issues are therefore examined from a State-wide perspective.

Issues specific to Royal North Shore Hospital ED – emergency specialists and registrars

4.16 A registrar is a 'doctor in training' who has not yet specialised in a particular area of medicine. An emergency registrar is a registrar working in the ED, and a 'basic emergency trainee' is a registrar that has chosen emergency medicine as a specialty. An emergency specialist is an experienced doctor specialising in emergency medicine. The term emergency physician has been used by participants in this inquiry and there is a difference between the two terms but for the purposes of this report the terms are used interchangeably.

4.17 There are 29 FTE (full time equivalent) positions for emergency registrars in the ED (14 FTE Basic Emergency Trainees and 15 Emergency Registrars). Vacancy rates are between 1 and 7 FTE positions for 2007. There was some discrepancy in figures provided for emergency specialist positions in the ED, with figures ranging from 9.8 FTE (full time equivalent) to 11.55 FTE positions. In its submission, the ED noted that there are currently 9.8 FTE funded positions for emergency specialists. At the time the submission was made, the ED stated that

8.8 positions were filled.[92] NSW Health noted in its original submission that RNSH has an above average number of emergency specialists, at 10.55 FTE.[93]

4.18 In its supplementary submission NSW Health advised that the preliminary results of a survey conducted in September 2007 by the Australian Medical Officers Federation (ASMOF) and the NSW Department of Health identified 11.3 FTE positions in the ED, with 1.5 FTE vacant. An earlier survey, conducted in July 2007, identified 10.55 FTE specialists and a further 1 FTE vacancy, a total staffing of 11.55 FTE.[94]

4.19 The ED referred to the Australian Medical Workforce Advisory Committee (AMWAC) report of 2003, which recommended minimum specialist staffing levels of between 11 and 16 emergency specialists at each major referral ED, as an immediate priority.[95] There was no discussion of whether the number of emergency registrar positions was appropriate, but the level of vacancies was cited as a contributor to the high workload of the ED.

4.20 Dr Robert Day, Director of Emergency Medicine at RNSH, told the inquiry:

> Medical staff vacancy rates have led to 50 to 150 shifts per month being filled by locum staff. Two years ago we did not need to use locums at all. The figure of 10.55 emergency specialist staff given by the Department of Health in its submission for Royal North Shore is incorrect. We currently have 9.8 positions, of which 8.8 are filled. We believe the Department of Health should urgently bring the number of emergency specialists up to the AMWAC recommended numbers so that we can provide at least 16-hour-a-day specialist cover.[96]

4.21 In evidence to the Committee, Dr Sally McCarthy, Vice President of the Australasian College for Emergency Medicine (ACEM), noted that despite the extensive use of locums there were still vacant doctor shifts in EDs across New South Wales:

> That is par for the course. No Emergency Department in New South Wales meets the Australian Medical Workforce Advisory Committee 2003 recommendations for specialist medical staffing in Emergency Departments and, in particular, Royal North Shore Hospital Emergency Department does not meet that guideline.[97]

4.22 The implication of the difference in staffing figures cited by NSW Health and the ED is that on NSW Health figures the ED already meets the AMWAC 2003 guidelines, although not all positions are filled. However, NSW Health identified the need to revisit the guidelines in light of revised models of care operating in EDs, including in RNSH ED, an issue discussed later in this chapter.

---

92 Submission 27, p 12

93 Submission 33, p 29, see also the figures in Appendix 6

94 Submission 33a, p 3

95 Submission 27, p 12. See also Dr Sally McCarthy, Vice President, Australasian College for Emergency Medicine, Evidence, 12 November 2007, p 64; and Dr Robert Day, Director of Emergency Medicine, RNSH, Evidence, 16 November 2007, p 13

96 Dr Day, Evidence, 16 November 2007, p 13

97 Dr McCarthy, Evidence, 12 November 2007, p 63

Issues specific to Royal North Shore Hospital ED – nursing

4.23 A shortage of nurses is a State-wide problem for EDs and for other hospitals, as discussed in Chapter 9. The Committee heard evidence related to vacancies, rather than the complement required for the provision of treatment.

4.24 Vacancies in ED nursing have ranged between 5 and 20 positions (out of 86.46 FTE) over the past 2 years. This has resulted in the regular use of agency nursing staff, who the ED described as having variable skills, a poor knowledge of the ED policies and procedures, a higher incidence of adverse events and requiring extra supervision by senior nurses.[98] The adequacy of the number of nursing positions in ED was not specifically addressed in the ED submission.

4.25 Coupled with high levels of nursing vacancies, the number of experienced nursing staff at the ED has declined in recent years. There has been a shift from Registered Nurses (RNs) with predominantly eight years or more experience to a majority of staff now being in their junior years. Many senior staff now work part time. This has meant that the skill base of the Department has suffered.[99]

4.26 Evidence presented to the Committee by three experienced Nurse Unit Managers from the ED further illustrated that the decline in experienced nursing staff was due to conditions in the ED, and commented on the implications of that trend:

> 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.[100]

4.27 This evidence was reiterated by Dr Robert Day, Director of the ED:

> Front-line nursing staff are overloaded with continuous high-intensity work. As a result, the most experienced nursing staff in Emergency at North Shore nearly all work part time. The most common full-time nurse is a junior second-year registered nurse. Nurse vacancy rates have been increasing year by year and in April this year we were 20 positions short.[101]

4.28 The ED submission particularly highlighted the increasing need for Clinical Nurse Educators (CNEs) to meet the current and ongoing education needs of the ED. Education is vital to providing junior nurses with skills to practise safe care, together with promoting job satisfaction, career growth and nurse retention. The role is particularly important in a situation where the majority of staff are relatively inexperienced. However, currently the Emergency Department has only two CNEs to support the nurses. The Intensive Care Unit at RNSH currently has four FTE CNEs for a similar workforce.[102]

---

98 Submission 27, p 10

99 Submission 27, p 11

100 Ms Michelle Beets, Nurse Manager, RNSH ED, Published in camera evidence, 22 November 2007, p 1.

101 Dr Day, Evidence, 16 November 2007, p 13

102 Submission 27, p 11

4.29 In her evidence, Ms Michelle Beets, Nurse Manager of the Emergency Department at RNSH, noted that one of the two CNE positions has been vacant for the best part of the year. Ms Beets subsequently indicated that she would like to see three or four nurse educators in the ED.[103]

4.30 Ms Beets also highlighted the difficulty that the Emergency Department is experiencing in recruiting, in part due to the bad publicity associated with events such as those that led to the establishment of this inquiry.[104]

State-wide ED staffing issues

4.31 Many participants in this inquiry from the emergency medicine area discussed the issue of staffing in EDs from a State-wide perspective.

4.32 For example, Dr Tony Joseph, Director of Trauma at RNSH, identified a shortage of emergency specialists in New South Wales as a whole. He compared the number of emergency specialists in Victoria (254, or 52 per million) with the number in NSW (234, or 36 per million population).[105]

4.33 In its submission, ACEM noted that NSW has one of the lowest ratios of emergency specialists to the number of patients treated in its EDs in Australia. In support, it cited workforce surveys that found that specialist trainee positions in NSW EDs are only filled by Australian trained, registered ACEM trainees in approximately 50% of cases, with the remainder being filled by overseas trained doctors, non-training doctors, locums or left vacant.[106]

4.34 Dr Joseph also commented on the shortage of sufficient staff for supervision and training of newly trained doctors seeking to work in EDs and the potential for problems into the future:

> We have a lower number of specialists, certainly in our workforce, and we are concerned we are not going to have enough to train young emergency physicians if we can actually manage to attract them back into the training scheme. [107]

4.35 Dr Clare Skinner, a registrar in the ED, similarly acknowledged that as more strain is placed on the EDs and senior specialists struggle to meet clinical targets, the opportunities for training the next generation of emergency specialists tend to 'fall by the wayside'. While the interns may be coming through, there may not be sufficient training places for them in the public hospital system.[108]

4.36 In a supplementary submission, NSW Health commented that the figures comparing emergency specialist numbers in Victoria and NSW cited by Dr Joseph (derived from ACEM)

---

103 Ms Beets, Published in camera evidence, 22 November 2007, pp 1,6

104 Ms Beets, Published in camera evidence, 22 November 2007, p 2

105 Dr Joseph, Evidence, 16 November 2007, p 11

106 Submission 36, Australasian College for Emergency Medicine, p 3

107 Dr Joseph, Evidence, 16 November 2007, p 16

108 Dr Clare Skinner, Registrar, RNSH ED, Evidence, 22 November 2007, pp 72-73

were not FTE figures but rather 'headcounts', making it difficult to draw any conclusions about how many hours of emergency specialist staffing is available for EDs in either State.[109]

4.37 NSW Health also noted that the number of emergency medicine trainees had increased by 13.6 per cent from 2005 – 2006, and that funding had been announced to support Area based service and training networks to further increase the number of training sites.[110]

4.38 In its submission, the ED noted some of the disadvantages of using locum medical staff in the ED:

> Locum medical staff do not know local systems and their level of skill levels is variable. Locums are also extremely costly, being paid $100-$130 per hour. There is good evidence that locum staff are associated with more adverse events and complaints. [111]

4.39 While noting with concern the low level of growth in Australian medical graduate numbers, NSW Health commented that regardless of the country in which a doctor or locum was trained, all working in the NSW public hospital system must be registered by the NSW Medical Board. NSW Health noted that '[e]thnicity and/or country of qualification is not a determinant of clinical competence'.[112]

4.40 NSW Health also commented in their supplementary submission on the AMWAC 2003 report and guidelines on appropriate minimum staffing levels in EDs. NSW Health cited the AMWAC 2003 report itself, which noted that jurisdictional implementation of the guidelines may be modified by significant changes to service delivery models.[113]

4.41 NSW Health advised that the AMWAC 2003 report guidelines were in need of revision, given the significant changes to service delivery models that have occurred since the report. Accordingly, NSW Health is establishing an expert group, The Emergency Department Workforce Reference Group, to consider optimum staffing profiles for EDs to meet the agreed service model.[114]

4.42 In response to the issue of employing more emergency specialists, Mr Matthew Daly, the Executive Director of NSCCAHS commented on the difficulty of finding them:

> I have spent the last four or five years in Health trying to attract more and more emergency physicians and the reality is in fact that there are far more positions that hospitals are willing and wanting to fund than there are emergency physicians, hence the amount of locums at extraordinary rates that we are obligated to employ in order to provide some emergency physician coverage.[115]

---

109 Submission 33a, pp 2, 4

110 Submission 33a, pp 3-4

111 Submission 27, p 12

112 Submission 33a, p 4

113 Submission 33a, p 3

114 Submission 33a, p 3

115 Mr Matthew Daly, Chief Executive, NSCCAHS, Evidence, 12 November 2007, p 28

4.43 Dr Skinner told the Committee that many ED medical staff do not see a future in emergency medicine:

> 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.

4.44 However, Dr Joseph observed that the shortage of emergency specialists was not nation-wide:

> My department is short three to five registrars for next year. That is in contrast to the Alfred Hospital in Melbourne, which is the busiest trauma centre in Australia. The emergency medicine director tells me that they have to turn away 30 registrars who want to work there every year. That says something about the working environment and the culture in Victoria.[116]

4.45 In correspondence from the Minister for Health to the Committee, the Minister gave an update on the actions she had taken to address the pressures on public hospitals, including challenges faced by EDs. She outlined a $30 million funding package on 15 November 2007, one element of which involves the provision of 35 additional emergency specialist positions. Some of those positions (2.25FTE) have been allocated to RNSH. Other relevant actions include the establishment of an Emergency Department Workforce Reference Committee to provide advice on workforce strategies and to provide regular reports to the Ministerial Taskforce on Emergency Care, a campaign to support recruitment of medical staff to areas of shortage, and the promotion of Nurse Practitioners and ED nursing as a specialty. [117]

4.46 NSW Health advised the Committee in its supplementary submission of recent events in the Industrial Relations Commission (IRC) concerning the Emergency Physician Staffing Determination of the Staff Specialists (State) Award agreed to in April 2006. The new Award had an allowance payable to emergency physicians of up to $58,000 for any emergency physician working at least 15 clinical shifts at locations beyond the scope of their normal work location/s. The new Award provisions also required emergency physicians to work five days per week rather than the current practice of four. The recommendation of the IRC following private conferences between the Department of Health and ASMOF will require emergency physicians to work five days per week and provide fifteen clinical shifts per year at locations outside the work locations, to receive payment of the allowance. [118]

Performance of the Emergency Department

4.47 Dr Richard Matthews, Deputy Director General, NSW Health told the Committee that there were seven major performance indicators for emergency departments, in three broad categories:

---

116 Dr Joseph, Evidence, 16 November 2007, p 12

117 Correspondence from Minister for Health, Hon Reba Meagher MP, to Committee, received 4 December 2007, pp 1, 2

118 Submission 33a, pp 5-6

- Off-stretcher time, the percentage of patients handed from the ambulance to the ED clinicians within 30 minutes.
- Access block, the percentage of patients transferred from ED to a ward in less than eight hours, in situations where admission is necessary.
- The remaining five performance indicators relate to the five triage categories under the Australian Triage Scale (ATS).[119]

4.48 The ATS sets benchmark times for treatment for each triage category, from 100 per cent of patients treated within two minutes for the most serious Category 1 through to 70 per cent of patients treated within 120 minutes for the least serious Category 5.

4.49 In its submission to the inquiry, NSW Health compared performance indicators for the RNSH to those for EDs in other peer hospitals.

4.50 NSW Health noted that peer hospitals often performed better under greater pressure than that experienced by RNSH:

> The comparison shows that not only was Royal North Shore the poorest performer in Emergency Admission Performance in 2006/07, many of its peers managed to substantially improve their performance in the face of greater demand pressures than those facing Royal North Shore.[120]

4.51 Off stretcher time performance for the ED at June 2006 was 55 per cent, that is, 55 per cent of all patients arriving by ambulance at the RNSH ED were transferred into the ED within 30 minutes of arrival. At June 2007 that figure was marginally lower, at 54 per cent. A comparison with the 10 highest volume EDs showed that the RNSH was the lowest performing ED in relation to off stretcher time performance.[121]

4.52 Emergency admission performance (the percentage of patients transferred from the ED within eight hours) was 66 per cent at June 2006 and June 2007, meaning that 34 per cent of patients requiring admission from the ED were not admitted to a bed in the hospital for at least eight hours. [122]

4.53 The NSW Health submission provides a table showing a comparison of the 10 highest volume EDs against the benchmark times for each triage category, for the 2006/07 period.[123]

4.54 The ATS benchmarks for each category are 100 per cent for Triage 1, 80 per cent for Triage 2, 75 per cent for Triage 3, and 70 per cent for Triage Categories 4 and 5.[124] The RNSH ED failed to meet benchmarks for Triage Categories 2, 3 and 4 and performed poorly against other high volume EDs.

---

119 Dr Richard Matthews, Deputy Director General, NSW Health, Evidence, 12 November 2007, p 13

120 Submission 33, p 31

121 Submission 33, p 31

122 Submission 33, p 31

123 Submission 33, p 32

124 Submission 32, AMA and ASMOF, p 15

4.55 The Hon Reba Meagher MP, Minister for Health, told the Committee that there had been improvements in the RNSH ED performance against some performance indicators from September 2007 to October 2007. She cited an improved off stretcher time performance of 71.2 per cent of ambulance patients moved from stretchers into the ED in October 2007, up from 63 per cent in September 2007. Performance for triage categories 3 and 4 also improved, up from 70 per cent to 76.1 per cent and 72 per cent to 82.6 per cent from September 2007 to October 2007 for each category respectively.[125] A supplementary submission provided by NSW Health on 3 December showed that performance for these triage categories continues to improve, with figures of 84 per cent for triage category 3 and 89 per cent for triage category 4.

Committee comment

4.56 The Committee notes that while there has been a growth in presentations to the Royal North Shore Hospital Emergency Department over the past couple of years, other Emergency Departments have also been confronted with an increase in presentations, in some cases at a higher rate. Evidence we have received indicates that RNSH has average levels of staffing compared with its peers.

4.57 The fact that there are other Emergency Departments across the State with similarly high presentations and similar staff levels does not, however, minimise the serious challenges confronted by the Royal North Shore Hospital in relation to increasing demand.

4.58 Medical workforce shortages are not confined to the RNSH ED, and are applicable across the nation. Competition to fill positions is strong, and good candidates are attracted to institutions with good reputations and supportive organisational cultures. The Committee examines the issue of organisational culture and the importance of effective organisational structures in Chapters 5 and 6. We believe that improving the culture of the RNSH and making it a proud and harmonious workplace will help attract staff to the hospital.

4.59 We note the measures suggested by the Minister for Health to address ED workforce issues, and further note the suggestions of NSW Health that the optimum ED workforce may have changed as a result of changes to the models of care now used in EDs.

4.60 The Committee also notes the advice of NSW Health in relation to the recent industrial negotiations between the Department of Health and emergency physicians, and the contribution these negotiations may have made to the complex issues around ED workforce.

4.61 The Committee believes that the optimum level of ED workforce needs to be agreed between the various parties and notes the establishment of the Emergency Department Workforce Reference Committee and the Ministerial Taskforce on Emergency Care. The Committee recommends that the work of these groups be expedited to provide a solid basis for workforce planning in the ED.

125 Hon Reba Meagher MP, Minister for Health, Evidence, 12 November 2007, p 2

Recommendation 2

That NSW Health expedite the work of the Emergency Department Workforce Reference Committee and the Ministerial Taskforce on Emergency Care in establishing optimum levels for Emergency Department workforces, including specialists, registrars and nurses, who are currently working in Emergency Departments.

4.62 The Committee notes the declining levels of experience among nursing staff of the ED. We recognise the need for experienced nursing staff to be available for the provision of education to less experienced nurses. To that end, the Committee recommends that NSRHS review the number of Clinical Nurse Educator positions available within RNSH Emergency Department, including comparison with peer hospitals, to determine the appropriate number of additional positions, and begin recruitment action to fill those positions immediately.

Recommendation 3

That NSRHS review the number of Clinical Nurse Educator positions available within RNSH Emergency Department, including comparison with peer hospitals, to determine the appropriate number of additional positions, and begin recruitment action to fill those positions immediately.

Access and exit block

4.63 Access block refers to the inability of emergency patients who have finished their emergency care but require admission to an inpatient hospital bed, to leave the ED.[126] Access block is measured by the Emergency admission performance indicator, measuring the percentage of patients admitted from ED in less than eight hours. The figure for RNSH ED is 66 per cent, giving a figure of 34 per cent of patients experiencing access block.[127]

4.64 The Australasian College of Emergency Medicine (ACEM) identified access block as the 'single biggest threat to the provision of emergency care'.[128] ACEM stated that EDs across New South Wales suffered from '30-40% of their patients experiencing access block and occupying beds that should be available for new patients.'

4.65 The AMA and ASMOF noted the high degree of access block operating within the RNSH Emergency Department. The organisations, citing figures from the Australasian College of Emergency Medicine, commented that the functionality of an ED degrades once access block exceeds 10 per cent of patients awaiting admission. The access block figure for RNSH of 34 per cent, in that context, 'is surely a cause of significant problems'.[129]

126 Submission 36, p 2

127 Submission 33, p 31

128 Submission 36, p 2

129 Submission 32, p 15

4.66 The Committee heard extensive evidence from participants to this inquiry commenting on the relationship between bed occupancy rates in the hospital as a whole and access block.

4.67 Bed occupancy refers to the number of beds occupied in a hospital at any time. Bed occupancy is expressed as a percentage, and usually refers to the average for a month. A bed occupancy rate of 90 per cent for June 2006, for example, means that in June 2006 there were on average only 10 per cent of the hospital's beds available for new patients.

How many beds are there in Royal North Shore Hospital?

4.68 Bed occupancy rates are based on a figure for the number of beds available. The question of how many beds there are at RNSH seems a simple one, but it does not have a simple answer. During the inquiry the Committee heard a range of figures and rationales for those figures. In particular, there was a discrepancy between the number of beds NSW Health said RNSH had and the number of beds clinicians working at RNSH said RNSH had.

4.69 In evidence to the Committee, the NSW Health Director General, Professor Debora Picone, outlined the number and type of beds available at RNSH:

> So, at the Royal North Shore Hospital we have, not wishing to bore you, day only beds, which exclude the renal beds and the emergency medical unit, of 28; 321 medical, surgical beds; 20 acute spinal; 25 acute geriatric; 36 intensive care beds; 20 paediatric beds; 32 maternity beds; 25 NICU—that is, neonatal intensive care unit and special care beds; 24 bassinettes, and they range from level one cots to level three; burns and plastics, 12; renal dialysis treatment chairs, 18; drug and alcohol, 14. That is subtotal off 145. And then the subtotal of acute beds is 575 and then we have 24 mental health psychiatric acute care beds, giving us a total of 599.[130]

4.70 Dr Richard Matthews, Deputy Director General of NSW Health told the Committee that one reason for disagreement over how many beds there are in a hospital is that doctors 'tend to go and count the beds that are relevant to them':

> So, if you are working in the Emergency Department you look at the medical and surgical beds and you look at the ICU, because the statewide beds such as the burns and spinal beds are not of such direct relevance. Because things like bassinettes and cots, which are available for very sick neonatal and can be transferred around the State, are not of direct relevance to your particular work, you may not include that in your count. I think it may be that the numbers we have quoted, and the Minister has quoted, are correct and it may be that the numbers that doctors have been talking about are correct within their frame of reference.[131]

4.71 Indeed, Dr Joseph, Director of Trauma at RNSH, recognised that while there were 599 available beds, only 406 of those beds were acute beds that were accessible to patients through the ED.[132]

---

130 Professor Debora Picone, Director General, NSW Health, Evidence, 12 November 2007, p 10

131 Dr Matthews, Evidence, 12 November 2007, p 10

132 Dr Joseph, Evidence, 16 November 2007, p 11

4.72 Dr Joseph, and other parties to the inquiry, pointed out that one problem with using bed occupancy figures to act as a guide to access block is that many of the beds included in the count are not available for admissions from ED.

4.73 Bed numbers at RNSH, and in fact across the State and internationally, have reduced over time although bed numbers have been increased in the past few years. NSW Health representatives explained to the Committee that changes in medical procedures and models of care worldwide have resulted in shorter hospital stays and therefore have reduced the need for hospital beds. There has also been a reinvestment in beds across the State in the past few years.

Causes of access block

4.74 There are a variety of causes of access block at RNSH. The most obvious one is high bed occupancy rates, meaning that there are no available beds in the hospital to which to admit patients from the ED who require further hospital treatment. Other less obvious causes relate to inefficiencies in the management of inpatient beds, communications issues between the ED and other Departments, and the capacity of the hospital to treat patients in areas other than the ED where appropriate.

4.75 For example, in her evidence, Dr Sue Ieraci, a specialist in emergency medicine at Bankstown Hospital, argued that over the past 20 years, there has been an increasing tendency for EDs to be used as the 'front door' of hospitals, with the result that all activity and patients are funnelled through Emergency, including mental health patients who might more appropriately be directed to mental health wards. This in turn is placing significant pressure on EDs. Dr Ieraci continued:

> Specialty units have to provide clinics or assessment units for patients who do not need emergency treatment. There are lots of those out in the community. Typical examples would be elderly nursing-home patients and, I will say again, mental health patients.[133]

4.76 The specific issue of mental health patients presenting to the ED at RNSH was raised by Ms Michelle Beets, Nurse Manager of the ED at RNSH. She noted that the lack of mental health beds for mentally ill patients is a huge issue for the ED, as mental health patients can be very disruptive and difficult to manage.[134] Dr Clare Skinner, a registrar in the Emergency Department at RNSH, submitted similar evidence.[135]

4.77 NSW Health provided information to demonstrate the bed occupancy rates for RNSH were 'around the average' for its peer hospital group. For 2005/06, the bed occupancy rate for RNSH was 90.4 per cent and for 2006/07 the rate was 89.8 per cent. Other peer hospitals ranged from a low of 86.6 per cent (John Hunter, 2006/07) to a high of 100.4% (Liverpool, 2006/07).[136]

---

133 Dr Sue Ieraci, Emergency Medicine specialist, Bankstown Hospital, Evidence, 16 November 2007, p 14

134 Ms Beets, Published in camera evidence, 22 November 2007, p 2

135 Dr Skinner, Evidence, 22 November 2007, p 71

136 Submission 33, p 32

4.78 Some participants in this inquiry identified higher rates of bed occupancy than those provided by NSW Health. For example, the submission of the RNSH ED commented that '[s]ince the late 1990's RNSH has run on a bed occupancy of well over 90%'.[137]

4.79 Dr Day, the Director of the RNSH ED, reiterated this comment in evidence to the Committee:

> The Department of Health in its submission gave an occupancy figure for North Shore Hospital of 90 per cent, which I believe is not correct, and it is likely to count beds that are not available to Emergency Department patients. Northern Sydney Central Coast Area Health Service data in my submission shows that at Royal North Shore for 9 of 12 months in 2006-07 the hospital occupancy was at 95 per cent or above. In emergency we collected figures for two months over winter that showed an average of 16 patients waiting in emergency every morning for a bed.[138]

4.80 The AMA and ASMOF commented that while strategies to manage patient flows and thus reduce access block had been implemented, the fundamental reason for access block remained a lack of inpatient beds:

> The inability to move patients who are designated for admission from the Emergency Department to inpatient wards, so-called access block, is fundamentally due to inadequate numbers of inpatient beds, with extremely high occupancy levels impacting upon the ability of clinicians and hospitals to effectively manage patient flows. Other strategies to manage patient flows have been implemented with varying degrees of success; however in the absence of sufficient inpatient beds these are only likely to have a marginal impact.[139]

4.81 The AMA and ASMOF cited an analysis by the Road Trauma and Emergency Medicine Unit of the Australian National University, which found that the high bed occupancy rate figures indicated a system under pressure:

> These figures are most consistent with a system which has passed the point of maximum efficiency and is now in a situation where even small changes in demand cause large changes in the number waiting.[140]

4.82 In their submissions to the inquiry, Dr Peter Roberts, Area Network Chair of Emergency Medicine for Northern Sydney Central Coast Area Health Service, and Dr Paul Cunningham, a senior staff specialist in the Ryde Hospital Emergency Department, both identified a lack of inpatient beds as the primary cause of access block.[141]

4.83 Dr Roberts commented that the shortage of inpatient beds was a nation-wide phenomenon, but was particularly pronounced in the NSCCAHS:

---

137 Submission 27, p 8

138 Dr Day, Evidence, 16 November 2007, p 13

139 Submission 32, pp 16-17

140 Submission 32, p 16

141 Submission 3, Dr Peter Roberts, p 1; Submission 4, Dr Paul Cunningham, p 1

> The root cause of patients being treated in waiting rooms is lack of beds accessible by emergency patients. This happens because there are not enough beds Australia wide, in NSW in particular, in public hospitals in particular, and most particularly in the part of NSCCAHS south of the Hawkesbury.[142]

4.84 Dr Tony Joseph, Director of Trauma at RNSH, told the Committee that the incident involving Ms Jana Horska on 25 September 2007 occurred 'due to the fact that the hospital was full to capacity and no bed was available in the Emergency Department'.[143]

4.85 Dr Joseph recommended that a bed occupancy rate of less than 85 per cent should be set as a benchmark for all public hospitals to address the problem of access block. [144] The AMA and ASMOF, confirmed that 85 per cent was the appropriate figure and suggested a number of new beds were required:

> Clearly at these high levels of occupancy, hospitals struggle to cope with both elective and emergency demand. A Royal North Shore Hospital with 600 beds and 95 per cent occupancy would need an additional 70 beds to achieve 85 per cent occupancy.[145]

4.86 However, in its supplementary submission to the inquiry, NSW Health noted that there is 'no accepted universal 'standard' percentage occupancy benchmark for hospitals' and there remained debate in the literature about what a safe, efficient and cost-effective level of hospital occupancy is. While acknowledging a need to develop strategies to manage demand, NSW Health commented that 'it is widely accepted that the provision of additional beds is not the single answer'.[146]

Exit block

4.87 Exit block refers to the situation where patients who are able to be discharged from hospital do not have a suitable place to be discharged to, such as a rehabilitation bed or an aged care facility. Elderly patients who require ongoing care that can be provided by a nursing home commonly experience exit block. Patients in need of ongoing rehabilitation care are another group that commonly experience exit block.[147]

4.88 Exit block is linked to access block because patients experiencing exit block are occupying beds that could be filled by patients in the ED.

4.89 Dr Danny Stiel, Clinical Director of the NSRHS Division of Medicine and Aged Care, commented that rehabilitation care was a particular problem:

> There is currently a very fragmented rehabilitation process. We have people who do a bit of rehabilitation at North Shore, we have Royal Rehabilitation at Ryde, and we

142 Submission 3, p 1

143 Dr Joseph, Evidence, 16 November 2007, p 11

144 Dr Joseph, Evidence, 16 November 2007, p 11

145 Submission 32, p 15

146 Submission 33a, p 8

147 Dr Day, Evidence, 16 November 2007, p 17

> have the Greenwich hospital run by Hope Healthcare. There is not good coordination between them.[148]

Overcoming access and exit block

4.90 The Committee heard a number of responses to the problems of access and exit block, and some recommendations for further action.

4.91 The RNSH ED submission suggested the most important solutions to ED overcrowding are:

- an increase in hospital beds to ensure less than 85 per cent occupancy
- the development of service plans to ensure appropriate referral patterns to RNSH from within and outside the Area
- further work at hospital level to ensure better patient flow through and efficient discharge processes
- better after hours availability of diagnostic services to allow ED to meet patient demand.[149]

4.92 Recognising the capacity and appropriateness of emergency specialists making binding decisions about the appropriate place for a patient to be admitted to, and having other Departments accept and implement those decisions, was suggested by a number of parties to the inquiry.[150] Dr Ieraci told the Committee that the ED model in hospitals has changed, from being just the 'front door' of the hospital to driving the activity of the hospital, but 'the resources and the policies' have not kept up with the change:

> What is the solution to that? Senior Emergency Department staff have to have the power to admit patients to the most appropriate team for their care; and having done that, the specialty teams that we refer patients to have to then take responsibility for their care.[151]

4.93 Similarly, Dr Peter Roberts, the Area Network Chair for Emergency Medicine at NSCCAHS, commented that once there was trust in the ED from other Departments, the decision to admit could be made in the ED and implemented:

> 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.[152]

---

148 Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Evidence, 16 November 2007, p 49

149 Submission 27, p 9

150 Dr Ieraci, Evidence, 16 November 2007, pp 13-14; Dr Peter Roberts, Area Network Chair, Emergency Medicine, North Sydney Central Coast Area Health Service, Evidence, 22 November 2007, p 76

151 Dr Ieraci, Evidence, 16 November 2007, pp 13-14

152 Dr Roberts, Evidence, 22 November 2007, p 76

4.94 AMEC provided a number of suggestions for overcoming access block in addition to providing extra inpatient beds, including:

- Increasing the number of specialist emergency physicians so as to reduce system reliance on junior, variably trained doctors.
- Supporting adequate numbers of clinical and support staff in Emergency Departments so as to realistically address current demands for emergency care.
- Improving support structures such as improved information management, with additional non-clinical support to allow clinical staff to focus more on the delivery of clinical care.[153]

4.95 Most participants agreed that while there were a range of strategies to address access block, increasing the number of acute inpatient beds was of primary importance.

4.96 Dr Joseph recommended 'the immediate introduction of at least 70 acute care beds', combined with a program to increase emergency specialist and senior nursing staff and the urgent development of the Area clinical services plan. [154] This figure was supported by the AMA and ASMOF.[155]

4.97 An increase of 150 beds across NSW hospitals has been announced by the Minister for Health as one measure to address access block in EDs, with an additional 12 beds for RNSH. NSW Health pointed to a number of additional measures intended to address access block in EDs across the State:

> The Clinical Service Redesign Project is a fundamental plank in supporting the health care needs of the community, as is sustainable access planning and the development of alternative models of care for groups of patients such as the elderly.[156]

4.98 To address the issue of exit block, Dr Stiel emphasised the importance of improving the operation of Aged Care Assessment Teams and rehabilitation services in the Area:

> These strategies to improve exit block include some of the things that have been mentioned—better aged care assessment team assessment. Probably the major thing for us is rehabilitation. … The Poulos report—Chris Poulos is a rehabilitation physician who suggested in April or May that we get a rehabilitation department with a clinical leader and really get moving on coordinating and getting things running.[157]

4.99 Mr Michael Devery, the Manager, Ambulatory Age Care and Rehabilitation Service, advised the Committee that:

> On the resource side, ACAT resources at RNS have been enhanced somewhat over recent years, but there are in my opinion significant deficits, principally: impoverished basic business operations and business infrastructure (most significantly, completely

153 Submission 36, p 4

154 Submission 48, Dr Tony Joseph, pp 8, 9

155 Submission 32, p 15

156 Submission 33a, p 18

157 Dr Stiel, Evidence, 16 November 2007, p 49

> inadequate information technology); inadequate Allied Health and Nursing resources; a clinical governance framework unsuited to the full integration of the Aged Care Assessment Program, and a cumbersome Health Service bureaucracy.
>
> I would say that there is a growing imbalance of demands and resources, and that the LNS ACAT is operating, at best, at the margins of its capacity. I think that to date the ACAT has managed to maintain its contribution to patient flow, and to a lesser extent to the quality of in-patient care, but it is not clear to me how the ACAT will meet the demands on it in the longer term if the balance of demands and resources continues to deteriorate.[158]

Committee comment

4.100 It is clear from evidence presented to the Committee that the root cause of problems facing the Royal North Shore Hospital Emergency Department does not stem from within the ED itself. Patients, once admitted to the ED, generally receive very good medical care. The problem is that those patients that require admission to another area of the hospital as inpatients are not moved on quickly enough, taking up space that could and should be used to treat newly arrived patients.

4.101 Figures provided by NSW Health for other hospitals show that bed occupancy rates are higher at many other hospitals, and yet their performance against the benchmark times for treatment after triage are much better. This suggests that the problem will not be solved by simply adding more beds to the hospital. A more comprehensive approach to the problem is required. We note the extensive evidence suggesting that the issues relating to access block are not limited to RNSH.

4.102 The Committee welcomes the announcement in November 2007 by the Minister for Health of the provision of an additional 150 acute hospital beds across NSW public hospitals, including an additional 12 at Royal North Shore Hospital, and her comments in relation to examining the placement of additional ED staff specialists across metropolitan hospitals.[159] The Committee believes that the additional beds are a good first step, but we are concerned that they may not be sufficient. Accordingly we recommend that NSCCAHS, as part of their role in the development of the Area clinical services plan, work with senior clinicians to determine if the RNSH needs additional beds.

Recommendation 4

That NSCCAHS, as part of their role in the development of the Area clinical services plan, work with senior clinicians to determine if the RNSH needs additional beds.

4.103 The Committee also believes that these additional beds may not be sufficient to address the issue of access block, even in conjunction with other strategies and recommendations outlined

158 Answers to questions on notice from 16 November 2007, Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Attachment, p 2

159 Hon Reba Meagher, Minister for Health, 'Additional beds allocated across NSW public hospitals', *Media Release*, 19 November 2007, available at: www.health.nsw.gov.au/news/2007/20071119_00.html (accessed 30 November 2007)

in this report. Therefore, the Committee recommends that NSCCAHS monitor and publicly report on the impact of the additional beds and implementation of the clinical services plan on access block at RNSH.

Recommendation 5

That NSCCAHS monitor and publicly report on the impact of the additional beds and implementation of the clinical services plan on access block at RNSH.

4.104 There is a need to change the way in which admissions are managed through the ED. EDs are set up to deliver emergency care, and they are not intended to treat patients for extended periods of time. It therefore makes sense that emergency physicians, once they have determined the appropriate action for their patient, should be able to make a decision about where that patient should be admitted and have that decision implemented.

4.105 The Committee notes the evidence that many other EDs are under similar pressures to the RNSH, with similar or higher bed occupancy rates, and yet perform better. We therefore recommend that NSW Health work with Area Health Services to analyse the relationship between bed occupancy rates and access block in hospitals across Area Health Services, to identify those practices and procedures that increase the effectiveness of hospitals in addressing access block.

4.106 One explanation for the better performance of other EDs might be that existing practices and procedures within RNSH are not optimal. We therefore make a number of recommendations intended to address this possibility.

4.107 The Committee also identifies some Area Health Service responsibilities, related to the development of the clinical services plan (discussion of which is contained in Chapter 7). Changes to the roles which hospitals within the Area play as part of the clinical services plan will have an impact on patient demand at Royal North Shore Hospital. The Committee therefore recommends that the Area review patient demand as part of the clinical services plan, with a view to developing bed management practices that will optimise bed availability. The review of patient demand should also include a review of the existing bed configuration to identify changes that will best support patient demand.

Recommendation 6

That NSW Health work with Area Health Services to analyse the relationship between bed occupancy rates and access block in hospitals across Area Health Services, to identify those practices and procedures that increase the effectiveness of hospitals in addressing access block.

Recommendation 7

That NSRHS work with NSCCAHS to immediately review:

- Bed management practices and nurse workloads to ensure that all existing beds are used as efficiently as possible, drawing on any good practice examples from other hospitals or Areas.
- Discharge practices to ensure that beds are made available as quickly as possible, drawing on any good practice examples from other hospitals or Areas.
- Communication practices between Departments within the hospital to ensure timely transfer of patients between wards and operating theatres.

4.108 The Committee recognises that the problem of access block is linked to the problem of exit block. Some of the recommendations of this section in relation to discharge planning will address exit block as well as access block. Exit block is also affected by the shortage of appropriate aged care facilities to which to discharge elderly patients. We acknowledge that effective discharge planning for elderly patients will be limited by the shortage of available places, both within Northern Sydney specifically and in the State more generally. We therefore recommend that the NSW Government prioritise discussions with the Australian Government to ensure sufficient aged care places are available in the Northern Sydney area and the State, to assist with safe and timely discharge of elderly patients.

4.109 Doctors gave evidence that a lack of rehabilitation care was a particular problem in causing exit block.[160] The Committee therefore recommends that NSW Health prioritise discussions with providers of rehabilitation services to ensure that sufficient rehabilitation outpatient services are available in the RNSH redevelopment and that further non-acute inpatient care is available for patients who are ready to be discharged from RNSH.

Recommendation 8

That the NSW Government prioritise discussions with the Australian Government to ensure sufficient aged care places are available in the Northern Sydney area specifically and in the State more generally, to assist with safe and timely discharge of elderly patients.

Recommendation 9

That NSW Health prioritise discussions with providers of rehabilitation services to ensure sufficient rehabilitation outpatient services are available in the RNSH redevelopment and that further non-acute inpatient care is available for patients who are ready to be discharged from RNSH.

160 See paragraphs 4.87 to 4.89

4.110 The Committee heard evidence that mental health patients are presenting to the RNSH ED when they should be more appropriately assessed and treated in other departments of the hospital.

The Australian Triage System

4.111 The current Australian Triage System (ATS) categorises patients according to the seriousness of their illness, on a scale of one to five where one is the most serious. Those people who present to the ED with immediately life threatening injuries are seen immediately.

4.112 There is no doubt that the ATS is a clinically appropriate system for categorising patients. However, a common thread to many of the complaints from patients about their treatment in the RNSH ED stems from their experience of that treatment.

4.113 The incident involving Ms Jana Horska on the night of 25 September 2007 highlighted a shortcoming of the triage system. The system does not take into account the emotional distress of the presenting person in the case of a threatened miscarriage, treating all injuries solely in terms of their potential threat to the life of the presenting patient and not the unborn child.

4.114 There was criticism of the nursing staff working in RNSH Emergency Department, and other areas of the hospital, from a number of patients and relatives of patients who gave evidence to the Committee.

4.115 For example, Mr Mark Dreyer told the Committee that he and his partner Ms Horska had experienced a robotic, unfeeling environment:

> We can talk all we want about lack of funding and how the hospital has got systematic problems and the health system has problems and all the rest of it, but the basic nursing qualities of care, comfort and reassurance to patients just were not there. My experiences with the nurses—the nurse that I dealt with and the other one there—were that they were cold and very robotic. Even at the time they came into the toilet there was no care, no comfort, no hug—nothing. It was just business. It was all business. It was robotic, it was mechanical and it was very cold.[161]

4.116 In his submission, Mr Peter Egan commented on his experience of waiting for an extended period for diagnosis and treatment of a pulmonary embolism in the RNSH ED. He suggested that 'Emergency Department staff need to come out from behind the bullet-proof glass and take ownership of their waiting rooms, toilets and building approaches'.[162]

4.117 Mr Donald Martin complained that when he arrived at the RNSH ED, '[t]wo women behind the thick glass panels that protect admission staff from the sick' kept their backs to him for twenty minutes. Mr Martin commented that he believed he had not received an appropriate assessment:

---

161 Mr Mark Dreyer, Relative of former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 54

162 Submission 18, Mr Peter Egan, p 2

> Those women may have been trained in distance diagnosis but on this occasion it was not reliable. At the time I must have been already showing advanced signs of the hypertension that later ended in a stroke …[163]

4.118 Dr Wendy Michaels described the treatment of her father on a number of visits to the ED, and commented that there appeared to be insufficient staff available to deal with the demand, and inexperienced, overworked and weary staff with inadequate supervision to properly assess patients.[164]

4.119 Mr and Mrs Ian and Christine Butters described the experience of Mrs Butters being discharged to a GP with a diagnosis of 'acute appendicitis' after hours of waiting, only to return to the ED following a visit to the GP. Mr and Mrs Butters commented that the subsequent explanation of the RNSH that the diagnosis provided was not the diagnosis of the ED reflected a 'self-serving, self-excusing attitude'.[165]

4.120 There were, however, also positive stories of treatment in the ED, as well as the hospital more generally. Some of the more general issues associated with complaints handling and the patient experience at RNSH are addressed in more detail in Chapters 3 and 11.

4.121 For example, Mr and Mrs Jean and David Ingman described the 'excellent treatment' received by Mr Ingman following his presentation with chest pains in January 2007.

> At every stage the staff were pleasant, informative, considerate and quite frankly very caring. We cannot speak highly enough of all the staff we came into contact with.[166]

4.122 Ms Millie Mills said of her treatment in the ED for food poisoning that the 'skill and care of all staff could not have been better'.[167]

4.123 Mrs Jenny Clarke was very complimentary of the treatment her son had received for his brain tumour at a number of RNSH Departments, including the ED:

> We will always be deeply grateful for the prompt, sensitive and incredible competence of all areas. We where overwhelmed by the quality of care since it was patently obvious they were grossly understaffed and under resourced.[168]

4.124 Dr Day, in his submission on behalf of the RNSH ED, stated that the ED is staffed by 'skilled, dedicated and committed professionals who are deeply affected by allegations of poor patient care'. Dr Day said that there have been a large number of letters and emails sent to RNSH in support of the ED since the negative publicity the ED had received following the media reports of Ms Horska's experience on 25 September 2007. He added that the accusations of a lack of compassion were not true:

---

163 Submission 20, Mr Donald Martin, p 2

164 Submission 39, Dr Wendy Michaels, p 2

165 Submission 57, Mr and Mrs Ian and Christine Butters, pp 1-2

166 Submission 26, Mr and Mrs Jean and David Ingman, p 1

167 Submission 62, Ms Millie Mills, p 1

168 Submission 67, Mrs Jenny Clarke, p 1

> The cause of most of the complaints that have come from patients is a stretched, overloaded workforce and a chronically overcrowded ED.[169]

4.125 Ms Michelle Beets, an experienced Nurse Unit Manager within the RNSH ED, commented on the very difficult and stressful job of the triage nurse:

> 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.[170]

4.126 A report into the events of the night of 25 September 2007 was commissioned by the Director General of NSW Health on 26 September 2007 and was conducted by Professor William Walters AM, head of the Royal Hospital for Women at Randwick, and Professor Cliff Hughes, Chief Executive Officer of the Clinical Excellence Commission. The report, released on 26 October 2007 and titled *Report of Inquiry into the care of a patient with threatened miscarriage at Royal North Shore Hospital on 25 September 2007* (the Walters/Hughes Report), recommended changes to the model of care for pregnant women presenting to Emergency Departments. The report, while not addressing the broader issue of access block, raised some important issues about the treatment of women who present with symptoms of miscarriage. A copy of the report is attached at Appendix 5.

4.127 Professor Hughes told the Committee that the focus of the report did not include broader issues affecting the operation of the ED:

> The terms of reference were such that we were not given the opportunity to look into the broader issues of the emergency department, in particular. [171]

4.128 The Walters/Hughes Report notes that the ED was extremely busy at the time that Ms Horska presented, and noted that the ED nurses on duty that night were under pressure and operating under a model of care that did not specifically provide for treatment of women in the early stages of pregnancy:

> Given the lack of relevant policies and procedures to guide them in the management and care of the early pregnancy patient, individual staff members in the hospital's ED cannot be held responsible for the inadequacies in the health care system that have been revealed as a result of this incident.[172]

4.129 There has been criticism of the way in which the Walters/Hughes Report was conducted. The Walters/Hughes Report stated that Ms Horska and Mr Dreyer declined to be interviewed as part of the inquiry. Mr Dreyer told the Committee that this was not the case:

---

169 Submission 27, p 2

170 Ms Beets, Evidence, 22 November 2007, p 2

171 Professor Cliff Hughes, Chief Executive Officer, Clinical Excellence Commission, Evidence, 12 November 2007, p 86

172 *Report of Inquiry into the care of a patient with threatened miscarriage at Royal North Shore Hospital on 25 September 2007* , p 19

> We never at any point declined to be interviewed. We sought early legal advice at that stage after I was given advice by a friend of mine. We left it in the hands of that particular legal guy at that time. There was a bit of to-ing and fro-ing with emails between the solicitor and Professor Walters. To go forward, the last email that virtually said there was a deadline, which our solicitor received a week earlier, was sent to us and, through a chain of events, we did not read it. It might sound like I am telling a story here but the truth is we had problems with our computer at home and we could not access our email. I was on night shift that week and I was not contactable. We basically found out about this deadline—I found out that the actual report was coming out when a journalist woke me up after night shift on the Friday afternoon. I was quite amazed that the inquiry had been completed without us having any input.[173]

4.130 Mr Dreyer was also critical of the tight deadline within which the Walters/Hughes Report was prepared:

> I cannot understand this deadline. What is this deadline business? That is my problem. Jana was not in a fit state that week to be sitting down and cross-examined about anything. We had just received the pathology results that week regarding the baby and we found out it was a boy. Jana was absolutely devastated; she was back to square one. There is no way I would have put her through meeting with these guys at all and having any sort of questioning.[174]

4.131 Mr Dreyer emphasised that he and Ms Horska were angry and upset about the implication that they had not been willing to participate in the Walters/Hughes Report:

> It is very hurtful. I think people realise—we have been very open with everybody in telling what has happened. It defies belief that we would not be willing to participate and contribute to our own inquiry into our miscarriage. It is unacceptable. You would not believe that we would be like that.[175]

4.132 In evidence to the Committee, a number of witnesses commented on the different motivations and expectations of staff of EDs and their patients.

4.133 Professor Cliff Hughes, one of the authors of the Walters/Hughes Report, commented on the difference in perspective of patients and clinicians in the ED:

> Clinicians do not mean to see it differently, they are just very busy carrying out the first rule, which is to be safe, and they were very busy on that particular night—extremely busy; every bed was occupied and some of those beds had been occupied two and three times. So they were busy trying to make life safe for most of their patients. In the meantime another patient's condition deteriorated rapidly and the quality of care that she received was simply appalling—not because anyone wanted it to happen or anything else, it was simply they were too busy with other priorities.[176]

---

173 Mr Mark Dreyer, Relative of former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 53

174 Mr Dreyer, Evidence, 16 November 2007, pp 53, 54

175 Mr Dreyer, Evidence, 16 November 2007, p 54

176 Professor Cliff Hughes, Chief Executive Officer, Clinical Excellence Commission, Evidence, 12 November 2007, p 91

4.134 Professor Bruce Barraclough AO, Chair of the Clinical Excellence Commission (CEC), commented that some of the programs that the CEC is working on are intended to make the health industry 'more like the hospitality industry' to bring about a better experience of treatment:

> One of the statements that we would very much like to hear is that culture eats strategy for lunch, and to get patients an appropriate experience, irrespective of the terrible things that they are going through in the health sense, we need to have an appropriate culture so that people actually treat patients as they would wish to be treated as human beings and not just in the technical expertise that they might have.[177]

4.135 Dr Clare Skinner, a Registrar in the Emergency Department of Royal North Shore Hospital, commented that she thought the ATS was 'good for what it does' but felt that miscarriage did not sit easily within the system 'because it is emotionally distressing whilst not being life threatening'.[178]

4.136 The Minister for Health, the Hon Reba Meagher MP, conceded that there were shortcomings with the current model of care operating in Emergency Departments for women presenting with signs of miscarriage:

> … we do need a more appropriate model of care to deal with women presenting to Emergency Departments. They are not like other people sitting in a waiting room with a temperature or a sprained ankle; they should be afforded more privacy and more dignity.[179]

4.137 The Minister informed the Committee that $4.5 million would be spent this financial year (2007/08) implementing the recommendations of the report 'to provide improved care for women in the early stages of pregnancy':[180]

> Women with early pregnancy problems who present to an Emergency Department, but do not need urgent medical attention will get rapid assessment and advice from new Early Pregnancy Units, co-located within most Emergency Department.[181]

4.138 The Minister explained that the fundamental principle of the models of care to be introduced to hospitals across the state is to divert women away from the Emergency Department as soon as they have been triaged, moving them into 'those parts of the hospital where staff are available who are specialised in providing the level of not only treatment but also of emotional support that women in those circumstances need'.[182]

---

177 Professor Bruce Barraclough, Chair, Clinical Excellence Commission, Evidence, 12 November 2007, p 92

178 Dr Skinner, Evidence, 22 November 2007, p 76

179 Hon Reba Meagher MP, Evidence, 12 November 2007, p 9

180 Hon Reba Meagher MP, Evidence, 12 November 2007, p 3

181 Correspondence from Hon Reba Meagher MP to Chair, received 4 December 2007, p 3

182 Hon Reba Meagher MP, Evidence, 12 November 2007, p 9

Committee comment

4.139 The treatment of Ms Jana Horska in the RNSH ED was unacceptable. The Committee appreciates the focus of the ED is on saving lives, but there should always be room for the provision of care with compassion. There are two broad reasons why Ms Horska was not treated with compassion.

4.140 The first reason is that the model of care in place in EDs at the time of Ms Horska's presentation made no allowance for the need to treat women in the early stages of pregnancy with dignity and sensitivity, but rather only according to the clinical requirements of the Australian Triage System. The lack of focus on the patient experience of care was identified by the Walters/Hughes Report and the recommendations of that report, now being implemented, are intended to change the model of care for pregnant women with threatened miscarriage.

4.141 The Committee notes the information provided by the Minister for Health in relation to the changed procedures for the assessment and treatment of women in the early stages of pregnancy presenting with signs of miscarriage. The Committee believes that the new procedures, and the wider availability of Early Pregnancy Units, will recognise the importance of treating these patients sensitively and will also recognise the importance of making sure that everything possible is done to preserve the life of the unborn baby. The Early Pregnancy Units are the appropriate place to provide patients with this reassurance and clinical care.

4.142 The second reason is that the ED is overcrowded and under pressure, pressure that could and should be alleviated by addressing the causes of access block in the RNSH. It has been argued that the nurses at work on that night were effectively too busy to be compassionate.

4.143 The Walters/Hughes Report addressed the first reason for why Ms Horska was not treated with compassion. The recommendations of the Walters/Hughes Report for changes to the way in which pregnant women are treated in the ED are sensitive, sensible and important.

4.144 The Committee notes that there was criticism from some parties to the inquiry that the Walters/Hughes Report did not address the contribution that access block made to the incident, the second reason for why Ms Horska was not treated with compassion. We acknowledge the explanation provided by Professor Hughes about the terms of reference of his inquiry provided by NSW Health. The terms of reference for the inquiry should also have included an analysis of possible structural reasons for the incident, as well as flaws in the existing model of care. Our report has provided an extensive discussion of the issues associated with access block, and made recommendations to address them.

4.145 The Walters/Hughes Report was also criticised for failing to involve Ms Horska and Mr Dreyer. It is unfortunate that Ms Horska and Mr Dreyer were not able to participate. At the very least, the timeframe for the inquiry should have been extended to allow the participation of Ms Horska and Mr Dreyer.

4.146 The Committee acknowledges and welcomes the actions taken by the Minister for Health in response to the recommendations of the Walters/Hughes Report. Where our report has identified further action that should be taken, we trust the Minister will be equally responsive.

One area addressed by the Walters/Hughes Report which the Committee believes is worthy of particular mention is in relation to the term 'triage'. The term derives from the French language, and the Walters/Hughes Report makes the point that the term should be changed to one that is more readily understood and recognised in the community. The Walters/Hughes Report suggests the term 'Priority Desk' should be used in Emergency Departments in place of 'Triage Desk'. The Committee therefore recommends that NSW Health change the terminology in use in Emergency Departments' signage, using the term 'patient priority' in place of 'triage'.

Recommendation 10

That NSW Health change the terminology in use in Emergency Departments' signage, by using the term 'patient priority' in place of 'triage'.

4.147 In addition, the Committee believes there is merit in reviewing the existing Australian Triage System categories to ensure they are appropriate. While symptoms of miscarriage may not be life-threatening for the pregnant woman, they are a threat to the life of the unborn child. We therefore recommend that the NSW Government seek to initiate a national review of the Australian Triage System categories in relation to women presenting to Emergency Departments with signs of a miscarriage, to ensure they are appropriate.

Recommendation 11

That the NSW Government seek to initiate a national review of the Australian Triage System categories in relation to women presenting to Emergency Departments with signs of miscarriage, to ensure they are appropriate.

4.148 Issues associated with the handling of patient complaints and the patient experience of care provided in the RNSH are addressed in Chapter 11.

Recommendation 12

That details of progress in implementing changed procedures for the assessment and treatment of women in the early stages of pregnancy presenting to Emergency Departments with signs of miscarriage and the establishment of Early Pregnancy Units be reported upon in the next Annual Report of NSW Health.

Chapter 5 Developing a positive workplace culture

> There is a culture of bullying and harassment at Royal North Shore Hospital and this is not just an issue in nursing but is across all disciplines.[183]

It is unarguable that a culture of bullying and harassment exists at Royal North Shore Hospital (RNSH). An overemphasis on performance measures and poor staff management practices are among several factors cited by inquiry participants as contributing to this climate. In addition to discussing these issues, this chapter seeks to identify ways to encourage a workplace culture characterised by teamwork and professional pride rather than dysfunction and intimidation.

A culture of bullying and harassment at RNSH

What is bullying and harassment?

5.1 The NSW Health Code of Conduct defines workplace bullying and harassment as behaviour that will generally meet the following four criteria:

- It is repeated
- It is unwelcome and unsolicited
- The recipient considers the behaviour to be offensive, intimidating, humiliating or threatening
- A reasonable person would consider the behaviour to be offensive, intimidating, humiliating or threatening.[184]

The Dalton/Meppem Report

5.2 In August 2007, the acting Chief Executive of NSCCAHS, Mr Terry Clout, asked Mr Vern Dalton and Professor Judith Meppem to conduct a review of allegations of a culture of bullying and harassment within the nursing workforce at RNSH. The request was made following claims of bullying behaviour at the hospital published in the *Daily Telegraph* on 27 July 2007. The reviewers were also asked to ascertain whether the recommendations of any previous reviews of alleged bullying had been implemented.[185] These reviews included an investigation conducted in 2003 by Mr John Kilkeary and Ms Jan Stowe.[186]

---

183 Dalton. V and Meppem. J, RNSH *Review of workplace culture and allegations of bullying and harassment,* September 2007

184 NSW Health *Code of Conduct*, October 2005, p 38

185 Dalton/Meppem Report, p 11

186 Kilkeary. J and Stowe. J, *Investigation into Nursing Management practice and Organisational Culture at RNSH,* 3 June 2003.

5.3 While the terms of reference for the review by Mr Dalton and Professor Meppem were focussed on nursing management, many non-nursing staff and the Health Services Union contacted the review team to discuss their concerns about bullying. The concerns of non-nursing staff were therefore also included in the review.

5.4 The Dalton/Meppem report was presented in September 2007. NSW Health summarised its findings as follows:

> The Dalton/Meppem Report revealed an unacceptable organisational culture that fostered and tolerated bullying behaviour and which failed to actively and effectively address its root causes and apply the relevant policies.[187]

5.5 Mr Dalton and Professor Meppem found little evidence that complaints have been taken seriously and that the recommendations of their predecessors, Kilkeary and Stowe, were just as valid today as they were in 2003. Much of what appears in the Dalton/Meppem report was echoed in the evidence by witnesses to this Committee.

5.6 According to Ms Samantha Flew, NUM in the Emergency Department, bullying is 'rampant' at RNSH:

> 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…[188]

5.7 The Committee took evidence from two nurses concerning their experience of bullying at the hospital. A senior nurse (Witness A) told the Committee about being bullied by a male clinician over an extended period:

> I have been subjected to a range of bullying behaviours by him, consisting of nitpicking …. the reporting of unfair comments about me to my managers, using his power to incite people to be part of the bullying; making unjustified criticisms of meeting, both in private and in public; many times he has yelled and screamed at me in front of my staff and patients. One attack was so hostile and abusive that it initiated some of my staff to stand with me for protection. They actually asked if I wanted to call security.[189]

5.8 Her experience has had a significant emotional impact:

> I had trouble sleeping at night. I still feel like that at times. I started getting sick. I thought … I had headaches, not to mention my self-esteem is shot to pieces. I have a little bit of low morale at the moment.[190]

5.9 In her evidence, Ms Helen Ganley, a nurse at RNSH, told the Committee:

---

187 Submission 33, NSW Health, p 17

188 Ms Flew, Published in camera evidence, 22 November 2007, p 8

189 Witness A (name suppressed), Published in camera evidence, 22 November 2007, p 2

190 Witness A, (name suppressed), Published in camera evidence, 22 November 2007, p 9

> 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.[191]

5.10 A small number of doctors questioned the existence or extent of bullying at the hospital. Dr Danny Stiel said that if there were issues of bullying and harassment, they should not be allowed to fester, but that bullying did not occur in the departments with which he has been associated.[192]

5.11 Dr Tom Hugh, Head of the RNSH Department of Gastro Intestinal Surgery, thought that the discussion about bullying at the hospital was a distraction from the 'real' issues confronting the 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.[193]

Why has a culture of bullying developed at RNSH?

5.12 Staff who participated in the Dalton/Meppem review were asked to comment on the cause of bullying at the hospital. Similar factors were identified by participants in the Committee's inquiry. These include:

- the extreme day to day pressure of patient throughput
- constant restructuring and turnover of senior staff and absence of consistently strong leadership
- a resistance to change on the part of some longstanding nursing and medical staff
- lack of support from managers and Human Resources.[194]

5.13 Participants in the Committee's inquiry identified similar reasons and these are discussed below.

---

191 Ms Helen Ganley , Royal North Shore Hospital, Evidence, 22 November 2007, p 2

192 Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Evidence, 16 November 2007, p 46

193 Dr Hugh, Evidence, 22 November 2007, pp 55-56

194 Dalton/Meppem Report, p 4

Stress caused by inadequate resources and unreachable goals

5.14 The Nurse Manager of the Emergency Department, Ms Michelle Beets, believes that bullying is a by product of trying to meet unattainable targets:

> … 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…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.[195]

5.15 Ms Beets' Emergency Department colleague, Ms Alicia Jackson RN, agreed with this assessment. While she believes the senior nursing management does engage in bullying, such behaviour is perhaps not surprising, given they are under constant pressure to meet KPIs that do not take into account the shortage of nursing staff and beds.[196] Similar sentiments about the cause of bullying were expressed by participants in the Dalton/Meppem review:

> Staff were very open about the constant demands and pressure of exit block, patient flow issues, meeting a range of DOH KPIs throughout the hospital…At the same time staff complained that management was so preoccupied with these demands that the pressure from this in turn impacts on staff.[197]

5.16 When asked during his evidence whether he believed bullying at the hospital was linked to budgetary pressures, the former acting Chief Executive of the Area, Mr Terry Clout said that while this was a 'simplistic' view, it has a 'modicum of truth' to it. He cited increased community expectations and high demand for services, as two additional contributing factors.[198]

5.17 Mr Dalton suggested that the stress caused by the need to meet performance indicators may be a convenient excuse for some people:

> 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.[199]

---

195 Ms Beets, Published in camera evidence, 22 November 2007, p 2

196 Ms Jackson, 22 November 2007, p 8

197 Dalton/Meppem Report, p 4

198 Mr Terence Clout, Chief Executive, South Eastern Sydney Illawarra Area Health Service, Evidence, 12 November 2007, p 69

199 Dalton/Meppem Report, p 4

Management structure and practices

5.18 The introduction of the divisional nurse management structure in 2006 was identified by several parties to the inquiry as a major factor in the decline of morale at the hospital. This issue is discussed in detail in Chapter 8.

5.19 The Director of Nursing and Midwifery Services at Sydney South-West Area Health Service, Professor Kerry Russell, believes that the new structural arrangements have had a negative impact on nurses' sense of identity and teamwork, and the ability to properly manage bullying and harassment. She believes that RNSH has the foundation to have a 'wonderful' nursing service if these 'structural' issues are resolved:

> 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… And I think you have got to have good systems in place and people feeling a sense of teamwork to make that happen….The nurses need to be able to function as a team…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.[200]

5.20 The divisional restructure was also cited in the Dalton/Meppem report as contributing to management problems at the hospital:

> ...Issues relating to a 'disconnect' between operational (line) and professional accountability and responsibility at divisional level were also raised by many people. The perceived 'disempowerment' of nursing particularly the role of the DON needs to be addressed as a matter of urgency…..[201]

5.21 Ms Beets also suggested that the high turnover of people in the General Manager position over the past decade has contributed to the negative culture at RNSH. Ensuring there is some stability in this position, rather than seeking to scapegoat this person, she argues, will help to facilitate cultural change.[202]

The management of staff grievances

5.22 Participants in the Dalton/Meppem review were extremely critical of the way staff grievances about bullying and harassment were managed including, the length of time taken to resolve grievances, and the perception that Human Resources was biased in favour of management.[203]

5.23 Similar concerns were expressed during the Committee's inquiry. Ms Ganley accused Human Resources of bullying and gross dishonesty. Two years later her grievance, remains unresolved:

> 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

200 Professor Russell, Evidence, 22 November 2007, p 10

201 Dalton/Meppem Report, p 7

202 Ms Beets, Published in camera evidence, 22 November 2007, p 13

203 Dalton/Meppem Report, p 3

> 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.[204]

5.24 Witness A also told the Committee about her longstanding, unresolved grievance. This nurse has been on suspended duties following a complaint made against her in August 2007. She believes the complaint against her was made in response to an earlier complaint she made about bullying within her section of the hospital. She told the Committee that she has not been informed of the substance of this complaint, nor has she been advised of the timeframe within which the matter is expected to be resolved. She has been instructed not to discuss her grievance with anyone connected to the part of the hospital she used to work in. With the exception of a short project which she has completed, she has not been assigned any other tasks while she waits for the matter to be resolved.[205]

5.25 Parties to the inquiry noted that support that should be provided by Human Resources was not always forthcoming. Several pointed out, however, that this did not necessarily stem from the failings of individuals, but rather the level of staffing in these sections. Ms Alison Mayhew, Nursing Unit Manager at RNSH, said that a shortage of Human Resources staff makes it difficult for nurse managers to get the support and advice they require to properly manage staff grievances:

> …unfortunately, when the restructure happened within the hospital a lot of human resources personnel were removed from the hospital and those responsibilities have gone back to nursing unit managers. It is difficult for us to try to get advice and support in dealing with grievances so those grievances could be extended for a long time…..My suggestion would be to provide more human resources staff within the organization…'[206]

5.26 Dr Stiel also commented on inadequate staffing levels in Human Resources:

> You cannot resolve this problem with a human resources department that has only a couple of people there and, hopefully, if you knock on the door, you might be lucky enough to find a secretary or someone—working frantically hard, do not get me wrong—totally underesourced. These are essential priorities.[207]

5.27 Dalton and Meppem concluded that Human Resources staffing in the northern Sydney sector was inadequate to deal with current and longstanding grievances.[208] Mr Dalton elaborated on this issue during his evidence to the Committee:

---

204 Ms Helen Ganley, Evidence, 22 November 2007, p 2

205 Witness A (name suppressed), Published in camera evidence, 22 November 2007, p 8

206 Ms Mayhew, Evidence, 26 November 2007, p 12

207 Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Evidence, 16 November 2007, p 46

208 Dalton/Meppem Report, p 7

> …there were two people[in Human Resources] 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….
>
> to be fair to them…they [Human Resources] were working under extreme pressure. I mean they were up to their backside in alligators and trying to do their best.[209]

5.28 In answer to a question taken on notice during her appearance, Ms Mary Bonner, the General Manager of NSRHS, informed the Committee that there were 22 open grievances, nine of which were notified in November.[210]

5.29 Mr Matthew Daly, Chief Executive of NSCCAHS, told the Committee that a Professional Practice Unit had been set up in NSCCAHS to handle complex complaints, initially at RNSH and eventually for the whole Area. He noted that a similar unit, set up in the wake of the inquiries into Camden/Campbelltown hospitals, was enormously successful in handling very, very difficult complaints to a resolution.[211]

5.30 Two other issues were raised during the inquiry and by Dalton/Meppem, which reflect poorly on the hospitals' Human Resources capability.

5.31 The first concerns Exit Interviews. Professor Meppem discovered during the conduct of the review, that there was no procedure in place to follow nurses up to find out why they have left the hospital.[212] In evidence to the Committee, Ms Bonner admitted that up until recently, exit interviews had been 'spasmodic'.[213]

5.32 The second issue concerns performance reviews. During the hospital's last accreditation survey, the surveyors identified two issues of concern. One was the fact that a significant number of senior medical staff had not had an annual performance review. According to Dr Phillip Hoyle, the Director of Clinical Governance at NSCCAHS, it was 'absolutely right' that that issue should be addressed, which he assured the Committee, did in fact occur.[214]

Involvement of the NSW Nurses' Association

5.33 The NSW Nurses' Association appear to have had very little involvement in addressing the problems with bullying and harassment at the hospital. Mr Brett Holmes, General Secretary of the NSW Nurses' Association, told the Committee that when serious allegations of

209 Mr Vern Dalton, Former Commissioner of Corrective Services, Evidence, 22 November 2007, p 36

210 Answer to questions on notice taken during evidence 12 November 2007, Ms Bonner, Question 8

211 Mr Daly, Evidence, 12 November 2007, p 23

212 Dalton/Meppem Report, p 3

213 Ms Bonner, General Manager, NSRHS, Evidence, 12 November 2007, p 40

214 Dr Hoyle, Evidence, 22 November 2007, p 24

widespread bullying and harassment were revealed in the media in July 2007, he concluded on the basis of an examination of complaints received from members at RNSH that 'we could not justify a call that there was widespread bullying.[215]

> We can only act on issues that are brought to us. On checking our records we had 23 issues where people were given advice on how to deal with their grievances…from an assessment of those records, we saw no different pattern in the records of Royal North Shore …from what one would find in any other large hospital.[216]

5.34 This lack of awareness may stem from the fact that the local branch of the Association was not active towards the end of 2006 and struggled to get re-established in the annual reformation that occurs before March 2007.[217] The former Branch President, Ms Mayhew, who is also a NUM at the hospital, told the Committee that she had to stand down from this position in 2006 because she had other roles and responsibilities.[218]

5.35 Ms Mayhew believes it may be possible that many nurses at the hospital have been unwilling to be active in the Association because 'unfortunately there has been a view within the hospital [management] that the association is frowned upon'.[219]

5.36 The role of the Association was also raised in the Dalton/Meppem report:

> We were surprised that the local NSW Nurses' Association Branch is inactive and understand that there are current efforts to resurrect the Branch.[220]

5.37 One of the recommendations of the Dalton Meppem report was that: 'The NSW Nurses' Association be urged to facilitate the revival of the local Branch at RNSH.[221]

5.38 Ms Mayhew advised the Committee that the NSW Nurses' Association Branch at RNSH had been reactivated after being dormant for a while.[222]

Overcoming a culture of bullying at RNSH

5.39 The remainder of the chapter discusses the way forward in developing a positive workplace culture at RNSH.

5.40 A common theme in the evidence to this inquiry is the deleterious effect on staff of trying to meet what many perceive to be impossible demands placed on them by the hospital, Area or the Department. Many of the recommendations in preceding chapters, concerning the

215 Mr Holmes, Evidence, 12 November 2007, p 59

216 Mr Holmes, Evidence, 12 November 2007, p 58

217 Mr Holmes, 12 November 2007, p 58

218 Ms Mayhew, Evidence, 26 November 2007, p 11

219 Ms Mayhew, Evidence, 26 November 2007, p 11

220 Dalton/Meppem Report, p 2

221 Dalton/Meppem Report, p 9

222 Ms Mayhew, Evidence, 26 November 2007, p 11

provision of additional resources for the hospital, and improving management structures and systems, if implemented, should have a marked effect on the workplace culture at RNSH.

5.41 The Dalton/Meppem report included several recommendations designed to overcome the culture of bullying at RNSH. Many of these recommendations were drawn from recommendations made by Kilkeary and Stowe in their 2003 report. Given the commitment of the NSCCAHS to implement all of these recommendations,[223] they are reproduced in full, below:

Recommendations from the Dalton/Meppem Report

- All managers down to and including the level of NUM and the equivalent in corporate, allied health and support services to be advised of the findings of this report.
- They be further advised that bullying and harassment will not be tolerated. Such behaviour by anyone or anyone condoning such behaviour by others will be regarded as misconduct and the person or persons concerned will be subjected to disciplinary action.
- That special in-service workshops on bullying and harassment be arranged for managers at all levels. The findings of this review and the conduct expected of managers in the future should form the basis of these workshops.
- Another major area concerns conflict resolution/communication skills between senior managers and subordinates to remove any notion that bullying, harassment and intimidation is just being 'assertive'.
- A memo to be issued by the General Manager to staff generally advising them of the strategies that have been developed to eliminate bullying and harassment and assure staff that they can have confidence in reporting such behaviour.
- Arrange and urgently implement a program to ensure all managers attend instruction on bullying and harassment and conflict resolution.
- Survey all staff on bullying and harassment annually until the Sector Manager is satisfied that this issue has been properly addressed.
- Include outcome measures in Performance Management Agreements between Sector General Manager/DON and each senior manager so that they are held accountable for addressing the issue of bullying and harassment.
- A cross discipline task force be established to deal with the issue of bullying and harassment on a hospital-wide basis. This task force comprise representatives from nursing, medicine, other clinical services, non-clinical services and Human Resources.
- Consideration to be given to an employee representative or a person nominated by the NSW Nurses' Association, Health Services Union and ASMOF.
- The task force be chaired by the General Manager with responsibility for the implementation of bullying and harassment policies and strategies across the hospital.

223 Ms Bonner, 12 November 2007, p 36

- The task force to be monitored by the Chief Executive and Area Executive with a particular focus by the Area Director of Nursing and Midwifery and the Area Director Workforce.
- The NSWNA, the HSU and ASMOF be advised of the action being taken by the hospital
- The NSW Nurses' Association be urged to facilitate the revival of the local Branch at RNSH.[224]

Response from NSCCAHS and NSW Health

5.42 NSW Health and the NSCCAHS have already put several initiatives in place to address the issues raised and these are detailed in their respective submissions. They include:

- a zero tolerance policy on bullying
- the release of a new departmental Guideline on the Prevention and Management of Workplace Bullying
- the establishment of a specialist reference group on bullying and harassment has which reports to the new Clinical Reference Group
- mandatory information and education sessions for all staff.
- the establishment of a Professional Practice Unit.[225]

Committee comment

5.43 The Committee welcomes the commitment from NSCCAHS to implement all of the recommendations of the Dalton/Meppem report, but it is well overdue. Failing to tackle longstanding concerns about inappropriate workplace behaviour has not only had a devastating impact on individuals involved in grievances, but has contributed to an unhealthy workplace culture. It is also likely that patient care has been compromised by allowing such behaviour to go unchecked.

Recommendation 13

That NSRHS, as an urgent priority, ensure that all recommendations from the Dalton/Meppem review into bullying and harassment are fully implemented.

5.44 In addition to supporting the recommendations made by Mr Dalton and Professor Meppem, we would like to make two additional recommendations not included in their report. At the time of their review, a Professional Practice Unit had not been established at the hospital. The Professional Practice Unit could potentially reduce much of the difficulty and delay that has

224 Dalton/Meppem Report, pp 8-9

225 Submission 34, NSCCAHS, pp 33-34; Submission 33, NSW Health, p 17

characterised the resolution of complex staff grievances at the hospital. It is vital that all staff know about its role and function.

5.45 The Dalton/Meppem report does not include any specific recommendations regarding Human Resources at the hospital or Area level, and yet the role of Human Resources was a major issue for many employees involved in grievances.

Recommendation 14

That NSCCAHS advertise the role of the Professional Practice Unit more widely across the Area.

Recommendation 15

That NSCCAHS review Human Resources staffing across the Area.

Chapter 6 The organisational structure

This chapter looks at the organisational structure at both the Northern Sydney Central Coast Area Health Service (NSCCAHS) and the Royal North Shore Hospital (RNSH) following the amalgamation of the former Northern Sydney Health Service and Central Coast Health Service in 2005. It examines concerns raised during the inquiry regarding the merger of Ryde and Royal North Shore Hospitals into the North Shore Ryde Health Service (NSRHS). It also examines whether the senior management structure of NSCCAHS and RNSH is appropriate and responsive to the needs of both organisations.

Organisational structure of the Area and the Royal North Shore Hospital

6.1 Under section 25 of the *Health Services Act 1997*, the management of an Area Health Service such as NSCCAHS rests with the Chief Executive. The Chief Executive is in turn subject to the control and direction of the Director-General of Health, who reports to the Minister for Health.

6.2 The Chief Executive of NSCCAHS, Mr Matthew Daly, was appointed on 24 September 2007, following the departure of the previous Chief Executive, Mr Stephen Christley, in July 2007.[226]

6.3 The Chief Executive of each Area Health Service is supported by an executive team comprising the following positions:

- Director, Clinical Operations
- Director, Population Health, Planning and Performance
- Director, Workforce Development
- Director, Corporate Governance
- Director, Clinical Governance
- Director, Nursing and Midwifery.

6.4 These directors are responsible for the Area-wide management and delivery of functions within their responsibility.[227]

6.5 The Corporate Governance and Accountability Compendium for NSW Health, issued in December 2005, contains the corporate governance principles and framework to be adopted by Area Health Services (AHSs).

6.6 The executive team of NSRHS comprises the General Manager supported by six corporate executives and six operational executive members. In turn, the General Manager of NSRHS

226 Mr Matthew Daly, Chief Executive, Northern Sydney Central Coast Area Health Service, Evidence, 12 November 2007, p 18. Prior to Mr Daly's appointment, Mr Terence Clout, now Chief Executive of the South Eastern Sydney Illawarra Area Health Service, acted in the position.

227 Submission 34, Northern Sydney Central Coast Area Health Service, p 6

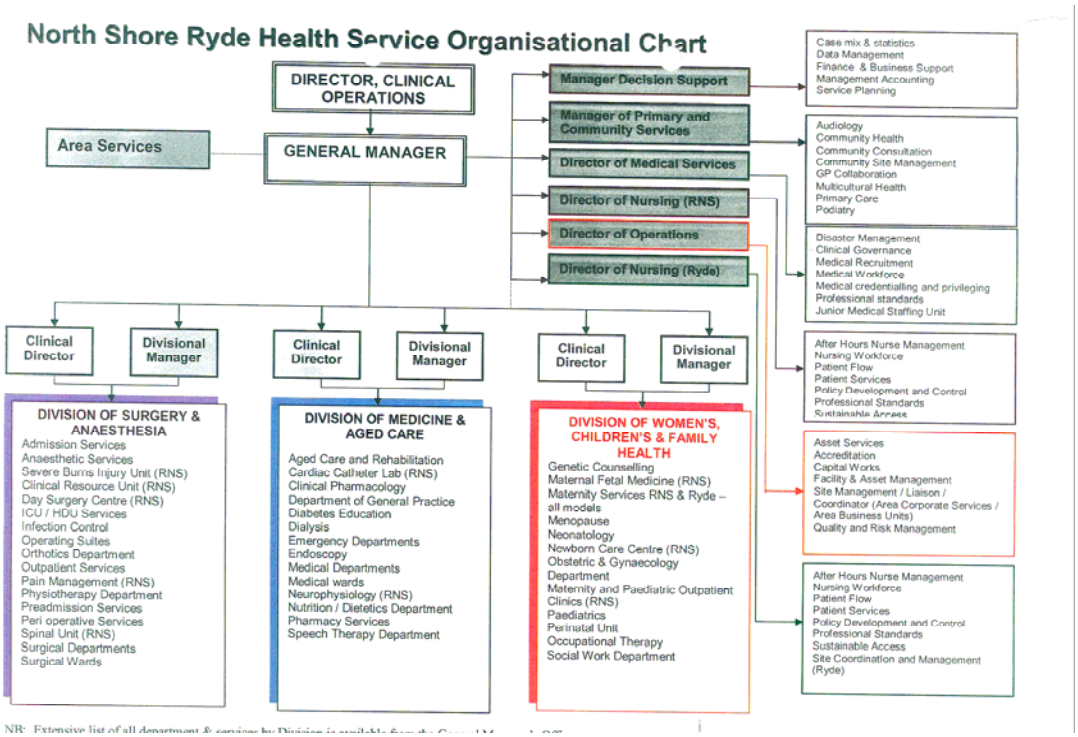
reports to the Director, Clinical Operations for NSCCAHS, who in turn reports to the Chief Executive of NSCCAHS.[228]

6.7 The General Manager of NSRHS, Ms Mary Bonner, was appointed in March 2005.[229]

6.8 With the exception of the Chief Executive and executive team of NSCCAHS outlined above, New South Wales Health does not mandate the organisational structures of Area Health Services and hospitals. Accordingly, they are able to develop structures suitable to their geography, demography and service and staff profiles.

6.9 Figure 6.1 below is an organisational chart of NSRHS.

Figure 6.1: NSRHS Organisational Chart



6.10 As indicated in the organisational chart above, each of the divisions in NSRHS is headed up by both a clinical director and a divisional manager. Each division includes a number of specialty departments and units, for example the Severe Burns Injury Unit, the Emergency Department, or Aged Care and Rehabilitation Department.

6.11 In his submission, Dr Stephen Christley, the former Chief Executive of NSCCAHS, submitted that this organisational structure is common across each Area Health Service in New South Wales.[230]

---

228 Submission 34, p 7

229 Ms Mary Bonner, General Manager, NSRHS, Evidence, 12 November 2007, p 32

230 Submission 37, Dr Stephen Christley, p 2

The decision to form the amalgamated Area in 2005

6.12 Some of the issues relating to the operation of RNSH discussed in this report concern the decision in 2004, implemented in 2005, to amalgamate the former Northern Sydney Health Service and Central Coast Area Health Service.

6.13 In his evidence to the Committee, Dr Christley indicated that the management structure across NSCCAHS was implemented in an attempt to break each Area Health Service into manageable units and then build networks from the bottom up across the Areas, so that people with budgetary and clinical responsibility in one area could work with colleagues in other areas to develop the best way to provide care.[231] Dr Christley later continued:

> I believe the clinical networks that have developed have brought enormous benefit to both Area Health Services – there has been learning for both. I think the disadvantages are where people chose to take the view that they wanted to defend their parochial patch rather than be part of the whole. I think that was really misunderstanding certainly what we were trying to do in Northern Sydney Central Coast Area Health Service. We wanted to build networks from the bottom up and I think people were coming to understand that and participated in those more fulsomely.[232]

6.14 Dr Antony Sara, President of the Australian Salaried Medical Officers Federation, also suggested in evidence that in other Area Health Services the mergers in 2005 delivered benefits in terms of reduced administrative costs and increased transfer of expertise across the area, particularly in rural areas.[233]

6.15 The Committee also notes the following comments of Mr Matthew Daly, Chief Executive of NSCCAHS:

> I can say a couple of things. One, I think the decision to amalgamate was probably the best thing in terms of patient care and patient safety. I am not sure that we have delivered on those as yet in northern Sydney and on the Central Coast because I do not believe the Area Health Service is operating as an Area Health Service. …
>
> People often ask: Are these Area Health Services too big? When I started, my initial response was: Yes. But having now worked through them over three years I think the economies of scale are there for the taking. I think the capacity for the deposit of clinical expertise that now exists within these larger Area Health Services that can be tapped into by smaller facilities and peripheral facilities in the outer metropolitan areas of Sydney are tremendous.[234]

231 Dr Stephen Christley, Former Chief Executive, Northern Sydney Central Coast Area Health Service, Evidence, 12 November 2007, p 77

232 Dr Christley, Evidence, 12 November 2007, p 84

233 Dr Antony Sella Sara, President, The Australian Salaried Medical Officers Federation, Evidence, 12 November 2007, pp 48-49

234 Mr Daly, Evidence, 12 November 2007, pp 25-26

The merger of Royal North Shore Hospital with Ryde Hospital

6.16 Since the merger of Area Health Services in 2005, RNSH together with Ryde Hospital have together formed the North Shore and Ryde Health Service (NSRHS). In addition, other services have been removed to Macquarie Hospital.

6.17 The Committee notes that some parties to the inquiry advocated that RNSH and Ryde Hospital should be separated again.

6.18 Most notably, in its submission, the Cardiology Department at RNSH argued that the governance structure is clearly not up to the standard required to run the hospital. It was argued that:

- Crucial departments and services such as finance, HR and IT have been removed and 'centralised' at Macquarie Hospital at Gladesville, with the result that access to these core resources is severely rationed.
- The roles and responsibilities of RNSH vis-à-vis other hospitals such as Ryde are not clear, which has led to confusion in funding and responsibilities.[235]

6.19 This was reiterated in evidence by Dr Stephen Hunyor, Director of the Cardiac Technology Centre at RNSH:

> Another issue relates to the Ryde, North Shore, Macquarie axis. Instead of functioning like major international medical centres, which serve as a fulcrum in the wheel, radiating high-level services and competence along its spokes, North Shore is lumbering along with two dysfunctional appendages, Ryde and Macquarie hospitals. This joining is irrational and not supported by staff in any of these institutions. It blurs the identity of North Shore. It blurs the use of resources purportedly going to it. These institutions need to be separated.[236]

6.20 Dr Hunyor subsequently indicated that in his area of specialty, cardiology, he would prefer to see only one hospital in NSCCAHS, either RNSH or the new Frenchs Forest Hospital, with responsibility for servicing the entire area, rather than having both hospitals doubling up with associated expenses.[237]

6.21 Similarly, in his submission, Dr Tony Joseph, Director of Trauma (Emergency) at RNSH, argued that the operational interdependence of RNSH and Ryde Hospital is a mismatch both clinically and operationally. He suggested that there is no operational cross-over and very few medical appointments across both hospitals. Dr Joseph reiterated this in evidence:

> With regard to North Shore and Ryde hospitals, it has been a very unhappy alliance for both groups. Dr Christley mentioned in his submission that the role of Ryde should be reviewed. We have been saying for a number of years that Ryde probably should not be working as an acute hospital and should be … concentrating on some

---

235 Submission 30, Section of Cardiology, Royal North Shore Hospital, pp 3, 8, 9

236 Professor Stephen Hunyor, Chairman of Cardiology, Royal North Shore Hospital, Evidence, 16 November 2007, p 3

237 Dr John Gunning, Head of Cardiology, Royal North Shore Hospital, Evidence, 16 November 2007, p 6

> of the aged care patients and less urgent surgery patients. That is something the Area could do in a very short time to increase efficiency for those two hospitals.[238]

6.22 The Committee also notes the evidence of Mrs Anne Heaton, Senior Orthopaedic Physiotherapist at RNSH, that there is a proposal to amalgamate the highly regarded RNSH physiotherapy department with the Ryde physiotherapy department. Mrs Heaton indicated that despite efforts to make this move a positive one, she did not believe that it would be successful, noting in particular the removal of accessible leadership under the change, and citing failures in the amalgamation of other departments with Ryde.[239]

6.23 Other parties to the inquiry did not advocate structural separation of RNS and Ryde Hospitals, but did cite the need for a clinical services plan to coordinate the operation of the two institutions.

6.24 For example, in her submission, Dr Sharon Miskell, Director of Medical Services at NSRHS, argued that the lack of a clinical services plan for NSCCAHS means that NSRHS has been unable to progress reconfiguration of clinical services delivery at both RNS and Ryde Hospitals to achieve a role delineation of minor risk/day 'cold' surgery at Ryde and overnight/emergency 'hot' surgery at RNSH. Nor is it possible for RNS/Ryde to delineate their services from other hospitals such as Hornsby Ku-ring-gai. This delineation has been achieved in other Area Health Services with significant efficiency gains and reduced lengths of stay and delays to surgery.[240]

6.25 Asked in evidence to comment on the suggestion of a de-coupling of RNS and Ryde Hospitals, Dr Sharon Miskell observed:

> What is needed is clear role delineation between the facilities. That requires a clinical services plan that will configure services across that Area Health Service appropriately. That has not been done. The two facilities are basically functioning as they were prior to the restructure, the only difference being that we now have cross-appointments of the executive.[241]

6.26 As indicated by Dr Miskell, one of the perceived advantages of the RNS-Ryde models is that it will allow elective 'cold' surgery to be done at Ryde, to free 'hot' beds for the Emergency Department at RNSH. Similar models have been employed at Fairfield and Liverpool Hospitals, and at Mount Druitt and Penrith Hospitals. Asked to comment on this, Dr Andrew Ellis, orthopaedic surgeon visiting medical officer (VMO) at RNSH observed:

> Of course it could work. The question is whether it is a better model of operation ... 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

238 Dr Tony Joseph, Director of Trauma (Emergency), Royal North Shore Hospital, Evidence, 16 November 2007, p 17

239 Mrs Anne Heaton, Senior Orthopaedic Physiotherapist, Royal North Shore Hospital, Evidence, 22 November 2007, pp 87-88

240 Submission 49, Dr Sharon Miskell, p 3

241 Dr Sharon Miskell, Director of Medical Services, NSRHS, Evidence, 16 November 2007, p 26

> 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.[242]

6.27 The Committee also notes the evidence provided by Dr Robert Day, Director of Emergency Medicine at RNSH, that RNSH specialises in a number of areas such as paediatrics, urology, vascular surgery and hand surgery, the result of which is that RNSH gets an inflow of patients from other areas where those specialty services are not available. He continued, however, that there has been planning of what roles the smaller district hospitals like Ryde, Manly, Mona Vale and Hornsby hospitals should perform vis-à-vis the role of RNSH.[243]

6.28 Finally, Mr Brett Holmes, General Secretary of the New South Wales Nurses' Association submitted in evidence:

> Of all the restructures across the State we had the most difficulty with Northern Sydney Central Coast. … we certainly had the most difficulty with the proposals at Royal North Shore in terms of how their management structure was changing.[244]

6.29 The need for a clinical services plan setting out clearly the roles and responsibilities of RNS and Ryde Hospitals is discussed in the following chapter.

Committee comment

6.30 The Committee supports the formation of NSCCAHS and NSRHS in 2005. The Committee endorses the objective of developing clinical networks across the area that will enable clinicians in one hospital to work with colleagues in other hospitals on the best way to deliver clinical care across the whole Area. The Committee also believes that the merger has the potential to deliver administrative savings and increased transfer of expertise across the Area. At the same time, the Committee acknowledges that the 2005 merger and subsequent clinical interdependence has been problematic due to the lack of a clinical services plan.

6.31 The Committee notes suggestions that the Ryde-RNS Hospital axis should be cut and recognises that RNSH has suffered a loss of identity since the formation of NSRHS in 2005. The Committee believes that the way forward to address this issue is to restore the identity and morale of RNSH by giving RNSH clear roles and responsibilities in the broader system delivering health services to the community. The Committee believes that an Area clinical services plan is the means for this to happen, as is discussed in the following chapter.

The senior management structure

6.32 The Committee notes that the senior management structure of NSCCAHS and RNSH was the subject of significant criticism during the conduct of the inquiry. A number of issues were raised, as discussed below.

---

242 Dr Andrew Ellis, VMO – Orthopaedic Surgery, Royal North Shore Hospital, Evidence, 22 November 2007, p 84

243 Dr Robert Day, Director of Emergency Medicine, Royal North Shore Hospital, Evidence, 16 November 2007, pp 16-17

244 Mr Brett Holmes, General Secretary, New South Wales Nurses' Association, Evidence, 12 November 2007, p 59

The size of NSCCAHS

6.33 There are serious concerns over a major Sydney teaching hospital such as RNSH being administered from a regional centre such as Gosford.

6.34 In its submission, the Cardiology Department at RNSH submitted that NSCCAHS is run by a 'grossly overstretched' Chief Executive whose responsibilities span a huge geographical area and a 'mind-boggling assortment' of healthcare facilities.[245]

6.35 This was reiterated in evidence by Dr Gunning, Head of Cardiology at RNSH, who emphasised that decisions are simply not being taken at RNSH because of the difficulty of contacting the Chief Executive. He urged the appointment of a CEO of RNSH with the capacity to make decisions affecting the hospital.[246]

6.36 Similarly, Dr Greg Purcell from the Department of Anaesthesia and Pain Management argued in evidence:

> The change to a single Chief Executive-controlled large Area in 2004 with the inordinate potential of the CE to appoint or dismiss almost every other appointment in the area, to redistribute funding and to only be responsible to the [Director-General] is inappropriate and flawed.[247]

6.37 In turn, the submission from the members of the Department of Neurology expressed concern at the establishment of the larger NSCCAHS and the removal of administration functions to Gosford, leading to a 'total disconnection' of management and clinicians.[248]

6.38 In response to some of these issues, Mr Matthew Daly, Chief Executive of NSCCAHS, submitted:

> Where should the head office be? I really do not care where it is because the nature of the way I work is that I am very hands-on. I do not sit in an office; I get out there and annoy the life out of people by seeing them in their units, in their wards and in their offices. So the nature of the Area executive now is that I have told them that they ought to expect to be travelling a lot and actually be in the facilities because that is where the core business is. So in some respects it actually suits my style, and certainly the team that I am building around me, by nature, will have a similar style—it will need to be because if I see them in their offices too often I will be kicking them out.[249]

245 Submission 30, p 3

246 Dr John Gunning, Evidence, 16 November 2007, pp 8-9

247 Submission 64, Dr Greg Purcell, p 5

248 Submission 38, Department of Neurology, Royal North Shore Hospital, p 7

249 Mr Daly, Evidence, 12 November 2007, p 26

The lack of authority of the General Manager

6.39 The Cardiology Department at RNSH also submitted that the 'administrative emasculation' of the hospital has seen the severe downgrading over the years of its former CEO to the current General Manager, with extremely circumscribed decision-making powers.[250]

6.40 Similarly, Dr Keegan, President of the Australian Medical Association Limited (NSW), submitted that management at RNSH has worsened considerably since the amalgamation of health services in 2005:

> Since amalgamation, authority and responsibility has resided solely with the Chief Executive, leading to frustrations and delays in decision making. Simple decisions on appointments, resources and equipment are delayed, and the phrase – on the Chief Executive's desk – has become a by-law for a system gone mad on red tape.[251]

6.41 Prior to the appointment of Ms Mary Bonner, the General Manager of NSRHS was Ms Deborah Latta. In separate correspondence to the Committee, Associate Professor Dale Bailey, Chair of the Royal North Shore Scientific Staff Council, indicated that Ms Latta was much liked on campus and had the full support of staff, but that the lack of control over the budget and decision making generally forced her to leave. At the time the Scientific Staff Council wrote to the former CE of NSCCAHS to try to forestall Ms Latta's resignation, but the Council indicated that no response was received.[252]

6.42 In evidence, Ms Latta acknowledged that as General Manager of NSRHS, she had less control over human resources, clinical and financial matters than she did in her previous appointment at Sutherland hospital.[253]

The high turnover of senior managers at NSCCAHS and RNSH

6.43 In its submission, the Medical Staff Council at RNSH cited the high turnover of senior managers of NSCCAHS and RNSH, and noted that a number of key positions are presently vacant or relieved. It also argued that managers are unable to fulfil their assigned role, including being unable to address critical issues adequately, failing to report critical issues upwards and failing to act strategically, typically placing financial concerns ahead of clinical considerations.[254] This view was not supported by other witnesses.

6.44 In its submission, the Cardiology Department at RNSH claimed that frequent changes and the brief tenure of middle and senior management over the past 10 to 15 years has deprived

---

250 Submission 30, p 9

251 Dr Andrew Keegan, President, Australian Medical Association (NSW), Evidence, 12 November 2007, p 46

252 Submission 89, Associate Professor Dale Bailey, Chair of the Royal North Shore Scientific Staff Council, pp 1-2

253 Ms Deborah Latta, Former General Manager, Royal North Shore Hospital, Published in camera evidence, 16 November 2007, pp 5-6

254 Submission 28, Medical Staff Council of Royal North Shore Hospital, p 4

RNSH of corporate memory, with particularly serious consequences for clinical management.[255]

6.45 In turn, the members of the Department of Neurology expressed frustration at the lack of continuity in management and constant replacement of administrators at both the area and hospital level. As a result, the hospital has been led for the past 11 years by a succession of eight short-term and disempowered managers, leading to a lack of continuity and loss of corporate memory.[256]

6.46 The Committee also notes the similar comments in relation to this issue contained in the submissions of Dr Tony Joseph, Director of Trauma (Emergency),[257] and the evidence of Dr Jeffery Hughes, a former senior orthopaedic consultant VMO at RNSH.[258]

6.47 In evidence, Ms Beets, Nurse Manager at the Emergency Department at RNSH stated:

> 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.[259]

6.48 In response, Ms Mary Bonner acknowledged that the high turnover of general managers at the hospital has led to difficulties for staff, and has meant a loss of corporate memory to the organisation.[260] However, she argued that the merger of the Northern Sydney and Central Coast Area Health Services to form NSCCAHS has not led to any diminution in attention to hospital services on the North Shore of Sydney and that she has no difficulty in accessing senior management of the Area Health Service.[261]

6.49 The Committee notes the evidence of Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care at NSRHS, that there is a broad groundswell of opinion that the current new executive can and will make a positive difference at the hospital.[262]

6.50 The Committee also notes the evidence of the Minister and senior executives of NSW Health that patient care is always a matter for clinicians.

---

255 Submission 30, pp 8-9

256 Submission 38, p 7

257 Submission 48, Dr Tony Joseph, p 3

258 Submission 13, Dr Jeffery Hughes, p 1; Dr Jeffrey Hughes, Former Senior Orthopaedic Consultant VMO, Royal North Shore Hospital, Evidence, 22 November 2007, p 82

259 Ms Michelle Beets, Nurse Manager, Emergency Department, Royal North Shore Hospital, Published in camera evidence, 22 November 2007, p 9

260 Ms Mary Bonner, General Manager, NSRHS, Evidence, 12 November 2007, p 33

261 Ms Bonner, Evidence, 12 November 2007, p 33

262 Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Evidence, 16 November 2007, p 45

The role of the Northern Sydney Central Coast Area Health Advisory Committee

6.51 In 2005, amendments to the *Health Services Act 1997* led to the development of Area Health Advisory Committees (AHACs), made up of clinicians and community members, in each Area. The role of AHACs is to provide advice to the Chief Executive of their respective Area Health Service on the delivery of health services. The working relationship between the Chief Executive team and the AHAC is said to be critical to the improvement of clinical services.[263]

6.52 In evidence, Professor Pollock, Chairperson of the NSCCAHS AHAC, indicated that the performance of RNSH has been a particular issue that has concerned the Committee. Indeed, the AHAC was actively raising many of the issues surrounding the operation of RNSH prior to this parliamentary committee inquiry, citing such issues as engagement of clinicians, governance structures, and the redevelopment of RNSH. Professor Pollock continued:

> I refer to my chair-in-review document that was submitted with my recent submission on behalf of the council that highlighted the activities of the Health Advisory Council. My opening statement was that the Area Health Service as a whole has faced challenges in 2006-07 that can be clustered into the following areas: budgetary; operational, including information technology; workforce; turnover in management; and planning for North Shore and northern beaches redevelopment. They are not things that have escaped our attention. We have certainly been bringing them to the attention of the Health Advisory Council, the Chief Executive and various people around the table. We are very much engaged and we are very willing to help. We have a fantastic group.[264]

6.53 However, in its submission, the Cardiology Department at RNSH argued that the AHAC is largely powerless and has been established only 'to give a veneer of respectability, transparency and accountability to the draconian powers of the CEO'. The submission continued that the AHAC's more significant recommendations have often been rejected and its power to influence important aspects of RNSH's operation is minimal'.[265]

6.54 In response, NSCCAHS acknowledged in its submission that the relationship between the NSCC AHAC and the NSCCAHS executive 'can be strengthened'. To achieve this, NSCCAHS indicated that it intends to increase the engagement of the AHAC in the area-wide planning process through the increased delivery of timely, meaningful performance and financial information, and requests for advice on strategic matters affecting the community and clinicians.[266]

A hospital board?

6.55 In response to their concerns cited above, the Cardiology Department at RNSH advocated the re-introduction of a hospital board. In support of this view, the Cardiology Department noted the introduction of 12 metropolitan and 8 regional health boards in Victoria, and cited a

263 Submission 34, NSCCAHS, p 19

264 Professor Carol Pollock, Chairperson, Area Health Advisory Council, Northern Sydney Central Coast Area Health Service, Evidence, 12 November 2007, pp 23-24

265 Submission 29, Section of Cardiology at RNSH, p 8

266 Submission 34, pp 19-20

recent AMA national comparison of state hospital performance which ranked Victorian hospitals as performing 30 per cent better than New South Wales hospitals.[267]

6.56 The Department went on to argue that such a board should be instituted by mid-2008, with a sub-committee appointed to manage staffing. In addition, the Cardiology Department advocated that position descriptions, including lines of responsibility and reporting, should be clearly articulated for all staff.[268]

6.57 This position was reiterated in evidence by Dr Stephen Hunyor, Director of the Cardiac Technology Centre at RNSH:

> The model of governance as it relates to Royal North Shore is visibly broken. Bold leadership is required for staff in the institution to shed their disdain and even cynicism and to regain trust and confidence in their leaders. Specifically, it requires a hospital board that is highly competent and involved – not filled with retired health bureaucrats – but one that is truly independent. The current models operating at Westmead Children's Hospital and in the 12 metropolitan and eight regional health facilities in Victoria warrant consideration.[269]

6.58 In response, however, Dr Patrick Cregan, Chair of the Clinical Services Taskforce in New South Wales Health and director of surgery for Sydney West Area Health Service, submitted that:

> 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.[270]

Committee comment

6.59 The Committee supports the current senior management structure of NSCCAHS and RNSH. This structure is consistent with the broader objective of the amalgamations in 2005 discussed earlier, namely to promote the development across NSCCAHS of strong clinical networks delivering coordinated and efficient clinical care services to the community across a whole area. Dismantling the senior management structure based along this model would not assist in the problems facing RNSH.

---

267 Submission 30, Section of Cardiology, RNSH, pp 8,9. See also Dr Stephen Hunyor, Director, Cardiac Technology Centre, Royal North Shore Hospital (RNSH), Evidence, 16 November 2007, p 7

268 Submission 30, Section of Cardiology, RNSH, p 10

269 Dr Stephen Hunyor, Director, Cardiac Technology Centre, Royal North Shore Hospital (RNSH), Evidence, 16 November 2007, p 2

270 Dr Patrick Cregan, Chair, Clinical Services Taskforce, Nepean Hospital, Evidence, 22 November 2007, p 32

AAt the same time, the Committee believes that the lack of control of the General Manager of NSRHS over human resources, clinical and financial matters must be addressed if RNSH is to regain its top rating in New South Wales.

6.60 The Committee does not support the proposal for a hospital board at RNSH. The Committee believes that such a board would be contrary to the intention of the development of Area Health Services, with hospitals operating within a clinical services network across the area in the delivery of services to the community.

6.61 However, the Committee does believe that senior management at NSRHS and NSCCAHS needs to be more responsive to the management issues raised by the AHAC and individual divisions and departments at RNSH. Accordingly, the Committee makes recommendations in Chapter 10 in relation to the financial autonomy of senior managers at RNSH.

Chapter 7 The clinical services plan

> … the clinical involvement [in the clinical services plan] 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.[271]

This chapter examines the need for a clinical services plan for both NSCCAHS and RNSH. A clinical services plan is needed across NSCCAHS to assist in the allocation of roles, responsibilities and most importantly resources to hospitals within the Area. The RNSH needs a clinical services plan to address issues such as managing patient flows and the increasing demands being placed on the Emergency Department.

The need for an Area-wide clinical services plan

7.1 A clinical services plan identifies the key strategic directions for an AHS for a set period (five years with a broad outlook to ten years), and should represent a 'big picture view' of an Area's current situation, anticipated future needs and priorities for action in the short to medium term, based on a particular operating environment.[272]

7.2 The reduction and merger of Area Health Services in 2005 led to the requirement for all Areas to develop new operational and clinical services plans.

7.3 The NSCCAHS is developing but has not finalised or implemented an Area-wide operational and clinical services plan. The plan remains in draft form.[273]

7.4 The failure of NSCCAHS to finalise and implement a new Area-wide operational and clinical services plan since its formation in 2005, could be the cause of some of the problems at RNSH. In its submission, New South Wales Health cited the South Eastern Sydney Illawarra Area Health Service Plan as a useful example of effective clinical engagement forming the basis of successful service planning:

- The plan was developed though consultations with over 30 clinical groups and divisions, over 600 individual staff and clinical partners, general managers and executive directors of hospitals, consumer representatives from the peak consumer groups and representatives of New South Wales Health
- Further consultation on the draft plan included over 150 senior legal staff, over 570 general staff (including nurses and allied health staff) and over 50 health consumers
- The process was overseen by the area's Clinical Executive Committee, involving 23 members from the spectrum of clinical specialties and facilities across the South Eastern Sydney Illawarra Area Health Service.[274]

---

271 Dr Philip Hoyle, Director, Clinical Governance, RNSH, Evidence, 22 November 2007, p 23

272 Submission 34, NSCCAHS, p 19

273 It should be noted that prior to the merger of the Northern Sydney Health Service and the Central Coast Health Service, both Area Health Services had a clinical services plan in place. See supplementary submission 37a, Dr Stephen Christley, p 3

7.5 The Committee notes advice that all Areas have been developing draft Area Health Service clinical service plans which are being submitted to the Department of Health for review.[275]

7.6 The need for NSCCAHS to finalise and implement an Area-wide clinical services plan was raised by various parties to the inquiry. It was highlighted in particular that without an Area-wide clinical services plan, it is hard to allocate resources appropriately – financial, human and capital – across NSCCAHS.

7.7 For example, in its submission, the Medical Staff Council of RNSH noted that without a clinical services plan for the Area, the clinical role of RNSH and other hospitals is undefined. As a result, workforce, funding and equipment requirements across the Area cannot be determined nor distributed appropriately.[276] This was reiterated in evidence by Dr Charles Fisher, Chair of the Medical Staff Council:

> I have mentioned the Area strategic plan [clinical services plan]. That is coming, but clearly without that plan you do not have a process to determine the workforce you need to deliver the services, the resources you need to deliver the services and then appropriately allocate them. So in the meantime clinicians will be doing the best job that they can within the environment they are allowed to work in.[277]

7.8 Similarly, Dr Joseph noted that a lot of specialty surgery and care is being concentrated at RNSH, such as spinal injuries and burns, but that there is no planning to cope with the increase of patients coming to RNSH. Similarly, the paediatric services at Ryde and Manly were closed and patients directed to RNSH, again without planning. For these reasons, he reiterated that NSCCAHS needs a clinical services plan.[278]

7.9 Ms Mary Bonner, the General Manager of NSRHS, also highlighted in her evidence the clear need for an Area-wide clinical services plan, to ensure services are provided appropriately.[279]

7.10 In its submission, NSCCAHS acknowledged that clinicians have made it clear that the Area Health Service needs an Area-wide clinical services plan to underpin the distribution of resources and to achieve better outcomes for patients.[280] The new Chief Executive of NSCCAHS, Mr Matthew Daly, reiterated this in evidence:

> Clinicians from Wyong to St Leonards have made it clear to me – and I totally agree – that the Area Health Service lacks a clinical services plan, a plan that is to clearly delineate the role of all hospitals, that will underpin decisions about how the resources

274 Submission 33, New South Wales Health, pp 10-11

275 The Hon Reba Meagher MP, Response to Questions on Notice from 12 November 2007, p 3

276 Submission 28, Medical Staff Council of Royal North Shore Hospital, p 2

277 Dr Charles Fisher, Chair of the Medical Staff Council and head of Department of Vascular Surgery, RNSH, Evidence, 16 November 2007, p 20

278 Dr Anthony Joseph, Director of Trauma (Emergency), RNSH, Evidence, 16 November 2007, p 19

279 Ms Mary Bonner, General Manager, NSRHS, Evidence, 12 November 2007, p 32

280 Submission 34, NSCCAHS, executive summary

> within the Area Health Service will be applied, and will aim to achieve equity of access and better outcomes for patients.[281]

7.11 The Committee notes that Mr Daly has asked that a clinical services plan be developed and implemented as a priority within the next 6 months. This timeframe was reiterated by the Minister in evidence:

> I have had discussions with my new Chief Executive around the importance of a clinical services plan for the Area Health Service, and I have given him six months to complete one. He has already indicated to me that he has started on the framework for putting together the reference groups for clinicians to have involvement in the development of those plans so the preliminary work is underway. I, too, believe it is very important and overdue that the area has a clinical service plan. That is why he is being tasked to get [it] up and running as soon as possible.[282]

7.12 As noted previously, NSCCAHS and RNSH have already developed some draft clinical services plans across key priority services. However, NSCCAHS acknowledged in its submission:

> All of these individual clinical service plans need to be considered in unison, as part of resolving the Area Healthcare Services Plan as a priority. This will provide a comprehensive and holistic view of clinical services across the Area, including how each hospital facility is delineated within a network model of service provision.[283]

7.13 In developing the clinical services plan for NSCCAHS, Dr Philip Hoyle, Director of Clinical Governance at NSCCAHS, stressed the importance of the involvement of both clinicians and the community. In addition, he submitted that managers should have a role both in coordinating the plan and in securing the resource allocations that flow from it.[284]

Committee comment

7.14 The Committee notes the strong support amongst clinicians for the finalisation and implementation of a clinical services plan for NSCCAHS.[285]

7.15 The Committee believes that the lack of a NSCCAHS clinical services plan is having a detrimental impact on the management and performance of RNSH. Put simply, it is not possible for roles, responsibilities and most importantly resources to be allocated appropriately across hospitals in NSCCAHS – including RNSH – because the clinical role of individual hospitals in NSCCAHS is undefined. The lack of a NSCCAHS clinical services plan means that:

---

281 Mr Matthew Daly, Chief Executive, NSCCAHS, Evidence, 12 November 2007, p 19

282 The Hon Reba Meagher MP, Minister for Health, Evidence, 12 November 2007, p 5

283 Submission 34, NSCCAHS, p 19

284 Dr Philip Hoyle, Director, Clinical Governance, RNSH, Evidence, 22 November 2007, p 23

285 See for example Dr Greg Fulcher, Director, Department of Diabetes, Endocrinology and Metabolism, RNSH, Evidence, 22 November 2007, p 16

- there is no strategic planning framework for making decisions about appropriate staffing levels and classifications for the senior and junior medical workforce, nursing workforce and ancillary workforce at RNSH and other hospitals in NSCCAHS
- there is no plan for the delivery of clinical services, including specialty services such as that provided by the burns, spinal and cardiology units at RNSH, or long-term care services such as aged care and mental health care
- there is no formula for the delivery and targeting of funding to individual hospitals or individual clinical services across NSCCAHS.

7.16 The Committee notes that the new Chief Executive of NSCCAHS has committed to the development and implementation of a clinical services plan for NSCCAHS within the next six months. The Committee strongly supports this pledge and urges management, clinicians, nurses and other staff at RNSH and across NSCCAHS to commit to the development and implementation of a new Area clinical services plan by April 2008.

Recommendation 16

That management, clinicians, nurses and other staff at RNSH and across NSCCAHS commit as a matter of urgency to the development and implementation of a new Area clinical services plan by April 2008.

The need for a clinical services plan for North Shore Ryde Health Service

7.17 Similar to NSCCAHS, NSRHS equally does not have a clinical services plan. Although clinical protocols and guidelines are in place in some areas of the hospital, they are often not well-known to medical and nursing staff, are often department specific and may be inconsistent, leading to confusion and uncertainty.[286]

7.18 The lack of a clinical services plan for NSRHS has significant implications for the operation of the hospital.

Managing patient flows

7.19 One of the principal challenges confronting RNSH is the need to manage patient flows. In its submission, the AMA (NSW) and the Australian Salaried Medical Officers Association (NSW) expressed concern at the lack of a system to manage patient flows at RNSH, leading to an 'unhealthy focus on output rather than outcome based management'.[287]

286 Submission 44, Dr Clare Skinner, p 1

287 Submission 32, The AMA (NSW) and the Australian Salaried Medical Officers Association (NSW), p 7

7.20 Similarly, in the absence of a clinical management plan at RNSH, Dr Tony Joseph, Director of Trauma (Emergency), argued that the provision of services at RNSH has been largely budget driven, without focusing on the outcomes for patients.[288]

7.21 In evidence, Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care at NSRHS, suggested that clinical redesign at the hospital could incorporate various aspects including sophisticated patient-flow systems, giving nurses meaningful handover and management tools in the wards, implementing estimated date of discharge practices, examining long-stay patients and why they are there, enlarging the transit lounge, setting up a medical assessment unit for the increasingly complex and elderly patients that now occupy 70 per cent to 80 per cent of emergency rooms, and creating a hospital avoidance clinic.[289]

The difficulty of scheduling surgery at RNSH

7.22 Many parties to the inquiry cited the difficulty of scheduling surgery at RNSH. Often surgery is scheduled, only to be cancelled and rescheduled, due to a lack of planning and coordination.

7.23 In his submission, Dr Greg Purcell from the Department of Anaesthesia and Pain Management at RNSH noted that the lack of any strategic management plan makes decision making in relation to surgery very difficult. For example, if confronted with staff leave due to illness that necessitates a reduction in surgery, it is uncertain whether the goal is to complete 'elective' surgery or to clear the unscheduled emergency cases. This has a significant impact on resource allocation.[290]

7.24 Similarly, Dr Jeffrey Hughes, a former Senior Orthopaedic Consultant VMO at RNSH, cited continual delays in surgery for patients due to the poor management of senior theatre managers and the proliferation of competing policies:

> 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.[291]

7.25 While not as critical of hospital management, Dr Andrew Ellis, an Orthopaedic Surgeon and VMO at RNSH, acknowledged that about two surgical cases are cancelled from the orthopaedic emergency list each day, with cases being rolled over 24, 48 and 72 hours on a

---

288 Submission 48, Dr Tony Joseph, p 1

289 Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Evidence, 16 November 2007, p 45

290 Submission 64, Dr Greg Purcell, p 5

291 Dr Jeffrey Hughes, Former Senior Orthopaedic Consultant VMO, RNSH, Evidence, 22 November 2007, p 81

regular basis. He also acknowledged, however, that the situation currently at RNSH is a lot better than it was.[292]

7.26 In evidence Associate Professor Bill Sears, a consultant neurosurgeon, indicated that the difficulty of scheduling surgery at RNSH and the continual delay of surgery for some patients has a detrimental impact on their health outcomes:

> The saddest part is patients being repeatedly delayed or even cancelled and I can think of one example in particular where a chap has been in hospital, he has been cancelled twice, and he is having serious problems just earning a living now because he has resigned his job to come and have a major spinal operation. We have patients who come down and they are on, then they are off, then they are on, then they are off. I understand why. It is because my colleagues here and the nursing staff one or two floors higher are trying to clear a bed for the patient, because you cannot start an operation unless you have a safe place for them to go afterwards, but they cannot get the patients out into the ward and we are supposed to start at 8 o'clock in the morning. I can think of times when I have sat in the tearoom for three hours.[293]

7.27 The Committee notes the evidence of Dr Denis King, Executive Clinical Director, South Eastern Sydney Illawarra Area Health Service, who conducted a number of reviews[294] of operating theatre capacity at RNSH and made recommendations relating to the number of theatres in use and means of scheduling non-elective surgery.[295]

The report of Professors Hughes and Walters

7.28 The Committee notes that the lack of a clinical services plan at RNSH was highlighted in the report by Professor Clifford Hughes and Professor William Walters into the miscarriage of Ms Jana Horska in the Emergency Department at RNSH on 25 September 2007. In their report, Professors Hughes and Walters noted that RNSH does not have specific system-wide policies and guidelines in place for the management and care of women presenting with a threatened miscarriage. On the night of Ms Horska's miscarriage, staff were following broader system-wide policies in relation to the management and care of patients presenting to the Emergency Department. By contrast, such policies and procedures to manage women presenting with a threatened miscarriage are in place in some Area Health Services and facilities, including Sydney South West Area Health Service, North Coast Area Health Service, Hunter New England Area Health Service, Royal Hospital for Women, Prince of Wales Hospital, Royal Prince Alfred Hospital, Westmead Hospital and Nepean Hospital.[296]

7.29 The report subsequently noted that following the events of 25 September 2007, RNSH has developed an interim procedure for the management of patients with complications of early

---

292 Dr Andrew Ellis, VMO – Orthopaedic Surgery, RNSH, Evidence, 22 November 2007, pp 82, 86

293 Associate Professor Bill Sears, VMO, RNSH, Evidence, 16 November 2007, p 34

294 The last review was titled 'RNS and RHS Surgical Services Review', September 2004

295 Dr Denis King, Executive Clinical Director, South Eastern Sydney Illawarra Area Health Service, Evidence, 26 November 2007, p 2

296 Prof Clifford Hughes and Prof William Walters, *Report of inquiry into the care of a patient with threatened miscarriage at Royal North Shore Hospital on 25 September 2007*, 26 October 2007, pp 7, 10

pregnancy. This involves one consultation room being set aside for such patients at all times. In the longer term, Professors Hughes and Walters recommended that system-wide policies and guidelines be developed for all public health facilities in NSW.[297]

7.30 In response to the failings of the clinical management systems at RNSH revealed by the case of Ms Horska, the Committee noted in Chapter 4 that the Minister, the Hon Reba Meagher, has taken steps to provide a more appropriate model of care for women presenting to emergency departments with early pregnancy complications.

The Clinical Services Redesign Program at RNSH

7.31 The Clinical Services Redesign Program is a $70 million program run by New South Wales Health since 2004 supporting Area Health Services and their hospitals to redesign operational processes to improve the quality of care. The program funds external partners to work with clinicians, patients and managers to map current processes and to implement improvements to the health care provided.

7.32 In its written submission, New South Wales Health noted that so far over 75 redesign projects have been undertaken across the New South Wales health system, tackling issues such as:

- the time people wait in an emergency department for a hospital bed
- reducing the time people wait to be transferred from an ambulance into an emergency department
- removing inappropriate delays in surgery
- increasing patient and staff satisfaction
- creating more flexible patient centred models of care.

7.33 The projects address not only emergency care but other areas such as surgery, mental health, aged and chronic care, cardiology, acute care, performance management and patient flows.[298]

7.34 Since the inception of the Clinical Services Redesign Program, clinical redesign projects have been undertaken in relation to the following areas of RNSH:

- the Emergency Department
- mental health
- surgical patient flow
- acute aged care and rehabilitation and continuing care
- cardiology.[299]

297 Walters/Hughes Report, 26 October 2007, pp 10-11

298 Submission 33, New South Wales Health, p 6

299 Submission 34, NSCCAHS, pp 11-12

7.35 While these projects have incorporated a number of improvements to clinical management systems in NSCCAHS and at RNSH, New South Wales Health acknowledged in its submission that implementation of the strategies has been limited, due to a number of factors:

- an absence of clear executive and clinical leadership
- a lack of engagement between executive leadership and clinical leadership
- a culture of professional 'silos' and resistance to change
- an unwillingness to be proactive in the management of projects and resources
- a lack of clearly defined roles and responsibilities for staff.[300]

7.36 Similarly, in its submission NSCCAHS noted that there have been varying degrees of success in implementation of the clinical redesign projects. The submission continued:

> A clearer commitment to implementation of solutions with leadership shown at all levels of the organisation is required to ensure that changes are fully embedded following the redesign projects at RNSH.[301]

7.37 The Committee looks at some of these issues in relation to clinical leadership, engagement between clinicians and management and a culture of professional silos in the following chapter.

7.38 However, the Committee also notes evidence from Ms Linda Davison, Acting Director of Nursing and Midwifery Services at RNSH, that some of the initiatives being implemented through the clinical services redesign plan at RNSH have been very beneficial. As an example, Ms Davison cited a four-week blitz of nursing staff whereby nurses were provided with a practice partner to work with to raise their consciousness about their patient management and communication skills. The feedback from both nursing staff and patients was extremely positive.[302]

Committee comment

7.39 The Committee believes that the lack of a clinical services plan for NSRHS is severely impeding the efficient and effective delivery of clinical care at the hospital. In the absence of a clinical services plan, RNSH does not have a framework around which to manage patient flows, leading to an unhealthy focus on output rather than outcome based management. This in turn places particular pressure on the Emergency Department. The failure of clinical systems at RNSH to cope with this increasing pressure is clearly demonstrated in the cases of Ms Horska and the other recent medical failings at RNSH cited in Chapter 3.

7.40 The Committee acknowledges that the Clinical Services Redesign Program to redesign operational processes to improve the quality of care provided by patients has had a positive impact on operational processes at RNSH, although the Committee also notes that the impact

300 Submission 33, New South Wales Health, p 7

301 Submission 34, NSCCAHS, p 17

302 Ms Linda Davidson, Acting Director of Nursing and Midwifery Services, Royal North Shore Hospital, Evidence, 12 November 2007, p 36

of the program, in the absence of a clinical services plan and engagement by clinicians in the management of the hospital, has been limited.

7.41 In the broader context of this report, however, the Committee believes it is imperative that NSRHS as a matter of urgency develop its own clinical services plan by April 2008, with appropriate system-wide policies and guidelines for the management of patients, resources and personnel. This plan must be guided by the development of the Area-wide clinical services plan.

Recommendation 17

That NSRHS as a matter of urgency develop its own clinical services plan by April 2008, with appropriate system-wide policies and guidelines for the management of patients, resources and personnel.

7.42 On the issue of scheduling surgery at RNSH, the Committee believes that NSRHS should urgently review the implementation of the recommendations of the review of surgical services at RNS and Ryde Hospitals undertaken by Dr Denis King entitled 'RNS and RHS Surgical Services Review', dated September 2004, and make the review results public.

Recommendation 18

That NSRHS urgently review the implementation of the recommendations of the review of surgical services at RNS and Ryde Hospitals undertaken by Dr Denis King entitled 'RNS and RHS Surgical Services Review', dated September 2004, and make the review results public.

Chapter 8 Management issues

> 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.[303]

This chapter examines the management of Royal North Shore Hospital and Northern Sydney Central Coast Area Health Service. In particular, it examines claims that there has been a disconnection at the hospital between clinical staff on the one hand, and management on the other. One of the facets of this disconnect is the perceived failings in the planning for the new Royal North Shore Hospital.

The decline in governance standards at RNSH

8.1 The Committee notes that RNSH once had a reputation for excellence in teaching, research and clinical care. It was at one point regarded as perhaps the premier hospital in New South Wales. Even today, as was emphasised by various parties to the inquiry, RNSH retains world class specialists and is a world leader in certain clinical fields.[304]

8.2 However, it is also clear that over the past few decades, governance standards at RNSH have dropped. The events leading to the establishment of this inquiry, are indicative of wider systemic and organisational problems within the organisation.

8.3 As evidence of this apparent decline in standards, various parties to the inquiry[305] cited the findings of the Australian Council of Health Standards'[306] three-yearly review of RNSH in April and May 2007. Following this initial review, a series of problems was identified at RNSH and requests were made to address them. A further review was conducted in late October 2007. As a result of this process, the RNSH was granted an interim 12-month accreditation.[307]

---

303 Dr Greg Fulcher, Director, Department of Diabetes, Endocrinology and Metabolism, Royal North Shore Hospital, Evidence, 22 November 2007, p 14

304 See for example Associate Professor Bill Sears, Consultant neurologist, Evidence, 16 November 2007, pp 27-28; Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Evidence, 16 November 2007, p 41; Dr Tom Hugh, Head, Department of Gastro Intestinal Surgery, Royal North Shore Hospital, Evidence, 22 November 2007, p 55; Professor David Sonnabend, Professor, Orthopaedics and Traumatic Surgery, University of Sydney, Chairman, Department of Orthopaedic Surgery, Royal North Shore Hospital, Evidence, 22 November 2007, p 80

305 See for example Submission 30, Section of Cardiology, RNSH, p 6; Submission 48, Dr Tony Joseph, p 1, Dr Tony Joseph, Director of Trauma (Emergency), Evidence, 16 November 2007, p 10

306 The Australian Council of Healthcare Standards is an independent, not-for-profit organisation dedicated to improving quality in health care. It is one of Australia's leading health care assessment and accreditation providers. See http://www.achs.org.au/aboutus/ (accessed 6 December 2007)

307 The core Australian Council of Health Standards' accreditation program is the Evaluation and Quality Improvement Program (EQuIP), guiding organisations through a four-year cycle of Self-Assessment, Organisation-Wide Survey and Periodic Review to meet ACHS standards. The Council

8.4 While RNSH has maintained its accreditation, parties to the inquiry noted that of five rating levels (LA – little achievement; SA – some achievement; MA – moderate achievement; EA – extensive achievement; and OA – outstanding achievement) in the Australian Council of Health Standards' review, RNSH received the middle score in each of the 7 reported 'clinical criteria', each of the 3 'support criteria' and each of the 4 'corporate criteria'. Although EA rating was awarded on 943 occasions across Australia in 2006, and the OA rating on another 26 occasions, RNSH failed to attract even one of these 969 higher levels of achievement in any category.[308]

8.5 In evidence, Dr Stephen Hunyor, Director of the Cardiac Technology Centre at RNSH, submitted:

> This year the Australian Council of Health Care Standards, which is a body that surveys hundreds of hospitals each year, granted North Shore-Ryde only a conditional one of a possible four years accreditation, to October 2008. … The council gave North Shore a mediocre report card, and that put it into the lowest 10 per cent. In management parlance, this is a fail.[309]

8.6 Dr Hunyor subsequently noted that the Australian Council of Health Standards identified serious problems at the hospital relating to risk management, the use of medical records in the delivery of care and the provision of quality and safe care through strategic and operational planning.[310]

8.7 Similarly, Dr Keegan, President of the AMA (NSW) submitted in evidence:

> Doctors at North Shore are frustrated and saddened by the perceived demise of their hospital. North Shore has gone from being one of the premier hospitals in Australia to last year not being able to achieve ACHS accreditation, and now operating under conditional accreditation.[311]

8.8 In response, the Committee notes the comments of Dr Philip Hoyle, Director of Clinical Governance at NSCCAHS, that while the Australian Council of Health Care Standards quite rightly found some systems failures at RNSH, those issues have now been addressed, and the hospital remains fully accredited until the next routine accreditation in October 2008.[312]

---

undertakes a comprehensive EQuIP standards review and consultation process every four years to ensure the standards remain current, continue to reflect best practice and evidence and are achievable.

308 Submission 30, p 6

309 Dr Stephen Hunyor, Director, Cardiac Technology Centre, Royal North Shore Hospital (RNSH), Evidence, 16 November 2007, p 2

310 Dr Hunyor, Evidence, 16 November 2007, p 2

311 Dr Andrew Keegan, President, Australian Medical Association (NSW), Evidence, 12 November 2007, p 45

312 Dr Philip Hoyle, Director, Clinical Governance, Royal North Shore Hospital, Evidence, 22 November 2007, pp 24-25

Committee comment

8.9 As indicated earlier, RNSH is one of the state's largest hospitals, servicing 12 per cent of the New South Wales population, and offering an extensive array of clinical service, including specialised care in many fields, and community health services. It is also one of the state's major trauma centres, and is the major tertiary referral, research and teaching hospital in NSCCAHS. It is a key hospital within NSCCAHS, and has for many years enjoyed a reputation for excellence.

8.10 Accordingly, the apparent decline in governance standards at RNSH in recent years, as measured by the 2007 Australian Council of Healthcare Standards yearly review of RNSH, is of particular concern.

8.11 The Committee believes that the management of NSCCAHS and RNSH, together with clinicians, nursing staff and ancillary staff at RNSH hospital, should set an urgent three-year objective of returning RNSH to the top echelon of hospitals in New South Wales, as measured by the Australian Council of Healthcare Standards.

Recommendation 19

That NSCCAHS and NSRHS, together with clinicians, nursing staff and ancillary staff at RNSH hospital, set an urgent three-year objective of returning RNSH to the top echelon of hospitals in New South Wales, as measured by the Australian Council of Healthcare Standards.

The perceived disconnect between clinical staff and management

8.12 During the inquiry significant concerns were expressed that management does not work hand-in-hand with clinical staff at RNSH. Whilst submissions and evidence all highlighted the high quality of clinical staff at the hospital, with many clinicians and clinical areas being world leaders in their particular fields, it was submitted that they are being hamstrung by poor management.

8.13 In its written submission, the Medical Staff Council argued that there is a lack of meaningful interaction by management with clinicians at RNSH. The Council suggested that the involvement of clinicians is often tokenistic and their recommendations on strategic and critical issues either rejected, misreported or not minuted.[313]

8.14 These concerns were also raised by the representatives of individual departments and units at RNSH. For example, the Cardiology Department argued that clinical management systems at the RNSH have become unresponsive to the needs of patients and staff. It was submitted:

> Medical staff input into the planning and running of clinical management systems has eroded to the point where it has become irrelevant. Doctors have been disenfranchised …[314]

313 Submission 28, Medical Staff Council of Royal North Shore Hospital, p 2

314 Submission 30, p 5

8.15 Dr Tony Joseph, Director of Trauma (Emergency) at RNSH, submitted that clinicians have been largely excluded or ignored in planning for the best and most appropriate way to deliver clinical care. He argued that the Clinical Council, the Medical Staff Council and hospital General Manager have little input into executive decision making which has been increasingly concentrated at the area executive level and is largely based on meeting budget targets imposed by the Department of Health.[315]

8.16 Similarly, Dr Ray Raper, Director of Intensive Care at RNSH submitted:

> All the people in the system are great. Wherever you scratch the surface and find someone, they say, 'Oh yeah, I can do that', 'I can fix that', 'I want to help that', but it does not change anything. The system is inept. The people are great, but the system is terrible.[316]

8.17 Dr Ross Wilson, Director of the Northern Centre for Healthcare Improvement, submitted:

> In summary, from my point of view, I make the point that the clinicians at Royal North Shore do a fantastic job. As someone who is one of them, and being one of them, and someone who has also been involved in assessing their care broadly, the clinical results are outstanding. We have very good measurement to support that..
>
> … in terms of the capacity or environment in which the clinicians work, the management has failed them. The management has failed in terms of helping them to give … good clinical care. It is almost as if we have had, up until the last year or so, two parallel systems. I acknowledge that there are improvements going on at the present time and I am optimistic for them to be successful. My comments reflect the last 20-plus years. … What we have had is clinicians desperately trying to manage the care while the parallel stream has been managing the buildings and the budget, and those two streams of activity have not always been well connected.[317]

8.18 The Committee also notes the comments of Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care at NSRHS,[318] Dr Tom Hugh, Head of the RNSH Department of Gastro Intestinal Surgery,[319] Professor David Sonnabend, Chairman of the Department of Orthopaedic Surgery at RNSH.[320]

8.19 In response to this issue, NSCCAHS acknowledged in its submission that:

> … it is apparent that RNSH has suffered a loss of staff engagement, particularly clinician engagement, in the governance of the hospital …

---

315 Submission 48, p 2. See also Dr Tony Joseph, Director of Trauma (Emergency), Evidence, 16 November 2007, p 11, Dr Ray Raper, Director, Intensive Care, RNSH, Evidence, 16 November 2007, p 29

316 Dr Ray Raper, Director, Intensive Care, RNSH, Evidence, 16 November 2007, p 29

317 Dr Ross Wilson, Director, Northern Centre for Healthcare Improvement, NSCCAHS, Evidence, 16 November 2007, p 40

318 Dr Stiel, Evidence, 16 November 2007, p 45

319 Dr Hugh, Evidence, 22 November 2007, p 55

320 Professor Sonnabend, Evidence, 22 November 2007, p 80

8.20 The NSCCAHS further accepted that the loss of engagement by clinicians at RNSH means a lost opportunity for managers at the hospital and for NSCCAHS to have the benefit, indeed necessary input, of clinicians into decisions about how most effectively to utilise resources. This disengagement has led to levels of frustration, cynicism and poor morale.[321]

8.21 This acknowledgement that clinicians have disengaged from the management and leadership of the hospital was reiterated in evidence by Professor Debora Picone, Director General of New South Wales Health and Mr Matthew Daly, the Chief Executive of NSCCAHS. [322]

8.22 However, the Committee also notes the alternative position put by Dr Patrick Cregan, Chair of the Clinical Services Taskforce in the NSW Department of Health and director of surgery for Sydney West Area Health Service:

> I would be so cautious [as] 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.[323]

8.23 Dr Cregan further argued that members of the College of Surgeons have a similar view that clinicians at RNSH are not necessarily interested in developing good processes that assist in the management of the hospital.[324] He noted:

> 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.[325]

8.24 Dr Cregan noted that by comparison, clinicians in other Area Health Services have adapted new models of care and cooperation across facilities – for example Westmead orthopaedic surgeons do most of their joint replacements at Mount Druitt, freeing up their ability to run Westmead orthopaedic and emergency facilities. By contrast, he suggested that there is not a strong equivalent of new models of care and cooperation between hospitals in NSCCAHS.[326]

---

321 Submission 34, NSCCAHS, executive summary

322 Ms Debora Picone, Director General, New South Wales Health, Evidence, 12 November 2007, p 8; Mr Matthew Daly, Chief Executive, Northern Sydney Central Coast Area Health Service, Evidence, 12 November 2007, p 18

323 Dr Patrick Cregan, Chair, Clinical Services Taskforce, Nepean Hospital, Evidence, 22 November 2007, pp 27-28

324 Dr Cregan, Evidence, 22 November 2007, pp 27-28

325 Dr Cregan, Evidence, 22 November 2007, p 31

326 Dr Cregan, Evidence, 22 November 2007, p 32

8.25 On the issue of getting clinicians and management to re-engage, Dr Cregan observed that it requires a commitment from both clinicians and management:

> … 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.[327]

8.26 Dr Cregan's view was disputed by some clinicians from RNSH. For example, Dr Tom Hugh, Head of the RNSH Department of Gastro Intestinal Surgery, told the Committee:

> … 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.[328]

The new Clinical Reference Group

8.27 On 24 September 2007 a new Clinical Reference Group framework was established at RNSH to respond to internal and external concerns about the operations of the hospital. The group is chaired by the Chief Executive of NSCCAHS, and includes the General Manager of RNSH, senior clinicians at RNSH, the Chairman of the NSCCH AHAC, selected NSCCAHS executive staff and external clinical leaders.

8.28 Reporting to the Clinical Reference Group are Specialist Reference Groups considering issues relating to:

- human resourcing (that is, bullying and harassment)
- the performance of the Emergency Department
- the nursing workforce
- quality reporting and clinical incidents
- financial and workforce resources
- staff morale.

8.29 In addition, a Community Engagement Group has been established to provide input into key issues, identify appropriate responses and improve communication with the community.[329]

8.30 In its submission, NSCCAHS stated:

> Since the appointment of the new Chief Executive there has been overwhelming willingness of clinical staff, of all disciplines, to come forward and say they want to be

327 Dr Cregan, Evidence, 22 November 2007, pp 29-30

328 Dr Hugh, Evidence, 22 November 2007, p 57

329 Submission 34, executive summary

> part of the solution. Hence the Clinical Reference Group, which is guiding the development of a management plan, supported by specialist groups including a community consultative committee, [is] re-establish[ing] RNSH as not just a superb teaching hospital but a great place to work.
>
> This willingness is also manifesting itself in an active clinical division management structure re-established and led by the current General Manager, which will when fully developed help embed clinician involvement at the operational level.[330]

8.31 In his evidence, Mr Matthew Daly highlighted the hand-in-glove partnership between management and clinicians at other Areas he has worked at, and reiterated that clinicians are giving very strong support across NSCCAHS, but particularly at RNSH, to re-engagement with the management process.[331]

8.32 In her evidence, the Minister indicated that she met with the Clinical Reference Group on 2 October 2007, and that in her opinion, clinicians have committed to working with the new management of the hospital to achieve improvements. She cited the Clinical Reference Group as an important step in re-engaging clinicians in decision making at the hospital.[332]

8.33 By contrast, however, in its submission, the Cardiology Department at RNSH argued that the Clinical Reference Group had been hastily convened by the new Chief Executive, and that the initial conditions for participation by the invited clinicians in the reference group have been disregarded.[333] The Committee was also told that the terms of reference of the Clinical Reference Group were not tabled until 15 November 2007.[334] The terms of reference were subsequently provided to the Committee by Mr Daly.[335]

8.34 This was reiterated in evidence by Dr Stephen Hunyor, Director of the Cardiac Technology Centre at RNSH:

> No one takes any notice of it and the clinical reference group that was established by our new chief executive officer just four weeks ago 'forgot' to invite the chair of our medical staff council to the first two meetings until the physicians urged him to do so. It is there in name only and that is the problem in the system.[336]

The operation of the Medical Staff Council

8.35 In its submission, the Cardiology Department at RNSH argued that the former vibrant and effective Medical Staff Council has become dispirited and irrelevant with meetings attended by

---

330 Submission 34, executive summary; see also Mr Matthew Daly, Chief Executive, Northern Sydney Central Coast Area Health Service, Evidence, 12 November 2007, p 18

331 Mr Daly, Evidence, 12 November 2007, p 22

332 The Hon Reba Meagher, Evidence, 12 November 2007, p 3

333 Submission 30, p 7

334 Dr Hunyor, Evidence, 16 November 2007, p 6

335 Mr Matthew Daly, Chief Executive, Northern Sydney Central Coast Area Health Service, Response to Questions on Notice from 12 November 2007, question 1, p 1

336 Dr Hunyor, Evidence, 16 November 2007, p 4

only approximately five per cent of the Council's membership. In response, the Cardiology Department advocated a new suitably empowered and resourced Medical Staff Council with effective representation on all significant administrative organs that affect the hospital's spheres of operation.[337]

8.36 This was restated in evidence by Dr Hunyor, Director of the Cardiac Technology Centre at RNSH. He indicated that the establishment of the divisional structure at RNSH (see Figure 6.1) has effectively disempowered the existing Medical Staff Council by putting medical staff in silos.[338]

8.37 At the same time, the Committee notes the evidence of Dr Charles Fisher, Chair of the Medical Staff Council at RNSH, that the last two meetings of the Council, in the lead up to the Committee's inquiry, were attended by at least 100 or 150 clinicians.[339]

Committee comment

8.38 The Committee is very concerned by evidence of a disengagement by clinical staff at RNSH in the management of the hospital, due in part to a lack of meaningful engagement of clinicians by hospital management.

8.39 Accordingly, the Committee recommends that the management of NSRHS fulfil its commitment to ongoing engagement with clinical staff at RNSH, including through the new Clinical Reference Group, to ensure appropriate high-level input from senior clinicians in the governance and management of the hospital.

Recommendation 20

That NSRHS fulfil its commitment to ongoing engagement with clinical staff at RNSH, including through the new Clinical Reference Group, to ensure appropriate high-level input from senior clinicians in the governance and management of the hospital.

8.40 The Committee also notes the evidence that clinicians also have to be willing to engage with management at the hospital, and that some may have been unwilling to do so in recent times, especially since the formation of NSCCAHS. The Committee reiterates that the process of management at RNSH must involve a partnership between clinicians and management, and that clinicians need to respond to change and adapt to new models of care and cooperation across hospital facilities under the new Area Health Service system.

Planning for the new RNSH

8.41 The redevelopment of Royal North Shore Hospital is to date the State's single largest capital investment in health at a cost of $702 million. The development is being delivered via a public private partnership, although its delivery is at least five years away.[340]

337 Submission 30, pp 5, 10-11

338 Dr Hunyor, Evidence, 16 November 2007, p 4

339 Dr Charles Fisher, Chair of the Medical Staff Council, RNSH, Evidence, 16 November 2007, p 20

8.42 A specific issue raised repeatedly during the inquiry was the perceived disconnection between clinicians and hospital managers in the planning and design of the new RNSH.

8.43 For example, the Medical Staff Council indicated that despite advice to the contrary, pathology services in the new hospital will either be off-site (for example histopathology) or do not appear to be anywhere (for example the blood bank). The Council submitted that clinicians have consistently recommended an institute based model of patient care which has been consistently rejected.[341]

8.44 Concerns were also expressed by the AMA (NSW) and the Australian Salaried Medical Officers Association (NSW) in its submission, and reiterated by Dr Keegan, President of the AMA (NSW) in evidence:

> We also call on the inquiry to urgently address our members' concerns about widespread failures in consultation associated with the redevelopment process of that hospital.[342]

8.45 Again, specific concerns were also presented by the representatives of individual departments and units at RNSH.

8.46 On behalf of the staff of the Haematology Department at RNSH, Dr Christopher Arthur submitted that the proposed new cancer ward would include 30 beds, compared to the current 35 to 50 bed ward. He argued that it is illogical to plan for less beds in the new hospital.[343] Dr Arthur elaborated on this point in evidence:

> 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.[344]

8.47 Professor Leslie Burnett, Director of the Pacific Laboratory Medical Services, Pathology at RNSH provided in evidence details of the difficulty Pathology has encountered over the past three years in the planning for the new hospital, including the apparent removal from the master plan of key services such as the blood bank and pneumatic tube system for transporting specimens.[345]

---

340 Submission 33a, New South Wales Health, p 5

341 Submission 28, p 2

342 Dr Keegan, Evidence, 12 November 2007, p 46

343 Submission 84, Dr Christopher Arthur, p 7

344 Dr Christopher Arthur, Director, Haematology Department, Royal North Shore Hospital, Evidence, 22 November 2007, p 46

345 Professor Leslie Burnett, Director, Pacific Laboratory Medical Services Pathology, Royal North Shore Hospital, Evidence, 22 November 2007, pp 47-48

8.48 The Committee also acknowledges the evidence of various other parties including Professor David Sonnabend, Chairman of the Department of Orthopaedic Surgery at RNSH, who argued that the consultation process over the hospital was fundamentally flawed,[346] Ms Barbara Lucas, Senior Paediatric Physiotherapist in the physiotherapy department at RNSH, who noted the lack of consultation in the removal of the hydrotherapy pool in the new hospital,[347] and Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care at NSRHS, who submitted:

> I do not like dwelling on history because I am not sure it is helpful. However, the process through which we have achieved the current development status – and I am not exaggerating – was appalling. There were very good clinician-led committees and planners and managers who looked at the model of care for the new hospital. We must be progressive; we cannot use the same models of care that we have been using. Halfway through that process, without warning, we were given a directive from the department that the type of models we were looking at were not acceptable and that we had to go down a particular path. I think it is fair to say that I do not know of a single clinician in the hospital – medical, nursing or allied health – who believes that was the right model to use. When I discussed this at forums I am on – such as the Department of Health physicians task force – and mentioned to my colleagues in other hospitals that they were asking us to do this they were gobsmacked.[348]

8.49 The Committee further notes that during his evidence, Dr Tom Hugh, Head of the RNSH Department of Gastro Intestinal Surgery and a member of the Royal North Shore Hospital Redevelopment Clinical Advisory Committee tabled a brief that was written in June 2007 by the committee in 'a last-ditch attempt' to address many of the issues relating to the capacity and design of the new hospital. He also tabled the response from New South Wales Health and the project team. In summation, he submitted that while some minor changes were made to the project, the response 'simply did not engage with most of the issues raised' and essentially stuck to the line that there would be no expansion of the project.[349]

8.50 These concerns contrast with the evidence of the Minister, who claimed that:

> The planning process has recognised clinicians' concerns regarding the capacity of the redevelopment, most notably with the design and number of operating rooms, the anticipated growth in maternity services and the number of general and intensive care unit beds. In May 2007, an additional operating room was supported by New South Wales Health following a review and clinician consultation.[350]

8.51 In her evidence, Ms Bonner acknowledged clinicians' concerns that the new hospital will have an insufficient number of operating theatres and beds, and that clinicians have expressed a desire for eight additional operating rooms to be incorporated into the plans. However, Ms Bonner indicated that the proposed number of 16 operating rooms and 13 procedure rooms

---

346 Professor Sonnabend, Evidence, 22 November 2007, p 80

347 Ms Barbara Lucas, Senior Paediatric Physiotherapist, Royal North Shore Hospital, Evidence, 22 November 2007, p 89

348 Dr Stiel, Evidence, 16 November 2007, p 47

349 Dr Hugh, Evidence, 22 November 2007, p 56

350 The Hon Reba Meagher, Evidence, 12 November 2007, p 6

will be sufficient to meet future demand.[351] Currently there are 15 operating rooms and eight procedure rooms.

8.52 In its supplementary submission, New South Wales Health addressed the planning issue in further detail. It indicated that planning for the new RNSH has been based on long-term acute inpatient demand modelling using a modelling tool called alM2005. The programs allows health service planners to project future demand based on trends in hospital admissions, population growth and ageing. It also allows health service planners to undertake scenario modelling at the local level to predict the possible impacts to changes in service provision such as the opening of a new hospital, the impact of clinical networking and the impact of providing new clinical services at existing hospitals.

8.53 The Committee notes that New South Wales Health also gave an assurance that 'under the New Chief Executive, the engagement of the clinicians will be considerably accelerated over the coming months particularly as the planning needs to be refined', and that New South Wales Health will work with the new Chief Executive to ensure the engagement of clinicians, nurses and allied health professionals in the process.[352]

Committee comment

8.54 The Committee is concerned that whilst the NSW Department of Health has properly based its design of the new Royal North Shore Hospital on clinical demand modelling of the population, in the process there has been an apparent lack of regard for clinicians' views on the design of the new hospital.

8.55 The Committee welcomes the assurance of Department of Health that the management of NSCCAHS and RNSH will actively engage clinicians in the planning and re-development of RNSH. In doing so, management should take into account the new NSCCAHS clinical services plan that will allocate specific roles and responsibilities to the RNSH within NSCCAHS.

Recommendation 21

That NSRHS ensure that senior clinicians are involved in the planning process for the redevelopment of RNSH through formal mechanisms such as the Clinical Reference Group.

The workload of clinical directors

8.56 As indicated in the organisational chart cited at Figure 6.1, there are three divisions in NSRHS: the Division of Surgery and Anaesthesia, the Division of Medicine and Aged Care, and the Division of Women's, Children's and Family Health. Each of these divisions is headed by both a clinical director and a divisional manager. Individual departments also have their own clinical managers.

351 Ms Mary Bonner, General Manager, NSRHS, Evidence, 12 November 2007, p 34

352 Submission 33a, pp 5-7

8.57 In their submission, the members of the Haematology Department at RNSH raised concerns about the excessive workload of clinical managers. The Department submitted that some of the duties required of clinician managers include performance appraisal, performance management, accreditation, policy implementation and planning, leadership, implementation of occupational health and safety measures, management of departmental finances, and human resources management and recruitment.

8.58 The Haematology Department further argued that in recent years the workload of clinical managers has increased as administrative and support services have been lost due to budget cuts. As a result, many clinical managers attempt to manage their department in the few moments between heavy clinical commitments, which inevitably affects their clinical work.[353]

8.59 This concern was reiterated in evidence by Dr Christopher Arthur, Director of the Haematology Department at RNSH:

> 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.[354]

8.60 The Medical Staff Council of Royal North Shore Hospital also contended in its submission that the roles and responsibilities of heads of department are ill defined and limited. For example they have no financial responsibilities and require approval for most expenditure, and they have no ability to appoint staff since approval is required at an area level to replace vacant medical positions.[355]

Committee comment

8.61 The Committee is concerned at evidence that clinical directors and clinical managers are being heavily involved in what are clearly day-to-day administrative and HR tasks such as management of OH&S and human resources. The Committee is of the opinion that day-to-day administrative responsibilities should be managed by the managers employed to run the hospital so that clinical directors can focus on the delivery of clinical services.

8.62 The Committee believes that this issue may reflect a failure on behalf of management at RNSH to properly administer the hospital, so as to allow senior clinical officers to focus on their clinical duties. It again emphasises the need for clinicians and management at the hospital to re-engage with one another in the management of the hospital so that both are performing appropriate roles.

353 Submission 84, p 2

354 Dr Arthur, Evidence, 22 November 2007, p 45

355 Submission 28, p 3

Recommendation 22

That NSRHS review the management structure of the RNSH to ensure appropriate tasks are undertaken by appropriately trained staff, with a particular view that directors should be able to focus on the delivery of clinical services.

The perceived disconnect between nursing staff and management

8.63 The Committee also notes concerns about the perceived disconnect between nursing management and the executive at RNSH.

8.64 In its submission, the Nurses' Association indicated that in 2005, following the formation of NSCCAHS, management at RNSH proposed a more 'professional' role for nursing management at the hospital with a change of focus from management of budgets and staff to a focus on professional leadership and development of nurses.

8.65 Under the new structure, Divisional Nurse Managers (DNM) are responsible for certain clinical operations such as patient throughput and bed availability, but have no direct control over the funds required for extra staff and beds. Mr Holmes, General Secretary of the NSW Nurses' Association, summarised the change as follows:

> The nub of that matter was that previously Royal North Shore had a divisional structure of management and nurses played a pivotal role in that divisional management structure. The divisional management position of the nurses included having operational and budget control and responsibility for nursing services within their division. The proposal being put forward by that area management was that that budget and operational responsibility would be removed and that nurses would be put into an advisory role. After nearly nine months of negotiation, including the industrial action, we have settled on a structure where, unfortunately, the divisional nurse manager was still in a position with limited amount of operational control but they ended up with the title 'operational nurse manager'. However, they were still reporting through to a divisional manager and a clinical director, who was part-time. That clinical director had to be a medical officer.[356]

8.66 The Nurses' Association argued that this structure has been unsuccessful. Under this arrangement, DNMs advise the Division Executive regarding the possible numbers of discharges that can occur safely, based on clinical advice from Nurse Unit Managers (NUMs). However, in some instances, due to budgetary pressures and insufficient beds, Divisional Managers do not follow the advice provided by DNMs. Subsequent pressure may then be placed on NUMs to either discharge patients early or accept admissions that, in reality, cannot be safely accommodated in a ward at that time, as insufficient staff are available. The Nurses' Association continued:

> Thus, with senior nursing management effectively 'sidelined', generic managers and doctors may demand more of nurses without providing them with sufficient staff and resources to do their jobs properly and safely. This leads to a state where nurses are attempting to deliver patient care in less than optimum, and occasionally unacceptable,

356 Mr Holmes, Evidence, 12 November 2007, p 56

> situations. A particularly distressing feature of this situation for our members is when the standards of nursing care, and at times the standards of nursing education, are criticised by those without an appreciation of the factors which are genuinely responsible for the negative consequences of these situations.[357]

8.67 In response, the Nurses' Association recommended that full operational control be returned to the DNMs and appropriate communication structures between divisional executives (including DNMs) and NUMs be put in place.[358]

8.68 The issue was also addressed by Ms Alison Mayhew, Nursing Unit Manager at RNSH:

> There is an operational nurse manager within each division but they have no accountability and no delegation within the hospital. We had argued that that position needed some authority. The NUMs do not report to that person and they have been excluded from the executive table even though their portfolio is basically patient flow. So we had asked at the beginning of the year if those positions could sit at the executive table to be able to at least debate and put forward ideas that would work at the clinical level. But that has been denied.[359]

8.69 The Committee also notes that several nurses suggested during the inquiry that the restrictions may have contributed to instances of bullying and harassment at the hospital. This was discussed in Chapter 5.

8.70 In response to this issue, New South Wales Health acknowledged in its submission that NUMs are the backbone of a hospital's clinical management system and that in mid 2006, nursing staff in NSCCAHS expressed serious concern over the lack of leadership positions and lack of nursing leadership support for NUMs in the new organisational structure.

8.71 The Department of Health subsequently indicated that it convened a series of meetings between senior executives of NSCCAHS and representative of the Nurses' Association in order to achieve a resolution of the structure of NSCCAHS that better reflected nursing leadership.[360]

Committee comment

8.72 The Committee believes that the restructure of the senior nursing management structure at NSRHS in 2006, and in particular the removal of operational control from DNM positions, has been a failure.

8.73 While the change was designed to allow a focus on professional leadership by nurses, it appears that the opposite has happened. The Committee also notes that while the Department of Health has convened various meetings to achieve a resolution of the role of nurses in the structure of NSCCAHS, as far as we can see, the issue is far from resolved.

---

357 Submission 29, Nurses' Association of NSW, p 7

358 Submission 29, p 8

359 Ms Alison Mayhew, Nurse Unit Manager, Royal North Shore Hospital, Evidence, 26 November 2007, p 14

360 Submission 33, NSW Health, p 18

8.74 The Committee accepts the evidence of the Nurses' Association that the appropriate management and communication structures within divisions at RNSH must include operational control for DNMs.

Recommendation 23

That the management of NSRHS review and modify the changes to nurse reporting structures implemented in 2006, in order to provide an operational voice for nurses in executive decisions.

Recommendation 24

That the role of Director of Nursing be reviewed as a matter of urgency, with a view to restoration of management responsibilities so that the most senior nurse on staff has authority to make decisions, and can provide leadership and support for the nursing staff.

Chapter 9 Workforce issues

This chapter identifies the difficulties that RNSH and other hospitals in the NSCCAHS face in recruiting and regaining clinical and nursing staff in the current tight labour market.

The New South Wales health workforce

9.1 There is considerable evidence from the Productivity Commission,[361] the Australian Medical Workforce Advisory Committee, the Australian Health Workforce Advisory Committee, the Commonwealth Department of Employment and Workplace Relations and the OECD[362] that there is a national shortage of health professionals in Australia.

9.2 This shortage is attributable to the restricted number of university places available for locally trained professionals, and the limited number of places for overseas trained medical graduates in the immigration program.

9.3 Despite this shortage, however, NSW Health indicated in its submission that there has been an increase of 4,261 full time equivalent frontline staff over the last three years.[363]

9.4 In relation to the nursing workforce in New South Wales, over the past 5 years, there has been a steady increase in the number of nurses and midwives employed in public hospitals across the state. In January 2002 there were 34,044 permanently employed nurses, both full and part-time. By August 2007 this had risen to 42,081 permanently employed nurses, both full and part-time, an increase of 8,077 or 23.8 per cent.

9.5 This year, the New South Wales Government sought from the Australian Government an additional 1769 university places in nursing for 2008, however only 200 were funded. Similarly, very few additional medical, dental and allied health university places were funded.[364]

Committee comment

9.6 The Committee notes that the staffing of the New South Wales hospital system is an ongoing issue. In the current international and domestic climate, there is intense competition to recruit and retain clinical and nursing staff.

9.7 In response, the Committee recommends that the New South Wales Government continue to liaise with the Australian Government to seek additional funding for clinical and nursing staff positions in the New South Wales university system.

---

361 Productivity Commission, 'Australia's health workforce: key points with research report', 19 January 2006

362 Organisation for Economic Cooperation and Development, 'Briefing note for OECD Health Data 2007: How does Australia compare?', 18 July 2007

363 Submission 33, New South Wales Health, p 15

364 Submission 33, p 14

Recommendation 25

That the New South Wales Government seek additional funding from the Australian Government for clinical and nursing staff positions in the New South Wales university system.

The RNSH medical workforce

9.8 The senior medical workforce at RNSH consists of staff specialists, clinical academics, visiting medical officers (VMOs) and honorary medical officers. In addition, specialists are employed or contracted under New South Wales Health awards or directives across almost all disciplines.

9.9 The junior medical workforce at RNSH comprises interns in their first postgraduate year, resident medical officers in their second and subsequent years post university, and registrars, mostly in their fourth and subsequent years after graduation, who have commenced a specialty training program. In addition there are a relatively small number of career medical officers and a few fellows, who are generally near or at the end of their specialty training but doing further subsequent research training.[365] In addition, agency doctors (also known as locum doctors) have been used at RNSH to meet shortfalls in the medical workforce.[366]

9.10 In its submission, the NSCCAHS noted that the national shortage of medical officers is affecting RNSH. Positions for specialists are becoming increasingly difficult to fill, especially surgical and emergency medicine positions. However, the NSCCAHS submitted that there are also significant specialist workforce shortages in general medicine, neonatology, neurosurgery and intensive care at RNSH.

9.11 There is also a reliance on junior and locum staff to fill shortfalls at RNSH. Despite the growing number of interns expected to graduate over coming years, the NSCCAHS submitted that relative shortages of suitably experienced junior medical staff are likely to continue for the next few years.[367]

Committee comment

9.12 RNSH, like other hospitals, is facing a medical workforce shortage which is only likely to get worse in the future. Accordingly, it is imperative that management of the NSRHS seek to make the best possible use of its existing medical workforce.

The RNSH nursing workforce

9.13 In is submission, the NSCCAHS indicated that there has been a gradual, but significant increase in nursing vacancies at RNSH in recent years, as a result of which the hospital

365 Submission 34, NSCCAHS, p 24

366 Submission 34, p 25

367 Submission 34, pp 27-28

currently has 50 per cent of total vacancies across the NSCCAHS. At present, there are approximately 100 FTE positions at the hospital which are vacant, being filled by a combination of employing agency nurses, overtime and employment from a casual pool.[368]

9.14 The NSCCAHS also indicated that the average number of nursing resignations per month at RNSH this year is 18 FTE staff, down from 19 FTE staff in 2006.[369]

Nurse workloads

9.15 In its submission, the Nurses' Association of NSW argued that the poorly functioning senior nursing structures, where NUMs are disempowered but put under overwhelming workloads, leads to excessive overtime, over-work and frustration. Understandably, in such situations, many nurses have left RNSH, while the morale of the remaining nurses is low.[370]

9.16 In evidence Ms Beets, Nurse Manager at the Emergency Department at RNSH indicated:

> 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 … 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.[371]

9.17 Similarly, Ms Alicia Jackson, a Registered Nurse at RNSH, indicated in evidence that the pressure and stress being experienced by nurses at the hospital is constant, with the result that many are suffering burnout, and a lot are leaving. In turn, positions are being filled with agency staff or enrolled nurses who do not have expertise in areas of high dependency such as the orthopaedic wards and spinal units.[372]

9.18 In response to the issue of nurse workloads, New South Wales Health noted in its submission that over the past few years, it has worked closely with the Nurses' Association to implement the reasonable workload clauses in the Nurses' Award. Reasonable workload committees have been established around NSW hospitals comprising management and frontline nursing staff to provide a mechanism for raising workload concerns and resolving them outside an industrial framework. However, it acknowledged that RNSH has struggled to achieve active staff participation in its Reasonable Workload Committee. New South Wales Health attributed this to ongoing staff morale issues at the hospital.[373]

9.19 Similarly, the Nurses' Association argued that management must do more to facilitate the effective functioning of the Reasonable Workloads Committee at RNSH. In particular, the

368 Submission 34, p 28

369 Submission 34, p 29

370 Submission 29, Nurses' Association of NSW, p 8

371 Ms Michelle Beets, Nurse Manager, Emergency Department, RNSH, Published in camera evidence, 22 November 2007, p 3

372 Ms Alicia Jackson, Registered Nurse, RNSH, Published in camera evidence, 22 November 2007, pp 2-3

373 Submission 33, p 17

Association argued that the committee must comprise appropriate personnel to provide a forum for consultation on reasonable workloads for nurses and a means to provide advice on workloads to management.[374]

9.20 The Committee also notes the evidence of Professor Kerry Russell, Director of Nursing and Midwifery Services, Sydney South West Area Health Service. She recently undertook an examination of the nurse staffing mix at RNSH in response to a request from Mr Matthew Daly, the Executive Director of NSCCAHS, to determine whether the staffing levels and mix was appropriate. Although the data was only available for one month and was not disaggregated by full-time/part-time status, she found:

- 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.
- quite a senior level of experience: 11 per cent of the staff at RSNH 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. The other category of staff that constitute 'junior' in the skill-mix area is trainee enrolled nurses. Again RNSH was fairly comparable to other hospitals.[375]

9.21 Professor Russell also submitted that from a purely desktop review of staffing numbers at RNSH in October-November 2007, there was probably enough staff at the time to open around 15 additional beds.

9.22 Professor Russell acknowledged, however, that this data set did not reveal whether RNSH was top heavy with the experienced nurses all working part-time. She also did not look specifically at the staffing of the Emergency Department.[376]

9.23 Finally, the Committee also notes the evidence of Ms Christine Rijks, the daughter of a former patient of RNSH, who indicated that the nursing staff at the hospital permitted her family to employ a private nurse to care for her father who was dying at the hospital. Ms Rijks indicated that she was very grateful that she was able to employ a private nurse, and that the nurse gave her father special care that the nursing staff of the hospital would probably not have had the resources to provide.[377]

---

374 Submission 29, Nurses' Association of NSW, p 10

375 Clinical Associate Professor Kerry Russell, Director of Nursing and Midwifery Services, Sydney South West Area Health Service, Evidence, 22 November 2007, p 7

376 Clinical Associate Professor Kerry Russell, Evidence, 22 November 2007, p 8

377 Ms Christine Rijks, Relative of former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 79

Nurse recruitment

9.24 During the inquiry, various parties emphasised that there are a large number of trained nurses in New South Wales who are not currently employed because the financial rewards and the conditions of employment do not make it attractive for them to return to the nursing workforce.[378]

9.25 In turn, it was suggested during the inquiry that attempts should be made to attract some of these nurses back to the nursing profession and RNSH by offering better conditions of employment. For example:

- Ms Michelle Beets, Nurse Manager of the Emergency Department at RNSH, suggested that there would be an opportunity to attract some nurses to RNSH by offering extended child care facilities up to at least 10 or 11 pm.[379]
- Professor Malcolm Fisher AO, Area Director of Intensive Care and Critical Care at RNSH, suggested that recruitment would be made easier if the hospital were able to advertise for nurses by offering to assist them with funding for post-graduate training.[380]

9.26 In response, Ms Davidson, Acting Director of Nursing and Midwifery Services at RNSH, elaborated on the steps being undertaken to recruit nursing staff to RNSH, including seeking to attract overseas nurses and nurses returning to nursing through the Reconnect program. In addition, RNSH is attempting to increase its graduate nursing intake in 2008 from 94 to 110.[381]

9.27 The Committee notes, however, the evidence of Ms Alison Mayhew, Nursing Unit Manager at RNSH:

> Many wards are now working with numerous nursing vacancies. Nursing unit managers have been asking for generic hospital advertising to be placed since April this year. This request has only just been completed in the past month, a notoriously bad time of the year to attempt any recruitment. The recruitment process is lengthy and unreliable and ward staff are working huge amounts of overtime to compensate for the hundred nursing vacancies within the organisation, and there is an expectation by management that working one nurse short is acceptable.[382]

The Royal North Shore Hospital Nurse Taskforce

9.28 In evidence to the Committee, the Chief Executive of NSCCAHS indicated that:

---

378 See for example Dr Tony Joseph, Director of Trauma (Emergency), RNSH, Evidence, 16 November 2007, p 15

379 Ms Michelle Beets, Published in camera evidence, 22 November 2007, p 10

380 Professor Malcolm Fisher AO, Area Director of Intensive Care and Critical Care, RNSH, Evidence, 16 November 2007, p 35

381 Ms Linda Davidson, Acting Director, Nursing and Midwifery Services, RNSH, Evidence, 12 November 2007, pp 41-42

382 Ms Alison Mayhew, Evidence, 26 November 2007, p 8

> On my second day as Chief Executive I suspended my diary appointments to travel from Gosford to Royal North Shore Hospital in response to a plea for help which came from a group of nursing staff. Thus the commencement of the nursing task force.[383]

9.29 In her evidence, the Minister indicated that the nursing taskforce meets weekly and reports to the Chief Executive on a fortnightly basis. It is developing plans and a timetable for action to address specific concerns relating to management systems, the workplace environment and communications systems. In addition, a number of actions have already been implemented including a review of nursing rosters and streamlining of the recruitment process. The Minister met with the taskforce early in November.[384]

9.30 The Committee understands that nursing recruitment and retention is a key issue addressed by the taskforce action plan.[385] In addition, the 12-point action plan developed by the Chief Executive during his meeting with nurses on 25 September 2007 included the need to advertise for nurses immediately, and also to develop better incentives to attract and keep nurses in the health system.[386]

9.31 At the same time, the Committee notes the evidence of Ms Alison Mayhew, Nursing Unit Manager at RNSH, that the Nurse Taskforce, without addressing the apparent disempowerment of senior nursing management structures, constitutes 'window-dressing'.[387]

Committee comment

9.32 The Committee is alarmed at the heavy workload of nurses at RNSH, with associated morale issues, together with the difficulties that the hospital is having in recruiting and retaining nurses. This is particularly concerning where senior and highly skilled nurses are being lost in high dependence care areas.

9.33 Ultimately, the Committee believes that the solution to these issues must involve a turn-around in the management and operation of the hospital. As indicated previously by the Committee, an essential step in that process is the early adoption of a clinical services plan for the NSCCAHS and for RNSH, setting out clear roles and responsibilities for RNSH. In turn, this should lead to more stable and effective working arrangements at the hospital. Another step is the return of operational control to DNMs.

9.34 However, the Committee also recommends that the NSRHS ensure the active engagement of nurses in the Reasonable Workload Committee. In the Committee's opinion, the failure of this committee to operate as well as it should up until now must be addressed.

---

383 Mr Matthew Daly, Chief Executive, NSCCAHS, Evidence, 12 November 2007, p 18

384 The Hon Reba Meagher MP, Minister for Health, Evidence, 12 November 2007, p 3

385 Submission 34, pp 30-31

386 Answers to questions on notice from 12 November 2007, Mr Matthew Daley, Chief Executive, NSCCAHS, pp 1-2

387 Ms Alison Mayhew, Evidence, 26 November 2007, p 14

Recommendation 26

That NSRHS ensure the active engagement of nurses in the Reasonable Workload Committee.

9.35 The Committee also notes evidence that there is a large number of trained nurses in New South Wales who are not currently employed, and who could with the right advertising and incentives be attracted back to work at RNSH. Accordingly the Committee recommends that NSRHS immediately review the nurse recruitment process at RNSH, including the current recruitment drive, to ensure that it is both timely and appropriately targeted.

9.36 The Committee notes that there are 99,638 nurses in NSW according to the NSW Health Annual Report for 2005/06,[388] yet the NSW Health submission[389] shows there are only 36,920 nurses employed in the NSW Public Health system.

9.37 The Committee further noteS evidence given by Mr Brett Holmes, General Secretary of the NSW Nurses' Association:

> There is already a significant delay in being able to recruit people because of the requirement to have the advertising and then the interview process and then the criminal records checked. So it can be six to eight weeks before you actually fill a position that becomes vacant. And if a person has only given you two weeks notice, as they are required under the award, that means you are running short for six weeks and you have to fill that with using overtime, casuals or agencies.[390]

Recommendation 27

That NSRHS immediately review the nurse recruitment process at RNSH, including the current recruitment drive, to ensure that it is both timely and appropriately targeted.

9.38 The Committee commends the new Chief Executive of NSCCAHS for his initiative in establishing and implementing the Royal North Shore Hospital Nurse Taskforce, and strongly supports its role in reviewing management systems, rostering arrangements and recruitment and retention issues.

Ancillary and administrative staff at RNSH

9.39 In its submission, the Nurses' Association of NSW noted that one of the most critical staffing shortages at RNSH is the lack of ancillary and administrative staff to support the clinical operations of the hospital. As stated by the Association:

> When ward clerks are absent it is nurses who assume the duties of the administrative operation of the ward; when pharmacy is short staffed it is nurses who assume the

388 NSW Health, *Annual Report 2005/06*, p 197

389 Submission 34, p 15, citing NSW Health, *Annual Report 2005/06*

390 Mr Holmes, Evidence, 12 November 2007, p 60

> duties of ensuring the ward has appropriate pharmacy cover; when ward support staff are absent it is nurses who assume the duties of delivering pathology specimens, escorting patients between departments, chasing missing equipment and endeavouring to ensure that all patients have not only received a meal but have received the correct meal.[391]

9.40 The Nurses' Association also cited the impact of the removal of positions from the human resources department at RNSH. Again this has had an impact on the management of rostering, sick leave and other absenteeism, and has obliged other staff to oversee the administrative operations of wards.[392]

9.41 Similarly, the Department of Neurology raised in its submission the lack of administrative support for clinicians in the areas of IT, financial and HR support. The Department submitted that the lack of ancillary support services leads to gross inefficiencies, where busy clinicians are diverted into other roles.[393]

9.42 In turn, Dr Clare Skinner, a Registrar in Emergency Medicine at RNSH since 2005, cited the poor support provided by the Junior Medical Staffing Unit (JMSU) at the hospital. The JMSU is responsible for recruitment, credentialing, rostering and payment of all intern, resident and registrar staff. However Dr Skinner suggested that the JMSU staff can be difficult to contact, timesheets and payments are often incorrect, it can be difficult to find contact details for on-call junior medical officers, and arranging cover for staff who call-in sick is problematic.[394]

9.43 Finally, the Committee also acknowledges the evidence of Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care at NSRHS, that while the inquiry did not hear much evidence about non-clinical staff – the orderlies, the PSAs, the clerks, the cleaners – they are as important as anybody else in the organisation.[395]

Committee comment

9.44 The Committee acknowledges the role of ancillary and administrative staff at RNSH and across the NSCCAHS, and the importance of appropriate and efficient ancillary and support services to clinicians and nurses, thereby enabling them to focus on their key roles and functions.

9.45 The Committee examines in the following chapter the need for appropriate administrative support for managers at RNSH as part of the provision of managers with greater financial responsibility.

---

391 Submission 29, p 9

392 Submission 29, pp 9-10

393 Submission 38, Department of Neurology at RNSH, p 7

394 Submission 44, Dr Clare Skinner, p 2

395 Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Evidence, 16 November 2007, p 45

Chapter 10 Financial management and resource allocation

> 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, or 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 really is the case? [396]

In this chapter the Committee examines the efficiency, effectiveness and appropriateness of resource allocation and utilisation within Royal North Shore Hospital. An overview of NSW Health funding is provided, including a brief explanation and examination of the Resource Distribution Formula, which is used to allocate funds across the eight Area Health Services within New South Wales. Issues associated with financial management within the hospital are also considered.

Resource allocation – the New South Wales Health budget

10.1 The 2007/08 budget for NSW Health is $12.5 billion, 28 per cent of the NSW State Budget and a 7.1 per cent increase on the budget for 2006/07.[397]

10.2 The source of funds for the NSW Health budget includes contributions from the Australian Government under the Australian Health Care Agreement (AHCA), NSW State Consolidated Fund contributions and special purpose funding and revenue obtained through 'fee for service' work within the health system. [398]

10.3 In its submission to the inquiry, NSW Health indicated that the contribution of the Australian Government to the running of NSW public hospitals had declined from 39 per cent in 2003/04 to 37 per cent in 2005/06.[399]

Distribution of the NSW Health budget to Areas

10.4 NSW Health funds are distributed to the eight NSW Area Health Services (AHSs or Areas) by the NSW Department of Health, using the Resource Distribution Formula (RDF) as a planning tool. Area Chief Executives then have the responsibility of allocating the budget within the Area to hospitals and other health facilities. [400]

10.5 Area Chief Executives are responsible for monitoring health service facilities to ensure health needs are met within budget, and ensuring creditors are paid in accordance with trading terms.

---

396 Dr Greg Fulcher, Director, Department of Diabetes, Endocrinology and Metabolism, Royal North Shore Hospital, Evidence, 22 November 2007, p 13

397 Submission 33, NSW Health, p 19

398 Submission 33, p 19

399 Submission 33, pp 19-20

400 Submission 33, p 20

The NSW Department of Health monitors financial performance through a reporting framework.[401]

The Resource Distribution Formula

10.6 The Resource Distribution Formula (RDF) is the planning tool used by the Department of Health for budget allocation to Areas. In its submission, NSW Health stated that 'the key principle guiding the development of the RDF is to enable the various geographic populations to have comparable access to services, given their health needs and the costs of delivering services'.[402]

10.7 The RDF replaced a system of funding allocation which was primarily focussed on hospitals, funded on an historical basis. The RDF allocates funding to Areas as a whole, not to individual hospitals within Areas. Factors taken into account by the RDF include the assessed health needs of the population, the local population's utilisation of private health services and additional cost components required to provide services to specific populations within Areas.[403]

10.8 NSW Health states that since the RDF was adopted in the late 1980s, the funds provided to Area Health Services have gradually come closer to being equitable. In 1989-90 Areas were 13.7 per cent away from what would constitute an equitable share under the RDF. Currently the Areas are within 2 per cent of their RDF target share, on average.[404]

10.9 The 2007/08 initial cash allocation provided to Northern Sydney Central Coast Area Health Service (NSCCAHS) was $1,219.5 million, 2.1 per cent more than its equitable share of the NSW Health budget, as determined by the RDF.[405]

Funding of Royal North Shore Hospital under the Resource Distribution Formula

10.10 During the inquiry concerns were raised that NSCCAHS, and RNSH in particular, are underfunded under the RDF, due to a range of factors including the specialty services provided State-wide to patients by RNSH, the large number of referrals from out of the area, and the financial effect of having a large number of private hospital beds in the Area. State-wide services provided by RNSH include the treatment of severe burn injury and spinal cord injury, genetics eduction and cerebrovascular embolisation.[406]

10.11 The Australian Medical Association (NSW) Limited and the Australian Salaried Medical Officers Federation (NSW) submitted that despite presumed adjustment within the RDF for

401 Submission 33, p 20

402 Submission 33, p 21

403 Answers to questions taken on notice during evidence 12 November 2007, Hon Reba Meagher MP, Minister for Health, p 6

404 Submission 33, p 21

405 Submission 33, pp 21, 22

406 Submission 34, NSCCAHS, p 8

treatment of patients residing outside NSCCAHS, there is a widely held view that the hospital is not adequately compensated for this workload. The workload was stated to be as much as 25 per cent of RNSH's total workload and was attributed to RNSH's wide referral network.[407]

10.12 While the AMA and ASMOF acknowledged the important objectives of the RDF in reducing inequality and improving health outcomes across the State, and noted that the RDF increases government transparency in relation to funding criteria and increases, both organisations reported that doctors at RNSH felt the RDF to be 'fundamentally flawed and unfair' to NSCCAHS.[408]

10.13 Similarly, the RNSH's Medical Staff Council submitted that despite assurances, the perception persists amongst many clinicians that RNSH is under funded.[409]

10.14 This position was reinforced by Dr Charles Fisher, Chair of the Medical Staff Council at RNSH, who maintained that there was a lack of data regarding the adequacy of funding for State-wide services actually provided, rather than anticipated to be provided:

> In other words, it is not possible to determine if part of RNSH's operating budget is used to cover shortfalls in funding for State-wide services.[410]

10.15 In his submission, Professor Malcolm Fisher, Area Director of Intensive Care for NSCCAHS, asserted that there were arguments that funding under the RDF does not adequately cover costs related to the complexity of care provided to patients admitted to the Intensive Care Unit from out of the Area.[411]

10.16 Professor David Sonnabend, Chairman of the Department of Orthopaedic Surgery at RNSH, submitted that it had been 'repeatedly suggested' that the State-wide spinal injury services 'are not adequately funded as a State-wide service' and therefore 'place excessive demand on the hospital budget'.[412]

10.17 However, not all RNSH staff members giving evidence to the Committee believed the RNSH was underfunded. Dr Philip Hoyle, Director of Clinical Governance for NSCCAHS, told the Committee::

> 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.[413]

---

407 Submission 32, AMA and ASMOF, p 7

408 Submission 32, p 19

409 Submission 28, Dr Charles Fisher, Medical Staff Council of Royal North Shore Hospital, p 4

410 Submission 28, p 3

411 Submission 52, Professor Malcolm Fisher AO, p 5

412 Submission 50, Professor David Sonnabend, p 3

413 Dr Philip Hoyle, Director, Clinical Governance, Royal North Shore Hospital, Evidence, 22 November 2007, p 25

10.18 Dr Patrick Cregan, Chair of the Clinical Services Taskforce, Nepean Hospital, suggested that the funding for RNSH was adequate and that a resistance to change among senior clinicians at the hospital might be responsible for inefficiencies:

> 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. … If the senior clinicians do not become part of the solution, then they remain part of the problem.[414]

10.19 The Committee also received evidence suggesting that the high levels of private hospital bed availability within the Area, a factor taken into account in determining the RDF allocation, may not translate into a reduced burden on the public health system.

10.20 For example, the Chair of the Medical Staff Council, Dr Charles Fisher, commented that the allowance made within the RDF for the private-public mix could result in insufficient funding for the Area, as a result of 'substantial volumes of acute services on medical patients with insurance as well as urgent surgical services' being undertaken in the public sector, often under Medicare rather than under private insurance.[415] The Committee notes the limited capacity of private hospitals to deliver emergency services in the Area.

10.21 In relation to the issue of revenue from private patients, Professor Malcolm Fisher told the Committee that the RNSH did not actively encourage those patients with private health insurance to become private patients:

> [W]e do not, as other hospitals do, coerce public patients into becoming private patients so that they become revenue and so their prostheses and pacemakers are paid for by private health funds.[416]

10.22 NSCCAHS identified revenue derived from fees for private patient beds and Department of Veteran Affairs payments as an important source of funding available to the RNSH with scope for 'improved performance'.[417]

Committee comment

10.23 The aims of the RDF are laudable, and the Committee appreciates the need for a strategic planning tool to guide funding across the State and ensure it is equitable. However it is clear from evidence received throughout this inquiry that there remains some doubt among the clinicians of RNSH about the fairness of the RDF for RNSH. The Committee accepts the possibility that the funding provided to NSCCAHS as a whole may not sufficiently take into account the financial impact of RNSH providing State-wide services such as spinal injury and severe burn treatment.

---

414 Dr Patrick Cregan, Chair, Clinical Services Taskforce, Nepean Hospital, Evidence, 22 November 2007, pp 27- 28

415 Submission 28, p 3

416 Professor Malcolm Fisher AO, Area Director of Intensive Care, NSCCAHS, Evidence, 16 November 2007, p 32

417 Submission 34, p 40

10.24 The Committee believes that there is a need to review the RDF, to ensure that it adequately covers the expenses associated with out-of-Area referrals/cross-border flows and State-wide services provided by large hospitals such as RNSH.

Recommendation 28

That the Resource Distribution Formula be reviewed by NSW Health to ensure that expenses associated with out-of-Area referrals/cross-border flows and the delivery of State-wide services by RNSH are specifically identified and accounted for. This review should occur within the next six months, with the results of the review published and any additional funds required provided immediately by NSW Health to NSCCAHS for allocation to RNSH.

10.25 The level of private health insurance in an AHS is a component of the RDF, and there is an assumption that in areas with a high level of private hospital bed availability that there is less of a strain on the public hospital system. We believe that the assumption that private hospital bed availability correlates with a reduced burden on the public hospital system is not necessarily accurate. We are concerned that there is therefore a possibility that the RDF may be setting the equitable funding level for NSCCAHS too low. The Committee therefore recommends that NSW Health review the existing parameters for considering the impact of private hospital bed availability within the Resource Distribution Formula to reflect the actual use of public health facilities.

Recommendation 29

That NSW Health review the existing parameters for considering the impact of private hospital bed availability within the Resource Distribution Formula to reflect the actual use of public health facilities.

10.26 While it is not the primary focus of this inquiry, the Committee also believes it is important to acknowledge the decline in funding to NSW public hospitals under the Australian Health Care Agreement, and the effect that decline has on the financial burden of the State. This situation affects all AHSs and has an impact on all public hospitals. The Committee hopes that the new Australian Government will review federal funding to public hospitals and increase the allocation to New South Wales. The Committee therefore recommends that the NSW Government seek additional funding for public hospitals from the Australian Government under the Australian Health Care Agreement.

Recommendation 30

That the NSW Government seek additional funding for public hospitals from the Australian Government under the Australian Health Care Agreement.

NSCCAHS budgeting and financial performance

10.27 The NSCCAHS initial cash allocation for 2007/08 was $1,219.5 million, a level of funding 5.1 per cent higher than that provided in 2006/07. The increase in funding is slightly lower than the average of 5.8 per cent for all Areas over the same period, and is consistent with average Area budget increases since 1994/95.[418]

10.28 The NSW Health *2005-2006 Annual Report* identified initial cash allocations for 2005/06 of 1,008.3 million and $929.1 million for 2004/05.[419]

Net Cost of Services

10.29 The Net Cost of Services (NCOS) figure is used in submissions from NSW Health and NSCCAHS when referring to annual budgets. The NCOS is the sum of the expenses incurred less the revenue received through the provision of health services by the Area. NSW Health assesses the financial management accountability of Area Chief Executives and Areas against Net Cost of Service General Fund General (NCOS GFG) budget performance. NCOS GFG figures provided by NSW Health for the financial years 2004/05 through to 2006/07 are provided in Table 10.1.

Table 10.1 Net Cost of Service General Fund General figures for 2004/05 – 2006/07 for NSCCAHS

Net Cost of Service General Fund General		Budget ($m)	Actual ($m)	Result ($m)
2004/05	Expenses	1,232.1	1,256.1	+24
	Revenue	222.6	236.7	(-14.1)
	NCOS	1,009.5	1,019.4	+9.9
2005/06	Expenses	1,287.2	1,280.9	(-6.3)
	Revenue	247.4	241.7	+5.7
	NCOS	1,039.8	1,039.0	(-0.6)
2006/07	Expenses	1,396.4	1,409.1	+12.7
	Revenue	265.2	264.1	+1.1
	NCOS	1,131.2	1,145.0	+13.8

Source: Submission 33, NSW Health, p 22

10.30 The table shows that NSCCAHS was over budget by $9.9 million in 2004/05, under budget by $0.6 million in 2005/06 and over budget by $13.8 million in 2006/07.

10.31 In its submission to the inquiry, NSW Health noted that the financial performance of NSCCAHS was not 'on a par' with other Areas. As well as the budget performance highlighted above, the Area also failed to meet the time benchmark for payment of 3,790

418 Submission 33, p 22

419 NSW Health *2005-2006 Annual Report*, available at: http://www.health.nsw.gov.au/pubs/2006/ar_2005_2006.html (accessed 2 December 2007)

creditors at June 2005, although it met the time benchmark for creditors at June 2006 and June 2007.[420]

10.32 Within NSCCAHS, the Director of Finance leads the budget allocation process, with budget principles and the allocation of budget 'enhancements and efficiencies' to facilities and divisions negotiated by the Area Executive.[421] A budget enhancement is an increase in the budget provided to a facility or division, and a budget efficiency is a decrease in the budget provided.

10.33 In its submission, NSCCAHS explained that a matrix structure is used across the Area, allowing performance to be measured on a clinical division and hospital basis. Clinical divisions operate across health services within the Area. The North Shore Ryde Health Service (NSRHS), for example, includes the Royal North Shore Hospital and the Ryde Hospital. Clinical divisions across NSRHS include Surgery & Anaesthesia, Women's, Children's & Family Health, and Medicine & Aged Care. The primary focus is on clinical divisions, but hospital performance is also evaluated. The clinical management structure operating across the Area is further explained in Chapter 5.[422]

10.34 It is important to note that while it is possible to identify a budget for a specific hospital, budgets are allocated to clinical divisions operating across health services including multiple hospitals, not just to hospitals themselves. Budget allocation letters are issued by the Chief Executive of the Area to all facility, major cost centres and Third Schedule Hospitals, with 'Health Service executives, facility/divisional directors and cost centre directors/managers' having 'clear accountability for their functional areas of responsibility'. [423] The clarity claimed by NSCCAHS was not reflected in evidence received from staff of the RNSH during this inquiry, as examined in a later section of this chapter.

10.35 The matrix situation appears to create problems with the transparency of funding arrangements and their allocation. For example, in a submission of behalf of the RNSH Cardiology Department, Professor Stephen Hunyor commented that the matrix system resulted in confusion, particularly in relation to funding and funding allocation:

> There was also the associated misfit merging of Ryde and RNS Hospitals, so RNSH ceased to be an entity, which has led to confusion, especially with funding transparency and its allocation. This is immediately obvious from recent NSCCAHS Annual Reports in which it is impossible to work out who works for and at RNSH, and what resources are devoted to that campus.[424]

10.36 The Chief Executive of NSCCAHS, Mr Matthew Daly, identified the root cause of problems at Royal North Shore Hospital as a lack of engagement by clinicians in the governance of the hospital, including in relation to budgeting:

---

420 Submission 33, p 22

421 Submission 34, p 36

422 Submission 34, p 40

423 Submission 34, pp 36, 40

424 Submission 30, Professor Stephen Hunyor, p 3

> The lack of effective and meaningful partnerships with clinicians has also impacted on the hospital's capacity to make the right investment decisions and set priorities to live within budget allocations provided to it.[425]

10.37 Mr Daly commented that since his appointment as Chief Executive of NSCCAHS he had been overwhelmed by the willingness of clinical staff to be involved in a solution to the problems faced by RNSH, and that the establishment of a Clinical Reference Group was an important step toward re-engaging clinicians in developing a management plan for the hospital and involving clinicians at the operational level.[426]

10.38 NSW Health stated in its submission that concerns regarding the financial performance of NSCCAHS were identified early in the 2006/07 financial year. Following a number of meetings intended to address these financial performance issues, the Director General of NSW Health met with the Chief Executive of NSCCAHS in April 2007 and agreed that there was a need for a change in leadership of the Area 'to expedite the process of necessary structural change'.[427]

Committee comment

10.39 The Committee notes that the responsibility for allocating budgets within NSCCAHS rests with the Chief Executive and Director of Finance. While funding provided to individual hospitals can be identified, it is not allocated to hospitals but rather to clinical divisions that span more than one hospital. This is confusing to the observer, and is evidently confusing to those who work within the system.

10.40 It is possible that the confusion over budget transparency and allocation is related to the frequent restructures which the RNSH has been through recently, and the disengagement of senior clinicians from governance issues, rather than being intrinsic to the matrix system now in use across NSCCAHS. The Committee also notes the recent change of Chief Executive at NSCCAHS and the generally positive response from staff of the RNSH toward the initiatives being pursued by the Chief Executive and his Area team, including in relation to financial performance.

10.41 Later in this chapter, the Committee further examines the degree of knowledge of and involvement in budgeting processes within the RNSH, and the impact of the matrix system of funding allocation and performance reporting on the autonomy of senior managers within the RNSH, from the General Manager down.

The Royal North Shore Hospital budget

10.42 Despite the fact that budgets are allocated by clinical division rather than by hospital, the matrix reporting structure in use at NSCCAHS also allows for funding figures to be compiled for RNSH. In this section, the budget for RNSH is outlined and an examination of the possible causes of recent budget over-runs is made.

---

425 Mr Matthew Daly, Chief Executive, Northern Sydney Central Coast Area Health Service, Evidence, 12 November 2007, p 18

426 Mr Matthew Daly, Evidence, 12 November 2007, p 18

427 Submission 33, p 24

10.43 The initial expenditure budget for RNSH for 2007/08 is $357.5 million, an increase of $9.5 million over the 2006/07 budget of $348.0 million. The figures provided in the NSW Health submission also cite a revenue figure of $52.8 million for 2007/08, an increase of $5.4 million over the 2006/07 figure of $47.4 million.[428]

10.44 In its submission to the inquiry, NSCCAHS identified initial expenditure budgets for RNSH of $357.5 million for 2007/08, $348.0 million for 2006/07 and $323.3 million for 2005/06. Taking into account internally generated revenue, the Net Cost of Services for the same periods was $304.7 million for 2007/08, $300.6 million for 2006/07 and $281.7 million for 2005/06.[429]

10.45 The RNSH budget has been exceeded for the previous two financial years. In 2005/06 the budget allocation was exceeded by $16.2 million and in 2006/07 the budget was exceeded by $12.3 million. NSCCAHS identified 'significant growth in employee related costs' as the main factor behind these budget over-runs.[430]

10.46 The contribution of the RNSH to the budget over-run of NSCCAHS is significant. In 2006/07, the RNSH budget over-run was $12.3 million, and the total area budget over-run was $13.8 million. Given the relative sizes of the budgets for the Area and the hospital, this is particularly concerning.

10.47 In evidence to the Committee, the Minister for Health, the Hon Reba Meagher MP, commented that while the operating budget for RNSH had increased over the last two years, there continued to be budget problems at the hospital:

> So our investment continues to rise in Royal North Shore Hospital. However, the hospital is operating over its allocated budget at this point in time. One of the areas of concern to me when I talk about the poor performance of the hospital [is the] poor financial management of the hospital.[431]

Financial management at Royal North Shore Hospital

10.48 During the inquiry, three broad areas of concern arose in relation to financial management at RNSH. The first of these concerns is the reliability of data used to determine the financial performance and efficiency of RNSH. The second is the lack of financial reporting and information provision to staff of the hospital, including heads of department and others who are expected to make decisions about service provision. The third concern is the lack of budget autonomy at various management levels within the hospital, from the General Manager down. These concerns are addressed in the following sections, with the overarching question being 'Is the Royal North Shore Hospital inefficient or underfunded?'

428 Submission 33, p 25

429 Submission 34, p 38

430 Submission 34, p 40

431 Hon Reba Meagher MP, Minister for Health, Evidence, 12 November 2007, p 4

Efficiency of Royal North Shore Hospital

10.49 One explanation for the budget over-runs of the RNSH, provided by NSW Health, is that the hospital is inefficient compared to peer hospitals. Other parties to the inquiry also noted that financial performance figures have been used to compare RNSH unfavourably with the performance of other peer hospitals, but raised questions about the reliability of the information used to prepare those performance figures.

10.50 'Clinical costing' is used by NSW Health to benchmark financial performance among peer hospitals. RNSH is categorised as a Principal Referral Hospital Category A1a, a category it shares with Royal Prince Alfred, Liverpool, St George, Prince of Wales, Westmead and John Hunter Hospitals. A brief, simplified explanation of clinical costing is provided below. It is not intended to be an exhaustive explanation of this complex area.

10.51 Hospitals are compared with their peers using a Peer Reference Cost (PRC), an averaged figure drawing on cost weighted separations for Diagnosis Related Groups (DRGs).[432]

10.52 The Diagnosis Related Group (DRG) classification is used within the health system to classify every acute inpatient episode into one of approximately 650 codes. Groups contain patients with similar conditions, requiring similar resources. Coders working within hospitals enter this information into a reporting system which provides the data to NSW Health.

10.53 A cost-weighted separation takes into account the resources required for the treatment of the condition represented by a DRG, with more complex conditions given a higher cost-weighting.

10.54 Data provided by NSW Health for the 2006/07 financial year showed that RNSH did slightly less work than was planned for 2006/07 (48,923 actual cost weighted separations against a target of 49,041), was $380 per cost weighted separation more expensive than the peer average ($4,146 per cost weighted separation against a PRC of $3,766) and was more expensive than the peer average by $18.6 million in total:

> In other words, if Royal North Shore operated with the same efficiency as the average of its peers it would have performed its activity for $18.6 million less. This represents a significant potential saving or the capacity for the hospital to perform significantly more services within existing funding.[433]

10.55 Many of the clinicians of the Royal North Shore Hospital commented that the existing comparisons between hospitals that identified RNSH as being inefficient and expensive were unreliable. Clinicians giving evidence to this inquiry disputed the conclusion that RNSH is inefficient, citing concerns about the accuracy of the data used to determine the clinical costings.

10.56 For example, Dr Bruno Giuffré, a Senior Staff Radiologist at RNSH, told the Committee that the conclusions reached from the data available 'are often misleading'. Dr Giuffré described the Information Technology situation at RNSH as 'desperately bad' and made explicit the connection between poor IT and poor data:

---

[432] Submission 33, p 25

[433] Submission 33, p 26

> That data comes from, lots of times, statistical tolls that are generated electronically nowadays. Because the IT situation at North Shore is so incredibly poor, some of the data may be inaccurate, inadequate, and the conclusions therefore reached are often misleading.[434]

10.57 Dr Ray Raper, Director of Intensive Care at RNSH, told the Committee that while clinicians at RNSH were constantly being told how very expensive they are, he could not see how, given the old equipment they use and how 'extraordinarily parsimonious' they are with medications. He was critical of the data used to support the finding that RNSH was expensive:

> The data—whenever data gets fronted out to us and it is said, 'Here, you are expensive', as soon as you scratch the surface, the data is rubbish. It is unreliable. I have sat with the accountants trying to go through our costs and I cannot make any sense of it and they cannot make me make any sense of it, so I do not have any faith in any of the data at all. [435]

10.58 Similar concerns were expressed by Professor Malcolm Fisher, Area Director of Intensive Care at NSCCAHS, who suggested that allegations of high costs at RNSH have usually not withstood close scrutiny. He suggested that such allegations have often been based on faulty data.[436] Professor Fisher told the Committee that there was a willingness amongst clinicians at RNSH to address areas of inefficiency, but the information used to identify RNSH as expensive was unreliable:

> The accounting systems are so bad within the Department of Health and our place that the only reliable system is the one we built ourselves. I do not believe someone can justify saying we are expensive with data.[437]

10.59 In his submission to the inquiry, Professor Fisher argued that when clinicians asked for information about areas of high cost they were informed of difficulties in benchmarking with other hospitals because of different accounting systems, and when areas of high cost were identified they did not withstand close scrutiny and were not supported by data available to clinicians. Professor Fisher also noted that problems with the data used to support the contention that RNSH was more expensive than other hospitals stemmed from inadequate information technology and measuring systems, and poor performance with coding.[438]

10.60 Professor Fisher suggested that, if it was true that RNSH was more expensive, there might be a number of reasons unrelated to inefficiency, including the possibility that RNSH takes more out-of-area critically ill complex patients than any other hospital, or funds some services such as haematology within budget while other hospitals receive special funding.[439]

---

434 Dr Bruno Giuffré, Radiologist, Royal North Shore Hospital, Evidence, 22 November 2007, p 12

435 Dr Ray Raper, Director, Intensive Care, RNSH, Evidence, 16 November 2007, p 29

436 Submission 52, p 4

437 Professor Fisher AO, Evidence, 16 November 2007, p 32

438 Submission 52, p 4

439 Professor Fisher AO, Evidence, 16 November 2007, pp 31- 32

10.61 In a submission of behalf of the RNSH Department of Neurology, Clinical Associate Professor Catherine Storey submitted that the DRG data source is inadequate due to poor data collection:

> Any attempts at challenging the allegations of excessive and expensive medical costs are met with the explanation that these figures are derived from DRG data. Data collection in this institution is far from satisfactory. … Overall the department is of the opinion that the financial situation in which RNSH now finds itself is largely as a result of poor data management.[440]

10.62 A/Prof Storey noted that the information collected independently by the Department of Neurology varied significantly in comparison with the official DRG derived figures used by the Area and NSW Health. A/Prof Storey gave the example of a particular kind of stroke, comprising 20% of all strokes admitted to RNSH, which 'did not even appear on the official data collection set'.[441]

10.63 In his submission on behalf of the Medical Staff Council, Dr Charles Fisher also cited a lack of accurate separations or cost-weighted separations data, partly due to inaccurate coding of data. Dr Fisher claimed that even simple data such as the number of discharges may be highly inaccurate, appearing to vary well beyond the suggested range of 20 per cent according to the source of the data.[442]

10.64 Dr Fisher argued that the debate regarding budget and perceived inefficiency would be more productive if accurate data for actual funding and actual services delivered was available for RNSH. Comparisons with peer hospitals would be more meaningful if all used the same expenditure assessment methods.[443]

10.65 NSCCAHS acknowledged that the data 'has not been robust', a situation the Area attributed to a lack of engagement by stakeholders in the maintenance of the data and costing rules.[444] Mr Matthew Daly, Chief Executive of NSCCAHS, acknowledged that there was a lack of confidence about the accuracy of data on costs. He gave two reasons for this: the fact that the casemix tool used for comparative purposes had not been used as a management tool within RNSH or the Area, and that clinicians had had little input into what the figures mean and how costs are determined:

> In the six weeks that I have been at the Area Health Service it has come very clearly from clinicians that they have not seen the data and they do not have the capacity to understand the data.[445]

10.66 NSW Health acknowledged that there are concerns over 'inconsistent practices across the health system in preparing data'. The NSW Health submission outlined the actions being undertaken to address these inconsistent practices, including the introduction of a standard

---

440 Submission 38, Clinical Associate Professor Catherine Storey, p 6

441 Submission 38, p 6

442 Submission 28, p 3

443 Submission 28, p 4

444 Submission 34, p 43

445 Mr Daly, Evidence, 12 November 2007, p 19

clinical costing system and business rules, a standard chart of accounts and associated business rules and the review of submitted data by the NSW Health Internal Audit Branch.[446]

10.67 NSW Health also noted that Area Health Services are required to review the accuracy of the data used to determine clinical costing figures, and take action to either improve the accuracy of the data, or if the data is accurate and the relative performance of the hospital or Area is poor, take action to 'improve areas of inefficient practice'.[447]

10.68 In a supplementary submission made to this inquiry, NSW Health noted concerns raised by clinicians of the RNSH during the inquiry about the accuracy of the cost data presented by NSW Health. While noting that data used for the cost comparison was derived from the Area, NSW Health provided additional information to demonstrate that the Area has higher staff costs with fewer separations and lower bed occupancy compared to its peer hospitals.[448] The table provided by NSW Health is replicated as Table 10.2:

Table 10.2: Comparison of staff costs, separations per Full Time Equivalent (FTE) position and numbers of occupied bed days per FTE, between Royal North Shore Hospital and the NSW Peer average for 2006/07 and 2007/08

	Royal North Shore Hospital (RNSH) 2007/08	RNSH 2006/07	NSW Peer average 2007/08	NSW Peer average 2006/07
Average staff cost Total expenses ($000)	136	146	123	131
Number of separations per Full Time Equivalent (FTE) position	18.4	18.7	21.7	22.2
Number of occupied bed days per FTE	73.2	74.1	79.4	88.1

Source: Submission 33a, NSW Health, p 8

Committee comment

10.69 There are, simplistically, two possible explanations for the budget overruns at RNSH. One is that the hospital is less efficient and more expensive than its peers, which is the explanation provided by NSW Health. The other explanation is that the information provided by NSCCAHS and used by NSW Health to compare RNSH with its peers is not reliable and understates the amount or complexity of work done and therefore overstates the average cost of the work done. If this is true, then the hospital is not more expensive than its peers and is instead underfunded.

446 Submission 33, p 26

447 Submission 33, p 25

448 Submission 33a, p 7

10.70 Clinicians working within RNSH are adamant that the information used is inaccurate. The Area and NSW Health have acknowledged that there are inaccuracies in the information used, however NSW Health has provided additional information to suggest that regardless of these inaccuracies there is nevertheless sufficient evidence to demonstrate that the hospital is more expensive than its peers. NSW Health clearly believes that the hospital, and Area, should concentrate on addressing inefficiencies to improve its budget situation.

10.71 The Committee believes there is an element of truth in both explanations.

10.72 The question of whether resource allocation and utilisation within RNSH has been efficient, effective and appropriate cannot be definitively answered when doubt exists as to the accuracy of the data upon which judgements are made.

10.73 The suggestion from many clinicians that data collection is inaccurate and unreliable is a matter of considerable concern. Of particular concern is the fact that individual departments have developed their own data collection which varies with that of the Area.

10.74 We have, however, heard sufficient anecdotal evidence to conclude that there are likely to be significant inefficiencies at work in RNSH that could contribute to making RNSH more expensive than its peers. The clearly inadequate IT infrastructure alone contributes to inefficiency. The lack of financial management information and capacity among clinical divisions and departments within RNSH about budgets, discussed in greater detail in the next section, is a further indicator of inefficiency and ineffectiveness. At the heart of the problem is the lack of clarity across the Area of the role that each hospital should play in the provision of services – determined by a clinical services plan. The Committee makes recommendations related to the importance of the clinical services plan in Chapter 5.

Recommendation 31

That NSCCAHS and NSRHS work with senior clinicians through the Clinical Reference Group to develop robust data on the cost of service delivery across the RNSH to inform planning decisions, and ensure that the data is available for internal analysis on an ongoing basis.

10.75 Later in this chapter the Committee addresses the issue of the inadequacy of Information Technology infrastructure, fundamental not only to the clinical management of patients but also to the collection of information used to measure the efficiency of the hospital.

10.76 While the focus of this chapter is on financial management and resource allocation within RNSH, it is important not to lose sight of the people who are affected by resource shortfalls. Staff of the hospital end up working harder and longer, doing more with less, and the consequences of that are felt by patients and families of patients, as demonstrated by the patient experiences outlined in Chapter 3.

10.77 The Committee also notes that a consistent theme from parties to the inquiry relates to the inadequacy of capital replacement planning, and the contribution this makes to ongoing budget problems. This issue is addressed in more detail later in the chapter.

Internal reporting and analysis of financial performance

10.78 During the inquiry, a number of parties raised significant issues in relation to the availability of financial performance information. A frequent complaint was not just that the data used to classify RNSH as expensive and inefficient was inaccurate, but that it was not made available to clinicians for their analysis.

10.79 For example, Dr Charles Fisher, Chair of the RNSH Medical Staff Council identified the lack of reliable financial data available to clinicians as a problem. Dr Fisher argued that while clinicians seek to provide the best care, they are constantly criticised for being 'too expensive', yet no hard data is available as to how the Area and hospital budget is actually spent, to help clinicians to help identify possible areas of financial inefficiency for clinicians to address.[449]

10.80 Dr Sharon Miskell, Director of Medical Services, NSRHS, indicated that since 2005, RNSH executives and clinicians have requested that the Area Executive provide analysis of cost data to understand why RNSH is reported as cost-inefficient. Dr Miskell submitted that RNSH Executive and clinicians have specifically requested those factors which are contributing to these high peer referenced costs, in order to achieve improvement in cost-efficiency. The factors include service category assignment, medical record documentation and coding accuracy, cost centre assignment, and inpatient fractions. Dr Miskell indicated that this information has not yet been provided.[450]

10.81 Dr Miskell indicated that there is no regular reporting nor reliable data to provide clinician department heads with monthly clinical and financial datasets which includes total separations, cost-weighted separations, length of stay, line item cost-centre reports. Dr Miskell argued that this information is essential to enable department heads effectively to manage departmental activity and budget, and to benchmark performance.[451]

10.82 Professor Stephen Hunyor, on behalf of members of the Department of Cardiology at RNSH, also advocated for budgeting and accounting procedures to be implemented that give regular, up to date and factual information that is readily available to senior medical staff.[452]

10.83 Similarly, the submission of the Department of Neurology noted that clinicians and other staff do not receive any information on medical costs associated with their departments, and explanations of how those costs are incurred. There is no information, for example, on whether the costs take into account such things as administrators' costs or university salaries.[453]

---

449 Submission 28, p 4

450 Submission 49, Dr Sharon Miskell, pp 2-3

451 Submission 49, p 3

452 Submission 30, pp 10-11

453 Submission 38, p 5

10.84 In his submission on behalf of the staff of the Haematology Department at RNSH, Dr Christopher Arthur noted that there are financial reports available in electronic format to clinician managers at RNSH, but that the format is very difficult to interpret. Hard copy financial reports were discontinued in 1999. He submitted that a detailed analysis of a department's financial position would take hours.[454]

10.85 In its submission, NSCCAHS acknowledged that casemix information 'has not been routinely used to assess the efficiency of practice against like hospitals, or improvements in efficiency over a period of time.' The Area identified the lack of casemix information as a 'major blockage' to improving the efficiency of resource use in the Area but stated that analysis based on DRGs 'is starting to be provided at a facility and clinician level and will be routinely provided from now on'.[455]

10.86 The clinical costing system used by NSCCAHS, Power Cost Manager, allows costing data to be grouped by patient, episode and DRG, however NSCCAHS acknowledged that the information produced by the system 'has not been widely used to support the assessment of efficient costs'.[456]

10.87 In its supplementary submission, NSW Health attributed the limited clinician access and input into financial information and analysis to a lack of clinical engagement, and cited the establishment of the Clinical Reference Group as a first step towards addressing the problem.[457]

Committee comment

10.88 The Committee notes and acknowledges the clear frustration of clinicians at the RNSH, who are being told they are inefficient and expensive but are not being provided with the detail on where those inefficiencies and expenses are. There is a clear need for the provision of meaningful and accurate financial information linked to clinical outputs and outcomes to Clinical Division managers in a timely fashion.

10.89 The Committee has heard evidence to suggest that there is very poor knowledge of even fundamental information about budget figures within the various clinical divisions and departments that make up the North Shore Ryde Health Service within which the RNSH is located. Recommendation 27 is intended to ensure that this information is available for internal analysis on an ongoing basis. There also appears to be a need for support and training to be made available in the interpretation and analysis of financial data. The Committee therefore recommends that NSCCAHS ensure that support and training in the interpretation and analysis of financial data is available to clinical directors and managers of divisions and departments within the North Shore Ryde Health Service.

454 Submission 84, Dr Christopher Arthur, pp 2-3

455 Submission 33, p 42

456 Submission 34, p 43

457 Submission 33a, p 6

Recommendation 32

That NSCCAHS ensure that support and training in the interpretation and analysis of financial data is available to clinical directors and managers of divisions and departments within the North Shore Ryde Health Service.

Budgetary control and autonomy

10.90 In her evidence to the Committee, Ms Deborah Latta, the former General Manager of North Shore Ryde Health Service, commented that she had found financial management 'particularly challenging' because she felt she did not have control over the financial situation at the hospital. She cited the altering of cash flows to cover costs on a month by month basis as an example of the kinds of actions that occurred which were beyond her control. These actions and decisions were being taken by the Area.[458]

10.91 Ms Latta compared her experience as General Manager of North Shore Ryde Health Service with her previous experience as General Manager at Sutherland Hospital. She commented that one key difference was the degree of autonomy given to the General Manager by the Area. At Sutherland Hospital many of the support and administrative services were the responsibility of the General Manager, where at Royal North Shore Hospital they remained at an Area level. Ms Latta felt the greater autonomy assisted in her ability to effectively manage a budget over-run:

> We put a lot of strategies in place, which I was actually able to work with the staff and the managers to do in an autonomous way, and we ended up coming $600,000 under budget without cutting any services, and that was things like increasing revenue, looking at streamlining things, and we made an additional $3 million revenue within the first year of me taking up that role and continued to develop that. I think it is that autonomy that is really important within a hospital and also I guess respecting the role of the general manager in being able to do the job that they are appointed to do and paid reasonably for.[459]

10.92 Ms Latta partially attributed the instability in executive management of RNSH to the lack of financial autonomy. She also noted that grouping administrative resources at an Area level had 'pluses and minuses', one of the minuses being a lack of 'loyalty or real drive to want to work within the hospital to make that particular hospital function better' due to the competing priorities facing administrators at an Area level.[460]

10.93 Ms Latta's observations were supported by other participants in this inquiry. Dr Danny Stiel, the Clinical Director of the Division of Medicine and Aged Care, NSRHS, noted that '[t]he

458 Ms Deborah Latta, Former General Manager, NSRHS, Published in camera evidence, 16 November 2007, pp 4-5

459 Ms Latta, Published in camera evidence, 16 November 2007, p 6

460 Ms Latta, Published in camera evidence, 16 November 2007, pp 6-7

level of discretionary spending and decision making has moved further and further away from the coalface'.[461]

10.94 In evidence to the Committee, the Head of the Cardiology Department, Dr John Gunning commented that he was not aware of his own Department's budget.[462]

10.95 Other parties to the inquiry noted that it is not a lack of financial delegation alone that restricts clinical managers; a lack of administrative support compounds the problem. Clinical Associate Professor Catherine Storey of the RNSH Neurology Department commented that the lack of access to administrative support services (such as human resources, financial advice and IT expertise) contributed to inefficiencies within the hospital:

> This leads to gross inefficiencies in the system, where busy clinicians are expected to fulfil many of these roles often encroaching on the time that can be spent in clinical activities.[463]

10.96 Similarly, Dr Christopher Arthur, Head of the Department of Haematology at RNSH, told the Committee that clinician managers found themselves facing the dual workloads of clinical and administrative decision making. Dr Arthur commented on his own experience.[464]

Committee comment

10.97 The current situation is obviously frustrating for those clinicians and managers at RNSH who do not have the financial delegation to make important financial decisions to address those areas of concern that they do identify.

10.98 The Committee is particularly concerned at the likely possibility that the high turnover of executive level staff at the North Shore Ryde Health Service and RNSH is a result of a lack of autonomy. It is unfair and unreasonable to expect senior managers, such as the General Manager, to bring about efficiencies in the operation of a hospital without the financial autonomy to support their decisions.

10.99 The Committee therefore recommends that the Area Health Service review the financial delegation of the General Manager and senior management at RNSH to ensure that decision-making is streamlined and that managers have the financial autonomy needed to effectively run their divisions and departments.

461 Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Evidence, 16 November 2007, p 49

462 Dr John Gunning, Head of Cardiology, RNSH, Evidence, 16 November 2007, p 5, see also Dr Fulcher, Evidence, 22 November 2007, p 13

463 Submission 38, p 7

464 Dr Christopher Arthur, Director, Haemotology Department, Royal North Shore Hospital, Evidence, 22 November 2007, p 45

Recommendation 33

That NSCCAHS immediately review the financial delegation of the General Manager and senior management at RNSH to ensure that decision-making is streamlined and that managers have the financial autonomy needed to effectively run their divisions and departments.

10.100 The Committee also believes that while clinician involvement in the management and administration of the hospital is important, it should not restrict front-line workers from performing their primary role as care-givers. While there has rightly been a focus in recent years on increasing the number of front-line workers both as a whole and as a proportion of the workforce (see Chapter 9 for more detail on workforce issues in RNSH), that increase is negated if the front-line workers are using too much time completing administrative tasks that could be performed by staff with different skill sets.

Capital funding at Royal North Shore Hospital

10.101 Information provided by NSW Health indicates that 'over $116 million' has been spent on major capital works projects and equipment at RNSH since 1995.[465]

10.102 Projects funded include:

- Refurbishment of the Cummins Ward ($1.3M) completed in December 1997.
- Purchase of a Linear Accelerator ($1.8M) in March 1998.
- Replacement of lifts to main building ($2.0M) completed in September 2002.
- Repairs to facade of main building ($1.5M) completed in June 2004.
- Linear Accelerator Replacement ($l.0M) completed in June 2004.
- Replacement Gamma Camera ($0.5M) completed in June 2004.
- Construction of a new pediatrics obstetrics emergency building ($54.6M) completed in July 2004.
- Replacement of Bi-plane neurointerventional radiology suite ($2.2M) completed in June 2005.
- The second stage of the refurbishment of the hospital facade($ 2.5M) completed in January 2006.
- NSCCAHS Capital Equipment Purchases ($1.4M) in June 2006.
- Burns Unit Upgrade ($0.5M) completed in June 2006.
- Minor Radiotherapy Equipment purchases ($0.4 M) in June 2006
- Replacement CT Scanner purchased ($1.8M) in July 2006.
- NSCCAHS Supplementary Equipment purchases 2005/06 ($7.1 M) in August 2006.

465 Submission 33, p 27

- Provision of RNSH High Dependency 23-Hour Care and Day Surgery
- Facilities ($6.9M) completed in June 2007.
- Royal North Shore Hospital Redevelopment Stage 2 - Pre-Project Works ($13.8M) completed in June 2007.[466]

10.103 However, a consistent complaint from participants in this inquiry related to the lack of capital and asset planning at RNSH. Many parties expressed concern that RNSH has significantly underinvested in medical equipment for at least a decade, and that funds have been redirected from investment in equipment to operational expenses.

10.104 In his submission on behalf of the Medical Staff Council, Dr Charles Fisher, the Medical Staff Council Chair, argued that most equipment at RNSH is outdated and may be a significant factor in the perceived inefficiency of clinical care at the hospital.[467] Dr Fisher gave the following assessment of medical equipment at RNSH:

> It is terrible. It is ageing, there is no asset register of what we have, and we certainly do not describe the quality. The equipment is outdated. … What we are particularly lacking is any sort of strategic plan to determine what equipment we need and what we are going to get.[468]

10.105 Concerns about the quality of medical equipment were reiterated by several individual clinicians during the inquiry:

- Dr Sharon Miskell, Director of Medical Services at NSRHS, noted cases where surgery had been delayed for 12 to 18 months because equipment was broken and the parts were no longer being manufactured to repair it. As a current example, she cited a cardiovascular operating table which is broken and needs to be replaced, at a cost of $300,000. The table has been on the capital replacement register for two years.[469]
- Dr Miskell also told the Committee that new laser equipment for the performance of ENT laryngeal surgery, valued at $160,000, had recently been ordered to replace the old, faulty equipment using funds raised by 'pink ladies', volunteers working in a small area of the foyer of the hospital.[470]
- Dr Jeffery Hughes, a former Senior Orthopaedic Consultant VMO at RNSH, cited instances of high-pressure hoses exploding during use in theatres and causing injury to staff, and of an operating table breaking in two due to age and fatigue whilst a patient was anaesthetised upon it.[471]

466 Submission 33, p 27

467 Submission 28, p 2

468 Dr Fisher, Evidence, 16 November 2007, pp 20-21

469 See Dr Sharon Miskell, Director of Medical Services, NSRHS, Evidence, 16 November 2007, p 21

470 Dr Miskell, Evidence, 16 November 2007, p 21

471 Submission 13, Dr Jeffery Hughes, p 1

- Dr Jennifer Donovan, Senior Staff Specialist in Radiation Oncology at RNSH, cited the extensive delay in the replacement of a machine to treat skin cancer in her unit from November 2003 to November 2005.[472]
- Dr John Vandervord, Clinical Head of the Division of Surgery and Anaesthesia at RNSH, cited the outdated and inadequate laparoscopic and thoracoscopic equipment being used for surgery in his area.[473]
- Dr Ian Farey, a spinal surgeon at the hospital's Spinal Injury Unit, cited a lack of appropriate operating tables for spinal surgery, such that the hospital frequently has to borrow an operating table from the neighbouring North Shore Private Hospital.[474]
- Ms Barbara Lucas, Senior Paediatric Physiotherapist in the Physiotherapy Department at RNSH, cited shortages in basic equipment such as ultrasound machines, computers and chairs.[475]
- Dr Steven Blome, Director of Radiology at RNSH, identified a considerable underinvestment in MRI scanning machinery at RNSH, culminating in the diverting of money set aside in a capital replacement fund for a new 3T MRI machine (an amount of $1.7 million) into operational expenses.[476]
- Dr Greg Briggs, Senior Staff Radiologist at RNSH, cited the rejection of submissions and business plans for a third CT [computerised tomography] scanner and a second MR scanner.[477]
- Dr Ray Raper, the Director of Intensive Care at RNSH told the Committee that some years ago the Intensive Care Unit had taken discarded ventilators from Westmead Hospital to 'prop up our ageing fleet'. Dr Raper said that the ventilators were no longer supported by the manufacturer and the ventilator model was 'the model after the one that Wollongong discarded as being obsolete about six or seven years ago'.[478]

10.106 In evidence to the Committee, the former General Manager for the Royal North Shore Hospital, Ms Deborah Latta, commented that there had been no capital or asset replacement plan for RNSH when she commenced in the position. She said that staff and managers would put up 'wish lists' for capital equipment without an adequate planning process, resulting in requests for equipment that may not have been required and was often not provided. A 10-year capital replacement plan subsequently developed by Ms Latta in 2005 identified a capital

472 Dr Jennifer Donovan, Senior Staff Specialist, Radiation Oncology, Royal North Shore Hospital, Evidence, 22 November 2007, p 46

473 Dr John Vandervord, Clinical Head, Division of Surgery and Anaesthetics, Royal North Shore Hospital, Evidence, 22 November 2007, p 54

474 Submission 53, Dr Ian Farey, p 2

475 Ms Barbara Lucas, Senior Paediatric Physiotherapist, Royal North Shore Hospital, Evidence, 22 November 2007, p 88

476 Submission 25, Dr Steven Blome, p 1

477 Dr Greg Briggs, Senior Staff Radiologist, Royal North Shore Hospital, Evidence, 22 November 2007, p 48

478 Dr Raper, Evidence, 16 November 2007, p 29

shortfall of $30 million. Ms Latta commented that 'capital expenditure is the first thing that goes when there are budgetary problems'.[479]

10.107 Dr Greg Purcell of the Department of Anaesthesia and Pain Management at RNSH, echoed the comments of Ms Latta and submitted that 'capital or equipment funds have been relocated to meet operating costs' at the hospital.[480]

10.108 Dr Greg Fulcher, Director of the Department of Diabetes, Endocrinology and Metabolism, at RNSH, told the Committee of his concern in 2004/05 over 'the complete lack of a process at North Shore hospital for capital equipment replacement'. He added that, as far as he was aware, the hospital still did not have an adequate process.[481]

10.109 Dr Fisher echoed Dr Miskell's call for a strategic plan to determine what equipment is needed and what will be provided. He noted that this information had been provided by clinicians to management and 'it is still sitting in a drawer somewhere'.[482]

10.110 Mr Matthew Daly, Chief Executive of NSCCAHS agreed that there was a need to address the capital funding needs of the hospital.[483]

10.111 Clinical Associate Professor Catherine Storey of the RNSH Neurology Department commented that 'there is no coordinated programme across all service departments for a process of equipment replacement'. A/Prof. Storey claimed that the lack of capacity to replace equipment leads to 'huge inefficiencies' within the hospital, adding to a patient's length of stay and contributing to his or her distress.[484]

10.112 Several clinicians, including former RNSH clinician, Dr Jeffrey Hughes, told the Committee that they believed inadequate staffing and physical resources may contribute to the level of adverse events at the hospital. Dr Hughes described poor equipment as potentially a major issue in contributing to adverse events. He added that he believed the skill level of many clinicians, coupled with 'sheer good luck', has kept the number of adverse events down.[485]

10.113 However, while Dr Ross Wilson, the Director of the NSCCAHS Northern Centre for Healthcare Improvement concurred with Dr Hughes about the skill and luck of clinicians being responsible for avoiding adverse events, he was not confident the luck would hold out.[486]

---

479 Ms Latta, Published in camera evidence, 16 November 2007, p 6

480 Submission 64, Dr Greg Purcell, p 7

481 Dr Fulcher, Evidence, 22 November 2007, p 13

482 Dr Fisher, Evidence, 16 November 2007, p 20-21

483 Mr Daly, Evidence, 12 November 2007, p 20

484 Submission 38, p 6

485 Dr Jeffrey Hughes, Former Senior Orthopaedic Consultant VMO, Royal North Shore Hospital, Evidence, 22 November 2007, p 81

486 Dr Ross Wilson, Director, Northern Centre for Healthcare Improvement, NSCCAHS, Evidence, 16 November 2007, pp 42- 43

Committee comment

10.114 The lack of an effective capital and asset replacement plan for an organisation the size and importance of Royal North Shore Hospital is a matter of great concern. The Committee is particularly concerned at the apparent underinvestment in medical equipment at RNSH over several years. Clearly, old and inadequate equipment places at jeopardy the provision of appropriate clinical care to patients and places greater demands on clinicians.

10.115 Accordingly the Committee recommends that the management of the NSCCAHS and RNSH, in consultation with senior clinicians, develop as a matter of urgency a ten-year capital equipment plan, which includes provision for the replacement of existing equipment as it deteriorates or becomes redundant, and allows for the funding of new technologies. The capital equipment replacement plan should be developed in the context of the requirements arising from implementation of the clinical services plan, once completed, and the forthcoming redevelopment of the hospital campus. The capital equipment plan should be implemented immediately.

Recommendation 34

That the management of NSCCAHS and NSRHS, in consultation with senior clinicians, develop a ten-year capital equipment plan which provides for the replacement of existing equipment and allows for the funding of new technologies. The capital equipment plan should be developed in the context of the requirements arising from the implementation of the clinical services plan, once completed, and the forthcoming redevelopment of the hospital campus. The capital equipment plan should be implemented immediately.

10.116 The Committee is particularly concerned at the evidence suggesting obsolete equipment is in regular use at RNSH. Therefore we recommend that as a matter of urgency (within the next six months), the NSW Government provide funding to RNSH to replace obsolete equipment, as identified in the ten year capital equipment plan.

Recommendation 35

That as a matter of urgency (within the next six months), the NSW Government provide funding to RNSH to replace obsolete equipment, as identified in the ten year capital equipment plan.

10.117 The Committee is also concerned at evidence that funds for medical equipment have in the past been diverted to meet ongoing operational requirements.

10.118 Accordingly, the Committee recommends that the ten-year capital equipment plan be properly implemented and that progress against the plan be reported in the NSCCAHS Annual Report to ensure that the funds are spent appropriately and transparently.

Recommendation 36

That the ten-year capital equipment plan be properly implemented and that progress against the plan be reported in the NSCCAHS Annual Report to ensure that the funds are spent appropriately and transparently.

Information Management and Technology services

10.119 A large number of participants in this inquiry identified a chronic deficiency in Information Technology (IT) funding at the RNSH. Concerns were raised that RNSH lags behind other hospitals in the application of IT, based on underinvestment over an extended period of time, affecting not only the efficiency of the hospital and the capacity to accurately measure performance, but also placing patient care at risk.

General information technology investment

10.120 Investment in IT equipment improves the quality and safety of patient care by making it easier for clinicians to access and keep track of up-to-date information about their patients.

10.121 However, in their submissions, NSW Health and NSCCAHS indicated that NSCCAHS – including Royal North Shore Hospital – has failed to plan and invest in IT equipment, with the result that the Area and RNSH in particular are now without some basic IT tools.[487]

10.122 By contrast, other Area Health Services have invested more heavily in IT, and have reaped major rewards in supporting clinical services. Examples include the Length of Stay Tool developed by the Hunter New England Area Health Service and the electronic 'bedboard'[488] developed by Sydney South West Area Health Service.[489]

10.123 Similar concerns were expressed by various other participants in the inquiry. For example, Dr Charles Fisher, Chair of the Medical Staff Council, commented that there was limited IT infrastructure and it was not clinically focused:

> Clinicians do not receive routine information as simple as how many admissions came in under your unit last month; what was their length of stay; what operations did they have? It makes it very hard for clinicians to benchmark their care.[490]

10.124 Dr Fisher, in his submission on behalf of the Medical Staff Council of Royal North Shore Hospital, described clinically focussed IT infrastructure as a core component of clinical

487 Submission 33, p 7; Submission 34, p 21

488 The bedboard provides ward staff with a visual display of bed availability and occupancy and assists with patient flow.

489 Submission 33, p 7. See also Mr Terence Clout, Chief Executive, South Eastern Sydney Illawarra Area Health Service, Evidence, 12 November 2007, p 71

490 Dr Fisher, Evidence, 16 November 2007, p 21

governance and argued that its deficiency 'contributes to both financial and clinical inefficiencies'.[491]

10.125 In his submission, made on behalf of clinical staff in relation to the 'parlous state' of Information Technology at RNSH, Dr Bruno Giuffre, a Senior Staff Radiologist at RNSH, argued that IT at RNSH was 'drastically under-resourced'. Quoting from the *Northern Sydney Information Management & Technology Strategic Plan 2004-2008*, Dr Giuffre cited a current level of direct funding to the Information Services Division of about 1.7 per cent of the total budget, compared to the international benchmarks for average expenditure within health care organisations of in excess of 4 per cent.[492]

10.126 The comments of Dr Giuffre were echoed by Dr Blome and Dr Steven Hunyor, who lamented the underinvestment in IT infrastructure.[493]

10.127 The *Northern Sydney Information Management & Technology Strategic Plan 2004-2008* states that while initial funding levels were adequate to meet strategic planning needs, IT budgets were usually used to balance the overall NSCCAHS budget:

> The consistent finding throughout the planning process has been that while initial budget allocations have been adequate to progress the strategic plan, these funds have later been reallocated to cover expenditure over-runs in other areas of service delivery.[494]

10.128 Dr Giuffre submitted that the lack of effective IT infrastructure impacted on patient care. The Area does not have the IT infrastructure necessary to support an electronic medical record for patients, for example, which leaves clinicians 'hamstrung in caring for patients adequately'.[495]

10.129 Dr Giuffre also described 'IT workarounds' in use within the Area, including the sending of imaging information on CD by taxi between locations, and using mobile phones to take photographs for emailing. The lack of capacity to implement the Picture Archive and Communication System (PACS) results in an inability to electronically send digital images. Dr Giuffre described this situation as dysfunctional.[496]

10.130 The Committee also notes the comments of Dr Clare Skinner,[497] Professor Malcolm Fisher, Senior Staff Specialist in Intensive Care at RNSH and Area Director of Intensive Care, NSCCAHS,[498] Dr David Waugh, Head of the Department of Renal Medicine,[499] Ms Davidson,

491 Submission 28, p 3

492 Submission 96, Dr Bruno Giuffre, p 1

493 Submission 25, p 5; Dr Stephen Hunyor, Director, Cardiac Technology Centre, RNSH, Evidence, 16 November 2007, p 5

494 *Northern Sydney Information Management & Technology Strategic Plan 2004-2008*, cited in Submission 96, p 1

495 Submission 96, p 2

496 Dr Giuffre, Evidence, 22 November 2007, p 15

497 Submission 44, Dr Clare Skinner, pp 2-3

498 Submission 52, p 4

499 Submission 58, Dr David Waugh, p 2

Acting Director of Nursing and Midwifery Services at RNSH,[500] and Dr Christopher Arthur on behalf of the staff of the Haematology Department at RNSH.[501] In evidence, Dr Arthur observed the difficulties that arise from poor information technology investment:

> 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.[502]

10.131 In his submission, Dr Steven Blome, the Director of the RNSH Radiology Department, echoed the comments of Dr Giuffre. He described state of the art imaging and distribution throughout the hospital as being 'critical to timely delivery of patient care'.[503] Dr Blome attributed the current decline in the provision of state of the art imaging services to inadequate investment in Radiology and IT infrastructure capital equipment.

10.132 Clinical Associate Professor Catherine Storey of the RNSH Neurology Department submitted that the computers in use within the Neurology Department had been donated by a government office after two years of use, and remained in use after four years.[504]

Future investment in Information Technology at Royal North Shore Hospital and across the Area Health Service

10.133 In their submissions, NSW Health and NSCCAHS indicated that they are working collaboratively to implement a number of State-wide IT projects to address some of the concerns cited above. These include:

- the Electronic Medical Record (eMR), a clinical information system where patients' details are entered once and are then available to all authorised clinicians.
- the Patient Administration System (PAS), designed to capture patient demographic data necessary for the roll-out of other IT applications.
- the Medical Imaging Program.[505]

10.134 NSCCAHS noted that it has developed an Information Communication Technology Strategy 2007-2010. The focus is on the implementation of the next stage of the eMR – new emergency department systems, theatres, discharge referrals and electronic order entry. In addition the strategy incorporates corporate IT solutions including new payroll and HR

500 Ms Linda Davidson, Acting Director, Nursing and Midwifery Services, Royal North Shore Hospital, Evidence, 12 November 2007, p 39

501 Submission 84, pp 3-4

502 Dr Arthur, Evidence, 22 November 2007, p 49

503 Submission 25, p 1

504 Submission 38, p 6

505 Submission 34, p 20

systems, together with the business information strategy (BIS).[506] Accordingly, the NSCCAHS submitted:

> Although RNSH has lagged in the development of up-to-date and functional IT systems and has a number of non-integrated systems, there is now a clear strategy in place which identifies the needs of the services at the facilities and addresses those needs through the roll-out program.[507]

The Electronic Medical Record

10.135 In June 2006, the NSW Government approved a request to bring forward the allocation of $40 million to the eMR project to support an accelerated and expanded scope for the eMR project to enable roll out to 188 hospitals. Under this strategy, the eMR is scheduled to be rolled out across the NSCCAHS in 2007-2010, with the RNSH roll out to occur during late 2007 and 2008.[508]

10.136 Commenting on the roll-out of the eMR project, Mr Matthew Daly, Executive Director of NSCCAHS observed:

> It is a major State investment for the electronic medical record, but it will have enormous clinical benefit. It will take a further few years to roll out all the benefits from it in terms of being able to order tests electronically and schedule patients, so it is a staged approach. Royal North Shore will be going live with the first stage of it early next year.[509]

10.137 However, in regard to the eMR project, the Committee notes the submission of Dr Bruno Guiffre, a radiologist at RNSH. He submitted that although the first phase of the eMR which is being rolled out to all the Area Health Services is finally being delivered to NSCCAHS, when this much-delayed tool is delivered it will be 'descoped' so that it does not include the very components which are likely to impact directly and positively towards health care. [510]

The Patient Administration System

10.138 In its submission, NSW Health stated that the Patient Administration System has now been rolled out on the Northern Beaches and Central Coast, and is due to be implemented at Ryde Hospital in December 2007 and at Royal North Shore Hospital during the first quarter of 2008.[511]

The Medical Imaging Program

10.139 The Medical Imaging Program will provide an integrated digital imaging and radiological information system to all Area Health Services in NSW. During 2007/2008, $11.1 million is

506 Submission 34, p 22

507 Submission 34, p 22

508 Submission 34, p 20

509 Mr Daly, Evidence, 12 November 2007, p 26

510 Submission 96, p 2

511 Submission 33, p 8

being spent to roll out the program at Royal North Shore, Nepean Hospital, Liverpool and Coffs Harbour Hospitals. The program is expected to be established at the Royal North Shore Hospital by the end of June 2008.[512]

10.140 The implementation of this program is aimed at addressing the concerns raised during this inquiry in relation to the lack of PACS at RNSH.

Committee comment

10.141 The importance of effective Information Technology infrastructure for the quality of information produced has been noted in a previous section of this chapter. The Committee believes that it is unacceptable that the RNSH does not have an adequate IT system.

10.142 The Committee notes that investment in information technology at RNSH and across NSCCAHS has for several years been significantly below the level required to deliver appropriate clinical services to patients. Clinicians are being hamstrung by inadequate IT infrastructure, in particular in relation to the Picture Archive and Communication System (PACS).

10.143 The Committee acknowledges that New South Wales Health and the NSCCAHS have flagged that the roll-out of an Electronic Medical Record (eMR) project and a medical imaging program is underway across the NSCCAHS. It is to be hoped that these projects when finalised and fully implemented will deliver significant benefits to clinicians and patients at RNSH.

10.144 Nevertheless, the Committee believes that there would be merit in the NSCCAHS undertaking an audit of the information technology systems in place at the RNSH and across the area to identify other information technology areas, alongside PACS and the eMR project, that should be prioritised for implementation.

Recommendation 37

That NSCCAHS undertake an audit of the Information Technology systems in place at the RNSH and across the Area to identify other Information Technology areas, alongside PACS and the eMR project, that should be prioritised for implementation.

10.145 The Committee believes there needs to be implementation of an IT system consistent with that in use in other Areas that will allow the collection of data for accurate comparisons to be made across Areas. The implementation plan must allow for improved accuracy of data entering, employment of IT support personnel and administrative clerks to support the system and recurrent funding to ensure that the performance of these information collection tasks do not detract from the front-line services offered by the hospital.

10.146 The Committee also believes that it is important that other Area Health Services maintain IT investment at appropriate levels, and therefore recommends that a review across all Area

512 Submission 33, p 9

Health Services be conducted to ensure that the percentage of IT infrastructure and support funding is at appropriate levels.

Recommendation 38

That a review across all Area Health Services be conducted to ensure that the percentage of Information Technology infrastructure and support funding is at appropriate levels.

The use of special purpose and trust funds

10.147 Trust funds, usually the result of donations or bequests from benefactors in the community, make a significant contribution to the capacity of public hospitals to maintain and replace assets.

10.148 In evidence to the Committee, Mr Ken Barker, the NSW Health Chief Financial Officer, explained the difference between special and general purpose funds:

> With a special purpose account, if money had been given by a group of individuals, an individual, an organisation—there are a lot of non-government type organisations—registered clubs, Lions clubs, and that type of thing, they give it for a specific purpose. The Area can then spend that money only for the specific purpose. If the specific purpose has a relationship to cardiology, in my view it is quite appropriate to spend it on cardiology. Other funds are also given which are generally called public contributions where they are general funds. Let me rephrase that. They are given for the general purpose of a hospital. It is then up to the Chief Executives to determine how to use that.[513]

10.149 The importance of trust funds for maintaining and providing essential equipment, and the decline in trust fund revenue as a result of the opening of a private hospital nearby was identified by Professor Malcolm Fisher:

> The use of trust funds for essential equipment (purchase, maintenance and replacement) has been a way of life at RNSH for many years. Since the opening of North Shore Private our capacity to do this has diminished considerably.[514]

10.150 Dr Stephen Christley, former Chief Executive of NSCCAHS, echoed the comments of Professor Fisher:

> One of the things that has happened with the move of work from the public sector to the private sector and private work is that there is a significantly reduced component of private practice trust grants at North Shore now available for discretionary distribution by clinicians, and that is certainly one of the challenges that the health service faces in terms of its capital and so on.[515]

513 Mr Ken Barker, Chief Financial Officer, NSW Health, Evidence, 12 November 2007, p 12

514 Submission 52, p 6

515 Dr Stephen Christley, Former Chief Executive, Northern Sydney Central Coast Area Health Service, Evidence, 12 November 2007, p 79

10.151 Some concern was expressed by parties to the inquiry that trust funds were being used contrary to their stated purpose. For example, Professor Steven Hunyor, on behalf of the Cardiology Department of RNSH, submitted that trust funds were transferred in the closing months of the financial year into the General Fund 'to bolster Management's performance'.[516]

10.152 Dr Greg Fulcher, Director of the Department of Diabetes, Endocrinology and Metabolism at RNSH, in detailing the discussions he and other senior clinicians had had in relation to problems within RNSH, commented on their concerns over trust funds:

> 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 …[517]

10.153 Mr Matthew Daly, the Chief Executive of NSCCAHS, told the Committee that he had never seen a breach of the terms of deed surrounding a trust and explained the way in which trust funds are used across the State:

> Special purpose and trust funds have deeds that are quite clear and quite specific about what funds can be used for, or not. It is not uncommon at all for special purpose and trust funds to be used quite regularly for the purchase of capital equipment. Every hospital in this State would do that on a routine basis. But for any funds to be used outside the terms of the deed specifically as it relates to donor funds, the rules around that are very, very clear. In my 29 years in Health, I have never seen them breached.[518]

10.154 However, the Acting Chief Financial Officer for NSCCAHS, Mr Robert Wright, told the Committee that he was aware of a practice 'some years ago' which involved the misuse of special purpose and trust funds:

> … there was a practice some years ago whereby … when the hospital was having trouble with its budget, [it] may have looked at the special purpose and trust funds to try to see if there were trust funds there they could use to offset the financial problem to pay for equipment they had bought out of the general fund.[519]

10.155 Ms Deborah Latta, former General Manager for the North Shore Ryde Health Service, confirmed that there had been instances of trust funds being used to cover the budget's bottom line at the end of the financial year both before and during her time as General Manager (February 2003 – August 2005). She commented that the trust fund in question had since been reimbursed.[520]

10.156 Dr Stephen Christley, former Chief Executive of NSCCAHS, acknowledged that there had been a misuse of a trust fund during his time as Chief Executive, and that the response to this misuse, once corrected, had led to changes in the way in which trust funds were administered:

---

516 Submission 30, p 14

517 Dr Fulcher, Evidence, 22 November 2007, p 13

518 Mr Daly, Evidence, 12 November 2007, p 21

519 Mr Robert Wright, Acting Chief Finance Officer, Northern Sydney Central Coast Area Health Service, Evidence, 12 November 2007, p 21

520 Ms Latta, Published in camera evidence, 16 November 2007, p 4

> What we did over the last couple of years is actually strengthen the governance process around trusts so that Professor Pollack, who was here before, one of the roles she did not talk to you about was that she is actually a member of a committee that looks at bequests and determines what purposes they can be put to so that there can be no diversion in any way from the intent of the donor in terms of donations.[521]

10.157 In evidence to the Committee, Professor Picone, Director General of NSW Health acknowledged that there was an internal audit into the status of funds provided for the training of foreign doctors.[522]

10.158 A copy of the draft internal audit report was provided to the Committee. The Committee agreed to keep it confidential at the Minister's request.[523]

10.159 Professor Picone commented that she believed the hospital had not been aware of the arrangements for the funds at the time, but that training is clearly provided by the hospital:

> So that was another one of those local discussions you have to have about what is fair and reasonable, what would go into your trust accounts, and then what is a reasonable cost to the hospital for the purposes of training.[524]

Committee comment

10.160 The Committee notes that future trust fund bequests to RNSH are likely to be reduced in favour of the Royal North Shore Private Hospital. The capital equipment plan discussed in the section above will need to take into account this likely future reduction.

10.161 Generosity from members of the public toward a respected institution like the RNSH is welcomed and the hospital should ensure that the trusts are correctly administered.

10.162 The Committee therefore recommends that the monitoring of trust funds be improved, with nominated hospital executives receiving monthly reports on income and expenditure from clinicians and administrators, and that this information be made publicly available annually on request. We believe that with this recommendation and the focus of the Area on this issue, donors in future can be assured that their donations will be directed to the purpose for which they were intended.

Recommendation 39

That the monitoring of trust funds be improved, with nominated hospital executives receiving monthly reports on income and expenditure from clinicians and administrators, and that this information be made publicly available annually on request.

---

521 Dr Christley, Evidence, 12 November 2007, p 79

522 Professor Debora Picone, Director General, NSW Health, Evidence, 12 November 2007, p 13

523 Answers to questions taken on notice during evidence 12 November 2007, Hon Reba Meagher MP, Minister for Health, Attachment 1 (confidential)

524 Professor Picone, Evidence, 12 November 2007, p 13

Chapter 11 Incident and complaint management

> When things go wrong we have systems in place to ensure that we learn from mistakes and make the system better.[525]

This chapter examines aspects of the incident management and complaint handling systems at Royal North Shore Hospital. While many of the conditions for an effective patient safety system are in place at the hospital, several clinicians indicated that the system is fundamentally flawed because the lessons learned from adverse events do not lead to improved practices.

The chapter also considers the management of complaints made by patients or their relatives about their healthcare at the hospital, and the proposals from the Department and the Area to address patients' concerns about the management of complaints.

The chapter begins with a brief overview of the development of the patient safety agenda over the past 30 years.

The quality in healthcare movement

11.1 The patient safety or 'Quality' movement is a relatively recent phenomenon in modern healthcare. Patient safety issues gained prominence in Australia with the publication in 1995 of the landmark *Quality in Australian Healthcare study*.[526] This was the first attempt to identify the number of adverse incidents in Australian hospitals. [527] The study found that 16 per cent of patients admitted to hospital suffered some sort of adverse event, and half of those events were preventable.[528]

11.2 In response to this heightened awareness about adverse events, health systems across the world, including NSW, developed programs to maximise the safety of healthcare services. High profile inquiries into Chelmsford Hospital, and more recently, into Camden and Campbelltown Hospitals, further underlined the importance of effective incident and complaints handling processes in health services in this State.

11.3 Incident management and complaints handling are interrelated processes. A healthcare 'incident' refers to any unplanned event resulting in, or with the potential for, injury, damage or other loss. These incidents may be clinical in nature, or they may involve corporate matters.

---

525 Submission 33, NSW Health, p 40

526 Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Healthcare: Final Report*, November 1995

527 An adverse event is 'an unintended patient injury or complication from treatment that results in disability, death or prolonged hospital stay or death, and is caused by healthcare management'. NSW Health, *Policy Document 2007 – 061 Incident Management Policy*, July 2007, p 32

528 Dr Ross Wilson, Director, Northern Centre for Healthcare Improvement, NSCCAHS, Evidence, 16 November 2007, p 39

'Incident management' refers to a systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident.[529]

11.4 Complaints refer to an expression of dissatisfaction or a concern that provides feedback about an aspect of the health service. Complaints may be about treatment, communication, access to service or corporate issues and may be made by staff, patients or their families.[530]

11.5 Incidents and complaints are entered into the Incident Information Management System (IIMS) database (see 11.10).

11.6 In her evidence to the Committee the Minister for Health, the Hon Reba Meagher, discussed some of the key principles of effective incident and complaint handling systems, including in particular, a preparedness to change systems or practices in response to medical errors:

> When someone has been let down by our health system, I will apologise. But it is important that we go further than that: we must acknowledge our mistakes, learn from them and provide answers to patients. However, importantly, we must make our system stronger so that we can prevent it from happening again.'[531]

11.7 The Minister's comments are reflected in several of the key principles of the NSW Health Incident Management Policy, including the 'obligation to act' and the 'prioritisation of action'.[532]

Incident management in the NSCCAHS

NSW Patient Safety and Clinical Quality Program (2004)

11.8 Clinical governance activities at NSCCAHS operate within the NSW Patient Safety and Clinical Quality Program. Detailed information about the Program, which was introduced in 2004, may be found in the submission from NSW Health.[533]

11.9 Key elements of this program include the state-wide implementation of the Open Disclosure Policy (being open with patients and families about health care incidents); the establishment of the Clinical Excellence Commission (to assist Area Health Services to achieve and maintain adequate standards of patient care) and the introduction of the Incident Information Management System (an electronic system for recording incidents and complaints).

529 NSW Health, *PD2007 – 061 Incident Management Policy*, July 2007, p 32. The Department favours the apparently more generic term 'incident' rather than 'adverse event'. Both terms will be used interchangeably throughout this chapter.

530 NSW Health, *PD2007 – 061 Incident Management Policy*, July 2007, p 32

531 Hon Reba Meagher MP, Minister for Health, Evidence, 12 November 2007, p 7

532 NSW Health, *PD2007 – 061 Incident Management Policy*, July 2007, p 5

533 Submission 33, pp 36-40

Incident Information Management System (IIMS)

11.10 The Incident Information Management System (IIMS) is an electronic management system that records all complaints and incidents at each location within an AHS. It was introduced to NSRHS in 2005.

11.11 Each complaint and incident entered into IIMS is prioritised according to a Severity Assessment Code (SAC). The SAC is a matrix that takes into account the consequences of an incident and the likelihood of its recurrence, with SAC 1 incidents being the most serious and SAC 4 the least serious. All SAC 1 incidents, and a small number of other incidents, must be reported to the Department, and require the conduct of a Root Cause Analysis (RCA), a methodology for investigating the 'root causes' of a healthcare incident. The NSCCAHS conducts a twice-yearly 'meta-analysis' of RCA causal statements to address the systems issues that underlie incidents. The meta-analysis is considered by the Area Executive Team, Quality and Improvement Committee and Clinical Council.[534]

11.12 IIMS is a Windows-based program, present on the 'desktops' of all networked computers within NSCCAHS.[535]

11.13 While the Committee was advised that there is a 'remarkable similarity' in the level of incident reporting across the different Area Health Services,[536] it did not receive any details regarding the number of incidents reported via IIMS.

Training in IIMS

11.14 According to Dr Philip Hoyle, the Director of Clinical Governance for NSCCAHS, while the Area does not keep a record of which categories of staff have had training in IIMS, it is believed that few doctors have received any formal training in the system:

> In 2005, when IIMS was first installed, there was a major training program that sought to reach all staff. While it was possible to reach certain specific groups (approximately 60 incoming junior staff were trained), it has proved much more difficult to attract senior staff to training. [537]

11.15 Dr Hoyle alluded to the difficulty of getting doctors to participate in patient safety initiatives, noting that while doctors comprise about 10% of the workforce, they only report 3% of the incidents:

> I would not be the first person in a position like mine to find it very difficult to get doctors trained in such things. [538]

534 Submission 34, NSCCAHS p 54

535 Answers to questions on notice taken during evidence 22 November 2007, Dr Phillip Hoyle, Director of Clinical Governance, Question 1, p 1

536 Professor Clifford Hughes, Chief Executive Officer, Clinical Excellence Commission, Evidence, 12 November 2007, p 90

537 Answers to questions on notice taken during evidence 22 November 2007, Dr Phillip Hoyle, Director of Clinical Governance, Question 1, p 1

538 Dr Philip Hoyle, Director, Clinical Governance, NSCCAHS,Evidence, 22 November 2007, p 21

11.16 Dr Hoyle believes the need for training has been obviated to a small degree by the fact that:

> IIMS is not a difficult system to use, and our experience is that most computer literate staff - even in 'high reporting' professions such as nursing – can use it without formal training.[539]

> The IIMS on-line training was made available on all computers at RNS. Doctors have the opportunity to use that. They have also used the available phone line to notify incidents and have always had the opportunity to use a paper form. They have used both alternate forms of notification albeit to a small extent.[540]

11.17 In response to a suggestion that some doctors could not access a computer in order to enter IIMS data, Dr Hoyle said that he understood that there should be many more computers in place following the rollout of the new a patient administration system in March 2008.[541]

11.18 Of particular concern are the comments made by Dr Christopher Arthur, the Director of Cancer Services at RNSH, about the use of IIMS by clinicians. Dr Arthur argues that serious incidents are not being entered into IIMS because doctors are too overwhelmed by their clinical workload:

> When the situation is so stressed even a few spare minutes cannot be found to locate a computer and navigate through multiple screens, recall, find and then enter data about an incident. We therefore believe that the IIMS system is not a true reflection of adverse events.[542]

11.19 He believes that the appointment of data managers or physician support personnel to work with senior clinicians would address this serious flaw in the incident reporting system at the hospital.

11.20 The Committee received a small amount of anecdotal evidence indicating a lack of awareness of IIMS. For example, one nurse told the Committee that said she had never heard of the IIMS system, despite witnessing several incidents that should have been reported.[543]

11.21 The submission from the NSCCAHS noted that further education for staff on the importance of entering complaints using the IIMS complaints form had commenced in November 2007 and that this would be followed by targeted education at the clinical unit level. [544]

Committee comment

11.22 Given the central importance of IIMS to the NSW Health patient safety agenda, and doctor's disinclination to report adverse events, it is unfortunate that more clinicians, including senior

---

539 Answers to questions on notice taken during evidence 22 November 2007, Dr Phillip Hoyle, Director of Clinical Governance, Question 1, p 1

540 Answers to questions on notice taken during evidence 22 November 2007, Dr Phillip Hoyle, Director of Clinical Governance, Question 1, p 1

541 Dr Phillip Hoyle, Evidence, 22 November 2007, p 20

542 Submission 84, Dr Christopher Arthur, Director, Cancer Services RNSH, p 11

543 Witness D, (name suppressed), Published in camera evidence, 26 November 2007, p 6

544 Submission 34, pp 47 and 55

staff, have not received formal training in IIMS. The Committee is particularly concerned about the comments made by Dr Arthur that clinicians routinely fail to report adverse incidents because they do not have time to enter the data into IIMS.

11.23 As a first step in addressing this issue, the Area should commence recording the number and categories of staff who receive training in the use of IIMS, with a view to expanding the training to all employees, including new staff, who should receive training as part of their formal induction activities. Reinforcing the value of incident reporting should be a major focus of this training.

Recommendation 40

That NSCCAHS:

- Provide training in the Incident Information Management System to all new staff, via the staff induction process.
- Provide training in the Incident Information Management System to senior clinical staff
- Record the number and categories of staff who receive formal training in the use of the Incident Information Management System.

Recommendation 41

That NSW Health review the operation of Incident Information Management Systems and training in their use across all Area Health Services and report the results of the review in the next NSW Health Annual Report.

Quality Assurance Royal North Shore (QaRNS)

11.24 RNSH was the first hospital in this State to seek to measure its rate of adverse events. This is achieved via Quality Assurance Royal North Shore (QaRNS), an initiative of the Northern Centre for Healthcare Improvement.

11.25 QaRNS is a systematic clinical audit of the medical records of all patient deaths, unplanned transfers to intensive care and unplanned returns to the operating rooms.[545] These medical records are reviewed on a weekly basis by a Clinical Review Committee, which includes representatives of senior management, nursing managers, ward nurses, junior doctors and consumers.

11.26 According to QaRNS, the adverse event rate at RNSH is approximately nine per cent, compared with 10-20 per cent for major hospitals across the world, and 16.6 per cent for Australian hospitals.[546] The Director of the Northern Centre for Healthcare Improvement, NSCCAHS, Dr Ross Wilson, suggested that 'the rate of adverse events at Royal North Shore

545 Submission 34, p 55

546 Dr Ross Wilson, Evidence, 16 November 2007, p 39

Hospital is lower than anywhere that we know and that despite the increasing complexity of its caseload, the hospital's adverse incident rate has remained steady over the past 10 or 12 years:

> … Professor Bob Gibberd, … predicts that our adverse event rate should have gone up about 60 per cent to 70 per cent in that time, based on the increasing complexity of patients and the increasing age of patients … [547]

11.27 Dr Wilson also claimed QaRNS to be a 'superior' tool compared with other patient safety initiatives introduced by NSW Health:

> ... A lot of initiatives broadly have come out of NSW Health to help to address this issue. The question I have is: Are they working and how would we know? Again, this is not just a question for New South Wales; it is a national and an international question. At some point we will have to address that question. It is not easy. We have addressed it at North Shore and we know. I would encourage others to work in the area and to try to do the same sorts of things.[548]

11.28 Dr Hoyle, the Director of Clinical Governance at NSCCAHS also believes QaRNS is a 'fantastic asset' which he would 'strongly recommend' be utilised by the rest of the State.[549] He referred the Committee to a recent study of reporting systems in the UK which concluded that, 'Healthcare organisations should consider routinely using structured case note review on samples of medical records as part of quality improvements.[550]

Committee comment

11.29 It is ironic that RNSH has received such negative publicity about patient care, when it arguably has one of the lowest reported rates of adverse events in Australia.

Recommendation 42

That NSW Health in conjunction with the Clinical Excellence Commission examine the use of systematic audits of medical records, such as QaRNS.

Failure to implement system changes as a result of incidents

11.30 While it would seem that valuable patient safety initiatives have been introduced to RNSH in recent years, the Committee heard from several clinicians who felt that the effectiveness of the patient safety program was compromised because the hospital did not ensure system improvements were implemented in response to healthcare incidents.

11.31 As the AMA told the Committee:

547 Dr Ross Wilson, Evidence, 16 November 2007, p 39

548 Dr Ross Wilson, Evidence, 16 November 2007, p 39

549 Dr Phillip Hoyle, Evidence, 22 November 2007, p 22

550 Sari A, Sheldon T, Cracknell A and Turnbull A, p 81

> Doctors advise that they are not provided with resources to deal with identified problems…Where issues are raised, systemic causes such as insufficient resources, beds or staffing, are not addressed. [551]

11.32 In his submission to the Committee, Dr Jeffery Hughes, a former RNSH Orthopaedic Consultant, told the Committee that 'the quality assurance schemes are a joke – they rigorously record patient misadventures, but do little to change the main reason for the failures'.[552] Dr Hughes' complaints included serious claims about inadequate patient care, such as an operating table breaking in two during an operation and people with fractures taking days to get to surgery. Dr Hughes spoke of the frustration he felt from being told over a number of years that resources would not be available to fix problems:

> So if I send a case to a department that says there is a shortcoming in care and they agree but their response to me will be, 'Yes, but why bother trying to ask for more staff?' or 'Why bother trying to get new equipment because we can't'.
>
> **…** Between 1998 and when I finally resigned in 2007 I treated a number of infections involving compound fractures and joint sepsis, 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.'

11.33 Dr Hughes told the Committee that the failure to ensure incident monitoring generated system changes has had a devastating impact on clinicians' morale and their preparedness to participate in improvement programs.[553] He argued that cultural change rather than more policies or structures is required to address this issue: 'It is the culture in which their complaint is being delivered … It really is a mindset that has to be changed'.[554]

11.34 The AMA believes that the failure of NSW Health to identify access block as a key issue in the review of the care afforded Ms Jana Horska in the RNSH Emergency Department conducted by Professor Hughes and Professor Walters, '… shows that the health system still is not able to look beyond individual patient incidents to address systemic factors that lead to unsatisfactory patient care'.[555]

11.35 While Dr Wilson believes QaRNS has generated clinical improvements at RNSH, the hospital's track record on more complex issues was not very impressive:

> If it [the solution to the problem] is within their purview, within their department, to fix it they do—promptly. If it is a bigger problem that they cannot fix within their

551 Submission 32, AMA/ASMOF, pp 10-11

552 Submission 13, Dr Sleye Hughes, p 1

553 Dr Ross Wilson, Evidence, 16 November 2007, p 43

554 Dr Jeffrey Hughes, Former Senior Orthopaedic Consultant VMO, Royal North Shore Hospital, Evidence, 22 November 2007, p 83

555 Dr Andrew Keegan, President, Australian Medical Association (NSW), Evidence, 12 November 2007, p 45

> department that is more difficult …They do not get fixed with quite the same speed.[556]

11.36 The Chief Executive of NSCCAHS, Mr Matthew Daly, acknowledged management's failure to act on problems identified by clinicians and the frustration that this generates:

> … the failure to act on problems that are brought to management's attention….is what drives frustration…where if a problem is raised time and time again and seemingly no action is taken it would drive me over the edge so I can totally understand why it would drive others.[557]

11.37 However, in its submission, the NSCCAHS painted a positive picture of its track record in implementing recommendations from RCA investigations:

> Recommendations from incident investigations are logged in a database and completion is tracked….Since 2003 RCA investigations [across the Area] have generated 500 recommendations and to date 75% of these have been implemented. RNSH has implemented 62% of its RCA recommendations with a further 28% currently in progress.[558]

11.38 While these statistics appear fairly impressive, it should be noted that SAC 1 incidents (such as patient deaths) are a very small proportion of all healthcare incidents reported via IIMS. The Committee understands that the Area plans to extend this monitoring to less serious clinical consequences be setting up a formal committee for incident and complaint management to review all incidents, including a review of recommendations from coroners and QaRNS Reports, SAC 2, 3 and 4…[559]

11.39 The NSCCAHS also told the Committee that while outcomes arising from incident investigations are required to be fed back to the people who notified the incident, 'this is not formally measured'.[560]

Committee comment

11.40 NSCCAHS has introduced several valuable patient safety initiatives over the past ten years. Indeed many of the processes and principles that inform the patient safety agenda in NSW were first articulated by RNSH clinicians.[561] It is also the only health service in NSW that is able to measure accurately its rate of adverse incidents, via QaRNS.

11.41 NSCCAHS must ensure recommendations from incident reporting are implemented. To be effective, an incident monitoring system must ensure that solutions identified in response to healthcare incidents are put into practice, and not only in relation to the most serious clinical

---

556 Dr Ross Wilson, Evidence, 16 November 2007, p 39

557 Mr Matthew Daly, Chief Executive, NSCCAHS, Evidence, 12 November 2007, p 23

558 Submission 34, p 54

559 Submission 34, p 54

560 Submission 34, p 53

561 Submission 33, p 36

events, such as SAC 1 incidents. If staff do not see any outcome from reporting incidents, they are unlikely to continue reporting or to be enthusiastic about patient safety initiatives.

11.42 It is hoped that addressing some of the management and resource issues discussed in Chapters 4 -8 will generate a renewed commitment to incident monitoring on the part of clinicians and managers. But in the meantime, important steps can be taken by the Area to restore people's faith in incident reporting. These include requiring that the outcomes of incident investigations are always fed back to staff, including those in relation to SAC 3 and 4, QaRNS reports and Coroners' reports. The newly established incident and complaints management committee could be tasked with recording who is notified of the outcomes of incident investigations and when this notification is received.

Recommendation 43

That NSCCAHS ensure that the recommendations from incident reporting are implemented.

Recommendation 44

That NSCCAHS ensure that the outcomes of incident investigations, including those in relation to SAC 3 and 4 incidents, Quality Assurance Royal North Shore reports, and Coroners' reports, are communicated to staff.

Patient complaints

11.43 As with incident management, RNSH has the relevant infrastructure to deal with patient complaints, all of which are well documented in the Area's submission.[562] These include: an Area Complaints Committee, the IIMS, Patient Representative Office and the recently established Professional Practice Unit.

11.44 RNSH compares favourably with other AHSs in terms of the number of complaints made, and with meeting relevant complaints handling benchmarks, such as the time taken to acknowledge and finalise complaints. [563]

11.45 Recent media attention may contribute to an increase in complaints from patients, though this has not been quantified. According to a NUM at the hospital, Ms Fiona Carmichael:

> Patients are making multiple complaints about things that in the past they possibly would not have complained about. Perhaps the windows might have been dirty, but in the past, 'Well, we're getting good nursing care' or 'I'm happy with my doctor, so that doesn't really matter', whereas now every little thing seems to be—it is a knock-on effect—something to be complained about. The nursing staff are really copping it at the bedside definitely.[564]

562 This section deals with complaints by patients about their care at the hospital. Staff complaints about workplace issues are discussed in Chapter 5

563 Submission 34, pp 44-53 Detailed information about complaints handling at the hospital and area level can be found on

564 Ms Fiona Carmichael , Evidence, 26 November 2007, p 12

11.46 In several of the cases that have been discussed in the media recently, it was the patient's 'experience' of care and not just the technical care they received that was identified as problematic. Professor Barraclough, the Chairman of the Clinical Excellence Commission, believes that health services should look to the hospitality industry to learn about ways to improve peoples' experience of healthcare:

> … We would regard a lot of the issues that come up to committees like this as being about the patient experience, not always about the technical care—in fact, often not about the technical care, but about the experience the patient has had while they have been receiving that care, and we need to improve that. It is about changing the culture so that it is much more like the hospitality industry than it is something where you go purely for what is often a very frightening and sometimes painful technical care.[565]

11.47 Many of the concerns raised by patients and their families during this inquiry were about the technical care they received at the hospital and communication issues.

11.48 Vanessa Anderson died at RNSH on 8 November 2005. Her parents, Mr Warren Anderson and Mrs Michelle Anderson, have serious concerns about the 'technical' aspects of their daughter's care (see 3.19) but they were also critical of the way their complaints about Vanessa's treatment were handled by hospital management and clinicians. In their submission to the inquiry, the Anderson's reported that meetings to discuss the circumstances of Vanessa's death were held on the grounds of the hospital against the family's request, that medical staff and management engaged in verbal disputes in the presence of the family and that one senior staff member appeared to be asleep during their meeting.[566]

11.49 Cautious of commenting on a matter before the Coroner, the former Chief Executive of NSCCAHS, Dr Christley, acknowledged that: '… I do not think the communication with the family in the Vanessa Anderson matter was as good as it should have been'.[567]

11.50 Ms Joyce Batterham had a serious fall while at RNSH, when a nurse, working unassisted, attempted to lift her from her wheelchair to a hospital bed during her stay. When she tried to complain about aspects of her mother's treatment, her daughter, Ms Lindy Batterham, was advised by staff that all OH&S policies and procedures were adhered to, and it was considered safe to move her this way:

> I was flabbergasted to hear this, but not as much as when I read the incident report I had requested. Some detail and sequence of events were quite different from how I had remembered and documented them. It was clearly a cover-up but the staff were sticking together. I felt great despair that there appeared to be no lessons learned.[568]

---

565 Professor Bruce Barraclough, Chair, Clinical Excellence Commission, Evidence, 12 November 2007, p 92

566 Submission 46, Mr and Mrs Anderson, p 3

567 Dr Stephen Christely, Former Chief Executive Officer, NSCCAHS, Evidence, 12 November 2007, p 78

568 Submission 47, Ms Lindy Batterham, p 4

11.51 Mrs Batterham was however, extremely grateful for the support she received from the hospital's Patient Representative, and was glad that position existed at the hospital.[569]

11.52 Mrs Jenny Langmaid experienced a miscarriage in the RNSH Emergency Department in June 2005. Media coverage of Ms Jana Horska's miscarriage in painfully similar circumstances to her own encouraged her to discuss her experience with the Committee. Ms Langmaid was frustrated that her suggestions regarding care for women with threatened miscarriages made two years ago, went unheeded:

> I know that a positive thing has come out of that in that now obviously all women presenting to emergency will be sent to maternity, but I did have that conversation with the NUM two years ago and I did actually make that suggestion myself and it is a shame that it fell on deaf ears.[570]

11.53 Despite having the necessary systems and policies in place, the Area acknowledges that there is a problem with the way the Area or the hospital has managed and responded to patient complaints. According to the Chief Executive, Mr Daly:

> Certainly many of those incidents can be tied back to a failure of our complaints management systems to fully embrace the concerns of patients or their next of kin, for us to feed back in a speedy but open and transparent way what the outcomes of, what poor clinical outcomes may have been and why that occurred and embracing patients or their next of kin in the process to review those incidents and the way forward to ensure they do not happen again.[571]

11.54 The Department/Area advised that the following improvements to complaints management at RNSH were being implemented:

- The Patient Representative Office (PRO) has developed a new complaints investigation report to improve complaint handling by frontline mangers
- PRO drafted and trialled a new Executive brief to be used as a formal mechanism to alert the RNSH Executive Management Team to systems issues arising from complaints which have not been managed at a lower level
- A new Area-wide NSCCAHS patient Rights and Responsibilities Brochure distributed to all patient care areas
- A regular weekly forum comprising RNSH executives to review complaints
- The Patient Representative Manager attends weekly Incident Management Committee meetings to achieve better integration between incident and complaint management
- Establishment of the Professional Practice Unit to deal with complex complaints[572]

---

569 Ms Lindy Batterham, Relative of former patient of Royal North Shore Hospital, Evidence, 22 November 2007, p 66

570 Mrs Jenny Langmaid, Former patient of Royal North Shore Hospital, Evidence, 16 November 2007, p 87

571 Mr Matthew Daly, Evidence, 12 November 2007, p 23

572 Submission 34, pp 51-54

Committee comment

11.55 This inquiry did not stem from any marked increase in the volume of formal complaints by patients about RNSH. While several participants were critical of the way their complaints were managed, it was their treatment at the hospital at first instance that was of primary concern.

11.56 The common 'complaints' made by these patients and their families during the inquiry included that they received inadequate clinical care, that clinicians were rude or extremely rushed and that facilities in the hospital were unhygienic. Few blamed individual doctors or nurses for these failings, but identified systemic issues, such as a shortage of medical staff and inadequate funding, as being at the heart of poor patient care. They realise that it is very difficult to provide high standards of patient care and to demonstrate empathy, when confronted with overcrowded hospital wards and a lack of staff.

11.57 This is not to suggest that improvements in managing patient complaints suggested by NSCCAHS are not welcome. But more importantly, the Area and the hospital need to focus on preventing complaints in the first place, by learning from adverse events to make the system better, and by addressing the management and resource issues discussed in earlier chapters of this report. This would be the most powerful way for the Area to demonstrate that it was serious about patient safety.

11.58 The Committee also believes that the experience that a patient has while in hospital and the experiences of the patient's family and carers who visit and interact with the hospital during the patient's stay should be key performance indicators for the hospital and its management personnel.

Recommendation 45

That the Clinical Excellence Commission give a high priority to the development and implementation of programs that measure patient satisfaction as a key performance indicator for each hospital and health facility, alongside key performance indicators relating to the delivery of technically excellent care.

Appendix 1 Submissions

No	Author
1	Emeritus Professor Al Willis
2	Confidential
3	Dr Peter Roberts
4	Dr Paul Cunningham
5	Mr Timothy Slee
6	Confidential
7	Mrs Kaye Preema
8	Confidential
9	Mrs Bernadette Farmer
10	Ms Maureen Cain
11	Ms Suzanne Benson
12	Mrs Marion Scott
13	Dr Jeffery Hughes
14	Mrs Therese Mackay
15	Dr Peter Short
16	Confidential
17	Confidential
18	Mr Peter Egan
19	Mr Wal Coskerie
20	Mr Donald Martin
21	Ms D. Purcell
22	Dr Eric Hinder
23	Confidential
24	Confidential
25	Dr Steven Blome (Radiology Department, RNSH)
26	Mr David Ingman and Mrs Jean Ingman
27	Dr Robert Day (Emergency Department, RNSH)
28	Dr Charles Fisher (Medical Staff Council, RNSH)
29	Mr Brett Holmes (Nurses' Association NSW)
30	Professor Stephen Hunyor (Cardiac Technology Centre, RNSH)
31	Confidential
32	Australian Medical Association Limited NSW and Australian Salaried Medical Officers Federation NSW

No	Author
33	Professor Debora Picone AM (NSW Health)
33a	Professor Debora Picone AM (NSW Health)
34	Mr Matthew Daly (NSCCAHS)
35	Confidential
36	Dr Sally McCarthy (Australasian College of Emergency Medicine)
37	Dr Stephen Christley
37a	Dr Stephen Christley
38	Clinical Associate Professor Christine Storey (Department of Neurology, RNSH)
39	Dr Wendy Michaels
40	Mrs Lyn Tonkin
41	Confidential
42	Confidential
43	Mr Philip Lee
44	Dr Clare Skinner
45	Mr Lindsay Skinner
46	Mr Warren Anderson and Mrs Michelle Anderson
47	Ms Lindy Batterham
48	Dr Tony Joseph
49	Dr Sharon Miskell
50	Dr David Sonnabend (Department of Orthopaedic and Traumatic Surgery, RNSH)
51	Confidential
52	Professor Malcolm Fisher AO
53	Dr Ian Farey
54	Dr Nick Pavlakis (Department of Medical Oncology, RNSH)
55	Confidential
56	Confidential
57	Mr Ian Butters and Mrs Christine Butters
58	Confidential
59	Mr Robert Neville
60	Ms Tonia De Launay
61	Mr Brian William Dugan
62	Ms Millie Mills
63	Confidential

No	Author
64	Dr Greg Purcell (Department of Anaesthesia and Pain Management, RNSH)
65	Mr John Clark
66	Mr Tyson Roach
67	Mrs Jenny Clarke
68	Confidential
69	Dr Carolyn Bennett
70	Ms Elizabeth Hamilton
71	Confidential
72	Mr Raymond Tooby
73	Mrs Catherine Martin
74	Ms Natalie Green
75	Dr Michael Kennedy
76	Dr Ronald Mackinnon
77	Confidential
78	Confidential
79	Ms Maureen Stephenson
80	Dr Leslie Woollard (Rural Doctors Association)
81	Ms Barbara Newrick
82	Confidential
82a	Confidential
83	Mr Neville Boyce
84	Dr Christopher Arthur (Department of Haematology, RNSH)
85	Confidential
86	Mr Kevin Isaksen
87	Mr Ray Bersten
88	Mr Rene Arnaud
89	Associate Professor Dale Bailey (Scientific Staff Council, RNSH)
90	Emeritus Professor James Lawson
91	Confidential
91a	Confidential
92	L. F. Keatinge
93	Mr Rodney Edwards
94	Confidential
95	Confidential
95a	Confidential

No	Author
96	Dr Bruno Giuffre
97	Ms Alexandra Rivers
98	Mr Allan Quirk
99	Dr Janine Kirkwood
100	Confidential
101	Confidential
102	Mrs Anne Heaton (Physiotherapy Department, RNSH)
103	Mrs Claire Keaney

Appendix 2 Witness list

A total of four public hearings were conducted at Parliament House. A list of witnesses is provided below and transcripts of the hearings are on the Committee's website at www.parliament.nsw.gov.au.

Date	Name	Position and Organisation
Monday 12 November 2007	Hon Reba Meagher MP	Minister for Health
	Professor Debora Picone AM	Director General, NSW Health
	Dr Richard Matthews	Deputy Director General, Strategic Management, NSW Health
	Mr Ken Barker	Chief Financial Officer, NSW Health
	Mr Matthew Daly	Chief Executive, Northern Sydney Central Coast Area Health Service
	Ms Julie Hartley-Jones	Acting Director, Clinical Operations, NSCCAHS
	Professor Carol Pollock	Chairperson, Area Health Advisory Council, NSCCAHS
	Ms Jenny Becker	Director, Workforce Development, NSCCAHS
	Mr Rob Wright	Acting Chief Finance Officer, NSCCAHS
	Mr Neville Onley	Acting Director Finance, NSCCAHS
	Ms Mary Dowling	Manager, Professional Practice Unit, NSCCAHS
	Ms Mary Bonner	General Manager, North Shore Ryde Health Service
	Mr Colin Murray	Acting Manager, Decision Support Unit, NSRHS
	Ms Linda Davidson	Acting Director of Nursing, Royal North Shore Hospital
	Dr Andrew Keegan	NSW President, Australian Medical Association
	Dr Antony Sara	President, Australian Salaried Medical Officers Federation
	Mr Sim Mead	Executive Director, Australian Salaried Medical Officers Federation
	Mr Brett Holmes	General Secretary, NSW Nurses' Association
	Ms Alison Mayhew	Former Branch President, NSW Nurses' Association
	Dr Sally McCarthy	Vice President, Australasian College for Emergency Medicine
	Mr Terry Clout	Former Acting Chief Executive, NSCCAHS
	Ms Phillipa Blakey	Former Director of Clinical Operations,

Date	Name	Position and Organisation
		NSCCAHS
	Dr Stephen Christley	Former Chief Executive, NSCCAHS
	Professor Cliff Hughes	Chief Executive Officer, Clinical Excellence Commission
	Professor Bruce Barraclough AO	Chairman, Clinical Excellence Commission
Friday 16 November 2007	Ms Debora Latta	Former General Manager, NSRHS
	Professor Stephen Hunyor	Director, Cardiac Technology Centre, RNSH
	Dr John Gunning	Head of Cardiology, RNSH
	Dr Tony Joseph	Director of Trauma (Emergency), RNSH
	Dr Robert Day	Director of Emergency Medicine, RNSH
	Dr Charles Fisher	Chair of the Medical Staff Council, RNSH
	Dr Sharon Miskell	Director of Medical Services, NSRHS
	Professor Malcolm Fisher AO	Area Director of Intensive Care and Critical Care, NSCCAHS
	Dr Ray Raper	Director, Intensive Care, RNSH
	Associate Professor Bill Sears	Consultant Neurologist, RNSH
	Dr Ross Wilson	Director, Northern Centre for Healthcare Improvement, NSCCAHS
	Dr Danny Stiel	Clinical Director of the Division of Medicine and Aged Care, NSRHS
	Ms Jana Horska	Former patient, RNSH
	Mr Mark Dreyer	Relative of former patient, RNSH
	Ms Sharon Hooper	Relative of former patient, RNSH
	Ms Wendy Gao	Relative of former patient, RNSH
	Mrs Therese Mackay	Relative of former patient, RNSH
	Ms Christine Rijks	Relative of former patient, RNSH
	Mrs Jenny Langmaid	Former Patient, RNSH
	Mr Steve Crosby	Relative of former patient, RNSH
Thursday 22 November 2007	Witness A	Nurse, RNSH
	Ms Alicia Jackson	Registered Nurse, RNSH
	Ms Samantha Flew	Nurse Unit Manager, RNSH
	Ms Michelle Beets	Nurse Unit Manager, RNSH
	Ms Helen Ganley	Former Nurse, RNSH
	Clinical Associate Professor Kerry Russell	Area Director, Nursing, Sydney South West Area Health Service
	Dr Greg Fulcher	Director, Department of Diabetes, Endocrinology and Metabolism, RNSH
	Dr Bruno Giuffré	Radiologist, RNSH
	Dr Philip Hoyle	Director, Clinical Governance, NSCCAHS

Date	Name	Position and Organisation
	Dr Patrick Cregan	Chair, Clinical Services Taskforce, Nepean Hospital
	Dr Adam Chan	Director, Emergency Department, St George Hospital
	Mr Vern Dalton	Former Commissioner of Corrective Services
	Dr Christopher Arthur	Director, Haematology Department, RNSH
	Dr Greg Briggs	Senior Staff Radiologist, RNSH
	Professor Leslie Burnett	Interim Cluster Director, Northern Pathology Cluster of NSW Health
	Dr Jennifer Donavon	Senior Staff Specialist, Radiation Oncology, RNSH
	Dr Tom Hugh	Head, Department of Gastro Intestinal Surgery, RNSH
	Dr John Vandervord	Clinical Head, Division of Surgery, NSRHS
	Mr Warren Anderson	Relative of former patient, RNSH
	Mrs Lindy Batterham	Relative of former patient, RNSH
	Dr Peter Roberts	Area Network Chair, Emergency Medicine, NSCCAHS
	Dr Paul Cunningham	Senior Staff Specialist, Emergency Department, RNSH
	Dr Clare Skinner	Registrar, Emergency Department, RNSH
	Dr Jeffrey Hughes	Former Senior Orthopaedic Consultant VMO, RNSH
	Professor David Sonnabend	Professor, Orthopaedics and Traumatic Surgery, University of Sydney, Chairman, Department of Orthopaedic Surgery, RNSH
	Dr Andrew Ellis	Orthopaedic Surgeon VMO, RNSH
	Ms Barbara Lucas	Senior Paediatric Physiotherapist, RNSH
	Mrs Anne Heaton	Senior Orthopaedic Physiotherapist, RNSH
Monday 26 November 2007	Witness B	Nurse, RNSH
	Witness C	Nurse, RNSH
	Witness D	Nurse, RNSH
	Dr Denis King	Executive Clinical Director, SESIAHS
	Ms Alison Mayhew	Nursing Unit Manager, RNSH
	Ms Fiona Carmichael	Nursing Unit Manager, RNSH

Appendix 3 Site visit

Monday 5 November 2007 **Royal North Shore Hospital**

The Committee attended the Royal North Shore Hospital and was met by the following:

- Mr Matthew Daly, Chief Executive, Northern Sydney Central Coast Area Health Service
- Prof. Carol Pollock, Chairperson, Area Health Advisory Council
- Ms Mary Bonner, General Manager, North Shore Ryde Health Service
- Ms Linda Davidson, Acting Director of Nursing and Midwifery, Royal North Shore Hospital
- Dr Daniel Stiel, Clinical Director, Aged Care and Medical Services, NSRHS

The Committee was taken on a tour of the Royal North Shore Hospital and met staff of the hospital. Specific areas visited included:

- The Emergency Department, where the Committee met members of staff including Dr Robert Day; Michelle Beets, Nurse Unit Manager; and Dr David Betty.
- The Severe Burns Injury Unit, including an Isolation Unit, where the Committee met members of staff including Dr John Vandervord, Clinical Director Surgery and Anaesthesia; and Dianne Elfleet, Nurse Unit Manager.
- The Intensive Care Unit, where the Committee met members of staff including Dr Ray Raper, Head of ICU; and Megan Inglis, Nurse Unit Manager.
- Ward 9A (Orthopaedics), where the Committee met members of staff including Robyn Stapley, Nurse Unit Manager, and Paula McCloud, Nurse Educator.
- A treatment room in Ward 10B.

At the conclusion of the tour of inspection, the Committee met with members of the North Sydney Central Coast Area Health Service and Royal North Shore Hospital executive, including:

- Dr Malcolm Fisher
- Dr Charles Fischer
- Dr Danny Stiel
- Dr Kate Storey
- Ms Joanne Prendergast
- Dr Michael Nichol
- Dr Greg Noble
- Dr Tom Hugh
- Dr Stephen Winger
- Dr Michael Nicol
- Ms Julie Hartley-Jones
- Dr Stephen Hunyor
- Dr Steven Blome

Appendix 4 Tabled documents

Monday 12 November 2007
Public Hearing, Jubilee Room, Parliament House

1. Three documents pertaining to budgetary allocations within NSCCAHS – tendered by Mrs Skinner

Thursday 22 November 2007
Public Hearing, Jubilee Room, Parliament House

1. Photographs taken in Royal North Shore Hospital - tendered by Mr Warren Anderson
2. Letter from Dr Lali Sekhon to Hon John Hatzistergos MLC as Minister for Health, relating to concerns about Royal North Shore Hospital - tendered by Mr Warren Anderson
3. Letter from Hon John Hatzistergos MLC as Minister for Health to Dr Lali Sekhon, responding to concerns about Royal North Shore Hospital - tendered by Mr Warren Anderson
4. Email correspondence between Dr Lali Sekhon and Mr Warren Anderson - tendered by Mr Warren Anderson
5. Analysis of Main Operating Rooms case load at Royal North Shore Hospital - tendered by Dr John Vandervord
6. Brief to the Re-development Project Team from the Royal North Shore Hospital Re-development Clinical Advisory Committee - tendered by Dr Tom Hugh
7. Response from the Royal North Shore Hospital and Community Health Service Redevelopment Team to Redevelopment Clinical Advisory Committee Brief - tendered by Dr Tom Hugh.

Monday 26 November 2007
Parliament House (requested to be published by the Minister)

1. The Royal North Shore Hospital Quality and Risk Management Plan or Risk Register (2004) - tabled by the Clerk to the Committee
2. The Best Practice Australia report – Climate Survey report for Royal North Shore Hospital (2004) - tabled by the Clerk to the Committee
3. Occupational Health and Safety Committee Minutes for Royal North Shore Hospital
4. Report on Quality Systems by Duncan Stewart (August 2003) –tabled by the Clerk to the Committee

Appendix 5 The Walters/Hughes Report

REPORT OF INQUIRY INTO THE CARE OF A PATIENT WITH THREATENED MISCARRIAGE AT ROYAL NORTH SHORE HOSPITAL ON 25 SEPTEMBER 2007

Prof Clifford Hughes AO
Prof William Walters AM
26 October 2007
1

Contents

TERMS OF REFERENCE

This inquiry is initiated under Section 122 of the *Health Services Act* (NSW) 1997.

It authorises Professor Cliff Hughes AO, Head of the Clinical Excellence Commission and Professor William Walters AM, Head of the Royal Hospital for Women Randwick, to jointly inquire into the administration and services of Royal North Shore Hospital, being a public hospital conducted by Northern Sydney and Central Coast Area Health Service in accordance with the following terms of reference:

1. To review and report on the adequacy and appropriateness of the clinical management and care of a patient with a threatened miscarriage who presented to Royal North Shore Hospital (the Hospital) Emergency Department on the evening of 25 September 2007 and who subsequently miscarried.
2. To review current practices and protocols at Royal North Shore Hospital and other hospitals within the NSW public health system concerning the clinical management, care and treatment of patients presenting with miscarriages or threatened miscarriages.
3. As a consequence of the above reviews, make recommendations concerning any action that should occur including referral to the Health Care Complaints Commission, changes considered appropriate to Hospital practices, policies or protocols or the development and implementation of state-wide policies, practices and protocols across the public health system.

The inquiry team is to report to me by 26 October 2007.

Debora Picone AM
Director-General, NSW Department of Health
26 September 2007

INQUIRY TEAM

Professor Clifford Hughes AO

MB.BS, FRACS, FACS, FACC, FICA(Hon), FCSANZ.

Professor Hughes is the Chief Executive Officer of the Clinical Excellence Commission of NSW.
He was previously Head of Department of Cardiothoracic Surgery at Royal Prince Alfred Hospital, Sydney. He was a foundation member of the Australian Council for Safety and Quality in Health Care, chairman of the Therapeutic Device Evaluation Committee (Australian Government) and founding chairman of the NSW Special Committee Investigating Deaths Associated with Surgery. He was a councillor, senior examiner and Division chairman (Cardiothoracic) for the Royal Australasian College of Surgeons.

Professor Hughes has trained and worked in the public health sector all of his professional life.

He trained at the University of New South Wales at Prince Henry and the Prince of Wales hospitals and also at Sutherland Hospital. Thirty years ago, as a general surgical trainee, he worked at the Royal North Shore Hospital. He undertook all his cardiac surgical training in public hospitals - at Royal Prince Alfred Hospital in Sydney, at Green Lane Hospital in Auckland and Johns Hopkins Hospital in Baltimore. Professor Hughes has also had experience in cardiothoracic surgery in Malaysia, Singapore, India and China, and twice as a General Surgeon in a small mission hospital in Bangladesh.

Professor William Walters AM

MB. BS, (Adel), PhD (Lond), FRANZCOG, FRCOG, FAChSHM (RACP)

Professor Walters is the Executive Clinical Director of the Royal Hospital for Women, Randwick. He is a Conjoint Professor at the University of NSW and Emeritus Professor at the University of Newcastle NSW. He is a senior obstetrician and Fellow of both the Royal Australian & New Zealand College of Obstetricians & Gynaecologists and the United Kingdom Royal College of Obstetricians & Gynaecologists. He has 180 publications in professional medical journals and books.
Professor Walters graduated in Medicine and Surgery from the University of Adelaide and undertook most of his training in obstetrics and gynaecology in the UK at the Jessop Hospital for Women in Sheffield, Hammersmith Hospital Postgraduate Medical School, London, and as a lecturer in obstetrics and gynaecology at the Aberdeen Maternity Hospital. Subsequently he was appointed senior lecturer, and then associate professor in obstetrics and gynaecology at Monash University and the Queen Victoria Memorial Hospital in Melbourne. Thereafter he was appointed Professor in Reproductive Medicine at the University of Newcastle and chair of the Department of Obstetrics and Gynaecology at John Hunter Hospital, Newcastle.

Professor Walters chairs the NSW Maternal and Perinatal Committee and the NSW Maternal and Perinatal Health Priority Taskforce and is a member of the NSW Health Care Advisory Council.

FOREWORD

At the outset we wish to express our sympathy for the distress that the early pregnancy patient and her partner experienced on the night of Tuesday 25 September 2007 and thereafter. They have experienced significant distress at the loss of their pregnancy and with the lack of privacy and dignity associated with that loss. The intense media attention in the following days and weeks no doubt added to this distress.

It would have been helpful to us in our inquiries and the preparation of this report to speak to the patient and partner to hear their personal account of the events that occurred at the Royal North Shore Hospital ED on that night. They were invited to speak to the inquiry team on several occasions but they declined. We respect their decision.

We also regret the distress experienced by members of staff in the ED as a result of these events and the ongoing pressures they will face through the various inquiries into these matters. It is important, nevertheless, that this matter be examined in its entirety and in detail, in order to bring about improvements to the systems of care for future generations of women who will inevitably present to EDs around the nation with a threatened miscarriage.

Miscarriage is a common medical event occurring in up to 20 per cent of recognized pregnancies. Problems associated with early pregnancy accounted for 11,254 presentations to NSW emergency departments in 2006-07. Of these, 9,536 related to miscarriage or threatened miscarriage, representing 84.8 per cent of the total. It should be noted that patients in early pregnancy who present with clinical signs of the type displayed by the patient whose management and care is the subject of this report almost invariably have a subsequent miscarriage.

The purpose of this inquiry is to investigate the circumstances surrounding a miscarriage that occurred in a toilet in the waiting room at the ED at RNSH on Tuesday 25 September 2007 and to identify ways in which the management and care of such patients presenting to public hospitals can be improved.

In reviewing the appropriateness of the management and care provided for the patient we have considered how she was triaged on presentation. The triage process is carried out to establish priority, based on the clinical urgency and safety of each individual patient. We have also considered the episode of care within the context of evolving changes in the management of such patients who present with threatened miscarriage.

We believe it is important to highlight the critical need for any woman (and her partner) experiencing miscarriage to be provided with privacy and treated with sensitivity and dignity during a time of great emotional distress and anguish. It is also important to provide the woman with adequate psycho-social support. As the events at RNSH on 25 September 2007 clearly show, when a patient with threatened miscarriage currently presents at a busy hospital ED after hours, it is sometimes difficult to ensure under the current model of care that she is provided with the necessary privacy and treated with the necessary dignity and sensitivity.

EXECUTIVE SUMMARY

This report examines the adequacy and appropriateness of the clinical management and care that was provided to a patient with a threatened miscarriage who presented to Royal North Shore Hospital (RNSH) Emergency Department on the evening of 25 September 2007 and who subsequently miscarried.

It reviews the current practices and protocols concerning the care and treatment of the many women who present to the NSW public health system with symptoms of threatened miscarriage. It also makes recommendations about changes considered necessary to improve the quality of clinical management of women in early pregnancy throughout NSW.

The objective in reviewing and reporting on these matters is to identify how the NSW public health system can apply the lessons learnt from the events that occurred at RNSH on 25 September to improve the model of care for the benefit of all such patients in NSW in the future. The report notes that when the patient presented at the RNSH Emergency Department (ED) she was entering a system of care that did not have specific system-wide policies and guidelines in place for the management and care of women in the early stages of pregnancy experiencing bleeding and/or pain. The review of the way in which the presentation was managed in the initial stages, including early assessment, found that it was undertaken appropriately and adequately by ED clinical staff, in compliance with current policies and procedures for the management and care of ED patients. It is also noted that within the prevailing model of care a patient's emotional needs are not considered under the Australian Triage Scale. It is recommended that the need for this emotional aspect of care be included in the ED protocols for the management and care of women with threatened miscarriage.

The inquiry did find that the patient was not clinically examined during a period of approximately one hour and twenty two minutes that elapsed after her vital signs had been taken. This delay was significantly longer than the accepted benchmark for Category 4 patients (1 hour). It has implications for the management and care of patients with threatened miscarriage in all NSW public health facilities and is addressed in the recommendations.

Apart from the requirement to develop and implement appropriate policies and guidelines for the management and care of patients with miscarriage or threatened miscarriage in NSW public health facilities, the inquiry team has identified a number of issues requiring attention relating to the physical environment of the RNSH ED specifically and perhaps EDs generally. These are addressed in the recommendations. We sincerely hope that by developing and implementing the state-wide policies and procedures recommended in this report the NSW public health system will in future provide women with a more satisfactory patient journey and experience than that provided to the patient who miscarried at the Royal North Shore Hospital on 25 September 2007.

TERMS OF REFERENCE ONE: THE PATIENT JOURNEY AND EXPERIENCE

To review and report on the adequacy and appropriateness of the clinical management and care of a patient with a threatened miscarriage who presented to Royal North Shore Hospital (the Hospital) Emergency Department on the evening of 25 September 2007 and who subsequently miscarried.

The information in this section of the report is based on a review of the contemporaneous records and interviews with relevant RNSH ED staff.

At 7.11pm on Tuesday 25 September 2007 a 32 year old woman presented at the Emergency Department (ED) of RNSH and advised the triage nurse that she had experienced vaginal discharge approximately one hour earlier and had mild pelvic pain. She indicated that she had with her the results of an ultrasound scan which had been performed that morning, following an episode of pelvic pain the previous day. The ultrasound scan report indicated an active intrauterine pregnancy of 14 weeks gestation. The nurse assessed the patient as Category 4 on the Australian Triage Scale (ATS) of clinical urgency and assessed her as suitable to be treated in the Emergency Treatment area of the ED, which is set aside for ambulatory patients with noncritical illness or injury. The patient was allocated to the Emergency Treatment waiting area, but remained in the main ED waiting room because there were no chairs available in the Emergency Treatment area. The triage nurse provided the patient with an 'Advice Sheet About Bleeding in Early Pregnancy'. (Appendix 1).

At 7.15pm a patient presenting with massive haemoptysis (coughing up blood) was brought into the ED by ambulance. In order to allow her to assess this critical patient, the triage nurse asked the Clinical Initiatives Nurse to take the vital signs of the early pregnancy patient.

At approximately 7.25pm the Clinical Initiatives Nurse reported to the triage nurse that the patient's vital signs were within normal limits and that she did not have a fever. Shortly after, the triage nurse handed over to another nurse, advising that the early pregnancy patient's vital signs were stable and that her condition was consistent with a threatened miscarriage.

At approximately 7.45pm the patient's partner approached the triage desk to express concern about how long she had been waiting. At approximately 8.45pm the patient's partner signalled to the triage nurse, who followed him into the toilet adjacent to the ED. She found the patient had miscarried in the cubicle and was holding the fetus. After attending to her immediate needs, the triage nurse transferred the patient with the fetus to consultation room 5 at approximately 8.55pm and advised the Nurse Unit Manager that the woman had miscarried. The patient was attended at this time and thereafter by ED nursing staff. The Nurse Unit Manager notified the ED Staff Specialist, who was attending to a Category 2 patient with head trauma in a resuscitation bay at the time. At approximately 9.15pm the Staff Specialist attended the patient who had miscarried and noted that she was haemodynamically stable. The Staff Specialist asked the Nurse Unit Manager to contact the Obstetrics & Gynaecology (O & G) Registrar, who advised he was performing a caesarean section. He advised that a Senior Resident Medical Officer (SRMO) would be sent to attend the patient.

At approximately 9.30pm the O & G SRMO arrived and examined the patient to ensure there was no need for any other intervention. After discussing the miscarriage and the proposed management plan with the patient the SRMO withdrew to another area to examine the fetus. He recommended to the patient that she remain overnight to be monitored and to have an ultrasound scan performed in the morning. After the necessary paperwork was completed, the patient was transferred to ward 10D at 11.45pm. This is a short-stay surgical ward for patients who require in-patient care for less than 24 hours.

At 7.15am the following day the patient was invited to see a social worker. She advised that she would. At 9.25am the O & G Registrar and SRMO attended the patient. The social worker was present. At 10.55am the patient was counselled by the social worker. A pelvic ultrasound scan was performed at 11.30am. The O & G Registrar later explained the scan result to the patient.

During the course of the morning the RNSH Patient Representative, the Acting General Manager and the Director of Nursing visited the patient.

In the afternoon, prior to her discharge from hospital, the Acting General Manager and a social worker spoke with the patient. Arrangements were made for a follow-up appointment with her GP in one week. An appointment was also made for her to attend the outpatient clinic on 11 October.

The patient was discharged from the hospital at 2.45pm.

ANALYSIS

Presentation

On 25 September 2007, when the patient presented at the of RNSH ED, she was entering a system of care that did not have specific system-wide policies and guidelines in place for the management and care of women who, in the early stages of pregnancy were experiencing bleeding and/or pain. Yet, as indicated earlier, problems associated with early pregnancy accounted for 11,254 presentations to NSW EDs in 2006-07, including 573 presentations to RNSH. These problems are associated with a range of clinical conditions, including ectopic pregnancy (8 per cent at RNSH), complications following abortion, spontaneous miscarriage and threatened miscarriage.

The ED records indicate that the patient was triaged within a matter of minutes by the triage nurse. During the process, the nurse read the ultrasound scan report, which indicated an active intrauterine pregnancy of 14 weeks gestation. This report enabled the triage nurse to discount the possibility of an ectopic pregnancy, a condition which can be dangerous and potentially lifethreatening for the patient. Identifying whether or not a patient is presenting with an ectopic pregnancy is one of the most critical tasks facing ED staff in assessing early pregnancy patients.
Such presentations are not uncommon. In 2006-07 there were 1025 presentations for ectopic pregnancy in NSW EDs, representing 9.1 per cent of all problems associated with early pregnancy.

The nurse assessed the patient as Category 4 on the ATS, which is the most common rating of clinical urgency for women presenting with problems in early pregnancy. The NSW Health data for 2006-07 show that 61 per cent of such patients presenting to EDs were either ATS Category 4 or 5 (74 per cent at RNSH). Given that the triage nurse had discounted the possibility of ectopic pregnancy the rating was appropriate. The patient was assessed as suitable for the Emergency Treatment waiting area, but had to remain in the main ED waiting room because there were no chairs available in the Emergency Treatment area. It must be noted that within the prevailing national model of emergency care a patient's emotional needs are not considered in the Australian Triage Scale. This scale correctly focuses on saving lives and assigning priority on the basis of patients' clinical needs. If a patient presenting with threatened miscarriage was given a higher triage rating, this could disadvantage patients in more urgent need of clinical care. It is important, nevertheless, that the need for this emotional aspect of care is included in the ED protocols for the management and care of women with threatened miscarriage. This point is relevant in considering the appropriateness of the current model of care, and will be addressed in a later section of this report. Based on her training and clinical experience, the triage nurse assessed that the patient was presenting with the signs of a threatened miscarriage. Accordingly, she provided the patient with a fact sheet entitled 'Advice Sheet About Bleeding in Early Pregnancy'. (Appendix 1) which contains information on bleeding in early pregnancy, threatened miscarriage and the normal procedures associated with presentations of this type.

At approximately 7.25pm the Clinical Initiatives Nurse took the patient's vital signs and reported to the triage nurse that they were within normal limits and that she did not have a fever. Shortly after, the triage nurse handed over to a colleague, advising the patient's vital signs were stable and her condition consistent with a threatened miscarriage.
Our review of the way in which the presentation was managed up to this point was that it was undertaken appropriately and adequately by ED clinical staff, in compliance with current policies and procedures for the management and care of ED patients.

Clinical Assessment

After she was triaged and had her vital signs taken (blood pressure, pulse and temperature) at approximately 7.23pm, the early pregnancy patient took a seat in the ED waiting room, directly in front of the triage desk. At approximately 7.45pm the patient's male partner approached the triage nurse to express concern about how long she had been waiting. An hour later, at approximately 8.45pm, he signalled to the triage nurse, who followed him into the ED toilet, where she found the patient had miscarried.

This chronology indicates that the patient was not clinically examined during a period of approximately one hour and twenty two minutes that elapsed after her vital signs had been taken until the miscarriage occurred. This delay was significantly longer than the accepted benchmark for all Category 4 patients (70% of Category 4 patients should be seen within 1 hour). It should be noted that this benchmark may not be appropriate for women with threatened miscarriage and should be reviewed in the development of policies and protocols for the clinical management and care of such patients in all NSW public health facilities.

It is also necessary to consider the broader context of the activity taking place in the ED at RNSH that night. The level of activity was extremely high. It could reasonably be described as a 'spike' of activity that pushed the capacity of the department to the limit. Over the course of the day 136 patients presented, including 20 triaged as Category 1 or 2.

At approximately 9.00pm all 26 available adult beds were in use (19 in the main area, three resuscitation and four consultation beds). Consultation room 4 (allocated for mental health patients), and consultation room 2 (eye and ENT patients), were not in use. They are allocated specifically for patients with these conditions. It should be noted that resuscitation 3 is a paediatric resuscitation room, which at the time, was being used for an adult patient. When all three resuscitation rooms are in use there is no capacity to care for a Category 1 patient arriving unexpectedly.

It should also be noted that according to hospital records there was a small shortfall of nursing staff in the ED on that evening. The evening shift requires 16 nurses in addition to the Nurse Unit Manager. A late notification of sick leave meant that there was one unfilled shift. The records show the following staff on duty (15 plus NUM):

1 – Nurse Unit Manager
1 – Clinical Nurse Specialist
2 – Registered Nurse Yr 8
1 – Registered Nurse Yr 6
1 – Registered Nurse Yr 5
1 – Registered Nurse Yr 4
4 – Registered Nurse Yr 3
1 – Registered Nurse Yr 2
1 – Registered Nurse Yr 1
2 – Enrolled Nurse Yr 5
1 – Endorsed Enrolled Nurse (I.V. Nurse)

At approximately 8.55pm, immediately following the miscarriage, the triage nurse transferred the patient and the fetus in a wheelchair to a consultation room. The response of ED clinical staff in the period immediately following the miscarriage was rapid and appropriate. The patient remained stable and able to be transferred to a hospital ward, requiring no significant medical intervention. The care and management of the patient beyond this point has been outlined in the factual account of the episode and, in our view, requires no further comment as it is considered adequate and appropriate.

The issue to focus on, therefore, is the time spent in the waiting room and the advice available to this patient. While there are signs recommending that if patients want to leave the waiting room they must inform the triage nurse, there is no specific mention of the toilets. Had the patient been made aware of the need to inform a nurse as soon as she felt the urge to go to the toilet, the nurse may have had the opportunity to find a more private location. As it was, the patient was unaware of the need to do this, and as a consequence was denied the privacy, and the attendant sensitivity and dignity, that a woman is entitled to receive at this time of emotional distress and anguish.

The 'Advice Sheet About Bleeding in Early Pregnancy' provided to the patient after triage does not advise a woman with threatened miscarriage should she need to go to the toilet. We will be addressing this matter in our recommendations regarding state-wide policies, practices and protocols.

TERMS OF REFERENCE TWO: CURRENT PRACTICES AND PROTOCOLS

To review current practices and protocols at Royal North Shore Hospital and other hospitals within the NSW public health system concerning the clinical management, care and treatment of patients presenting with miscarriages or threatened miscarriage.

While there are policies and procedures concerning the clinical management and care of patients presenting with miscarriages or threatened miscarriages in some NSW area health services and individual hospitals, there is currently no state-wide policy that applies across the NSW public health system. We are aware, however, that at the time the NSW Department of Health had begun working on policies in this area.

Relevant policies and procedures are in place in some area health services and facilities, including the following:

- Sydney South West Area Health Service
- North Coast Area Health Service
- Hunter New England Area Health Service
- Royal Hospital for Women
- Prince of Wales Hospital
- Royal Prince Alfred Hospital
- Westmead Hospital
- Nepean Hospital

These areas and individual facilities provide guidelines for the management and care of women who are less than 20 weeks pregnant and who are experiencing bleeding, pain or other problems related to their pregnancy. Royal Hospital for Women, for example, requires such patients who are in a stable condition to be referred to the hospital's Early Pregnancy Clinic and those requiring urgent attention to be referred to the Prince of Wales ED for assessment. The clinical policies and guidelines for patients with threatened miscarriage who present at the Prince of Wales ED state that '*Rapid assessment and definite management are desirable'* for these patients. A number of these hospitals provide an Early Pregnancy Assessment Service (EPAS) to co-ordinate assessment, scanning, diagnosis and management planning for women who experience pain and/or bleeding in early pregnancy. The EPAS also enables woman and their partners to access appropriate psycho-social support.

It is important to note that there were no specific policies and guidelines in place on the night of 25 September 2007 at the RNSH ED for patients presenting with miscarriage or threatened miscarriage. Clinical staff on duty in the ED were following broader system-wide policies and procedures relating to the triaging, management and care of patients presenting to EDs. Following the events of 25 September 2007, the RNSH ED has developed an interim procedure for the management and care of patients with complications of early pregnancy. This procedure involves one consultation room (room 6) being kept aside for the use of these patients to provide a bed with some privacy to be available at all times. The flowchart of the draft procedure is attached to this report. (Appendix 2). If such an arrangement had been in place on 25 September the patient would have been clinically assessed (examined) and the nature and stage of the pregnancy complication would have been assessed more rapidly. The patient would then have been managed with dignity and privacy.

Considering the policies and guidelines for patients with threatened miscarriage across the entire range of health care facilities, it is obvious that the same options will not be available in every facility. If such patients present at Royal Prince Alfred Hospital, for example, they are assessed to determine whether they are in a clinically stable condition. If stable, they are referred to the Early Pregnancy Assessment Service. If unstable, patients with threatened miscarriage are referred to the hospital's ED for appropriate management and care. Early pregnancy patients attending the hospital are supported by the Antenatal Shared Care Program, which is run by the hospital and the woman's GP. The aim of this program, which involves a network of appropriately accredited GPs, is to provide a high standard of care for women who have a low-risk pregnancy.

At the other end of the spectrum, if the same patient experienced complications in a rural or remote area, she would have limited services available for O & G other than a GP, nurse or midwife. The management and care provided by these practitioners may be entirely adequate and appropriate, depending on the nature of the presentation, but if the patient is in circulatory collapse or experiencing great pain, she requires access to an ED where she can be promptly

triaged and admitted for an emergency O & G procedure if necessary. To ensure that any woman experiencing complications in early pregnancy is provided with adequate and appropriate management and care it is recommended that system-wide policies and guidelines be developed for all public health facilities in NSW.

Additional information on these proposals, which would provide guidance for all clinical staff in the NSW public health system, is outlined in the report recommendations. These guidelines for staff attending patients with threatened miscarriage should include the following check-list:

- Have I adequately ensured the safety of this patient?
- Is the patient being treated with courtesy and respect while she is waiting for treatment?
- Does the patient understand the process for her care, the way in which the hospital will provide that care and how she can have any questions answered?
- Is there capacity for this patient to receive appropriate treatment in the event of any unexpected change in her condition or dramatic increase in ED workloads?

Of course, any guidelines will need to be adapted to the local situation and clinical need.

ED – Physical Environment

Apart from the requirement for appropriate policies and procedures for patients with miscarriage or threatened miscarriage at NSW public health facilities, the inquiry team has identified a number of issues requiring attention relating to the physical environment of RNSH ED specifically and EDs generally.

1. *The Waiting Room*

Waiting rooms have long been a source of irritation and occasional distress for patients who are ill and are seeking treatment. They are impersonal and often uncomfortable. The name itself is annoying when people who believe they are in an 'emergency' (rightly or wrongly) sit in rows of uncomfortable chairs. A reception area is much more friendly, welcoming and reassuring. The patient may perceive that they have already arrived at the hospital and are now in the system.

For the staff, however, even though the patients in the waiting room have been triaged and are in the system, they are not yet the primary focus of emergency care. With the advent of the Clinical Initiative Nurses, waiting rooms are now, in fact, pre-treatment areas where initial assessment and even some diagnostic steps can begin. However, the Clinical Initiative Nurses are still not considered essential in the waiting room. They are regularly called into the ED itself to add 'surge capacity' during busy times. It is during these very times that waiting delays become particularly long and when the condition of patients in the waiting room can change. It is more, rather than less important, therefore, for a Clinical Initiative Nurse to be in the waiting room at these busy times.

Clinical observation of patients in the waiting room is critically important. In the RNSH ED waiting room partitions are opaque in the lower half. This makes it difficult for the triage nurse to see all patients. Partitions should be transparent or removed, so that all patients in the reception area can be observed at all times.

2. *Security and Screens*

NSW Health has a policy of zero tolerance of violence.

Due to increasing numbers of assaults on staff in EDs, concerns related to OH&S have resulted in various forms of protective screens being installed between triage staff and patients. Provision of these protective measures for staff is to be commended, but it raises questions concerning the protection of patients in the waiting room.

NSW Department of Health policies, including the policy titled 'Protecting People and Property: NSW Health Policy Guidelines for Security Risk Management in Health Facilities', indicate:

a. a risk management approach should be implemented when determining the nature and level of access controls to be put in place.

b. building design should ensure, where possible, that waiting areas

- Are comfortable, decorated in muted colours and spacious
- Have a clear path to commonly used fittings and facilities (eg phones, water and
- snack dispensers, toilets etc)

- Have adequate signage, seating, ventilation and temperature control
- Have furnishings that cannot be moved and/or used as weapons
- Are well maintained (eg water and snack dispensers, lighting, phones are in working order and clean and tidy etc)

Furthermore, the Australian Health Facility Guidelines provide policies for screens, counters, partitions and other design strategies to control security risks. We believe that the application of these policies should be reviewed within the ED precinct at RNSH.

The policy directive titled 'Training Program – A Safer Place to Work: Preventing/Managing Violent Behaviour – NSW Health' mandates training for ED staff in at least two modules on dealing with aggression minimisation. This training will support the safety of patients, the Clinical Initiative Nurse and others in the waiting room.

3. *Staff refreshment areas*

It was noted during this inquiry that due to the high level of activity in the ED some staff members were taking late meal breaks and finishing their shifts late. The dedication of these staff members is to be commended.

It is recognised that staff members need to take refreshments and that these should be available close to the workplace. It is recommended that separate staff areas be provided close to the workplace, where staff members can have a meal or take a tea break.

4. *Public toilets*

Public toilets should be clean, in close proximity to the waiting room and have a call button for emergencies. They should be easily identified with simple signage.

ED – Communication

1. *Effective communication*

The core components of quality care of patients in an ED are:

- Safety
- Ease of access
- Efficiency
- Efficacy
- Appropriateness
- Consumer participation

Each of these components requires that attention be paid to effective communication. This is recognised in the hospitality industry, which places great store in the communication training of all staff as a pre-requisite of their employment and an essential component of customer focus.

The increasing emphasis on competence, performance and clinical outcomes in health has tended to distract staff, and indeed the health care system more generally, from the essentials of good communication. Traditionally, clinicians with good communication skills were perceived as having a 'good bedside manner'. As we have sought to improve our expertise in producing good outcomes, the focus on developing good communication skills is no longer viewed as a key priority. This needs to be re-focused, particularly as new models of care are developed and which may not be familiar to many patients.

All staff should have communication training before they embark on frontline positions and there should be regular updates on the skills that are so crucial in dealing with the critically ill, the urgent and the less critically ill patients who present to EDs. Patient safety is of paramount importance in the health care system, but as this episode demonstrates, the focus on patient safety should not overshadow the need for quality of care for each patient. Effective communication is an essential element in delivering quality of care.

2. *Signage and written advice for patients*

Signage in EDs is often confusing, poorly placed, uses professional language and may add to confusion rather than reduce it. The word triage, for example, is a 200 year old French military term. Clearly this is not the intent of the current system and the term should be abandoned for use with the public. Perhaps a better term for the triage desk is the Priority Desk. The NSW Department of Health should develop signage guidelines/templates in order to provide

uniform signage at all hospitals. Simple signage with plain language should be used wherever possible in EDs to avoid confusion. Language that may not be understood by some members of the public, such as 'Triage', should be abandoned in public areas.
It could be replaced by the term 'Priority', with instructions such as 'All patients must report to the Priority Desk on arrival for initial assessment'. Patients could then be directed to the administration officers where paperwork will be completed. This area should be referred to as 'Reception' rather than 'Admission Desk' to reduce the impression of a distant bureaucracy and to provide a more welcoming approach to patients who are our first responsibility.

When patients are given their priority category, they should also be given a leaflet indicating what that priority means and explaining why they may experience delays. The leaflet should also indicate the different pathways for different clinical groups, for instance paediatrics, mental health and sexual assault. There should be a clear sign in the ED saying that 'if your condition changes, you should notify the staff member at the Priority Desk immediately'.

A series of brochures outlining the steps that are likely to be encountered by patients with the 10 most common conditions could be prepared for distribution to patients presenting with those conditions. The *'Advice Sheet About Bleeding in Early Pregnancy',* for women presenting with threatened miscarriage, should include the advice: 'Let the nurse know immediately if you feel the urge to go to the toilet'.

It is pleasing to note that staff members in the ED at RNSH wear uniforms which clearly identify their role. These identifiers, however, are not known to visitors and patients attending for the first time. They require explanation in either the leaflet referred to previously or by wall signage. The explanation should be large enough for people with impaired vision to read.

The Role of the ED
It is clear that public perception of the ED is different from the way clinicians see it. Doctors and nurses see it as an area where emergency medicine is practised based on a carefully prescribed set of clinical priorities to ensure the safety of each patient. For many members of the public, however, the ED is the place to go when they cannot find any other medical assistance available.

The effect of this perception is that EDs become very busy places, particularly after hours, when many people present with relatively minor conditions that could be more appropriately managed in a GP clinic or other primary care facility. This situation is compounded by the number of chronically ill patients, who are generally older with complex health needs, who present to EDs. These patients cannot adequately be managed by GPs and require significant time and resources to be adequately managed and cared for in the ED. There is an urgent need for a public education program around this issue.

The design and layout of the RNSH ED reflects the different health needs of various patients. The Emergency Treatment area is provided to deal specifically with patients presenting with less critical conditions, thereby reducing the clinical load on the main ED. A paediatrics area is provided specifically for the treatment of children. The public perception of how this system operates, however, can be quite misleading. On the night of 25 September 2007 the male partner of the early pregnancy patient complained to staff that he had observed children with minor complaints such as coughs and colds being directed through to what he believed to be the main ED treatment area. In fact, they were being taken through to the designated and separate children's area. In the same way, patients being directed to the Emergency Treatment area with less critical health needs could be perceived as being given priority for treatment.

The patients or people accompanying them are not responsible for this incorrect perception. It results from a lack of information about how the triage system works and the different models of care that are provided for patients with different clinical needs. In the RNSH ED a sign below the triage nurse's desk lists the various triage categories and the relevant treatment pathways. It is expressed in clinical terms, however, and therefore does not address the patients' information needs. Providing patients and the people accompanying them with the leaflet suggested in the section headed *Signage and written advice for patients* would help to reduce this confusion.

Alternative Pathway for Early Pregnancy Patients

It is understood that NSW Health is currently considering alternative approaches to the management and care of chronically ill, older patients with complex health needs. This includes the development of Medical Assessment Units. The objective of this alternative approach is to provide these patients with the medical assessment and in-patient treatment they require, while at the same time reducing the clinical load they currently place on the ED.

A similar approach could be adopted to provide a more appropriate pathway for the management and care of patients with threatened miscarriage whose condition is stable. An area with privacy, facilities for examination and for a partner to be present would provide an ideal solution. This would not have to be part of the ED but should be close by and have access, on call as required, to staff with expertise in midwifery and O & G. Many early pregnancy patients, in fact, could be better managed by a midwife, in a GP clinic or other non-urgent outpatient facility, so long as they are adequately assessed and have ready access to an ED in the event of a rapid change in condition.

At RNSH ED the consultation area currently set aside for the management and care of sexual assault patients provides a possible solution. It is close to the ED and consists of three rooms, including an examination room. It is not in high demand for its current designated purpose.

Nevertheless, there is a possibility that it may be in use for other purposes when a patient with threatened miscarriage presents. That potential contingency will need to be managed at the time. The staffing issues associated with the use of this area would also need to be addressed, but could involve the cooperation of the gynaecology and obstetrics units as well as midwives, nurse practitioners and, of course, the ED itself.

Educational material on early pregnancy

It is clear that there is a significant lack of readily available educational material for women in the first trimester of pregnancy. Many women do not seek medical attention until they book in to an obstetrician at the end of the trimester. It is important, therefore, that a new approach to providing this educational material be implemented as quickly as possible. The main point of contact with women at the earliest stage of pregnancy is the pregnancy test kit.

We recommend that governments explore the possibility of gaining the commitment of manufacturers/distributors of these kits and pharmacists, to provide evidence-based information on early pregnancy, including miscarriage, as part of each kit. This should be a condition of supply.

A number of relevant help line services for women in early pregnancy have been identified, including those provided by Tresillian, Mothersafe, Bonnie Babes Foundation and Sids and Kids. Hospitals, including RNSH, also have dedicated volunteers, chaplains and established relationships with service organisations. It is recommended that EDs and Early Pregnancy Advisory Services develop linkages and memoranda of understanding with organisations providing relevant help line services that are willing to provide psycho-social support for women in early pregnancy and their partners.

The inquiry team has also noted that obstetricians in NSW have developed a voluntary advice line, the Pregnancy Advice Line (PAL), which enables any doctor managing a pregnancy to obtain expert pregnancy advice at any time. This model should be supported and promoted by local public health facilities, Area Health Services and the NSW Department of Health.

TERMS OF REFERENCE THREE: RECOMMENDATIONS

As a consequence of the above reviews, make recommendations concerning any action that should occur including referral to the Health Care Complaints Commission, changes considered appropriate to Hospital practices, policies or protocols or the development and implementation of state-wide policies, practices and protocols across the public health system.

Having reviewed the adequacy and appropriateness of the clinical management and care of a patient with threatened miscarriage who presented at Royal North Shore Hospital ED on the evening of 25 September who subsequently miscarried, and having reviewed current practices and protocols concerning the clinical management, care and treatment of such patients, wemake the following recommendations.

In relation to referral to the Health Care Complaints Commission it is recommended that:
1. No clinical staff members involved in the management and care of the early pregnancy patient at RNSH ED be referred to the Health Care Complaints Commission by the inquiry team.

In relation to the presentation of patients with miscarriage or threatened miscarriage it is recommended that:
2a. New system-wide models of care to be developed as a matter of urgency for all public health facilities in NSW concerning the management, care and treatment of patients presenting with miscarriages or threatened miscarriages. This process should include a review of the maximum waiting time under ATS categories for women with threatened miscarriage.

2b. Models of care for low risk pregnancy such as the Early Pregnancy Assessment Service(EPAS) should be developed in all Area Health Services. Relevant clinicians must be involved to individualise these guidelines to clinical need and local circumstances.

3. Patients presenting to a NSW public health facility with threatened miscarriage be provided with privacy and treated with sensitivity and dignity. They are also to be provided with timely and appropriate psycho-social support. It is important that the need for this emotional aspect of care is included in the ED protocols for the management and care of women with threatened miscarriage.

4. Patients presenting with an early pregnancy complication be examined as soon as possible to assess the nature of the complication, the stage it has reached and an appropriate ATS category.

5. Guidelines for staff attending patients with threatened miscarriage include the following checklist:

- Have I adequately ensured the safety of this patient?
- Is the patient being treated with courtesy and respect while she is waiting for treatment?
- Does the patient understand the process for her care, the way in which the hospital will provide that care and how she can have any questions answered?
- Is there capacity for this patient to receive appropriate treatment in the event of any unexpected change in her condition or dramatic increase in ED workloads?

6. Fact sheets provided for patients with threatened miscarriage include the following directive:
'Let the nurse know immediately if you feel the urge to go to the toilet'.

In relation to the presentation of patients with miscarriage or threatened miscarriage at Royal North Shore Hospital ED it is recommended that:

7. As an interim measure, consultation room 6 be considered as a private area for the management and care of patients with threatened miscarriage. The staffing issues associated with the use of this area for this purpose are to be addressed. A more permanent solution will need to be developed in consultation with the staff of the relevant units.

In relation to the role of Clinical Initiative Nurses in EDs it is recommended that:
8. Clinical Initiative Nurses be assigned primarily to the ED waiting room, particularly at busy

times, when waiting times can be particularly long. The practice of calling the Clinical Initiative Nurse into the ED itself to add surge capacity during busy times is to be reviewed and alternative staffing arrangements employed.

In relation to signage in EDs it is recommended that:
9. The NSW Department of Health develop signage guidelines/templates in order to provide uniform signage in all hospitals.

10. Simple signage with plain language be used wherever possible in EDs to avoid confusion. Language that may not be understood by some members of the public, such as 'Triage Desk', should be abandoned for public use. It could be replaced by the term 'Priority Desk'.

11. The term 'Reception' be used instead of 'Admission Desk' and 'Reception Area' instead of 'Waiting Room'.

12. Prominent signs be provided in the ED stating: 'If your condition changes you should notify the nurse immediately'.

In relation to communication with ED patients it is recommended that:
13. Public education programs be developed to address the perceptions of the public concerning the role of Emergency Departments for low risk and non-urgent presentations

14. Fact sheets be developed for patients presenting to EDs explaining what their ATS category means and why they may experience delays. The fact sheets are also to indicate the different pathways provided for different clinical groups.

15. Fact sheets for ED patients should help them identify the role of clinical staff members. This information could also be displayed on wall signage.

16. All staff members be provided with appropriate communication training before taking up frontline positions in the health system, such as the ED, to assist them in communicating effectively with patients and members of the public.

In relation to the security and physical environment of EDs it is recommended that:
17. The application of NSW Department of Health policies and Australian Health Facility Guidelines relating to security risks be reviewed within the ED precinct at RNSH.

18. A staff area be provided close to the ED workplace where staff members can have a meal or take a tea break.

19. Partitions in ED waiting rooms be transparent or removed so that all patients can be observed at all times.

20. Public toilets in EDs be clean, in close proximity to the waiting room and have a call button for emergencies.

In relation to the provision of educational material on early pregnancy it is recommended that:
21. Governments explore the possibility of gaining the commitment of manufacturers/distributors of early pregnancy kits and pharmacists to provide evidence-based information on early pregnancy, including miscarriage, as part of each kit. This should be a condition of supply.

22. EDs and Early Pregnancy Advisory Services develop linkages and memoranda of understanding with organisations providing help line services that are willing to provide psychosocial support for women in early pregnancy and their partners.

CONCLUSIONS

This inquiry has examined the adequacy and appropriateness of the clinical management and care that was provided to a patient with threatened miscarriage who presented to the ED at RNSH on the night of 25 September 2007.

We have noted that there were no specific policies and guidelines in place at the RNSH ED for patients presenting with miscarriage or threatened miscarriage on that evening. Clinical staff on duty in the ED were following broader, system-wide policies and procedures relating to the triaging, management and care of patients presenting to EDs.

We do know that this matter has been addressed by the ED staff at RNSH (Appendix 2). This has implications for the management and care of patients with threatened miscarriage in all NSW public health facilities. We therefore recommend that appropriate state-wide policies and procedures for the management and care of such patients be developed and implemented as a matter of urgency.

Such policies and procedures should ensure that when a patient with early pregnancy complications presents at a hospital she should be seen immediately by the clinical staff and then examined promptly to assess her condition. It has been shown that most early pregnancy patients can be safely managed with a more conservative approach. The patient should be advised that she is miscarrying, and be given the choice of either staying at the hospital for observation or going home to wait for nature to take its course. The risks of infection and bleeding should be explained. She should also be advised that there is usually no need for further medical intervention except for an examination to ensure that no pregnancy tissue is retained in the cervix or vagina following the miscarriage.

We note that an increasing number of women, aware that they are about to miscarry, choose to remain at home in a familiar environment with their partner or family members. Having noted this appropriately more conservative approach to medical intervention, we believe it is important to highlight the critical need for any woman (and her partner) experiencing miscarriage to be provided with privacy and treated with sensitivity and dignity during a time of great emotional distress and anguish. It is also important to provide her with adequate and appropriate psycho-social support.

The other matter that should not be overlooked in this report is the impact this incident and associated public controversy has had on the RNSH and its staff. Given the lack of relevant policies and procedures to guide them in the management and care of the early pregnancy patient, individual staff members in the hospital's ED cannot be held responsible for the inadequacies in the health care system that have been revealed as a result of this incident.

Emotional debate and controversy that impugns the professional integrity and reputation of clinical staff can all too easily turn into a self-fulfilling prophecy. This can, in turn, adversely influence public confidence in a hospital and the quality of its services. Despite the impact this incident has had on the morale of clinical staff working in a good hospital with a proud tradition of quality care they are committed to improving the quality of care and responding to the lessons learnt as a result of this event.

Our objective in reviewing and reporting on these matters is to identify how the entire NSW public health system can apply these lessons to improve the model of care for all such patients in the state.

We sincerely hope that by developing and implementing the state-wide policies and procedures recommended in this report that the NSW public health system will in future provide women with a more satisfactory patient journey and experience than that provided to the patient who miscarried at the Royal North Shore Hospital on 25 September 2007.

ACKNOWLEDGMENTS

The inquiry team gratefully acknowledges the input and assistance in conducting the inquiry and preparing this report of the following:

- Associate Professor Christopher Benness, Chair of the NSW State Committee of the Royal Australian & New Zealand College of Obstetricians & Gynaecologists
- Professor Katherine McGrath, Deputy Director-General, NSW Health
- Staff of the NSW Health Clinical Services Redesign Program
- Staff of the NSW Health Quality and Safety branch
- Staff of the Clinical Excellence Commission
- Clinical staff of the Royal North Shore Hospital
- NSW Midwives Association
- Bonnie Babes Foundation, NSW
- The College of Nursing (incorporating the New South Wales College of Nursing)

We also acknowledge the many individual physicians, obstetricians, midwives, nurses, social workers, health administration staff and other persons who so readily agreed to participate in this inquiry.

LIST OF ABBREVIATIONS

ATS - Australian Triage Scale
ED - Emergency Department
EFT - Equivalent Full Time
EPAS - Early Pregnancy Assessment Service
GP - General Practitioner
NUM – Nurse Unit Manager
O & G - Obstetrics & Gynaecology
OH & S – Occupational Health and Safety
RNSH – Royal North Shore Hospital
SRMO - Senior Resident Medical Officer

APPENDIX 1

Northern Sydney Health

ROYALNORTHSHOREHOSPITAL

ADVICE SHEET ABOUT BLEEDING IN EARLY PREGNANCY

Did you know that when a woman knows she is pregnant about one in seven (or 15%) of those pregnancies will end in miscarriage?

What is a threatened miscarriage?

A threatened miscarriage is the term used for pregnancies in which there is some early vaginal bleeding which occurs over several days or weeks. The amount of blood loss can vary greatly. If any bleeding occurs it is important to consult a doctor. A threatened miscarriage *may* result in a miscarriage, although, if the symptoms cease, the pregnancy may continue and the outcome is usually good.

What is a miscarriage?

A miscarriage is the spontaneous ending of pregnancy usually during the first three months. In most cases, there is some problem with the pregnancy. In some cases the baby has not developed at all, and there is just a small amount of tissue in the uterus. There are many reasons why pregnancies fail after the first three months, but we often don't know the cause.

In the vast majority of cases miscarriage occurs by chance and could have happened to anyone. Many women have at least one miscarriage during their reproductive life and go on to have normal pregnancies.

Why is my blood group checked?

We check your blood group because women with an Rh (Rhesus) Negative blood group can make antibodies against the cells from an Rh positive baby. These antibodies can have harmful effects in your next pregnancy. This can be prevented by giving you a special injection at the time of miscarriage.

Why do I need an ultra sound?

You will be asked to see your family doctor tomorrow to arrange an ultrasound, or return to the hospital (usually the next day) for an ultrasound. The ultrasound will help your family doctor or our Emergency staff give you advice about the status of your pregnancy.

• If you are returning to the hospital for your ultrasound, call the Ultrasound Department in the morning on 9926 8505 to book an appointment. Following your ultrasound, please come directly to the Emergency Department. Because we must, at all times, provide an emergency service you will go through the 'triage' system once again. This may seem difficult under the circumstances but we hope you understand that we are unable to make appointments.

• If you see your family doctor to arrange your ultrasound, information will be available in a similar time frame.

• Please decide your preferred approach in consultation with Emergency staff. And remember, both approaches are equally acceptable.

What is a curette?

A curette is an instrument shaped like a small spoon. It is used to remove blood clots and placental tissue from the uterus. A curette is performed in an operating theatre by specialist medical and nursing staff. You may experience some bleeding for a week after a curette has been performed.

Is anyone or anything to blame for my miscarriage?

People do not 'cause' a miscarriage. Whether you played tennis, went dancing, or had sexual intercourse, it is extremely unlikely that anything that you did caused or hastened your miscarriage.

Likewise, there is nothing that you could have done to prevent it happening. Pap smears or internal examinations do not cause miscarriages.

When can I try to get pregnant again?

No one is sure whether it is better to try straight away, or to wait until you have a normal period. Whichever you choose, the chances are good that everything will be normal.

After one miscarriage, the risk of miscarriage in future pregnancies is about 20%. If you have three miscarriages in a row, we suggest you see your doctor as tests to identify a cause may be useful. However most often these tests do not find a problem. It's important to remember that even if you have three miscarriages in a row, you still have up to a 75% chance you will carry your next pregnancy to full term.

How will I cope with a miscarriage emotionally?

Whether a pregnancy fails at the end or at the beginning woman often feel a great sense of loss, disappointment and sometimes even anger. These feelings may last for months or even longer. It's important to allow yourself to grieve and give yourself time to get over your loss.

Can I get more information?

The hospital can provide you and your family with support and information. Your nurse or doctor will help.

What support services are available for families who experience a miscarriage?

SIDS and Kids NSW Counselling support and information
1800 651 186
Your local GP Information and medical advice
Social Work Department Counselling and resources 9926 7580
Chaplains & Ministers
Offer spiritual comfort and rituals
Bonnie Babes Foundation 03 9758 2800

APPENDIX 2

DRAFT PROCEDURE FOR PRESENTATION OF PATIENTS WITH COMPLICATIONS OF EARLY PREGNANCY

RNSH EMERGENCY DEPARTMENT

Patient with PV bleeding and / or pelvic pain likely related to early pregnancy presents to triage

Triage using normal ATS guidelines.

Provide patients with 'Advice Sheet for Early Pregnancy Bleeding'

Suitable for ET if:
- ambulatory
- TC 4 or 5
- 1st Trimester
- minimal PV bleeding
- nil or minimal pain

Suspect ectopic pregnancy or cervical shock if abnormal vital signs (eg tachycardia or bradycardia, hypotension) or looks unwell. Ensure senior doctor / NUM aware and arrange immediate bed in resus / main

If normal vital signs but not suitable for ET, patient should go into **Consult Room 6** to ensure ET Doctor to assess patient

Inform O&G Registrar to review patient

Organise pelvic U/S as inpatient or outpatient as required

Triage nurse to inform O&G Registrar that patient is in ED

ED Doctor to assess patient

TC 2 Doctor or Resus Registrar to assess and treat patient
- inform O&G Registrar to Organise U/S with Radiology as required

Notes
- Consult Room 6 is to only be used for the treatment of patients with early pregnancy complications for the duration of this guideline
- Vaginal examination in a patient with early pregnancy bleeding is not always required and has a poor predictive value compared to ultrasound
- Vaginal examination should be performed where ectopic pregnancy is suspected or where there may be products of conception in the cervical os which need to be removed.
- Vaginal examination must be performed with a chaperone present

Robert Day - ED Director

Draft for review November 2007

Appendix 6 Emergency Department comparisons

The following tables were provided by NSW Health in its submission to the inquiry (Submission 33).

Table 1: Performance of 10 highest volume NSW hospital EDs against triage benchmark times.

Hospital	**Triage category**				
	Triage 1 *Immediately life threatening* % treated in 2 minutes	Triage 2 *Imminently life threatening* % treated in 10 minutes	Triage 3 *Potentially life threatening* % treated in 30 minutes	Triage 4 *Potentially serious* % treated in 60 minutes	Triage 5 *Less urgent* % treated in 120 minutes
John Hunter	100	95	79	80	90
Liverpool	100	80	64	70	91
Royal North Shore	**100**	**81**	**60**	**65**	**87**
Royal Prince Alfred	100	89	70	73	85
St George	100	86	66	75	91
Westmead	100	90	58	58	75
Gosford	100	71	60	63	84
Penrith-Nepean	100	78	50	62	85
Wollongong	100	88	66	67	83
Children's Hospital (Westmead)	100	100	68	62	79

Submission 33, NSW Health, p 32

Table 2: Senior medical specialist staff and treatment spaces in 10 NSW hospitals with greatest volume of ED presentations

Hospital	Attendances 06/07	Emergency Specialist FTE	No. of ED beds/treatment spaces	EMU beds
John Hunter	58,117	8.75	35	16
Liverpool	57,211	10.125	40	10
Royal Prince Alfred	54,962	8	32	8
St George	53,707	10	24	12
Penrith-Nepean	50,994	11.4	34	16
Royal North Shore	**49,900**	**10.55**	**32**	**5**
Westmead	49,779	10	35	7
Children's Hospital (Westmead)	48,03	6.3	24	0
Gosford	48,581	7.8	26	0
Wollongong	47,782	8.35	32	0

Submission 33, NSW Health, p 29

Appendix 7 Minutes

Minutes No 1
Wednesday 24 October 2007
Joint Select Committee on the Royal North Shore Hospital
At Room 1136, Parliament House, at 1:06 pm

1. Chairman opened meeting

The Chairman of the Committee declared the meeting open at 1.06pm.

The Clerk of the Committee tabled the resolutions establishing the Committee, and confirmed the membership of the Committee.

The Clerk of the Committee advised the Committee that the Legislative Council Standing Orders would apply for the duration of the Committee's existence.

2. Members Present
Revd Fred Nile (Chairman)
Ms Amanda Fazio
Mr Michael Daley
Dr Andrew McDonald
Mr Peter Draper
Mrs Jillian Skinner
Miss Jenny Gardiner
Ms Carmel Tebbutt

3. Election of Deputy Chair

The Chairman called for nominations for Deputy Chair

Mr Daley moved: That Mr Draper be elected Deputy Chair of the Committee.

Miss Gardiner moved: That Ms Skinner be elected Deputy Chair of the Committee.

The Chairman informed the Committee that there being two nominations, a ballot would be held.

The Chairman announced the result of the ballot as follows:

Mr Draper – 6 votes
Ms Skinner – 2 votes

Mr Draper, having a majority of the members present and voting, was therefore declared elected Deputy Chair of the Committee.

4. Correspondence

The Committee noted the following correspondence:

Received

- Memo to Committee members from Rev Hon Fred Nile regarding the possibility of holding a site visit/hearings in North Sydney (17 October 2007)
- Memo to Committee members from Rev Hon Fred Nile regarding possible hearing dates (23 October 2007)

5. Procedural Resolutions

Resolved, on the motion of Ms Fazio: That the following initial resolutions be adopted for the life of the Committee:

Sound and television broadcasting of public proceedings
That the Committee authorises the sound and television broadcasting of its public proceedings, in accordance with the resolution of the Legislative Council of 18 October 2007.

Publishing transcripts of evidence
That the Secretariat be empowered to publish transcripts of evidence taken at public hearings, in accordance with section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and under the authority of standing orders 223 and 224.

Media statements
That media statements on behalf of the Committee be made only by the Chair.

Inviting witnesses
That arrangements for inviting witnesses be left in the hands of the Chair and the secretariat after consultation with the Committee.

Ms Skinner advised the Committee that during the Inquiry she would be making comments relating to the Royal North Shore Hospital in her capacity as Shadow Minister for Health and not in her capacity as a Member of the Committee.

6. Conduct of the Inquiry

Advertising
The Committee considered the proposed advertising schedule for the call for submissions.

Resolved, on the motion of Mr Daley: That advertisements calling for submissions be placed in:

- The Daily Telegraph
- The Sydney Morning Herald
- The North Shore Times
- The Mosman Daily
- The Manly Daily
- The Hornsby and Upper North Shore Advocate
- The Central Coast Express Advocate.

Letters to Inquiry participants
Resolved, on the motion of Mr Daley: That the Chairman write to potential Inquiry participants inviting submissions, with lists of potential Inquiry participants provided by Members to the secretariat by **5:00pm Friday 26 October 2007.**

Witnesses
Resolved, on the motion of Ms Fazio: That the Committee invite representatives of NSW Health, the Royal North Shore Hospital, the North Sydney/Central Coast Area Health Service, the Clinical Excellence Commission, the Australian Medical Association (NSW), and the Nurses' Association to give evidence at the Committee's first public hearing.

Resolved, on the motion of Ms Fazio: That, at a meeting to be held at 1.30pm on Thursday 25 October 2007 in Room 1136, the Committee:

- finalise the individual witnesses to be invited to the first public hearing; and
- consider proposed witnesses for subsequent hearings, with Members to nominate proposed witnesses for all hearings to the secretariat by **10:00am Thursday 25 October 2007.**

The Chairman indicated that additional witnesses for subsequent hearings could be nominated as the Inquiry progresses.

Resolved, on the motion of Mr Daley: That the Committee briefly adjourn to allow filming by the media.

The media were admitted.

The media withdrew.

The deliberative resumed.

Hearings
Resolved, on the motion of Mr Draper: That the Committee conduct a site visit to the Royal North Shore Hospital from 2:30pm to 4:00pm on 5 November 2007, including a guided tour of the Emergency Department, treatment rooms and other relevant facilities conducted by a senior RNSH official.

Resolved, on the motion of Mr Daley: That the Committee adopt the Inquiry schedule proposed by the Chairman, subject to the Committee's consideration of an extension to the final reporting date, with public hearings on the following dates: Monday 12 November 2007, Friday 16 November 2007 and Thursday 22 November 2007, and a closing date for submissions of 12 November 2007.

Mrs Skinner indicated that she would need to check her availability on the hearing dates proposed by the Chairman.

The Chairman indicated that consideration would be given to accepting submissions lodged after the closing date.

7. Adjournment
The committee adjourned at 1:53 pm until 1:30 pm on Thursday 25 October 2007 in Room 1136, Parliament House.

Beverly Duffy
Clerk to the Committee

Minutes No 2
Thursday 25 October 2007
Joint Select Committee on the Royal North Shore Hospital
At Room 1136, Parliament House, at 1:35 pm

1. Members Present
Revd Fred Nile (Chairman)
Mr Peter Draper (Deputy Chair)
Ms Amanda Fazio
Mr Michael Daley
Dr Andrew McDonald
Mrs Jillian Skinner
Miss Jenny Gardiner
Ms Carmel Tebbutt

2. Confirmation of Minutes

Resolved, on the motion of Mr Draper: That Minutes No. 1 be confirmed.

3. Conduct of the Inquiry

Proposed hearing witnesses and schedule

The Committee considered the proposed witnesses and schedule of hearings for the Inquiry.

Resolved, on the motion of Ms Fazio: That at the first hearing on 12 November 2007 the following witnesses be invited to attend, appearing in chronological order as listed below:

NSW Health senior management, and Minister for Health

- Hon Reba Meagher MP, Minister for Health
- Professor Debora Picone AM, Director General
- Dr Richard Matthews, Deputy Director General, Strategic Management
- Mr Ken Barker, Chief Financial Officer

North Sydney Central Coast Area Health Service senior management

- Matthew Daley, Chief Executive Officer
- Julie Hartley-Jones, Director of Clinical Operations
- Professor Carol Pollock, Chair NSCCAHS Advisory Council
- Jenny Becker, Assistant to Director of Clinical Operations
- Director of Finance
- Management Accounting

Royal North Shore Hospital senior management

- Mary Bonner, General Manager
- Mary Dowling, Chair, Professional Practice Unit
- Chief Financial Officer

Clinical Excellence Commission

- Professor Bruce Barraclough, Chairman
- Professor Clifford Hughes, Chief Executive Officer

Representatives of professional associations

- Brett Holmes, General Secretary of the NSW Nurses' Association
- Emma Smith, NSW Nurses' Association delegate - RNSH
- Dr Andrew Keegan, President, Australian Medical Association
- Dr Sally McCarthy, Vice President of the Australasian College for Emergency Medicine
- Representative, Australian Salaried Medical Officers Federation (NSW)

Former staff of organisations above

- Philipa Blakey, former Director of Clinical Operations, NSCCAHS
- Terry Clout, former Chief Executive Officer, NSCCAHS
- Stephen Christley, former Chief Executive, NSCCAHS
- Deborah Latta, former general manager, RNSH

Resolved, on the motion of Ms Fazio: That at the second hearing on 16 November 2007 the following witnesses be invited to attend:

Clinicians of the Royal North Shore Hospital

- Dr Charles Fisher, Chair of the Medical Staff Council, RNSH
- Dr Tony Joseph, senior emergency physician
- Associate Professor Bill Sears, neurosurgeon
- Dr Malcolm Fisher, Director of Intensive Care
- Dr Greg Fulcher, Chair of RNSH Medical Staff Council, Director, Department of Diabetes, Endocrinology and Metabolism
- Dr Stephen Hunyor, Director, Cardiac Technology Centre
- Head, Department of Cardiology
- Dr Danny Stiel, Clinical Head, Division of Medicine
- Dr Ross Wilson, Quality Management, former Director of Intensive Care

Patients of the Royal North Shore Hospital and relatives of patients

- Mr Mark Dreyer and Ms Jana Horska
- Sharon Hooper, granddaughter of Edith King
- Christine Rijks, daughter of Phil Linsday

- Wendy Gao
- Dr Peter Golding
- Ms Tonia de Launay
- Leng Liu
- Cathy Wastell
- Jenny Langmaid
- Therese Mackay

Resolved, on the motion of Ms Tebutt: That patients of the Royal North Shore Hospital (and their relatives) appear in the first half of the hearing, and that clinicians from the Royal North Shore Hospital appear in the second half of the hearing.

Resolved on the motion of Mr Daley: That priority be given to hearing from recent patients of the RNSH.

Resolved, on the motion of Ms Fazio: That at the third hearing on 22 November 2007 witnesses from the following groups and two named witnesses be invited to attend, with the witness list to be finalised at a later meeting of the Committee:

- Nurses of the Royal North Shore Hospital
- Academics
- Clinicians from hospitals other than the Royal North Shore Hospital
- Ms Judith Meppem
- Mr Vern Dalton

Resolved, on the motion of Mr Daley: That the schedule for hearings on 12, 16 and 22 November have an extended finishing time of 5:00pm.

Resolved, on the motion of Mr Daley: That dates for possible additional hearings on 26 November 2007 (2-5pm), 30 November 2007 and 3 December 2007 be reserved.

Correspondence

The Clerk to the Committee tabled the following correspondence:

Received

- Letter from Melanie Palmer, McLaughlin and Riordan, solicitors for the Anderson family, regarding the making a written submission to the Inquiry (25 October 2007)

Resolved, on the motion of Mr Daley: That the Chairman write in response to the correspondence received from Ms Palmer and invite the written submission of the Anderson family.

Site Visit to the Royal North Shore Hospital

The Clerk tabled a draft itinerary for the Committee's forthcoming visit to RNSH.

The Chairman informed the Committee that any suggested changes to the itinerary should be communicated to the secretariat.

Timeline for the Inquiry

Resolved, on the motion of Ms Fazio: That the Chairman be authorised to release the Inquiry timeline, including hearing dates, reserve hearing dates and the closing date for submissions.

4. Adjournment

The committee adjourned at 2.20 pm until 2.30 pm on Monday 5 November 2007 at the Royal North Shore Hospital.

Beverly Duffy
Clerk to the Committee

Minutes No 3
Monday 5 November 2007
Joint Select Committee on the Royal North Shore Hospital
At Royal North Shore Hospital, at 2:30 pm

1. Members Present

Revd Fred Nile (Chairman)
Mr Peter Draper (Deputy Chair)
Ms Amanda Fazio
Mr Michael Daley
Dr Andrew McDonald
Mrs Jillian Skinner
Miss Jenny Gardiner
Ms Carmel Tebbutt

2. Site visit to the Royal North Shore Hospital

The Committee attended the Royal North Shore Hospital and was met by the following:

- Mr Matthew Daly, Chief Executive, Northern Sydney Central Coast Area Health Service
- Prof. Carol Pollock, Chairperson, Area Health Advisory Council
- Ms Mary Bonner, General Manager, North Shore Ryde Health Service
- Ms Linda Davidson, Acting Director of Nursing and Midwifery, Royal North Shore Hospital
- Dr Daniel Stiel, Clinical Director, Aged Care and Medical Services, NSRHS

The Committee was taken on a tour of the Royal North Shore Hospital and met staff of the hospital. Specific areas visited included:

- The Emergency Department, where the Committee met members of staff including Dr Robert Day; Michelle Beets, Nurse Unit Manager; and Dr David Betty.
- The Severe Burns Injury Unit, including an Isolation Unit, where the Committee met members of staff including Dr John Vandervord, Clinical Director Surgery and Anaesthesia; and Dianne Elfleet, Nurse Unit Manager.
- The Intensive Care Unit, where the Committee met members of staff including Dr Ray Raper, Head of ICU; and Megan Inglis, Nurse Unit Manager.
- Ward 9A (Orthopaedics), where the Committee met members of staff including Robyn Stapley, Nurse Unit Manager, and Paula McCloud, Nurse Educator.
- A treatment room in Ward 10B.

At the conclusion of the tour of inspection, the Committee met with members of the North Sydney Central Coast Area Health Service and Royal North Shore Hospital executive, including:

- Dr Malcolm Fisher
- Dr Charles Fisher
- Dr Danny Stiel
- Dr Kate Storey
- Ms Joanne Prendergast
- Dr Michael Nichol
- Dr Greg Noble

- Dr Tom Hugh
- Dr Stephen Winger
- Dr Michael Nicol
- Ms Julie Hartley-Jones
- Dr Stephen Hunyor
- Dr Steven Blome

3. Adjournment

The committee adjourned at 4:35 pm until 9.30 am on Monday 12 November 2007, Jubilee Room, Parliament House.

Beverly Duffy
Clerk to the Committee

Minutes No 4
Monday 12 November 2007
Joint Select Committee on the Royal North Shore Hospital
At Jubilee Room, Parliament House, at 9:05am

1. Members Present

Revd Fred Nile (Chairman)
Mr Peter Draper (Deputy Chair)
Ms Amanda Fazio
Mr Michael Daley
Dr Andrew McDonald
Mrs Jillian Skinner
Miss Jenny Gardiner
Ms Carmel Tebbutt

2. Confirmation of Minutes

Resolved, on the motion of Ms Fazio: That Minutes No. 2 and 3 be confirmed.

3. Conduct of the Inquiry

Submissions

The Clerk tabled two submissions received from the NSW Nurses' Association (No 29) and Professor Hunyor (No 30).

Resolved, on the motion Ms Fazio: That according to section 4 of the *Parliamentary Papers* (Supplementary Provisions) Act 1975 and Standing Order 223(1), the Committee authorise the publication of Submissions No. 1, 3-5, 7 -11, 13-15, 18-22, 25-30.

Resolved, on the motion of Ms Fazio: That Submissions No. 2, 6, 16, 17, 23, and 24 be kept confidential, Submission No. 12 be kept partly confidential by the removal of medical details, Submission No. 14 be kept partly confidential by the removal of the names of hospital personnel, and Submission No. 31 be kept partly confidential by removal of details that might identify the authors.

Witness schedule 16 and 22 November

The Committee considered the proposed witness schedules for 16 and 22 November.

Resolved, on the motion of Dr McDonald: That the second hearing schedule for 16 November 2007 be adopted.

Resolved, on the motion of Dr McDonald: That members provide names of witnesses for the third hearing on 22 November 2007 to the secretariat by 5pm Tuesday 13 November, for consideration at a meeting to be held at 6.30pm, Wednesday 14 November in the Legislative Council Member's Lounge.

Correspondence

The Committee noted the following correspondence:

Received:

- Email from Mike [no surname provided] to Chairman regarding Inquiry process (18 October 2007)
- Email from Ms Pauline Mitchell to Chairman regarding inadequate medical services at Royal Prince Alfred Hospital (20 October 2007)
- Email from Dr Charles McCusker to Committee offering to provide verbal evidence (6 November)
- Letter from Ms Dominique Egan, TressCox Lawyers, to Director, regarding legal representation for witnesses at hearings on 12 and 16 November (9 November 2007)

Sent:

- Letter from Chairman to Minister for Health, Hon Reba Meagher MP, inviting the Minister to give evidence and notifying the Minister of NSW Health staff invited to give evidence (31 October 2007)

Resolved, on the motion of Ms Gardiner: That the Chairman, on behalf of the Committee, write to the Minister for Health requesting that the following documents be provided to the Committee:

- Royal North Shore Hospital Quality and Risk Management Plan or Risk Register (2004)
- Best Practice Australia report – Climate Survey Report Royal North Shore Hospital (2004)
- Occupational Health and Safety Committee minutes (Royal North Shore Hospital)
- Report on Quality Systems by Duncan Stewart (August 2003).

Resolved, on the motion of Ms Fazio: That the timing of questioning for the hearing be as follows: 10 minutes for Opposition members, 10 minutes for Government members and 10 minutes for Cross-bench members.

4. Public Hearing

Witnesses, the public and media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was examined under former oath:

- Hon Reba Meagher MP, Minister for Health.

The following witnesses were sworn and examined:

- Professor Debora Picone AM, Director General, NSW Health
- Dr Richard Matthews, Deputy Director General, Strategic Management, NSW Health
- Mr Ken Barker, Chief Financial Officer, NSW Health.

The evidence concluded and the witnesses withdrew.

Resolved, on the motion of Ms Fazio: That Submission No. 32 from the Australian Medical Association/Australian Salaried Medical Officers Federation and Submission No. 33 from NSW Health, be published.

The following witnesses were sworn and examined:

- Mr Matthew Daly, Chief Executive, North Sydney Central Coast Area Health Service (NSCCAHS)
- Ms Julie Hartley-Jones, Acting Director, Clinical Operations, NSCCAHS
- Professor Carol Pollock, Chairperson, Area Health Advisory Council, NSCCAHS

- Ms Jenny Becker, Director, Workforce Development, NSCCAHS
- Mr Rob Wright, Acting Chief Financial Officer, NSCCAHS
- Mr Neville Onley, Acting Director of Finance, NSCCAHS
- Ms Mary Dowling, Manager, Professional Practice Unit, NSCCAHS

The evidence concluded and the witnesses withdrew.

The Committee took a short break for morning tea.

The following witnesses were sworn and examined:
- Ms Mary Bonner, General Manager, NSRHS
- Mr Colin Murray, Acting Manager, Decision Support Unit, RNSH
- Ms Linda Davidson, Acting Director of Nursing, RNSH

The evidence concluded and the witnesses withdrew.

Dr McDonald informed the Committee that he was a current member of ASMOF.

The following witnesses were sworn and examined:
- Dr Andrew Keegan, NSW President, Australian Medical Association
- Dr Antony Sara, President, Australian Salaried Medical Officers Federation (ASMOF)
- Mr Sim Mead, Executive Director, ASMOF

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Mr Brett Holmes, General Secretary, NSW Nurses' Association
- Ms Alison Mayhew, Former Branch President, NSW Nurses' Association

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:
- Dr Sally McCarthy, Vice President, Australian College for Emergency Medicine

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:
- Mr Terry Clout, Former Acting Chief Executive Officer, NSCCAHS

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:
- Dr Stephen Christley, Former Chief Executive, NSCCAHS
- Ms Phillipa Blakely, Former Director of Clinical Operations, NSCCAHS

Dr Christley tabled his submission to the inquiry.
Resolved, on the motion of Ms Fazio: That the Committee publish Dr Christley's submission.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:
- Professor Cliff Hughes, Chief Executive Officer, Clinical Excellence Commission (CEC)
- Professor Bruce Barraclough AO, Chairman, CEC

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 5.30pm. The public and the media withdrew

Mrs Skinner tabled three documents pertaining to NSCCAHS.

5. Adjournment

The committee adjourned at 5.33pm until 6.30 pm on Wednesday 14 November 2007 in the Member's Lounge of the Legislative Council.

Beverly Duffy
Clerk to the Committee

Minutes No 5
Wednesday 14 November 2007
Joint Select Committee on the Royal North Shore Hospital
At Legislative Council Member's Lounge, Parliament House, at 6:30 pm

1. Members Present

Revd Fred Nile (*Chairman*)
Ms Amanda Fazio
Mr Michael Daley
Dr Andrew McDonald
Mr Peter Draper (*Deputy Chair*)
Mrs Jillian Skinner
Miss Jenny Gardiner
Ms Carmel Tebbutt

2. Previous Minutes

The Clerk to the Committee advised of an amendment to draft minutes no 4 regarding the submissions made public.

The Committee previously resolved to request several documents from NSW Health, including 'Occupational Health and Safety Committee minutes'. Miss Gardiner asked the Secretariat to advise NSW Health that the Committee requires these minutes for the period 2003-2007.

Resolved, on the motion of Ms Tebbutt: That draft Minutes No. 4, as amended, be confirmed.

3. Correspondence

The Committee noted the following items of correspondence received:

- Email from Mr Bruce McNamara to North Sydney Central Coast Area Health Service (copied to Committee) offering support and congratulations to the Royal North Shore Hospital (13 November 2007)
- Letter from Professor David Sonnabend, Chairman, Department of Orthopaedic and Traumatic Surgery, Royal North Shore Hospital, to Chairman raising issues associated with the operation of the Royal North Shore Hospital and offering to appear before the Committee (13 November 2007)

Resolved, on the motion of Ms Tebbutt: That according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act* 1975, the Committee authorise the publication of the correspondence from Professor Sonnabend and that his correspondence be considered to be a submission to the Inquiry.

The Committee noted the following items of correspondence sent:

- Letter to the Minister for Health, the Hon Reba Meagher, from the Chair, requesting access to certain documents concerning RNSH (12 November 2007)

4. Submissions

Resolved, on the motion of Ms Fazio: That, according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and Standing Order 223(1), the Committee authorise the publication of Submissions No. 34, 36, 38, 40, 43-49 (and submission 50 from Professor Sonnabend).

Resolved, on the motion of Ms Fazio: That Submission No. 39 be published but with the attachments kept confidential, and that Submissions No. 35, 41 and 42 be kept fully confidential.

5. Transcript correction, Hearing 12 November 2007

Resolved, on the motion of Ms Fazio: That a footnote be added to p4 of the published transcript of the Minister Meagher's evidence to the Committee on 12 November 2007, noting that the budget increase referred to by the Minister relates to the NSCCAHS, rather than to the RNSH..

6. Proposed Witness Schedule Thursday 22 November 2007

The Committee noted the proposed witness lists submitted by Ms Fazio and Ms Skinner.

The Committee deliberated.

Resolved, on the motion of Ms Fazio: That the hearing on 22 November be scheduled from 9:00 am until 6:00 pm, with a deliberative from 8:30 am until 9:00 am.

Resolved, on the motion of Ms Fazio: That the two nurses who have provided submissions, and any other former or current Royal North Shore Hospital nurses who subsequently provide submissions, be invited to appear between 9:00 and 10:30 am, and that they be permitted to appear in camera if this is requested.

Ms Skinner tabled a copy of the letter from Dr Sue Ieraci, which had been previously published in the *Sydney Morning Herald* on 14 November 2007.

Resolved, on the motion of Dr MacDonald: That Dr Ieraci be invited to appear at the hearing on 16 November 2007 together with Dr Day and Dr Joseph, or on the 22nd, if she is not available to attend on the 16th.

Resolved, on the motion of Ms Fazio: That Ms Kerry Russel be invited to appear for 30 minutes after 11:00 am and that Dr Patrick Gregan, Dr Denis King and Dr Adam Chan be invited to appear as a panel prior to the lunch break on 22 November 2007.

Mr Draper left the meeting.

Resolved, on the motion of Ms Fazio, that the following witnesses proposed by Ms Skinner be invited to appear at the hearing on 22 November between 2.15 pm and 6:00 pm:

- Dr Christopher Arthur
- Dr Greg Briggs
- Professor Leslie Burnett
- Dr Tom Hughes
- Dr John Vandervord
- Dr Philip Hoyle

- Dr Peter Roberts
- Dr Paul Cunningham

- Dr Jeffrey Sleye Hughes

- Professor David Sonnabend
- Dr Claire Skinner
- Dr Jennifer Donnovon

- Ms Anne Osborne
- Ms Lindy Batterham
- Mr Warren Anderson

The Chairman indicated that the secretariat should request Ms Batterham and Mr Anderson consult with their legal advisors before accepting an invitation.

Mrs Skinner moved: That the Committee hold a hearing on 26 November 2007, to which the following witnesses be invited:

- The Minister for Health Ms Reba Meagher
- Hospital and Area Health Authority witnesses previously appearing on 12 November
- Professor Kerry Goulston
- Dr Cameron Bell
- Professor Leslie Burnett
- Professor Michael Cousins
- Dr Michael Nicholl
- Dr Garrett Smith
- Ms Joanne Prendergast
- All staff who have submitted grievances that have not been dealt with

Question put.

The Committee divided.

Ayes: Revd Nile, Mrs Skinner, Miss Gardiner
Noes: Mr Daley, Ms Fazio, Dr MacDonald, Ms Tebbutt

Question resolved in the negative.

Mrs Skinner left the meeting.

7. Consideration of request for in camera evidence

Resolved, on the motion of Mr Daley: That the Committee agree to hear part or all of Ms Deborah Latta's evidence in camera.

8. Referral of individual complaints

Ms Fazio advised the committee that she would send to the secretariat a list of submission authors whose submissions document an individual health care complaint. As per the inquiry terms of reference, the secretariat will advise these authors about the possibility of making a complaint to the Health Care Complaints Commission.

Dr MacDonald left the meeting.

9. Inquiry timeline

Resolved, on the motion of Mr Daley: That the following timeline be adopted:

Thur 6 Dec - Report to Chair
Fri 7 Dec - Report to Committee
Wed 12 Dec - Deliberative
Fri 14 Dec - Table report

The Chairman requested the secretariat circulate the proposed timeline to all committee members.

10. Adjournment

The committee adjourned at 7:40 pm until 8:30 am on Friday 16 November 2007 in the Jubilee Room, Parliament House.

Beverly Duffy
Clerk to the Committee

Minutes No 6
Friday 16 November 2007
Joint Select Committee on the Royal North Shore Hospital
At Jubilee Room, Parliament House, at 8.30am

1. Members Present
Revd Fred Nile (*Chairman*)
Mr Peter Draper (*Deputy Chair*)
Ms Amanda Fazio
Dr Andrew McDonald
Mr Michael Daley
Mrs Jillian Skinner
Miss Jenny Gardiner
Ms Carmel Tebbutt

2. Confirmation of minutes
Resolved, on the motion of Mr Draper: That Minutes No. 5 be confirmed.

3. Conduct of the inquiry

Submissions
Resolved, on the motion of Ms Fazio: That according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and Standing Order 223(1), the Committee authorise the publication of Submissions No.52, 53, 54, 58, 59 and 60.

Resolved, on the motion of Ms Tebbutt: That Submission No.57 be kept partly confidential and Submissions No. 51, 55, and 56 be kept fully confidential.

4. In camera evidence
Resolved, on the motion of Mr Draper: That the Committee hear the evidence of Ms Latta in camera.

The following witness was sworn and examined:
- Mrs Deborah Latta, former General Manager of North Shore Ryde Health Service.

Persons present other than the Committee:
- Mr Simon Johnston, Clerk to the Committee
- Ms Beverly Duffy, Committee Director
- Ms Elizabeth Galton, secretariat staff
- Mr Maurice Rebecchi, Chamber and Support staff
- Mr David Latta, husband of Mrs Deborah Latta
- Hansard reporters

The evidence concluded and the witness withdrew.

Ms Latta indicated that she did not have any objections to the Committee publishing the transcript of her evidence.

Resolved, on the motion of Ms Fazio: That, in the public interest and according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and Standing Order 223(2), the Committee authorises the publication of the *in camera* transcript of evidence of Mrs Deborah Latta on 16 November 2007.

Resolved, on the motion of Ms Fazio: That the Committee resume hearing its evidence in public.

5. Public hearing

Witnesses, the public and media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Dr Stephen Hunyor, Director, Cardiac Technology Centre, Royal North Shore Hospital (RNSH)
- Dr John Gunning, Head of the Department of Cardiology, RNSH

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Tony Joseph, Director of Trauma, RNSH
- Dr Robert Day, Director of Emergency Medicine, RNSH
- Dr Sue Ieraci, Emergency Medicine Specialist, Bankstown Hospital

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Charles Fisher, Chair of the Medical Staff Council and Head of the Department of Vascular Surgery at Royal North Shore Hospital
- Dr Sharon Miskell, Director of Medical Services at NSRHS

The Committee took a short break for morning tea.

The following witnesses were sworn/affirmed and examined:

- Dr Ray Raper, Director of the Intensive Care Unit at Royal North Shore Hospital
- Professor Malcolm Fisher, Area Director of Intensive and Critical Care, NSCCAHS
- Associate Professor Bill Sears, Visiting Medical Officer at Royal North Shore Hospital

Professor Fisher tabled a document, outlining comparative capital spending.

Resolved, on the motion of Ms Fazio: That the document tabled by Professor Fisher, be published.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Dr Ross Wilson, Director, Northern Centre for Healthcare Improvement, NSCCAHS

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS

The witness tabled copies of the four different letterheads used by the Area over the past several years.

The Committee took a short break for lunch at 1:03 pm.

The Committee resumed hearing its evidence at 1:30 pm.

The following witnesses were sworn and examined:

- Ms Jana Horska, former patient of RNSH.
- Mr Mark Dreyer, husband of Ms Horska.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Sharon Hooper, relative of a former patient of RNSH.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Ms Wendy Gao, former patient of RNSH.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Mrs Therese Mackay, relative of a former patient of RNSH.

The evidence concluded and the witness withdrew.

The Committee took a short break for afternoon tea.

The following witness was sworn and examined:

- Mrs Christine Rijks, relative of a former patient of RNSH.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Mrs Jenny Langmaid, former patient of RNSH.

The following witness was sworn and examined:

- Mr Steve Crosby, relative of former patient of RNSH.

The evidence concluded and the witness withdrew.

6. Adjournment

The Committee adjourned at 5:17pm until Thursday 22 November at 8.30am.

Beverly Duffy
Clerk to the Committee

Minutes No 7
Thursday 22 November 2007
Joint Select Committee on the Royal North Shore Hospital
At Jubilee Room, Parliament House, at 8:33 am

1. Members present

Rev Mr Fred Nile (*Chair)*
Mr Peter Draper *(Deputy Chair)*
Mr Michael Daley
Ms Amanda Fazio
Miss Jenny Gardiner
Dr Andrew McDonald
Mrs Jillian Skinner
Ms Carmel Tebbutt

2. Confirmation of minutes

Resolved, on the motion of Ms Fazio: That draft Minutes No 6 be confirmed.

3. Conduct of the inquiry

Correspondence

The Committee noted the following items of correspondence received:

- Fax from Ms Carolynne Daws, RN attaching a memo distributed to Area Staff in October 05 (13 October 2007)
- Letter from Mr Gerard Dangar regarding his positive experience of treatment at RNSH (10 November 2007)
- Email from Mrs Therese Mackay regarding the inquiry timeline (19 November 2007)
- Answers to QON taken by the NSAHS at the hearing on 12 November 2007 (19 November 2007)
- Letter to Ms Dowling, cc'd to the Committee, regarding treatment of a patient at RNSH (19 November 2007)
- Letter from Mr Rodney Edwards regarding alleged bullying culture at RNSH (20 November 2007)
- Letter from Ms Melanie Palmer, McLaughlin & Riordan, advising that Ms Palmer will attend the inquiry to provide legal advice (if necessary) to Mr Warren Anderson (20 November 2007)
- Letter from an anonymous NSCCAHS employee, attaching a copy of the Dalton/Meppem review

Submissions
Resolved, on the motion of Ms Tebbutt: That according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and Standing Order 223(1), the Committee authorise the publication of Submissions 62, 64-67, 69-70, 74, -76, 79- 81, 83-84, 86, 87, 88 - 90, 92, 93, 96.

Resolved, on the motion of Ms Fazio: That the following submissions be kept partially confidential at the request of the author and/or suggestion from the secretariat: No 61 (remove name of doctor); 68 (name of author and daughter removed); 72 (remove doctor's names); 73 (remove name and medical records).

Resolved, on the motion of Ms Tebbutt: That the following Submissions be kept fully confidential at the request of the author and/or suggestion from the secretariat 63, 77, 78, 82 and supp submission 82a 85, 91 and 94.

Resolved, on the motion of Ms Fazio: That Submission 58 be kept confidential.

Resolved, on the motion of Ms Tebbutt: That submission 47 be kept partially confidential, by removing the names of medical personnel cited in the submission.

Additional hearing day

Resolved, on the motion of Ms Tebbutt: That the Committee hold a hearing from 2-5pm on Monday 26 November 2007, to which the following witnesses be invited:

- Ms Alison Mayhew, Nursing Unit Manager, Royal North Shore Hospital
- Ms Fiona Carmichael, Nursing Unit Manager, Royal North Shore Hospital
- Dr Denis King

Mr Daley entered the room.

Resolved, on the motion of Ms Fazio: That the Committee invite the Royal North Shore Hospital Emergency Department triage nurse and Clinical Initiative Nurse on duty on the evening of 25 September 2007, to make a submission, or to give evidence on 26 November 2007, in camera if requested. The Committee secretariat is to make it clear that the invited nurses are free to decline the invitation.

Resolved, on the motion of Ms Fazio: That the Committee hold a further deliberative meeting at the conclusion of the public hearing to discuss whether to invite additional witnesses to the public hearing on 26 November 2007, and the Committee's reporting date.

4. *In camera* evidence
Resolved, on the motion of Ms Tebbutt: That the Committee hear the evidence of the first four witnesses in camera.

The following witness was sworn and examined:

- Witness A, Royal North Shore Hospital.

Persons present other than the Committee:

- Ms Beverly Duffy, Committee Director

- Mr Simon Johnston, Clerk to the Committee
- Ms Elizabeth Galton, secretariat staff
- Mr Steven Reynolds, Clerk Assistant – Procedural Support
- Mr Maurice Rebecchi, Manager, Chamber and Support Services
- Hansard reporters

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Michelle Beets
- Ms Samantha Flew
- Ms Alicia Jackson

Ms Beets tabled her opening statement.

The witnesses indicated that they did not have any objection to their evidence being published.

Resolved, on the motion of Ms Fazio: That, in the public interest and according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and Standing Order 223(2), the Committee authorises the publication of the *in camera* transcript of evidence of Ms Michelle Beets, Ms Samantha Flew and Ms Alicia Jackson on Thursday 22 November 2007, and that the document tabled by Ms Beets be accepted as a submission.

Resolved, on the motion Ms Fazio: That the Committee resume hearing its evidence in public.

5. Public hearing

Witnesses, the public and media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was sworn and examined:

- Ms Helen Ganley, former nurse at Royal North Shore Hospital

Ms Ganley tabled a document regarding risk factors and risk controls.

Resolved, on the motion of Ms Fazio: That the document tabled by Ms Ganley be published.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Clinical Associate Professor Kerry Russell, Area Director of Nursing, Sydney South West Area Health Service.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Greg Fulcher, Director, Department of Diabetes, Endocrinology and Metabolism, Royal North Shore Hospital.
- Dr Bruno Giuffre, Senior Staff Specialist, Diagnostic Radiology, Royal North Shore Hospital.

The evidence concluded and the witnesses withdrew.

The Committee took a short break for morning tea.

The following witness was sworn and examined:

- Dr Philip Hoyle, Director, Clinical Governance, Northern Sydney Central Coast Area Health Service

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Patrick Cregan, Chair, Clinical Services Taskforce, Nepean Hospital
- Dr Adam Chan, Director, Emergency Department, St George Hospital

The evidence concluded and the witnesses withdrew.

The Committee broke for lunch at 12:45 pm.

The Committee resumed hearing its evidence at 1:30 pm.

The following witness was sworn and examined:

- Mr Vern Dalton, Former Commissioner of Corrective Services

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Dr Christopher Arthur, Director, Haematology Department, Royal North Shore Hospital, Area Director of Cancer Services, Northern Sydney Central Coast Area Health Service
- Dr Greg Briggs, Senior Staff Radiologist, Royal North Shore Hospital
- Professor Leslie Burnett, Interim Cluster Director, Northern Pathology Cluster of NSW Health
- Dr Jennifer Donovan, Senior Staff Specialist, Radiation Oncology

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Tom Hugh, Head, Department of Gastrointestinal Surgery
- Dr John Vandervord, Clinical Head, Division of Surgery

Dr Vandervord tabled documents pertaining to surgical networking.

Dr Hugh tabled documents relating to the redevelopment of Royal North Shore Hospital.

The evidence concluded and the witnesses withdrew.

The Committee took a short break for afternoon tea.

The following witness was sworn and examined:

- Mr Warren Anderson, relative of former patient at Royal North Shore Hospital

Mr Anderson tabled several letters and a document containing photographs of Royal North Shore Hospital.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Mrs Lindy Batterham, relative of former patient at Royal North Shore Hospital

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Dr Peter Roberts, Area Network Chair, Emergency Medicine, Northern Sydney Central Coast Area Health Service
- Dr Paul Cunningham, Senior Staff Specialist, Emergency Department, Ryde Hospital
- Dr Clare Skinner, Registrar, Emergency Department, Royal North Shore Hospital.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Jeffrey Hughes, Former Senior Orthopaedic Consultant Visiting Medical Officer, Royal North Shore Hospital
- Professor David Sonnabend, Chairman, Department of Orthopaedic Surgery, Royal North Shore Hospital
- Dr Andrew Ellis, Orthopaedic Surgeon Visiting Medical Officer, Royal North Shore Hospital.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mrs Barbara Lucas, Senior Paediatric Physiotherapist, Royal North Shore Hospital
- Mrs Anne Heaton, Senior Orthopaedic Physiotherapist, Royal North Shore Hospital.

The evidence concluded and the witnesses withdrew.

The public and media withdrew.

6. Deliberative meeting

Resolved, on the motion of Ms Fazio: That the answers to QoN taken by the NSCCAHS at the hearing on 12 November, be published.

Resolved, on the motion of Mr Daley: That the Committee publish the following documents tabled at the hearing today:

- Photographs taken in Royal North Shore Hospital, tendered by Mr Warren Anderson
- Letter from Dr Lali Sekhon to Hon John Hatzistergos MLC as Minister for Health, relating to concerns about Royal North Shore Hospital, tendered by Mr Warren Anderson
- Letter from Hon John Hatzistergos MLC as Minister for Health to Dr Lali Sekhon, responding to concerns about Royal North Shore Hospital, tendered by Mr Warren Anderson
- Email correspondence between Dr Lali Sekhon and Mr Warren Anderson, tendered by Mr Warren Anderson
- Analysis of Main Operating Rooms case load at Royal North Shore Hospital, tendered by Dr John Vandervord
- Brief to the Re-development Project Team from the Royal North Shore Hospital Re-development Clinical Advisory Committee, tendered by Dr Tom Hugh
- Response from the Royal North Shore Hospital and Community Health Service Redevelopment Team to Redevelopment Clinical Advisory Committee Brief, tendered by Dr Tom Hugh.

Resolved, on the motion of Mr Daley: That the Committee agree to the request received from Tress Cox Lawyers, to place a copy of the submission and evidence from the AMA/ASMOF on the AMA's website and to publish extracts of the submission and Dr Keegan's evidence in NSW Doctor.

Resolved on the motion of Ms Skinner: That the author of submission 91 be invited to appear at the committee's hearing on 26 November.

Ms Gardiner moved: That the Minster of Health, and the officers who appeared with the Minister on 12 November, be invited to reappear at the committee's hearing 26 November.

The Committee divided:

Ayes: Mrs Skinner, Miss Gardiner
Noes: Ms Fazio, Ms Tebbutt, Mr Daley, Dr MacDonald, Mr Draper, Revd Nile

Question resolved in the negative.

Miss Gardiner moved: That the committee seek an extension to the reporting date for its first report to 20 December 2007 and a further extension for a supplementary report to 28 February 2008, so as to take into account any relevant recommendations and/or findings of the Coroner in respect of the death of Vanessa Anderson.

The Committee divided

Ayes: Mrs Skinner, Miss Gardiner, Mr Draper
Noes: Ms Fazio, Ms Tebbutt, Mr Daley, Dr MacDonald, Revd Nile

Question resolved in the negative.

Resolved, on the motion of Ms Fazio: That the Committee seek an extension of the reporting date to 20 December 2007.

Resolved on the motion of Ms Fazio: That the Committee deliver its Final Report on 20 December 2007, and recommends to the Parliament that if there are any recommendations from the Coroner's Report into the death of Vanessa Anderson that are within the terms of reference, the Parliament consider re-establishing this Committee for inquiry and report into these matters.

Resolved, on the motion of Mr Daley: That the decisions made by the committee regarding the report and tabling date be made public.

The Committee adjourned at 6.30pm until 2:00 pm on 26 Monday November 2007.

Beverly Duffy
Clerk to the Committee

Minutes No 8
Monday 26 November 2007
Joint Select Committee on the Royal North Shore Hospital
At Jubilee Room, Parliament House, at 2:00 pm

1. Members present
Rev Mr Fred Nile (*Chair)*
Mr Peter Draper *(Deputy Chair)*
Mr Michael Daley
Ms Amanda Fazio
Miss Jenny Gardiner
Dr Andrew McDonald
Mrs Jillian Skinner
Ms Carmel Tebbutt

2. *In camera* hearing
Resolved, on the motion of Ms Fazio: That the Committee hear the evidence of the first three witnesses in camera.

The Chairman advised the Committee that the witnesses would be accompanied by Ms Michelle Beets and Ms Peta Kava.

The following witnesses were sworn and examined:
- Witness B, Royal North Shore Hospital
- Witness C, Royal North Shore Hospital.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:
- Witness D, Royal North Shore Hospital.

The Chairman advised that the witness would be accompanied by a friend (name withheld).

Persons present other than the Committee:
- Ms Beverly Duffy, Committee Director

- Mr Simon Johnston, Clerk to the Committee
- Ms Elizabeth Galton, Committee Secretariat
- Mr Steven Reynolds, Clerk Assistant – Procedural Support
- Mr Samuel Griffith, Committee Secretariat
- Mr John Ferguson, Chamber and Support Services
- Hansard reporters

The witness indicated that they did not have any objection to their evidence being published.

The evidence concluded and the witness withdrew.

Resolved, on the motion of Ms Fazio: That the Committee resume hearing its evidence in public.

The Committee took a short break for afternoon tea.

3. Public hearing

Witnesses, the public and media were admitted.

The following witness was sworn and examined:

- Dr Denis King, Executive Clinical Director, South Eastern Sydney and Illawarra Area Health Service.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Ms Fiona Carmichael, Nursing Unit Manager, Royal North Shore Hospital

The following witness was examined on previous oath:

- Ms Alison Mayhew, Nursing Unit Manager, Royal North Shore Hospital

The evidence concluded and the witnesses withdrew.

The public and media withdrew.

4. Deliberative meeting

Previous minutes

Resolved, on the motion of Ms Fazio: That Minutes No 7 be confirmed.

Correspondence

The Committee noted the following items of correspondence received:

- Email from Mr Daniel Brezniak to Chairman regarding treatment of his mother in Royal North Shore Hospital (16 November 2007)
- Email from Dr John Roberts to Chairman regarding transfer of patients from Port Macquarie and Taree Hospitals to tertiary level care (21 November 2007)
- Email from Dr John Wright to Chairman regarding his experience in relation to complaining about dangerous work practices in hospitals 20 years ago (21 November 2007)
- Letter from Hon Reba Meagher MP, Minister for Health, to Chairman providing answers to questions taken on notice during evidence 12 November 2007 (22 November 2007)

The Minister has requested that the Committee keep Attachment 1 confidential.

- Email from Dr Denis King to Committee secretariat attaching 2004 Ryde/Royal North Shore Hospital Review (22 November 2007)
- Email from Ms Judy Willis, NSW Health, to Chairman attaching copy of document referred to by Dr Patrick Cregan in evidence 22 November 2007 (23 November 2007)
- Email from Ms Fiona Thomas to Committee regarding treatment of her mother in Royal North Shore Hospital in June 2006 (23 November 2007)
- Email from staff member of Royal North Shore Hospital to Director regarding experiences of bullying and harassment at Royal North Shore Hospital (23 November 2007) **confidential**

- Letter from Associate Professor Kerry Russell, Area Director Nursing and Midwifery, Sydney South West Area Health Service, to Chairman providing answers to questions taken on notice during evidence 22 November 2007 (26 November 2007).

Resolved, on the motion of Ms Fazio: That the committee publish the answers to questions taken on notice on 12 November 2007 by the Hon Reba Meagher MP, Minister for Health, with the exception of Attachment 1.

Resolved, on the motion of Mr Daley: That the committee publish the answers to questions taken on notice on 22 November 2007 by Associate Professor Kerry Russell, Area Director Nursing and Midwifery, Sydney South West Area Health Service.

Submissions
Resolved, on the motion of Mr Daley: That according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and Standing Order 223(1), the Committee authorise the publication of Submissions No. 97, 98, 99 and 37a.

Resolved, on the motion of Ms Fazio: That Submission No. 95 and 100 be kept confidential.

5. Publication of material requested by the Committee from the Minister
Resolved, on the motion of Ms Tebbutt: That the Committee authorise the publication of the following documents, with the removal of names from the Best Practice Australia Climate Survey Report where identified by the Committee secretariat:

- The Royal North Shore Hospital Quality and Risk Management Plan or Risk Register (2004)
- The Best Practice Australia report – Climate Survey report for Royal North Shore Hospital (2004)
- Occupational Health and Safety Committee Minutes for Royal North Shore Hospital
  Report on Quality Systems by Duncan Stewart (August 2003).

6. Publication of transcript from 22 November and confidential submission no 51
Resolved, on the motion of Mrs Skinner: That according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and Standing Order 223(1), the Committee authorise the publication of submission no 51, subject to the omission of the author's identifying details and the identifying details of those people who are adversely mentioned.

Resolved, on the motion of Ms Tebbutt: That the Committee defer the publication of the transcript of evidence of the first in camera witness who appeared on 22 November until she has had an opportunity to review the unedited version of the transcript, and the version of the transcript edited by the Secretariat to remove her name and the names or position titles of people who are adversely mentioned.

7. Inquiry timeline
Resolved, on the motion Dr McDonald: That the Committee adopt the proposed inquiry timeline.

- Report to members — Fri 14 December
- Deliberative meeting — Tuesday 18 Dec (start 9am)
- Table report — Thursday 20 December

8. Next meeting
The Committee adjourned at 4:30 pm until 9:00 am on 18 December 2007.

Beverly Duffy
Clerk to the Committee

Minutes No 9
Wednesday 5 December 2007
Joint Select Committee on the Royal North Shore Hospital
At Legislative Council Member's Lounge, Parliament House, at 2:00 pm

1. Members present

Rev Mr Fred Nile *(Chair)*
Mr Peter Draper *(Deputy Chair)*
Mr Michael Daley
Ms Amanda Fazio
Miss Jenny Gardiner
Dr Andrew McDonald
Mrs Jillian Skinner
Ms Carmel Tebbutt

2. Previous minutes

Resolved, on the motion of Ms Fazio: That Minutes No 8 be confirmed**.**

3. Correspondence

The Committee noted the following items of correspondence received:

- Email from Ms Helen Ganley, regarding bullying at RNSH (28 November 2007)
- Email from (name withheld) regarding evidence of Ms Helen Ganley on 22 November 2007 (28 November 2007)
- Letter from Dr Keith Jonson advising Committee of his consultancy's diagnostic techniques (29 November 2007)
- Letter from Dr Jennifer Donovan regarding factual inaccuracies in her transcript (30 November 2007)
- Letter from Dr Steve Kelly regarding the evidence of Dr Philip Hoyle on 22 November 2007 (4 December 2007)
- Letter from Minister for Health, Hon Reba Meagher MP, providing relevant information (4 December 2007).

Resolved, on the motion of Ms Fazio: That the committee:

- publish Dr Donovan's letter of 28 November 2007 correcting errors of fact in her transcript of evidence
- add a footnote to the first page of Dr Donovan's transcript of evidence referring readers to her letter of 28 November 2007, and include this letter on the inquiry website.

The Committee noted the following items of correspondence sent:

- Letter to TressCox Lawyers informing them of Committee's decision to allow the publication of submission 32 and the evidence of Dr Andrew Keegan on the AMA (NSW) website and in AMA (NSW)'s journal, *NSW Doctor*.

4. Submissions

Resolved, on the motion of Mr Draper: That according to section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and Standing Order 223(1), the Committee authorise the publication of Submissions No. 102 and 33a.

Resolved, on the motion of Ms Fazio: That Submission No. 100 be kept confidential.

Resolved, on the motion of Mr Daley: That Submission No. 8 remain confidential to the Committee until the author has further responded.

Resolved, on the motion of Ms Fazio: That Submission No. 91a be kept partially confidential at the request of the author with amendments to protect the identity of the author.

5. Publication of amended *in camera* transcripts

Resolved, on the motion of Mrs Skinner: That the Committee publish the transcript of the first *in camera* witness who appeared on Thursday 22 November, as amended.

Resolved, on the motion of Mrs Skinner: That the Committee publish the transcript of the second *in camera* witness who appeared on Monday 26 November, as amended.

6. Distribution of Chairman's Draft Report

The Committee indicated that the Draft Report should be distributed electronically and in hard copy at 2:00 pm on Friday 14 December 2007.

7. Next meeting

The Committee adjourned at 6:44 pm until 9:00 am on 18 December 2007.

Beverly Duffy
Clerk to the Committee

Draft Minutes No 10
Tuesday 18 December 2007
Joint Select Committee on the Royal North Shore Hospital
Room 1102, Parliament House, at 9:00 am

1. Members present

Rev Fred Nile (*Chairman)*
Mr Peter Draper *(Deputy Chair)*
Mr Michael Daley
Ms Amanda Fazio
Miss Jenny Gardiner
Dr Andrew McDonald
Mrs Jillian Skinner
Ms Carmel Tebbutt

2. Previous minutes

Resolved, on the motion of Ms Fazio: That Minutes No 9 be confirmed**.**

3. Correspondence

The Committee noted the following items of correspondence received:

- Six documents pertaining to answers to questions taken on notice by Dr Philip Hoyle, Director, Clinical Governance, NSCCAHS. (previously circulated)
  1. Two articles from the British Medical Journal relating to incident reporting
  2. Extract from ACHS Report on Health Services Accreditation 2003-2006
  3. Draft report of the Periodic Review for the ACHS Evaluation and Quality Improvement Program
  4. ACHS Survey Report (2001)
  5. Letter from ACHS reinstating accreditation for RNSH from July 2002
  6. Briefing on the number of doctors trained to use IIMS.

- Answer to a question taken on notice by Dr Daniel Stiel, Clinical Director, Division of Medicine and Aged Care, Royal North Shore and Ryde Hospitals, relating to Aged Care Assessment Teams at Royal North Shore Hospital
- Email from Mr Ian Blackshaw detailing his wife's experience at Royal North Shore Hospital as a country patient
- Letter from Mr Bruce McLeod praising the treatment he received at Royal North Shore Hospital.
- Letter from NSW Health Watch Inc responding to terms of reference (confidentiality requested)
- Letter from Mr David Mudgee adversely reflecting on his treatment at Royal North Shore Hospital (confidentiality recommended)
- Letter from Mr Peter Burton adversely reflecting on his treatment at Royal North Shore Hospital (confidentiality recommended)

Resolved, on the motion of Ms Fazio: That the following correspondence remain confidential to the committee

- Letter from NSW Health Watch Inc responding to terms of reference
- Letter from Mr David Mudgee adversely reflecting on his treatment at Royal North Shore Hospital
- Letter from Mr Peter Burton adversely reflecting on his treatment at Royal North Shore Hospital

Resolved, on the motion of Mr Draper: That the committee publish:

- Dr Phillip Hoyle's answers to questions on notice numbers 1,2, 5 and 6.
- Dr Stiel's answers to questions

The committee clerk tabled a letter from Ms Mary Bonner, General manager, RNSH, received by the secretariat on 18 December, responding to a question taken on notice and advising transcript corrections

Resolved, on the motion of Ms Fazio: That the secretariat be authorised to make the transcript corrections advised by Ms Bonner.

4. Submissions

Resolved, on the motion of Ms Fazio: That Submissions No. 101 and 103 be kept confidential.

5. Consideration of Chairman's Draft Report

The Chairman tabled his draft report entitled 'The Royal North Shore Hospital', having been previously circulated.

The Chairman read to members of the committee standing order 228 relating to dissenting statements.

Resolved, on the motion of Mrs Skinner, that the Glossary include a definition of 'enrolled nurse'.

Chapter One read.

Debate ensued.

Miss Gardiner moved: That paragraph 1.1 be amended by omitting the words: 'On 16 October 2007, Revd the Hon Fred Nile MLC', and inserting instead: 'After a series of allegations about poor patient care and a culture of bullying and harassment at Royal North Shore Hospital, Revd the Hon Fred Nile MLC, on 16 October 2007,'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Mr Daley: That paragraph 1.11 be amended by inserting the words 'Some of' at the beginning of the first sentence.

Miss Gardiner moved: That first sentence of paragraph 1.14 be amending by omitting 'significant' and inserting 'shocking'.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Mrs Skinner: That paragraph 1.14 be amended by inserting a new dot point above the current fourth dot point on page 3 in the following words: 'Clinical staff criticism of the 2005 restructure of the

health system which merged Northern Sydney and Central Coast Area Health Services to create the larger Northern Sydney Central Coast Area Health Service.'

Resolved, on the motion of Ms Fazio: That paragraph 1.14 be amended by omitting the word 'many' from the third dot point on page 4 and inserting instead: 'some'.

Miss Gardiner moved: That paragraph 1.14 be amended by omitting the word 'high' from the sixth dot point on page 4 and inserting instead: 'unsafe'.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Ms Fazio: That paragraph 1.14 be amended by omitting the words 'Diversion of trust funds and' from the fifth dot point on page 4 and inserting instead: 'A diversion of a trust fund and diversions of'.

Resolved, on the motion of Ms Tebbutt: That paragraph 1.14 be amended by omitting the word 'widespread' from the final dot point on page 4.

Resolved, on the motion of Miss Gardiner: That paragraph 1.14 be amended by inserting the words 'and management commitment' immediately after the word 'staffing' on the final dot point on page 4.

Chapter Two read

Debate ensued.

Resolved, on the motion of Miss Gardiner: That paragraph 2.5 be omitted and replaced with: 'NSCCAHS came into existence on 1 January 2005 as part of the health reform package of the then Minister for Health, the Hon Morris Iemma. Mr Iemma's package, titled *Planning Better Health*, included a reduction in the number of Area Health Services across New South Wales from 17 down to eight through a series of mergers and boundary changes.'

Resolved, on the motion of Ms Fazio: That paragraph 2.18 be amended by omitting the words: 'Helicopter Care Flights' and inserting instead: ', including a specialist burns unit and a specialist spinal unit. Helicopter ambulance flights'.

Chapter Three read.

Resolved, on the motion of Ms Tebbutt: That the first introductory paragraph be amended by inserting the words: 'or poor distribution' immediately after the word 'lack'.

Resolved, on the motion of Mrs Skinner: That paragraph 3.24 be amended by omitting the first sentence and inserting instead: 'Mr Anderson told the inquiry he believed that more needed to be done to encourage nurses back into the system. He said, We have not got a shortage of nurses in Australia. The nurses have left the system.'

Resolved, on the motion of Ms Fazio: That paragraph 3.39 be amended by inserting the following sentence at the end of the paragraph: 'Mrs Rijks strongly stated that the option of employing a private nurse should remain available.'

Resolved, on the motion of Ms Tebbutt: That paragraph 3.57 be amended by omitting the words: 'This room was reported in the media to be a 'cupboard', as there was medical supplies stored in there, including oxygen tanks.' and inserting instead: 'Medical supplies were stored in this room, including oxygen tanks.'

Resolved, on the motion of Ms Tebbutt: That paragraph 3.59 be amended in inserting the words: 'said she' immediately after the word 'Hooper'.

Resolved, on the motion of Ms Fazio: That the sub-heading 'The 'treatment room" appearing immediately before paragraph 3.78 be omitted.

Resolved, on the motion of Ms Fazio: That paragraphs 3.78 and 3.79 be amended by omitting the inverted commas from the phrase treatment room.

Resolved, on the motion of Ms Fazio: That paragraph 3.78 be amended by omitting the words: 'what was referred to as' appearing immediately after the word 'in' and by inserting the words: 'that had also been used to store equipment' immediately after the word 'room'.

Resolved, on the motion of Mr Daley: That paragraph 3.79 be amended by omitting the word 'likely' and inserting instead 'possible' and by omitting the words 'would frequently' and inserting instead 'may'.

Resolved, on the motion of Mrs Skinner: That the following new paragraph be inserted immediately after the sub heading Committee Comment after paragraph 3.84: 'The Committee notes that, throughout patient evidence, there were references to:

- Overworked clinicians
- A lack of continuity of care
- A lack of information sharing with patients and their families
- Inadequate priority given to women threatening or undergoing a miscarriage
- A lack of diagnostic capacity out of hours
- Poor complaints handling
- A lack of cleanliness in certain areas.'

Resolved, on the motion of Ms Fazio: That paragraph 3.85 be amended by omitting the word 'dilapidation' and inserting instead: 'physical environment'.

Resolved, on the motion of Mr Daley: That paragraph 3.86 be amended by omitting the word 'spring' and inserting instead 'project'.

Resolved, on the motion of Mrs Skinner: That paragraph 3.87 be amended by inserting at the end of the paragraph: 'All areas of the hospital should be cleaned, including those used by clinicians that are not routinely visible to patients or visitors.'

Resolved, on the motion of Ms Fazio: That Chapters One, Two and Three, as amended, be adopted.

Chapter Four read.

Resolved, on the motion of Mr Daley: That paragraph 4.6 be amended by inserting a new dot point referring to **'**The groundbreaking acute interventional rescue of heart attack victims in the ETAMI and SALAMI programs.'

Resolved, on the motion of Mrs Skinner: That the following new paragraph and quote be inserted immediately after paragraph 4.19: 'Dr Robert Day, Director of Emergency Medicine at RNSH told the inquiry:

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

Mrs Skinner moved: That paragraph 4.21 be omitted and replaced with: 'The implication of the different claims about emergency physician staffing levels by NSW Health and the head of the ED shows that there is a lack of clarity about even the most fundamental workforce issue such as the number of doctors staffing the ED.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Miss Gardiner moved: That paragraph 4.38 be amended by omitting the words: 'While noting with concern the low level of growth in Australian medical graduate numbers'.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Miss Gardiner moved: That paragraph 4.44 be amended by inserting the words: 'the day before the Committee's second public hearing' immediately after the words '15 November 2007'.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Ms Fazio: That paragraph 4.47 be amended by omitting the last sentence of the third dot point and inserting the following new paragraph immediately after the third dot point: 'The ATS sets benchmark times for treatment for each triage category, from 100 per cent of patients treated within two minutes for the most serious Category 1 through to 70 per cent of patients treated within 120 minutes for the least serious Category 5.'

Mrs Skinner moved: That immediately after paragraph 4.53 a new paragraph be inserted that refers to the fact that in evidence to the Committee the Minister for Health made no comment with respect to any improvement in performance for triage category 2.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Miss Gardiner: That paragraph 4.55 be amended by omitting the word 'trivialise' and inserting instead 'minimise'.

Miss Gardiner moved: That immediately after paragraph 4.58 the following new paragraph be inserted: 'Although NSW Health was able to make a supplementary submission commenting on evidence presented by other witnesses to the inquiry, the Committee majority voted not to recall the Minister for Health or the Director General and other senior NSW Health officers as to test the evidence they presented at the beginning of the Committee's first hearing with that presented by any other witnesses.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That immediately after paragraph 4.58 the following new paragraph be inserted: 'It is noted that NSW Health and the Minister had the advantage of providing supplementary submissions to the Committee after reading evidence from doctors working at the hospital. These supplementary submissions have dismissed claims about inadequate emergency specialist levels and rejected the 2003 AMWAC guidelines because of changes to service delivery models. In light of consistent claims by doctors working in the hospital that workforce shortages are impacting the work of the ED, the Committee recommends that these doctors be engaged in the review process.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Mrs Skinner: That recommendation 2 be amended by inserting the following words at the end of the recommendation: 'who are currently working in Emergency Departments'.

Resolved, on the motion of Ms Tebbutt: That paragraph 4.60 be amended by omitting the words: 'acknowledge that it is not possible to simply recruit more experienced nurses, but'.

Resolved, on the motion of Ms Fazio: That recommendation 3 be amended by omitting all the words appearing after 'That NSRHS' and inserting instead: 'review the number of Clinical Nurse Educator positions available with the RNSH Emergency Department, including comparison with peer hospitals, to determine the appropriate number of additional positions, and begin recruitment action to fill those positions.

Resolved, on the motion of Ms Fazio: That paragraph 4.71 be amended by omitting all the words appearing after 'Bed numbers at RNSH, and in fact across the State' and inserting instead: 'and internationally, have reduced over time although bed numbers have been increased in the past few years. NSW Health representatives explained to the Committee that changes in medical procedures and models of care worldwide have resulted in shorter hospital stays and therefore have reduced the need for hospital beds. There has also been a reinvestment in beds across the State in the past few years.'

Resolved, on the motion of Miss Gardiner: That paragraph 4.78 be amended by inserting the words 'for access block' immediately after the words 'fundamental reason'.

Miss Gardiner moved: That paragraph 4.95 be amended by inserting the words: 'during this inquiry' immediately after the words 'Minister for Health'.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved on the motion of Miss Gardiner: That paragraph 4.96 be amended by inserting the following words at the end of the paragraph:

Mr Michael Devery, the Manager, Ambulatory Age Care and Rehabilitation Service, advised the Committee that:

> On the resource side, ACAT resources at RNS have been enhanced somewhat over recent years, but there are in my opinion significant deficits, principally: impoverished basic business operations and business infrastructure (most significantly, completely inadequate information technology); inadequate Allied Health and Nursing resources; a clinical governance framework unsuited to the full integration of the Aged Care Assessment Program, and a cumbersome Health Service bureaucracy.
>
> I would say that there is a growing imbalance of demands and resources, and that the LNS ACAT is operating, at best, at the margins of its capacity. I think that to date the ACAT has managed to maintain its contribution to patient flow, and to a lesser extent to the quality of in-patient care, but it is not clear to me how the ACAT will meet the demands on it in the longer term if the balance of demands and resources continues to deteriorate. (Answers to questions on notice from 16 November 2007, Dr Danny Stiel, Clinical Director of the Division of Medicine and Aged Care, NSRHS, Attachment, p 2)

Mrs Skinner moved: That paragraph 4.98 be omitted and replaced with: 'Many witnesses identified a lack of inpatient beds as the main cause of access block. Different claims about bed numbers quoted by the Minister for Health and NSW Health included bassinets, dialysis chairs and even beds in a patient's home while ED doctors focus on inpatient beds available to admit their patients.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner, Mr Draper
Noes: Mr Daley, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That immediately after paragraph 4.98 the following new paragraph be inserted: 'Similarly bed occupancy rates quoted by NSW Health (90%) are based on all beds, while doctors worrying about where to place ED patients quote much higher (95%) occupancy rates for those beds. It is noted that NSW Health advised that there is no standard bed occupancy rate but a figure of 85% was recommended by trauma doctors, the AMA and ASMOF. The AMA/ASMOF Submission 32 at p14 cited 'UK Department of Health's Economics and Operational Research Division which showed a clear relationship between high occupancy and the risk of cancellation of elective admissions. It is established that at occupancy rates higher than 83 per cent the risk becomes pronounced. University of York research which used a different methodology found very similar results.' The Australasian College of Emergency Medicine [ACEM] and the Australian Medical Association have identified that bed occupancy rates in excess of 85 per cent lead to elective surgery cancellations and delays in patients being transferred from Emergency Departments to inpatient hospital beds'. In light of this the Committee recommends that the introduction of a bed occupancy benchmark rate of 85% be investigated.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That paragraph 4.99 be amended by replacing the word 'may' with the word 'will'.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That paragraph 4.99 be amended by omitting all the words appearing after 'determine' and inserting instead 'how many beds will be needed to ensure less than an 85% occupancy rate, ensure appropriate referral patterns to RNSH from within and outside the Area, ensure better patient flow-through and efficient discharge processes and provide better after hours availability of diagnostic services to allow ED to meet patient demand.'

Question put.

The Committee divided.

Ayes: Mr Draper, Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That recommendation 4 be omitted and replaced with: 'That an extra 70 beds are immediately opened at RNSH, with adequate resources to staff and operate them as recommended by the AMA and ASMOF and further that, as part of its role in developing the Area Clinical Services Plan, NSCCAHS work with senior clinicians to determine the roles of each of the hospitals in the region, how many beds will be needed to ensure less than an 85% occupancy rate at RNSH, ensure appropriate referral patterns to RNSH from within and outside the Area, ensure better patient flow-through and efficient discharge processes within the hospital and provide better after hours availability of diagnostic services to allow RNSH ED to meet patient demand.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That paragraph 4.100 be amended by omitting all words after 'in this report' and inserting instead: 'In light of evidence from numerous witnesses that clinical service plans have been started previously, that reviews have been done but not effectively implemented, the Committee recommends an independent body be established to report on the implementation of recommendations in this report, in particular the impact of the clinical services plan on access block at RNSH' and that the following quotes be inserted after paragraph 4.100:

> 'A series of reviews over the past few years have highlighted the issues facing RNSH ED but action on the recommendations has been slow or absent.' (Submission 27, RNSH ED, page 3)

> 'There was an Area Business Planning Forum in March 2006 to develop a Clinical Services Plan for the Area, which was to be delivered by July 2006, but this did not occur.' (Submission 48, Dr Tony Joseph, page 4)

> 'In June 2006 Northern Sydney Central Coast Health Service (NSCCHS) re-structured, and a new Divisional structure was implemented in NSCCHS to achieve efficient and effective operational management of the four health services in NSCCHS, including North Shore and Ryde Health Service. At the same time, a new Clinical Network structure was to be implemented for NSCCHS to provide a strategic planning framework for NSCCHS. This has not occurred.' (Submission 49, Dr Sharon Miskell, page 3)

> 'We are particularly demoralized by the ineffectiveness of our repeated submissions to both external (Chairperson - Dr King) and internal (Chairperson - Professor Pollock) formal enquiries. Other related inquiries have addressed resource and case allocation within the NSCCAHS and the role of Ryde Hospital, and numerous consultants, internal and external have interviewed us repeatedly, all to no apparent avail.' (Submission 50, Dr David Sonnabend, page 3)

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Mrs Skinner: That immediately after paragraph 4.105, the following new paragraph be inserted: 'Doctors gave evidence that a lack of rehabilitation care was a particular problem in causing exit block (4.85 and 4.87). The Committee therefore recommends that NSW Health prioritise discussions with providers of rehabilitation services to ensure sufficient rehabilitation outpatient services are available in the RNSH redevelopment and that further non-acute inpatient care is available for patients who are ready to be discharged from RNSH'.

Resolved, on the motion of Mrs Skinner: That after Recommendation 8, the following new recommendation be inserted: 'That NSW Health prioritise discussions with providers of rehabilitation services to ensure sufficient rehabilitation outpatient services are available in the RNSH redevelopment and that further non-acute inpatient care is available for patients who are ready to be discharged from RNSH'.

Resolved, on the motion of Ms Fazio: That the paragraph 4.106 be amended by omitting the words 'The treatment of patients with mental illness in the ED is not appropriate and contributes to the problem of ED overcrowding'.

Resolved, on the motion of Miss Gardiner: That paragraph 4.109 be amended by inserting after the word 'presenting person' the words 'in the case of threatened miscarriage'.

Resolved, on the motion of Miss Gardiner: That paragraph 4.130 be amended by omitting the words 'of the CEC' and inserting instead 'that the CEC is working on'.

Resolved, on the motion of Miss Gardiner: That paragraph 4.140 be amended by omitting the words 'of the terms of reference' and inserting instead 'about the terms of reference of his inquiry provided by NSW Health'.

Resolved, on the motion of Ms Tebbutt: That paragraph 4.141 be amended by omitting the words 'The failure to involve the people whose experience triggered the inquiry is very disappointing and quite puzzling. The tight timeframe of the inquiry is also puzzling, and the Committee has not been provided with a convincing reason for it' and inserting instead 'It is unfortunate that Ms Horska and Mr Dreyer were not able to participate'.

Resolved, on the motion of Mrs Skinner: That paragraph 4.143 be amended by omitting the words 'We believe this change in terminology should be extended to the Australian Triage system itself, replacing the word 'triage' with 'patient priority', and inserting the word 'signage' after 'Emergency Departments' in the last sentence.

Resolved, on the motion of Mrs Skinner: That Recommendation 9 be amended by inserting the word 'signage' after 'Emergency Departments'.

Resolved, on the motion of Ms Fazio: That Recommendation 10 be amended by deleting all words after 'That' and inserting instead 'the NSW Government seek to initiate a national review of the Australian Triage System categories in relation to women presenting to Emergency Departments with signs of miscarriage, to ensure they are appropriate.'

Resolved, on the motion of Miss Gardiner: That immediately after Recommendation 10 the following new recommendation be inserted: 'That details of progress in implementing changed procedures for the assessment and treatment of women in the early stages of pregnancy presenting to Emergency Departments with signs of miscarriage and the establishment of Early Pregnancy Units be reported upon in the next Annual Report of NSW Health.'

Resolved, on the motion of Ms Fazio: That Chapter Four, as amended, be adopted.

Chapter Five read.

Debate ensued.

Resolved, on the motion of Ms Fazio: That immediately after paragraph 5.37 the following new paragraph be inserted: 'Ms Mayhew advised the Committee that the NSW Nurses' Association Branch at RNSH had been reactivated after being dormant for a while.' (Page 11 of transcript 26 November 2007).

Resolved, on the motion of Ms Fazio: That paragraph 5.41 be amended by omitting the word 'adopting' from the first dot point.

Resolved, on the motion of Mr Daley: That Chapter Five, as amended, be adopted.

Chapter Six read.

Debate ensued.

Resolved, on the motion of Dr McDonald: That paragraph 6.12 be amended by omitting the words 'At the root of many' and inserting instead 'Some'.

Miss Gardiner moved: That paragraph 6.12 be amended by inserting the words 'by the then Minister for Health, the Hon M Iemma' after 'decision'.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That immediately after paragraph 6.30, the following new paragraph be inserted: 'The Committee noted that discontent with amalgamation of the former Northern Sydney Area Health Service and Central Coast Area Health Service and in particular Royal North Shore Hospital with Ryde Hospital was expressed by many doctors actually working in the hospitals, while championed by health managers as a way of achieving economies of scale -as yet unrealised. Further, many clinicians complained that the new structure had added layers of bureaucratic barriers dramatically slowing down approvals for basic items and important staffing issues (such as filling nurse vacancies). Numerous doctors commented about the geographical remoteness of the Area Chief Executive, the lack of access to the CEO and the power accorded that position at the same time as RNSH general manager lost 'control over the budget and decision making.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That paragraph 6.30 be amended by omitting the words 'The Committee supports the formation of NSCCAHS and NSRHS in 2005.'

Question put.

The Committee divided.

Ayes: Mr Draper, Miss Gardiner, Mrs Skinner
Noes: Noes: Mr Daley, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That paragraph 6.30 be amended by omitting the words 'The Committee also believes that the merger has the potential to deliver administrative savings and increased transfer of expertise across the Area'.

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Miss Gardiner moved: That immediately after paragraph 6.38 the following new recommendation be inserted: 'That the Minister for Health review the geographic size of the eight Area Health Services created in 2005.'

Question put.

The Committee divided.

Ayes: Mr Draper, Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Ms Fazio: That paragraph 6.43 be amended by inserting the sentence 'This view was not supported by other witnesses' at the end of the paragraph.

Resolved, on the motion of Ms Fazio: That immediately after paragraph 6.49, the following new paragraph be inserted: 'The Committee also notes the evidence of the Minister and senior executives of NSW Health that patient care is always a matter for clinicians.'

Mrs Skinner moved: That paragraph 6.58 be deleted.

Question put and negatived.

Ms Tebbutt moved: That paragraph 6.60 be amended by omitting the words 'In the future, however, it may be necessary to trial a hospital board model, similar to the Westmead Children's Hospital Board, for a five year period, followed by a review, in order to restore RNSH to its former glory'.

Question put.

The Committee divided:

Ayes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Ms Tebbutt
Noes: Miss Gardiner, Revd Nile, Mrs Skinner.

Question resolved in the affirmative.

Miss Gardiner moved: That paragraph 6.60 be amended by omitting the words 'The Committee does not support the proposal for a hospital board at RNSH' and inserting instead 'Dr Cregan's view was disputed by some clinicians from RNSH. For example, Dr Tom Hugh, Head of the RNSH Department of Gastro Intestinal Surgery, told the Committee: '… 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' (Transcript, 22 Nov 07, p57)

Question put.

The Committee divided.

Ayes: Miss Gardiner, Revd Nile, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Ms Tebbutt.

Question resolved in the negative.

Chapter Seven read.

Debate ensued.

Miss Gardiner moved: That paragraph 7.4 be amended by omitting the words after 'contrasts with other Area Health Services, and' and inserting instead 'conforms with the experience of most of the other Area Health Services formed by Mr Iemma. This'.

Question put and negatived.

Resolved on the motion of Mrs Skinner: That paragraph 7.4 be amended by omitting the words 'contrasts with other Area Health Services, and'.

Resolved, on the motion of Mr Daley: That paragraph 7.4 be amended by inserting the words 'some of' after 'cause of'.

Miss Gardiner moved: That paragraph 7.40 be amended by omitting the words 'has had' and inserting instead 'may have had'.

Question put and negatived.

Resolved, on the motion of Miss Gardiner: That paragraph 7.41 be amended by omitting the words 'may need to be' and inserting instead 'must be'.

Resolved, on the motion of Mr Draper: That Chapter Seven, as amended, be adopted.

Chapter Eight read.

Debate ensued.

Resolved, on the motion of Ms Tebbutt: That the heading immediately before paragraph 8.1 be amended by omitting the word 'healthcare' and inserting instead 'governance'.

Resolved, on the motion of Ms Tebbutt: That paragraph 8.2 be amended by omitting the words 'standards of care' and inserting instead 'governance standards'.

Resolved, on the motion of Mr Daley: That paragraph 8.10 be amended by omitting the words ' fall in the quality and delivery of health care at RNSH in recent years, as demonstrated by the series of patient care incidents and' and inserting instead 'decline in governance standards'.

Resolved, on the motion of Miss Gardiner: That immediately following paragraph 8.25, the following new paragraph be inserted: 'Dr Cregan's view was disputed by some clinicians from RNSH. For example, Dr Hugh told the Committee: '… 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." (Transcript, 22 Nov 07, p57)

Miss Gardiner moved: That paragraph 8.32 be amended by inserting '(the day before a further public hearing of this parliamentary committee)' immediately after the words '15 November 2007'.

Question put and negatived.

Resolved, on the motion of Ms Tebbutt: That paragraph 8.37 be amended by omitting the words 'It is not surprising that clinicians have disengaged from management when it appears that no consideration is given to their views.'

Mrs Skinner moved: That immediately after paragraph 8.37 the following new paragraph be inserted: 'The Committee notes that many clinicians identified a disconnect between management and the medical workforce. There was considerable evidence given and submissions made that highlighted concerns that:

- Clinicians have been excluded or ignored in planning for the best and most appropriate way to delivery clinical care
- Clinical bodies that previously played a considerable role had been downgraded – including the Clinical Council, Medical Staff Council and the hospital General Manager
- Even the newly created Clinical Reference Group did not have terms of reference until the day before members gave evidence to the Parliamentary inquiry.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That immediately after paragraph 8.46 the following quotation be inserted:

> '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.' Prof Leslie Burnett – evidence page 47 22 November.

Question put.

The Committee divided.

Ayes: Mr Draper, Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Mr Daley: That paragraph 8.50 be amended by inserting the sentence 'Currently there are 15 operating rooms and eight procedure rooms' at the end of the paragraph.

Mrs Skinner moved: That paragraph 8.54 be omitted and replaced with: 'While the Committee welcomes the Department of Health assurance that the management of NSCCAHS and RNSH will actively engage clinicians in the planning and redevelopment of RNSH, it is concerned that this has been compromised by the announcement about the new hospital made by Health Minister Reba Meagher in Parliament on November 29, 2007 – in the midst of this inquiry – in which she confirms details of the development, advises that 'three consortia have submitted tenders' and states 'whilst that committee considers evidence the Government will not wait around.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That immediately after paragraph 8.54 the following new paragraph be inserted: 'The Committee notes that concerns had already been raised by clinicians practicing at Royal North Shore Hospital about these details, particularly a lack of sufficient capacity in the proposed new hospital. Dr Tony Joseph, Director of Trauma stated in evidence on November 16th: 'The Minister has now stated in this inquiry that there will be 626 beds in the new hospital – this is the first time we have heard that number – including 46 critical care beds and 40 mental health beds. Thus the new hospital will provide a total of 27 more beds than the current total of 599, which is a concern given the projected population growth for the northern part of Sydney. Professor Pollock has also expressed concerns about the lack of a clinical service plan for the new northern beaches hospital because that would impact on the services provided at the Royal North shore Hospital.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Mrs Skinner moved: That Recommendation 19 be omitted and replaced with the following: 'That the government immediately convene a working party of clinicians through the formal mechanism of the Clinical Reference Group to review the new hospital proposals announced by the Minister for Health in Parliament on November 29th.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Mrs Skinner: That immediately following paragraph 8.61, the following new recommendation be inserted: 'That NSRHS review the management structure of RNSH to ensure appropriate tasks are undertaken by appropriately trained staff with a particular view that directors should be able to focus on the delivery of clinical services.'

Resolved, on the motion of Ms Tebbutt: That Recommendation 20 be amended by omitting the word 'reverse' and inserting instead 'review and modify'.

Resolved, on the motion of Mrs Skinner: That immediately after Recommendation 20, the following new recommendation be inserted: 'That the role of the Director of Nursing be reviewed as a matter of urgency, with a view to restoration of management responsibilities so the most senior nurse on staff has authority to make decisions, and can provide leadership and support for the nursing staff.'

Resolved, on the motion of Mr Daley: That Chapter Eight, as amended, be adopted.

Chapter Nine read.

Debate ensued.

Miss Gardiner moved: That paragraph 9.2 be omitted and replaced with: 'However, the Committee noted the evidence of the AMA which pointed to the policy initiatives of the Howard Government 'associated with the increased medical student numbers … NSW Health should have responded in a more timely fashion to the clear implications. The following graph sets out the proposed increases in medical students in NSW. [Include graph – Medical Student Statistics – p 17, AMA sub].

The AMA's submission stated that NSW Health's 'lack of planning has an impact on hospitals such as Royal North Shore who will be unable to cope with the increased demand on supervision and teaching and will no doubt lead to poor patient outcomes'.

In evidence to the Committee, the AMA NSW President, Dr Keegan said: 'The workforce is going to be a major thing in terms of medicine. We are not aware in New South Wales of any workforce planning across New South Wales of note. We are going to have an increased number of medical graduates… We are anxious to see any planning on how those graduates are going to be trained to become specialist and general practitioners. As far as we can see, that is not happening… I also understand that it was supposed to be two years ago that a study or an assessment was to be done of how many various specialties were required across the State, and that was to be managed, recorded, and planning made to maintain their workforce and enhance that workforce. We understand that is not happening.' (Dr Keegan, transcript, 12 Nov 07, p48).

The Committee also noted the evidence of Dr Clare Skinner: 'In coming years we have almost doubled the number of 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.' (Dr Skinner, transcript, 22 Nov 07, p71)'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Mrs Skinner: That paragraph 9.35 be amended by inserting at the end of the paragraph: 'The Committee notes that there are 99,638 nurses in NSW according to the NSW Health Annual Report for 2006/06, yet the NSW Health submission shows there are only 36,920 nurses employed in the NSW Public Health system.'

Resolved, on the motion of Mrs Skinner: That immediately after paragraph 9.35 the following new paragraph be inserted: 'The Committee further notes evidence given by NSWNA General Secretary Brett Holmes:

> 'There is already a significant delay in being able to recruit people because of the requirement to have the advertising and then the interview process and then the criminal records checked. So it can be six to eight weeks before you actually fill a position that becomes vacant. And if a person has only given you two weeks notice, as they are required under the award, that means you are running short for six weeks and you have to fill that with using overtime, casuals or agencies." (transcript November 12th, p60)

Miss Gardiner moved: That paragraph 9.41 be amended by inserting 'due to its brevity' after 'the inquiry'.

Question put and negatived.

Chapter Ten read.

Resolved, on the motion of Ms Fazio: That paragraph 10.19 be amended by omitting the words 'health insurance' and inserting instead 'hospital bed availability'.

Resolved, on the motion of Mrs Skinner: That paragraph 10.20 be amended by inserting the following sentence at the end of the paragraph: 'The Committee notes the limited capacity of private hospitals to deliver emergency services in the Area.'

Resolved, on the motion of Mr Daley: That paragraph 10.23 be amended by omitting the word 'suspicion' and inserting instead 'doubt'.

Resolved, on the motion of Ms Fazio: That recommendation 24 be amended by inserting the words '/cross-border flows' immediately after the words 'out-of-Area referrals'.

Resolved, on the motion of Ms Fazio: That recommendation 24 be amended by omitting the word 'two' and inserting instead 'six'.

Resolved, on the motion of Ms Fazio: That paragraph 10.25 be amended by omitting the words 'health insurance' from the first and last sentences and inserting instead 'hospital bed availability'.

Resolved, on the motion of Ms Fazio: That paragraph 10.25 be amended by omitting the words 'with private health insurance' from the last sentence.

Resolved, on the motion of Ms Fazio: That recommendation 25 be amended by omitting the words 'health insurance' and inserting instead 'hospital bed availability'.

Resolved, on the motion of Ms Fazio: That recommendation 25 be amended by omitting the words 'and services by people with private health insurance'.

Mrs Skinner moved: That immediately after paragraph 10.44 a new paragraph be inserted with the words: 'These figures are different to those provided by Health Minister Reba Meagher on October 26 2007, in answer to a question asked during a meeting of General Purpose Standing Committee No 2. The Minister's written response indicated a 2007-2008 Net Cost of Service budget for North Shore Ryde of 4346.2million. This agrees with the figure included in a NSCCH Net Cost of Services Summary paper tabled by Committee member Jillian Skinner.'

Question put.

The Committee divided.

Ayes: Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Ms Tebbutt moved: That paragraph 10.72 be amended by deleting the words: 'The Committee is not convinced that information provided by NSW Health is sufficiently accurate to come to the conclusion that RNSH is inefficient in comparison with its peers.'

Question put.

The Committee divided.

Ayes: Mr Daley, Mr Draper, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt
Noes: Miss Gardiner, Mrs Skinner.

Question resolved in the affirmative.

Resolved, on the motion of Ms Fazio: That paragraph 10.115 be amended by inserting the words 'and the forthcoming redevelopment of the hospital campus,' immediately after the words 'once completed'.

Resolved, on the motion of Ms Fazio: That recommendation 30 be amended by inserting the words 'and the forthcoming redevelopment of the hospital campus.' immediately after the words 'once completed'.

Resolved, on the motion of Ms Tebbutt: That paragraph 10.146 be amended by omitting the words: 'that is, at least four per cent of the total budget'.

Resolved, on the motion of Ms Tebbutt: That recommendation 34 be amended by omitting the words: 'that is, at least four per cent of the total budget'.

Resolved, on the motion of Ms Fazio: That paragraph 10.158 be amended by omitting all words appearing after 'provided to the Committee' and inserting instead 'and the Committee agreed to keep it confidential at the Minister's request.'

Resolved, on the motion of Ms Tebbutt: That paragraph 10.161 be amended by omitting 'The Committee is concerned that the existing trust funds are not properly managed, and is particularly concerned at suggestions that the trust funds may be being inappropriately used to meet operational expenses rather than for the purpose for which they were intended by those people who provided them.'

Resolved, on the motion of Mr Daley: That paragraph 10.162 be amended by deleting the words after 'that' in the first line until the word 'request' and inserting instead: 'the monitoring of trust funds be improved, with nominated hospital executives receiving monthly reports on income and expenditure from clinicians and administrators, and that this information be made publicly availably annually on request'.

Mr Daley moved: That recommendation 35 be amended by inserting the following words after the word 'that': 'the monitoring of trust funds be improved, with nominated hospital executives receiving monthly reports on income and expenditure from clinicians and administrators, and that this information be made publicly availably annually on request'.

Question put.

The Committee divided.

Ayes: Mr Daley, Ms Fazio, Ms Tebbutt, Dr McDonald, Mr Draper, Revd Nile
Noes: Miss Gardiner, Mrs Skinner.

Question resolved in the affirmative.

Resolved, on the motion of Mr Daley: That Chapter Ten, as amended, be adopted.

Chapter Eleven read.

Resolved, on the motion of Miss Gardiner: That immediately after Recommendation 36, the following new recommendation be inserted: 'That NSW Health review the operation of Incident Information Management Systems and training in their use across all Area Health Services and report the results of the review in the next NSW Health Annual Report.

Resolved, on the motion of Ms Tebbutt: That paragraph 11.24 be amended by omitting 'RNSH is the only hospital in this State that seeks to measure its rate of adverse events' and inserting instead: 'RNSH was the first hospital in the State to seek to measure its rate of adverse incidents.'

Resolved, on the motion of Mr Daley: That paragraph 11.26 be deleted.

Resolved, on the motion of Ms Fazio: That paragraph 11.31 be deleted.

Resolved, on the motion of Ms Fazio: That Recommendation 37 be amended by omitting all words appearing after 'That NSW Health' and inserting instead: 'in conjunction with the Clinical Excellence Commission examine the use of systematic audits of medical records, such as QaRNS.'

Resolved, on the motion of Miss Gardiner: That the following new paragraph and recommendation be inserted immediately after paragraph 11.59: 'The Committee also believes that the experience that a patient has while in hospital and the experiences of the patient's family and carers who visit and interact with the hospital during the patient's stay should be key performance indicators for the hospital and its management personnel.'

Recommendation
That the Clinical Excellence Commission give a high priority to the development and implementation of programs that measure patient satisfaction as a key performance indicator for each hospital and health facility, alongside key performance indicators relating to the delivery of technically excellent care.'

Mrs Skinner moved: That a new section entitled *Monitoring of the implementation of the recommendations of this report* be inserted with the following text to appear below the new sub-heading: 'In light of evidence from numerous witnesses that clinical service plans have been started previously, that reviews have been done but not effectively implemented, the Committee recommends an independent body be established to report on the implementation of recommendations in this report, in particular the impact of the clinical services plan' '[include quotes from Submission 27, p3; Submission 48, p4; Submission 49, p3; Submission 50, p3.]'

'Recommendation
That an independent oversight panel be established to monitor and report on the implementation of recommendations in this report. A particular emphasis is to be placed on the development, implementation and impact of the clinical services plan. To be known as the RNSH Clinicians Oversight Panel, it will comprise eminent clinicians representing the major medical/nursing colleges (Emergency Medicine, Physicians, Anaesthetists, Pathology, Nursing etc), endorsed by members of the RNSH Medical Staff Council.'

Question put.

The Committee divided.

Ayes: Mr Draper, Miss Gardiner, Mrs Skinner
Noes: Mr Daley, Ms Fazio, Dr McDonald, Revd Nile, Ms Tebbutt.

Question resolved in the negative.

Resolved, on the motion of Ms Tebbutt: That the draft report, as amended, be the report of the Committee.

Resolved, on the motion of Mr Daley: That the Committee present the report to the House, together with transcripts of evidence, submissions, tabled documents, minutes of proceedings, answers to questions on notice and correspondence relating to the inquiry [except for in camera evidence and documents kept confidential by resolution of the Committee].

Resolved, on the motion of Mr Daley: That Dissenting Reports be submitted to the secretariat by 12 noon on Wednesday 19 December.

The Chairman advised the Committee of his intention to hold a media conference in the press room after tabling the report on Thursday.

6. Adjournment

The Committee adjourned at 4.10pm *sine die*

Beverly Duffy
Clerk to the Committee

Appendix 8 Dissenting statements[1]

Dissenting statement – Mrs Jillian Skinner MP

DISSENTING REPORT BY JILLIAN SKINNER, MP, (Liberal)

Shocking allegations lead to inquiry

This Inquiry was established after a series of shocking allegations about patient care, budget problems, bed shortages and emergency department blockages with overworked and stressed staff leading to a culture of bullying and harassment at RNSH.

Opposition Members of the Joint Select Committee on the Royal North Shore Hospital Inquiry accept that its report highlights the main issues presented in evidence to the inquiry. However, the Opposition Members believe that some of the recommendations fall short of providing solutions that will resolve long standing problems.

In these dissenting statements we recommend:

- establishment of an independent oversight body to monitor and report on the implementation of recommendations in this report,
- the NSW Government make more hospital based training places available for specialist training
- involvement of emergency department (ED) doctors in establishing optimum levels for ED workforces recommended in the report (building on AMWAC guidelines)
- an extra 70 beds immediately opened at RNSH, with adequate resources to staff and operate them with further work to determine how many beds will be needed to ensure less than an 85% occupancy rate
- the development of clinical service plans to determine the roles of each of the hospitals in the region,
- establishment of a RNSH Board
- greater transparency and accountability in budgets, including trust funds

Monitoring the implementation of this report

We believe that the way forward is of fundamental importance – and thus start by noting evidence from numerous witnesses that clinical service plans have been started previously, that reviews have been done but not effectively implemented.

[1] The Dissenting Reports by Joint Select Committee Opposition Members Jillian Skinner and Jenny Gardiner are to be read together. (There are two Opposition Dissenting Statements due to the Legislative Council's Standing Orders word limit on dissenting reports. Some topics are covered in this Statement and the remainder are in Jenny Gardiner's Statement).

'A series of reviews over the past few years have highlighted the issues facing RNSH ED but action on the recommendations has been slow or absent.'[2]

'There was an Area Business Planning Forum in March 2006 to develop a Clinical Services Plan for the Area, which was to be delivered by July 2006, but this did not occur.'[3]

'In June 2006 Northern Sydney Central Coast Health Service (NSCCHS) re-structured, and a new Divisional structure was implemented in NSCCHS to achieve efficient and effective operational management of the four health services in NSCCHS, including North Shore and Ryde Health Service. At the same time, a new Clinical Network structure was to be implemented for NSCCHS to provide a strategic planning framework for NSCCHS. This has not occurred.'[4]

'We are particularly demoralized by the ineffectiveness of our repeated submissions to both external (Chairperson - Dr King) and internal (Chairperson - Professor Pollock) formal enquiries.[5]

In light of these strong views and to avoid the feared 'shelved report gathering dust' syndrome, Jillian Skinner moved that an independent oversight panel - the RNSH Clinicians Oversight Panel - be established to monitor and report on the implementation of recommendations in this report. It should comprise eminent clinicians representing the major medical/nursing colleges (Emergency Medicine, Physicians, Anaesthetists, Pathology, Nursing etc), and supported by members of the RNSH Medical Staff Council.

We note that although NSW Health and the Minister for Health were able to make supplementary submissions commenting on evidence presented by other witnesses to the inquiry, the Committee majority voted not to recall the Minister or the Director General and other senior NSW Health officers so as to test the evidence they presented at the beginning of the Committee's first hearing with that presented by any other witnesses.

We also note that some measures adopted or announced by the Minister in relation to RNSH – for example the major cleaning blitz and announcements about increased beds, extra specialists and purchase of some badly needed equipment – happened only after the start of this inquiry.

Shortage of emergency specialists

We note that emergency department (ED) doctors claimed there were fewer funded (and filled) emergency specialist positions in the department than suggested by NSW Health. In light of the Government's rejection of the 2003 AMWAC staffing guidelines, and because of their strongly held views that specialist doctor shortages are impacting on the work of the ED, Opposition Members

[2] *Dr Robert Day, Director Emergency Department RNSH, Submission 27 p3*

[3] Dr Tony Joseph, Director of Trauma (Emergency) RNSH, Submission 48 p4

[4] Dr Sharon Miskell Director of Medical Services, NSRHS, Submission 49 p3

[5] Dr David Sonnabend, Chairman, Department of Orthopaedic and Traumatic Surgery, RNSH Submission 50 p2

believe that ED doctors should be engaged in establishing optimum levels for ED workforces recommended in the report.

We believe the NSW Government must make more hospital based training places available for medical students and graduates, based on the concerns expressed by the NSW) AMA and ASMOF about the failure of the NSW Government to provide funding for hospital based training places for medical students and graduates:

> ***'Over the past five years, AMA and ASMOF have been advising NSW Health and the NSW Government of the potential concerns associated with the increased medical student numbers. While the policy initiatives have been generated by the Federal Government, NSW Health should have responded in a more timely fashion to the clear implications.'***[6]

AMA President, Dr Andrew Keegan testified:

> ***'The workforce is going to be a major thing in terms of medicine. We are not aware in New South Wales of any workforce planning across New South Wales of note. We are going to have an increased number of medical graduates, as is mentioned in our submission. We are anxious to see any planning on how those graduates are going to be trained to become specialist and general practitioners. As far as we can see, that is not happening.'***[7]

And further evidence was given that:

> ***'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.'***[8]

Access block

Access block problems addressed in chapter 4 include evidence from the Minister for Health regarding claimed improvements in performance against triage categories three and four. We note that she failed to mention any improvement in triage category two where patients in 'imminently life threatening condition' are supposed to be seen within 10 minutes. It is most frequently these patients who need to be admitted to hospital for further treatment, but must wait in the ED because they cannot be found a bed in the wards. This is known as access block and we note that many witnesses identified a lack of inpatient beds as its main cause.

(Jenny Gardiner MLC (The Nationals) will make further comments in her dissenting statement)

[6] Australian Medical Association (NSW) Limited and the Australian Salaried Medical Officers Federation (NSW), submission 32 P17

[7] Dr Andrew Keegan, President AMA (NSW), evidence 12 November 2007 p48

[8] Dr Clare Skinner, Emergency Registrar, RNSH, evidence 22 November 2007 p71

Dissenting statement – Hon Jenny Gardiner MLC

Dissenting report- Hon Jenny Gardiner
(The Nationals)

Bed numbers and the bed occupancy rate

The Liberal and Nationals Members of the JSC on RNSH note the recommendation of several clinicians and professional medical bodies that a benchmark bed occupancy rate of 85% be adopted. The AMA and ASMOF cited:

> ***'UK Department of Health's Economics and Operational Research Division which showed a clear relationship between high occupancy and the risk of cancellation of elective admissions.'***
>
> ***'The Australasian College of Emergency Medicine [ACEM] and the Australian Medical Association have identified that bed occupancy rates in excess of 85 per cent lead to elective surgery cancellations and delays in patients being transferred from Emergency Departments to inpatient hospital beds.'***[1]

The **Opposition Members believe** that an extra 70 beds should be immediately opened at RNSH, with adequate resources to staff and operate them as recommended by the AMA and ASMOF and further, that, as part of its role in developing the Area Clinical Services Plan, NSCCAHS work with senior clinicians to determine the roles of each of the hospitals in the region, how many beds will be needed to ensure less than an 85% occupancy rate at RNSH, ensure appropriate referral patterns to RNSH from within and outside the Area, ensure better patient flow-through and efficient discharge processes within the hospital and provide better after hours availability of diagnostic services to allow RNSH ED to meet patient demand.

Structure of Northern Sydney Central Coast Area Health Service

The Opposition Members support the testimony of front-line clinicians that the 2005 amalgamation of Northern Sydney and the Central Coast into one large NSCCAHS by the then Minister for Health, Hon. Morris Iemma, has made delivery of health care more difficult.

We note the discontent with the amalgamation of the Area Health Services and also the merging of Royal North Shore Hospital with Ryde Hospital expressed by many doctors actually working in the hospitals[2]. Numerous doctors commented about the geographical remoteness of the Area Chief

[1] Australian Medical Association (NSW) Limited and the Australian Salaried Medical Officers Federation (NSW), Submission 32 P14

[2] Submission, Department of Neurology, Submission 38 p7

Executive, the lack of access to the CEO and the power centralised to that position[3] at the same time as the RNSH general manager lost 'control over the budget and decision making'[4].

Lack of a clinical services plan

We note that underlying many of the concerns expressed by doctors is the lament that the lack of a clinical services plan for the two hospitals – and others in the region including Hornsby and the proposed new Northern Beaches hospital – means there is 'no clear role delineation between the facilities'[5]; 'North Shore is lumbering along with two dysfunctional appendages'[6]; 'there is no operational cross-over and very few medical appointments across both hospitals'.[7] We further note comments that clinical service planning had been initiated earlier without result and consequently recommend a mechanism statement (see Dissenting Report by Jillian Skinner, MP) to monitor implementation of the plan now promised.

Royal North Shore Hospital Board

The Opposition Members accepted the proposition put to the inquiry by Professor Stephen Hunyor, Director Cardiac Technology Centre, RNSH,[8] that a RNSH Board should be established along the lines of the Westmead Children's Hospital Board for a five-year period followed by a review.

Planning for the new RNSH

We are concerned that NSW Health assurances that the management of NSCCAHS and RNSH will actively engage clinicians in the planning and redevelopment of RNSH, has been compromised by the announcement about the new hospital made by Health Minister Reba Meagher in Parliament on November 29, 2007 – in the midst of this the parliamentary inquiry – in which she confirms details of the development, advises that '***three consortia have submitted tenders'*** and states ***'whilst that committee considers evidence the Government will not wait around'***.[9]

We note that concerns about the details of the redevelopment had already been raised by RNSH clinicians particularly a lack of sufficient capacity in the proposed new hospital. Dr Tony Joseph, Director of Trauma stated:

> ***'The Minister has now stated in this inquiry that there will be 626 beds in the new hospital – this is the first time we have heard that number – including 46 critical care beds and 40 mental health beds. Thus the new hospital will provide a total of 27 more beds than the current total of 599, which is a concern given the projected population***

[3] Dr Greg Purcell, Department of Anaesthesia and Pain Management, Submission 64 p5

[4] Prof Dale Bailey, Chair of the Royal North Shore Scientific Staff Council, Submission 89 pp1-2

[5] Dr Sharon Miskell Director of Medical Services, NSRHS, evidence 16 November 2007 p 26

[6] Prof Stephen Hunyor, Chairman of Cardiology, RNSH, evidence 16 November 2007 p3

[7] Dr Tony Joseph, Director of Trauma (Emergency) RNSH, Submission 48 p4

[8] Prof Stephen Hunyor, Chairman of Cardiology, RNSH, evidence 16 November 2007 p2

[9] Hon Reba Meagher, Minister for Health in answer to RNSH redevelopment question without notice, NSW Legislative Assembly, 29 November 2007

growth for the northern part of Sydney. Professor Pollock has also expressed concerns about the lack of a clinical service plan for the new northern beaches hospital because that would impact on the services provided at the RNSH."[10]

We further note the farcical response by hospital planners to concerns raised by clinicians such as that described in evidence by Prof Leslie Burnett:

> **'…**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."*** Prof Leslie Burnett, Director Pacific Medical Laboratory Services Pathology, RNSH, evidence 22 November 2007 p47

Workforce issues

We also note that many clinicians identified a disconnect between management and the medical workforce. There was considerable evidence tendered that highlighted concerns that:

- Clinicians have been excluded or ignored in planning for the best and most appropriate way to delivery clinical care
- Clinical bodies that previously played a considerable role had been downgraded – including the Clinical Council, Medical Staff Council and the hospital General Manager
- Even the newly created Clinical Reference Group did not have terms of reference until the day before members gave evidence to the Parliamentary inquiry.

Financial management and resource allocation

The report acknowledges that RNSH clinicians generally expressed the view that they believed the hospital was under-funded, particularly because of the large number of 'out of Area' patients accessing the statewide services provided by the hospital including treatment for burns, spinal cord injury, the intensive care unit and so on. And it acknowledges that many expressed doubts about the accuracy of data collected by management to determine the claimed cost of services at RNSH.

[10] Dr Tony Joseph, Director of Trauma (Emergency) RNSH, evidence 16 November p11

However, the Opposition Members believe that resource allocations included in the report are not clear and point to differences in NSW Health figures presented in the report and those provided by Health Minister, Reba Meagher, to General Purpose Standing committee No 2 on October 26 2007. The Minister's written response indicated a 2007-2008 Net Cost of Service budget for North Shore Ryde of $346.2million. This agrees with the figure included in a NSCCH Net Cost of Services Summary paper tabled by Committee member, Jillian Skinner.

Further, we are of the opinion, based on evidence presented to the inquiry about inappropriate use of trust funds, that greater public accountability will only be possible if the status of all trust funds relevant to RNSH are reported in the NSCCAHS annual report.