



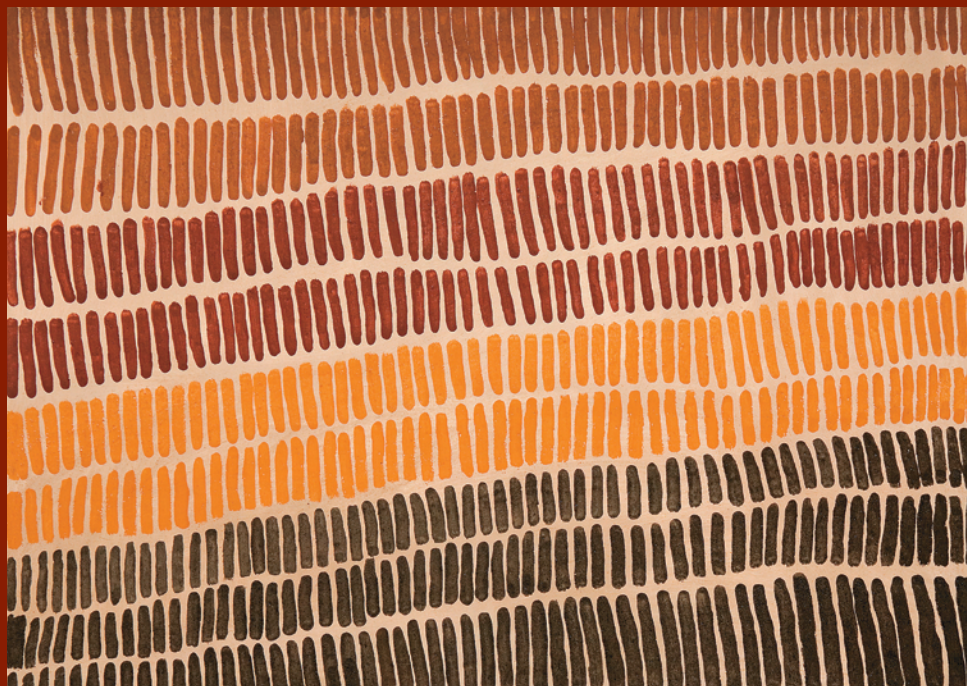
Special Commission of Inquiry

Acute Care Services in NSW Public Hospitals

# Final Report of the Special Commission of Inquiry

## Acute Care Services in NSW Public Hospitals

Volume 3



Peter Garling SC  
27 November 2008

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Acute Care Services in New South Wales Public Hospitals

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**Special Commission of Inquiry**

**Acute Care Services in NSW Public Hospitals**

# Part F

# Practical components





## 25 Funding

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- 25.1 In this chapter, I will examine:
- (a) how much money is spent on NSW public hospitals each year, either by the State or Commonwealth Governments;
  - (b) whether it is enough;
  - (c) how money is allocated to hospitals; and
  - (d) proposed improvements to this system.

## Commonwealth Government funding

- 25.2 The Commonwealth Government does not directly provide any patient care services<sup>1</sup> but does provide funding for:
- (a) payments to the States and Territories through the Australian Health Care Agreement (“AHCA”) and other agreements for health and hospital services;
  - (b) Medicare Benefits Schedule (“MBS”) including paying GPs for primary health care;
  - (c) Pharmaceutical Benefits Scheme (“PBS”);
  - (d) long term aged care; and
  - (e) the private health insurance 30% rebate.
- 25.3 The Commonwealth Government provides this funding under its constitutional powers in respect of health as follows:
- (a) Section 51(xxiiiA) of the Constitution gives power to make laws relating to “provision of pharmaceutical, sickness and hospital benefits, medical and dental services”. This forms the basis for MBS, PBS and the private health insurance rebate.
  - (b) Section 96 empowers the Commonwealth to make grants to States to as Parliament see fit. This is the basis for Special Purpose Payments to the States and Territories, GST distribution, and the Australian Health Care Agreements.

## Australian Health Care Agreements

- 25.4 The Federal Government provides money to each of the States and Territories for public hospitals every year under the Australian Health Care Agreements that are made between the Federal Government and each State and Territory. The agreements are generally for 5 years. The most recent agreement ran from July 2003 to June 2008. This agreement was extended to 1 July 2009 at the Council of Australian Governments meeting on 26 March 2008. I understand that it is anticipated that a new agreement will be entered into before the end of 2008, which will commence with effect from 1 July 2009. It would be idle of me to speculate about the contents of that agreement. The Commonwealth has increased its contribution to NSW by an additional \$167.1 million dollars above its expected contribution for the 2008/09 financial year.<sup>2</sup>
- 25.5 There are a number of different monetary grants that the Commonwealth Government provides to the New South Wales Government under the Australian Health Care Agreement. The amount that the Commonwealth pays to NSW is calculated through a formula contained in Schedule G of the 2003 Australian Health Care Agreement. The base health care grant is the primary sum of money paid to NSW. It contains 3 parts.<sup>3</sup>

- (a) **The general component** – This is calculated by reference to the State’s “weighted population”. The weighted population is an adjustment of the actual population according to the ages of the residents. Different age groups are assigned a numerical value. This value is multiplied by the respective numbers in each age group to determine the weighted population. For example a male aged 5–14 is weighted at 0.225421, whereas a male aged 85+ is weighted 5.715956.<sup>4</sup> Therefore, a State with a higher percentage of older residents will receive more money than one with a predominantly younger population;
- (b) **A palliative care component** – This is also determined on a weighted population basis; and
- (c) **A safety and quality component** – This is determined in a curiously complex way which involves taking of a fixed sum of \$50.12M which is an amount in 2002-03 prices and then adjusting it for inflation by using the Commonwealth factor.
- 25.6 Each of the components above are annually adjusted for inflation by use of the Commonwealth’s Wage Cost Index. For 2008, this Index is 2.1%, which is also the average of this index since 2000-01. The inflation factor in 2008-09 will be significantly higher than this figure (in the order of 5%).
- 25.7 The formula in Schedule G of the Australian Health Care Agreement is also adjusted annually for the increase in usage of public hospital services. This adjustment which is 1.7% per annum is applied to only 75% of the total funding, resulting in an effective annual rate of 1.2%. Other slight adjustments are made in the calculations.
- 25.8 Once the annual total is calculated the Commonwealth pays 96% of the sum of the all of the above components to NSW. As I understand it, the total Commonwealth funding provided to NSW for 2007-08 was \$3,062,038,000. Total funding expected in 2008-09 is \$3,389,263,000.<sup>5</sup> This money is paid to the NSW Government and distributed to NSW Health through the consolidated fund.

### Commonwealth funding conditions

- 25.9 The Australian Health Care Agreement contains various conditions that impose rigidity on this funding. Under the current agreement, NSW is responsible for the provision of public hospital services to eligible persons and will:
- “b) ensure that eligible persons are able to access public hospital facilities, free of charge, as public patients;”
- 25.10 “Eligible person” is taken to be as defined in section 3(1) of the *Health Insurance Act 1973* (Cth),<sup>6</sup> and is as “an Australian resident or an eligible overseas representative”.<sup>7</sup> The definition of Australian resident is broad and includes: Australian citizens; holders of permanent visas; New Zealand citizens and others who are legally in Australia without any time limitation on their stay.<sup>8</sup>
- 25.11 Under all of the Agreements, the States and Territories have also been obliged to increase their own source funding for public hospital services to match, or exceed, the cumulative rate of growth of the Commonwealth funding.<sup>9</sup> All of the States and Territories exceeded this commitment in 2005-06.<sup>10</sup>
- 25.12 The Commonwealth, for its part, contributes to the cost of State public hospital services, at the level specified in the agreement, subject to NSW meeting its obligations. This arrangement has been criticised by many as it places the responsibility with the States and Territories without any reciprocal responsibility being held by the Commonwealth.<sup>11</sup>

- 25.13 To ensure that it is getting what it perceives to be value for money, the Commonwealth Government has imposed a large number and variety of performance indicators which occupy many pages of text. I was told that they amount to volumes and that a significant number of staff are retained by NSW Health to report compliance with that multitude of indicators.<sup>12</sup>
- 25.14 New South Wales is currently required to report on information such as: the number of admissions; waiting times for elective surgery; hospital admissions from the emergency department; number of patients within the recommended time by triage category; total number of beds and average length of stay.<sup>13</sup> These indicators of hospital performance are relatively easy to determine and are understood by the public and media, although they may not truly reflect the extent of hospital activity and performance.<sup>14</sup> In fact, they tend to encourage throughput at the cost of all other features, many of which are, to my mind more important. The Commonwealth reporting indicators do not put the patient and patient care at the centre of their concern, rather they make volume, turnover and throughput the principal indicators.
- 25.15 The Commonwealth requirement for these kinds of performance indicator is continuing and I am informed that the performance targets are a key part of the negotiations for the new Australian Health Care Agreement, due to be signed before the end of 2008.<sup>15</sup>

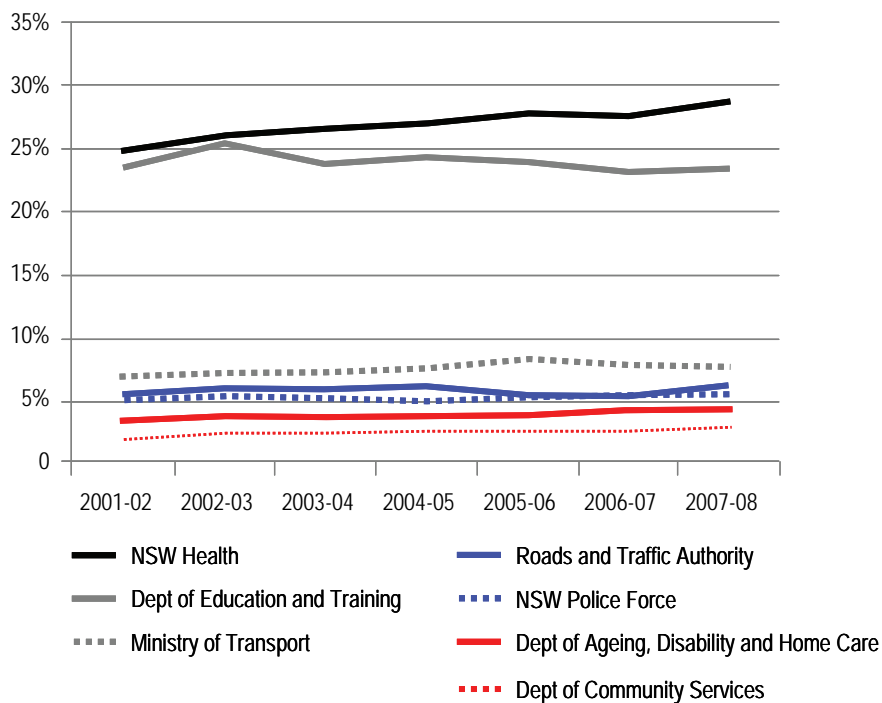
## NSW Government funding

- 25.16 NSW Health receives funding from the following sources:
- (a) the Commonwealth Government through the Australian Health Care Agreement, Special Purpose Payments, other grants and the Department of Veterans' Affairs;
  - (b) the NSW Government, which co-funds public hospitals, population health, prisoner health, ambulance and community health;
  - (c) private health insurance and injury compensation refunds;
  - (d) individual out of pocket expenses and co-payments;
  - (e) other revenue, for example, car parking; and
  - (f) donations.<sup>16</sup>
- 25.17 With these funds, the NSW Government provides public health services through:
- (a) public hospitals;
  - (b) State Government nursing homes;
  - (c) community health; and
  - (d) a wide variety of other programs.
- 25.18 The NSW Government is also responsible for building hospitals and providing infrastructure.<sup>17</sup>

## NSW Health budget 2008-09

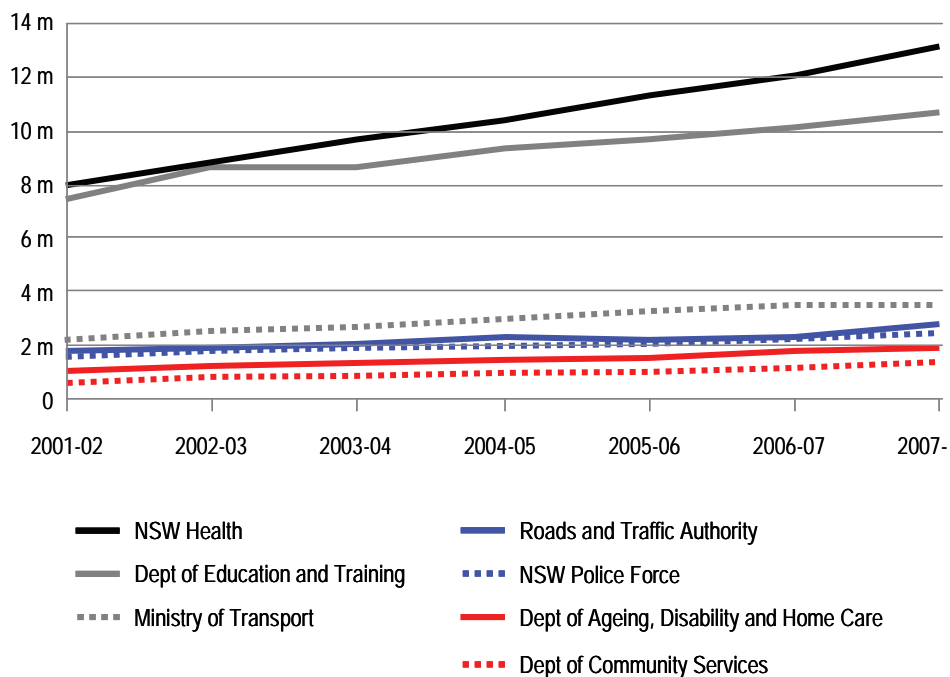
- 25.19 The current NSW Health budget is \$13.2 billion, amounting to 27.7% of the entire budget for NSW.<sup>18</sup> This includes the funding provided to it by the Commonwealth under the Australian Health Care Agreements. The following graph demonstrates that the proportion of NSW Total Budget being spent on health has been constantly increasing for the years 2001-02 to 2007-08:

Figure 25.1 Share of NSW General Government expenditure (%)



25.20 The amount of money being spent on health has also been steadily increasing, as demonstrated on the following graph.

Figure 25.2 Share of NSW General Government expenditure (\$000's)



- 25.21 The majority of this money is distributed to each of the area health services using the resource distribution formula, discussed below. The remaining money is allocated for specific purposes. For example:
- (a) almost \$20 million was allocated for 160 extra community-based residential or aged care places in the community (CAPAC – Community Acute/Post Acute). Treatment in the community equates to half of the cost of acute care beds in hospitals, so by supporting the treatment of the aged in the community they are reducing some of the pressure on beds;
  - (b) \$32.3 million for new and replacement equipment. This will be implemented through a state-wide contract and bulk purchasing; and
  - (c) almost \$20 million for an additional 72 medical assessment unit (MAU) beds.<sup>19</sup>
- 25.22 The 2008/09 budget for health has increased by \$632 million, approximately 5%, on the 2007/08 budget.<sup>20</sup>
- 25.23 One important issue in determining the budget in each year is how the impact of inflation is taken into account. Inflation ordinarily is measured by the rate of change in the consumer price index, or CPI, as reflected in the increase in the cost of goods and services. The rate of increase of costs in the health sector (“health inflation”) is not necessarily in step with that of general inflation.<sup>21</sup> A comparison of the annual rates of health inflation and general inflation from 1993-4 to 2003-04 reveals that the health inflation rate has been on average 0.8% higher than the general inflation rate.<sup>22</sup>
- 25.24 In addition, health expenditure is increasing as a result of other factors including population growth and ageing, new health technologies such as new clinical treatments and medications, and rising community expectations, which increase the usage of health services and require changes in the mix of services provided. I note that the combined increase in health costs which includes both health inflation and the increases to which I have just referred appears to be at least 4.8% in the year from June 2007 to June 2008, whereas the combined average of the other sectors (excluding housing and financial and insurance services) was 3.3%.<sup>23</sup> It may be that comparing these figures leads to some confusion because the health price index and the consumer price index are not necessarily comparable. It is sufficient for the purposes of this report to note that possible confusion, but nevertheless to conclude that the annual cost of continuing to provide health care in NSW is growing at a rate which to me significantly exceeds the costs of the provision of services in other sectors and the ordinary rate of inflation.
- 25.25 In 2003, the Commonwealth Government released its *Intergenerational Report* that examined the Commonwealth’s financial policies in light of the ageing population and long term demographic and population trends. The Report recognised that the areas of growth in the context of various Government policies, were particularly health, aged care, social security payments and education. The Report found that the cost of health services, for reasons beyond normal population growth and economic change, was increasing at a rate faster than other areas of Government spending. Technological change, new medications on the PBS, and greater use of diagnostic procedures mean that health expenditure is growing faster other areas. For example, the non-demographic real growth rate for Commonwealth health spending (population and age structure removed) from 1989-90 to 2000-01 was 3.2%.<sup>24</sup> The *Intergenerational Report 2007* updated these figures by reporting that the non-demographic growth rate for the period from 1995-96 to 2005-06 was 3.92%.<sup>25</sup>
- 25.26 I was told that NSW Health had negotiated with NSW Government Budget Committee to be allocated an extra amount each year to compensate for the increase in health expenditure, known as general growth funding. At present the allocation amounts to a

2.25% increase in some but not all of the base funding provided by NSW (but not the Commonwealth), and is additional to the standard escalation of funding to adjust for inflation which is applied to every agency's allocation as part of the annual budget process and to any increases for specific programs. NSW Health is the only NSW Department that receives an extra amount for general growth funding and it is provided to counteract the increasing rate of health spending (health inflation). In the 2008/09 Budget allocation this general growth funding amounts to an increase of about \$112 million.<sup>26</sup>

- 25.27 Wages and other staffing costs amount to approximately 61.5% of the health budget.<sup>27</sup> Under the NSW Government wages policy, increases of 2.5% in taxpayer funding for the wages of all NSW public sector employees are factored into the budget for all NSW Government Departments. This policy is designed to rationalise the large increases that public sector employees have received over the last decade that were considerably higher than in the private sector in this period.<sup>28</sup> The rate of 2.5% was decided upon because it represents the mid-point in the range of the Reserve Bank's target inflation rate of 2 to 3%. It is a matter wholly for the NSW Government as to the way in which it fixes its wages policy and it is not for me to comment on that matter. However, the rate which it fixes, will, if it does not match the real inflation rate, lead to pressure being placed on the existing health budget and will have consequences on the workforce, some effects of which have become apparent in the course of my Inquiry and to which I make reference elsewhere.
- 25.28 The policy does allow for increases greater than 2.5% but "only where the additional expense is offset by employee-related cost savings" at a department level.<sup>29</sup> I am told that when NSW Health wishes to increase salaries beyond the mandated 2.5%, it makes up the shortfall either through its recurrent funding, cuts to staffing levels, reducing conditions such as the maximum number of accumulated rostered days off or else with other workplace efficiencies.
- 25.29 The national inflation rate applied in the 2008/09 Federal budget was 4.25%. I understand the NSW Government uses the Sydney inflation rate, which is different from the national average. The consumer price index change for Sydney from the March quarter 2007 to the March quarter 2008 was 3.9%. Whilst I understand the argument for restraining wage increases on the basis that these become embedded expenses and "represent a structural weakening of the budget position",<sup>30</sup> the reality is that, without the savings referred to in the previous paragraph, employees would be left with an effective reduction in their pay unless pay is increased according to inflation.

#### *Other funds*

- 25.30 Each year NSW Health also generates its own revenue from a variety of sources including charges to patients, revenue from private patients and various grants and contributions. This amounts to approximately \$1.8 billion per annum with an average increase of approximately \$150 million per year. This amount is included in the overall Health budget.



- 25.31 I was told by officers of the NSW Treasury that additional funding is made available to NSW Health under what is termed "maintenance of effort" funding. This is the term said to be applied to the funding increases above the forward estimates that are approved in the annual Budget process for the continuance of existing services, including projects that were the subject of a variation in the previous budget allocation. For example, if there has been an identified need for a particular service half way through the year, a variation may be granted and additional funds made available. If this service continues into subsequent years, then it will be recorded as maintenance of effort. In the 2008/09 budget the maintenance of effort total is approximately \$142.7 million. Having examined the detail in the current 2008-09 year of this funding, I have concluded that most of this funding does not represent a real increase in the amount of money available to deliver services but is somewhat illusory, consisting largely of technical and accounting adjustment factors.
- 25.32 The NSW Department of Health also receives money from the Department of Veterans Affairs (Commonwealth) for the health needs of gold card holders. This money is paid directly to NSW Health. Any money that is paid for the health needs of veterans is directed back to the area health service in which the care was provided. This provides an incentive to the area health services to identify those patients, track their treatments accurately and bill them appropriately.<sup>31</sup>

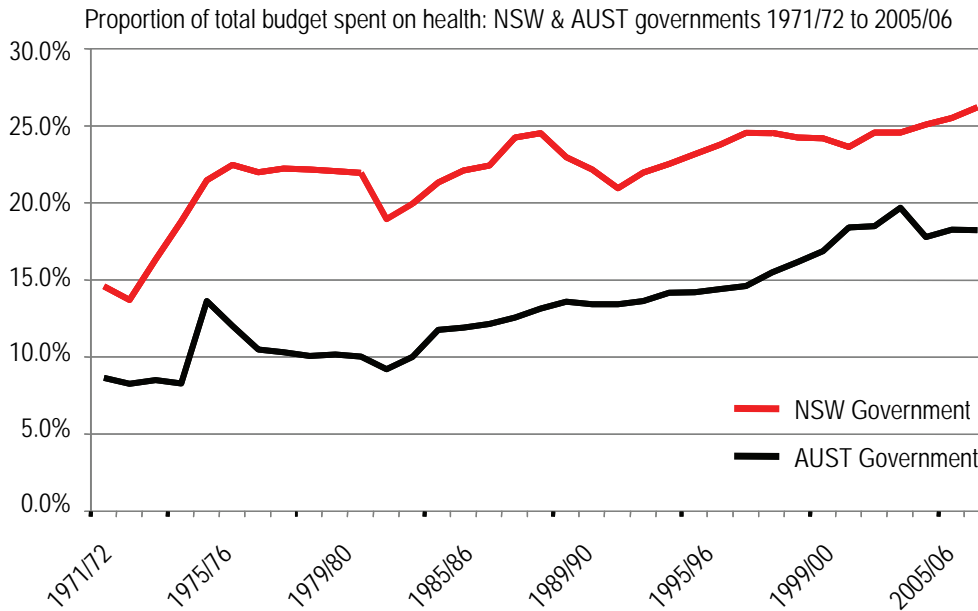
#### *Efficiency targets*

- 25.33 Since 2005-06, as part of an attempt to reduce excessive spending, the NSW Government has imposed efficiency targets, usually called the efficiency dividends, on all government Departments including NSW Health. The theory behind this program is that all government departments can become more efficient in the way in which they deliver their current services. Greater efficiency ought to lead to a lower cost of service delivery. Accordingly, by requiring monetary savings to be made which are returned to central funds (for re-distribution as appropriate), services will be delivered more efficiently. The policy requires each Department to reduce its expenditure ostensibly by becoming more efficient in the management of its resources. These savings are to be made by on-going efficiencies that do not result in a reduction of front-line clinical services. NSW Health was required to save \$91.3 million in 2005-06. In 2008/09 this has increased to an annual sum of \$118.1 million. This efficiency target is cumulative with the effect that in each year the Department is expected to again make all of the saving from the previous year and then to add the target for that year. What that means is that the program requires that in the current year, NSW Health has a total efficiency target of \$417.5M. Over the 3-year period, the main saving that NSW Health has made has been through procurement, the reduction in administration and support staff, and the amalgamation of the area health services.<sup>32</sup>
- 25.34 To reach the efficiency target of \$118.1 million for the 2008/09 budget, NSW Health plans to make savings through the implementation of episode funding, shared services and procurement. I was told that approximately \$35.6 million will be saved this year through the introduction of episode funding, \$21 million in shared services and \$7 million on procurement.<sup>33</sup> I have discussed this below.

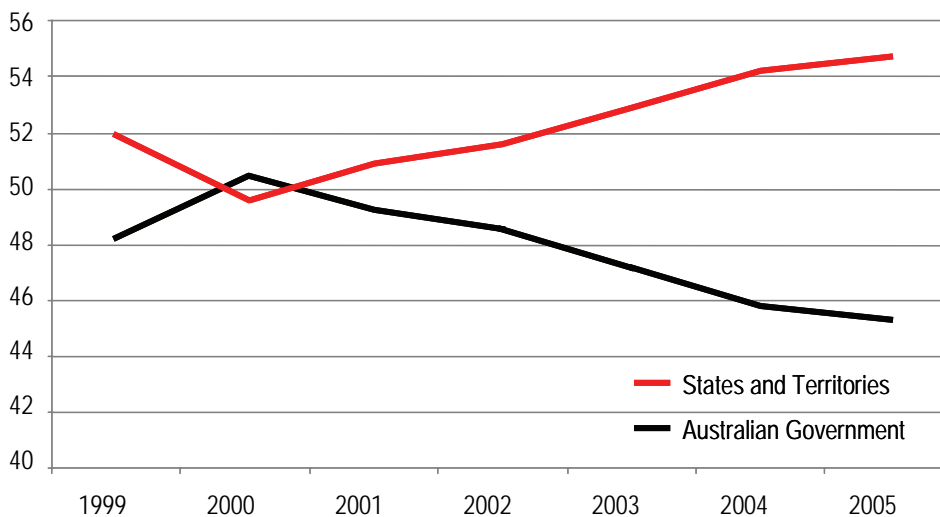


## Trends and comparisons

25.35 Both the Commonwealth and NSW Governments have increased the proportion of their total budgetary spending on health over the last 30 years. The graph below demonstrates the increase in the percentage of spending on health by each Government.



25.36 The share of funding for public hospitals by the Commonwealth Government as compared with the NSW Government has decreased over time, as demonstrated in the following graph. I note that since 2000, where the funding was almost equal, there has been a steady decline in the proportion of Commonwealth funding. The decrease in the Commonwealth contribution is due to the change in the adjustment rates in the Australian Health Care Agreements and the amount of money that the States receive under these agreements. I was told that this has occurred for two reasons: firstly the introduction of the 30% health insurance rebate, and second the introduction of the Medicare safety net,<sup>34</sup> both of which were considered to be a reallocation, as opposed to a reduction, of funds.



25.37 The gross domestic product, or GDP, is the total market value of all final goods and services produced within a country in a given period of time (usually a year). The percentage of GDP spent on health in Australia in 2006-07 is often cited as 9.7%. To arrive at this amount, health expenditure is taken to include research and development, food standards and hygiene and environmental health. The World Health Organization (WHO) and the Organisation for Economic Co-operation and Development (OECD) have recently agreed to apply the International Classification of Health Accounts as the standard means of counting health expenditure. This standard does not include research and development, food standards and hygiene and environmental health. The below chart indicates the comparative proportion of GDP spent on health with the Australian value adjusted to compare with the limited international definition of health expenditure.<sup>35</sup>

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	1995		2000		2005	
	Health to GDP (%)	Per Person \$AUD	Health to GDT (%)	Per Person \$AUD	Health to GDP (%)	Per Person AUD\$
United States	13.3	4,826	13.2	5,985	15.3	8,833
Germany	10.1	2,937	10.3	3,451	10.7	4,536
France	9.9	3,394	10.4	4,167	11.6	5,764
Canada	9.0	2,715	8.8	3,287	9.8	4,590
Italy	7.3	2,062	8.1	2,722	8.9	3,494
<b>Australia</b>	<b>7.4</b>	<b>2,111</b>	<b>8.3</b>	<b>2,956</b>	<b>8.8</b>	<b>4,121</b>
United Kingdom	7.0	1,827	7.3	2,435	8.3	3,759
Median of all 29 countries in the source document	7.5	2,062	8.1	2,722	9.0	4,038

Source: Adapted from Australia's Health 2008, page 403-404.

25.38 By these international standards, Australia's total expenditure, particularly having regard to its universality of provision of healthcare is a most reasonable sum. I note that all of the countries listed have increased their percentage of GDP spent on health and that Australia is close to the median for the complete list of 29 countries. It is interesting to note that its expenditure is around half of the expenditure in the United States of America and comparable with the level in the United Kingdom.

*How does NSW compare to other States?*

- 25.39 On the most recent figures, NSW now ranks third in the recurrent expenditures person (weighted population) for all public hospital services (including psychiatric hospitals). NSW spends above the national average, and marginally more than Western Australia and Victoria. Recurrent expenditure does not include spending on buildings or infrastructure.

**Table 25.1 Public Hospital Services – recurrent expenditure per person, weighted population, states and territories, 2006-07**

States and Territories 2006–07	\$
New South Wales	1,262
Victoria	1,238
Queensland	1,065
Western Australia	1,246
South Australia	1,133
Tasmania	1,131
Australian Capital Territory	1,473
Northern Territory	2,223
Australia	1,213

Note: No data provided for Tasmania public psychiatric hospitals, excludes depreciation and does not take into account patients treated in a different State or Territory to which they reside.

- 25.40 I was told that NSW public hospitals are more expensive than the Australian average for acute hospital services. Analysis also shows that for the same level of acute patient activity, NSW public hospital expenditure is 4.7% higher than under the Victorian episode funded system. If NSW achieved a Victorian average length of stay there would be a potential saving of over 300,000 bed days.<sup>36</sup>
- 25.41 I note, also, that cost benchmarking between Australian States and Territories indicate that treatment in a NSW hospital is more expensive than it is in some other states. The table below demonstrates that when comparing all Australian States and Territories on an average cost of a hospital stay, Victoria, Queensland and South Australia are less expensive. Western Australia, Tasmania, NT and ACT are more expensive.

**Table 25.2 NSW Average Cost compared to other States**

	Average Cost per Weighted Separation (\$)	distance from NSW (%)
NSW	3,499	-
Vic	3,234	8
Qld	3,298	6
SA	3,283	7
WA	4,028	-13
Tas	3,959	-12
NT	4,532	-23
ACT	4,157	-16

Source: National Hospital Cost Data Collection 2005/06

- 25.42 Another way of examining the comparative prices for health care in hospital between different states is to compare the cost of a patient episode in a public acute hospital.<sup>37</sup> Through assigning the average cost of a patient episode the value of 1.00, it is possible to compare the cost for that episode in each State. In Queensland the cost of the procedure is on the average, 1.01. Victoria rates below average at 0.95. New South Wales however scores the highest rate of any State or Territory at 1.06.<sup>38</sup>
- 25.43 These differences are also reflected in the average length of stays in a public acute hospital. In Victoria, the average length of stay is 3.3 days. The average for all of Australia is 3.6, whereas NSW has an average of 3.9.<sup>39</sup> It has been suggested to me that the Victorian health system is set up differently with mostly big hospitals in metropolitan areas and a smaller rural area. In NSW, we have a hospital in a large number of rural towns with the consequent fixed infrastructure, costs and low occupancy.<sup>40</sup> I will examine this further in Chapter 26.
- 25.44 As the above information demonstrates, whilst NSW compares favourably with the other States in terms of expenditure, the cost of hospital treatment and length of hospital stay reveals inefficiencies in the way in which healthcare is being provided in hospitals.

## Is it enough money?

- 25.45 It is clear to me that the level of funding presently provided to NSW public hospitals is inadequate to deliver the service that the public of NSW expect without significant changes to the way in which services are provided.
- 25.46 The principles of freedom of choice and universality of health care are not only articulated in the Australia Health Care Agreement, they are also enshrined in NSW legislation.<sup>41</sup>
- 25.47 These principles enable patients to elect to have free treatment in public hospitals.
- "It does not matter who you are, how rich or how poor, or where you live, you have the right to enter our public health care system free of charge. That is the thing we obviously hold most dear in the system."<sup>42</sup>
- 25.48 Hospital managers seem to uniformly proceed on the basis that the funding allocated to their hospital is manifestly insufficient to deliver all of the services they are required to deliver and engage in various techniques in order to attempt to achieve the best performance which they can. I heard evidence from a hospital manager who told me that they are constantly over budget but on benchmark. A hospital is on benchmark if they are providing a particular volume of service at a cost which is equivalent to the average cost of providing that care at other hospitals in the same peer group. The hospital is provided a budget at the beginning of the year that hospital managers understand to be insufficient to provide the services that they are required to deliver. Each month, the hospital has extra activity that puts them over budget. The manager points to the extra activity and demonstrates that the extra activity has produced additional costs and that they had not been funded for the extra amount. When this occurs, the hospital is over budget but under benchmark.<sup>43</sup>

*Case Study: I received evidence from a hospital manager who had been in that role for a number of years prior to the restructure into the 8 area health services. Prior to the restructure, the hospital management was able to do a "zero based budget", meaning that they were able to calculate the required budget for the following year including the anticipated cost for staffing, goods and services plus an increase due to inflation. This amount was then negotiated with the area health service. Since the restructure, the hospital has been allocated the same budget for 3 years. There has been is no acknowledgement of the increases in cost to provide the services caused by inflation, increased volume of activity, increases in birth rate or other demographic changes. Last year, they were asked to do a zero based budget for salaries and wages. This was achieved, however when the budget was allocated, it was \$750,000 under the amount that was needed for salaries and wages. One position that was affected by the budget shortfalls was for a child protection worker, usually a social worker earning, on average, \$85,000. There was only money in the budget of \$27,000 for this position. Meanwhile, the manager, who does not have any input into the budget, is open to criticism for not meeting the waiting list targets for planned and elective surgery.<sup>44</sup>*

- 25.49 I heard of inappropriate spending of money when extra funding does become available. For example, at Wagga Wagga Base Hospital a decision was made to purchase 4 new ventilator machines for the intensive care unit. In the opinion of the senior nursing staff, the existing ventilators were satisfactory and the money could have been used in other, more useful ways. In the nurses' opinion the ventilators were purchased due to the prevailing management attitude of "if you don't spend it, you lose it". The staff were not consulted nor their opinions sought for their suggestions on the most appropriate way to spend this money.<sup>45</sup> I have referred to this issue in greater detail elsewhere.
- 25.50 These concerns were also echoed at a number of locations. For example, I was told at Tamworth that they do not have enough money to provide even a base-line service<sup>46</sup> and at the Children's Hospital at Westmead I was told that at any one time having staff vacancies of between 70 and 100 establishment positions assists in maintaining the budget.<sup>47</sup>
- 25.51 The complaint of managers and the clinicians working in hospitals in respect of efforts to save money wherever possible was eloquently articulated by Paul Scofield, Executive Officer, Director of Nursing, Maclean District Hospital, at the Coffs Harbour hearing. He told me that the North Coast, whilst exploding in terms of population, was significantly under funded; that there was an obsession with savings and savings strategy; and that the hospital "had lost the plot" in terms of providing service to the community:
- "...because we are overwhelmed with this constant desire to justify ourselves against saving targets that are quite impossible to achieve."<sup>48</sup>
- "What's happened here is we've now got so many financial managers, we are losing the fact that our service provision relies on clinicians providing service."<sup>49</sup>
- "There is just no understanding what it is like in the real world by these people. They come from offices and then they are in finance and they know their finances are going up, they know the budget is blowing out, but they don't understand that the service they are providing is there to be seen and the clinicians are providing a service and we all have an economical and efficient culture and we don't waste, but we have got to provide a service to the Community we're serving"<sup>50</sup>

- 25.52 One strategy that has been used to save money is to not replace staff on maternity or other paid leave. This was particularly an issue with nursing and allied health staff. I have referred to this extensively elsewhere. This is not denied by NSW Health, which acknowledges that this is an undesired, but effective, way of reducing expenditure.<sup>51</sup>
- 25.53 It was explained to me whilst that extra staffing provisions are built into the staff arrangements, there is, within those provisions, a limit to the number of staff who can take leave at the same time. If that limit is exceeded, then there will be delays or shortfalls in the appointment of more staff. I note that NSW Health does have active policies that mandate the early replacement of nursing staff that are going on leave, however this policy directive does not extend to allied health professionals. From the evidence that I heard, it sounds that even this policy to protect nursing staff levels is ignored in implementation when budgetary constraints are real.

### *Not paying bills*

- 25.54 Another cash flow management measure (which some would mistakenly describe as cost saving) that I heard as I travelled around to different hospitals is that some hospitals are perpetually late in paying some basic bills. I heard evidence about a range of services such as couriers,<sup>52</sup> plumbers, pharmaceutical supply companies, locksmiths, technicians, software suppliers and milkmen not being paid on time.<sup>53</sup> Invoices have been allowed to become overdue in excess of 90 days.
- 25.55 Failure to exercise good business practice in this regard affects future business and can lead to the suspension of services, delays in supplying goods, and additional time wasted in trying to have the orders filled. The situation becomes dire when a hospital does not have hot water because the plumbing supplies bill has not been paid<sup>54</sup> or is not able to obtain necessary medications.<sup>55</sup> The negative patient safety consequences of this dangerous situation does not require further elaboration.
- 25.56 Recently the Daily Liberal newspaper from Dubbo featured a story that revealed that the Greater Western Area Health Service has sincerely apologised to creditors who have not received payment within agreed terms. Greater Western Area Health Service conceded it owed money to an unspecified number of businesses. One software supplier, Global Direction, had threatened to suspend services to Dubbo Hospital after being owed \$22,500 for 5 months.<sup>56</sup> I hardly need to stress the unfairness to business suppliers in rural areas who find that their contracts with a government agency are simply not honoured whether at the behest of the managers of an area health service unable to budget efficiently or as a result of inadequate funding at the area health service level.

### **Conclusion**

- 25.57 I received many submissions and heard a considerable amount of evidence that informed me that there was not enough money to pay for services, equipment, building and staff. The easy answer to this problem is to conclude that more money is required and staff needs to be employed, building constructed, equipment provided and services rendered.
- 25.58 Having said this, I note again the NSW Health receives a large proportion (about 27%) the NSW State budget. There are many other meritorious claims to the state's funds, including education, police, roads and so on. Health cannot, in good conscience, expect much more.

"This is not a realistic alternative unless governments are prepared to increase taxation, fees and charges or divert funds from other essential services."<sup>57</sup>

- 25.59 Some argue that it is not the amount of money that is spent on health that is the problem, rather fundamental flaws in the way that health is managed and the way in which funds are allocated. I received a submission from Mr John Menadue who observed that:

"...health ministers across Australia keep pouring money into health to address the 'hot button' issues, particularly in acute hospitals. But crises keep bubbling up week after week despite more dollars. Money is not the major problem."<sup>58</sup>

- 25.60 I agree with Mr Menadue that additional money is not necessarily the answer to the problem. I have included elsewhere in this Report a number of recommendations that, I believe, will assist in increasing the efficiency and cost effectiveness of providing health services in NSW and will achieve better patient outcomes. To realise the potential of these efficiencies it will involve the expenditure of additional capital. This cannot be avoided. On the other hand, it is unreasonable to expect that spending on health can continue to consume a greater proportion of the GDP and the NSW budget. This is unsustainable. Efficiencies and rationalisations must occur.

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- 25.61 Beyond this, it seems to me that the NSW Health needs to consider how to increase income from privately insured patients and other patients who are using the public hospital system for free.

*Private sector substitution and ineligible*

- 25.62 When privately insured patients are treated in a public hospital in NSW the hospital can raise revenue. Under the Australian Health Care Agreement, the hospitals may charge for treating privately insured patients and others according to an arranged value.

"Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by New South Wales."<sup>59</sup>

- 25.63 The federal Health Minister determines the value of the payment to public hospitals. This is called the default benefit payable and it varies from state to state.<sup>60</sup> It is important to note that this rate equates to approximately 1/3 of the actual cost of providing the service. Therefore, when a privately insured patient is treated in a public hospital it creates revenue raising stream, albeit about 1/3 of the actual cost. Currently NSW receives revenue of about \$940 million per year from private health insurers.<sup>61</sup>

- 25.64 Private hospitals, however, receive the full amount of the overnight bed stay from the private health funds. If public hospitals received the same amount as private hospitals then insurance premiums are likely to rise which may lead to a decrease in the numbers of privately insured patients.<sup>62</sup>

- 25.65 Patients can chose which hospital to attend. The Australian Health Care Agreement provides that privately insured patients are entitled to chose whether to use their insurance or not when visiting a public hospital.

"Where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms."<sup>63</sup>



- 25.66 Should a privately insured patient elect to use their insurance, they may be subject to a gap payment which reflects the difference between what they are charged and the benefit paid by their insurer. This will vary considerably depending upon the charges raised by the hospital or service provider and the level and type of private insurance coverage which the patient has. This gap payment may act as a disincentive for the patients to nominate themselves as private patients and to use their private insurance cover. It should be noted that the Commonwealth funds a 30% rebate on insurance premiums, notwithstanding which the privately insured patient may simply opt to be treated free of charge in a public hospital.
- 25.67 Some hospitals have come up with creative ways, within the constraints of the Commonwealth requirements, of encouraging their patients to use their private health insurance. I observed at one hospital a number of signs advising patients that if they were admitted as private patients the hospital would reimburse them for the gap, if any, between charges and insurance reimbursement.<sup>64</sup>
- 25.68 I was told that the only part of the hospital in which patients are not entitled to use their private health insurance is the Emergency Department.<sup>65</sup> I understand that this is implied from the Australian Health Care Agreement<sup>66</sup> as the election to be treated as a private patient can only occur once the patient is to admitted to the hospital.
- 25.69 I heard at Manly Hospital that they receive many foreign tourists who do not qualify as "eligible" for free treatment in the Emergency Department due to being located close to the beach and having a large transient population. Many of these patients present with conditions related to drug and alcohol abuse. If these people are ineligible to receive a free service then the hospital is entitled to charge for the service provided. However, I was told that often the hospital does not receive payment for these services as enforcement is very difficult.<sup>67</sup>
- "...often they present with no form of money. Our policy is to get the money upfront, credit card imprints, but often people in Health get a bit lenient and there is a high level of debt write-off because they can't recover the money...
- There are undoubtedly lots of examples of poor practices in hospitals where they don't chase the revenue which is there or which they can legally collect if they are prepared to do that little bit more."<sup>68</sup>
- 25.70 It is obvious that one potential source of revenue is not being fully utilised by our public hospitals. It is not clear to me whether this would result in the recovery of any significant revenue stream. Nevertheless, it ought not be ignored.

#### *Public expectations*

- 25.71 NSW is fortunate to have a high standard of care in its public hospitals. This service is provided by trained professionals and support staff.
- "we have created a government charitable hospital service that claims to offer unlimited healthcare on demand as a right to every citizen regardless of circumstances."<sup>69</sup>
- 25.72 It was submitted to me that the public are not truly 'customers' of this system as we are not required to pay for the services provided, nor are we made aware of the cost of the service that is provided to us.
- "At no stage is a public patient required to sign a 'payment authorisation', nor do they receive an itemised statement of what a visit or treatment has cost."<sup>70</sup>



- 25.73 As the above demonstrates, part of the problem with the funding and paying for NSW health services is that the public is not aware of the cost and nor is it aware of who pays for their treatment, except perhaps for a general notion that the system is funded by the taxpayers of Australia..
- 25.74 In my opinion, the public need to be aware of how the money is being used to provide the 'free' service, and how much their health care costs. Ultimately all tax payers are supporting this service and have an interest in how the money is being spent, even if we, as patients have little interest in the system beyond our own healthcare needs.
- "As public patients we have little or no interest in the cost of the service or its efficiency cost-wise."<sup>71</sup>
- 25.75 It is impossible for the public to have realistic expectations of health care if they remain ignorant of the actual cost of the service provided. The first step in rationalising the provision of health care in NSW is to start to educate patients about the cost of the services which they can access for free. Some private hospitals issue a statement to the patient when they leave the hospital that outlines the cost of services provided. Often the patient is not required to pay, if they are privately insured, however this informs them of the benefit that they are obtaining from their insurance. Ultimately such information may assist the patient in considering whether the premiums justify the cost of the benefit received.
- "...the current system has the distinct disadvantage of not providing any clear signals about the 'cost' of the service. It is also likely that where a service is provided 'free of charge', the recipient does not seriously think about whether or not the service is really required or if it reflects value for money."<sup>72</sup>
- 25.76 As the hospitals are becoming increasingly aware of the cost of providing the service on an episode funding arrangement, why not inform the patient? This is not done in NSW public hospitals. Patients remain ignorant of the cost of the service that they are receiving.
- 25.77 It was suggested to me that there should be a continuing public education campaign to explain to the public the costs associated with funding the health system.<sup>73</sup> This is a good idea.

## Problems posed by State vs Commonwealth funding

- 25.78 The NSW Treasury maintains that the principal dual sources of funding have caused multiple distortions in the delivery of health services in NSW.
- "The current Commonwealth-State split in roles and responsibilities for the funding, regulation and provision of health services is complex and provides scope for service gaps, overlaps, poor communication and other inefficiencies."<sup>74</sup>
- 25.79 I was told that there has not to date been a comprehensive national health or hospitals plan and that there is an increasing overlap in key priority areas, a lack of accountability and clear responsibility; and constant duplication of effort between Commonwealth and State.<sup>75</sup> The absence of a national health or hospitals plan or coordination between Commonwealth and State has resulted in some fundamental problems and dysfunctional funding arrangements in the provision of health services.

"So long as dual responsibility continues for the funding of public hospitals, largely unproductive debates about cost shifting will continue."<sup>76</sup>

- 25.80 As discussed above, the Australian Health Care Agreements dictate different responsibilities between the different levels of government. However it was pointed out to me that the responsibilities under the current agreement essentially mean that one party provides the money and the other party has the responsibility for providing the service as well as providing some of the monies as well. This relationship is bound to cause problems.

"The parties obligations are thus quite different. On the Commonwealth side it is to pay money, on the State and Territory side to deliver services to acceptable standards, whatever the cost. It is an arrangement guaranteed to create discord and blame shifting."<sup>77</sup>

- 25.81 The ability to slot a particular health service neatly into either a Commonwealth or State funding source can cause that service to prosper or fail. Here are some examples which were raised with me during the course of my Inquiry which indicate significant service deficiencies or funding inefficiencies which occur in practice:

- (a) There has been a lot of focus on the Commonwealth-State divide in terms of health funding, for example GP services. GPs are, by and large, paid by the Commonwealth Government through the MBS, however GPs are increasingly difficult to see and may charge above the Medicare scheduled rate. For many conditions, the same primary care service can be provided by the Emergency Department in a public hospital and paid for by the State Government. However, treatment in an emergency department is free to the patient and a patient visiting their GP may be required to pay for some of the service the gap. It is for this reason that such tension is caused by the flow of 'GP patients' in emergency departments across the State. As one clinician expressed it to me:

"These patients need care. I don't really care where they get that care, but whoever provides it needs to be properly funded and recognised for providing that service, and we need to get away from saying that's a Commonwealth issue or that's a State issue."<sup>78</sup>

- (b) In other ways, the funding of GPs by the Commonwealth reduces the incentive on NSW hospitals to provide services such as ante-natal services which can be provided by GPs. There is presently no incentive for area health services to set up ante-natal clinics when the cost of this care is currently being paid by the Commonwealth through GPs who are delivering the ante-natal care. In the last 10 years, about 130 maternity units have shut in Australia so many women are travelling long distances for maternity care. This results in the burden of antenatal care being shifted onto GPs, many of whom no longer bulk bill. I was told that many women are now not having any antenatal care due to the cost.<sup>79</sup> I have not ascertained the present statistics on this issue because as I have discussed elsewhere, there are appreciable benefits in continuity of maternity care. It is sufficient to note that this example demonstrates a fundamental problem with the division of health funding between different Governments, where the patient and proper patient care suffers.
- (c) As discussed in Chapter 3, a real problem in NSW public hospitals is the number of elderly patients who have completed their hospital treatment but continue to occupy an acute bed for weeks or months until an aged care bed becomes available. The Commonwealth Government funds the bed in the aged care facility, while the State Government funds the extended stay in hospital.

"You probably wouldn't have a bed problem if they could be taken somewhere else, but that is the State/Federal mix that is causing a problem with funding."<sup>80</sup>

This has resulted in NSW Health developing ways of moving elderly patients out of acute care hospitals. In the 2008/09 NSW health budget almost \$20 million was assigned to providing 160 extra community-based or aged care places. The rationale for this was that it is cheaper to house these patients outside of the hospital than within and therefore, it was a worthwhile program for NSW to fund what is otherwise, and should be, a Commonwealth service.

- (d) Hospital in the Home, which I discuss in Chapter 3, is a very sensible idea, which should be expanded on a larger scale to take pressure off NSW public hospitals and better treat a wide range of patients in their homes, particularly the elderly or those with complex, chronic problems. Currently, Acute Post-Acute Care Packages are paid for primarily by the State.<sup>81</sup> The main obstacle to the development of Hospital in the Home is that it blurs the boundaries between the hospital and the community and gives rise to problems such as whether the costs are borne by the State or the Commonwealth. Broadly, the States fund the public hospitals and the Commonwealth funds primary health. There seems to be a lack of a suitable funding model to encourage care of this kind. Clearly, this is a matter which needs careful consideration at a State and National level because rational support for programs of this kind will benefit the overall health budget enormously.<sup>82</sup>
- (e) Some services, such as the Royal Flying Doctor Service, (RFDS), receive funds from both the Commonwealth and State Governments, and struggle to provide their services in a rational, efficient manner whilst complying with the varying restrictions imposed upon each source of funds. The RFDS provides an excellent example of the problems associated with dividing funding responsibility between both the Federal Government and the NSW area health services.

*Case study: The RFDS has four discrete divisions throughout Australia: central operations, Queensland section, the western division and the south east division. The south east division covers NSW, Victoria and Tasmania. The services provided include a 24 hour emergency retrieval service, inter-hospital transfers, and air ambulance agreements with the respective State Governments. Of the total \$56 million budget for the south east division of RFDS for the financial year ending 30 June 2007, approximately half of the revenue was raised through Government contracts, approximately one fifth from Commonwealth grants and donations and bequests and the remainder from State grants and other sources.<sup>83</sup>*

*I heard evidence during a hearing at Broken Hill Hospital and received a submission<sup>84</sup> about some of the problems that the multiple sources of funding have on the provision of this valuable service:*

*The services delivered in NSW are currently delivered from Mascot, Bankstown, Dubbo and Broken Hill. Those sites are funded under a different arrangement through NSW Health. This arrangement does not allow the RFDS to freely move their aircraft across the State or ensure the best utilisation of the aircraft.*

*The Commonwealth funding for RFDS is restricted to Broken Hill and Dubbo. Commonwealth funding is also limited to picking up a patient from where there is no health service to deliver the patient to a clinic. It does not extend to taking a patient from one hospital to another. The problem is that both services are done using the same aeroplane in the same day.*

*I understand that the South Eastern Section of the RFDS has proposed a "whole of state" funding approach to blend both funding models and have one fleet of aircraft across NSW. I am told that the proposal would save NSW Health an estimated \$19.8 million in capital funding over 10 years and would permit an additional aircraft to be stationed at Dubbo and two replacement aircraft for Broken Hill in 2009.<sup>85</sup>*

- 25.82 Problems with the present funding arrangements have been recognised by all governments within the Federation, and some efforts are underway to reform it.

### National Health and Hospitals Reform Commission

- 25.83 My Terms of Reference provide that I:

"may have regard to the developments arising from the National Health and Hospitals Reform Commission and other Commonwealth-State reforms in relation to Australian health care delivery, to the extent that they arise before the date for the delivery of your report."

- 25.84 It is within my Terms of Reference to consider the effect that the current Commonwealth and State funding arrangements have on the provision of acute care services in NSW public hospitals.
- 25.85 The National Health and Hospitals Reform Commission, or NHHRC, was established by the Commonwealth Government in February 2008 to "develop a long term health plan for a modern Australia".<sup>86</sup> The NHHRC is tasked with providing advice on the framework of the new Australian Health Care Agreements. The NHHRC is also examining the rapidly increasing burden of chronic disease, ageing population, rising health costs and inefficiencies exacerbated by cost shifting between different levels of Government. The Commission reports to the Commonwealth Health Minister, the Prime Minister and the Council of Australian Governments. It comprises 10 commissioners chaired by Dr Christine Bennett, currently Chief Medical Officer at MBF. The Commission is due to deliver its first report in November 2008 and produce the long-term health reform plan in June 2009.
- 25.86 NHHRC released its first report in April 2008 entitled "Beyond the Blame Game" in which the authors identify 3 key elements that require changing for the new policy framework: scope; funding; and accountability. The April report examines the 3rd of these issues.
- 25.87 Beyond the Blame Game includes principles, challenges and proposed performance accountability framework and has identified 12 health challenges and corresponding performance benchmarks for the new Australian Health Care Agreements. These performance indicators list either the Commonwealth or the States to be accountable for meeting the benchmark. For example, the Commonwealth is accountable for the health challenges of closing the gap in indigenous health status and investing in illness prevention. The States are responsible for ensuring timely hospital access and caring for and respecting the needs of people at the end of life.<sup>87</sup>
- 25.88 The preliminary accountability arrangements proposed by the National Health and Hospitals Reform Commission are:
- (a) One level of government should be held accountable to the public for overall service performance in each area.
    - (i) The States should be accountable for public hospitals, mental health services, public health services and maternal and child health services.

- (ii) The Commonwealth should be accountable for all primary healthcare services, prevention, aged care and indigenous health.
- (b) The accountable level of government for a particular service type does not have to be directly involved in providing that service.<sup>88</sup>

25.89 Currently, as the below diagram prepared by the Australian Institute of Health and Welfare illustrates, the responsibility for most areas of health are shared by both the Commonwealth and NSW Government.

Table 25.3 AIHW - Priority reform indicators and accountability

Better health		Appropriate care
Life expectancy	Focus on prevention	Accreditation
Child mortality	Immunisation	In-hospital mortality reviews
Avoidable deaths	Overweight/obesity	Antibiotic prescriptions
	Smoking	Diabetes annual cycle of care
Accessible	Risky alcohol consumption	Asthma plans
Services per 1,000 places	Inactivity	Antenatal checks
Number of aged care places	High blood pressure	In-hospital death rates
Waiting times for services	Cancer screening rates	Preventable hospitalisations
	Infant health checks	Unplanned readmissions to hospital
Integration and continuity	GP (EPC) health checks	Sustainable
Nursing home-type patients in hosps	Preventative health \$ (%)	Workforce inflows and outflows
Hospital discharge plans	Safe	Training places
Home medication reviews	Adverse events in care settings	Public hospital funding shares
Efficient	VTE risk assessment	Patient-centred
Cost per hospital separation	Falls in care settings	Experience/satisfaction survey

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State/Territory
  Shared responsibility
  Commonwealth

25.90 This is further complicated when remembering that healthcare is also provided through private insurance payments and private facilities. The health care system in Australia, by all accounts, has evolved into an entangled system of funders and providers.

“Through this evolution of the Australian health care system, spurred by various incremental policy reforms over time, Australia has developed a complex system defined by mix of public and private providers, and funded through a combination of payments by the Commonwealth, the States and Territories, private insurers and users (patients).”<sup>89</sup>

25.91 I note that the NHHRC does briefly consider the suggestion that a single level of government should be accountable for all health services, however, it “believes that it would be premature to make such a recommendation so early in its work.”<sup>90</sup> In my view, based upon what my Inquiry has seen and heard to which I make some further reference below, there are very strong arguments tending towards being overwhelming, to support the view that there ought be a single government funding stream for the provision of all healthcare throughout Australia, and that only one level of government ought be accountable for the entire spectrum of healthcare. That does not mean that service would be delivered by a single level of government. After all, healthcare service

delivery is, and ought remain, a broad cathedral of activity. I have identified very few, if any, arguments which merit careful consideration which contend for the retention of the current complex and inefficient system. Ultimately, this is a matter for the NHHRC and its consideration. To the extent, my Inquiry has any influence, I would seriously urge a reform of the current system to embrace the approach to which I have just referred.

### Council of Australian Governments

- 25.92 The Council of Australian Governments (**COAG**) has during 2008 been interested in and engaged in the process of active consideration of the reform of the health sector, including the funding models which are presently in place.<sup>91</sup>
- 25.93 At the time of writing, there are a number of upcoming meetings scheduled in which the Commonwealth-State funding relationship will be discussed. Some of the major reform priorities are:
- (a) the new Commonwealth-State financial arrangements;
  - (b) preventative health;
  - (c) complex chronic disease managements;
  - (d) hospitals (including the primary care interface and activity-based funding reform [episode funding]); and
  - (e) fixing the intersection of aged care and disability services, roles and responsibilities.
- 25.94 COAG have an ambitious agenda for settling the arrangements for future Commonwealth funding and State obligations under the new Australian Health Agreements. COAG have been considering a new model for federal financial relations since March 2008 with the intention of modernising payments for specific purposes and the development of National partnership payments.
- 25.95 In July 2008, COAG noted the preliminary outputs and performance measures for the new funding agreements. At the meeting presently scheduled for late November 2008, COAG plan to finalise the funding arrangements and agree on the new special purpose payments and proposals for the national partnership payments.<sup>92</sup>

#### *The future*

- 25.96 In 2006, the House of Representatives Standing Committee on Health and Ageing released its report entitled "The Blame Game: Report on the Inquiry into health funding" ("COAG Report"). The COAG Report is the product of the Inquiry into the role of the Commonwealth Government "in improving the efficient and effective delivery of highest-quality health care to all Australians". The Terms of Reference included the following :
- "(a) examining the roles and responsibilities of the different levels of government (including local government) for health and related services;
  - (b) simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;"<sup>93</sup>
- 25.97 This COAG Report articulates many of the problems caused by the current division of responsibilities between Commonwealth and State and Territory Governments, primarily the cost shifting and blaming between different governments.



"Cost shifting can occur at the boundaries of different parts of the health system, such as between general practice and hospitals, general practice and aged care and aged care and hospitals."<sup>94</sup>

- 25.98 I note that the COAG Report identifies and discusses the following main themes of relevance to my Terms of Reference:
- (a) the health system is complex;
  - (b) funding for health needs to be re-orientated so that it focuses on wellness rather than illness;
  - (c) the current funding models do not support the health and education system to deliver a sustainable workforce; and
  - (d) the community's knowledge and understanding about the Australian health system needs to be improved to balance community expectations.<sup>95</sup>
- 25.99 Many of these concerns were repeated to me throughout the course of my Inquiry.
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- "...it is often preferable to refer patients discharged from the emergency department to GPs... this is in breach of the Medicare agreement which requires all the costs associated with the episode of illness that required presentation to the ED to be funded by the State. The patients, of course, don't care whether the service is funded by the Commonwealth or the State, as long as the service is competent and convenient."<sup>96</sup>
- 25.100 In order to achieve an efficient delivery of healthcare services, there are really only two principal solutions. On the one hand, the roles, responsibilities and accountabilities need to be clearly articulated in the Australian Health Care Agreements so that each level of government can be identified as solely (not jointly) accountable for the funding and delivery of the service, or, on the other, the funding of health should be designated to one level of government, be it State or Federal which is then fully accountable for service delivery.
- 25.101 Some commentators have no doubts about where the future of responsibility in the provision of health services should be.
- "The most fundamental structural weakness of the system is that responsibility for its funding, management and operations is divided between nine governments."<sup>97</sup>
- "There will never be enough funds to meet all possible demands for health services. Politics is simply another name for a process by which priorities are set and resources allocated. An integrated, transparent and accountable national health system offers the best hope of allowing these debates to be conducted honestly and openly."<sup>98</sup>
- 25.102 I note that some have argued that a single source of health funding is required to improve efficiency.<sup>99</sup>
- 25.103 I received a copy of a report prepared by TFG International Pty Ltd that recommends that the Federal Government should take full responsibility for funding public hospital services ("TFG Report").<sup>100</sup> This transfer of responsibility it argues should be facilitated through the 2008-2013 Health Care Agreements between the Federal Government and the States. The TFG Report does not envisage that this transfer of responsibility would happen immediately. Many of the other recommendations in the TFG Report are directed at facilitating the progress to the ultimate transfer of authority to the Federal

sphere. The TFG Report contains a suggestion that the Australian Health Care Agreements,

"...should be structured in a way that allows the federal government to progressively, and in an orderly way, take over public hospital funding as well as simultaneously placing greater emphasis on public health programs that keep people out of hospitals."<sup>101</sup>

- 25.104 Mr John Menadue submitted to me that there should be a joint Commonwealth/State Commission where both Commonwealth and State money for health care is pooled and distributed for NSW.<sup>102</sup> In addition to this Commission, he identifies the need for a small, independent and external monitoring group that reports publicly to the accountable Minister on the performance of all health units including the Department.

## Conclusion

- 25.105 The current funding arrangements between NSW and the Commonwealth and the provision of health services is a systemic impediment to the provision of acute care services in NSW public hospitals. The current system is at the least inefficient, and may be seen to have reached, or be nearing, the stage of being dysfunctional. It needs to be reformed to assist in the provision of health care at a sustainable level into the future.
- 25.106 My last word on the subject is this: as a minimum, clear lines of responsibility between Commonwealth and the States need to be established. The ideal medium in which to articulate responsibility and accountability is in the Australian Health Care Agreements.<sup>103</sup> My concern with this medium is that it may assist in determining who is responsible for a particular service and dissolve the blame game, however it may not assist in the continuity of care for patients between services. Patients may still fall between the gaps, or become blocked at one point in their journey due to imbalances in services. Ultimately, if public hospital treatment is to remain 'free' throughout Australia, then it is time to treat healthcare as an Australian service.

"I think the public interest is, is it the State's interests or the Commonwealth's interests? Should all CEOs cost shift to put the costs on to the Commonwealth because that's in the State public's interest? It's not on their budget then: it's on Medicare. Or should we say the public is the Australian public and you shouldn't be shifting costs from the State to the Commonwealth."<sup>104</sup>

- 25.107 It seems to me that a single level of funding is the only way to resolve many of these long-standing inefficiencies and distortions brought about by the dual funding model.

"Our present allocation of health resources is haphazard, secretive, costly and unjust."<sup>105</sup>

## How funding is allocated within NSW Health

- 25.108 NSW Health allocates funding to the area health services in two ways:
- (a) About 61% of funds are allocated to area health services using the Resource Distribution Formula ("RDF"), which is meant to ensure an equitable distribution of core health service funding; and
  - (b) About 39% of funding relating to specific programs (such as population health and mental health) is excluded from the RDF funding pool and allocated to Areas directly.<sup>106</sup>



- 25.109 The distribution of those RDF and particular program funds from the area health services to particular hospitals is now guided by episode funding, which focuses on efficiency and effectiveness.<sup>107</sup>

### Resource distribution formula

- 25.110 The resource distribution formula (RDF) is an elegant planning tool that is used to assist in determining the appropriate allocation of funds to the 8 area health services.<sup>108</sup> The RDF is not used to allocate funds to state-wide services such as NSW Ambulance Service and NSW Justice Health or The Children's Hospital at Westmead. Mental health, alternative birthing services and State Government residential aged care facilities are also excluded from the RDF.
- 25.111 Under the RDF, the weighted population is calculated according to the numbers within different age and gender categories. The RDF weighting also includes specific need factors such as, the estimated numbers of indigenous population, homeless population, the numbers of smaller hospitals and many other factors including the utilisation rate of private health insurance in the area. For the purpose of calculating the weighted population, an estimate of the number of veterans who hold a gold card in the areas is calculated and that number is removed from the total. That is because, as I have earlier noted, veteran's healthcare is funded separately through the Department of Veteran's Affairs.<sup>109</sup>
- 25.112 Adjustments are also made according to the historical demands for particular types of services, such as oral health care, Emergency Departments, outpatients, acute inpatient services and mental health services. Some areas, for example with high smoking populations, have a sicker population and a greater demand for services. Allowance is also made for small rural hospitals and the historical patient flows from one area to another.

### *How is it applied?*

- 25.113 Allocation of funds under the RDF has not ever been strictly applied. I note that the RDF is "one of several tools used in guiding the allocations of resources".<sup>110</sup> I have not discovered, other than historical costing any of the other "tools" that are used to allocate the money to the area health services.
- 25.114 Since its introduction in the late 80's, the total allocation of health funding has progressively moved towards to an equitable distribution of funds calculated by using the RDF. By equitable, I mean a comparable level of health services while taking into account the health needs of the population. I understand that the difference between the actual amount allocated and the target amount under the RDF has moved considerably so that most areas are now within 2% of their target share of resources. Although 2% is a small percentage, it nevertheless is still quite a large amount of money, which for the largest area health service would be in the order of \$35M.<sup>111</sup>
- 25.115 The explanation provided by NSW Health and the RDF Technical Paper for why the RDF has never been strictly applied is that historically there have been discrepancies in the allocation of funds to different areas. The gradual move to the full application of the RDF is an attempt to "achieve equity in funding" by correcting these historical discrepancies.<sup>112</sup> Areas within NSW that are recognised as being previously under funded are western Sydney, the Central Coast and the North Coast.<sup>113</sup>
- 25.116 I was told that the Director General can allocate small amounts of unallocated growth funding, approximately \$40 million in the current budget, to assist in helping the under

funded areas to receive a share of resources to bring them closer to the RDF target.<sup>114</sup> Often this funding is directed to specific initiatives.<sup>115</sup>

- 25.117 The allocation of funding according to the RDF is quite complex and unsurprisingly, poorly understood. An examination of the details contained within the RDF Technical Paper published by NSW Health demonstrates that complexity. There is no ready access to the detail of how the RDF is applied with respect to a budget of an area health service. This may be one reason why there are perceived to be problems and inequities with the application of the formula.

*Problems with the application of the RDF*

- 25.118 The discrepancies between the money calculated according to the RDF and the money that is actually allocated are interpreted by some to be driven by political motivation. I heard evidence from witnesses from the North Coast Area Health Service area who are concerned that the RDF has never been fully implemented. They noted, as I have above, that the North Coast area has historically been under funded. Furthermore, it seems that even after the historical inequality, the North Coast Area Health Service still does not receive their full share of the distribution.
- 25.119 I was told that the North Coast Area Health Service has been under funded by approximately \$70M per year according to the funding which it would get if the RDF was properly applied.<sup>116</sup> I received another submission in which the author stated that the allocation for the North Coast Area Health Service is 7% whereas it should be 7.7% of the recurrent budget.<sup>117</sup> Currently, the annual budget of the North Coast Area Health Service is 680M. A 10% inequity in funding would come to \$68M. The submissions are roughly concordant. One explanation which was advanced to me was that the North Coast Area Health Service received less than its share of the funding according to the RDF because it consisted of safe National Party electorates and there was no real representation in government.<sup>118</sup>
- “[T]here has been a politicisation of the health service, how the money is rolled out, certainly around election times.”<sup>119</sup>
- 25.120 I have not attempted to investigate whether this is so or not. It would not be fruitful. However, I record it here because there is a strong perception amongst many of the staff in the area that the lack of fair and equitable distribution of funding is a deliberate decision for reasons which are not associated with clinical care and performance. Whatever be the truth of the matter, about which I make no finding, it is clearly one matter that needs to be addressed in considering the future allocation of funds.
- 25.121 The RDF Technical Paper states that from 1989-90 through to 2007/2008, the North Coast Area Health Service (as a combined area health service) has never received the RDF target share of funding.<sup>120</sup>
- 25.122 A number of residents of the North Coast have called for the end to the current allocation of funds,<sup>121</sup> and supported the full implementation of the RDF to ensure that each area receives their full allocation of State funding for acute services.

“I have read the technical paper on resource distribution, and I think it is a symphony, it’s just beautiful the way it is calculated. They allocate different amounts of funding to smaller hospitals because they are more expensive to run. They allocate funding according to the age of the population, the birth rates of the population, and a whole range of factors. It’s

really well put together, but it is not used by the Health Minister.”<sup>122</sup>

- 25.123 In the submission that I received from the North Coast Maternity Action Group it was suggested that:

“the Health Minister provide large one-off grants to address decades of neglect... and then allocate resources each year according to the formula, instead of taking pride in gradually making adjustments.”<sup>123</sup>

- 25.124 As I have said this is a matter which needs to be addressed, and the resource distribution formula thoroughly applied or else an adequate explanation given as to why this is not so.
- 25.125 I do note that in the figures for the Health Services Initial Budget for 2008/09, the North Coast Area Health Service obtained a 5.4% increase on their previous budget totalling an increase of \$36.7 million. This is the second highest increase out of all of the area health services, the Greater Southern Area Health Service having an increase of 6%.

### *Mental health Funding*

- 25.126 As I have referred to elsewhere, funding for mental health has not been subject to the same increases as other areas of health expenditure in 2008-09. Current funding for mental health is \$1,092 million which I have been told is a \$41 million or 3.9% increase on last year. However, this needs to be viewed against the background of significant increases in mental health funding which have occurred in prior years.
- 25.127 As I understand it, currently mental health funding is omitted from the resource distribution formula. I have been told that the mental health component of the RDF has not yet been developed and that mental health services are currently funded based on the net cost of services derived from audited statements from the area health services.
- 25.128 I am concerned that the appropriate share of funding for mental health services has not yet been fully considered.

“Mental health funding is not allocated money under the RDF, so its fairness can only be a vague guess.”<sup>124</sup>

**Recommendation 115:** *The resource distribution formula should be expanded to include mental health services. The area health services should be funded for these services according to their calculated entitlement under the resource distribution formula.*

### **Episode funding**

- 25.129 Historically, the area health services have allocated money to the hospitals according to what they had received the previous year with an allowance for increases in the consumer price index caused by inflation. The historical funding models supported the existing structures irrespective of the patient activity and efficiency. Consequently, there was no incentive for hospitals to perform better or to become more efficient. I was told that hospitals must become more competitive in how they operate and should examine the existing hierarchies that justify the disproportionate cost of services. This level of cost rigour, I was told, has been missing from the NSW health system.<sup>125</sup>
- 25.130 Episode funding, also known as activity-funding, case-mix or diagnosis related group funding, is a system developed at Yale University in the early 1980s. The episode

funding model allocates funds to hospitals according to their level of activity. Hospital activity is closely monitored through coding each separation by international classifications.

- 25.131 As the funds are allocated according to each patient episode, the best price can be negotiated between different providers. In the US, payments to hospitals became based upon this system, called the prospective payment system.<sup>126</sup>

“The case mix [episode funding] system potentially generates a capacity for health related information gathering, analysis and choice by government and consumers which did not previously exist.”<sup>127</sup>

- 25.132 Episode funding is recognised internationally as a price signal of competitiveness as it brings market economics into a public sector monopoly. Episode funding classifications allow for a direct comparison between the actual and average costs of service provision in each facility.

“Promote efficiency by providing a standard basis for comparisons in cost per service between facilities.”<sup>128</sup>

- 25.133 The episode funding models are beneficial in that they:
- (a) create an explicit relationship between funds allocated and services provided;
  - (b) shift the focus of management to outputs, outcomes and quality;
  - (c) encourage clinicians and managers to identify variations in costs and practices so these can be managed at a local level in the context of improving efficiency and effectiveness; and
  - (d) provide mechanisms to reward good practice and support quality initiatives.<sup>129</sup>

#### *How does it work?*

- 25.134 Since 1993/94, the Australian Institute of Health and Welfare has been collecting data from the State and Territory health authorities on the activities of Australian public and private acute and psychiatric hospitals. When a patient is discharged from a hospital, their diagnosis, and the care that they have received, is recorded against the principal condition and any secondary conditions or complications. The Australian Institute of Health and Welfare has collated the number of each type of major patient outcome in Australia according to their major diagnostic category and common complications. These are referred to as the Australian Refined - Diagnosis Related Groups, or AR-DRG.
- 25.135 The AR-DRG groups are based on the diseases and conditions coded by the international classification of diseases. In Australia, the standard is the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification*, or ICD-10-AM.<sup>130</sup>
- 25.136 The National Hospital Cost Data Collection determines the average cost of each type of major patient episode, allowing for complications, in Australia. This is the basis of episode funding. The price of each procedure is determined by reference to the average price for each procedure determined by the AR-DRG. For example, a complete patient episode for a heart transplant on average will cost \$133,814, including approximately \$8,088 for pathology, \$2,751 for medical imaging and \$11,258 for pharmacy.<sup>131</sup>

- 25.137 Episode funding as a model has been implemented and developed many variations throughout Australia and the rest of the world. Whilst it is widely accepted as best practice for health services, the variations are considerable.

*Episode funding in Victoria*

- 25.138 Episode funding was introduced into Victoria in 1993/94 and has proved to be a very efficient funding model. The Victoria episode funding model uses the AR-DRG categories and assigns each procedure a cost weighting based around the notional value of 1. Complex procedures are allocated a high number, for example liver transplant is 30.02, and simple procedures a low number, same day chemotherapy patient, 0.19. This is referred to as the weighted inlier equivalent separation, or WIES. "Inlier" is a standard procedure without any factors that may result in the treatment costing more, for example a longer hospital stay. The WIES can be adjusted to account for variations in the particular treatment received (referred to as outliers) such as the length of stay of a patient.
- 25.139 The notional value of the treatment may differ depending on the location and the type of services that it offers. For example, the Metropolitan hospitals might receive \$3,279 per WIES, whereas the rural hospitals may be calculated on a higher level, due to the additional costs associated with providing the service in a more remote area. The WIES is multiplied by the value of the notional number to determine the cost of the patient episode in the particular hospital. This amount is multiplied by the expected number of that type of patient episode to determine the appropriate level of funding for the hospital.
- 25.140 Hospitals in Victoria have capped annual health budgets and therefore they know in advance how many courses of treatment they have available until the end of the year. Additional funding is not ordinarily available. Hospitals receive a target WIES allocation at the beginning of each year and they are funded for WIES up to, but not in excess of, that target.
- 25.141 Variation in the hospital budget from year to year is based on the historical allocation of the resource, plus any planned growth due to population increase, special projects and whether the hospital is in an area of higher or lower age, sex, socioeconomic adjusted population utilisation of hospital services. Under the episode funding model, hospitals in Victoria are paid based upon the numbers and types of patients they treat, not upon the resources they use.
- 25.142 Cost weights are developed each year based upon the costs of treating individual patients in Victorian public hospitals. Hospitals in Victoria report the costs of over half a million patient episodes annually.
- 25.143 Along with the episode funding allocations there are a number co-payments and specific grants that are not tied to WIES for items such as teaching and research.<sup>132</sup>

*Episode funding in NSW*

- 25.144 Episode funding was only introduced on a state-wide basis on 1 July 2008 however it has been in use in NSW since 2000 as a means of benchmarking and comparing the costs of particular procedures at different hospitals.<sup>133</sup> For example, by using the data that has been collected on the cost of each type of hospital episode from a number of hospitals it has been possible to derive an average cost for treating each particular type of patient in NSW. The results of this work provides a useful illustration of the benefits which episode funding is expected to bring to the system for allocating funding, as demonstrated below.

- 25.145 There are significant cost variations between similar NSW public hospitals for providing the same type of services. Some hospitals have costs significantly higher than the average of their “peer” hospitals. As the below table demonstrates, the average cost per weight separation was \$4,389 but the hospitals ranged from a low of \$3,385 (Liverpool Hospital) to a high of \$5,694 (Royal North Shore Hospital). Contributing factors appear to be above average nursing and medical costs at the Royal North Shore Hospital. On the other hand, Liverpool is starved for staff. Additional ward and medical costs are also a feature of more established hospitals that have a greater proportion of senior staff.<sup>134</sup>

Table 25.4 Average hospital costs by cost group 2005/06

Hospital	A	B	C	D	E	F	G	H	I	Principal Referral
Seps	57,879	29,514	35,184	44,666	49,031	36,045	62,551	62,528	65,607	443,005
ALOS	4.1	3.7	3.7	4	3.5	3.6	3.4	3.8	3.5	3.7
Wardmed	594	631	437	971	355	600	474	746	848	638
Wardnurse	1,385	1,497	1,340	1,737	1,361	1,357	1,143	1,563	936	1,344
Path	266	225	210	272	190	155	24	134	128	169
Imag	163	149	147	177	129	125	166	194	104	151
Allied	113	84	60	145	89	141	57	101	159	107
Pharm	582	313	217	260	200	295	167	397	217	298
Crit	387	467	252	493	308	532	293	335	205	348
OR	638	599	620	615	494	623	481	616	542	575
Emerg	55	189	107	228	151	134	98	87	57	113
Prosth	327	247	237	251	117	179	71	185	165	191
Deprec	194	83	131	236	105	171	176	261	143	174
Oncosts	340	325	332	308	232	291	234	285	226	280
Total	5,044	4,808	4,090	<b>5,694</b>	3,731	4,603	<b>3,385</b>	4,905	3,731	<b>4,389</b>

- 25.146 I have referred to the peer grouping of hospitals later in this chapter.
- 25.147 The following table demonstrates that for a specific procedure, in this case a coronary bypass without invasive cardiac investigations with catastrophic or severe complications and/or co-morbidities, the average cost ranges from \$18,123 to \$23,868. The average cost of this procedure in hospitals of this category, or peer group (A1a – principal referral group A), is \$21,773. The Royal Prince Alfred Hospital was 17% below the average and the Royal North Shore Hospital was 10% above the average.<sup>135</sup>

Table 25.5 Average costs for a selected DRG

	Hospital A	Hospital D	Principal Ref GP A
Seps	150	137	999
CWSA	916	867	6,192
ALOS	9	11	11
Wardme	2,919	4,931	3,500
Wardnu	2,078	3,955	4,178

	Hospital A	Hospital D	Principal Ref GP A
Path	863	1,555	763
Imag	1,179	318	624
Allied	451	541	386
Pharm	1,440	551	902
Crit	2,929	4,093	3,503
OR	2,221	5,131	5,080
Emerg	15	30	27
Prosth	2,045	285	542
Depre	752	1,120	946
Oncost	1,230	1,357	1,324
<b>Total</b>	<b>18,123</b>	<b>23,868</b>	<b>21,773</b>

### *Support for episode funding*

25.148 I was told that the episode funding model is beneficial as it bases the funding around the patient and not the institutions. If the funds are allocated to the departments on a historical demand basis, then there may be issues arising out of which department pays for a particular service, and out of which budget. Under episode funding, it does not matter where in the hospital the patient is treated, the entire patient episode is paid for and follows the patient and is not assigned to a particular ward.<sup>136</sup>

"Funding [for] our public hospital system does not come through the front door with each patient. The majority of revenue comes from compulsory taxes through the back door in the form of annual budgets designed to meet political objectives."<sup>137</sup>

25.149 I was told that in the United Kingdom, the hospitals are not provided budgets as such, rather the money follows the patient. There are 604 National Health Service procedures and a price has been determined for each one of them. If a hospital treats a particular patient then they get the money determined to be appropriate for that procedure. Hospitals have to attract the patients to stay viable, and so they have to perform as efficient and cost effective institutions.<sup>138</sup> This application of the episode funding model is designed to promote healthy competition amongst service providers.

25.150 The Liverpool Medical Staff Council conducted a questionnaire about funding being allocated according to clinical throughput. Of the 40 respondents who participated, 36 believed that this model would be an improvement for the hospital and the department.

"The funding at the moment is very opaque, as far as we are concerned, and the budgetary process is not always very clear as to how these decisions are made."<sup>139</sup>

25.151 At Lismore, I heard that there is a disconnect between clinical activity and funding levels. Strong support was expressed for budgets being based on activity and quality parameters, and not on historic levels.<sup>140</sup> I imagine that this is particularly relevant to areas experiencing large growth in population.

25.152 Both the Commonwealth Government and NSW Treasury have pressed for the adoption of episode funding in NSW.<sup>141</sup> NSW Treasury is keen for NSW Health to



implement a more transparent and accountable funding model for health service to provide a clear price signal to drive efficiency.

“NSW Treasury considers activity [episode] based funding is a significant improvement over funding facilities on a historic block funding basis.”<sup>142</sup>

- 25.153 Additional Commonwealth funding of health is conditional upon all States adopting episode funding. NSW and Qld are the final jurisdictions to introduce episode funding.<sup>143</sup>
- 25.154 There are a number of other benefits that it is anticipated that the introduction of episode funding will bring. It may help to promote more specialisation in some hospital service delivery in areas where the comparative expertise and treatment advantage is greatest. It may also promote the more effective use of very expensive technology. If a hospital is able to increase their efficiency and treat a patient at less cost than the DRG, the hospital may obtain the benefit of its increased efficiency.<sup>144</sup>

#### *Limitation of episode funding*

- 25.155 Episode funding seems a very sensible idea, and I found that most clinicians that I spoke to about it were enthusiastic. However, I note that in Victoria, where this model has proved to be effective, only two thirds of acute funding is allocated through episode funding in Victoria, with the remainder of the money paid through a variety of other grants where episode funding is not considered to be appropriate.
- 25.156 It was argued that some hospitals in NSW were not suitable for episode funding, for example, very small hospitals who are not able to provide services with the same economy as larger hospitals because of the fewer numbers of patients treated. Hospitals in remote areas also have higher costs due to the difficulty in recruiting staff many of whom have to travel large distances. The isolation of the location might require that some service is given, even if it is provided at a rate, which is higher, than the base rate that can be achieved in the metropolitan areas.
- 25.157 For example, I was told that Broken Hill Hospital would “go belly-up” with episode funding, as there are legitimate additional costs associated with providing services in remote areas.<sup>145</sup> I accept this point, however this problem could be rectified by appropriately weighting isolated areas at a higher level so that for each separation they receive a greater allocation of money. The COAG commitment to move towards a more nationally consistent approach to activity-based (episode) funding recognises the importance of smaller and more remote hospitals and recognises the need to make some provision for the needs of those facilities. I note that Broken Hill is peer grouped as a C1 “District Group 1” hospital to which episode funding applies.
- 25.158 A similar problem was raised in relation to some specialist service providers who are concerned that the AR-DRG may not adequately reflect the full range of complexities of some patient conditions. For example, I received a copy of a study that had examined the cost of providing specialist paediatric services in Australia. This study found that the AR-DRG did not adequately account for the full range of paediatric co-morbidities and the consequential increased cost of providing paediatric services. The study identified almost 1,500 diagnosis codes that are not part of the AR-DRG system. It was argued that episode funding model should not be applied to paediatric hospitals, as this would have a major impact on the financial viability of these services.<sup>146</sup>
- 25.159 From 1 July 2008, episode funding was introduced in NSW as a mandatory funding tool.<sup>147</sup> Area health services are now required to use episode funding as a hospital



budget setting system and financial performance measurement system. It applies to approximately 86% of NSW public hospital activity and includes admitted acute care, emergency care, intensive care, and designated sub and non-acute patient activity.<sup>148</sup> It does not include primary care or outpatient services. The model currently covers approximately 85% of acute expenditure and 60% of total NSW Health expenditure. The resource distribution formula will continue to guide the allocation of funds to the area health services from NSW Health.<sup>149</sup>

- 25.160 Hospitals that do not provide acute inpatient services, peer grouped at C2 or below, are not included in the episode funding. These hospitals and services are allocated block grants based on historical budgets. Some of these facilities, that are designated as providing occasional periods of sub-acute or non-acute care, are allocated a sum of money based on the mid-range cost of each acute patient episode.<sup>150</sup>
- 25.161 The allocation of funds to each facility to which episode funding applies is determined through reference to the AR-DRG and the weighting of each patient episode, referred to above. These cost weights have been adjusted to represent the relative value of providing the service in NSW.<sup>151</sup>
- 25.162 Each facility is funded according to state-wide average price for their peer grouping by the number of weighted separations. The prices for acute inpatient episode per peer hospital group for 2008/09 are as follows:

Table 25.6 Acute Inpatient Prices for 2008/09<sup>152</sup>

	Peer Hospital Group	Price, per weighted separation
A1a	Principal Referral Group A	\$4,017
A1b	Principal Referral Group B	\$3,950
A2	Specialist Paediatric	\$4,318
A3	Ungrouped Acute	\$3,601
B1	Major Metropolitan	\$3,825
B2	Major Non-Metropolitan	\$3,535
C1	District Group 1	\$3,946

- 25.163 I note that the price per weighted separation for specialist paediatric services is the highest. The price for District Group 1 peer grouped hospitals is more than it is for peer grouped hospitals A3, B1 and B2. These differences in prices are to allow for the additional costs associated with providing these services, discussed above.
- 25.164 There are a number of additional factors and adjustments that can be made to allow for the patient episodes that are unusually long and complicated or for the provision of services that are not included in the AR-DRG coding.<sup>153</sup>
- 25.165 As mentioned above, The Children’s Hospital at Westmead is not funded under the RDF, instead it is based according to historical levels. I was made aware of the following concern:

“Although other areas are allocated their funding on a population based model there are perverse incentives within the health system allowing other Areas to divest services and to avoid taking care of their resident patients as much as possible. A reduction in activity for them is not followed by a reduction in funding.”<sup>154</sup>

- 25.166 Whilst the episode funding model does apply to the allocation of funds to Ambulance Service of NSW or Justice Health, the reporting requirements do apply to The Children’s

Hospital at Westmead. The unique position of this hospital is acknowledged in the episode funding policy document.<sup>155</sup>

"The application of episode funding to the Children's Hospital at Westmead will require special consideration and will be reviewed as part of the ongoing development of the policy. The Hospital is however still expected to report within the Episode Funding framework."<sup>156</sup>

25.167 I have been informed that since the introduction of episode funding there has been no change to the allocation of funds to the Children's Hospital at Westmead.<sup>157</sup> It appears that, at the moment at least, the Children's Hospital at Westmead is not subject to the same formula for population demographics (RDF) nor activity based funding arrangements (episode funding), however they are required to report their activity level under this scheme. In this respect, the Children's Hospital at Westmead is in an entirely unique funding position in NSW.

25.168 The continuing implementation of episode funding involves a number of steps and adjustments that are required to be taken by both NSW Health and the area health services:<sup>158</sup>

- (a) Area health services will negotiate an annual price and volume agreement with each in-scope (hospitals to which episode funding applies)<sup>159</sup> hospital.
- (b) Area health services will develop a transition plan over 3 years for each hospital operating above its peer average costs. The plan will specify agreed levels of funding and volume of activity per annum and achievement of quality indicators plus specific strategies to move average cost down to peer average. By the end of year 4, the budget equivalent should be equal to the episode funded amount.<sup>160</sup>
- (c) Hospitals operating below their peer average price will initially be expected to maintain their current expenditure and activity profile. The unallocated difference may be used to fund additional activity (subject to NSW Health approval).<sup>161</sup>
- (d) The potential use of incentive payments to encourage specific performance is still being considered. Any incentives that are being considered should "drive reform in specific priority areas of activity, such as efficiency, quality, access and demand management".<sup>162</sup>
- (e) Performance accountability framework involving hospitals, area health services and NSW Health will address the costs for relevant services, service mix and volume of activity and quality.
- (f) Budget and activity reviews by hospital, area health services and system-wide will be undertaken through quarterly management reporting. The initial return was due on 29 August 2008 and the first quarter report on 17 November 2008.<sup>163</sup>

25.169 I note the observations from NSW Treasury about the limitations of episode funding and the problems with implementation, namely:

"1. activity [episode] funding is not yet well developed beyond acute care services;

2. the specifics of the funding model require careful consideration to ensure that pricing signals are appropriate (e.g. Victoria's system encourages same-day admissions rather than outpatient procedures);

3. its effectiveness depends on the quality of information available on costs and activity, and on the extent to which health providers use the information

provided by activity [episode] funding to implement best practices; and

4. budgets at the whole-of-agency level must take into account the broader context, including factors such as the fiscal situation and community service obligations. Treasury does not anticipate that NSW Health budgets will be based on strict activity-times-price formula in the foreseeable future."<sup>164</sup>

*Who makes the decisions?*

- 25.170 An important question, in my mind, is who will decide how many types of a particular procedure will be performed each year? Will this be doctors, having regard to patient need, or NSW Health working within the budget it is given, or will it be a matter for government through the funding allocation mechanism. This question does not appear to have a ready answer. It is unclear whether episode funding will give the control to Area or NSW Health or the Treasury to determine how many of a particular type of treatment will occur and in what level of hospital. A clear answer to this question is necessary before I would be prepared to express with confidence any opinion about the appropriateness of moving the entire funding of the health portfolio to be based on episode funding.
- 25.171 The criticism that was raised through the course of my Inquiry was about the difficulty that clinicians encounter in fixed budgets. Each hospital is provided with a set level of funding without any consideration of the workload or recognition that the hospital cannot control the numbers who present at the Emergency Department. Currently the decisions are being made at the "coal-face" and the practitioners are having to make decisions and cuts to try to balance their budgets and face the patients to whom they are unable to provide the treatment that they need. It is argued that the benefit of the Victorian system is that the bureaucrats who control the funding must take some of the responsibility for the difficult decision-making as they determine the number of patient episodes of particular types that will occur each year.<sup>165</sup>
- 25.172 The two staged allocation for funding in NSW has the advantage of retaining the decision making on spending at the area health service level as they are the source of the funds in the episode funding model: however if patient demand increases, where is the money going to come from?
- 25.173 The question that inevitably arises concerns any facility which has an unfunded increase in activity in a particular year. Do they stop providing a service? What happens if on day 250 of the year the area health service finds that the demand for services, provided at the AR-DRG rate, has exhausted the budget allocation?
- 25.174 NSW Health told me that the introduction of episode funding would pose considerable problems unless it is accompanied by an agreement with NSW Treasury about the level of activity which it will fund in the health system.<sup>166</sup> NSW Treasury told me that they were concerned that money is often allocated to acute services and not enough is spent on illness prevention. If there is an increase in demand and the AR-DRG models are strictly applied then this problem may become exacerbated.
- 25.175 I, immediately, say that I do not have the answers for these difficult issues. However, I identify and raise them so that they can be addressed by those who have the responsibility for any change in the funding model for NSW Health.

## Budget cycles

- 25.176 Funding is provided to NSW Health (and other government departments) from the parliament on a 12 month basis as specified in the relevant Appropriation legislation. In any given year, the NSW Government determines the specific budget allocation for each government department and a projection for the next 3 years anticipated funding. NSW Treasury informed me that agencies are required to plan across the 4-year forward estimates period, but budgeting in NSW Health focuses largely on the budget year. NSW Treasury further informed me that the process for NSW Health is that, following receipt of the agency-level allocation letter from Treasury, NSW Health head office sends allocation letters to each area health service confirming the budget for the current year and forward estimates for the remainder of the 4-year planning period.
- 25.177 Forward estimates can change and be changed by mere administrative action and do not require parliamentary approval, because until they become the subject of the appropriation legislation, they remain estimations and can never be guaranteed. This can be the cause of difficulty at the service delivery level because NSW Health and the area health services cannot firmly commit to any specific level of funding of recurrent expenditure beyond the immediate 12 month budget year. Indeed, many would regard it as the height of imprudence and irresponsibility to enter into commitments on the basis of future estimates which cannot be guaranteed.
- 25.178 I was told that clinicians find the 12 month budget cycle frustrating as, for many clinical programs they need to spend money at the outset to save money in subsequent years.
- "It is a pity that there are not a few more risk takers in the system and the risks would pay off, but there seems to be that attitude of 'I have to come in on budget'." <sup>167</sup>
- 25.179 I heard that the provision of services is done on a short term 12 to 18 month basis and lack of certainty is perceived by some to be "mainly for political reasons to reduce waiting lists, for instance, or to remove an area that is creating bad media". <sup>168</sup> Whilst it is all too easy for the allocation of funding to be criticised for being politically motivated, it would equally be naïve to assume that it is never the case.
- 25.180 I was informed that as a matter of history, at least from the clinicians perception, there was one year, some years ago, when there was a 3 year guaranteed budget allocation for health. It was said to me that even though the funding was guaranteed over this period, there were routine reviews to ensure that the budget was being met. This longer period was preferred both by clinicians and administrators and furthermore, during this period, no area health service seemed to get into budgetary difficulties. <sup>169</sup> NSW Treasury officials told me that they were unaware of any change of this kind and suggested that what was referred to was an internal NSW Health mechanism for dealing with forward estimates. I can't resolve the differences in what I was told. Perhaps there was an intention by NSW Health to have a multi year budget cycle which did not ultimately obtain central agency approval. However, what is important was that clinicians learnt of the program, endorsed it and took to the role of interaction with the budgetary process much more readily than they otherwise might.
- 25.181 I am not sure what, if any, causal relationship there is between these two factors. Nevertheless, I was told that if three year budgets were reintroduced it would assist in discussions with senior clinicians around prioritisations and networking and the services that are going to be provided. Clinicians are not interested in a one year planning cycle.

- 25.182 Lack of budget certainty is not particularly suitable for planning the provision of medical services where the timeframes involved are often medium rather than short term. It may take a year to set up a new health initiative, with rewards in the form of improved health care delivery and reduced length of stay reaped in subsequent years. A short term budget cycle reduces the possibility of embarking on such projects, as there is no certainty of receiving the funding required after Year 1 to bring the project to fruition.
- 25.183 I was told by NSW Treasury that NSW Government departments are informed of the 3-year forward estimates in each budget and that they can be responsibly relied upon for the purpose of forward planning.<sup>170</sup> But this really begs the question as I discuss above. Either funding is guaranteed or it isn't. Long term commitments in the absence of guaranteed funding can be fraught with difficulty.
- 25.184 I have been provided on a confidential basis with details of the forward estimates for health for the years 2009-10 through to 2012-13. The estimates include allowances for NSW escalation, NSW general growth, Commonwealth escalation, and revenue escalation. I note that the anticipated movements for each year broadly align with the historic average of the Health Price Index published by the Australian Institute of Health Welfare. This, in my view, is a conservative estimate of the necessary increase in the health budget for these years, as the Index reflects input cost increases not demand growth.
- 25.185 It is worth noting that a single percent of the current NSW Health budget is approximately \$132 million and therefore, even a single percent difference in the adjustments made to the Health budget whether by way of an increase or decrease, does have a noticeable effect on the way in which NSW Health operates. The forward estimates provide some guidance as to the amount of money that NSW Health may have to spend in the years to come and can be used to support forward planning beyond the one-year horizon subject to the contingencies which I have discussed above.

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<sup>1</sup> NSW Health Briefing, 13 March 2008, transcript 4.8-19.

<sup>2</sup> Email from NSW Health to Special Commission of Inquiry, 30 June 2008.

<sup>3</sup> This discussion contains a basic summary of the components comprising the AHCA Federal financial contribution, including the relevant information only. Schedule G, *Australian Health Care Agreement between the Commonwealth of Australia and the State of New South Wales 2003-2008*. Individual Australian Health Care Agreements are available from: <http://www.health.gov.au/ahca> (17 November 2008).

<sup>4</sup> Schedule F, *Australian Health Care Agreement between the Commonwealth of Australia and the State of New South Wales 2003-2008*.

<sup>5</sup> Australian Government, *Budget Paper No. 3: Australia's Federal Relations 2008-9*, Appendix B: Payments to the States, 13 May 2008.

<sup>6</sup> Schedule A, *Australian Health Care Agreement between the Commonwealth of Australia and the State of New South Wales 2003-2008*.

<sup>7</sup> Section 3(1), *Health Insurance Act 1973* (Cth) provides:  
"eligible overseas representative means a person who is:  
(a) the head of a diplomatic mission of another country, or the head of a consular post of another country, established in Australia; or  
(b) a member of the staff of such a diplomatic mission, or a member of the staff of such a consular post; or

(c) a member of the family of a person referred to in paragraph (a) or (b), being a member who forms part of the household of that person;

being a person who is neither an Australian citizen nor a person domiciled in Australia but who, under an agreement between the Government of the Commonwealth and the Government of that other country, is to be treated, for the purpose of the provision of medical, hospital and other care, as if the person were an Australian resident.”

<sup>8</sup> Section 3(1), *Health Insurance Act 1973* (Cth).

<sup>9</sup> Clause 11, *Australian Health Care Agreement between the Commonwealth of Australia and the State of New South Wales 2003-2008*.

<sup>10</sup> Commonwealth Department of Health and Ageing, *The State of Our Public Hospitals, June 2007 Report*, 2007, Commonwealth Department of Health and Ageing, Canberra, p. 16.

<sup>11</sup> Deeble J, “Funding the Essentials: The Australian Health Care Agreements, 2003-2008” (2002) 25(6) *Australian Health Review* 1.

<sup>12</sup> NSW Health Briefing, 13 March 2008, transcript 6.34-38.

<sup>13</sup> Commonwealth Department of Health and Ageing, *The State of Our Public Hospitals, June 2008 Report*, 2008, Department of Health and Ageing (Commonwealth), Canberra, p. 67.

<sup>14</sup> Deeble J, “Funding the essentials: the Australian Health Care Agreements, 2003-2008” (2002) 25(6) *Australian Health Review* 1.

<sup>15</sup> NSW Health Briefing, 28 May 2008, transcript 15.28-34; NSW Health, *Special Commission of Inquiry Presentations: COAG Update*, 28 May 2008, p. 10.

<sup>16</sup> NSW Health, *Special Commission of Inquiry Presentations: Funding for Health*, 13 March 2008, p. 2

<sup>17</sup> NSW Health, *Special Commission of Inquiry Presentations: Funding for Health*, 13 March 2008, p. 3.

<sup>18</sup> NSW Treasury, Office of Financial Management, *Budget Paper 2: Budget Statement 2008-09*, 3 June 2008, Chapter 3: General Government Expenditure, p. 12.

<sup>19</sup> NSW Health Briefing, 2 June 2008.

<sup>20</sup> NSW Treasury, Office of Financial Management, *Budget Paper 2: Budget Statement 2008-09*, 3 June 2008, Chapter 3: General Government Expenditure, p. 12.

<sup>21</sup> NSW Health Briefing, 13 March 2008, transcript 60.20-47.

<sup>22</sup> Australian Institute of Health and Welfare, *Australia’s Health 2006*, 2006, Australian Institute of Health and Welfare, Canberra, p. 289.

<sup>23</sup> Australian Bureau of Statistics (ABS), *6401.0 - Consumer Price Index, Australia, June 2008*, 2008, ABS, Canberra, <http://www.abs.gov.au> (17 November 2008).

<sup>24</sup> Australian Government, The Treasury, *Budget Paper No. 5: Intergenerational Report 2002-03*, 14 May 2002, p. 36.

<sup>25</sup> Australian Government, The Treasury, *Intergenerational Report 2007*, 2 April 2007, p. 48.

<sup>26</sup> NSW Treasury, Responses to questions from the Special Commission of Inquiry, 1 October 2008.

<sup>27</sup> NSW Treasury, Office of Financial Management, *Budget Paper 2: Budget Statement 2008-09*, 3 June 2008.

<sup>28</sup> NSW Treasury, Office of Financial Management, *Budget Paper 2: Budget Statement 2008-09*, 3 June 2008, Chapter 2: Fiscal Strategy and Outlook, p. 11.

<sup>29</sup> NSW Treasury, Office of Financial Management, *Budget Paper 2: Budget Statement 2008-09*, 3 June 2008, Chapter 2: Fiscal Strategy and Outlook, p. 11.

<sup>30</sup> NSW Treasury, Office of Financial Management, *Budget Paper 2: Budget Statement 2008-09*, 3 June 2008, Chapter 2: Fiscal Strategy and Outlook, p. 10.

<sup>31</sup> NSW Health Briefing, 13 March 2008, transcript 52.4-7.

<sup>32</sup> NSW Health Briefing, 13 March 2008, transcript 59.26-62.35.

<sup>33</sup> NSW Health Briefing, 2 June 2008.



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- <sup>34</sup> NSW Health Briefing, 13 March 2008, transcript 51.30-39.
- <sup>35</sup> Australian Institute of Health and Welfare, *Australia's Health 2008*, 2008, Australian Institute of Health and Welfare, Canberra, pp. 402-4.
- <sup>36</sup> NSW Health, *Special Commission of Inquiry Presentations: Episode Funding*, 4 April 2008, p. 7; NSW Health Briefing, 4 April 2008, transcript 14.29-47.
- <sup>37</sup> This method applies the cost per procedure as determined by the Australian Refined – Distribution Resource Grouping (AR-DRG) that is the basis of the episode funding model. I discuss the AR-DRG later in this chapter.
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- <sup>39</sup> Australian Institute of Health and Welfare, *Australian Hospital Statistics 2006-07*, May 2008, Australian Institute of Health and Welfare, Canberra, Table 2.4, p. 24.
- <sup>40</sup> NSW Health Briefing, 4 April 2008, transcript 17.16-23.
- <sup>41</sup> Section 68, *Health Services Act 1997* (NSW).
- <sup>42</sup> NSW Health Briefing, 13 March 2008, transcript 5.29-36.
- <sup>43</sup> Confidential hearing at the Inquiry's offices via video link from Tweed Heads, 29 May 2008, transcript 11.27-41.
- <sup>44</sup> Confidential Mudgee hearing, 20 March 2008, transcript 11.40-13.40.
- <sup>45</sup> Submission of Tanya Gleeson and Sherylle Sheehy, 23 April 2008, SUBM.073.0093 at 96.
- <sup>46</sup> Dr Peter Finlayson, Tamworth hearing, 25 March 2008, transcript 821.2-4.
- <sup>47</sup> Meeting with Roger Corbett, Chairman of the Advisory Council, The Children's Hospital, Westmead, 6 May 2008
- <sup>48</sup> Paul Scofield, Coffs Harbour hearing, 27 March 2008, transcript 956.27-29.
- <sup>49</sup> Paul Scofield, Coffs Harbour hearing, 27 March 2008, transcript 958.21-23.
- <sup>50</sup> Paul Scofield, Coffs Harbour hearing, 27 March 2008, transcript 960.19-27.
- <sup>51</sup> NSW Health Briefing, 2 June 2008.
- <sup>52</sup> Janet Ogden, Prince of Wales Hospital hearing, 1 May 2008, transcript 2569.17-19.
- <sup>53</sup> Confidential Wollongong hearing, 14 April 2008, transcript 7.27-45.
- <sup>54</sup> Ann Stublely, Sydney Children's Hospital hearing, 19 May 2008, transcript 3030.22-30.
- <sup>55</sup> Ann Stublely, Sydney Children's Hospital hearing, 19 May 2008, transcript 3029.44-3030.19.
- <sup>56</sup> "Health cluster merger proposed", *Daily Liberal*, 27 August 2008.
- <sup>57</sup> Australian Centre for Health Research, *Australian Health Care Agreements: 18 Recommendations for Improvement*, provided with submission of Ken Baxter, Chairman TFG International, 18 March 2008, SUBM.032.0004 at 5.
- <sup>58</sup> Submission of John Menadue, 20 March 2008, SUBM.046.0007 at 7.
- <sup>59</sup> Clause 49, *Australian Health Care Agreement between the Commonwealth of Australia and the State of New South Wales 2003-2008*.
- <sup>60</sup> NSW Health Briefing, 4 April 2008, transcript 26.44-27.5.
- <sup>61</sup> NSW Health Briefing, 4 April 2008, transcript 28.3-6.
- <sup>62</sup> NSW Health Briefing, 4 April 2008, transcript 27.39-28.18.
- <sup>63</sup> Clause 43, *Australian Health Care Agreement between the Commonwealth of Australia and the State of New South Wales 2003-2008*.
- <sup>64</sup> Information observed during visit to Corowa Multi-Purpose Service on 23 April 2008.
- <sup>65</sup> NSW Health Briefing, 4 April 2008, transcript 9.15-21.
- <sup>66</sup> NSW Health Briefing, 4 April 2008, transcript 9.18-21.
- <sup>67</sup> Information provided during visit to Manly Hospital on 12 March 2008.
- <sup>68</sup> NSW Health Briefing, 13 March 2008, transcript 53.42-54.11.
- <sup>69</sup> Submission of Stephen Milgate, Australian Doctors' Fund, 16 February 2008, SUBM.032.0191 at 193.

- <sup>70</sup> Australian Centre for Health Research, *Report into the operation and future of the Australian Health Care Agreements and the funding of public hospitals*, report prepared by TFG International, provided with submission of Ken Baxter, Chairman of TFG International, 29 February 2008, SUBM.032.0004 at 77.
- <sup>71</sup> Submission of Stephen Milgate, Australian Doctors' Fund, 16 February 2008, SUBM.032.0191 at 200.
- <sup>72</sup> Australian Centre for Health Research, *Report into the operation and future of the Australian Health Care Agreements and the funding of public hospitals*, report prepared by TFG International, provided with submission of Ken Baxter, Chairman of TFG International, 29 February 2008, SUBM.032.0004 at 42.
- <sup>73</sup> Australian Centre for Health Research, *Report into the operation and future of the Australian Health Care Agreements and the funding of public hospitals*, report prepared by TFG International, provided with submission of Ken Baxter, Chairman of TFG International, 29 February 2008, SUBM.032.0004 at 80.
- <sup>74</sup> NSW Treasury, Office of Financial Management, *Budget Paper 2: Budget Statement 2008-09*, 3 June 2008, Chapter 3: General Government Expenditure, p. 12.
- <sup>75</sup> NSW Health Briefing, 13 March 2008, transcript 5.44-6-8.
- <sup>76</sup> Australian Centre for Health Research, *Report into the operation and future of the Australian Health Care Agreements and the funding of public hospitals*, report prepared by TFG International, provided with submission of Ken Baxter, Chairman of TFG International, 29 February 2008, SUBM.032.0004 at 70.
- <sup>77</sup> Deeble J, "Funding the essentials: the Australian Health Care Agreements, 2003-2008" (2002) 25(6) *Australian Health Review* 1, p. 1-2.
- <sup>78</sup> Dr Roderick Bishop, Nepean hearing, 8 April 2008, transcript 1386.45-1387.13.
- <sup>79</sup> Professor Sally Tracey, Sydney Children's Hospital hearing, 19 May 2008, transcript 3024.1-13.
- <sup>80</sup> Confidential Bankstown hearing, 13 May 2008, transcript 33.42-45.
- <sup>81</sup> Nicholas Marlow, Royal North Shore hearing, 14 March 2008, transcript 327.18-21.
- <sup>82</sup> Dr Nicholas Collins, Sydney Children's Hospital hearing, 19 May 2008, transcript 3043.7-3044.18.
- <sup>83</sup> Royal Flying Doctor Service of Australia, South Eastern Section, *Annual Report 2007*, 2007, Royal Flying Doctor Service of Australia, p. 37.
- <sup>84</sup> Captain Clyde Spence Thomson, Broken Hill hearing, 7 May 2008, transcript 2643.20-2645.29; Confidential submission, 3 May 2008, SUBM.078.0172.
- <sup>85</sup> Information provided to the Inquiry on a confidential basis.
- <sup>86</sup> National Health and Hospitals Reform Commission website, <http://www.nhhrc.org.au> (2 October 2008).
- <sup>87</sup> National Health and Hospitals Reform Commission (Dr Christine Bennett, Chair), *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*, April 2008, National Health and Hospitals Reform Commission, Canberra, pp. 28-31.
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- <sup>89</sup> Australian Centre for Health Research, *Evaluating Health Outcomes in Australia's Health Care System - A Scoping Study of Potential Methods and New Approaches*, report prepared by Insight Economics Deloitte, June 2007, p. 6.
- <sup>90</sup> National Health and Hospitals Reform Commission (Dr Christine Bennett, Chair), *Beyond the Blame Game: Accountability and performance benchmarks for the next Australian Health Care Agreements*, April 2008, National Health and Hospitals Reform Commission, Canberra, p. 22.
- <sup>91</sup> NSW Health Briefing, 28 May 2008, transcript 7.40-46.
- <sup>92</sup> NSW Health Briefing, 28 May 2008, transcript 6.16-28.



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- <sup>93</sup> The Parliament of the Commonwealth of Australia, House of Representatives, Standing Committee on Health and Ageing (Alex Somlyay, Chair), *The Blame Game – Report on the Inquiry into Health Funding*, 2006, Commonwealth of Australia, Canberra, p. xi.
- <sup>94</sup> The Parliament of the Commonwealth of Australia, House of Representatives, Standing Committee on Health and Ageing (Alex Somlyay, Chair), *The Blame Game – Report on the Inquiry into Health Funding*, 2006, Commonwealth of Australia, Canberra, p. 26.
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- <sup>97</sup> Bowtell B, "Health", from Manne R (ed.), *Dear Mr Rudd: Ideas for a better Australia*, 2008, Black Inc., Melbourne, p. 191.
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- <sup>106</sup> NSW Health, *Special Commission of Inquiry Presentations: Funding for Health*, 13 March 2008, p. 9; NSW Health Briefing, 13 March 2008, transcript 55.7-13.
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- <sup>110</sup> NSW Health, *Policy Directive: Episode Funding Policy 2008/09*, PD2008\_063.
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- <sup>114</sup> NSW Health Briefing, 2 June 2008.
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- <sup>116</sup> Dr Christopher Ingall, Lismore hearing, 28 April 2008, transcript 2198.13-28.
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- <sup>118</sup> Claire Simmonds, Coffs Harbour hearing, 27 March 2008, transcript 963.37-42.

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- <sup>162</sup> NSW Health, *Policy Directive: Episode Funding Policy 2008/09*, PD2008\_063.
- <sup>163</sup> NSW Health, *Policy Directive: Episode Funding Policy 2008/09*, PD2008\_063.
- <sup>164</sup> NSW Treasury, Responses to questions from the Special Commission of Inquiry, 1 October 2008.
- <sup>165</sup> Meeting with representatives of the Hospital Reform Group, 23 May 2008.
- <sup>166</sup> NSW Health Briefing, 4 April 2008, transcript 19.16-36.
- <sup>167</sup> Meeting with the Greater Metropolitan Clinical Taskforce, 7 March 2008, transcript 63.6-9.
- <sup>168</sup> Dr Ian Incoll, Gosford hearing, 10 March 2008, transcript 43.37-40.
- <sup>169</sup> Meeting with the Greater Metropolitan Clinical Taskforce, 7 March 2008, transcript 64.15-19.
- <sup>170</sup> Meeting with representatives from NSW Treasury, 19 September 2008, transcript 5.23.

Funding

## 26 Hospitals

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- 26.1 As the most populous state, NSW has the largest number of hospitals and hospital beds of any Australian state or territory. There are 251 public hospitals in NSW providing about 19,170 hospital beds,<sup>1</sup> which translates to approximately a third of Australia's public inpatient beds.<sup>2</sup> Private hospitals in NSW have a further 6,208 beds, which comprises about 24% of total hospital beds in this State.<sup>3</sup>
- 26.2 In NSW, the average number of available public hospital beds per 1,000 persons is 2.8.<sup>4</sup> This is compared with an average of 2.3 in Victoria, and the national average, which is 2.6.<sup>5</sup> The combined public and private hospital bed numbers in NSW are comparable to the OECD average: 3.8 beds per 1000 persons in NSW in 2006-07 compared to an OECD average of 3.9 in 2005.<sup>6</sup>
- 26.3 It should be noted that an OECD comparison of acute care hospital beds per capita in 1990 to 2005 showed a long-term trend towards decline in the number of acute care beds.<sup>7</sup>
- 26.4 I could not find any data which I could reliably use to compare the number of hospitals per capita in Australia with other like countries. I am not certain that it would, in any event, be a particularly meaningful comparison.

## Types of public hospitals

- 26.5 NSW Health categorises public hospitals in a number of ways.
- 26.6 NSW Health groups its hospitals into "peer groups" according to the types of care provided by the hospital, together with the complexity of that care and the size of the facility. Hospitals are grouped into "peer groups" so that NSW Health can compare the activities and costs of the hospitals in each group, and for planning services. As the hospitals within each peer group are engaged in similar activities, data collected can be usefully compared against the performance of other hospitals in the group, for example, in respect of the length of stay of patients receiving a hip replacement.
- 26.7 The statistical means by which NSW Health groups hospitals into peer groups is complex. A complete description can be found at <http://www.chs.health.nsw.gov.au/pubs/h/yb9798/peergrps.html>.<sup>8</sup> I have simplified this considerably for the purposes of this chapter. There are two terms with which one should have a passing familiarity in order to understand what follows:
- (a) "separation" means the completion of an episode of admitted patient care. A separation may be the total hospital stay (e.g. from admission to discharge), or a portion of a hospital stay either before or after a change in the type of care (e.g. from acute care to rehabilitative care);<sup>9</sup> and
  - (b) "casemix weighted separations" means the total of admitted public patients treated by a hospital in a specific period where episodes of care are "weighted" depending on the conditions and resources used to provide various episodes of care. Casemix classifications provide a way of describing and comparing hospitals and other services for management purposes.<sup>10</sup>
- 26.8 Starting with the largest hospitals and working down to the smaller facilities, the "peer groups" are as follows:

Table 26.1 NSW Peer Hospital Groups – Acute Hospitals

Peer group	Description	Examples
A1 Principal referral	13 hospitals which treat 25,000 or more acute casemix weighted separations per annum. There are two sub-groups: <ul style="list-style-type: none"> <li>A1a hospitals have more than one specialty service.</li> <li>A1b hospitals have less speciality services.</li> </ul>	Royal Prince Alfred Hospital, John Hunter Hospital and Wollongong Hospital
A2 Paediatric specialist	2 hospitals with a primary role to provide specialist acute care services for children.	The Children's Hospital at Westmead, Sydney Children's Hospital
A3 Ungrouped acute	4 hospitals with a primary role to provide acute services of a specialised nature for which there are insufficient peers to form additional peer groups.	Sydney Eye Hospital Royal Hospital for Women
B1 Major metropolitan	12 hospitals which treat between 10,000 and 25,000 acute casemix weighted separations per annum.	Hornsby & Ku-ring-gai Hospital Sutherland Hospital
B2 Major non-metropolitan	12 hospitals which treat 10,000 or more acute casemix weighted separations per annum that are located in rural areas providing acute specialist and referral services for a catchment population from a large geographical area.	The Tweed Hospital Albury Base Hospital
C1 District Group 1	13 hospitals in this group, treating between 5,000 and 10,000 acute casemix weighted separations per annum.	Armidale Hospital Bowral Hospital Broken Hill Hospital
C2 District Group 2	There are 26 hospitals in this group, being those treating between 2,000 and 5,000 acute casemix weighted separations per annum, together with acute hospitals treating less than 2,000 acute casemix weighted separations per annum but with more than 2,000 separations per annum.	Mudgee Hospital Milton & Ulladulla Hospital
D1 Community acute	This peer group is sub-divided into: <ul style="list-style-type: none"> <li>D1a - "<b>Community Acute with Surgery</b>" which includes 15 hospitals treating less than 2,000 acute casemix weighted separations per annum, and less than 2,000 acute separations per annum, with less than 40% non-acute and outlier bed days of total bed days and greater than 2% of their acute weighted separations being surgical.</li> <li>D1b - "<b>Community Acute without Surgery</b>" includes 18 hospitals treating less than 2,000 acute casemix weighted separations per annum, and less than 2,000 acute separations per annum, with less than 40% non-acute and outlier bed days of total bed days, and less than 2% of their acute weighted separations being surgical.</li> </ul>	Bellinger River District Hospital Quirindi District Hospital  Mullumbimby & District Hospital Wellington Hospital

Table 26.2 NSW Peer Hospital Groups – Non-acute Hospitals

Peer group	Description	Examples
D2 Community Non-Acute	There are 37 hospitals in this group, which treat less than 2,000 acute casemix weighted separations per year, and less than 40% non-acute and outlier bed days of total bed days.	Narromine District Hospital Gundagai District Hospital
F1 Psychiatric	NSW also 9 psychiatric hospitals, which are considered to be 'non-acute', as the majority of patients in these institutions are receiving types of care other than acute. <sup>11</sup> However, in 2006-07, almost 10,000 acute care episodes occurred in these facilities. <sup>12</sup>	Cumberland Hospital James Fletcher Hospital
F2 Nursing Homes	There are 20 nursing homes, which provide long-term care to chronically ill, frail, disabled or convalescent or senile patients.	Lourdes Hospital, Dubbo Wallsend District Nursing Home
F3 Multi-purpose Services	There are 48 MPSs, which provide integrated acute health, nursing home, hostel, community health and aged care services under one organizational structure.	Dorrigo MPS Oberon MPS Rylstone MPS Wilcannia MPS
F4 Sub-Acute	There are 12 hospitals in this group, which primarily provide sub-acute services.	St John of God Hospital, Goulburn Port Kembla District Hospital
F5 Palliative Care	There are 2 facilities in this group, which provide palliative care to terminally ill patients.	Neringah Home of Peace Cottage Bear Cottage
F6 Rehabilitation	There are 5 facilities, which provide services to people with an impairment, disability or handicap.	Royal Rehabilitation Hospital, Ryde
F7 Mothercraft	There are 3 facilities, which help mothers acquire mothercraft skills in an inpatient setting.	Tresillian, Karitane
F8 Ungrouped Non-Acute	There are 12 facilities, which provide non-acute services and for which there are insufficient peers to form their own group.	United Dental Hospital Tibooburra District Hospital

26.9 For the purpose of my Inquiry, I have not felt constrained by how a hospital is categorized by NSW Health. Whatever the characterisation of a hospital, I have looked at the services provided by the hospital. I have simply considered all evidence and submissions received by reference to whether the issues raised fall within my Terms of Reference.

26.10 Some of these peer groups warrant further mention.

### Major non-metropolitan hospitals

26.11 As a whole, these hospitals (such as Coffs Harbour, Tweed Heads, Lismore, Port Macquarie, Tamworth, Dubbo, Wagga Wagga and Albury) were extremely stretched. The hospitals were full, the Emergency Department was overloaded, operating theatres could not meet demand, and hospital clinicians and managers were showing signs of real strain as they attempted to ensure a continuity of good patient care.



## Lost peer groups

- 26.12 On the other hand, a mixture of Major Metropolitan, District Group 2 and Community Acute hospitals were struggling for an identity on the hospital hierarchy.
- 26.13 For Community Acute hospitals (such as Pambula, Bellinger River, Quirindi, Wellington and Gulgong) bed occupancies rates were generally much less than the major regional hospital. Surgical and maternity facilities were either withdrawn or much reduced. Beds were mostly occupied by elderly patients.
- 26.14 The communities surrounding these hospitals were extremely concerned about the future of these hospitals, and whether medical services would continue to be provided to meet the communities' needs. I found that often the expectation of the surrounding community was that it was entitled to have, and to expect, a hospital which provided a comprehensive service covering all conditions except those which needed highly specialised assistance. Such communities saw the retention of the hospital and the keeping of the range of services as being closely linked to the economic and social viability and the general status of the community. They uniformly saw such retention of the hospital as being far more important than having an effective overall health system. They often saw the retention of the hospital as being of greater importance than the need to achieve good quality of patient care.
- 26.15 I was told by a GP obstetrician at Bellinger River District Hospital that staff have to fight NSW Health to retain obstetric services, and that recently a cardiotocography (CTG) machine, used to record foetal heartbeat and uterine contractions during pregnancy, had been withdrawn by it.<sup>13</sup> Another GP obstetrician told me Bellinger River District Hospital is an unused resource for the excess demand at the Coffs Harbour Base Hospital, which is overloaded.<sup>14</sup> Though Bellinger District Hospital receives a number of dementia patients from Coffs Harbour, there are apparently inadequate resources to fully care for them. The lack of resources tends to reinforce the view that the district hospital level is struggling for both an identity and a position within the hospital hierarchy.
- 26.16 Similarly, in other parts of the State, district hospitals can and do usefully provide much needed support to major non-metropolitan hospitals. For example, Wellington Hospital, which has about a 60% occupancy rate, takes patients from Dubbo Base Hospital who do not require a high level of care or who are in need of rehabilitation care.
- 26.17 In contrast, at Quirindi Hospital I was told that after the hospital's operating theatre had closed and obstetric services ceased, patients from the area must now travel 70 kilometres to Tamworth.<sup>15</sup> An experienced VMO at Quirindi told me that this is too far a distance, and would dislocate families and increase the possibility of women delivering babies on the road side. According to the VMO, Quirindi Hospital provides a good service in which there is less crowding and patients are more comfortable. Additionally, a study by the Rural Doctors Network has found that maternity services are more safely undertaken in district hospitals.<sup>16</sup> There is a 50% occupancy rate at Quirindi Hospital, which can and does take patients from Tamworth Hospital when it experiences bed block.
- 26.18 It seems to me that the issue for these hospitals is that they are trying to be, or else are expected to be, "all things to all people" but struggling to achieve this. These hospitals are the 'second tier' in their relevant areas. The first tier hospitals attract the patients and clinicians, leaving the second tier to struggle.
- 26.19 In truth, what is lacking is a clear role delineation<sup>17</sup> and appropriate staffing levels to fulfil those roles.

- 26.20 There seems to me to be a place for re-invigorating such hospitals to take the overload from major non-metropolitan hospitals in clearly defined areas such as low risk surgeries, rehabilitation and care of elderly patients requiring long term acute care. This can be achieved by:
- (a) clear role delineation; and
  - (b) clinician reorganisation.

### Multi-Purpose Services

- 26.21 There are 48 Multi-Purpose Services (MPSs) in NSW.<sup>18</sup> MPSs provide integrated acute health, nursing home, hostel, community health and aged care services under one organizational structure. They were introduced under a joint Commonwealth-State funded project which sought to improve the provision of community, aged and health care services in rural and remote areas of Australia.<sup>19</sup> The MPS model enables rural communities to be provided with effective and viable services by incorporating them in one location or else under one roof. An MPS can provide a limited degree of emergency care, which typically involves assessment and treatment allowing resuscitation and limited stabilisation prior to transfer to a higher level of care.<sup>20</sup> Under the model, the Commonwealth Government provides aged care funding which is combined with State Government funding for health services and infrastructure to provide the service under one MPS management structure.<sup>21</sup> As at 30 June 2008, there were 117 MPSs in operation nation-wide, with several more under development.<sup>22</sup> The model allows MPS staff to work across residential aged care, acute care and community care settings as the need arises.
- 26.22 I visited 6 MPSs and was very impressed with this type of facility. They seem to be working well in small communities and are generally quite new and in reasonably good condition.<sup>23</sup> For example:
- Dorrigo MPS is a well-functioning unit with many positive and proactive programs that interact well with both the GPs in the community, who are VMOs of the facility, and community health centres.<sup>24</sup> It is an impressive facility both in terms of the cohesiveness and morale of the staff, as well as in terms of the cleanliness and modernity of the facility. The staff that I met there had a very positive attitude to the MPS model and were very engaged by various initiatives being run by NSW Health for their community. The facility is well-designed and well-supported locally: its monthly MPS advisory council meeting was described to me by staff at the facility as excellent;<sup>25</sup>
  - the Braidwood MPS is a highly integrated facility, where community health nurses also act as ward nurses. The ward, nursing home and community health centre (as well as the private doctor's surgery) are co-located, meaning Braidwood MPS is a true "health precinct". I was told this permits excellent communication between the different health professionals working in the precinct, and provides a holistic approach to patient care so that there is little fragmentation of services. The service is also very highly valued by staff;<sup>26</sup> and
  - I was very impressed with Wilcannia MPS, which is a modern, seemingly well equipped facility with a positive environment which seems to serve its community well.<sup>27</sup>
- 26.23 Some district hospitals, such as Holbrook, are called "District Hospitals" but, the truth is, they operate as MPSs. They primarily provide some acute care, after hours primary care, aged care, and stabilise patients who require emergency care (for example, a heart attack) prior to them being transported to where they can receive acute care.<sup>28</sup>

- 26.24 It seems to me that several older, rural hospitals would benefit from becoming an MPS, although there was community resistance in some areas, which appeared to me to be based on an incomplete appreciation of the attractive features of an MPS examples of which I have set out above. Indeed, at Bellinger River Hospital, I heard a great deal of local opposition to the construction of an MPS, in circumstances where I am assured by the Chief Executive Officer of the area health service that there is no plan to build one.
- 26.25 In particular of the hospitals which I visited:
- Cobar Hospital, which is a large older hospital, would suit an MPS model well. However, there is local resistance to the development of an MPS. The Mayor of Cobar, Councillor Lilliane Brady, told the Inquiry that the issue is not with the MPS model itself, but rather that an MPS would be built without the inclusion of an operating theatre.<sup>29</sup> The concern is that the mix of services provided by an MPS typically do not include surgical services, and that, given Cobar is a booming mining town with a growing population, these services should be provided.<sup>30</sup> However, I was told by the Director of Health Services at Cobar that the existing hospital is relatively large, underutilised and very expensive to maintain;<sup>31</sup>
  - Gulgong Hospital if it were thought appropriate to retain at all, would also be well suited for an MPS. The existing hospital is old and poorly laid out. It operates as a de facto MPS as it cares for many long term, aged care patients due to the absence of a local nursing home.<sup>32</sup>
- 26.26 I note that one of the fundamental questions to be addressed when considering the suitability of facilities is whether the emergency departments in these smaller facilities are providing real emergency care or essentially after hours acute or primary care. The answer to this will affect how NSW Health should configure these services and how they should be resourced, in terms of workforce levels.

## Historical development of the hospital network

- 26.27 To understand the NSW Hospital system, it is important to take into account its origins and historical development.
- 26.28 First, as settlement spread across NSW, communities built hospitals as an important phase in the establishment of the community. All towns of any size had a hospital. However, this also meant that the development of a particular hospital did not necessarily reflect the most efficient allocation of resources. This view is reflected in a comment by the NSW Medical Staff Executive Council that:
- "A lack of adequate urban planning has seen the development of a number of smaller hospitals in close proximity to each other."<sup>33</sup>
- 26.29 There was also an expectation that the community would find all medical services that they might need at their local hospital. Certainly, in the past, this expectation was generally satisfied as hospital care was largely based on basic surgery and a leisurely convalescence. However, with increased growth, complexity and sheer range of treatments, there has been a shift towards a more centrally planned development of hospitals as a system which necessarily involved limiting the resources distributed to particular hospitals by reference to needs of all hospitals as part of a system taking precedence over individual demand.

26.30 The history of hospitals and health services in Australia and NSW charts an evolutionary shift from reactionary to planned development, albeit with remnants of the earlier approach latched on:

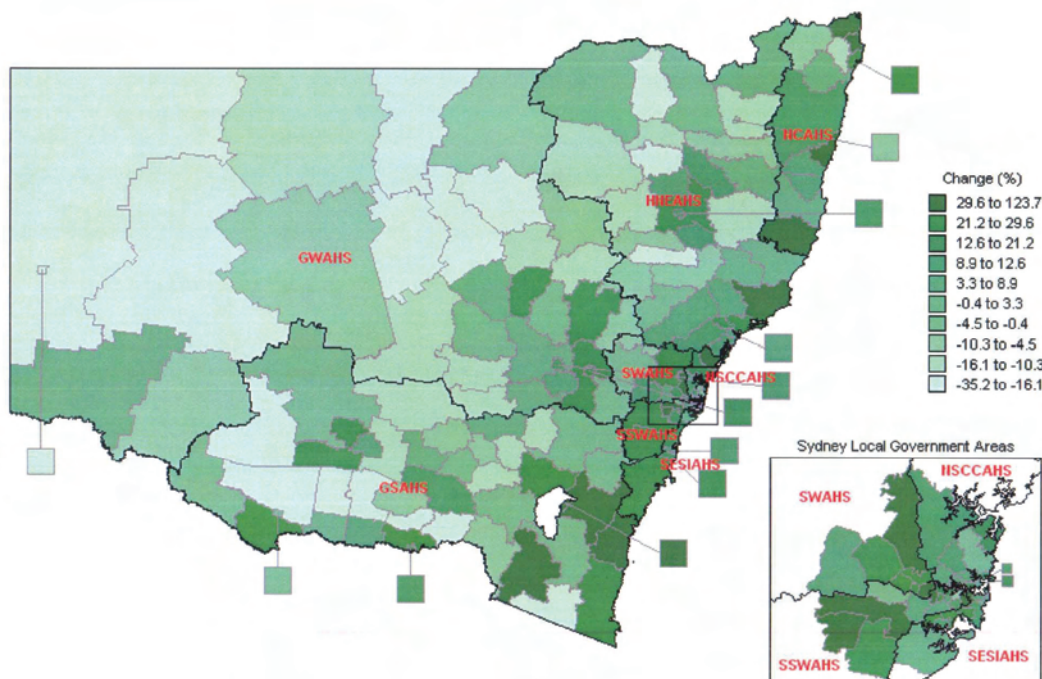
“The Australian system of financing and managing health care services is complex and difficult to understand unless one takes an historical perspective, for it is a system which has been evolving gradually from a private entrepreneurial-philanthropic way of providing care towards a government funded and controlled service organisation. Because the system has evolved and is still evolving, it reflect compromise rather than rational planning.”<sup>34</sup>

26.31 Nevertheless, the location of hospitals; and the communities attachment to them is rooted in 19th century models of care in which everything was provided locally and every town had a hospital<sup>35</sup> and expected that all forms of medical care would be available there. As stated by the NSW Medical Staff Executive Council:

“Local public expectations [were] increasingly unrealistic; their local hospital had to offer all the services they would require at the highest standard”<sup>36</sup>

26.32 Second, during Australia’s white settlement era in the first half of the nineteenth century, the prevailing health issues occupying the minds of health administrators were infectious diseases and sanitation, which meant that preventing and remedying poor hygiene and sanitation was the focus of health services. As technology improved, health care costs increased, and the population of Australia continued to spread, it became increasingly difficult to provide an even apportionment of medical services in the State. This challenge was exacerbated by the nature of the medical profession, which is typically, an inter-dependant profession, reliant on an array of support staff and equipment for both training and the provision of services.

26.33 Third, NSW Health has told the Inquiry that geospacial mapping population change between 2005 and 2026 shows a migration to the eastern seaboard and along the Victorian border.<sup>37</sup> This will impact on the provision of services in the context of a population density decline in many areas.



26.34 Fourth, as Bill Bowtell told the Inquiry planners had not adjusted to where people have moved around the state.

"The conservative and reactionary nature of our system persists in pretending they are all somewhere where they are not."<sup>38</sup>

26.35 The foundations of some of the present problems with the hospital system and the nature, type, size and location of the existing hospitals within that system were laid, at the least, many decades ago.

## Today's priorities for a hospital network

26.36 The present system sees hospitals as a part of a state-wide system, in which health services are, or ought be, provided where most appropriate having regard to several factors:

- (a) current population distribution, demographics and health needs of the local community in the context of wider area health service and state;
- (b) the need to staff the hospital to safe levels, in the face of workforce shortages;
- (c) the need for a critical mass in the delivery of all specialized medical services;
- (d) in the interest of each and every patient, the need for safety and quality in the delivery of healthcare; and
- (e) the need to provide a health service to the whole state in the most efficient manner, given severe funding constraints.

26.37 The above factors are considered at the Service Planning phase, which is the first of four phases of the planning process required under NSW Health's Total Asset Management Plan (TAM)<sup>39</sup> that must be followed if NSW Health wants to build a new hospital or introduce a new health care service. Service planning requires a sound understanding of the health needs of the population in question, thorough assessment of morbidity and mortality data, information about how and where the population accesses (or does not access) services, and resource requirements.<sup>40</sup>

26.38 Area Health Services have a statutory responsibility under the *Health Services Act 1997* (NSW) to plan and deliver services for their catchment population and gather information through local consultative structures and through state-wide Health Priority Taskforces and other clinical advisory groups, and to develop strategies and initiatives which will enhance service delivery with respect to their populations.<sup>41</sup>

26.39 Service plans may focus on a particular:<sup>42</sup>

- type of service, such as community health care;
- category of service, such as maternity services, cardiology services or renal services;
- population group, such as Aboriginal people, people with chronic illness or older people;
- health priority issue, such as mental health or drug and alcohol use.

26.40 I was pleased to see the accurate perception in the submissions of the NSW Medical Staff Executive Council, when it acknowledged that "... for decades most of our



*Metropolitan hospitals have operated as 'islands in an ocean of health care'...*

However, it went on to submit that:

"the attitude of public hospital clinicians has changed with clinicians ... being increasingly willing to participate in master planning for the delivery of services across the metropolitan area", to the point where "it is now widely accepted by public hospital clinicians that an individual hospital should be an invaluable asset for a 'networked' hospital system with the services it offers and, equally important, does not offer, based on its ability to ensure quality and safety".<sup>43</sup>

26.41 Regrettably, not all medical practitioners to whom I spoke in the course of the Inquiry accepted that position.

26.42 The NSW Medical Staff Executive Council also submitted that more than one hospital could be run by one administration:

"These institutes should act as 'one hospital' on two sites offering excellence at both but not duplication of services."<sup>44</sup>

26.43 I will explore some of the factors impacting upon determining location of and the level of service provision in hospitals in more detail below.

### Patient safety

26.44 In my opinion, patient safety in the provision of health care is the critical consideration for determining what hospital service is provided and where.

26.45 It is unacceptable to admit patients to, and to treat patients at, an unsafe facility. For NSW Health to keep open a hospital or maintain a service which is unsafe is to fail the public of NSW in the provision of healthcare.

26.46 In the current state of healthcare in NSW, if not Australia, it is to ignore reality to pretend that every hospital can and does provide comprehensive medical care unless, behind the entrance door, you have the necessary clinicians, facilities and equipment to actually provide such care. According to the NSW Medical Staff Executive Council quality and safety is at risk due to the sheer number of services which public hospitals are expected to provide:

"Hospitals in the Sydney metropolitan basin are expected to provide a huge array of quality services. Given the budget restraints faced by all hospitals and the shortage of clinical staff this expectation is inevitably compromising quality and safety."<sup>45</sup>

26.47 In many small rural hospitals across NSW there are actually no doctors present. When a patient arrives at the hospital, one of the rostered doctors has to be located and called into the hospital to treat the patient, or else the patient is transferred to another hospital which is staffed. Modern health care, technology, diagnostics and treatment required mean that many of these smaller facilities do not in fact provide acute care other than assessment, stabilisation and transport to a higher level of care.<sup>46</sup> NSW Health told the Inquiry that in some small facilities this works well. However, in others:

- (a) there are no GPs in the vicinity who are willing or able to work on the after hours roster,<sup>47</sup> and GPs increasingly do not want to take on rural practices because the after hours requirements;<sup>48</sup>

- (b) the procedural GPs are even smaller in number and even harder to attract as they are not doing enough procedural work to justify or warrant maintaining their skills and are concerned about medical indemnity issues, as well as work/life balance,<sup>49</sup>
  - (c) there are very few nurse practitioners, particularly in rural areas,<sup>50</sup>
  - (d) there are big gaps in services in smaller hospitals with a high level of locum coverage of unpredictable quality<sup>51</sup> and
  - (e) because of the absence of doctors, a large responsibility falls on the nurses.<sup>52</sup>
- 26.48 In many other hospitals, there are medical staff present, but only in particular specialities, so patients arriving who have health conditions requiring the attention of a different specialist have to be immediately transferred to another facility.
- 26.49 I could give many examples of this proposition which I came across in the course of my Inquiry. A few will suffice. I was told that at Mt Druitt Hospital there are no physicians, no intensive care unit and only a nominal high dependency unit.<sup>53</sup> This gives rise to its own set of problems, including that the clinicians have to be very careful about the types of patients they allow in the hospital for surgical intervention. Unless they are careful about this, and the patient needs to be transferred, the clinicians will often have difficulty transferring them because other hospitals have access block.<sup>54</sup>
- 26.50 A doctor at Shellharbour Hospital told the Inquiry that Shellharbour is so limited in the service that it provides to critically ill patients although it has a high dependency unit that it regularly has to attempt to transfer patients to Wollongong Hospital. It is frequently fully occupied. For the patient to remain at Shellharbour Hospital is to keep a patient in unsafe conditions.<sup>55</sup>
- 26.51 Frankness with the public is an important feature of patient safety in the present context. This provides the basis for the understanding of the public who wish to access a hospital service as to precisely what the nature of the hospital is and what services it can provide. Unless there is adequate information about this, people will go to the wrong hospital. They will not be treated by clinicians who are appropriately skilled to provide the treatment which they need. An example of this, that I received in evidence was when I was told that Bulli Emergency Department is a "misuse of the name".<sup>56</sup> I was also told that a few years ago a patient who arrived at Bulli Hospital with a significant cardiac problem, was not satisfied with the treatment received and complained about the treatment. The treating doctor drafted a letter in response advising the patient that, in future, having regard to his particular clinical condition, he should take such health problems to Wollongong Hospital. He was not permitted to send the letter with that advice in it.<sup>57</sup> That witness went on to say:
- "It is very hard under the current system to be frank, to the point where I think the public is actually at risk with some of the stuff that we write. Now that person doesn't know that next time they shouldn't go to Bulli and they'll probably turn up at Bulli again. It is ... really frustrating. We are not permitted to state what is obviously the case. I don't really think that is going to damage [anybody] ... to say 'Bulli has a primary care type facility. It is not the place to turn up to with potentially a heart attack'. Currently we can't do that."<sup>58</sup>
- 26.52 This is not just a problem which sits with administrators and managers, it is a systemic issue. The Inquiry received evidence from Emeritus Professor Kerry Goulston AO and Bill Bowtell that clinicians have not engaged the public in the debate about what

services are or are not provided at a hospital.<sup>59</sup> Bill Bowtell noted *“the people who create the public opinion when the hospitals have to be shut are the clinicians”*. It seems to me that the reason why clinicians are important in the debate is because it largely centres upon whether services can be safely maintained at any one facility. Professor Goulston said:

“I don’t think clinicians have engaged the public here in NSW – I don’t know about other places but we really haven’t engaged the public. We haven’t come out honestly and said that we have [35] emergency departments [in the metropolitan area health services] some of which are unsafe and should be closed, that children shouldn’t be looked after at some of the other hospitals at all. We haven’t been honest and come out and said that to the public. So some of that is our failure, I think. That is the only thing the politicians act on – public opinion.”<sup>60</sup>

26.53 During the Shellharbour hearing, a witness, a senior clinician gave evidence to a similar effect. He said:

“I don’t know that we’ve ever been as open as we should be with the community and with politicians, that we cannot deliver safe health care with the staffing issues at all of these small hospitals.”<sup>61</sup>

26.54 Other clinicians, particularly in confidential hearings and private conversations with me were of very similar opinions. Administrators and managers also held those opinions. It is clear that this present situation about the level of safety of some facilities and the services which are or are not provided is not well understood by the community. Perhaps, as it was suggested to me, it is not something which the community wishes to hear. It is certainly not a message which is particularly palatable to the elected representatives, be they at local council, state or federal level. It is my strong view, that the time has arrived for these issues to be dealt with openly and candidly, bearing in mind the overall public interest in securing a comprehensive and safe health system for NSW.

### A Principled Basis for Hospital Reconfiguration

26.55 In the Report of the 1925 Commonwealth Royal Commission on Health chaired by G.A. Syme, the Commissioners concluded their report by saying:

“We believe that the citizens of the Commonwealth will realise the need for co-operation in measures for promoting ... health and individually and collectively conform to and support such measures as may be adopted, recognising the truth of the old Roman saying ‘salus populi suprema lex esto’.”<sup>62</sup>

26.56 The usual translation of this phrase is “Let the good of the people be the supreme law” or “The welfare of the people shall be the supreme law”.

26.57 To me it exemplifies the central principled basis for the consideration of the location and distribution of hospitals and the provision of hospital services in NSW, namely they must be located, and provided, for the benefit of the whole of the population and not just for one group or another. It is the welfare of all of the people which is paramount, not the welfare of small sectional interests.

26.58 Public outcries by communities about changes to “their hospital” are understandable as an immediate reaction. But these expressions of view are necessarily sectional and



partisan. They have to be respected but they do not have to be bowed to because they are not paramount in guiding the overall development of the health system. What is paramount is making available a system which provides safe services of good quality for access by the population of the whole state.

### Critical mass

- 26.59 In specialised areas of medicine, clinicians need to treat a good number of patients each year in order to maintain their specialist skills and competencies. In NSW, there are only enough patients with a particular condition each year to support one specialist unit, for example, St Vincent's Hospital in Sydney is the sole provider of adult heart transplants. Centralisation of all such cases to one specialist unit has the advantage of attracting interested specialists and forming a centre of excellence. It also means that greater investment can be made in the facility and equipment than if, say, 5 such units had to be supported across the State. This is an example of what is known as critical mass. NSW Health has already applied critical mass theory in respect to a number of services across the State.
- 26.60 For example, complex transplantation in NSW is provided in three centres of excellence under the Selected Specialty and State-wide Services Program:
- Royal Prince Alfred Hospital – Liver Transplantation;
  - Westmead Hospital – Pancreas Transplantation;
  - St Vincent's Hospital – Heart and Heart/Lung Transplantation.
- 26.61 The notion of critical mass is important because it acknowledges a relationship between volume of patient load and the necessity of safety and quality in the delivery of health service. It puts safety and quality as the principal determinant. In my opinion, not only is this correct but it is essential to keep it as the principal determinant of patient care. It puts patient care at the forefront.
- 26.62 The Selected Specialty and State-Wide Service Program was developed in 2001-02 in response to the report of the NSW Health Council (Menadue Report) in 2000<sup>63</sup> which proposed, for the first time in NSW, the manner in which speciality health services were to be provided in the State.<sup>64</sup> It looked at key metropolitan hospital services (for example complex transplantation services, severe burns, and trauma services), and developed clinical plans in collaboration with clinicians (including bodies such as the Greater Metropolitan Services Implementation Group chaired by Emeritus Professor Kerry Goulston AO and Mr Jon Blackwell) to guide the future delivery of those services.<sup>65</sup> These services were characterised by one, or a combination of the following factors:
- a demonstration of a relationship between volume and quality;
  - the treatment of conditions that are not common;
  - the need for specialised skills of individual clinicians or teams;
  - the need for highly specialised equipment and/or support services;
  - the early stage of development of the speciality;
  - shortages in supply or distribution of the workforce;
  - high cost infrastructure.<sup>66</sup>
- 26.63 I received the following submissions and heard the following evidence about the need to rationalise on the basis of critical mass theory a variety of services:
- One person said, that all paediatric organ transplants should only occur at one site in the State, instead of at 2, as is now the case.<sup>67</sup>

- I was told that, for orthopaedic trauma, patients get a better outcome if they are operated on in dedicated trauma centres,<sup>68</sup> and that 2 separate services in an area of the size of the Northern Sydney Central Coast Area Health Service would dilute the expertise of staff.<sup>69</sup>
- In relation to paediatric cardiac surgery, I was told that there is a critical mass issue at Sydney Children's Hospital following the resignation of one cardiac surgeon, as it was thought this may lead to the loss of other services.<sup>70</sup>
- In the sub-specialty of severe burns, critical mass is essential to maintain the skills of staff: there are only 50 severe burn adult patients in NSW each year, but there are 2 specialty units.<sup>71</sup> There are another 300 serious burn adult patients who, I was told, did not need to have all of their treatments at a severe burns unit.
- A senior specialist doctor submitted that there is good evidence that patient outcomes from teams performing surgical procedures and complex interventions improve with increasing throughput.<sup>72</sup> He gave the example that emergency surgery in elderly patients often causes temporary failure of the lungs, heart and/or kidneys. In a facility in which such surgery is performed it is necessary to ensure the availability of high quality intensive care and respiratory, cardiology and nephrology teams in addition to the skilled surgical teams. However, given the public's natural desire to access such services as close as possible to their homes and families, it was submitted that there needs to be greater honesty with the public, who must be told that attempts to replicate and distribute the delivery of sophisticated care across Sydney and NSW consumes workforce and threatens quality.<sup>73</sup> The doctor submitted that concentrating activities in major medical centres "reduces workforce requirements and improves patient outcomes".<sup>74</sup>
- According to the NSW Medical Staff Executive Council, concentration of services as a critical mass also improves team work and morale:

"Where role delineation has occurred, a new focus on fewer services has seen mediocrity replaced by excellence with a predictable surge in staff morale"

...

"Even for some of the services offered by major referral hospitals, evidence suggests that some highly specialised services should be restricted to a few institutes so that the volume of cases treated allows for experienced teamwork and better outcomes."<sup>75</sup>

- 26.64 The concept of critical mass, to continue with my earlier example, is at odds with having a heart transplant unit conveniently accessible at most hospitals in the state. However, critical mass was accepted amongst the clinicians I spoke to as being a non-controversial element of the modern networking and systems of hospitals. Indeed, in some fields of medicine, clinicians have themselves worked out, with the assistance of the Greater Metropolitan Clinical Taskforce, how best to deliver medical services through a single centre for excellence or a clinical network.
- 26.65 Professor Tony Dodds, the eminent Director of Haematology in Bone Marrow Transplant at St Vincent's Hospital in Sydney explained the benefit of using critical mass and clinical networks. He said that it requires involving all clinicians, not just doctors but also nurses and allied health professionals together to work out where services may be best delivered.<sup>76</sup> For example, the Bone Marrow Transplant Network looked at where those services would be best delivered and came up with two sites for complex, expensive treatments (Westmead Hospital and St Vincent's Hospital). Three new centres were also opened in Wollongong, Nepean and Gosford to ensure better equity of access for people living in those areas to bone marrow transplantation services.<sup>77</sup> All

the services are networked and St Vincent's Hospital has mentored the new units and helped them to commence running by providing them with, for example, laboratory services. St Vincent's Hospital also runs a monthly web-cast where a clinician, nurse or doctor gives a one hour lecture, which can be viewed around the world. They also run nurse education days and an annual education day, as a lot of actual treatment in bone marrow transplantation is done by the nurses themselves. According to Professor Dodds:

"it's terribly important to empower these clinicians and educate them... I think that's the beauty of clinician networks."<sup>78</sup>

26.66 I agree.

### Efficiency and cost effectiveness

- 26.67 Clinical staff, administrative staff, equipment procurement and maintenance staff all must comply with minimum standards at each hospital. As well, each hospital facility needs a minimum staffing level regardless of patient occupancy.
- 26.68 In many ways it seems logical, that if one large hospital can meet the health needs of a region in place of 6 small hospitals, then it would be prudent to employ the use of the large hospital to avoid duplication of costs. In addition, transferring patients to small, off-site facilities with limited or no medical diagnostic back up introduces greater clinical risk because they may not be staffed or equipped to manage unstable patients.
- 26.69 The disadvantages of this approach are that the patient has lost the benefit of convenience and also that there is no reason to think that large hospitals which continue to grow are necessarily more efficient or cost effective.
- 26.70 At the hearing at Prince of Wales Hospital in Sydney, I was told that the current model, where larger hospitals are surrounded by many small hospitals is inefficient and resource intensive, without producing enough compensating outcomes.<sup>79</sup>
- 26.71 During my visit to Mullumbimby Hospital, I was told there had been plans to amalgamate the hospital with Byron Bay Hospital for over 10 years. Both hospitals are old and experience problems recruiting staff, meaning Byron Bay and Mullumbimby "fight" over the nursing population, which is by-and-large nearing retirement.<sup>80</sup> I was told that both the communities welcomed the proposed combined facility,<sup>81</sup> and that it would be possible once combined to provide better care.<sup>82</sup>
- 26.72 It was submitted to me that smaller general hospitals are usually older and more expensive to maintain.<sup>83</sup> According to the Australian Health Policy Institute, it is cheaper to get people to travel by limousine to a specialty hospital than to keep open the very small general hospitals which have served local communities over time.<sup>84</sup>
- 26.73 During the hearing at Wollongong Hospital, one witness said that smaller, offsite hospitals create additional expenses as a consequence of the need for patient transport, and more significantly, a considerable extension of the average length of patient stay, therefore contributing to access block downstream<sup>85</sup>:

"Patients will have this hiatus where they're almost finished acute care, [but] they're not really ready [to be transferred there]... because they're not medically stable enough... some research work that we've done suggests that hiatus is around two to three days."<sup>86</sup>

- 26.74 I am told by NSW Health that there are approximately 100 small rural and regional hospitals that are essentially occupied by patients who really need to be in long term aged care facilities.<sup>87</sup> I understand these cost a 'disproportionate dollar figure' per patient.<sup>88</sup>

## Rationalisation of the hospital network

- 26.75 The existing network of hospitals in NSW is in need of extensive rationalisation. There are a number of areas which to me seem to be ripe for rationalisation.
- 26.76 Before moving to consider the options which are open, it is appropriate that I refer to and summarise the extent of the evidence which I received dealing with this subject. I will then move on to consider the objections that I perceive to amount to impediments in the way of such rationalisation.

### Rural hospitals

- 26.77 I have already commented on peer groups of hospitals in rural areas.
- 26.78 It is fair to say that I received no evidence from any rural locations which I visited that expressed the view that local facilities ought be closed. On the contrary, most rural residents wanted their local facilities upgraded, if not renewed, and a greater level of services provided. Rural residents were quick to acknowledge the difficulty in attracting and retaining qualified staff but nevertheless, advanced as the preferable option the renewal and upgrading of local facilities.
- 26.79 The submissions which called for an enhancement of services did not seem to me to pay any attention to the realities of geography and the modern roads network.
- 26.80 For example, Gulgong is a little over 28km from Mudgee, along a tarred road which can be driven in a little over 20 minutes. I still heard residents advance the argument with passion and vigour that the Gulgong District Hospital which offered a limited emergency department, a ward of acute care beds and other limited facilities, but housed in a very old and run down building, ought be upgraded rather than being transferred to, and combined with Mudgee District Hospital which is a much larger facility.
- 26.81 As I understand it, and as it was reported to me that the towns of Parkes and Forbes which are about 33km apart, again over good roads of a driving distance of about 25 minutes or so, both cannot sustain a safe maternity service but neither community is willing to close their maternity service and have it located at the other facility.
- 26.82 I do not wish in any way to denigrate the sincerity of the views expressed by the rural residents and health care workers with whom I spoke. I do not suggest that these views were not strongly held and well articulated. They were.
- 26.83 In a perfect world where there were no constraints of workforce or financial resources, I would wish to be the first to endorse and support their views. But as I have said elsewhere, the present day reality is different and accordingly it is not possible to accept all of these arguments which are advanced.
- 26.84 As I have already said, I think that there is room for consideration of whether some small rural hospitals should be enlivened to take the overload from major non-metropolitan hospitals. This reflects the submissions which I recount elsewhere, that I received about the role of District Hospitals.

## Metropolitan hospitals

- 26.85 It was submitted to me that there are too many hospitals in metropolitan Sydney, and that a reduction in the number of hospitals is long overdue and must be done in order to ensure the viability and safety of the public health system for the future.
- 26.86 After the release of *The State of our Public Hospitals, June 2005 Report*, the Australian Government Department of Health And Ageing website reported on the concentration of medical services across Australia:
- “Although principal referral hospitals, specialist hospitals and large hospitals only account for 16 per cent of public hospitals, you are more likely to be treated in them than other hospital types as they contain 62 per cent (33,108) of the 53,000 public hospital beds in Australia.
- In fact, more than 60 per cent of public hospital admissions occur in principal referral hospitals, which only make up 9 per cent of the total number of Australia’s public hospitals.”<sup>89</sup>
- 26.87 It was submitted to me that in metropolitan Sydney, if you were designing a health system from scratch you would have 6-10 major hospitals with a network of primary health care and community health care around them.<sup>90</sup> Currently, there are 40 public hospitals in metropolitan Sydney and over 30 emergency departments. This creates large infrastructure costs, for example, CT scanners, MRIs and other expensive equipment in each hospital, some of which are only used for limited periods each day. I am told there is enormous potential for staff rationalisation if you consolidate a number of these hospitals into one site. I was told there are far fewer public hospitals in Auckland, where 1.5 million people are provided with 3 public hospitals, each with an emergency department and one trauma centre for the whole city. Sydney is 3 times the size of Auckland in population terms and yet has 40 hospitals.<sup>91</sup>
- 26.88 One witness said:
- “that whereas the clinicians might agree, the politicians will not permit certain options to be taken. Having a hospital on every corner would make the community extremely happy but the health outcomes would be much worse.”<sup>92</sup>
- 26.89 It was submitted to the Inquiry that NSW Health should double the size of Royal North Shore Hospital and close Manly and Mona Vale Hospitals for acute services, making them “convalescent only” units.<sup>93</sup> One witness said that:
- “That issue has now been around for two decades and is still going on.”<sup>94</sup>
- 26.90 Another witness recommended closing Manly, Mona Vale and Ryde hospitals and replacing them with larger hospitals at Frenchs Forest and Royal North Shore.<sup>95</sup>
- 26.91 I also received submissions to the effect that there are too many hospitals, and too many emergency departments, in the Illawarra area.
- 26.92 During the hearing at Wollongong Hospital, one witness submitted that there are too many hospitals in the Northern Illawarra.<sup>96</sup> I was told that their number should be decreased from 6 to one or 2 hospitals because currently, the required nursing, allied health and medical staff to cover 6 hospitals was not able to be provided. In addition, servicing all of the hospitals after hours was extremely expensive, which was

compounded by duplication of administrative staff. There is also a greater risk to patient safety due to the need to transport them between hospitals.

26.93 During a hearing at Shellharbour Hospital a witness said:

“I have often said that the history and geography of the Illawarra is against us. We had the mining industry, which was very important and small sort of cottage hospitals developed largely to support the mining industry in the late 19<sup>th</sup> Century, early 20<sup>th</sup> Century. That is not the way to run health care now, but every time the issue is raised, it seems to get caught up with this view that local politicians will not tolerate closures of small hospitals.”<sup>97</sup>

26.94 That witness was also of the view that the smaller facilities at Coledale, Bulli, Port Kembla and Kiama Hospitals should be closed. The witness thought that building a large hospital with 800 beds or else keeping the existing Wollongong Hospital, and building a 300 bed hospital, say, at Shellharbour would represent the ideal configuration.<sup>98</sup> That same witness was also of the view that it would be much more efficient to have 2 emergency departments properly staffed with specialist emergency physicians.<sup>99</sup>

### Consideration

26.95 A review of the evidence persuades me to a high level of satisfaction that the present hospital network does not meet the ideal requirements for patient safety, critical mass and efficiency and is, in some respects, quite unsafe.

26.96 In my view, there needs to be a complete state-wide review undertaken by NSW Health which involves:

- (a) the identification of a set of criteria, which relate to at least, patient safety, necessary workforce skills, and the volume and quality of services regarded as an appropriate critical mass for the services provided across NSW in public hospitals;
- (b) a determination of whether each hospital, having regard to its location, the available workforce determined on a long term basis, the size of the population which it services, the alternative locations within an appropriate distance (measured by time or distance) and the age and state of repair of the facilities and equipment, is (or can become) a location for the delivery of safe patient care;
- (c) a clear delineation of the role of each hospital – what it can and can't do;
- (d) clear communication of the role of a local hospital to its community, and community understanding of the limitations of the local hospital;
- (e) re-allocation of specialist medical services to hospitals in NSW best placed to deliver those services; and
- (f) the consideration of the availability of an efficient transport and retrieval system state-wide to transport patients to the hospital best placed to provide the medical service required, and return the patient to their original locations.

26.97 Following upon such a review, a plan which defines the delivery of services which best promotes patient safety and the delivery of good quality health services need to be devised and implemented.



- 26.98 Having received a very large number of submissions on the topic of hospital closures and having expressed a view about the principles which ought guide any decision about hospital closures and re-allocations of roles and services in and between hospitals, and suggested that a comprehensive review be undertaken, it is appropriate that I express my views, which may assist to guide the process which I anticipate is ahead of NSW Health.
- 26.99 Before doing so, I will repeat what seems to me to be the critical principles:
- (a) The delivery of a safe health services of as high a quality as possible is the paramount determinant;
  - (b) The principled basis for reconfiguration is what is best for all of the people of NSW, not one section or part of the community;
  - (c) The reconfiguration of services is based on what is clinically appropriate;
  - (d) The beds and services in an existing hospital which may be removed from one hospital must be added to an identified location where the services will continue to be available.
- 26.100 In the 4 metropolitan based area health services, it seems to me that careful consideration needs to be given to the reconfiguration of the services by way of hospital closure, amalgamation and service retention and re-organisation of the hospitals. The starting point of that consideration is where and how emergency services ought be provided.

#### *Emergency Departments*

- 26.101 It was suggested to me that several metropolitan emergency departments should be closed. It was submitted that there should only be emergency departments in hospitals that can provide the services for the patients that present there. I was told that a significant number of hospitals currently have emergency departments that are understaffed, are unable to provide services and as a result they are fundamentally unsafe.<sup>100</sup>
- 26.102 It was suggested that Emergency Departments at Manly, Ryde, Sydney and possibly Mt Druiitt Hospitals ought be closed because they are under-utilised.<sup>101</sup>
- 26.103 The Royal Australasian College of Surgeons, are of the view that closure of the Emergency Department at Ryde Hospital would not lessen access to emergency care provided a retrieval service that is adequately resourced is installed.<sup>102</sup>
- 26.104 One witness was of the view that Camden Hospital Emergency Department should be closed because it is understaffed. It remains open on account of political pressure.<sup>103</sup> I note that the distance between Camden and Campbelltown Hospitals is 14.2km, a driving time of about 20 minutes.
- 26.105 At Mona Vale Hospital I was told that the Emergency Department is useful for stabilisation purposes, but seriously ill patients need to be transferred to Royal North Shore Hospital:
- "The patient is better off in the ICU ambulance on the way to Royal North Shore Hospital than in the ED at Mona Vale."<sup>104</sup>
- 26.106 I also received a submission that there should only be 5 emergency departments in northern Sydney, rather than 7, in order to promote economies of scale.<sup>105</sup>

- 26.107 The NSW Medical Staff Executive Council submitted that emergency departments should be “sub-classified” as they are not all similarly resourced.<sup>106</sup> For example, some could be “re-badged” as acute care centres.
- 26.108 I was also told that the model used at Mt Druitt Hospital is “fundamentally unsafe”.<sup>107</sup> That witness said that about 4 years ago, all the physicians at Mt Druitt Hospital (save for the cardiologists and paediatricians) resigned and went to Blacktown Hospital because (amongst other reasons) the Emergency Department continues to treat all patients, apart from non-interventional cardiology patients.
- 26.109 Having regard to the volume of patients, their level of acuity, the level of provision of services and the proximity of other larger hospitals, I am of the view that the following emergency departments in metropolitan Sydney ought be closed: Manly Hospital, Ryde Hospital, Sydney Hospital, Mt Druitt Hospital, Auburn Hospital, and Camden Hospital.
- 26.110 Whether at those facilities an acute primary care centre is established in lieu of the emergency department would be a matter for careful consideration and review by NSW Health.
- 26.111 It is appropriate that I again emphasise that closures of this kind are being made for the purpose of ensuring patient safety and not for budgetary reasons. I cannot emphasise too greatly that adjoining emergency departments will need to be supplemented to take account of the additional volume of patients created by these closures. For example, Mona Vale Hospital will receive a significant number of the presentations at Manly Emergency Department. A careful examination will need to be undertaken to see what supplementation Mona Vale Hospital requires.
- 26.112 In the Illawarra area, the emergency department at the Bulli District Hospital ought be closed. It is unsafe in my view by reason of its through put and the services which are available.
- 26.113 In the Newcastle area, in my opinion the emergency department at the Kurri Kurri Hospital ought not be maintained and ought be closed.
- 26.114 Serious consideration then needs to be given as to whether, once these emergency departments are closed, it is viable to keep open a hospital and if so, what its purpose and role ought be. Speaking for myself, at the end of this Inquiry, I cannot see any argument in favour of retaining, for any general hospital service the facilities at Manly or Ryde. It is possible that the facilities at Kurri Kurri and Bulli can be used and I express no view about that, other than to say that a definite role would need to be established and articulated.
- 26.115 Otherwise, the question of which hospitals ought remain open and what services ought be provided at those hospitals ought to wait the review, which I suggest be conducted.

#### *Major Trauma Centres*

- 26.116 Patients suffering severe trauma are those who are “at a high risk of having serious injury” as the result of the traumatic event: the common example is a motor vehicle accident.<sup>108</sup> According to the prehospital trauma triage tool used by the Ambulance Service, “Protocol 4 Early Notification and Bypass System”,<sup>109</sup> after patients are identified they “enter” the NSW trauma network on the basis of their vital signs and injuries, including things such as a high level of respiratory distress, unconsciousness, penetrating injury to the head, neck, chest, abdomen, perineum or back, severe burns, or, for example, that they have been involved in certain high risk situations such as a serious motor vehicle crash or fall.<sup>110</sup>



- 26.117 In 1991 NSW Health introduced the State Trauma Plan (“STP”) in the Sydney metropolitan area.<sup>111</sup> Under the STP, trauma patients bypassed the local hospital and were taken to a major trauma centre. It was introduced in rural areas in 1993.
- 26.118 Under the current STP there are 8 adult Major Trauma Services and 2 Major Trauma Services for children in metropolitan Sydney.<sup>112</sup> There are also Major Trauma Services at John Hunter Hospital and John Hunter Children’s Hospital in Newcastle.
- 26.119 In addition there are speciality trauma services in respect of spinal cord injury (located at Prince of Wales Hospital and Royal North Shore Hospital) and severe burns (Concord Repatriation General Hospital, Royal North Shore Hospital, and The Children’s Hospital at Westmead).<sup>113</sup>
- 26.120 Regional trauma services are provided by Nepean, Gosford and Wollongong Hospitals.<sup>114</sup> These hospitals are located in urban areas, have a high level of clinical services, but do not have the full range of specialist services, required to operate as a Major Trauma Service. Having said that those hospitals are able to provide care for a defined group of seriously injured patients.<sup>115</sup> They also provide initial assessment, stabilisation and definitive care, and initiate transfer to the major trauma service when a patient requires services not available at the hospital.
- 26.121 The principle of critical mass compels me to express the opinion that the number of trauma centres in NSW. In Sydney, the 8 trauma centres should be reduced to 3.<sup>116</sup>
- 26.122 One witness was of the view that Sydney would require 2 trauma facilities with one major centre with an emphasis on teaching, education and training.<sup>117</sup> The trauma services would need to be strategically placed across Sydney so they are accessible. For this reason, it would make sense to co-locate trauma services with nearby existing hospitals.<sup>118</sup>
- 26.123 It was also suggested that, of the 8 trauma centres in Sydney, only 3 or 4 should remain.<sup>119</sup>
- 26.124 I was told that in 1993, the Commonwealth Government Working Party on Trauma Systems (“NRTAC”), recommended that there ought to be one trauma centre for every 2-3 million people. One person suggested that Sydney might only require one trauma training and teaching hospital if one was built at John Hunter and the other at Canberra (each taking 300-400 cases). That person also suggested those hospitals would need about 650 major traumas each year for critical mass.
- 26.125 NSW Health set up a workshop to review its trauma services in October 2004 in consultation with Area Health Services, clinicians, interstate providers, the Ambulance Service and other clinical stakeholders.<sup>120</sup> The object of the review was to achieve:
- (a) A critical mass of severe trauma patients; and
  - (b) Provide for a sustainable, skilled trauma services workforce through the development of a comprehensive trauma training and accreditation program which is underpinned by a centralised trauma training and research centre and supported by the Royal Australasian College of Surgeons.
- 26.126 As a result of the workshop, the *NSW Trauma System Health Care Advisory Council Summary Paper* was provided to members of the Health Care Advisory Council (“HCAC”) in June 2007, which the HCAC endorsed at its August 2007 meeting. The Summary Paper set out the preferred direction for major trauma services as follows:
- (a) 5 Trauma Networks:
  - (b) 6 Major Trauma Services supporting the Trauma Networks:

- (i) Liverpool;
- (ii) Royal North Shore;
- (iii) Royal Prince Alfred;
- (iv) St George;
- (v) Westmead; and
- (vi) John Hunter.

(c) Each Trauma Network to have a single Area Trauma Director.

26.127 According to the *NSW Trauma System Health Care Advisory Council Summary Paper*, the 6 major trauma services would provide the following:<sup>121</sup>

- Good geographic cover for greater metropolitan Sydney, including the central business district, the airport and provide flexibility in response to statewide demands;
- A concentration of services that will provide core case numbers to develop well-defined, comprehensive in-hospital trauma care, without overloading existing services and compromise access to these services for other patient groups;
- A concentrated workload to sustain a highly specialised workforce and train the future workforce;
- The ability for injured patients within metropolitan Sydney to access a major trauma service within 60 minutes of sustaining injury (30 minutes ambulance response and treatment at the scene, 30 minutes transport time);
- The ability for injured patients in rural areas to access a major trauma service within 90 minutes of sustaining injury (30 minutes ambulance response and treatment at the scene, up to 60 minutes transport time), in consultation with a medical retrieval consultant;
- Well defined networks with rural regional hospitals that support the transfer of patients to the major trauma service and back transfer for ongoing care and rehabilitation;
- Clinical support and education within each network led by the major trauma service; and Trauma networks will be closely aligned with established critical care referral networks.

26.128 In my view, the above can be achieved without providing Major Trauma Services at Royal Prince Alfred and St George Hospitals. NSW instead should have the following adult Major Trauma centres:

- (a) one in Newcastle;
- (b) one in northern Sydney, at Royal North Shore;
- (c) one in South West Sydney, at Liverpool; and
- (d) one in western Sydney at Westmead.

26.129 However, there must be the requisite support services behind these centres. Peter Campbell, Clinical Nurse Consultant in Burns and Plastic Surgery, submitted that obstetrics/gynaecology, spinal/neurology, cardiothoracic surgery, and paediatrics, orthopaedic trauma surgery services are needed to support a trauma service.<sup>122</sup>

26.130 The *NSW Trauma System Health Care Advisory Council Summary Paper* identifies the following issues in relation to support services and patient volume:

"2. Core Case Numbers

The current major trauma caseload is spread across nine centres, resulting in underdeveloped trauma services within these facilities. Trauma care is complex and crosses the disciplines of Emergency Medicine, Intensive Care, Neurosurgery, General Surgery, Orthopaedics, Cardiothoracic Surgery, Anaesthetics, Imaging and Rehabilitation...

A critical mass of patients is required to effectively develop and utilise the trauma resources - staff, related clinical services and equipment - necessary in establishing comprehensive in-hospital trauma care"<sup>123</sup>

"In NSW, trauma services are provided within the context of critical care service delivery along with intensive care, emergency medicine and medical retrieval services. Trauma services encompass Radiology, Acute Surgical and Rehabilitation services. A significant increase in the volume of major trauma patients at any one facility will impact on the ability of specialty services to continue to provide services to other patient groups. Similarly, an overly concentrated trauma system offers least flexibility in the event of significant fluctuations in demand."<sup>124</sup>

- 26.131 In addition, a specialised workforce is essential for the management of major trauma patients, requiring a concentration of the workload.<sup>125</sup> The management of trauma covers a number of specialities, in addition to surgical specialities, so a broad base of specialities are required to complement the current workforce at the Major Trauma Services.<sup>126</sup>
- 26.132 In my view critical mass and the required support services is provided by having Major Trauma Services at 3 centres in Sydney and one in Newcastle.

**Recommendation 116:** *By 1 July 2009, NSW Health is to designate and resource only three Major Trauma Centres in the Sydney metropolitan area and one Major Trauma Centre for rural NSW which is to be located in Newcastle.*

## Obstacles to rationalisation

- 26.133 If it were easy to rationalise the delivery of services in hospitals and the hospital network, then it would already have been done. There are significant obstacles to overcome in order to do so. I was told the impediments to change are politicians, the general public and health providers.<sup>127</sup> However, it was stressed to me that we cannot afford the direction in which we are going and that strategic changes to the health system have to be made.<sup>128</sup>
- 26.134 Professor Leslie White of the Sydney Children's Hospital submitted that proper long term planning for the hospital system also requires inclusion of a national component.<sup>129</sup> This is because of flows across state borders, as well as the fact that there are now some very highly complicated treatment modalities and rare conditions within the health system that by their nature need to be managed across the whole country.

## Politics

- 26.135 The historical development of the public hospital system throughout the State still shapes the way our political representatives view their obligations to the local communities within their electorates. Their objective is to provide the best health care

for those within their constituencies. In order to bring this about, a major task of Members of Parliament appears to be to ensure that their local hospitals remain open (or, preferably, a new one is built in its place) and to get more beds, equipment and staff. However, the reality of modern medicine and the hospital system is that it no longer ensures that the nearest hospital will be able to treat, and in an emergency, save the life of the local resident, who is seriously injured, or having a stroke or heart attack.

- 26.136 That level of care requires technology and medical professionals who are unavailable in small local hospitals but not, I emphasise, unavailable to residents of small local communities. The model of comprehensive local hospitals in as many communities as possible has been replaced with highly advanced quaternary and tertiary hospitals in the larger population centres, then radiating out hospitals with more limited facilities – for example, without a burns unit or major trauma centre. This is accompanied by efficient and professional retrieval services.
- 26.137 Again, limits on funds and on personnel make this inevitable. The role of government, is to make decisions which ensure that funding is available and doctors and nurses on hand to provide the best care in highly specialised hospitals which serve the whole state (eg the tertiary children’s hospitals) or large regions. Nobody argues that the resources of government should be spread so thinly across the State that every small community will have a third rate burns unit staffed by doctors and nurses who are not specialists in burns in order to satisfy local “demands” for a “proper hospital”. This example can be multiplied dozens of times: the availability of Magnetic Resonance Imaging (“MRI”) scans, of facilities for complicated births, radiotherapy and oncology services.
- 26.138 It is better to concentrate these services in centres of excellence and to ensure that patients have the means to get there quickly in an emergency. This is the reality of the hospital system as it has evolved in the last 3 decades. The key to its acceptance is a fast, reliable retrieval service ie land and air transport to link the local communities to the centres of excellence. By local communities, I include inhabitants of metropolitan, regional, rural and remote areas: no one lives “next door” to a hospital with the highest grade of every specialty on offer; almost everyone will need ready transport to a specialist unit in urgent cases. The issue for all communities is how quickly patients can get to the level of care they need, not how close the nearest hospital is. I agree with the notion that lies behind this example:

“The patient is better off in an Intensive Care Unit (“ICU”) ambulance on the way to Royal North Shore Hospital than in the ED at Mona Vale.”<sup>130</sup>

- 26.139 I would with respect suggest that it may be better for the health needs of their communities if local members concentrated on getting their constituents access to the best health care quickly rather than more attractive short-term solutions such as: buying an MRI machine, keeping open an under-staffed operating theatre, leaving the emergency sign on when the hospital can only support a junior night nurse.
- 26.140 The NSW Medical Staff Executive Council submitted that political considerations ought not be able to prevent the closure of unsatisfactory services:<sup>131</sup>

“Proper role delineation for individual hospitals remains in the politically ‘too hard’ basket. This is true even when a hospital’s clinicians have asked the Department to allow them to withdraw an unsatisfactory or even unsafe service. This situation must change.”<sup>132</sup>

- 26.141 It seems to me that the mark of success for any Member of Parliament must no longer be the number of hospitals in the electorate but, rather, how well the medical needs of

the constituents and indeed of all the residents in the state are being met, whether at a local hospital or otherwise.

### Public understanding

- 26.142 The allocation of health services according to state-wide concerns does not always align with a community's desire for particular services at the local hospital. It can cause inconvenience to patients who have to travel for particular treatment, and to local doctors and nurses who have to juggle these additional logistics. It leads to community discontent and agitation, of which I heard much expression during the course of this Inquiry. The key issue is to achieve an equitable distribution of health services and a rational use of resources. Economics may dictate that the public sector reach a commercial arrangement with a private provider. This in turn can result in frustration and delay if the medical transport system is inadequate. Thus there needs to be a balance between the location of the patients, the location of highly expensive equipment, or specialist services and the system which connects the two.
- 26.143 For example, at Wagga Wagga Base Hospital there are no angiography or MRI services. There is only private sector imaging available in Wagga Wagga.<sup>133</sup> In addition, there is no vascular lab or cardiac catheter lab, and limited ultrasound services at the public hospital. Patients requiring MRI or other services need to travel via hospital transport, or with NSW Ambulance in an emergency situation, to a private imaging facility in Wagga Wagga with a nurse escort. Often, while the nurse waits for the procedure to be completed, the ambulance is called out to another emergency and the nurse must wait at the private imaging facility for several hours until the ambulance is available, which often happens after hours.<sup>134</sup>
- 26.144 On the NSW North Coast, it was submitted to me that excessive money and resources are spent sending patients to private hospitals in the Tweed area for investigation, because there are no cardiac investigations or diagnostic procedures are performed at The Tweed Hospital.<sup>135</sup> There is only one cardiologist there, and I am told it is difficult to attract other staff due to the fact that these procedures are not performed.<sup>136</sup>
- 26.145 There is a large gap between community expectation of a hospital network and what is actually safe and achievable in today's environment. The considerations of patient safety, critical mass and efficiency are here to stay and much work needs to be done to inform the community about these factors. I was told often that communities have an expectation about what an emergency department does, which NSW Health say is most often beyond what those services are actually providing, and which needs to be changed through a process of education.<sup>137</sup>
- 26.146 The NSW Medical Staff Executive Council submitted that a "master plan" would explain to hospitals and the community that their hospital was not being singled out for change (that is, treated inequitably).<sup>138</sup>
- 26.147 The time has surely come for the public health system to begin to educate the people of NSW as to the risks to patient safety and quality of care under the present hospital arrangements; and as to what can and cannot be realistically and safely done in their local communities.

### The way forward

- 26.148 One option is to establish, a non-political body to review and advise on the reconfiguration of the number and location of hospital and specialist medical services in NSW.

- 26.149 The Ontario Government did this in 1996 when it established the *Health Services Restructuring Commission* (HSRC), an independent body with a four-year mandate to facilitate and expedite hospital restructuring in Ontario.<sup>139</sup>
- 26.150 The HSRC's mandate included making binding decisions on restructuring Ontario's public hospitals. The Commission was also required to advise the Minister of Health for Ontario about which health services would need reinvestment as a result of changes to the hospital system and changing needs of the population. The HSRC was also required to make recommendations on restructuring other components of the health care system to improve quality of care, outcomes and efficiency and help create an integrated health services system.
- 26.151 The Minister for Health was given sweeping powers to reorganise Ontario's health system, including powers to reduce or terminate grants or loans, to order boards of public hospitals to close, and to amalgamate, continue to provide or cease to provide services.<sup>140</sup>
- 26.152 The HSRC's final report identified that during the early days of its mandate, there was concern about the changes being made, particularly regarding the closure of local hospitals, and the perception that health reform and hospital restructuring was being driven solely by financial considerations, and undertaken by government on its own, and not the public's, behalf.<sup>141</sup> This was against a set of political factors, such as the difficulty for provincial politicians to support its work, and its arms-length relationship with the government.<sup>142</sup>
- 26.153 In addition, there were reactions from health providers to the effect that health services would suffer as a result of HSRC decisions.<sup>143</sup>
- 26.154 The HSRC reflected on the experience and future challenges with the release of its "Seven points for Action" report in March 2000. This included a vision for the future health system:
- "Our vision is of a sustainable health system that provides compassionate, comprehensive, high quality care to everyone who needs help to regain and maintain good health. While reflecting community and regional differences, the system's health care providers work together towards the common purpose of meeting the publicly set goals, objectives, policies and priorities necessary to achieve Ontario's vision of health."
- 26.155 Sometime ago in NSW the provision of hospital services and the location of hospitals was controlled by a Hospital Commission of NSW. There is no need for me to undertake an analysis of the work of that Commission. Its original intent was that it would be an apolitical commission which would determine the provision of hospital services for the whole of the state.
- 26.156 It seems to me that in modern government, the provision of health services, and the location of that provision is a core business of government. The person ultimately responsible is the Minister for Health and the responsibility of the Minister incorporates issues which relate to all of government budgetary matters and participating in the priorities determined by the government of the day as to how much, where and when funds will be spent for health services.
- 26.157 I am not persuaded that a so called non-political, but nevertheless independent commission, is the best body in NSW.



- 26.158 In my view, it is a matter for the Minister for Health taking account of such advice as he or she may receive from the Director General of Health.
- 26.159 It is for that reason that I favour the establishment by the Department in order to prepare advice for the Minister of the review to which I have earlier made reference, the purpose of which is to comprehensively assess what ought be done with respect to the provision of hospital services and their location across the state.

**Recommendation 117:** *In my view, there needs to be a complete state-wide review undertaken by NSW Health which involves:*

- (a) *the identification of a set of criteria, which relate to at least, patient safety, necessary workforce skills, the volume and quality of services regarded as an appropriate critical mass for the services provided across NSW in public hospitals;*
- (b) *a determination of whether each hospital, having regard to its location, the available workforce determined on a long term basis, the size of the population which it services, the alternative locations within an appropriate distance (measured by time or distance) and the age and state of repair of the facilities and equipment, is (or can become) a location for the delivery of safe patient care;*
- (c) *a clear delineation of the role of each hospital – what it can and can't do;*
- (d) *clear communication of the role of a local hospital to its community, and community understanding of the limitations of the local hospital;*
- (e) *re-allocation of specialist medical services to hospitals in NSW best placed to deliver those services; and*
- (f) *the consideration of the availability of an efficient transport and retrieval system state-wide to transport patients to the hospital best placed to provide the medical service required, and return the patient to their original locations.*

## Security

- 26.160 I heard evidence of security problems experienced at various hospitals across NSW.
- 26.161 Staff described a lack of CCTVs, security doors and security staff to come to their assistance when required. A nurse submitted that the newly refurbished psychiatric unit at Port Macquarie Hospital has new security doors which cannot be used because they are not secure.<sup>144</sup>
- 26.162 An employee of the Armidale Community Health Centre told me there is only one security guard to cover both the Armidale Hospital and the community health centre, which was considered inadequate.<sup>145</sup>
- 26.163 An experienced security guard submitted that the increase in violent presentations to emergency departments has not been met with increased resources to respond to those challenges, which is unacceptable.<sup>146</sup> It was submitted that over the years, the area health services have removed the essential tools of a security officer's trade, for example batons and handcuffs, whereas the opposite should be happening.<sup>147</sup>



- 26.164 Security officers have long argued for more officers who are appropriately trained as special constables, with a minimum equipment list of 2-way radio, pager, mobile phone, extendable baton, handcuffs, capsicum spray and an optional “taser”, depending upon each facilities demands.<sup>148</sup> It was submitted that NSW Health policy “that patients are not to be handcuffed” is “ridiculous”, applying to security officers but not police.<sup>149</sup> This was because security officers did not have the luxury of waiting for police to arrive, which could take hours sometimes, even with respect to serious matters. Security should be treated as a frontline resource with appropriate support.<sup>150</sup> Since March 1999, the author of the submission had sustained 20 injuries, some requiring operative treatments.<sup>151</sup>
- 26.165 The problem was most often expressed in respect of Emergency Departments, particularly given increases in drug and alcohol problems amongst patients.
- 26.166 I was told that at Port Macquarie Hospital the Emergency Department has no CCTV, giving rise to additional security concerns.<sup>152</sup>
- 26.167 During the hearing at Prince of Wales Hospital, I heard that the level of violence and aggression in the Emergency Department is particularly high.<sup>153</sup> I understand that in April 2008 there had been approximately 30 incidents of aggression and threats to staff and patient safety of which, only 3 (which involved assaults) were reported by staff.<sup>154</sup>
- 26.168 I was told that at Queanbeyan Hospital, there have been significant episodes of violence in the Emergency Department associated with drug and alcohol intoxication and psychiatric illness.<sup>155</sup> I am told there is a security guard present at the hospital, who often has other roles which take him/her away from the Emergency Department.<sup>156</sup> I agree with the submission that staff should be given security training to deal with such violence, particularly those that work with psychiatric patients.<sup>157</sup>
- 26.169 I was told during the hearing at Bankstown Hospital, that security in the Emergency Department is a particular problem, especially after hours,<sup>158</sup> despite lobbying management for a security guard for the last 4-5 years. Staff tell me that they do not have access to duress alarm pendants, which are only available to the triage nurse and the reception staff.
- 26.170 These concerns were expressed in rural as well as metropolitan areas.
- 26.171 At the Mudgee Hospital hearing, I was told that security in rural health services is abysmal.<sup>159</sup> The staff at Mudgee Hospital are, however, comparatively lucky, because staff there have access to a duress alarm system. The nurses there wear duress alarm pendants and there are hospital security systems available 24 hours a day provided by wardsmen who act as hospital security as well as cleaners.<sup>160</sup> A witness told me that she received a police report saying that the hospital needs to introduce a swipe card system, however, she understands the Mudgee Health Service has no budget for this.<sup>161</sup>
- 26.172 I understand that the Emergency Department at Goulburn Hospital is cleared when a prisoner from the local gaol needs to be treated. Whilst the prisoner would be accompanied by Corrective Services staff, I was surprised to find that Goulburn Hospital does not employ security staff. Having said that, I understand that wardsmen are currently being trained in security.<sup>162</sup>
- 26.173 According to the NSW Bureau of Crime Statistics and Research, there was a 50% increase in the number of police-recorded incidents of assault on hospital premises in the State between 1996 and 2006.<sup>163</sup> The number of assaults increased from 214 in 1996, to 322 in 2006.<sup>164</sup> Population-adjusted data also confirmed the increase: the

number of police-recorded hospital assaults per 100,000 people in NSW increased from 3.5 in 1996 to 4.7 in 2006.<sup>165</sup> Most of the growth in hospital assaults occurred between 1996 and 2001, which is reflective of the general increase in assault rates in NSW over this period. Since 2001, assaults in general have remained relatively stable, and assaults on hospital premises have dropped by some degree, most notably between 2005 (6.2 hospital assaults per 100,000 people) and 2006 (4.7 hospital assaults per 100,000 people).

26.174 Most hospital assaults occurred between the hours of 3pm and 9pm, and in over two-thirds of cases the person of interest and the victim were previously unknown to each other (i.e. stranger assaults).<sup>166</sup> The most common day of the week for a hospital assault was Sunday. In the case of stranger assaults, the victim was most often a hospital staff member (37.4%) or a police officer (26.3%).<sup>167</sup> In fact, across all hospital assaults in 2006, the victim was most often a hospital staff member (33.3%), closely followed by a patient or visitor (31.2%), a law enforcement officer (18.7%), and a hospital security guard (10.6%).<sup>168</sup> When a hospital staff member was assaulted, the perpetrator was almost always a stranger.<sup>169</sup>

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26.175 It is alarming to note the following conclusion of the study:

"The biggest threat of violence to the minority of patients who have been assaulted on hospital premises comes from the people who are visiting them. This is consistent with the spike in assaults between 3pm and 6pm on Sundays, as this is a time when there are likely to be a high number of patient visits."<sup>170</sup>

26.176 The Bureau considers that many more assaults in hospitals are not reported to police, and these would not be captured in the above data.<sup>171</sup> This is supported by an announcement of a NSW Health representative which identified that, based on 2003 data, an average of eight assault incidents occurred across the entire NSW Health system per day.<sup>172</sup>

26.177 Clearly, each area health service needs to improve the security systems they have in place and the number of security guards they have on duty. Obviously, with proper systems in place, medical staff will not have to assume the role as security staff.<sup>173</sup> In my view these steps are imperative.

<sup>1</sup> Commonwealth Department of Health and Ageing (DoHA), *The State of our Public Hospitals: June 2008 Report*, DoHA, Canberra, p.11; NSW Health, *Annual Report 2006/07*, 2007, NSW Health, North Sydney, p. 242.

<sup>2</sup> In 2006-07, Australian public hospitals provided 55,904 beds: Australian Institute of Health and Welfare (AIHW), *Australian hospital statistics 2006-07*, 2008, Cat no. HSE 55, AIHW, Canberra, <http://www.aihw.gov.au/publications/hse/ahs06-07/ahs06-07.pdf> (27 October 2008), p. 9; NSW Health, *Annual Report 2006/07*, NSW Health, North Sydney, p. 25.

<sup>3</sup> NSW Department of Health, *Annual Report 2006/07*, NSW Department of Health, North Sydney, p. 25, year ended 30 June 2007, p.240.

<sup>4</sup> At 2005/06; Commonwealth Department of Health and Ageing (DoHA), *The State of our Public Hospitals: June 2008 Report*, DoHA, Canberra, p.11.

<sup>5</sup> Organization for Economic Co-operation and Development (OECD), *Health at a Glance 2007: OECD Indicators*, 2007, OECD, Paris, p.11.

<sup>6</sup> Department of Health and Ageing, Commonwealth of Australia, *The State of Our Public Hospitals: June 2008 Report*, p.11; Organization for Economic Co-operation and Development, *Health at a Glance 2007: OECD Indicators*, p. 63.

- 7 Organization for Economic Co-operation and Development (OECD), *Health at a Glance 2007: OECD Indicators*, 2007, OECD, Paris, p. 62.
- 8 Also see: [http://www.health.nsw.gov.au/pubs/2003/pdf/yellowbook\\_vol2\\_99-00.pdf](http://www.health.nsw.gov.au/pubs/2003/pdf/yellowbook_vol2_99-00.pdf)
- 9 Australian Institute of Health and Welfare, *Australia's Health 2008*, 24 June 2008, AIHW, Canberra, <http://www.aihw.gov.au/publications/index.cfm/title/10585> (4 September 2008), p. 345.
- 10 Australian Institute of Health and Welfare, *Australian hospital statistics 2006-07*, May 2008, Cat no. HSE 55, AIHW, Canberra, <http://www.aihw.gov.au/publications/hse/ahs06-07/ahs06-07.pdf> (27 October 2008), p. 364.
- 11 Australian Institute of Health and Welfare, *Australian hospital statistics 2006-07*, May 2008, Cat no. HSE 55, AIHW, Canberra, <http://www.aihw.gov.au/publications/hse/ahs06-07/ahs06-07.pdf> (27 October 2008), p. 35.
- 12 Letter from NSW Health to Special Commission of Inquiry, 11 February 2008, p. 3, citing NSW Health Information Exchange.
- 13 Information provided during visit to Bellinger River District Hospital on 26 March 2008.
- 14 Information provided during visit to Bellinger River District Hospital on 26 March 2008.
- 15 Information provided during visit to Quirindi District Hospital on 25 March 2008.
- 16 Information provided during visit to Quirindi District Hospital on 25 March 2008. For further information: Tracey S, Sullivan E, Dahlen H, Black D, Wang Y, Tracey M. "Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women", *British Journal of Obstetrics and Gynaecology*, (2006), 113: 86-89.
- 17 Role delineation is a process which determines the level of support services, staff profile, minimum safety standards and other criteria required to ensure that clinical services are provided safely and are appropriately supported: NSW Department of Health, *Guide to Role Delineation of Health Service*, Third Edition, 2002, NSW Department of Health, North Sydney, p. 1.
- 18 Number of MPSs is as at 20 October 2008: Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- 19 Information provided during visit to Braidwood Multi-Purpose Service on 15 April 2008; Commonwealth Department of Health and Ageing (DoHA), *Background information on the development on the Multi-Purpose Service (MPS) Program*, DoHA, 2008, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-services-mps-introduction.htm> (22 October 2008).
- 20 Hunter New England Area Health Service; *Review of Clinical Emergency Department On-Call Status*, 2008, material provided by Hunter New England Area Health Service in response to Summons.
- 21 Commonwealth Department of Health and Ageing, *Background information on the development on the Multi-Purpose Service (MPS) Program*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-services-mps-introduction.htm> (22 October 2008).
- 22 Commonwealth Department of Health and Ageing, *Background information on the development on the Multi-Purpose Service (MPS) Program*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ruralhealth-services-mps-introduction.htm> (22 October 2008).
- 23 Professor Lynette Fragar, Armidale hearing, 26 March 2008, transcript 899.05-13; information provided during visit to Oberon MPS on 17 March 2008; Dorrigo MPS on 26 March 2008 and Braidwood MPS on 15 April 2008.
- 24 Information provided during visit to Dorrigo MPS on 26 March 2008.
- 25 Information provided during visit to Dorrigo MPS on 26 March 2008.
- 26 Information provided during visit to Braidwood MPS on 15 April 2008.
- 27 Information provided during visit to Wilcannia MPS on 8 May 2008.
- 28 NSW Health Briefing, 22 September 2008, transcript 17.25-44.
- 29 Telephone conversation with Councillor Lilliane Brady on 27 October 2008.
- 30 Telephone conversation with Councillor Lilliane Brady on 27 October 2008.

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- 32 Information provided during visit to Gulgong District Hospital on 29 March 2008.
- 33 Submission of Professor Graeme Stewart and Professor John Dwyeron behalf of the NSW Medical Staff Executive Staff Executive Council, 28 March 2008, SUBM.034.0056 at 69.
- 34 Crichton, A., *Slowly Taking Control? Australian Governments and Health Care Provision 1788-1988*, 1990, Allen and Unwin, Sydney, p. 7.
- 35 NSW Health briefing, 13 March 2008, transcript 49.11.
- 36 Submission of Professor Graeme Stewart and Professor John Dwyer on behalf of the NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- 37 NSW Health Briefing, 2 July 2008, transcript 48.31; *Special Commission of Inquiry Presentations: Health of the People of New South Wales – Report of the Chief Health Officer*, June 2008, NSW Health, p. 11.
- 38 Bill Bowtell, Expert Conference, 15 September 2008, transcript 43.19-21.
- 39 NSW Health, Total Asset Management Plan, 2007/08 – 2017/18, NSW Health 2007, NSW Health, Version 9.0, 7 December 2007.
- 40 Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- 41 Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- 42 Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- 43 Submission of Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- 44 Submission of Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- 45 Submission of Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- 46 NSW Health Briefing, 22 September 2008, presentation p. 4.
- 47 NSW Health Briefing, 22 September 2008, transcript 17.10.
- 48 NSW Health Briefing, 22 September 2008, transcript 25.23-38.
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- 51 NSW Health Briefing, 22 September 2008, transcript 27.37.
- 52 Confidential Albury hearing, 23 April 2008, transcript 56.46.
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- 54 Confidential hearing at Westmead Hospital, 26 May 2008, transcript 68.31.
- 55 Shellharbour Hospital hearing, 14 October 2008, transcript 335.32-33.
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- 62 Report of the Royal Commission into Health 1926 at p. 55. The phrase is found in Cicero's *De Legibus* (Book III, Part III, Sub VIII). It is used by John Locke as the epigraph in his *Second Treatise on Government*.
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- <sup>65</sup> The Hon Craig Knowles MP, NSW Minister for Health, *Key Metropolitan Hospital Services: NSW Government Response*, 2001, NSW Government, Sydney.
- <sup>66</sup> NSW Health, *Selected Specialty and Statewide Services Plans, Number One: Heart Lung Transplantation*, January 2002, NSW Health Department, North Sydney.
- <sup>67</sup> Meeting with Roger Corbett AM, Wendy Haigh and Dr Ralph Hanson, Children's Hospital Westmead on 6 May 2008.
- <sup>68</sup> Dr Ian Incoll, Gosford hearing, 10 March 2008, transcript 46.38-40.
- <sup>69</sup> Dr Ian Incoll, Gosford hearing, 10 March 2008, transcript 46.38-40.
- <sup>70</sup> Information provided during visit to Sydney Children's Hospital on 19 May 2008.
- <sup>71</sup> Professor Peter Maitz, Prince of Wales Hospital hearing, 1 May 2008, transcript 2587.20.
- <sup>72</sup> Submission of Dr Phillip J. Harris, 27 March 2008, SUBM.041.0279 at 280.
- <sup>73</sup> Submission of Dr Phillip J. Harris, 27 March 2008, SUBM.041.0279 at 280.
- <sup>74</sup> Submission of Dr Phillip J. Harris, 27 March 2008, SUBM.041.0279 at 280.
- <sup>75</sup> Submission of Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- <sup>76</sup> Dr Anthony Dodds, St Vincent's Hospital hearing, 30 April 2008, transcript 2471.45-2472.40.
- <sup>77</sup> Dr Anthony Dodds, St Vincent's Hospital hearing, 30 April 2008, transcript 2471.45-2472.40.
- <sup>78</sup> Dr Anthony Dodds, St Vincent's Hospital hearing, 30 April 2008, transcript 2471.45-2472.40.
- <sup>79</sup> Dr Yahya Shehabi and Dr James Mackie, Prince of Wales Hospital hearing, 1 May 2008, transcript 2614.4.
- <sup>80</sup> Information provided during visit to Mullumbimby Hospital on 29 April 2008.
- <sup>81</sup> Information provided during visit to Mullumbimby Hospital on 29 April 2008.
- <sup>82</sup> Information provided during visit to Mullumbimby Hospital on 29 April 2008.
- <sup>83</sup> Dr Christopher Poulos, Wollongong Hospital hearing, 14 April 2008, transcript 1660.39-47.
- <sup>84</sup> Meeting with Australian Health Policy Institute, 11 April 2008, transcript 39.32.
- <sup>85</sup> Dr Christopher Poulos, Wollongong hearing, 14 April 2008, transcript 1658.12-18
- <sup>86</sup> Dr Christopher Poulos, Wollongong Hospital hearing, 14 April 2008, transcript 1658-1659.
- <sup>87</sup> Meeting with NSW Health, 13 March 2008, transcript 67.11 ff.
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- <sup>89</sup> Commonwealth Department of Health and Ageing (DoHA), *The State of Our Public Hospitals June 2005*, 2005, DoHA, Canberra, p. 12.
- <sup>90</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 2517.36.
- <sup>91</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 2517.36.
- <sup>92</sup> Professor Carol Pollock, Experts Conference, 15 September 2008, transcript 72.44-47.
- <sup>93</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 28.04.
- <sup>94</sup> Alan Kinkade, Experts Conference, 15 September 2008, transcript 65.25-27.
- <sup>95</sup> Meeting with Dr Stephen Nolan and Mr Matthew Daly on 21 October 2008, p. 2.
- <sup>96</sup> Dr Clair Langford, Wollongong Hospital hearing, 14 April 2008, transcript 1680.
- <sup>97</sup> Shellharbour Hospital hearing, 14 October 2008, transcript 3358.16, although he concedes given the geography this would be difficult.
- <sup>98</sup> Shellharbour Hospital hearing, 14 October 2008, transcript 3358.17-24.
- <sup>99</sup> Shellharbour Hospital hearing, 14 October 2008, transcript 3358.17-24.
- <sup>100</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 26.27.
- <sup>101</sup> Meeting with Dr Tony Joseph and Dr Sally McCarthy, Australasian College of Emergency Medicine, 27 June 2008.
- <sup>102</sup> Meeting with General Surgeons of Australia and the Royal Australasian College of Surgeons, 25 June 2008, p 8.
- <sup>103</sup> NSW Health briefing, 2 June 2008, p 3.



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- <sup>104</sup> Information provided during visit to Mona Vale Hospital on 12 March 2008.
- <sup>105</sup> Dr Peter Roberts, Hornsby Hospital hearing, 11 March 2008, transcript 202.37-203.27.
- <sup>106</sup> Submission of Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- <sup>107</sup> Confidential Westmead Hospital hearing, 26 May 2008, transcript 69.06.
- <sup>108</sup> NSW Health, Notification (Early) of Severe Trauma in Rural New South Wales, PD2005\_266, p. 7.
- <sup>109</sup> NSW Health, Notification (Early) of Severe Trauma in Rural New South Wales, PD2005\_266, p. 7, 12.
- <sup>110</sup> NSW Health, Notification (Early) of Severe Trauma in Rural New South Wales, PD2005\_266, p. 7.
- <sup>111</sup> NSW Health, Notification (Early) of Severe Trauma in Rural New South Wales, PD2005\_266, p. 1.
- <sup>112</sup> Letter from NSW Health to Special Commission of Inquiry, 11 November 2008.
- <sup>113</sup> Letter from NSW Health to Special Commission of Inquiry, 11 November 2008.
- <sup>114</sup> NSW Health, *The NSW Trauma System - Health Care Advisory Council, Summary Paper*, p. 7 in Letter from NSW Health to Special Commission of Inquiry (Request No. 122), 11 November 2008.
- <sup>115</sup> NSW Health, *The NSW Trauma System - Health Care Advisory Council, Summary Paper*, p.7 in Letter from NSW Health to Special Commission of Inquiry (Request No. 122), 11 November 2008.
- <sup>116</sup> Letter from NSW Health to Special Commission of Inquiry, 11 November 2008.
- <sup>117</sup> Meeting with Dr Tony Joseph and Dr Sally McCarthy, Australasian College of Emergency Medicine on 27 June 2008 at page 3.
- <sup>118</sup> Meeting with Dr Tony Joseph and Dr Sally McCarthy, Australasian College of Emergency Medicine on 27 June 2008 at page 3.
- <sup>119</sup> Dr Richard Cracknell, Liverpool Hospital hearing, 17 April 2008, transcript 1855.20-35.
- <sup>120</sup> Letter from NSW Health to Special Commission of Inquiry, 11 November 2008, p. 1.
- <sup>121</sup> NSW Health, *The NSW Trauma System - Health Care Advisory Council, Summary Paper*, p.5 in Letter from NSW Health to Special Commission of Inquiry, 11 November 2008.
- <sup>122</sup> Submission of Peter Campbell OAM, 13 May 2008, SUBM.037.0037 at 38.
- <sup>123</sup> NSW Health, *The NSW Trauma System - Health Care Advisory Council, Summary Paper*, p.2 in Letter from NSW Health to Special Commission of Inquiry, 11 November 2008.
- <sup>124</sup> NSW Health, *The NSW Trauma System - Health Care Advisory Council, Summary Paper*, p.3 in Letter from NSW Health to Special Commission of Inquiry, 11 November 2008.
- <sup>125</sup> NSW Health, *The NSW Trauma System - Health Care Advisory Council, Summary Paper* in Letter from NSW Health to Special Commission of Inquiry, 11 November 2008.
- <sup>126</sup> NSW Health, *The NSW Trauma System - Health Care Advisory Council, Summary Paper* in Letter from NSW Health to Special Commission of Inquiry, 11 November 2008.
- <sup>127</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 26.12.
- <sup>128</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 29.35.
- <sup>129</sup> Professor Leslie White, Sydney Children's Hospital hearing, 19 May 2008, transcript 3062.25.
- <sup>130</sup> Information provided during visit to Mona Vale Hospital on 12 March 2008.
- <sup>131</sup> Submission of Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- <sup>132</sup> Submission of Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- <sup>133</sup> Confidential hearing at the Inquiry's offices via video-link from Wagga Wagga, 30 May 2008, transcript 4.3-5.

- <sup>134</sup> Confidential hearing at the Inquiry's offices via video-link from Wagga Wagga, 30 May 2008, transcript 4.3-5.
- <sup>135</sup> Madelaine Green, Tweed Heads Hospital hearing, 29 April 2008, transcript 2536.31.
- <sup>136</sup> Madelaine Green, Tweed Heads Hospital hearing, 29 April 2008, transcript 2356.
- <sup>137</sup> NSW Health briefing, 22 September 2008, transcript 32.33.
- <sup>138</sup> Submission of Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 10 April 2008, SUBM.034.0056 at 69.
- <sup>139</sup> Ontario Health Services Restructuring Commission, *Looking Back, Looking Forward: A Legacy Report (Regard sur le passe, regard vers l'avenir: Rapport de Travail)*, March 2000, <http://www.health.gov.on.ca/hsrc/HSRC.pdf> (24 October 2008), p.iii.
- <sup>140</sup> Ontario Health Services Restructuring Commission, *Looking Back, Looking Forward: A Legacy Report (Regard sur le passe, regard vers l'avenir: Rapport de Travail)*, March 2000, <http://www.health.gov.on.ca/hsrc/HSRC.pdf> (24 October 2008), p.12.
- <sup>141</sup> Ontario Health Services Restructuring Commission, *Looking Back, Looking Forward: A Legacy Report (Regard sur le passe, regard vers l'avenir: Rapport de Travail)*, March 2000, <http://www.health.gov.on.ca/hsrc/HSRC.pdf> (24 October 2008), p.12.
- <sup>142</sup> Ontario Health Services Restructuring Commission, *Looking Back, Looking Forward: A Legacy Report (Regard sur le passe, regard vers l'avenir: Rapport de Travail)*, March 2000, <http://www.health.gov.on.ca/hsrc/HSRC.pdf> (24 October 2008), p.12.
- <sup>143</sup> Ontario Health Services Restructuring Commission, *Looking Back, Looking Forward: A Legacy Report (Regard sur le passe, regard vers l'avenir: Rapport de Travail)*, March 2000, <http://www.health.gov.on.ca/hsrc/HSRC.pdf> (24 October 2008), p.13.
- <sup>144</sup> Confidential submission, 28 April 2008, SUBM.045.0043 at 44.
- <sup>145</sup> Confidential submission, 31 March 2008, SUBM.009.0086 at 91.
- <sup>146</sup> Submission of Greg Kincaid, 9 June 2008, SUBM.074.0058 at 60.
- <sup>147</sup> Submission of Greg Kincaid, 9 June 2008, SUBM.074.0058 at 59.
- <sup>148</sup> Submission of Greg Kincaid, 9 June 2008, SUBM.074.0058 at 59.
- <sup>149</sup> Submission of Greg Kincaid, 9 June 2008, SUBM.074.0058 at 60.
- <sup>150</sup> Submission of Greg Kincaid, 9 June 2008, SUBM.074.0058 at 60.
- <sup>151</sup> Submission of Greg Kincaid, 9 June 2008, SUBM.074.0058 at 60.
- <sup>152</sup> Allan Pretty, Port Macquarie hearing, 28 March 2008, transcript 1115.40.
- <sup>153</sup> Barbara Daley, Prince of Wales Hospital hearing, 1 May 2008, transcript 2575.16.
- <sup>154</sup> Dr Sally McCarthy, Prince of Wales Hospital hearing, 1 May 2008, transcript 2577.45-2578.16.
- <sup>155</sup> David Erskine, Queanbeyan Hospital hearing, 15 April 2008, transcript 1723.11-29.
- <sup>156</sup> David Erskine, Queanbeyan Hospital hearing, 15 April 2008, transcript 1724.38-1725.6.
- <sup>157</sup> Submission of Albert White, undated, SUBM.031.0236 at 236.
- <sup>158</sup> Confidential Bankstown Hospital hearing, 13 May 2008, transcript 62.29-47.
- <sup>159</sup> Confidential Mudgee hearing, 20 March 2008, transcript 25.40-26.42.
- <sup>160</sup> Confidential Mudgee hearing, 20 March 2008, transcript 25.40-26.42.
- <sup>161</sup> Confidential Mudgee hearing, 20 March 2008, transcript 25.40-26.42.
- <sup>162</sup> Information provided during visit to Goulburn Hospital on 28 February 2008.
- <sup>163</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p.1.
- <sup>164</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p.1.
- <sup>165</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p.1.



- <sup>166</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p.1.
- <sup>167</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p. 4.
- <sup>168</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p.4.
- <sup>169</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p.5.
- <sup>170</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p.9.
- <sup>171</sup> NSW Bureau of Crime Statistics and Research (Kirin Hilliar), "Police Recorded Assaults on Hospital Premises in New South Wales: 1996-2006", *Crime and Justice Bulletin*, No. 116, July 2008, Attorney General's Department of NSW, Sydney, p.9.
- <sup>172</sup> NSW Health, *Zero tolerance for violence in health system*, NSW Health media release, 4 March 2004, [http://www.health.nsw.gov.au/news/2004/20040304\\_00.html](http://www.health.nsw.gov.au/news/2004/20040304_00.html) (18 February 2008).
- <sup>173</sup> Submission of Greg Kincaid, 9 June 2008, SUBM.074.0058 at 60.

Hospitals

## 27 Transport

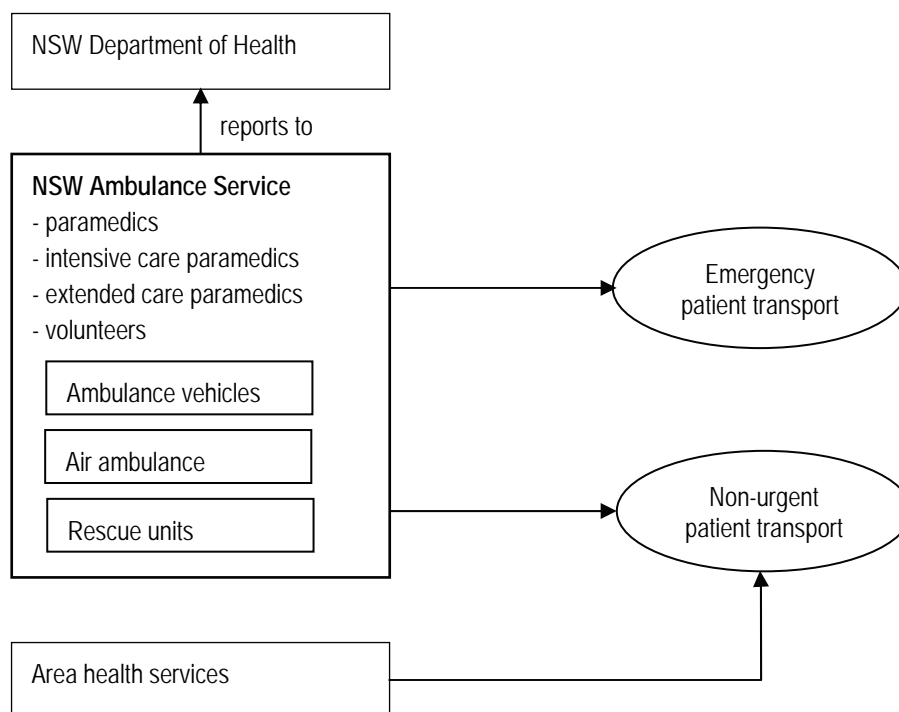
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- 27.1 A key ingredient of a safe and high quality health system is the ability to transport patients to hospital, and between hospitals, in appropriate timeframes, so that the patient receives the medical treatment they need when and where they need it.<sup>1</sup>
- 27.2 In this chapter, I will examine the two broad categories of patient transport: emergency and non-urgent. I have also made some recommendations to make better use of the highly skilled paramedics working in the NSW Ambulance Service.
- 27.3 Elsewhere in my report, I have dealt with the following topics concerning transport:
  - (a) Transport of patients back to regional and rural areas after treatment is discussed in Chapter 6.
  - (b) Financial assistance for travel expenses for rural and remote patients is also discussed in Chapter 6.
  - (c) A recent performance review undertaken by Graeme Head on behalf of the NSW Department of Premier and Cabinet into the NSW Ambulance Service<sup>2</sup> raised issues of workplace culture, which I have considered further in Chapter 12.
  - (d) 'Off-stretcher time', which is a key performance indicator focusing on the time between the arrival of a patient at hospital by ambulance and the time when the patient is handed over to the care of Emergency Department staff,<sup>3</sup> is examined in Chapter 17.

## NSW Ambulance Service

- 27.4 In NSW, both emergency and non-urgent patient transport is provided by the NSW Ambulance Service, albeit the latter is also provided by area health services. I set out below, in a diagram, how patient transport services are provided in NSW.

Figure 27.1 Overview of structure and transport services



- 27.5 There are a total of 226 ambulance stations throughout NSW, located within 4 separate divisions: Sydney, Northern, Southern and Western. The Sydney Division has 46 stations.<sup>4</sup>
- 27.6 On a typical day in NSW, the NSW Ambulance Service:
- (a) deals with 1,847 emergency incidents and 700 non-emergency incidents;
  - (b) transports 1,378 emergency patients and 657 non-emergency patients; and
  - (c) fields 1016 emergency ambulance crews.<sup>5</sup>

### Relationship with NSW Health

- 27.7 The NSW Ambulance Service is a part of NSW Health. The chief executive of the service is appointed by and reports to the Director-General of NSW Health. Its budget is provided by NSW Health.<sup>6</sup>
- 27.8 I was dismayed to be informed of long-standing relationship problems between the leadership of the Health Services Union and the NSW Ambulance Service.<sup>7</sup> The problems, I was told, are due to discontentment with the Ambulance Service falling within the NSW Health umbrella. The basis for this was said to be that the Ambulance Service had more in common with the uniformed services which provide emergency and rescue services, such as the NSW Police Service and the NSW Fire Brigade, than it had with NSW Health.<sup>8</sup> Whilst the NSW Ambulance Service necessarily has to liaise with and work jointly and closely with these services, its principal focus is on the provision of paramedical care and timely transport to patients in need. It is an integral part of NSW Health and operates a vital health service as part of a NSW wide health system.

### Ambulance officers

- 27.9 Ambulance officers are paramedics, who are trained to apply life saving skills and administer drugs at the scene of an incident, and during transport to a hospital. They assess, treat and stabilise patients for a wide variety of illnesses and accidents.<sup>9</sup> Their care is driven by and provided in accordance with carefully produced protocols of care (which are regularly updated).
- 27.10 Most paramedics receive their training through a 3 year Diploma in Paramedical Science (Ambulance) provided by the NSW Ambulance Service.<sup>10</sup> This training involves an 8 week induction period, 2 extended periods of on-the-job practical training and 2 periods of in-service training.<sup>11</sup> I was informed that the cost of providing this training was approximately \$16,500 per trainee in 2007/08.<sup>12</sup>
- 27.11 Alternative recruitment pathways for paramedics include a one-year graduate internship program and the recognition of prior learning program.<sup>13</sup> The internship program is an accelerated stream that recognises university graduates with qualifications in pre-hospital care, paramedical science and certain recognised nursing degrees. The cost of providing this training was approximately \$9,300 per trainee in 2007/08.<sup>14</sup> The prior learning program is provided for those with paramedic qualifications and experience from other jurisdictions.<sup>15</sup>
- 27.12 Qualified paramedics receive on-going professional development training from the NSW Ambulance Service and are required to re-certify every 3 years.<sup>16</sup>

*Intensive care paramedics*

- 27.13 Once a paramedic has 4 years experience, they may undertake an advanced diploma in order to become an intensive care paramedic.<sup>17</sup> Such paramedics have advanced clinical and pharmacological skills. The training is conducted over a 6 month period and involves 6 weeks of in-service training, a 3 week hospital placement and a 14 week on-road placement. I was informed that the cost of providing this training was approximately \$14,800 per trainee in 2007/08.<sup>18</sup>

*Extended care paramedics*

- 27.14 Extended care paramedics have recently been introduced to the NSW Ambulance Service on a trial basis.<sup>19</sup> I was told that details of the role, responsibility and training of these paramedics will not be finalised until an evaluation of the results of the trial have been considered.<sup>20</sup> Extended care paramedics in the trial project have undergone 8 weeks of training in a university clinical school and 2 weeks of practical experience training.<sup>21</sup> The cost of providing this training for the pilot project was estimated to me to be \$30,000 per trainee.<sup>22</sup>
- 27.15 Extended care paramedics operate individually to provide care to patients with emergency conditions and also patients with sub and non-acute health care needs. Extended care paramedics are trained to treat and discharge a patient using care pathways for certain common conditions such as asthma, falls and burns.<sup>23</sup> They are also able to refer a patient to a non-emergency health care service such as general practitioner for follow-up.<sup>24</sup> Extended care paramedics are a referral option for operational paramedics whose patients present with sub or non-acute health care needs. I was told that the objective of the Extended care paramedics program is to reduce unnecessary presentations to Emergency Departments where appropriate alternatives exist.<sup>25</sup> As one ambulance officer suggested to me, and I agree, extended care paramedics could be well utilised in isolated areas where there is a lack of nursing staff.<sup>26</sup>
- 27.16 I was informed that early indications suggest that 40 to 50% of patients seen by an extended care paramedic may avoid the need to go to the Emergency Department.<sup>27</sup> This has significant implications for avoidable presentations.

*Volunteers*

- 27.17 The assistance of volunteers is relied upon in some rural areas that cannot sustain a professional ambulance service. Volunteer Ambulance Officers or Community First Responders are trained by the NSW Ambulance Service in conjunction with the State Emergency Service, Rural Fire Service and NSW Fire Brigades.<sup>28</sup> They provide crucial emergency pre-hospital care while awaiting the arrival of ambulance paramedics.<sup>29</sup>

**Air ambulance**

- 27.18 The NSW Ambulance Service operates both a fixed wing air ambulance service and a helicopter retrieval service. In 2006-07,
- (a) the fixed wing service transported 5,950 patients, and
  - (b) the helicopter retrieval service carried 3,213 patients.<sup>30</sup>

During that year, 95% of urgent medical retrievals by air occurred within 3 hours of request.<sup>31</sup>

- 27.19 The fixed wing service provides aircraft on a 24-hour basis for emergencies, and also conducts routine scheduled flights. Its role is to provide long distance transport between hospitals while continuing the patient's medical and nursing care *en route*.<sup>32</sup> The Royal Flying Doctors Service is used in some circumstances, depending on the patient's location and the availability of an air ambulance.<sup>33</sup>
- 27.20 The helicopter retrieval service collects patients to take them to hospital and also transports patients between hospitals. Paramedics, and often doctors, provide patient care during the flight.<sup>34</sup>
- 27.21 These air services provide an important method for transporting critically ill patients from rural and regional locations to specialised tertiary care. As well, helicopter retrieval services are used to transport patients around and within the metropolitan area of Sydney, Newcastle and Wollongong. It is expected that the demand for these services will significantly increase in the future.<sup>35</sup>
- 27.22 I have addressed below problems presently being experienced with the co-ordination of air ambulance services.

### Rescue units

- 27.23 NSW Ambulance operates a number of rescue units.<sup>36</sup>
- 27.24 On 2 September 2008, the then NSW Health Minister announced the decision to transfer responsibility for some of NSW Ambulance's 14 rescue units to the NSW Fire Brigades.<sup>37</sup> This decision followed a recommendation by the recent performance review undertaken by Graeme Head, Chair of the Performance Review Unit, on behalf of the NSW Department of Premier and Cabinet. The Review undertook a thorough analysis and concluded that there was no compelling reason for the NSW Ambulance Service to retain a rescue function: other emergency services are well placed to undertake this role and benefits would flow to the NSW Ambulance Service if it was transferred.<sup>38</sup> The Review considered whether the status quo should be maintained, or alternatively which of the following two strategies to withdraw the rescue function should be adopted:
- (a) a partial cessation of the function based on a rural/metropolitan split, where the NSW Fire Brigade takes on the function in the metropolitan area and rural and regional areas continue in accordance with current arrangements; or
  - (b) a complete cessation of NSW Ambulance Service rescue activity, with the function being taken over by the NSW Fire Brigade and other providers as required.
- 27.25 The Review set out the advantages and disadvantages of each option,<sup>39</sup> concluding that a complete cessation of the NSW Ambulance Service rescue activity was the only viable option.<sup>40</sup> The Review noted that, while there are likely to be minimal actual Budget savings, it believes that the NSW Ambulance Service rescue function should be rationalised, as it does not represent core ambulance activity.<sup>41</sup> The Review suggested that further negotiations should be undertaken with the State Rescue Board and its partner agencies (particularly the NSW Fire Brigade) and with the Health Services Union on a strategy to withdraw the NSW Ambulance Service from the rescue function.<sup>42</sup> The recommendation made by the Review was:
- "That the Ambulance Service rescue function be transferred to [the NSW Fire Brigade]. The Ambulance Service, in consultation with [the NSW Fire Brigade] and the [Health Services Union], should develop a transition plan (by 1 December 2008) to facilitate the transfer."<sup>43</sup>

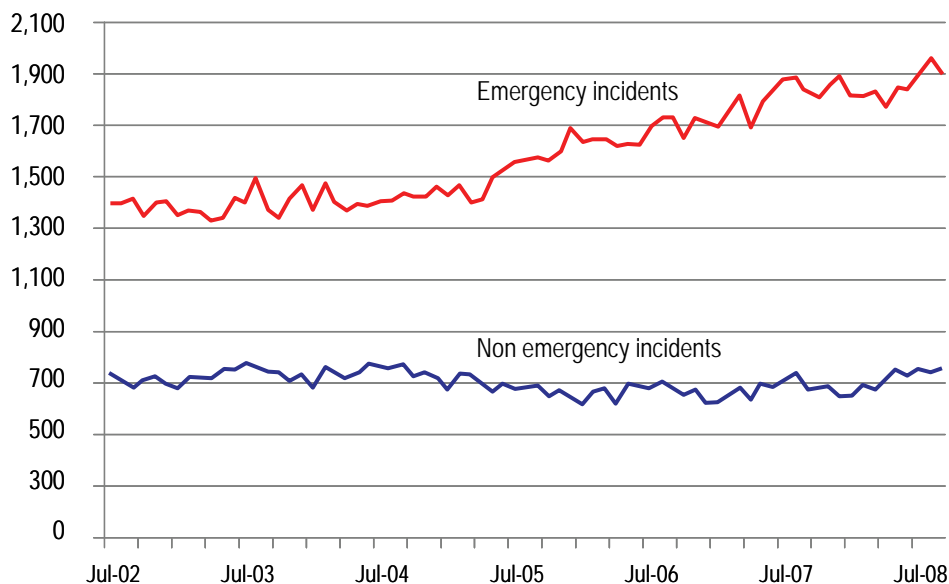


- 27.26 The Government's decision, announced on 2 September 2008, was to transfer responsibility for some of NSW Ambulance's rescue units, reportedly leaving responsibility for Tamworth, Cowra, Wagga Wagga, Singleton, Rutherford and Bomaderry, in the hands of the NSW Ambulance Service. This was due to a view that there were no other adequate volunteer or fire brigade services in those areas.<sup>44</sup>
- 27.27 Prior to this decision being announced, a range of members of the NSW Ambulance Service with whom I spoke told me that they would not be averse to relinquishing control over these operations.<sup>45</sup> There seems to be a real issue as to whether the NSW Ambulance Service should be providing primary rescue coverage at all.<sup>46</sup>
- 27.28 Having regard to the nature and extent of Mr Head's report, there is no need for me to separately investigate this issue. Indeed, it would be a waste of time and resources. Given the increase in demand for the services of urgent ambulance transport, and the fact that the rescue units form a very small part of the Ambulance Service, I think that it is sufficient for me to endorse Mr Head's recommendations about the transfer of the rescue function from the NSW Ambulance Service. Despite the apparent opposition to the decision in some quarters, I believe that the remaining rescue units should be removed from the NSW Ambulance Service in order that the benefits envisaged by the performance review be fully realised.

## Emergency patient transport

- 27.29 In NSW, emergency patient transport is provided by the NSW Ambulance Service.
- 27.30 There has been a dramatic increase in emergency ambulance activity in recent years.<sup>47</sup> Between 2002-03 and 2006-07, there was a 26% increase in emergency ambulance incidents,<sup>48</sup> which is an increase in demand significantly above corresponding demographic changes.<sup>49</sup>
- 27.31 The following graph shows the increase in ambulance arrivals from July 2002 to July 2008.<sup>50</sup>

Figure 27.2 Average Daily Ambulance Incidents, NSW, July 2002 to July 2008



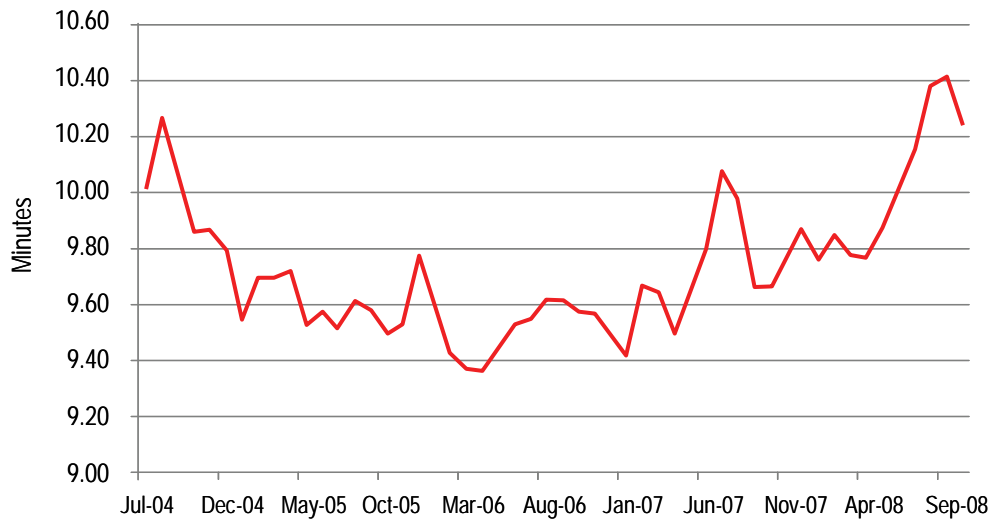
## Responding to '000' calls

- 27.32 The procedure for responding to '000' calls was described to me by the chief executive of the NSW Ambulance Service as follows.
- (a) A '000' call seeking ambulance assistance is connected by the 000 call-centre operator to the closest of 4 operations centre, which are located in Sydney, Dubbo, Charlestown (Newcastle) and Warilla (Wollongong). The call-taker asks a series of structured questions that enable the call to be prioritised as urgent or non-urgent.
  - (b) For urgent calls, the call-taker sends an electronic message to the Dispatch Controller responsible for the sector from which the call came. As that is happening, the call-taker continues to talk to the caller to obtain further information. The computer-aided dispatch system determines the priority of response to each call and the Dispatch Controller sends an ambulance to the patient. Any additional information obtained by the call-taker is sent electronically to the ambulance whilst it is on the journey to the patient. The call-taker will often remain on the line until the ambulance arrives at the scene. The call-taker can, if appropriate, also provide paramedics at the scene with further information on treatment for the patient.<sup>51</sup>
  - (c) For calls received by the Sydney Operations Centre that are assessed as non-acute, the call is transferred to a nurse or experienced paramedic in the Health Access Coordination Unit who conducts a secondary triage to determine the seriousness of the incident and whether an ambulance is, in fact, needed. This operator can and does provide additional health advice.<sup>52</sup> In 2007, the Health Access Coordination Unit processed 30,600 calls of which 1,811 callers decided that they did not need an ambulance or immediate hospital transport.<sup>53</sup> Currently, only calls received in the Sydney Operations Centre are transferred to the Health Access Coordination Unit; however, after completion of an upgrade to the NSW Ambulance Service's computer-aided dispatch system, the unit will be available to receive calls from all NSW Operations Centres.<sup>54</sup> Apart from the use of the Health Access Coordination Unit, the procedure for receiving and responding to '000' calls is uniform across all 4 NWS Ambulance Service Operations Centres.<sup>55</sup>
- 27.33 Except in some rural areas and under ordinary circumstances, the crew of an ambulance consists of 2 paramedics.
- 27.34 Within the Sydney Division of the NSW Ambulance Service, there is an option of sending a rapid responder, which is a single paramedic on a motorbike or in a motor vehicle. There are 8 rapid responders rostered each day from 7am to 7pm in the Sydney Division.<sup>56</sup> The paramedic is able to respond quickly to life threatening situations and commence treatment while awaiting an ambulance. Rapid response paramedics are well experienced in the assessment of patients and can call off the ambulance where it is not required.<sup>57</sup>

## Deteriorating response times

- 27.35 As noted above, there has been a dramatic increase in demand for emergency ambulances in recent years. It is perhaps not surprising, therefore, that ambulance response times started to deteriorate and continued rather alarmingly until April 2006. Since then, there has been an overall improvement, but the performance has again fluctuated downwards since July 2007, as shown in the graph below.<sup>58</sup>

Figure 27.3 **Response to potentially life threatening cases - 50<sup>th</sup> percentile response time (minutes), NSW, July 2004 to October 2008**



- 27.36 Response times depend, principally, on the availability of a properly staffed ambulance being free to attend. The deterioration in response times needs to be addressed so as to ensure that the NSW Ambulance Service is able to continue to save lives and do its job properly. In order to improve response times, ambulance availability must be improved through the following means:
- improving station locations and capacity, in respect of which it appears to me that plans and funding are well in hand;<sup>59</sup>
  - reducing avoidable transports,
  - reducing the use of ambulances for non-urgent patient transports, which I will discuss below;
  - reducing the downtime of paramedics waiting with their patients in the Emergency Department which I discuss in Chapter 17; and
  - increasing crew numbers through workforce redesign to achieve role flexibility.

### Avoidable transports

- 27.37 Ambulance transports are avoidable where the patient's clinical condition can be adequately dealt with by a paramedic at the scene, or by a GP, without the need for the patient to be taken to the Emergency Department.
- 27.38 I was told that there has been a recent increase in people calling for an ambulance who do not need to be taken to the Emergency Department,<sup>60</sup> for example, young people using ambulances instead of taxis due to a poor understanding of the costs of an ambulance and who pays those costs.<sup>61</sup> I was told that staff working in aged care facilities or in nursing homes ask that residents be taken to the Emergency Department by ambulance because they were unable to see a GP.<sup>62</sup>
- 27.39 It was suggested to me that there needs to be broader community education regarding what ambulances are for, what the costs are and who pays.<sup>63</sup> I agree.

27.40 Patients of the NSW Ambulance Service are entitled to free Ambulance Services within NSW only if they are in receipt of a benefit entitlement, at the time of receiving the service, that provides them with one of the following:<sup>64</sup>

- (a) Health Care Concession Card;
- (b) Pensioner Concession Card;
- (c) Commonwealth Seniors Health Care Card; and
- (d) certain Department of Veterans' Affairs card holders.<sup>65</sup>

This includes free non-emergency ambulance services where the person satisfies the criteria for non-emergency transport,<sup>66</sup> which I discuss further elsewhere in this chapter. For patients other than those entitled to free services, the cost of emergency road or fixed wing transport currently comprises of a call-out fee of \$290 plus a variable rate of \$2.62 per kilometre (for the round trip travelled by the ambulance, ie. distance travelled from the point of leaving the base station nearest the patient's location to the point of returning to that station).<sup>67</sup> Patients who are treated but not transported are also charged.<sup>68</sup> The charge amount represents 51% of the actual cost to the NSW Ambulance Service of providing the individual transport.<sup>69</sup>

27.41 The NSW Ambulance Service has undertaken several initiatives to help reduce avoidable transports.

27.42 Firstly, the NSW Ambulance Service is using extended care paramedics, as discussed above.

27.43 Second, separately from the Extended Care paramedic program, the NSW Ambulance Service is providing enhanced training to some paramedics, under the Clinical Assessment and Referral Program, to provide standard treatments and advice for certain non-acute conditions so that transport to the Emergency Department becomes unnecessary.<sup>70</sup> In appropriate circumstances, these paramedics are able to advise on a self-care regime, recommend further treatment by a GP, and refer to a local allied health professional. The clinical conditions for which they are trained to manage include minor wounds and lacerations, mild asthma and diabetic hypoglycaemia.<sup>71</sup>

27.44 The NSW Ambulance Service has protocols and policies in place that guide both of these initiatives.<sup>72</sup>

27.45 Mr Head, Chair of the Performance Review Unit that conducted the review into the NSW Ambulance Service, informed me that paramedics transport patients in excess of 95% of the time. He told me that most paramedics would only transport a patient 60% of the time if they were to make the decision purely on clinical grounds.<sup>73</sup> This figure is supported by a study published in the *Journal of Accident and Emergency Medicine*, which estimates that about 40% of emergency calls do not actually require an emergency response.<sup>74</sup> Mr Head also told me that there is a view amongst ambulance officers that they are being underutilised.<sup>75</sup>

27.46 Mr Head expressed the view to me that many in the Ambulance Service thought that these non-transport protocols were drawn far too conservatively.<sup>76</sup> At the same time, Health Services Union representatives pointed out that ambulance officers do not feel confident that they will be supported by management in their non-transport decisions.<sup>77</sup>

27.47 The effectiveness of the non-transport protocols is subject to the following limitations:

- (a) To work effectively, there has to be a commitment on the part, not just of the extended care paramedics, but also on the part of their supervisors and

management to the protocols and the support of paramedics who are implementing them.<sup>78</sup>

- (b) The paramedics are obliged to transport the patients if they request it, regardless of the paramedic's clinical judgement, and their ability to comply with the non-transport protocol.<sup>79</sup>

- 27.48 In my view, non-transport protocols should be strengthened to permit paramedics to take a patient to a GP instead of the Emergency Department if the paramedic forms the view that the patient's clinical condition does not require treatment at hospital.

**Recommendation 118:** *Extend the number of paramedics who are qualified and trained as extended care paramedics and who are also qualified and trained to make non-transport decisions in accordance with the relevant protocols of care.*

### Distribution of ambulance deliveries to hospital

- 27.49 The distribution of ambulance deliveries to public hospitals in the metropolitan areas of Sydney, Newcastle and Wollongong is done by a patient allocation matrix system ("the Matrix"). The Matrix has been in use since June 2005. It was introduced to overcome problems identified with the previous system, which allowed hospitals to divert ambulances away in "non-life threatening" situations during normal operation. I was told that this resulted in unnecessarily increased travel time and, often, the need for the patient to be transferred a second time to an appropriate hospital.<sup>80</sup>

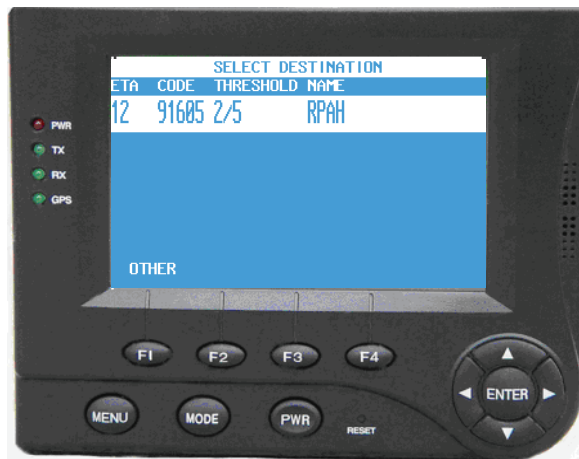
- 27.50 Under the Matrix, Emergency Departments accept patients:
- (a) from within the catchment area of the Emergency Department;
  - (b) experiencing a problem within the range of clinical capability of the Emergency Department; and
  - (c) up to a threshold number of patients per hour.

Clinical capabilities and thresholds were agreed with area health services for each Emergency Department during development of the Matrix.<sup>81</sup>

- 27.51 The Matrix system is designed with the aim of avoiding any hospital exceeding its threshold for more than an hour each day.<sup>82</sup> Where a particular Emergency Department exceeds their agreed arrival rate, and it is appropriate to do so, ambulances are diverted to the next closest, clinically appropriate hospital.<sup>83</sup>

#### *How does the Matrix work?*

- 27.52 The paramedic determines the appropriate clinical category for the patient at the scene and enters this into a mobile data terminal.
- 27.53 The NSW Ambulance Service's computer aided dispatch system then calculates the closest clinically appropriate hospital, taking into account threshold arrival rates. The most appropriate hospital is recommended to the paramedic by a message to the mobile data terminal, as shown in the following picture.<sup>84</sup>

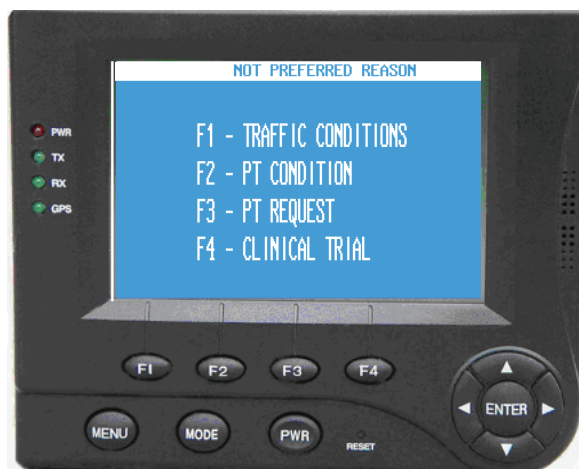


27.54 The paramedic may request alternative destinations and override the recommendation where they determine that it is appropriate to do so. The Matrix can be overridden in one of 4 situations:

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- (a) to avoid traffic disruptions;
- (b) where the patient's clinical condition warrants it, for example, where the patient has already received treatment for the condition at a particular hospital;
- (c) where the patient requests a specific hospital; or
- (d) where the patient qualifies for admission to a particular hospital under the model of care such as Emergency Treatment of Acute Myocardial Infarction ("ETAMI").<sup>85</sup> Under ETAMI, the paramedics conduct an emergency diagnosis and triage of heart attack patients, and depending on the results, may transport the patients to the cardiac catheter lab of a regional heart attack centre rather than to the nearest hospital.<sup>86</sup>

27.55 The paramedic's decision to override the Matrix is guided by the NSW Ambulance Service's Transport Decision Guide and Mobile Data Terminal User Manual.<sup>87</sup> The reason for each override is entered by the paramedic and these reasons are recorded, monitored and reviewed.<sup>88</sup>



- 27.56 Ambulance Liaison Officers employed by each area health service review Matrix override decisions and provide feedback to ambulance staff and hospital staff on the appropriateness of override decisions.<sup>89</sup> Where appropriate, individual paramedics are counselled on the correct process.<sup>90</sup>
- 27.57 Once a destination hospital is selected and entered by the paramedic, a summary of the case and expected arrival time is transmitted to the destination hospital and displayed on an ambulance status board in the Emergency Department.

*Review of operation of matrix.*

- 27.58 Some nursing and medical staff at metropolitan Emergency Departments criticised the Matrix's operation. Some argued that their Matrix threshold is too high when compared to bed capacity.<sup>91</sup> Others indicated that, in practice, ambulances still arrive even when their Emergency Department is already overloaded on the Matrix.<sup>92</sup> Still others believed that they received more patients than their threshold while other hospitals didn't get any.<sup>93</sup> It was suggested that a reputation for timely admissions was a magnet for NSW Ambulance Service to send more ambulances – success was rewarded with more arrivals.<sup>94</sup>
- 27.59 A review of the Matrix system in 2007 found that:
- (a) 99.4% of patients were taken to a clinically appropriate hospital, of which 28.9% were **not** taken to the **nearest** clinically appropriate hospital; and
  - (b) arrival rates exceeded thresholds less than 1% of the time, overall<sup>95</sup> (although this overall figure conceals the reality for particular individual hospitals, as it is evident from information I received from the NSW Ambulance Service that particular hospitals frequently exceed their threshold more than 1% of the time).<sup>96</sup>
- 27.60 I was told that the performance of the Matrix is reviewed daily, weekly and annually. Data collected in relation to the Matrix is used to review and re-calibrate clinical categories and arrival thresholds by agreement between the NSW Ambulance Service and the area health services, taking into account hospital service changes and overall demand for emergency ambulance services.<sup>97</sup>
- 27.61 Overall, the Matrix appears to me to be an improvement on the haphazard hospital driven system which previously existed and to generally be working well. The system is closely monitored and there are mechanisms to improve its operation in respect of particular hospitals.
- 27.62 As discussed above, one of the features of the Matrix system is that the performance of the ambulance fleet can be tracked daily. The figures collected are appropriately used to review performance and effectiveness. It would in my view assist relations between the NSW Ambulance Service and the hospitals with which it deals for that information to be made publicly available on a regular basis. This would assist in removing the different perceptions which exist between paramedics and the NSW Ambulance Service on the one hand and the Emergency Department staff on the other about the operation of the Matrix. The only problem I am concerned about with the Matrix is the patient override function, discussed below.

*Patient override*

- 27.63 A NSW Ambulance Service review of the Matrix override function indicated that, over the 6 month period between May to October 2007, 4.4% of all emergency ambulance patients (which would represent approximately 11,000 emergency transports)<sup>98</sup> were



taken to a destination other than the Matrix recommended hospital. Of these, 65.8% were recorded to be at the request of the patient.<sup>99</sup>

- 27.64 Clinicians were fiercely critical of patient override,<sup>100</sup> claiming that the decisions are usually not legitimate and lead to clinical frustration because of the excessive demands which it placed on the Emergency Department of a hospital.<sup>101</sup> In short, it was reported to me that this was an abuse of the system, albeit by a relatively small number of individuals.
- 27.65 The NSW Ambulance Service, by and large, also does not like patient override. The Superintendent of the Sydney Operations Centre said that removing patient override would lead to “better utilisation of emergency capacity”, and that catering for patient requests has a cascading effect of removing resources from a particular area.<sup>102</sup>
- 27.66 In my view, the patient override feature on the Matrix should be abolished. I see no reason why precious resources designed to be available to be used in an emergency to provide rapid treatment for seriously injured or sick patients should be able to be used, without regard to the clinical and health system context, to cater for the predilection of the individual patient. The only valid exception seems to me to be where the patient has recently received treatment for the same condition which they are then experiencing from a particular hospital, in which case the patient should be taken to that hospital if possible. This is to permit a better continuity of care which is appropriately a clinically based reason.<sup>103</sup>

**Recommendation 119:** *The patient override function in the Matrix used by the NSW Ambulance Service should be abolished.*

### Co-ordination of air ambulance

- 27.67 Air ambulance services are co-ordinated by 2 services:
- (a) the Newborn & Paediatric Emergency Transport Service (**NETS**); and
  - (b) the Aeromedical and Medical Retrieval Service.
- 27.68 The evidence I received indicates that there are some problems with arranging for the transport of patients using these services.

#### *NETS*

- 27.69 NETS coordinates the emergency air or road transport of critically ill and injured newborns, infants, children and high risk obstetric cases from smaller hospitals to tertiary hospitals with a paediatric intensive care unit or a neonatal intensive care unit.<sup>104</sup>
- 27.70 According to the relevant NSW Health policy, the referring hospital is required to contact their preferred tertiary perinatal referral centre or children’s hospital in the first instance. It is then the responsibility of the first tertiary centre contacted to:
- (a) advise the referring hospital in relation to the transfer, and
  - (b) to arrange a bed, either in their hospital or an alternative destination.

According to the policy, it is only then that NETS is contacted, if retrieval is contemplated.<sup>105</sup>

- 27.71 However, NETS advised me that it experiences difficulties when hospitals making use of its services inadequately utilise their senior medical staffing resources for clinical

support. This adds to the workload pressure on NETS' consultants. I was told that this is particularly an issue with metropolitan hospitals rather than rural hospitals.<sup>106</sup>

#### *Aeromedical and Medical Retrieval Service*

- 27.72 The Aeromedical and Medical Retrieval Service, within the NSW Ambulance Service, organises air retrieval services generally. Doctors based at the Ambulance Service advise staff at the sending hospital, by telephone or video-link, in respect of the transfer.<sup>107</sup>
- 27.73 The Aeromedical and Medical Retrieval Service also provides a referral service which locates an intensive care bed for the patient.<sup>108</sup> This service is only supposed to be provided where patients are being transferred between different area health services, as opposed to within the same area health service.<sup>109</sup> As the NSW Health policy directive, "Critical Care Adult Tertiary Referral Networks – Intensive Care Default Policy", states,

"each Area Health Service has a responsibility to ensure that all options for placement of the patient within the Area have been explored".<sup>110</sup>

- 27.74 However, the Superintendent of the NSW Ambulance Service's Sydney Operations Centre informed me that, in reality, some area health services do not appear to make any effort to find a bed within their area health service, but simply state that their area has no bed, thereby making it the task of the Aeromedical and Medical Retrieval Service to find one. Indeed, some area health services had even refused to provide clinical advice in respect of the transfer.<sup>111</sup> The superintendent summarised the attitude of some area health services as being,

"If you give an Area Health Service the option to say no, they will."<sup>112</sup>

- 27.75 On the other hand, some clinicians complained to me that the Aeromedical and Medical Retrieval Service "is now not assisting as a one stop shop"<sup>113</sup> as a call to the service no longer ensured that both patient transport and a bed at the final destination were arranged by the service. A clinician provided an example where the Aeromedical and Medical Retrieval Service "just gave out different ICUs to try".<sup>114</sup>
- 27.76 It is clear from the evidence that I received that clinicians are unclear about their role and the protocol regarding Aeromedical and Medical Retrieval Service's role in finding a bed for the patient.<sup>115</sup>

#### *The way forward*

- 27.77 It seems to me that the NSW Health policy in relation to NETS' retrievals is clearer in respect of where the responsibility to find a bed lies, that is, with the preferred receiving hospital. The question is whether the NSW Health policy in relation to the Aeromedical and Medical Retrieval Service should be brought into line with this.
- 27.78 Issues raised in this area will also be assisted by observations that I have made in regards to bed management in Chapter 28.

## Changing roles for paramedics

- 27.79 In my view, there a ways in which the skills of paramedics can be better utilised in the NSW health system.

## Increased role in the Emergency Department

- 27.80 In Chapter 10, I have recommended inter-disciplinary training of clinicians, and this appears to me to have real benefits in respect of ambulance paramedics.
- 27.81 Particularly in rural areas, I was told how ambulance officers help out in Emergency Departments from time to time, and find this quite rewarding as it keeps their skills current, and is more interesting than waiting in an ambulance station for the phone to ring.<sup>116</sup>
- 27.82 While such arrangements are *ad hoc*, in my view, the necessary education and training should be made available to paramedics interested in providing greater assistance in the Emergency Department, particularly in rural and remote areas. They may also be of assistance in overloaded metropolitan Emergency Departments.<sup>117</sup>

**Recommendation 120:** *Paramedics in regional, rural and remote locations ought receive additional training so as to enable them to assist in the provision of immediate or emergency care delivered at the regional, rural or remote hospitals.*

**Recommendation 121:** *In regional, rural and remote areas, it is desirable that ambulance stations be co-located with the principal hospital facility of the city or town.*

## Using non-paramedic drivers

- 27.83 Funding has been allocated in the 2008-09 Health Budget by the NSW Government to recruit an extra 75 new full-time staff.<sup>118</sup> Despite this, however, I have received evidence that the average age of paramedics is increasing and that the impact of the take-up of new recruits upon increasing demand for services is mitigated by an increasing number of retirements.<sup>119</sup>
- 27.84 Presently, 2 paramedics usually work together on each ambulance as a unit. I was told this was because of the existence of a number of local and state-wide industrial agreements and a general resistance to change.<sup>120</sup> In my view, as a widespread practice, this is probably under-utilisation of a scarce resource when it may be sufficient to have one paramedic with one aide.
- 27.85 To assist in responding to the increasing demand on the NSW Ambulance Service, one paramedic should be sent out together with a non-paramedic whose role is to drive and assist the paramedic. Such a system was implemented in the United Kingdom where an ambulance paramedic is accompanied by a non-paramedic, for example, an enrolled nurse or nursing assistant.<sup>121</sup> It was suggested to me that this idea would be particularly useful in NSW in remote locations.<sup>122</sup> Others suggested that the use of paramedic assistants would be attractive to those interested in joining the NSW Ambulance Service but unwilling to undergo the training required to become a paramedic.<sup>123</sup>
- 27.86 I understand that previous efforts by NSW Health to introduce this have met with resistance,<sup>124</sup> and that disagreements between the rank and file, the Health Services Union, and the NSW Ambulance Service make it difficult to implement changes of this kind.<sup>125</sup> Nonetheless, the issues of scarcity of a highly trained workforce and a growing demand for ambulance services, together with the existing cost pressures, in my view, combine to make essential the introduction into the NSW Ambulance Service of a new class of employee known as a paramedic assistant whose principal task would be to

drive the ambulance and provide the paramedic with such assistance as may be appropriate.

**Recommendation 122:** *NSW Health should develop a role description for an introduce a new category of staff member in the NSW Ambulance Service whose task would be principally to do all non-treatment duties which presently a two person team attends to, such as driving and attending to radio transmissions and paperwork.*

## Non-urgent patient transport

27.87 Non-urgent patient transport is provided by the NSW Ambulance Service and area health services.

### *NSW Ambulance Service*

27.88 In 2006-07, the NSW Ambulance Service transported 245,723 non-emergency patients.

- (a) In Sydney, the NSW Ambulance Service uses some 20 to 30 green patient transport vehicles for non-urgent transports, although about half of non-urgent patients still travelled in an emergency ambulance.
- (b) In rural areas, emergency ambulances are used.<sup>126</sup>

27.89 People are not automatically entitled to have non-emergency patient transport provided to them by the NSW Ambulance Service. NSW Health policy dictates that to be eligible for non-emergency transport to and from health services, the patient's condition must prohibit them from the use of alternative means of transport, public or private, and the request must be authorised by a registered medical practitioner.<sup>127</sup> The policy indicates that, to be eligible, the patient must be "medically unsuitable" and, normally, would require a stretcher, or active monitoring in transit, or have a condition that could cause them grave embarrassment or would be unacceptable to others on public transport.<sup>128</sup>

27.90 Hospitals pay for the use of ambulances for non-urgent, inter-hospital patient transport.<sup>129</sup> There is no cost recovery to the hospital from the patient for this service.<sup>130</sup>

### *Area health services*

27.91 Non-urgent transport services offered by area health services differ in scope. The availability and operation of such services is idiosyncratic.<sup>131</sup> For example:

- (a) I was told of an inter-hospital transport service operated in Wollongong which moves 70 patients a day with 5 vehicles. Patients are accompanied by a registered nurse.<sup>132</sup> Where all such vehicles are in use, the hospital has to book a NSW Ambulance Service vehicle. I was told that such bookings are costing some \$80,000 a month,<sup>133</sup> which tends to suggest that the area health service's transport could be and perhaps should be expanded.
- (b) The North Coast Area Health Service operates transport units to coordinate transport for patients using the facilities that exist in their areas.<sup>134</sup>
- (c) Some rural area health services have transport coordinators, who I was told were very effective.<sup>135</sup>

27.92 There are several advantages to non-urgent patient transport being provided by an organisation separately from the urgent services of the NSW Ambulance Service:

- (a) Ambulance vehicles are freed up to attend to emergencies which is their principal role. It would assist in avoiding very sad situations, such as that of Mrs Daphne Jones, who apparently died after being unable to obtain emergency transport in Condobolin due to the only 2 ambulances in town being occupied with inter-hospital transfers.<sup>136</sup> This would also address the problem of the diminishing job satisfaction of ambulance officers many of whom feel as though they are being used as “patient taxis”.<sup>137</sup>
- (b) Non-urgent transport becomes more reliable, enabling more accurate discharge planning. It is more convenient than putting a patient ready for discharge on a waiting list for an ambulance, as the patient is then subject to the NSW Ambulance Service’s emergency workload.<sup>138</sup> This can be illustrated by the use of a mini-bus by Mona Vale Hospital to ensure timely discharge of patients to aged care facilities and retirement villages. I was told that whilst this has not only improved the reliability of patient transport, it has also reduced access block by 25%.<sup>139</sup>
- (c) It is less expensive to operate. I was given much evidence as to the significant cost and expense incurred by area health services in using the NSW Ambulance Service for non-urgent patient transport.<sup>140</sup> NSW Health recognises that it is cheaper for area health services to provide non-urgent patient transport.<sup>141</sup>

27.93 Funding from NSW Health is available for application by area health services, as guided by their ‘Transport for Health’ policy.<sup>142</sup> However, it is apparent that no logical or rational system exists for the overall development of a reliable, widely accessible system.<sup>143</sup>

### Lack of non-urgent patient transport

27.94 The potential of non-urgent transport services offered by area health services is evident, especially when considered in light of the many examples I received of patients who found themselves with no transport at all. For instance:

- (a) I was told of a patient who had to transport herself between hospitals to obtain a CT scan, even though a doctor determined that she was potentially seriously ill at the time.<sup>144</sup>
- (b) I received evidence of several instances of patients being discharged without any transport assistance, even though their individual circumstances arguably warranted assistance.<sup>145</sup> In some of these cases, due to an oversight by the hospital staff, the patient was left with no choice but to use a taxi service and depend upon the kindness of the driver for physical assistance into their home. In one case a frail, elderly patient was dropped off at an empty house near midnight.<sup>146</sup>

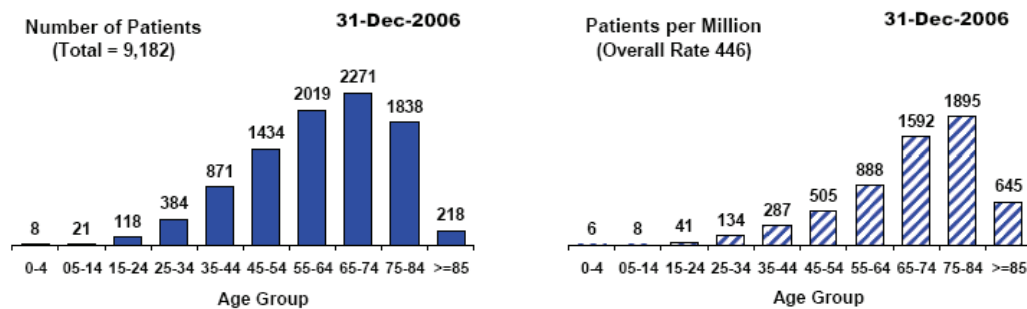
27.95 In some areas, community organisations arrange transport to and from hospitals in nearby towns. For example, the Maari Ma Health Aboriginal Corporation runs a community bus service taking patients from remote communities to Broken Hill for treatment.<sup>147</sup> I was told by a member of parliament that, but for such services, some of his constituents would decide not to have treatment at all.<sup>148</sup>

### *Renal patients*

27.96 Renal patients are peculiarly affected by the present deficiencies in arrangements for non-urgent patient transport, particularly in rural and remote areas.

- (a) Treatment for renal patients requires that they attend at hospital for dialysis 3 times a week, every week.<sup>149</sup> The treatment lasts for 4 to 5 hours, but the complete trip from home to the hospital and back may take up to 10-11 hours.<sup>150</sup>
- (b) After treatment, patients are often not sufficiently well to get home by public transport. Low blood pressure is a common side-effect of dialysis.<sup>151</sup> I was told by an elderly dialysis patient that he feels “quite flat” after treatment and needs to get home to rest.<sup>152</sup> It was submitted to me by the daughter of another dialysis patient that it is unreasonable to expect renal patients to use public transport at all.<sup>153</sup> One of the sadder cases I heard about during this Inquiry was the death of Wayne Brown, who travelled home by train and foot on a hot day after receiving dialysis and died later that night. It appears that nobody at the hospital appears to have assumed the responsibility of ensuring he got home in an appropriate way.<sup>154</sup>
- (c) Many renal patients are elderly. The need for renal dialysis increases dramatically with age, with almost 50% of all patients aged over 65, as shown in the below graph.<sup>155</sup>

Figure 27.4 Prevalent dialysis patients (Australia)



- 27.97 In rural areas lacking public transport, where the hospital or community does not have any alternative arrangements for transporting patients to and from hospital, renal patients travel by ambulance if they satisfy the eligibility requirements referred to above. Otherwise they are required to make their own arrangements.<sup>156</sup> This arrangement is far from ideal.
- (a) Anomalies exist in some areas where, due to changes in eligibility criteria, the ambulance will collect dialysis patients who were ‘on their books’ prior to the changes, but not newer patients. This means that the ambulance may pick up a patient from one house but not pick up a dialysis patient living next door.<sup>157</sup>
- (b) It reduces the number of ambulances available to respond to emergencies.<sup>158</sup>
- (c) The cost of travelling by ambulance is considerable. I was provided with a clear example by Mr and Mrs Bailey in Tweed Heads. Mr Bailey travels from Nunderi to Tweed Heads Hospital 3 times a week for treatment. The ambulance costs \$335 each way, although as a pensioner, Mr Bailey does not have to pay. A taxi would cost \$65 each way. By Mr Bailey’s calculations, using a taxi would save \$103,755 a year!<sup>159</sup>
- (d) If an emergency occurs while a patient is waiting to be taken for dialysis, then the renal patient has to wait until the ambulance becomes available again, and will arrive late for treatment. This causes the dialysis centre to run late. If an emergency occurs when the patient is waiting to be taken home after treatment, the patient again has to wait and may be waiting until midnight for a lift home. After treatment, patients are often fatigued and tired, so this is not ideal.<sup>160</sup> As Mr



Bailey pointed out, a taxi would enable Mr Bailey to arrive on time and leave straight away after receiving treatment.<sup>161</sup>

- (e) Those who drive do so reluctantly as they often lack confidence and feel unsafe driving due to the common feeling of fatigue and tiredness associated with dialysis treatment.<sup>162</sup>

27.98 The result for rural and remote patients, I am told, is that some leave their small communities behind and move to the town where dialysis treatment can be received. By virtue of leaving their support networks behind, such patients require more supports in the larger centres, which costs the community more.<sup>163</sup> One witness commented,

"[I]t borders on cruelty to make renal patients spend 3 days a week all day somewhere else when they could be having dialysis in their local community."<sup>164</sup>

27.99 Some suggestions were made to my Inquiry as to how to remedy this situation:

- (a) Ms Barber, team leader of social work at Nepean Hospital, suggested that dialysis centres could be funded to provide transport for such patients, as they know how many patients are coming and from where.<sup>165</sup>
- (b) Ms Passey, a social worker at Armidale, suggested the use of community buses, taxi vouchers, hospital cars with paid or volunteer drivers, or smaller dialysis centres in rural areas.<sup>166</sup>
- (c) The daughter of a renal dialysis patient suggested parking cost concessions for renal patients who have their own transport.<sup>167</sup> However, on this last point, I don't believe hospitals should be called on to provide these concessions – it is not about making the treatment cost neutral for patients, but ensuring that patients who wouldn't otherwise be able to receive medical treatment due to lack of transport or an inability due to their frail condition to use public transport, have access to treatment.

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27.100 NSW Health in the *NSW Renal Dialysis Service Plan to 2011* issued in January 2007 identified the transport of renal patients as an issue in effective renal dialysis service delivery.<sup>168</sup> The report noted that this issue was being considered by NSW Health in its implementation of the Transport for Health Policy, which is discussed below.<sup>169</sup> NSW Health have informed me that a transport working group was established in January 2008 under the Renal Services Network of the Greater Metropolitan Clinical Taskforce. The role of this group is to "identify strategies to address current inequities experienced by disadvantaged patients receiving dialysis".<sup>170</sup> The group is to report to the Renal Services Network and make recommendations. The implementation of these recommendations will be subject to additional resources being made available to NSW Health.<sup>171</sup> I commend the task of this group. However, it seems to me that solutions to the problem are taking far too long to be implemented.

### Getting organised

- 27.101 It is obviously not good use of public resources to send patients to hospital by ambulance where their medical condition does not require it. A taxi, or non-urgent patient transport arranged by the hospital, would be better.
- 27.102 I was informed by senior officers within the NSW Ambulance Service that having urgent and non-urgent patient transport within the same organisation or "... under the same roof ..." is problematic.<sup>172</sup> Mr Head, told me that a comprehensive transport strategy between area health services and the NSW Ambulance Service is needed, otherwise there will be a deterioration in response times of ambulances. It was suggested that a



clear timeframe for implementation is essential, and that it needs to be headed by someone with transport logistics expertise.<sup>173</sup>

- 27.103 I am told that the NSW Ministry of Transport has engaged an independent consultant to review various community transport services operated by different government agencies, such as the Home & Community Care Community Transport Program for frail aged and younger people with disabilities, and their carers, which is administered by the NSW Department of Ageing, Disability and Home Care.<sup>174</sup> I was also told that the Ministry was working in an attempt to better integrate the various services.<sup>175</sup>
- 27.104 NSW Health is looking at ways to improve the provision of transport services to patients.<sup>176</sup> In 2006 it introduced the Transport for Health policy.<sup>177</sup> The policy aims to integrate all non-emergency health related transport service provision throughout NSW into one program. It also establishes health transport units, which act as a single point of access and coordination for transport services within each area health service.<sup>178</sup> There was a \$16.4 million budget allocated to the program for 2007-08, which, I am told, was distributed amongst the area health services to fund aspects of transport related service provision under the Policy.<sup>179</sup>
- 27.105 As well as the existing Transport for Health policy, I understand that following the recommendations of the performance review undertaken by Mr Head to which I have earlier made reference, a review of the current non-emergency patient transport system with the help of an independent expert is to take place.<sup>180</sup> I am told that this review will not be completed before the conclusion of this Inquiry.<sup>181</sup> Furthermore, in its Mini-Budget for 2008-09, the NSW Government has allocated funding to the Department of Health in its forward estimates (from 2009-10) for the “development of non emergency ambulance transport under a separate service model to reduce service cost and free up Ambulance officer time for emergency work”.<sup>182</sup>
- 27.106 It is appropriate however that I express my views on this issue.
- 27.107 I am convinced that an efficient non-urgent patient transport system is an important ingredient in delivering hospital treatment in an efficient, economic manner. The structure of the hospital system in NSW is that services are provided in clinically appropriate settings which are not always geographically convenient. That fact can only be ameliorated by the provision of an efficient retrieval service for urgent cases on the one hand, and an efficient non-urgent patient transport service on the other.
- 27.108 In my view, urgent and non-urgent patient transport needs to be separated. Non-urgent patient transport needs to be provided across the state, but there is not necessarily any reason to think that it can only happen with a single state-wide system which is centrally organised.
- 27.109 The service could be provided by an area health service, which has the advantage of being an integral part of the delivery of hospital (and health services) in that area. The area would ordinarily be the organisation best placed to have a sense of when patients need to travel. However, I would not rule out the provision of the service by private industry such as exists in Melbourne. Another possibility is to expand the present non-emergency ambulance operation. A combination of any of these options may also be appropriate.<sup>183</sup>
- 27.110 I do not think that this Inquiry is best fitted to design the system, nor even to suggest one model over another. Clearly, this requires careful investigation and consideration of the various options. However, it is appropriate for me to emphasise the need for such a system and the steps which will assist on the path to the implementation of that system.

27.111 I suggest that clear guidelines need to be formulated as to:

- (a) which patients are suitable for non-urgent patient transport,
- (b) what escort, if any, is required for particular types of patients, and
- (c) what type of vehicles are appropriate including what equipment should be contained in the vehicles.

Vehicles should also have a ready means of communication with the hospital, and the NSW Ambulance Service, if an emergency occurs *en route* that is beyond the capacity of the escort.

27.112 I would also suggest that to be effective, patient transport services need to operate well beyond the hours of 9 am to 5 pm and in a way which is flexible and suits the needs of the patients. The precise hours would depend on a particular hospital's need, for example, having regard to their patterns of patient discharge, the need for urgent transport to a tertiary hospital for diagnostic tests, and the like. As well, the system needs to be available on 7 days of the week and not just during Monday to Friday.

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**Recommendation 123:** *NSW Health is to ensure that there is provided, separately from the emergency transport service of NSW Ambulance, a non urgent transport service which is responsible for:*

- (a) *The return transport of rural patients from metropolitan or rural referral hospitals to either their hospital of origin or their home depending upon their clinical condition;*
- (b) *The transport of metropolitan patients between hospitals or from hospitals to aged care facilities; and*
- (c) *Any other transport required to enable timely investigation and treatment of patients where their clinical condition necessitates access to specialised transport.*

<sup>1</sup> Meeting with Professor Graeme Stewart and Professor John Dwyer, NSW Medical Staff Executive Council, 26 June 2008.

<sup>2</sup> See Department of Premier and Cabinet, New South Wales Government, *Performance Review: Ambulance Service of NSW*, June 2008 and New South Wales Parliament, General Purpose Standing Committee No 2, Legislative Council, *Inquiry Into the Management and Operations of the NSW Ambulance Service*.

<sup>3</sup> Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.

<sup>4</sup> NSW Ambulance Service website, [http://www.ambulance.nsw.gov.au/corporate\\_info/facts\\_figures.html](http://www.ambulance.nsw.gov.au/corporate_info/facts_figures.html). Material provided by NSW Ambulance Service in response to summons, AMB.001.0004.

<sup>5</sup> Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.

<sup>6</sup> NSW Ambulance Service, *Organisational Structure as at February 2008* provided in response to summons, AMB.001.0017. Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008 at 60.

<sup>7</sup> NSW Health Briefing, 31 March 2008, transcript 2.40-43.

<sup>8</sup> NSW Health Briefing, 31 March 2008, transcript 2.43-3.1; 3.25-28.

<sup>9</sup> Material provided by NSW Ambulance Service in response to summons, AMB.001.0021.

<sup>10</sup> NSW Health, Submission to the Legislative Council, General Purpose Standing Committee No.2, The Management and Operations of the Ambulance Service of NSW, July 2008,

provided in letter from NSW Health to Special Commission of Inquiry, 4 July 2008 at 3. Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008 at 84. Submission of NSW Health, 14 April 2008, SUBM.075.0002 at 060.

- 11 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 12 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 13 Material provided by NSW Ambulance Service in response to summons, AMB.001.0021. NSW Health, Submission to the Legislative Council, General Purpose Standing Committee No.2, The Management and Operations of the Ambulance Service of NSW, July 2008, provided in letter from NSW Health to Special Commission of Inquiry, 4 July 2008 at 3. Submission of NSW Health, 14 April 2008, SUBM.075.0002 at 060. Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 14 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 15 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 16 NSW Health, Submission to the Legislative Council, General Purpose Standing Committee No.2, The Management and Operations of the Ambulance Service of NSW, July 2008, provided in letter from NSW Health to Special Commission of Inquiry, 4 July 2008 at 3. Submission of NSW Health, 14 April 2008, SUBM.075.0002 at 060.
- 17 NSW Ambulance Service website  
[http://www.ambulance.nsw.gov.au/about\\_us/paramedics.html](http://www.ambulance.nsw.gov.au/about_us/paramedics.html) (19 November 2008).
- 18 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 19 Material provided by NSW Ambulance Service in response to summons, AMB.001.0021. Ronald Mawhinney, Royal North Shore Hospital hearing, 14 March 2008, transcript 355.6-14.
- 20 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 21 Material provided by NSW Ambulance Service in response to summons, AMB.001.0021. NSW Ambulance Service Briefing, 31 March 2008, transcript 6.30-7.08. Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 22 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 23 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 24 NSW Ambulance Service Briefing, 31 March 2008, transcript 6.30-7.08. Material provided by NSW Ambulance Service in response to summons, AMB.001.0021. Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 25 Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- 26 Confidential Bourke hearing, 9 May 2008, transcript 12.45-13.22.
- 27 NSW Ambulance Service Briefing, 31 March 2008, transcript 7.10-17. Material provided by NSW Ambulance Service in response to summons, AMB.001.0021.
- 28 Ambulance Service of New South Wales, *Annual Report 2006-07*, 2007 at 11 and 58.
- 29 Ambulance Service of New South Wales, *Annual Report 2006-07*, 2007 at 58.
- 30 Ambulance Service of New South Wales, *Annual Report 2006-07*, 2007 at 10.
- 31 NSW Health, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 4.
- 32 NSW Health, Submission to the Legislative Council, General Purpose Standing Committee No.2, The Management and Operations of the Ambulance Service of NSW, July 2008, provided in letter from NSW Health to Special Commission of Inquiry, 4 July 2008, p. 2; NSW Ambulance Service website,  
[http://www.ambulance.nsw.gov.au/about\\_us/ambulance\\_operations/emergency\\_response.html](http://www.ambulance.nsw.gov.au/about_us/ambulance_operations/emergency_response.html) (19 November 2008).
- 33 Information provided during visit to Royal Flying Doctor Service on 19 March 2008; NSW Ambulance Service website,  
[http://www.ambulance.nsw.gov.au/about\\_us/ambulance\\_operations/emergency\\_response.html](http://www.ambulance.nsw.gov.au/about_us/ambulance_operations/emergency_response.html) (19 November 2008).
- 34 NSW Ambulance Service Briefing, 31 March 2008, transcript 10.27-39 and 11.29.

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- <sup>35</sup> Operational Research in Health Ltd, *Review of Fixed Wing Services in NSW – Draft Report*, September 2007 at 28 [response to summons - AMB.005.0188]. Operational Research in Health Ltd, *Review of Rotary Wing Services in NSW – Final Report*, December 2004 at 34 [response to summons - AMB.002.0267].
- <sup>36</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 8.08-43.
- <sup>37</sup> Natasha Wallace, "Firies to Take Over Some Ambulance Rescue Units", *The Sydney Morning Herald*, 3 September 2008.
- <sup>38</sup> Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008 at 6, 100-102.
- <sup>39</sup> Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008, p. 102.
- <sup>40</sup> Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008, p. 101.
- <sup>41</sup> Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008, p. 102.
- <sup>42</sup> Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008, p. 102.
- <sup>43</sup> Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008, p. 102.
- <sup>44</sup> Natasha Wallace, "Firies to Take Over Some Ambulance Rescue Units", *The Sydney Morning Herald*, 3 September 2008.
- <sup>45</sup> Information provided during visit to the Sydney Ambulance Centre on 29 May 2008. NSW Ambulance Service Briefing, 31 March 2008, transcript 9.42-10.02.
- <sup>46</sup> NSW Health, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 6.
- <sup>47</sup> NSW Health, *Special Commission of Inquiry Presentations: Sustainable Access Health Priority Taskforce*, 5 June 2008, p. 5.
- <sup>48</sup> NSW Health, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 6.
- <sup>49</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- <sup>50</sup> NSW Health, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 7; Letter from NSW Health to Special Commission of Inquiry, 13 November 2008.
- <sup>51</sup> Information provided during visit to the Sydney Ambulance Centre on 29 May 2008. Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- <sup>52</sup> Information provided during visit to the Sydney Ambulance Centre on 29 May 2008. NSW Ambulance Service Briefing, 31 March 2008, transcript 5.01-16. Material provided by NSW Ambulance Service in response to summons, AMB.001.0021. Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- <sup>53</sup> Material provided by NSW Ambulance Service in response to summons, AMB.001.0021.
- <sup>54</sup> Letter from NSW Health to Special Commission of Inquiry, 10 September 2008. I was informed that the planned completion date for the upgrade is early 2009.
- <sup>55</sup> Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- <sup>56</sup> Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- <sup>57</sup> Material provided by NSW Ambulance Service in response to summons, AMB.001.0021. NSW Ambulance Service Briefing, 31 March 2008, transcript 6.2-10.
- <sup>58</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 19.36; NSW Health, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 11; Letter from NSW Health to Special Commission of Inquiry, 13 November 2008.
- <sup>59</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 36.7-14; NSW Health, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 28; NSW Health, Media Release: "Funding Boost for Ambulance Service of NSW", Minister for Health, 3 June 2008.

- <sup>60</sup> Ronald Mawhinney, Royal North Shore Hospital hearing, 14 March 2008, transcript 354.30-44. See also Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008 at 36.
- <sup>61</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- <sup>62</sup> Submission of Jim Stirling, 14 March 2008, SUBM.053.0103 at 103.
- <sup>63</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- <sup>64</sup> NSW Ambulance Service, *Provision of Ambulance Services – Frequently Asked Questions*, <http://www.ambulance.nsw.gov.au/docs/080707ipartfaq.pdf>. Letter from NSW Health to the Special Commission of Inquiry, 13 November 2008.
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- <sup>66</sup> Letter from NSW Health to the Special Commission of Inquiry, 13 November 2008.
- <sup>67</sup> NSW Ambulance Service, *Provision of Ambulance Services – Frequently Asked Questions*, <http://www.ambulance.nsw.gov.au/docs/080707ipartfaq.pdf>. The maximum total charge payable is \$4,752.
- <sup>68</sup> Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008 at 58.
- <sup>69</sup> NSW Ambulance Service, *Provision of Ambulance Services – Frequently Asked Questions*, <http://www.ambulance.nsw.gov.au/docs/080707ipartfaq.pdf>. Independent Pricing and Regulatory Tribunal of NSW, *Review of Financial Aspects of the Ambulance Service of NSW – Report to the Minister for Health on Revenue and Charging Structures*, November 2005 at 26.
- <sup>70</sup> Material provided by NSW Ambulance Service in response to summons, AMB.001.0021.
- <sup>71</sup> NSW Ambulance Service, *Clinical Assessment and Referral (CARE) – Standard Operating Policy*, SOP2008-021. Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008 at 54-55. Letter from NSW Health to Special Commission of Inquiry, 10 September 2008.
- <sup>72</sup> Letter from NSW Health to Special Commission of Inquiry, 10 September 2008 (Request 45). Ambulance Service of New South Wales, *Non-Transport Special Projects – Protocol P3*; Ambulance Service of New South Wales, *Expanded Decision Making (EDM) – Clinical Care Pathways – Protocol P5*; Ambulance Service of New South Wales, *Clinical Assessment and Referral (CARE): Standard Operating Policy*, SOP2008\_021.
- <sup>73</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 5 August 2008.
- <sup>74</sup> Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008 at 53. See Snooks H et al, "Appropriateness of Use of Emergency Ambulances" (1998) 15 *Journal of Accident and Emergency Medicine* 212-218.
- <sup>75</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 5 August 2008.
- <sup>76</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 5 August 2008.
- <sup>77</sup> Meeting with Health Services Union, 15 July 2008.
- <sup>78</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- <sup>79</sup> See Ambulance Service of New South Wales, *Non-Transport - Special Projects, Protocol P3* and Ambulance Service of New South Wales, *Expanded Decision Making (EDM) – Clinical Care Pathways, Protocol P5*.
- <sup>80</sup> Letter from NSW Health to Special Commission of Inquiry, 20 March 2008. Material provided by NSW Ambulance Service in response to summons, AMB.001.0021. NSW Ambulance Service Briefing, 31 March 2008, transcript 19.44-22.6.
- <sup>81</sup> NSW Ambulance Service, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 17.
- <sup>82</sup> Letter from NSW Health to Special Commission of Inquiry, 20 March 2008; Material provided by NSW Ambulance Service in response to summons, AMB.001.0021; NSW Ambulance Service, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 17.



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- <sup>83</sup> Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>84</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 24.3-34 and NSW Ambulance Service, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, pp. 19-20; Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>85</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 24.03-34 and presentation at 19-20. Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>86</sup> This model of care is partially in operation in northern and western Sydney (since 2004), with apparently positive outcomes: submission of Dr Gregory Nelson, 12 March 2008, SUBM.013.0011 at 11.
- <sup>87</sup> Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>88</sup> Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>89</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 29.07. Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>90</sup> Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>91</sup> Submission of Dr Gregory Purcell provided by hand at Royal North Shore Hospital hearing, 14 March 2008, SUBM.013.0206 at 210.
- <sup>92</sup> Information provided during visit to Concord Hospital on 21 February 2008.
- <sup>93</sup> Information provided during visit to St George Hospital on 21 February 2008.
- <sup>94</sup> Information provided during visit to Royal Prince Alfred Hospital on 14 February 2008. Information provided during visit to Westmead Children's Hospital on 15 May 2008.
- <sup>95</sup> NSW Ambulance Service, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 22; Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>96</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 29.35-30.4 and additional graph 1.
- <sup>97</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 25.1-6, 30.44–31.4; NSW Ambulance Service, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, pp. 21-24.
- <sup>98</sup> Calculation derived from information provided in letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>99</sup> NSW Ambulance Service, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 23; Letter from NSW Health to Special Commission of Inquiry, 20 March 2008.
- <sup>100</sup> Information provided during visit to Prince of Wales Hospital on 21 February 2008. Information provided during visit to Concord Hospital on 21 February 2008.
- <sup>101</sup> Dr Kathryn Porges, Gosford hearing, 10 March 2008, transcript 68.34, 68.42.
- <sup>102</sup> Information provided during visit to the Sydney Ambulance Centre on 29 May 2008.
- <sup>103</sup> Christine Parker, Sonia Chatri and Susan Monaro, Concord hearing, 24 April 2008, transcript 2136.9-32; NSW Health Briefing, 31 March 2008, transcript 27.04-8.
- <sup>104</sup> Newborn & Paediatric Emergency Transport Service website, <http://www.nets.org.au/main/what.htm> (September 2008); Submission of Dr Andrew Berry, Paul Gallagher and Dr Christopher Webber, Newborn & Paediatric Emergency Transport Service, 10 June 2008, SUBM.074.0004 at 4.
- <sup>105</sup> NSW Health, *Emergency Obstetric and Neonatal Referrals – Policy*, PD2005\_156 and NSW Health, *Emergency Paediatric Referrals – Policy*, PD2005\_157.
- <sup>106</sup> Submission of Dr Andrew Berry, Paul Gallagher and Dr Christopher Webber, Newborn & Paediatric Emergency Transport Service, 10 June 2008, SUBM.074.0004 at 5.
- <sup>107</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 11.45-12.05. NSW Health, Submission to the Legislative Council, General Purpose Standing Committee No.2, The Management and Operations of the Ambulance Service of NSW, July 2008, provided in letter from NSW Health to Special Commission of Inquiry, 4 July 2008 at 2.
- <sup>108</sup> Information provided during visit to the Sydney Ambulance Centre on 29 May 2008.

- 109 Information provided during visit to the Sydney Ambulance Centre on 29 May 2008.
- 110 NSW Health, *Critical Care Adult Tertiary Referral Networks – Intensive Care Default Policy*, PD2006\_046 at 10. See also page 4 of the policy regarding situations where assistance will be provided.
- 111 Information provided during visit to the Sydney Ambulance Centre on 29 May 2008.
- 112 Information provided during visit to the Sydney Ambulance Centre on 29 May 2008.
- 113 Submission of Associate Professor Martin Jones, 12 June 2008, SUBM.074.0050 at 050.
- 114 Annexure to the submission of Associate Professor Martin Jones, 12 June 2008, SUBM.074.0051 at 051.
- 115 Geoffrey White, Royal Prince Alfred Hospital hearing, transcript 3127.38-3128.18.
- 116 Confidential Bourke hearing, 9 May 2008, transcript 11.01-12.06.
- 117 Submission of Stan Walden, 20 February 2008, SUBM.015.0193 at 193.
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- 119 Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- 120 Department of Premier and Cabinet, NSW Government, *Performance Review: Ambulance Service of NSW*, June 2008, pp. 6, 74, 78; NSW Ambulance Service Briefing, 31 March 2008, transcript 40.42-41.08; Operational Research in Health Ltd, *Operations Centres Review – Final Report*, 26 February 2002, p. 19. [response to summons - AMB.003.0001].
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- 123 Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- 124 NSW Ambulance Service Briefing, 31 March 2008, transcript 40.42-41.08.
- 125 Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- 126 NSW Ambulance Service Briefing, 31 March 2008, transcript 12.7-11 and NSW Ambulance Service, *Special Commission of Inquiry Presentations: Ambulance Service of NSW*, 31 March 2008, p. 5; Material provided by NSW Ambulance Service in response to summons, AMB.001.0021 at 29-30.
- 127 NSW Health, *Ambulance Coverage Following the Introduction of Medicare*, PD2005\_537.
- 128 NSW Health, *Ambulance Coverage Following the Introduction of Medicare*, PD2005\_537.
- 129 NSW Ambulance Service Briefing, 31 March 2008, transcript 12.15-33. Letter from NSW Health to the Special Commission of Inquiry, 14 November 2008.
- 130 Letter from NSW Health to the Special Commission of Inquiry, 13 November 2008.
- 131 Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- 132 Grant Solomon, Wollongong hearing, 14 April 2008, transcript 1603.17-1604.29.
- 133 Grant Solomon, Wollongong hearing, 14 April 2008, transcript 1608.30-1609.34.
- 134 NSW Health Briefing, 22 May 2008, transcript 10.06-37.
- 135 Annexure to the submission of Hon Richard Torbay, MP, 18 March 2008, *Major Health Reforms for Rural New South Wales*, SUBM.015.0121.
- 136 Letter annexed to the submission of Patricia Hicks, 25 March 2008, SUBM.007.0512.
- 137 Submission of Richard McMaster, 26 February 2008, SUBM.012.0224 at 225.
- 138 NSW Health Briefing, 31 March 2008, transcript 12.44-13.39.
- 139 NSW Health Briefing, 22 May 2008, transcript 12.28-13.03.
- 140 Grant Solomon, Wollongong hearing, 14 April 2008, transcript 1608.31-1609.3. Confidential submission, 18 April 2008, SUBM.031.0059 at 066.
- 141 NSW Ambulance Service Briefing, 31 March 2008, transcript 12.15-33.
- 142 NSW Health, *Transport for Health*, PD2006\_068.
- 143 Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- 144 Submission of Greg Field, undated, SUBM.005.0189.



- <sup>145</sup> Submission of Lexie Lord, Peel Community Forum on Health, 23 April 2008, SUBM.026.0188; submission of Wendy Grimshaw, 28 April 2008, SUBM.040.0312; submission of Stephanie Faulkner, 15 May 2008, SUBM.040.0076.
- <sup>146</sup> Submission of Wendy Grimshaw, 28 April 2008, SUBM.040.0312; submission of Stephanie Faulkner, 15 May 2008, SUBM.040.0076.
- <sup>147</sup> Richard Western, Broken Hill hearing, 7 May 2008, transcript 2622.37-2623.11.
- <sup>148</sup> Thomas George, MP, Lismore hearing 28 April 2008, transcript 2211.22-30.
- <sup>149</sup> Submission of Catherine Passey, 26 March 2008, SUBM.024.0177 at 177.
- <sup>150</sup> Letter provided in support of evidence of Judith and Lynton Bailey at Tweed Heads hearing, 29 April 2008, SUBM.020.0005 at 1-2. NSW Health Briefing, 31 March 2008, transcript 14.35-15.01.
- <sup>151</sup> "Some Physical Side Effects of Dialysis and How to Prevent Them", <http://www.davita.com/dialysis/c/310#> (September 2008).
- <sup>152</sup> Judith and Lynton Bailey, Tweed Heads hearing, 29 April 2004, transcript 2331.19-24.
- <sup>153</sup> Confidential submission, 1 May 2008, SUBM.044.0036 at 037.
- <sup>154</sup> Kim McCall, Nepean Hospital hearing, 8 April 2008, transcript 1367.30-1368.43.
- <sup>155</sup> North Coast Area Health Service, NSW Health, *Renal Dialysis Services Strategy 2006-2011*, March 2007, p. 9; Australia and New Zealand Dialysis and Transplant Registry, <http://www.anzdata.org.au/anzdata/AnzdataReport/30thReport/Ch04Dialysis.pdf> (October 2008). NSW Health, *NSW Renal Dialysis Service Plan to 2011*, January 2007, p. 12.
- <sup>156</sup> Catherine Passey, Armidale hearing, 26 March 2008, transcript 926.7-23; Letter from NSW Health to Special Commission of Inquiry, 24 September 2008. Eligibility criteria for non-emergency ambulance transport is set out in NSW Health, *Ambulance Coverage Following the Introduction of Medicare*, PD2005\_537. Eligibility for alternative travel subsidy schemes under the NSW Health *Transport for Health Guidelines* (PD2006\_068) is discussed elsewhere.
- <sup>157</sup> Catherine Passey, Armidale hearing, 26 March 2008, transcript 926.07-23.
- <sup>158</sup> NSW Health Briefing, 31 March 2008, transcript 14.35-15.1.
- <sup>159</sup> Judith and Lynton Bailey, Tweed Heads hearing, 29 April 2008, transcript 2329.47-2332.25. Letter provided in support of evidence of Judith and Lynton Bailey at Tweed Heads hearing, 29 April 2008, SUBM.020.0005 at 007.
- <sup>160</sup> Submission of Catherine Passey, 26 March 2008, SUBM.024.0177 at 177.
- <sup>161</sup> Judith and Lynton Bailey, Tweed Heads hearing, 29 April 2008, transcript 2330.05-15.
- <sup>162</sup> Submission of Catherine Passey, 26 March 2008, SUBM.024.0177 at 177.
- <sup>163</sup> Catherine Passey, Armidale hearing, 26 March 2008, transcript 924.22-925.25.
- <sup>164</sup> Bronwyn Taylor, Queanbeyan hearing, 15 April 2008, transcript 1734.17-20.
- <sup>165</sup> Pauline Barber, Nepean Hospital hearing, 8 April 2008, transcript 1455.33-1457.19.
- <sup>166</sup> Submission of Catherine Passey, 26 March 2008, SUBM.024.0177 at 178.
- <sup>167</sup> Confidential submission, 1 May 2008, SUBM.044.0036 at 037.
- <sup>168</sup> NSW Health, *NSW Renal Dialysis Service Plan to 2011*, January 2007 at 35.
- <sup>169</sup> NSW Health, *NSW Renal Dialysis Service Plan to 2011*, January 2007 at 35.
- <sup>170</sup> Letter from NSW Health to the Special Commission of Inquiry, 13 November 2008.
- <sup>171</sup> Letter from NSW Health to the Special Commission of Inquiry, 13 November 2008.
- <sup>172</sup> Information provided during visit to the Sydney Ambulance Centre on 29 May 2008.
- <sup>173</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 11 April 2008.
- <sup>174</sup> NSW health Briefing, 22 May 2008, transcript 7.29-40; NSW Ministry of Transport website, <http://www.transport.nsw.gov.au/lact/programs-review.html> and <http://www.transport.nsw.gov.au/lact/hacc.html> (September 2008).
- <sup>175</sup> NSW health Briefing, 22 May 2008, transcript 7.29-40.
- <sup>176</sup> NSW health Briefing, 22 May 2008, transcript 3.36-4.09 and presentation at 4-5.

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- <sup>177</sup> NSW Health, *Transport for Health*, PD2006\_068.
- <sup>178</sup> NSW Health, *Transport for Health*, PD2006\_068, pp. 1 and 12, see also policy summary. NSW Health, Submission to the Legislative Council, General Purpose Standing Committee No.2, The Management and Operations of the Ambulance Service of NSW, July 2008, provided in letter from NSW Health to Special Commission of Inquiry, 4 July 2008 at 40.
- <sup>179</sup> NSW health Briefing, 22 May 2008, transcript 5.01 and presentation at 7. Letter from NSW Health to the Special Commission of Inquiry, 13 November 2008.
- <sup>180</sup> NSW Health, Submission to the Legislative Council, General Purpose Standing Committee No.2, The Management and Operations of the Ambulance Service of NSW, July 2008.
- <sup>181</sup> Meeting with Graeme Head, Department of Premier and Cabinet, 5 August 2008.
- <sup>182</sup> NSW Government, *Mini-Budget 2008-09*, 2008, NSW Government, Sydney, p. A – 6.
- <sup>183</sup> NSW Ambulance Service Briefing, 31 March 2008, transcript 14.17-33.

## 28 Beds

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- 28.1 A key resource in NSW public hospitals is beds.
- 28.2 In the health setting, a 'bed' can take on several forms. It can be a physical bed or chair, as in the case of renal dialysis treatment. It can also be 'virtual' as in the case of the 'Hospital in the Home' program, where the patient is treated in their private residence.<sup>1</sup>
- 28.3 Apart from this 'physical' aspect, there are costs and operational factors associated with a hospital bed: related equipment and staffing, for example. In effect, a bed is a bed when it is immediately available to be used, with all associated operational factors in place, by an admitted patient.<sup>2</sup>
- 28.4 Several issues came up during the course of my Inquiry in relation to beds:
- (a) whether there are enough beds;
  - (b) difficulties getting patients moved from one part of the hospital to another in a timely fashion, whether that be:
    - (i) from the Emergency Department to a bed in a hospital ward;
    - (ii) from intensive care to a bed in a hospital ward, or from a ward to intensive care (the traffic goes both ways),
    - (iii) from one hospital to another hospital, and
  - (c) difficulties getting patients discharged from hospital altogether in a timely fashion, which, to my observation, was generally not working well but there were 2 groups who seem to have particular difficulties:
    - (i) elderly patients; and
    - (ii) severely disabled patients who were too young for an aged nursing home.
- 28.5 These issues, which are collectively referred to in NSW Health as "**bed management**", all have implications for:
- (a) patient length of stay,
  - (b) cancellations of planned surgery;
  - (c) patient safety and quality of care; and
  - (d) "bed block" or "access block" issues for the Emergency Department.
- 28.6 Tackling these problems in a co-ordinated, logical and efficient way is essential to making the health system efficient and cost effective.

## What does a bed cost?

- 28.7 The physical bed itself may range in cost from \$731 for a bassinet to \$250,000 for an intensive care bed with related technology and equipment.<sup>3</sup>
- 28.8 But this is just the beginning of the story. There are many ancillary costs associated with the operation of a hospital bed. To name but a few, many beds, for example, will need to be provided with ready access to oxygen and monitoring equipment. There are costs associated with servicing the bed, including linen. And, there are other direct costs to the hospital including the cost of pharmacy and diagnostic tests for the patient in it.

- 28.9 The real cost of a bed, however, is the staff who provide medical and nursing care to the patient in it. The cost of this will range considerably depending on the hospital ward in which the bed is located, for example, whether the bed is in a rehabilitation ward or intensive care. It will also depend upon which hospital the bed is located in.
- I was informed that the current average annual cost of an occupied rehabilitation bed is estimated to be approximately \$256,000, 62% of which is made up of salaries and wages.<sup>4</sup>
  - the average annual cost of an occupied intensive care bed, I was told, is estimated to be approximately \$1.53 million, 46% of which is made up of medical and nursing salaries.<sup>5</sup>
- 28.10 To give a further indication of the cost of hospital beds, the NSW Government budgeted an annual expenditure of \$48.9 million in the 2008-09 budget for the provision of 180 extra acute hospital beds which suggests an average annual cost of \$271,667.<sup>6</sup>

## Are there enough beds?

- 28.11 Today when it comes to beds, NSW public hospitals are doing more with less. In, say, the 1980s, a patient would spend about 2 weeks in hospital recovering from a cholecystectomy (surgical removal of the gall bladder), but today the same patient may well be treated as a day procedure and be home that evening.<sup>7</sup> Advances in medical treatments leading to shorter lengths of stay, and the prevalence of day surgery, mean that NSW public hospitals are treating more patients with fewer beds.
- 28.12 For example, I was told that where there were 650 beds at St Vincent's Hospital in 1975, now there are 220.<sup>8</sup> Likewise, 30 years ago, there were 1,100 beds at Prince Henry Hospital and 600 at Prince of Wales. Now, these hospitals are consolidated on one site with 450 beds and are doing more work.<sup>9</sup> The management and treatment wheels are spun much faster.<sup>10</sup> Hospitals now overwhelmingly deal with acute episodes; long-term convalescent patients in hospitals are generally a thing of the past.<sup>11</sup>
- 28.13 I have discussed elsewhere in my report how patients can be and are being treated in their homes through Hospital in the Home, together with proposed models of care for the treatment of the chronically ill outside of hospital. As the science and art of medicine continues to improve in this way, more patients will be able to receive health care whilst public hospitals continue with the same number of beds.
- 28.14 Most OECD countries show a similar trend toward a decline in the number of acute care hospital beds available.<sup>12</sup> NSW combined public and private hospital bed numbers are comparable to the OECD average: 3.8 beds per 1000 of population in NSW in 2006-07 compared to an OECD average of 3.9 in 2005.<sup>13</sup> NSW Health informed me that their opinion was that OECD countries can be considered as useful for comparative purposes because of a similarity in the level of economic development and health system development within such countries.<sup>14</sup>
- 28.15 On a national comparison, NSW is performing as well as, if not better than, other states. Over the past 4 years overall public hospital bed numbers have increased by 11% in Australia and 14% in NSW.<sup>15</sup> In 2006-07 NSW had 2.8 public hospital beds per 1000 of population compared to a national average of 2.6.<sup>16</sup>
- 28.16 Nonetheless, it is important to note that despite the advances in treatment, some witnesses pointed out that there have been reductions in bed numbers at an individual hospital level.<sup>17</sup> The Australian Health Policy Institute informed me that public hospitals

are facing increasing numbers of patients presenting to Emergency Departments - a 6.6% increase in services between 2001-02 and 2005-06 in NSW - and hospitals are facing sicker patients with increasing average length-of-stays.<sup>18</sup> The Australian Health Policy Institute believes that this increase in hospital bed usage has led to an overburdened system, which poses significant challenges for health care professionals to accommodate the increase in patients requiring admission.<sup>19</sup>

28.17 The Harges Report 2007 commissioned by NSW Health projected that population growth in NSW, alone, will require an additional 341 beds per year to 2011, rising to 386 beds per year to 2016.<sup>20</sup>

28.18 In the 2008-09 budget, the NSW Government announced funding for 72 beds in medical assessment units, 52 acute beds, 160 community-based residential or aged care places, 4 additional intensive care beds, one additional paediatric intensive care bed, and one additional neo-natal intensive care cot: a total of 290 beds. This is in addition to the 180 new acute beds announced in November 2007.<sup>21</sup> This effort appears to go some way to meeting the projected need. But, if the effort cannot be consistently sustained over the long term, "we need to get cleverer at what we do".<sup>22</sup>

28.19 Unsurprisingly, the announcement of bed increases has not yet had any impact on the ground. I often heard evidence during the course of my Inquiry that there are not enough beds in some hospitals, particularly major regional and outer metropolitan hospitals.

- I was told of the bed blockage problem in the Dubbo area, which was described as a "critical shortage of beds" due to a constant decline in bed numbers over the last 7 years or a shortage of nursing staff to manage the beds.<sup>23</sup>
- In Coffs Harbour I received evidence that, on average, there were about 20 outlying patients waiting to be admitted to a medical ward.<sup>24</sup>

"Every morning when I come to work at 7 [a.m.], there'd be 48 patients in the ward and there will be patients waiting in the emergency department."

- Dr Branch spoke of a lack of intensive care beds throughout the whole of NSW.<sup>25</sup>
- Dr Roger of Gosford Hospital said:

"We need more beds on the Central Coast. We can't do more work because we just don't have enough beds. The only way we can do that is a further injection of funds. Unfortunately that is what the community and Treasury have to realise. There just is not the slack in the system to cope with the current workload."<sup>26</sup>

- I was informed of the results of a survey conducted by the Medical Staff Council at Liverpool hospital, which I am told revealed a staff perception that Liverpool Hospital is very stretched in terms of being over capacity. There is access block, blocks to theatre access, and waits for diagnostic tests.<sup>27</sup>

28.20 The "bed occupancy rate" is the percentage of available beds that are occupied. It is a measure of the utilisation of hospital resources.<sup>28</sup> Current NSW bed occupancy rates were brought to my attention.

- Employees at Nepean Hospital spoke of a shortage of beds evidenced by a daily occupancy rate of almost 100%.<sup>29</sup>
- Occupancy at the orthopaedic ward of Gosford Hospital was estimated at 120%, accounting for the over-demand for a bed or alternatively the provision of care to a patient in a bed which is physically available but is not counted in the census of beds because no funding is available for it.<sup>30</sup>

- 28.21 Such figures need to be treated with great caution and cannot be considered as applicable to the whole of NSW (or even across an area health service). However, I note that NSW Health quote an occupancy rate of 85.3% for all major NSW Health facilities as at November 2007.<sup>31</sup> And, the NSW Auditor-General quotes average occupancy rates of 71.8% (Greater Southern Area Health Service), 73.8% (Greater Western Area Health Service), 92.3% (Sydney South Western Area Health Service) and 95.1% (South Eastern Sydney and Illawarra Area Health Service) across different area health services in NSW for the whole of a year.<sup>32</sup> The NSW Auditor-General concluded that metropolitan bed occupancy rates are significantly higher than most rural areas.<sup>33</sup>
- 28.22 Another approach is to look at occupancy rates according to a hospital's peer group. Average bed occupancy rates for the month of November 2007 include:
- 89.3% for 'principal referral group A' hospitals;
  - 97.7% for 'paediatric specialist hospitals'; and
  - 86% for 'major metropolitan hospitals'.<sup>34</sup>

These averages hide the wide variation that appears to be present across hospitals and the individual wards within the hospital.

### NSW Health review of beds

- 28.23 I was informed by NSW Health that average bed occupancy rates have been the primary measure it uses at an individual hospital level to guide hospital bed capacity decisions at policy, long-term health service planning, and operational levels.<sup>35</sup> It should be noted that NSW Health also seeks to address bed capacity issues through measures other than increasing bed numbers, such as clinical redesign initiatives and changing models of care.
- 28.24 NSW Health described to me their procedure for monitoring hospital bed numbers and projecting future demand for hospital beds. I was told that each respective area health service reports the number of beds available each day for each ward to NSW Health on a monthly basis. NSW Health utilises a projection planning tool called the "aIM2005" to model projected activity and indicative bed requirements for inpatient services. This is based on utilisation data for the previous 5 year period. This modelling incorporates certain drivers of demand, such as population growth, the ageing of the population, and new technologies. The tool enables estimated projections to be made at local government area and area health service levels, taking into account variations in utilisation between area health services and local considerations such as anticipated changes in health delivery.<sup>36</sup>
- 28.25 I was further informed that NSW Health determines planned occupancy levels by types of services and admission type. Generally, the planned occupancy rate is 85%, although a reduced rate is used for some services (such as maternity and paediatric services) and in some geographical settings where, for example, workforce availability might be an issue.<sup>37</sup>
- 28.26 The processes used by NSW Health to monitor bed capacity at individual hospitals, and for projecting future demand for hospital beds, appear to me to be working well in identifying areas of concern. While this may be so, a problem remains in relation to the amount of time that it takes to address bed capacity issues that come to light.



## Consequence of lack of beds

### Implications for patient safety

28.27 An insufficient number of beds has implications for patient safety. I received much evidence on this point. Hospital staff feel as though their hands are tied when all beds are full:

“we have all our bases loaded, we have nowhere to send people”.<sup>38</sup>

28.28 I was told that a lack of beds affects decision making. It causes staff not to admit someone that they would normally admit and it puts pressure on junior medical staff on the wards to discharge patients too soon.<sup>39</sup>

“there is a risk that some people will be sent home who should stay in hospital”.<sup>40</sup>

28.29 Some found that the result of quick discharges was that patients “keep bouncing back”.<sup>41</sup> Others said that a lack of beds makes it harder to maintain a high standard of care and increases the risk of clinical error.<sup>42</sup>

28.30 In relation to intensive care, I received evidence that a lack of capacity means that critically ill patients need to be transferred to other hospitals after an operation, increasing the risks associated with their stabilisation.<sup>43</sup> Alternatively, surgery may be cancelled.

28.31 Studies were brought to my attention that link access block, associated with high bed occupancy rates, to increased lengths of stay, poor infection control and increased mortality.<sup>44</sup>

28.32 An associated problem occurs where patients end up in the wrong bed, that is, in a ward inappropriate for their condition simply because of the unavailability of a more appropriate bed.<sup>45</sup> These patients are called “outliers” and are less likely to receive the specialist medical and nursing attention that their condition needs.

- I was told of an example of this at Wollongong, where 241 patients in the recovery ward last year were not post-operative patients, but rather patients admitted through the Emergency Department who could not be allocated a bed, resulting in the recovery area being used inappropriately.<sup>46</sup>
- Similarly, I was told that stroke patients at Gosford Hospital are commonly found scattered throughout surgical and other medical wards, rather than the neurology ward.<sup>47</sup>

28.33 Clinicians at Tweed Heads, told me that they have experienced situations where patients who should be in intensive care or the high dependency unit are being nursed on the wards, and Emergency Department doctors are looking after critically unwell patients for prolonged periods of time trying to get them into an intensive care or high dependency bed.<sup>48</sup> In response, intensive care clinicians at Tweed Hospital attempt to look after critically unwell patients on the ward via an outreach service from the intensive care, trying to make an intervention that will hopefully prevent them having to go to the intensive care. However, I was told that as the hospital grows, the logistics of this becomes almost impossible.<sup>49</sup> Of this situation, I was told that there appear to be no plans as to how the situation is going to be managed in the future.<sup>50</sup>

28.34 I heard evidence that this ‘outlier’ phenomenon has led to instances of patient mortality where the signs of patient deterioration were not detected by staff unfamiliar with the

condition for which such a patient was being treated. I was told of research that shows that morbidity and mortality of patients who experience myocardial infarction is improved if they are in coronary care units.<sup>51</sup> Similarly, for stroke patients, a senior staff specialist told me that evidence shows that placing them within a stroke unit reduces the incidence of morbidity and mortality.<sup>52</sup> Professor Paddy Phillips informed me of evidence from Flinders Hospital that the mortality rate for outliers is twice that of other patients.<sup>53</sup>

- 28.35 I heard evidence that the 'outlier' phenomenon also leads to increased patient length of stay. A clinician described to me how if patients are not in a home ward, it makes it difficult to do efficient ward rounds, adequately supervise junior staff, assemble staff to co-ordinate treatment, and communicate treatment information and discharge information.<sup>54</sup> The gravity of this became evident to this particular clinician when a geriatric ward was opened at Gosford, where geriatric services had previously been spread throughout the hospital. After the geriatric ward was opened, the clinician said,

"Our length of stay within 3 weeks went from 13 days to 7.9 days. We did nothing else apart from meet together and work in a coordinated fashion."<sup>55</sup>

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- 28.36 I was told that a hospital executive at Gosford, a few years ago, demonstrated that placing patients in a ward other than the home ward increased the lengths of stay by 1 to 2 days. It was an important issue both for quality of care and length of stay to get patients "on to the home ward from their first admission".<sup>56</sup> Another doctor informed me that,

"the Health Department has its own figures which show that if patients are managed outside of the speciality or home ward, they have increased length of stay, increased morbidity and even increased mortality."<sup>57</sup>

### Implications for patient recovery and dignity

- 28.37 I heard evidence and received submissions that a lack of beds has led to men occupying women's wards, children occupying adult wards, and *vice versa*.
- 28.38 Of the "genderless wards",<sup>58</sup> a clinician said that they reduce personal dignity and mean that some patients have the curtains drawn around their beds for most of the time.<sup>59</sup> In a written submission, Ms Armelle Swan described to me her unpleasant experience of being admitted into a mixed-gender room. She explained that she felt vulnerable and feared for her security, leading to personal emotional distress. She said that her privacy was jeopardised because of this and she felt that it prevented her from openly discussing issues with her doctor.<sup>60</sup>
- 28.39 The Council on the Ageing (NSW) Inc and the Council of Social Service of NSW believe that mixed gender wards are inappropriate. Patients find mixed gender wards embarrassing and uncomfortable. Patients are put under stress in these situations, especially where fearful of the risk of sexual assault.<sup>61</sup> The Council on the Ageing recommends that NSW Health rethink this practice, in the interests of patients.<sup>62</sup>
- 28.40 She described mixed wards as:
- "...fundamentally unsafe, indecent and unacceptable..."
- 28.41 The purpose of patients being in hospital is to provide treatment with the aim of promoting rapid recovery. The use of "genderless" wards seems to me to take away from that purpose by adding fear, stress and anxiety to a patient's state of mind. Anything which is an impediment to, free and frank communication between a health

professional and a patient must be eliminated. Anything which places a patient when vulnerable at a risk of harm is unacceptable and must be removed.

- 28.42 In my opinion the use of mixed wards or “genderless” wards is an affront to the dignity of patients and a significant impediment to the delivery of good care. The practice ought cease forthwith.

**Recommendation 124:** *The policy which authorises, and the practice which gives effect to, using inpatient wards (except Intensive Care Units, High Dependency Units and Emergency Departments) to house both men and women in the same room, or separate ward space ought to cease forthwith.*

- 28.43 A consultant paediatrician raised concerns in a submission to me about the co-location of adults on the children's and adolescent's ward of the Sutherland Hospital. He raised the following issues that have resulted from the co-location:

- (a) nursing staff morale is poor because paediatric nurses are required to look after adults;
- (b) it is difficult for nurses to focus on paediatric nursing education when having to care for both children and adults;
- (c) medication errors are made, as paediatric nurses may be unfamiliar with "adult" medications;
- (d) safety concerns result from having "mixed" adult and child patients, as nurses may be unfamiliar with current adult nursing practice - there are documentation and resuscitation equipment "differences" with respect to the nursing of children and adults;
- (e) child protection issues attend co-location of adults and children; and,
- (f) children, on occasion, are denied admission to the children's ward as adult patients occupy the beds.<sup>63</sup>

- 28.44 From my visits to hospitals around the State, I observed that the practice described by Dr Glenn Stephens seems quite widespread, and is not just limited to Sutherland Hospital.

- 28.45 The Australian Confederation of Paediatric and Child Health Nurses, who also raised grave concerns about this practice, submitted to me that over 30% of Australian hospitals have indicated that they are not always able to accommodate children in areas separate from adults.<sup>64</sup>

- 28.46 I anticipate that the reforms which I propose for the creation of a child and young peoples health authority ought satisfactorily address the problem. It is clear, as with my views on “genderless wards”, this practice is risky and undesirable. It should also cease forthwith.

### Implications for staff

- 28.47 I heard evidence that a lack of beds presents a time-consuming problem for hospital staff, who are distracted from patient care by the task of thinking about how to get patients into a bed.<sup>65</sup>

- 28.48 As is clear from my discussions about Emergency Departments, a lack of beds impacts significantly on the stress on, and workloads of, staff in the Emergency Departments.

## What is a safe level of bed occupancy?

- 28.49 I was repeatedly told that the optimal occupancy level for beds is 85%.<sup>66</sup>
- 28.50 It seems to have become an article of faith. Most recently the Australian Medical Association in its November 2008 report, "Public Hospital Report Card 2008", argued that any level of occupancy in public hospitals which exceeded 85% was unsafe. It argued that:
- "The 85% rule should apply in every hospital."<sup>67</sup>
- 28.51 The AMA asserts it is the Australasian College of Emergency Medicine which has substantiated the validity of the "85% rule".<sup>68</sup>
- 28.52 The Australasian College of Emergency Medicine, produced a paper in April 2004 entitled "Access Block and Overcrowding in Emergency Departments", which seems to be the publication to which the AMA was making reference.<sup>69</sup>
- 28.53 At page 5 it reads:
- "Queuing Theory developed by Erlang nearly 100 years ago, tells us that systems are most efficient when they operate at 85% capacity. This applies to queues at the local bank waiting for a teller or at ticket booths at the MCG. It is no surprise that queuing theory also applies to acute care hospitals..."
- 28.54 The publication has footnoted the article by Bagust et al, entitled "Dynamics of Bed Use in Accommodating Emergency Admissions: Stochastic Simulation Model". This publication was also brought to my attention in many submissions and discussions.<sup>70</sup>
- 28.55 Some reflection on this article which occupies the central place in the support for the "85% Rule" is worthwhile.
- 28.56 The setting for the study was a hypothetical 200 bed acute hospital in England. The design for the study used a statistical model known as a discrete-event stochastic simulation model. The main outcome measures of the study were:
- the risk of having no bed available for any patient requiring immediate admission;
  - the daily risk that there is no bed available for at least one patient requiring immediate admission; and
  - the mean bed occupancy rate.
- 28.57 As I understand it, the results of the study showed:
- At or about an 85% mean bed occupancy level, a hospital can expect to be short of beds for admissions from the Emergency Department on 4 days in a year;
  - At or about a 90% mean bed occupancy level, a hospital can expect to have a crisis day (ie a day when at least one patient requiring admission cannot be accommodated) on about 15 days in a year (ie a 4% probability of a poor outcome);
  - At about 95% mean bed occupancy level, the probability of a poor outcome (ie a crisis day) is between 10% and 20% of the days in a year.
- 28.58 The authors of the article having acknowledged the inherent difficulties in evaluation, unless effects are monitored over a long time (5-10 years) or across a very large sample of hospitals, express this opinion:
- "Emergency admissions are ... difficult to predict. Our model shows that spare capacity is essential if an

emergency admission service is to operate efficiently and at a level of risk acceptable to patients. ... it must be recognised ... that maintaining some unoccupied staffed beds is not wasteful but is a cost which must be incurred if a quality service is to be sustained."

- 28.59 With this conclusion, I emphatically agree. However, the study provides no basis for any assertion about the safety of hospital services when an 85% mean bed occupancy rate is exceeded. It is, in my view, mischievous to suggest it does.
- 28.60 I note that 85% is the planned occupancy rate generally used by NSW Health in its projections for future demands for hospital beds.<sup>71</sup> The planning rate used by the NHS in the United Kingdom is 82%.<sup>72</sup>
- 28.61 Whilst it is entirely appropriate to use 85% mean bed occupancy rate as a planning figure, I have seen no material which suggests that occupancy becomes unsafe above this figure.
- 28.62 It will be borne in the mind that the term "safety" is usually used to represent a relative rather than an absolute concept. A level of risk may be acceptable, in some circumstances. An obvious example is that either driving, or else being a passenger in, a motor vehicle carries with it a level of risk. Whether it is unsafe is a matter of judgment which balances the risk against the possible consequences.
- 28.63 In my view, the study of Bagust et al raises an important and interesting question about the safe level of occupancy of a hospital. But more research, in the NSW context needs to be done before any actual conclusion can be reached. NSW Health ought commission a research project, the purpose of which is to establish what level of risk and safety, accompanying varying levels of bed occupancy within a hospital facility.
- 28.64 In my view, pending the result of any study, NSW Health should regard a safe level of bed occupancy as probably in the order of a maximum of 92% to 95% for each facility, and not measured on a state-wide basis. That is, if bed occupancy were calculated on a state-wide, or each area health service wide basis, facilities exceeding this limit would be obscured by the many facilities with occupancy levels in the 60<sup>th</sup> percentile. I would recommend that the occupancy level of a hospital should not be allowed to exceed the range of 92-95% until a study is undertaken to establish on a scientific basis the appropriate mean bed occupancy level.

**Recommendation 125:** *NSW Health should commission a research project, the purpose of which is to establish what levels of risk and safety accompany varying levels of bed occupancy within a hospital facility, in order to determine a desirable bed occupancy level for NSW public hospitals.*

### Inability to accept transfers

- 28.65 The provision of medical services in NSW hospitals is based upon only a proportion of those hospitals providing tertiary levels of care, and patients from smaller hospitals requiring such care being transferred to tertiary hospitals in a timely way.
- 28.66 However, this system breaks down when the tertiary or referral hospitals have no vacant beds to accept such transfers. I heard evidence that this is happening, particularly in respect of intensive care beds. The intensive care unit at Wollongong, for example, operates at greater than 100% occupancy. It refuses up to 40 admissions per year and is no longer able to accept deteriorating patients from other hospitals.<sup>73</sup> Similarly with Royal Prince Alfred Hospital, I was told that a lack of resources, especially

beds, is affecting the transfer of acutely ill patients from rural and remote hospitals. More frequently, they are having to decline these transfers because of a lack of beds or intensive care beds.<sup>74</sup> Others spoke of a similar difficulty, including arranging transfer from smaller urban facilities.<sup>75</sup>

- 28.67 There is a related difficulty in transferring a patient to their usual hospital after treatment in another facility, for the same reason.<sup>76</sup>

### Implications for surgery

- 28.68 A lack of available beds, either in intensive care, high dependency units, speciality wards or at all, means that surgery has to be cancelled as there is nowhere for the patient to go to recover from the surgery.<sup>77</sup> A U.K Department of Health report found that hospitals with higher average bed occupancy rates cancelled a greater proportion of elective operations.<sup>78</sup> I was told that 60 patients for day surgery at the Children's Hospital, Westmead were cancelled in a month due to a lack of beds in intensive care.<sup>79</sup> Similarly, an anaesthetist at Royal North Shore Hospital informed me that because of inadequate numbers of beds in the cardiothoracic unit, heart operations are routinely cancelled.<sup>80</sup> Such cancelled surgery sometimes leads to a situation where nurses, surgeons and anaesthetists are left with nothing to do, not to mention the effect on the patient and their family who have prepared for the surgery.<sup>81</sup> It is little wonder that clinicians view this as a "phenomenal waste of resources".<sup>82</sup>

- 28.69 I heard evidence that cancellation of surgery is occurring particularly in the overloaded major regional hospitals.

- A specialist vascular surgeon at Port Macquarie told me that surgery is disrupted every day due to a lack of beds in the hospital or in intensive care. She estimated that about 20-30% of her planned surgeries had been cancelled in the 6 months preceding her evidence.<sup>83</sup>
- Liverpool Hospital intensive care apparently experiences bed occupancy of 100-120%, regularly causing cancellation of up to 3 surgeries per week.<sup>84</sup>
- Similarly, I was told that Concord Hospital experiences elective surgery cancellations because of an inability to free up space in intensive care.<sup>85</sup> A clinician complained that the 'fat in the system' has been taken away to the point where a bed shortage poses problems for transferring patients from Emergency Departments to intensive care and from intensive care to wards. This means that intensive care has no alternative but to maintain patients that are able to move into a normal bed, but for the blockage.<sup>86</sup>
- I received evidence that Wollongong Hospital, too, cannot keep pace with the demand for elective surgery. I was told by a clinician of the figures for the 2007 calendar year, which demonstrate that the lack of ward beds is causing exit block from recovery: there were 9,335 surgical patients at Wollongong Hospital, of these 834 patients remained in recovery over night, and 150 of these patients remained in recovery for more than 24 hours.<sup>87</sup> This clinician went on to say that a lack of intensive care and high dependency beds causes major surgery to be cancelled or delayed. He informed me that when surgery is delayed until very late in the day at a point where a high dependency bed becomes available, the patient is recovered in the evening when there is a relative lack of supervision.<sup>88</sup>

"A large part of my day is spent re-organising theatre lists to compensate for the confusion and disorganisation that results from a lack of ICU/HDU beds which usually occurs because of a lack of ward beds, so we have patients in HDU that have been discharged medically but cannot be moved on because of a lack of ward beds".<sup>89</sup>



## Finding a bed

- 28.70 I have separately discussed the problem of moving patients from the Emergency Department to a hospital ward in a timely fashion due to the unavailability of an inpatient bed. Similar problems occur with moving patients out of Intensive Care into a general hospital bed.<sup>90</sup> I received evidence that up to 50% of intensive care patients at RPA Hospital may experience difficulties of this kind during the winter period.<sup>91</sup>
- 28.71 Whether it be moving a patient within the hospital, or between hospitals, a recurring complaint from clinicians was the problems finding a bed – numerous phone calls had to be made by doctors and this was, rightly, regarded as a poor use of their time.<sup>92</sup> It was brought to my attention that default referral guidelines are often ineffective because the receiving hospital is often too full to accept the patient.<sup>93</sup>
- 28.72 The implications of this are very significant.
- 28.73 I was informed that referral hospitals sometimes throw up barriers to prevent transfers, such as refusing a transfer on the grounds that there is no definite diagnosis (a catch-22 situation where the smaller hospital does not have the facilities to obtain a definite diagnosis, eg. because it lacks specialised imaging facilities), or refusing on grounds that the patient has not been seen by a specialty consultant (even though the consultant has advised transfer based on the information provided by the Emergency Department).<sup>94</sup> This indicates that referral or transfer will not be based on what is best for the patient but rather who is best at persuading the receiving hospital. It also leads to over-stating the seriousness of the clinical condition in order to secure a bed.
- 28.74 Some solutions to this problem were offered to me in the course of my Inquiry.
- Dr Brock, a career medical officer, suggested measures to encourage full disclosure of empty beds to the Emergency Department (in the UK, failure to declare an empty bed can be the subject of disciplinary action).<sup>95</sup>
  - Dr Marinucci proposed a centralised state bed management system.<sup>96</sup>
  - Similarly, Dr Golding suggested the establishment of a central body to take responsibility for finding a bed.<sup>97</sup> Dr Golding further recommended a system of mandatory acceptance by tertiary hospitals where the patient requires specialist service that the referring hospital cannot provide and the referring hospital has been unsuccessful in finding a bed within a maximum set timeframe.<sup>98</sup> This later point was supported in a confidential submission that suggested that unnecessary transfers could be prevented by a rigid consultative process, potentially with the aid of a developed tele-medicine communication system network, to ensure that transfer is necessary.<sup>99</sup>
- 28.75 To some extent, where a patient is being transferred by air, the Aeromedical and Medical Retrieval Service of the NSW Ambulance Service will assist in finding a bed.
- 28.76 This seems to me to be an area in which technology can assist.
- Technology is currently being utilised for this purpose by the neonatal unit at Royal Prince Alfred Hospital, for example. This unit has access to a “Perinatal Resource Summary” - a computer system showing the beds available at all units across the state including the A.C.T.<sup>100</sup>
  - The Cumberland Hospital uses a computer system, ‘FirstNet’, to view a real-time list of mental health patients at various Emergency Departments in its area, enabling them to pull these patients out of those departments and admit them in a timely way.<sup>101</sup>



- I was told of a “one number to call” system that is being utilised in Ontario to assist the patient flow issue. Where a doctor has a critically ill patient for whom they don’t have the capability or capacity to manage, the doctor can call this number to be connected to a centralised department. The department is linked to an information system that enables them to see where beds are available. The department then facilitates communication between the hospitals to discuss the transfer of the patient.<sup>102</sup>

## Discharging patients from hospital

- 28.77 A key blockage in getting patients into a bed is getting existing patients, who have completed their hospital treatment, discharged, so that the bed becomes available. This appears to be surprisingly difficult to do in an efficient manner. Without detracting from the need for more beds in some hospitals, improvements in the area of discharge may ameliorate the shortage of beds to some extent. Professor Stephen Leeder put it this way:

"For a hospital with 350 beds, reducing the occupancy rate from 95% to 85% would require an increase of 40 beds or a reduction in bed days of 35 every day. Alternatively, the pressures and risks faced by public hospitals could be alleviated if the average length of stay for every admission was shortened by less than a day".<sup>103</sup>

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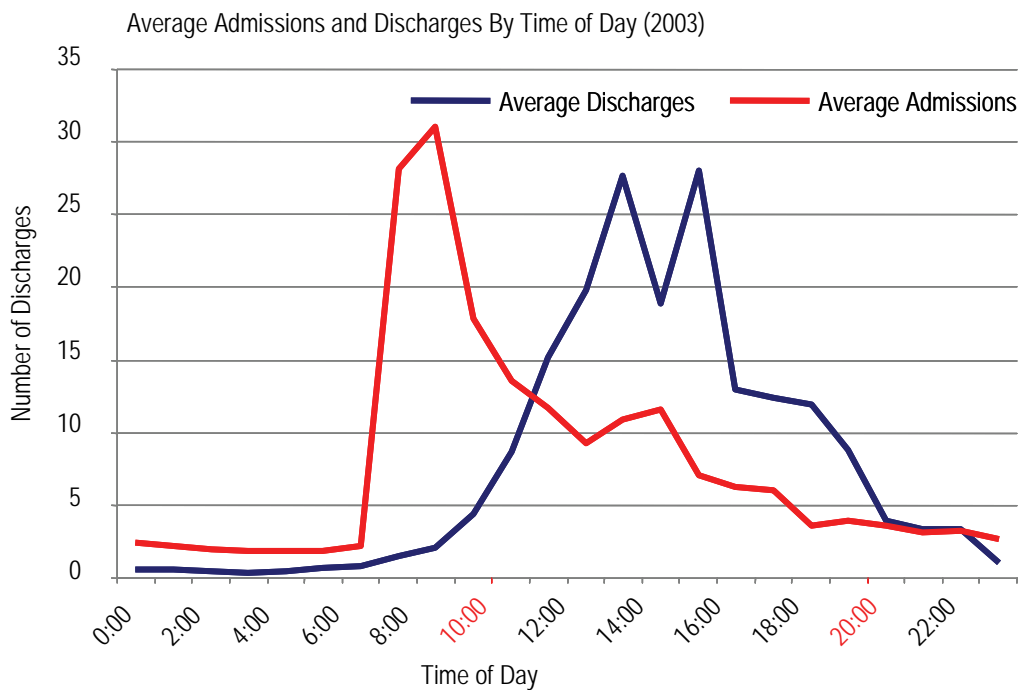
- 28.78 I was informed of a variety of tools used by hospitals to increase the efficiency of discharging patients.
- Some hospitals such as Blacktown Hospital have a “patient flow unit”, which uses an electronic medical record system to manage patient flow and facilitate admission. Patients are colour coded depending on how long they have been in hospital. I was informed that the target is to have each patient out within 5 days. The system allows for each patient’s care plan to be viewed and allows clinically qualified managers to remotely supervise activity levels to identify any issues such as a high percentage of patients exceeding the target stay. Where issues are identified, managers discuss them with the relevant medical team.<sup>104</sup> Some submitted that these units are unsatisfactory because they shift bed management considerations from patient care to management concern.<sup>105</sup> However, the Blacktown example, which builds in a clinician consultation process, suggests otherwise.
  - Mona Vale Hospital takes a very proactive role in ensuring transport issues do not delay discharge, by starting to organise the patient’s transport in the days leading up to the estimated date of discharge. The hospital purchased a bus to help organise transport home in a timely manner.<sup>106</sup>
  - I was informed of initiatives at Port Macquarie Base Hospital, such as the Preadmission Clinic and expansion of the Acute Pain Service, which have allowed the Hospital to manage increased productivity by reducing demand for inpatient beds and reducing duration of a patient’s post-operative stay.<sup>107</sup>
- 28.79 Some hospitals use discharge lounges, to which patients are moved from an inpatient bed and into a lounge chair while discharge paperwork and procedures are completed. I think that although this idea is not without some critics, this is a good idea provided that adequate monitoring of the patient is continued.<sup>108</sup>

*Use of discharge planners*

- 28.80 It was suggested to me that the use of discharge planners is a good idea.<sup>109</sup> Discharge planners facilitate a more rapid discharge by, for example, addressing a patient's mobility problems on day one, rather than day 5 when they are about to be discharged.<sup>110</sup>
- 28.81 Some submitted that more discharge planners are needed to capitalise on the important function they carry out.<sup>111</sup> I was informed that a lack of discharge planners at Broken Hill Hospital has implications for Aboriginal people going back into their communities, in particular organising the care that they need to get once they are back in those communities.<sup>112</sup> Clearly, to be effective, discharge planners need to be able to effectively interact with community services.
- 28.82 However, the main problems appear to me to be matching discharge and admissions times.

**Matching discharge and admission times**

- 28.83 In most hospitals, most patients occupying beds in hospital wards are not discharged until the afternoon.<sup>113</sup> This means that beds do not become available on the hospital ward for patients being admitted from the Emergency Department until late in the day.<sup>114</sup> Unfortunately, these beds are required from early in the morning – particularly between 6am and noon.<sup>115</sup> This is demonstrated in the following diagram which is also set out in Chapter 20:<sup>116</sup>



- 28.84 What this graph clearly shows is this:
  - The major peak time for admissions from Emergency Departments is at about 8am;
  - A smaller peak occurs at about 2pm;
  - The majority of discharges happen between 1pm and 4pm;
  - The timing of the need for admissions, and occurrence of discharge is discordant.

- 28.85 The time for discharge needs to be brought forward, so as to match, or be earlier than, the time when beds for admissions are needed.
- 28.86 This was supported by evidence I received in relation to Westmead Children's Hospital, and information I received from the Manager of the Sydney Operations Centre of the NSW Ambulance Service.<sup>117</sup>
- 28.87 Mr Alchin, a patient flow nurse manager from Gosford Hospital, said:
- "I think that if we had a better strategy for getting patients out at an earlier time, we would probably manage the Emergency Department a lot better, and that queuing effect that happens in the Emergency Department where we have no bedded patients in the morning but the peak period starts at about 11.00 a.m. when ambulances start to come and so do their patients, and we really struggle in that period between 11.00 a.m. and 3.00 or 4.00 in the afternoon. If we don't get over that period, we struggle well into the evening as well."<sup>118</sup>
- 28.88 A similar problem occurs because patients need to be, and are, admitted to hospitals 24 hours a day, 7 days a week whereas patients tend to only be discharged from hospital during business hours from Monday to Friday. Consequently, a lack of available beds is a problem which tends to occur more frequently in the evenings and on weekends which, coincidentally, is when proportionately more emergency cases are brought to hospitals.<sup>119</sup> As an example, I was informed that the Liverpool Hospital intensive care experiences exit block for 60% of patients on weekends and after hours.<sup>120</sup> It was suggested to me that access block from the Emergency Department would be greatly assisted if there were greater rates of weekend discharges of patients from inpatient wards.<sup>121</sup>
- 28.89 Peak time for discharge patients from hospital wards needs to be in the morning and discharge needs to happen on each day of the week. This can be achieved by changing work practices. I have discussed this issue in Chapter 20 as discharge practices directly affect patient flow through the Emergency Department. As noted in that chapter, the challenges that need to be addressed to ensure effective, safe and timely discharge include:
- requiring consultants to do ward rounds more frequently and in the first part of the morning so that patients may be discharged in a timely fashion;
  - establishing an estimated date of discharge on the first day a patient is admitted to a ward. This enables clinicians to work towards this date, together with the patient and his or her family or carer, by arranging the multitude of tasks which need to be completed before a patient can be discharged;
  - establishing protocols which permit patients to be discharged by a junior doctor or senior nurse in certain circumstances without the need for the consultant to specifically 'approve' discharge;
  - ensuring that all processes for discharge are well planned in advance.
- 28.90 To summarise the conclusions I reach in Chapter 20, it seems to me that universal documentation of estimated date of discharge, coupled with well defined protocols empowering registrars and, in appropriate cases, senior nurses to discharge patients, will assist to reduce bottlenecks due to lack of discharge planning.
- 28.91 NSW Health policy already requires that an estimated date of discharge be established at the time of admission for elective patients and within 48 hours of admission for patients admitted through the Emergency Department. The issue is therefore one of compliance. Also, for reasons discussed in Chapter 20, I consider that it should be

possible for hospitals to exploit the broad range of information they already collect about patients for the purposes of estimating a date of discharge in appropriate cases.

- 28.92 All processes for discharge need to be well planned and in advance (to avoid, so far as practicable, patients being told that they can leave hospital “today”). I am convinced that this will have a significant affect on the availability of beds by freeing up beds earlier, and more frequently, than is presently the case.

### Feedback to clinicians

- 28.93 I was told that some patients have a longer stay in hospital than expected due to the practices of some consultants. This problem may be partially addressed by establishing protocols of care and estimated dates of discharge (as discussed above and in Chapter 20). It would also assist, it seems to me, if management of hospitals provided clinicians with timely information about patient length of stay, so that individual clinicians could see whether there is any problem with the discharge process in respect of their patients. The data would allow clinicians to examine relationships between patterns of lengths of stay and clinical factors and thereby address delays in service provision.<sup>122</sup>
- 28.94 I was made aware that this is not, in fact, happening generally.<sup>123</sup> It was claimed that the result of this, insofar as discharging patients goes, is that:

“the doctors do not seem to have the sense of urgency that nurses are under”.<sup>124</sup>

- 28.95 It was suggested to me by 2 nurse unit managers that management should pursue medical staff rather than nurses in relation to reducing length of stays as the doctors are the ones who determine when patients are discharged:

“There seems to be reluctance to individually approach them about their length of stay. Some people have an exorbitantly long length of stay, but no one seems to be taking that on.”<sup>125</sup>

- 28.96 These same nurse unit managers described to me their experience of a situation where this practice was, at one time in the past, taking place in a particular hospital. They informed me of how comparisons of patient lengths of stay for each doctor were given to visiting medical officers and nurse unit managers for discussion. They also informed me of how a previous executive general manager of the hospital used to individually discuss length of stay statistics with the physicians to assess whether there were any problems that could be overcome with his help. The nurse unit managers said that this was no longer taking place, but considered both of these practices to be helpful.<sup>126</sup>
- 28.97 The practice of feeding data back to individual clinicians is, in my opinion, a good idea.

**Recommendation 126:** *Within 18 months, NSW Health should ensure that area health services provide to clinicians every 6 months information about their patients’ lengths of stay and comparable data with their colleagues in the hospital.*

### Waiting for sub-acute accommodation

- 28.98 I have already discussed the widespread problems of discharging elderly patients in a timely fashion, caused by lack of aged care beds, delays in ACAT assessments or Guardianship Tribunal hearings.

- 28.99 I heard of similar delays whilst patients waited for a rehabilitation or palliative bed.<sup>127</sup> For example, I was told that, on any given day, there could be 15 to 20 patients at Gosford Hospital waiting for transfer to a sub-acute facility.<sup>128</sup> I was told by a nurse unit manager that such people sometimes have to essentially be rehabilitated on the ward until they can be sent home.<sup>129</sup>
- 28.100 In relation to palliative care, I was informed by a clinical nurse consultant of a ward that three quarters of the patients were in his opinion palliative care patients, who would be better placed elsewhere.<sup>130</sup> He described that these patients were unable to move on to their place of choice outside the hospital, however, because of a lack of resources, at those places.
- 28.101 He said that more and more people were coming back into acute hospital settings and the system is “being gridlocked” by patients who are unable to move on to their place of choice. The nurse informed me that palliative care facilities are driven by short stays, so if a patient’s life expectancy is too long, they may have no alternative but to stay in the hospital. The nurse described a situation where a patient stayed in the hospital for 5 months because of this. This particular patient, I was told, had needs that were too complex for a nursing home. It was not until the patient was actually in the terminal stages of the illness that he could be moved to a palliative care bed. The nurse suggested that there is a need for more facilities for long-term palliative patients with complex needs.<sup>131</sup>

### Severely disabled young

- 28.102 A group of patients who appear to have largely become invisible are those severely afflicted by brain damage or physical disability, but who are too young to qualify for an aged care bed.
- 28.103 Some examples of such patients that I heard evidence about included:

#### *Patients with long term ventilation needs*

- 28.104 I received evidence which said that there is a lack of community services for ventilated quadriplegics. A physiotherapist informed me that such people need 24-hour nursing care, but there is nowhere to which they can be discharged.<sup>132</sup>
- 28.105 I was told by a nurse practitioner of a unit that has been set up at the Children’s Hospital, Westmead to help support the transition of, and engage their families to be able to care for, children with long-term ventilation needs in the community. I was informed that NSW Health provides some funding for these children to receive essential respiratory equipment and respite care. However, I was informed that a difficulty still remains with securing ongoing therapy and other services for these children from services within their communities.<sup>133</sup>
- 28.106 This difficulty was described to me through the example of a young girl who required long term ventilation. I was told that she was in intensive care for 400 days before being sent to a ward. She remained in hospital for 4½ years before she was discharged to her home for long-term ventilation with the assistance of the then newly introduced funding by NSW Health. I was told that the long term ventilation unit at Children’s Hospital, Westmead is now trying to work with the Department of Housing and the Department of Education in order to support the family with housing and schooling. The child was ready to be discharged from hospital anywhere from 2.5 years before they were able to discharge her into the community.<sup>134</sup>

*Young patients who are severely disabled*

- 28.107 I received much evidence that suggested that there are very limited options for permanent care for children and young people with severe developmental disabilities who cannot be discharged to the community due to the complexity of their needs and a lack of community support services.<sup>135</sup> I was told that residential care places are extremely limited and that it is very difficult to secure nursing home placements for these people, which may not necessarily be appropriate in any event.<sup>136</sup>
- 28.108 As a result it is necessary for these young people to either remain in hospital wards for months at a time or to be cared for by their families who may not have the capacity or support to do so.<sup>137</sup> In one example I received, a particular woman was an inpatient in a hospital for nearly 12 months whilst waiting for a group-housing place.<sup>138</sup>
- 28.109 I heard of a woman who is under 40 but suffers from intellectual impairment and severe liver disease due to alcohol abuse. She is incapable of living an independent life. The woman is too young for the aged care system. She has nowhere to go outside of the hospital. However accommodating her in an acute care bed costs between \$800 to \$1,000 per day and ties up the acute care bed.<sup>139</sup>

*Wheelchair-bound patients*

- 28.110 I was also told that a common cause of delay in discharging wheelchair bound patients is a lack of public housing with wheelchair accessibility.<sup>140</sup>

*Huntington's disease*

- 28.111 I was told that a similar issue exists in relation to young people with Huntington's disease, where it is very difficult to find community care packages for post-acute care.<sup>141</sup> As a result, I was told that the Huntington's Disease Service at Westmead Hospital has over 100 young people placed in a variety of aged care facilities. I was told that it is increasingly difficult to obtain this kind of care and so the provision of acute care ends up with the young person an inpatient in the public hospital.<sup>142</sup>

*Patients with brain injuries*

- 28.112 I was told of the difficulty experienced in relation to discharging young patients with acquired brain injuries due to a lack of adequate services.<sup>143</sup>
- I was made aware of an example of a patient who spent 18 months in the neurology ward of Westmead Hospital because there was no other place for this young person to go.<sup>144</sup>
  - Another example given to me was that of a 9 year-old girl with a serious brain injury that resulted from uncontrollable seizures. After an extensive period in intensive care, she was moved to a ward. I was told by a clinical nurse consultant associated with her care that in the adult world she would be transferred to a nursing home, but there is no such facility for children. Due to the complexity of her needs, the nurse explained that understandably the family don't have the confidence to take her straight from the acute care facility home. I was told that the family has been attempting to negotiate with their local hospital to get her back there, but this is proving to be extremely difficult since the nursing staff there have very limited resources and it would be very difficult for them to accept a girl with such complex support needs.<sup>145</sup>



- More generally too, I was told by a doctor at Camden Hospital that a significant number of patients between the ages of 40 and 60 who are cared for at the hospital for brain injury related conditions would not necessarily need to receive treatment by the hospital if there were adequate community placements.<sup>146</sup>

- 28.113 Because these patients are not elderly, they do not qualify for aged care places in nursing homes funded by the Commonwealth Government.<sup>147</sup> But nor does there appear to be an adequate provision of facilities in the community. As a consequence, NSW public hospitals become the default care provider for these patients.<sup>148</sup> Long term accommodation in a public hospital is obviously not cost effective – I was informed that the average daily cost of providing continuing care in these circumstances amounts to \$616 per day and in some settings this may be higher.<sup>149</sup> Nor is hospital accommodation at all suitable for a patient, who needs personal care in a non-hospital setting.<sup>150</sup>
- 28.114 It appears to me that a state-wide assessment needs to occur of the accommodation needs of these patients, both in terms of type of accommodation and the number of beds, so that these patients can be provided with long-term sub-acute accommodation suitable to their needs, including rehabilitation and socialisation. This ought result in the freeing up of a not insignificant number of beds within the acute care section in public hospitals.
- 28.115 According to a progress report of the implementation of the Department of Ageing, Disability and Home Care's policy, *Stronger Together: A New Direction for Disability Services in NSW 2006 – 2016*,<sup>151</sup> it appears that some advances are being made in this area.<sup>152</sup> It is apparent from the evidence given to me that these improvements are, however, far from adequate to address the situation in the near future.

## Conclusion

- 28.116 It will be clear to the reader that I have not yet answered the question which I asked at the outset, namely, are there enough beds.
- 28.117 On one view, whilst ever there is a waiting list for hospital inpatient services, or there is a queue of any length, it can be argued that there are insufficient beds to cater for the health of the people of NSW.
- 28.118 But this argument is to set the level of service to be provided, so it seems to me, at too high a level. NSW (and no other state in Australia) can afford a health system where there are no queues for admission to a public hospital and no waiting lists for health care services.
- 28.119 Rather, the question is more likely to be appropriately expressed as whether, in providing a safe health care service of a good quality through the public hospital system for the people of NSW, that service can be provided reasonably efficiently and in a cost effective and sustainable way.
- 28.120 Clearly, in some particular hospitals there are more than enough beds. For example, some hospitals, particularly rural hospitals, have occupancy rates of 50% to 60%. Their occupancy rarely exceeds 75%. Clearly for the services being provided in these hospitals there are enough beds.
- 28.121 On the other hand, as I have alluded to earlier in this report, some hospitals are operating at or above an occupancy rate of 100%. Clearly these hospitals do not have enough beds for the level of service which is being provided.



- 28.122 Throughout this report I have made comments about and recommendations with respect to improving the way in which public hospitals operate. These recommendations and suggestions will, I anticipate, have a significant effect on the availability of beds in hospitals. By way of example and without needing to be specific about particular numbers, a re-arrangement of the times of discharge and admission will mean that extra beds will become available. As well reduction of variations in treatment by reference to standard models of care or protocols will also free up a significant number of beds. Ensuring that changes are made to enable the discharge of patients to aged care facilities, where they will be better cared for, will also free up a significant number of beds.
- 28.123 However, given that the demand for hospital beds generally exceeds the available supply, it is hard to escape the conclusion that these efficiencies will serve only to cater for existing demand and existing waiting lists and thereby enable a greater through put of patients who require services.
- 28.124 Such benefits as one might expect from these efficiencies are unlikely, in most very busy hospitals, to cater for the projections dealing with population growth. Earlier in this chapter I drew attention to the conclusions of the HARDS Report which suggests that there is a need for an additional 341 beds per year to 2011 rising to 386 beds per year to 2016,<sup>153</sup> which are anticipated to deal with the projected population growth in NSW.
- 28.125 Doing the best I can, on the basis of the evidence and material which I have received, it seems to me that it will be necessary for NSW Health to increase its bed base by about the numbers projected in the HARDS Report. It is difficult for me to be precise because, necessarily, time will need to pass to study the effects of any reforms which are brought into existence consequent upon this report.
- 28.126 However, it is tolerably plain that a combination of increased through put and escalating demand by reason of population growth cannot be addressed by efficiencies only and will require an increase in the bed base. Such an increase ought be part of the regular and standard planning for the delivery of health services in NSW for the foreseeable future.

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- <sup>1</sup> Letter from NSW Health to Special Commission of Inquiry, 13 March 2008. NSW Health, *Bed Types Categories for Inpatient Units from 1 March 2008*, PD2008\_034: see domain definition for 'Hospital in the Home – General' and 'Same Day Renal Dialysis'.
  - <sup>2</sup> Letter from NSW Health to Special Commission of Inquiry, 13 March 2008. Steering Committee for the Review of Government Service Provision, *Report on Government Services 2008, Volume 2*, Productivity Commission, Canberra at 10.9: see Figure 10.5, quoting the *National Health Data Dictionary*.
  - <sup>3</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008. The quoted bassinet cost is exclusive of GST. The quoted ICU bed cost was based upon 2005/06 figures.
  - <sup>4</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008.
  - <sup>5</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008.
  - <sup>6</sup> NSW Government, The Treasury, Office of Financial Management, *Budget Estimates 2008-09* at 12 – 14, [http://www.treasury.nsw.gov.au/\\_\\_data/assets/pdf\\_file/0012/11424/bp3\\_12health\\_n.pdf](http://www.treasury.nsw.gov.au/__data/assets/pdf_file/0012/11424/bp3_12health_n.pdf).
  - <sup>7</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 20.39.
  - <sup>8</sup> John Harkness, St Vincent's Hospital hearing, 30 April 2008, transcript 2427.11.
  - <sup>9</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 20.8-12.

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- <sup>10</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 20.12-15.
- <sup>11</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 20.36-38.
- <sup>12</sup> Organisation for Economic Co-operation and Development, *Health at a Glance 2007: OECD Indicators*, p. 62.
- <sup>13</sup> Australian Government Department of Health and Ageing, *The State of Our Public Hospitals: June 2008 Report* at 11. Organisation for Economic Co-operation and Development, *Health at a Glance 2007: OECD Indicators*, p. 63.
- <sup>14</sup> Letter from NSW Health to Special Commission of Inquiry, 13 March 2008.
- <sup>15</sup> Submission of Professor Stephen Leeder, Australian Health Policy Institute, 28 March 2008, SUBM.044.0107 at 110.
- <sup>16</sup> Australian Government Department of Health and Ageing, Commonwealth of Australia, *The State of Our Public Hospitals: June 2008 Report* at 11.
- <sup>17</sup> John Harkness, St Vincent's Hospital hearing, 30 April 2008, transcript 2427.18-22.
- <sup>18</sup> Submission of Professor Stephen Leeder, Australian Health Policy Institute, 28 March 2008, SUBM.044.0107 at 110-112.
- <sup>19</sup> Submission of Professor Stephen Leeder, Australian Health Policy Institute, 28 March 2008, SUBM.044.0107 at 112.
- <sup>20</sup> NSW Health, *Special Commission of Inquiry Presentations: Sustainable Access Health Priority Taskforce*, 5 June 2008, p. 2; Dr Michael McGlynn, Sydney Children's Hospital hearing, 19 May 2008, transcript 3089.26-31. Harges and Associates, *Acute Hospital Demand Projections – 2006/2007 Base Update*, November 2007.
- <sup>21</sup> NSW Health, Media Release: *Health Investment Delivers Better Patient Care*, 3 June 2008 [http://www.health.nsw.gov.au/news/2008/20080603\\_02.html](http://www.health.nsw.gov.au/news/2008/20080603_02.html). NSW Government, The Treasury, Office of Financial Management, *Budget Estimates 2008-09* at 12 – 14 <[http://www.treasury.nsw.gov.au/\\_data/assets/pdf\\_file/0012/11424/bp3\\_12health\\_n.pdf](http://www.treasury.nsw.gov.au/_data/assets/pdf_file/0012/11424/bp3_12health_n.pdf)>
- <sup>22</sup> Dr Michael McGlynn, Sydney Children's Hospital hearing, 19 May 2008, transcript 3089.31-32.
- <sup>23</sup> Dr Dean Fisher, Dubbo hearing, 19 March 2008, transcript 653.35-46.
- <sup>24</sup> Susan Saunders, Coffs Harbour hearing, 27 March 2008, transcript 1008.38-1009.06.
- <sup>25</sup> Dr Judith Branch, St Vincent's Hospital hearing, 30 April 2008, transcript 2469.4-10.
- <sup>26</sup> Dr Simon Roger, Gosford hearing, 10 March 2008, transcript 127.19-25.
- <sup>27</sup> Dr Peter Collett, Liverpool hearing, 17 April 2008, transcript 1817:30-38.
- <sup>28</sup> NSW Auditor-General, *Auditor-General's Report to Parliament 2008, Financial Audits, Volume 1*, p. 24.
- <sup>29</sup> Demaris Wickham, Nepean Hospital hearing, 8 April 2008, transcript 1388.32.
- <sup>30</sup> Dr Ian Incoll, Gosford hearing, 10 March 2008, transcript 47.13-16.
- <sup>31</sup> Letter from NSW Health to Special Commission of Inquiry, 13 March 2008 (DOH.055.0185). This figure includes all A1-C2 facilities and reflects all admitted patient activity.
- <sup>32</sup> NSW Auditor-General, *Auditor-General's Report to Parliament 2008, Financial Audits, Volume 1* at 24.
- <sup>33</sup> NSW Auditor-General, *Auditor-General's Report to Parliament 2008, Financial Audits, Volume 1* at 24.
- <sup>34</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008.
- <sup>35</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008.
- <sup>36</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008.
- <sup>37</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008.
- <sup>38</sup> Angela Monger, Gosford hearing, 10 March 2008, transcript 139: 5-10.
- <sup>39</sup> Dr Randall Greenberg, Dubbo hearing, 19 March 2008, transcript 643.44-644.12.
- <sup>40</sup> Confidential submission, 20 May 2008, SUBM.040.0127.
- <sup>41</sup> Demaris Wickham, Nepean Hospital hearing, 8 April 2008, transcript 1388.34-38.

- <sup>42</sup> Vittorio Cintio, Nepean Hospital hearing, 8 April 2008, transcript 1374.14-20. Peter Collett, Liverpool hearing, 17 April 2008, transcript 1817.38-41.
- <sup>43</sup> Confidential submission, 25 March 2008, SUBM.009.0150 at 154.
- <sup>44</sup> Submission of Dr Richard Cracknell, 3 March 2008, SUBM.003.0202 at 209-210. Submission of Professor Stephen Leeder, 28 March 2008, SUBM.044.0107 at 113. Letter from Sarah Bennett, Australasian Medical Association (NSW) Ltd to The Executive Officer, Special Commission of Inquiry, 22 July 2008. Confidential submission, received 8 April 2008, SUBM.036.0087 at 090. The relevant studies identified include: Cunningham JB et al, "Bed Occupancy and Turnover Interval as Determinant Factors in MRSA Infections in Acute Settings in Northern Ireland: 1 April 2001 to 31 March 2003" (2005) 61 *Journal of Hospital Infection*, 189-193; Borg MA, "Bed Occupancy and Overcrowding as Determinant Factors in the Incidence of MRSA Infections Within General Ward Settings" (2003) 54 *Journal of Hospital Infection*, 316-318; Department of Health (UK), *Hospital Organisation, Specialty Mix and MRSA*, Report No. 9163 (December 2007); Richardson DB, "The Access-Block Effect: Relationship Between Delay to Reaching an Inpatient Bed and Inpatient Length of Stay" (2002) 177 *Medical Journal of Australia* 492-495; Sprivulis PC et al, "The Association Between Hospital Overcrowding and Mortality Among Patients Admitted Via Western Australian Emergency Departments" (2006) 184 *Medical Journal of Australia*, 208-212; and, Richardson D, "In crease in Patient Mortality at 10 Days Associated with Emergency Department Overcrowding" (2006) 184 *Medical Journal of Australia*, 213-216.
- <sup>45</sup> Vittorio Cintio, Nepean Hospital hearing, 8 April 2008, transcript 1374.14-20.
- <sup>46</sup> Dr Liam Grundy, Wollongong hearing, 14 April 2008, transcript 1624.03-1625.02.
- <sup>47</sup> Dr Scott Whyte, Gosford hearing, 10 March 2008, transcript 92:30-40.
- <sup>48</sup> Dr Barry Rigby, Tweed Heads hearing, 29 April 2008, transcript 2340.41-2341.09.
- <sup>49</sup> Dr Barry Rigby, Tweed Heads hearing, 29 April 2008, transcript 2341.21-41.
- <sup>50</sup> Confidential hearing at the Inquiry's offices via video-link from Tweed Heads, 29 May 2008, transcript 3.23-32.
- <sup>51</sup> Madeleine Green, Tweed Heads hearing, 29 April 2008, transcript 2355.06-11.
- <sup>52</sup> Dr Scott Whyte, Gosford hearing, 10 March 2008, transcript 94.40-95:07.
- <sup>53</sup> Professor Paddy Phillips, Experts Conference, 15 September 2008, transcript 93.27-30.
- <sup>54</sup> Dr John Death, Gosford hearing, 10 March 2008, transcript 153.24-154.38; 155.13-25.
- <sup>55</sup> Dr John Death, Gosford hearing, 10 March 2008, transcript 157.04-16.
- <sup>56</sup> Dr Scott Whyte, Gosford hearing, 10 March 2008, transcript 97.24-37.
- <sup>57</sup> Dr Christopher Arthur, Royal North Shore Hospital hearing, 2 April 2008, transcript 1245.38-42.
- <sup>58</sup> This expression is used for inpatient wards where men and women occupy beds in the same room or physical space. It does not apply to Emergency Departments, Intensive Care Units or High Dependency Units.
- <sup>59</sup> Dr Geoffrey White, Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 3130.30-3131.19.
- <sup>60</sup> Submission of Armelle Swan, 6 May 2008, SUBM.074.0151.
- <sup>61</sup> Submission of David Skidmore, Council of the Ageing (NSW) Inc., 28 March 2008, SUBM.034.0036 at 040-041. Submission of the Council of Social Service of NSW (NCOSS), March 2008, SUBM.041.0032 at 042.
- <sup>62</sup> Submission of David Skidmore, Council of the Ageing (NSW) Inc., 28 March 2008, SUBM.034.0036 at 040-041.
- <sup>63</sup> Submission of Dr Glenn Stephens, 20 May 2008, SUBM.053.0097.
- <sup>64</sup> Submission of Karen Rankin, Australian Confederation of Pediatric and Child Health Nurses (NSW Branch) Inc., 27 March 2008, SUBM.014.0007 at 007, 009.
- <sup>65</sup> See, for example, Dr Randall Greenberg, Dubbo hearing, 19 March 2008, transcript 643.46-644.08. See also Dr Liam Grundy, Wollongong hearing, 14 April 2008, transcript 1626.28-32.

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- <sup>66</sup> Letter from Sarah Bennett, Australian Medical Association (NSW) Ltd to The Executive Officer, Special Commission of Inquiry, 22 July 2008.
- <sup>67</sup> AMA Public Hospital Report Card, November 2008 at 6.
- <sup>68</sup> AMA Public Hospital Report Card, November 2008 at 6.
- <sup>69</sup> Australasian College for Emergency Medicine: April 2004: "Access Block and Overcrowding in emergency Departments": [http://www.acem.org.au/???/Access\\_Block1.pdf](http://www.acem.org.au/???/Access_Block1.pdf), (30 October 2008).
- <sup>70</sup> Submission of Professor Stephen Leeder, 28 March 2008, SUBM.044.0107 at 112. Letter from Sarah Bennett, Australasian Medical Association (NSW) Ltd to The Executive Officer, Special Commission of Inquiry, 22 July 2008. Information provided during visit to Ryde Hospital on 12 March 2008. Bagust et al, "Dynamics of Bed Use in Accommodating Emergency Admissions: Stochastic Simulation Model" (1999) 319 *British Medical Journal*, 155-158.
- <sup>71</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008.
- <sup>72</sup> Letter from Sarah Bennett, Australasian Medical Association (NSW) Ltd to Special Commission of Inquiry, 22 July 2008.
- <sup>73</sup> Dr Adam Purdon, Wollongong hearing, 14 April 2008, transcript 1668.19-1669.06.
- <sup>74</sup> Dr Geoffrey White, Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 3126.36-3127.27. Confidential St George Hospital hearing, 14 May 2008, transcript 40.02-08.
- <sup>75</sup> Submission of Dr Michael Golding, received 13 March 2008, SUBM.023.0202 at 203; Confidential submission, received 8 April 2008, SUBM.036.0087 at 094.
- <sup>76</sup> Submission of Dr Michael Boyd, Australian Society of Career Medical Officers, received 8 April 2008, SUBM.036.0087 at 092.
- <sup>77</sup> Confidential hearing at the Inquiry's offices via videolink from Wagga Wagga, 30 May 2008, transcript 8.43-9.6.
- <sup>78</sup> Report by the Comptroller and Auditor General, *Inpatient Admissions And Bed Management In NHS Acute Hospitals*, NHS Executive, London, February 2000 [http://www.nao.org.uk/publications/nao\\_reports/9900254.pdf](http://www.nao.org.uk/publications/nao_reports/9900254.pdf).
- <sup>79</sup> Information provided during visit to Westmead Children's Hospital on 15 May 2008.
- <sup>80</sup> Dr Gregory Purcell, Royal North Shore Hospital hearing, 14 March 2008, transcript 413.06-414.30.
- <sup>81</sup> Dr Russell Brereton, Royal North Shore Hospital hearing, 14 March 2008, transcript 334.32-47.
- <sup>82</sup> Dr Russell Brereton, Royal North Shore Hospital hearing, 14 March 2008, transcript 334.47.
- <sup>83</sup> Dr Jennifer Chambers, Port Macquarie hearing, 28 March 2008, transcript 1079.18-26, 1080.14-16. See also submission of Dr Jennifer Chambers, 27 March 2008, SUBM.022.0093 at 093.
- <sup>84</sup> Information provided during visit to Liverpool Hospital on 26 February 2008.
- <sup>85</sup> Information provided during visit to Concord Hospital on 21 February 2008.
- <sup>86</sup> Confidential Concord hearing, 24 April 2008, transcript 27.47-28.33.
- <sup>87</sup> Dr Liam Grundy, Wollongong hearing, 14 April 2008, transcript 1623.47-1624.09.
- <sup>88</sup> Dr Liam Grundy, Wollongong hearing, 14 April 2008, transcript 1625.13-27.
- <sup>89</sup> Dr Liam Grundy, Wollongong hearing, 14 April 2008, transcript 1625.29-37.
- <sup>90</sup> See, for example, Randall Greenberg, Dubbo hearing, 19 March 2008, transcript 644.14-26; Information provided during visit to Liverpool Hospital on 26 February 2008; Submission of Robert Herkes, 28 March 2008, SUBM.007.0394 at 401. Confidential St George Hospital hearing, 14 May 2008, transcript 40.02-08.
- <sup>91</sup> Alan Gardo, Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 3124.6-16.
- <sup>92</sup> Confidential submission, 7 April 2008, SUBM.036.0087 at 094.
- <sup>93</sup> Submission of Dr Michael Golding, 13 March 2008, SUBM.023.0202 at 203. Confidential Albury hearing, 23 April 2008, transcript 57.16-42.
- <sup>94</sup> Confidential submission, 7 April 2008, SUBM.036.0087 at 094.

- 95 Submission of Dr David Brock, 28 April 2008, SUBM.021.0051 at 056.
- 96 Private hearing at Coffs Harbour, 27 March 2008.
- 97 Submission of Dr Michael Golding, 13 March 2008, SUBM.023.0202 at 203.
- 98 Submission of Dr Michael Golding, 13 March 2008, SUBM.023.0202 at 203.
- 99 Confidential Albury hearing, 23 April 2008, transcript 57.40-58.27.
- 100 Information provided during visit to Royal Prince Alfred Hospital on 20 May 2008.
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- 103 Submission of Stephen Leeder, Australian Health Policy Institute, 28 March 2008, SUBM.044.0107 at 113.
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- 107 Submission of Frederik Lips, received 28 March 2008, SUBM.026.0031 at 31.
- 108 See submission of Melissa Lintott et al, NSW Nurses' Association Calvary Mater Newcastle Branch, 9 May 2008, SUBM.044.0150 at 152.
- 109 Ruth Arnold, Orange hearing, 18 March 2008, transcript 618.05-18.
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- 115 NSW Health, *Special Commission of Inquiry Presentations: Major Reform in Health Service Delivery – Clinical Services Redesign Program (CSR)*, 13 March 2008, transcript 77.25-40. Kathryn Porges, Gosford hearing, 10 March 2008, transcript 68.10-17. Jason Mullavey, Nepean Hospital hearing, 8 April 2008, transcript 1361.23-34.
- 116 NSW Health Briefing, 13 March 2008, presentation at 9.
- 117 Information provided during visit to Westmead Children's Hospital on 15 May 2008. Information provided during visit to Sydney Ambulance Centre on 29 May 2008.
- 118 John Alchin, Gosford hearing, 10 March 2008, transcript 133.1-10.
- 119 Dr Simon Battersby, Gosford hearing, 10 March 2008, transcript 163.25-31. Ronald Mawhinney, Royal North Shore Hospital hearing, 14 March 2008, transcript 353.42-354.10. Submission of Dr Richard Cracknell, 3 March 2008, SUBM.003.0202 at 205.
- 120 Information provided during visit to Liverpool Hospital on 26 February 2008.
- 121 Submission of Dr Rod Bishop and Ms Sue Strachan, Ministerial Taskforce on Emergency Care in NSW, March 2008, SUBM.002.0070 at 76.
- 122 Ruth Arnold, Orange hearing, 18 March 2008, transcript 619.22-39.
- 123 Ruth Arnold, Orange hearing, 18 March 2008, transcript 619.22-39.
- 124 Jennifer Baroutis, Port Macquarie hearing, 28 March 2008, transcript 1102.47-1103.040
- 125 Confidential Bankstown hearing, 13 May 2008, transcript 34.01-11.
- 126 Confidential Bankstown hearing, 13 May 2008, transcript 34.13-39.
- 127 Karen Bowen, RPA Hospital hearing, 20 May 2008, transcript 3111.16-29.
- 128 John Alchin, Gosford hearing, 10 March 2008, transcript 150.38-40.
- 129 Karen Bowen, Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 3111.16-29.
- 130 Confidential Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 65.07-12.
- 131 Confidential Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 63.37-64.31.
- 132 Julia Batty, Sydney Children's Hospital hearing, 19 May 2008, transcript 3004.32-36.



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- <sup>133</sup> Bradley Ceely, Westmead Children's Hospital hearing, 15 May 2008, transcript 2966.09-41.
- <sup>134</sup> Bradley Ceely, Westmead Children's Hospital hearing, 15 May 2008, transcript 2969.10-2970.22. Information provided during visit to Sutherland Hospital on 14 May 2008: I was told of another patient who spent over 4 years in the ICU at Sutherland Hospital due to his ventilation dependency. But for his dependence upon ventilation, there was no other clinical reason for him to remain in ICU.
- <sup>135</sup> Lyn Biviano, Westmead Children's Hospital hearing, 15 May 2008, transcript 2984.04-09. Claudia Graham, Westmead hearing, 26 May 2008, transcript 3167.01-09. Confidential Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 43.09-26. Karen Bowen, Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 3109.21-39. Bradley Ceely, Westmead Children's Hospital hearing, 15 May 2008, transcript 2963.13-18.
- <sup>136</sup> Lyn Biviano, Westmead Children's Hospital hearing, 15 May 2008, transcript 2984.04-09. Kathleen Gradidge, Nepean Hospital hearing, 8 April 2008, transcript 1471.37-38. Claudia Graham, Westmead hearing, 26 May 2008, transcript 3167.01-12.
- <sup>137</sup> Confidential Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 43.09-26. Karen Bowen, RPA Hospital hearing, 20 May 2008, transcript 3109.21-3110.04. Bradley Ceely, Westmead Children's Hospital hearing, 15 May 2008, transcript 2963.13-18.
- <sup>138</sup> Julia Batty, Sydney Children's Hospital hearing, 19 May 2008, transcript 3011.02-05.
- <sup>139</sup> Dr Alexander Wodak, St Vincent's hearing, 30 April 2008, transcript 2464.34.
- <sup>140</sup> Julia Batty, Sydney Children's Hospital hearing, 19 May 2008, transcript 3010.44-3011.02.
- <sup>141</sup> Information provided during visit to Cumberland Hospital on 13 May 2008. Dr Elizabeth McCusker, Westmead hearing, 26 May 2008, transcript 3211.41-3212.06.
- <sup>142</sup> Dr Elizabeth McCusker, Westmead hearing, 26 May 2008, transcript 3212.29-31.
- <sup>143</sup> Submission of Nadia Schweizer, 28 March 2008, SUBM.050.0031 at 031. Pauline Barber, Nepean Hospital hearing, 8 April 2008, transcript 1453.29-1454.09. Merennege Salgado, St George Hospital hearing, 14 May 2008, transcript 2886.30-40.
- <sup>144</sup> Dr Elizabeth McCusker, Westmead hearing, 26 May 2008, transcript 3212.38-41.
- <sup>145</sup> Fiona Wade, Westmead Children's Hospital hearing, 15 May 2008, transcript 2970.24-2971.35.
- <sup>146</sup> Information provided during visit to Camden Hospital on 16 April 2008.
- <sup>147</sup> I was told from several sources that a person under the age of 65 years who has acquired their illness after birth is not eligible to access Commonwealth funded nursing home placement: Information provided during visit to Camden Hospital on 16 April 2008; Pauline Barber, Nepean Hospital hearing, 8 April 2008, transcript 1453.29-1454.09; Confidential Royal Prince Alfred Hospital hearing, 20 May 2008, transcript 43.09-26.
- <sup>148</sup> Information provided during visit to Camden Hospital on 16 April 2008.
- <sup>149</sup> Letter from NSW Health to Special Commission of Inquiry, 17 October 2008.
- <sup>150</sup> Information provided during visit to Camden Hospital on 16 April 2008.
- <sup>151</sup> NSW Department Ageing, Disability and Home Care, *Stronger Together: A New Direction for Disability Services in NSW 2006 – 2016*, <http://www.dadhc.nsw.gov.au/NR/rdonlyres/93E65784-353B-4E01-8858-303F4B247A76/1986/StrongerTogetherPlan2.pdf>.
- <sup>152</sup> NSW Department Ageing, Disability and Home Care, *Stronger Together: A New Direction for Disability Services in NSW 2006 – 2016 – Progress Report Card*, January 2008 [http://www.dadhc.nsw.gov.au/NR/rdonlyres/93E65784-353B-4E01-8858-303F4B247A76/3852/Stronger\\_Together\\_Report\\_Jan2008.pdf](http://www.dadhc.nsw.gov.au/NR/rdonlyres/93E65784-353B-4E01-8858-303F4B247A76/3852/Stronger_Together_Report_Jan2008.pdf) at 3-4.
- <sup>153</sup> Harde and Associates, *Acute Hospital Demand Projections – 2006/2007 Base Update*, November 2007.

 Beds



## 29 Food

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- 29.1 Healthy eating is vital to good health. It is vital that patients receive good nutritious food as part of their patient care in hospital to obtain and maintain good health.
- 29.2 Fresh, well prepared food can encourage patients to eat well, giving them the nutrients they need to recover from surgery or illness, or even malnutrition, which in turn aids faster recovery and frees up beds.
- 29.3 Sadly, it became apparent to me during my Inquiry, that the quality and method of delivery of food in hospitals has been compromised whilst attempts have been made to save money. To my mind, this is a false economy; because inadequate nutrition increases a patients stay.<sup>1</sup> I was most surprised to hear one witness say:

"we have patients starving in our public hospitals in New South Wales."<sup>2</sup>

## Importance of food for patients

- 29.4 One only needs to consider the importance of nutrition for all human beings, to easily appreciate its significance for patients trying to recover. I could not agree more with a gastroenterologist who, during a hearing at Royal North Shore Hospital said:

"...nutrition is part of patient care. It should be seen as such and some of the ineffective and adverse patient outcomes may well be related to poor nutrition."<sup>3</sup>

- 29.5 A dietician said:

"if nutritional needs that have been identified are not supported it does have a direct link to mood, feeling, response to injury, infection rates going up [and] length of stay..."<sup>4</sup>

- 29.6 For reasons unexplainable, it seems that instead of treating food as part of the clinical aspect of a patient's stay; hospital administrators have treated it as an ancillary service often provided by external service providers. That initially became evident when a witness told me that:

"Presently there is no [Food] section, there is nobody in the department who takes any responsibility for nutritional care of patients within hospitals. There is no one we can go to that we can work with. Its just not seen as a priority and we think it should be a high priority."<sup>5</sup>

- 29.7 This was later confirmed by another witness who told me that the food service is viewed as non-core and non-clinical and a place where savings are sought to be made by NSW Health.<sup>6</sup> Given there has been little clinician involvement in food services in hospitals it is no surprise. But this needs to change.
- 29.8 The way in which the food is presented is also very important. Like all people, patients feeling sick, or nauseous need encouragement to eat. The 9 food processing units currently serve food on paper plates and drinks in plastic cups. And I understand this practice will continue once food services are transitioned to Health Support Services. Whilst I understand that this method has its advantages, such as quality, food safety and economies of scale,<sup>7</sup> care must be had to ensure that the food is appealing.
- 29.9 I understand there is a plethora of examples of unhappiness with the current systems in place for preparation and delivery of food. A dietician from Royal Prince Alfred Hospital reported that food is put on cold plates and reheated in a trolley that does not allow the

temperature to be adjusted. As a result, food is often wasted as smaller servings dry up and larger servings do not heat all the way through.<sup>8</sup>

- 29.10 In this chapter I examine:
- the preparation of hospital food,
  - the nutritional standards applied,
  - the process of serving food to patients,
  - monitoring the nutritional status of patients,
- and how these should be improved.

## Food preparation

- 29.11 A NSW Health briefing<sup>9</sup> revealed that:
- (a) over \$230 million is spent each year on food production and services,
  - (b) about 22 million meals are served each year,
  - (c) over 2,800 staff manage and deliver food services,
  - (d) over 200 hospitals have some form of kitchen area where food is either prepared or assembled.
- 29.12 There are 9 food production units across NSW servicing 230 public hospitals.<sup>10</sup> The food that is prepared at each of the production units is later transported in controlled service trolleys to each hospital.<sup>11</sup> Once it arrives at the hospital, the meals are heated or chilled (as required), assembled in kitchens and delivered to the patients in the wards.<sup>12</sup> I understand the assembling process is the most costly part of the process because it is labour intensive.<sup>13</sup>



- 29.13 There are some exceptions to the above rule. For example, Cobar and Macksville Hospitals, continue to prepare their own meals.<sup>14</sup> That allows the catering staff at those hospitals to use locally grown produce and serve slightly fresher food.
- 29.14 In June 2007, the Australian Food and Safety Standards were amended to impose stricter food preparation and storage requirements.<sup>15</sup> As a result, NSW Health will need to upgrade their older style kitchens<sup>16</sup> so they are compliant with the changes. I

understand NSW Health has retained private specialist suppliers to help them comply with the changes, until they transition the management of food services from area health services to Health Support Services.<sup>17</sup> I discuss the transition further – below.

### Transition to Health Support Services

- 29.15 Food is currently administered by each of the area health services in NSW. I understand that each area health service sources between 50% - 90% of the food it delivers to hospitals from private providers.<sup>18</sup>
- 29.16 By the end of 2009, NSW Health intend on having completed transitioning food services from each area health service to Health Support Services; the new entity responsible for all support services in NSW.
- 29.17 By transitioning food to Health Support Services, NSW Health hopes ultimately to:<sup>19</sup>
- (a) reduce the number of food production units from 9 to one;
  - (b) standardise production, packaging and delivery;
  - (c) improve quality of food, service and safety;
  - (d) achieve better economies of scale;
  - (e) improve relationships between professional and other stakeholders involved in the provision of food;
  - (f) stimulate debate about nutritional needs of patients;
  - (g) clarify accountabilities of staff involved with food;
  - (h) create performance reporting to enable greater transparency;
  - (i) ensure dietary needs of patients are met.
- 29.18 During a hearing at Liverpool Hospital, a nurse told me that since food services were moved off site, it has been more difficult to liaise with the people preparing meals.<sup>20</sup>
- 29.19 On a visit to Dorrigo Multi-purpose Service, I was told that since the move to centralisation, the food is more expensive and it is less fresh.<sup>21</sup>
- 29.20 Some believe NSW Health should obtain more input from *clinical* dieticians about menu design - because they have day to day experience with patients' dietary needs.<sup>22</sup> In my view, Health Support Services should consult clinical dieticians to ensure they achieve the aims set out above.
- 29.21 Given that many people were unhappy when food services were removed from the hospitals to the 9 food production units around the State, Health Support Services will need to ensure they focus on the issues that were the cause for unhappiness whilst attempting to achieve the aims set out above.
- 29.22 I understand that Health Support Services intends on replacing raw produce with pre-cooked and packaged foods which will be supplied in bulk from external providers and stored in refrigerators at each hospital.<sup>23</sup> This will apparently allow Health Support Services to offer a greater variety of food, thus aiding catering for patients with special dietary needs.<sup>24</sup> I am told that these packaged foods will comply with Australian Food Safety Standards.<sup>25</sup>
- 29.23 Whether a hospital will be well-served by a centralised food production unit remains to be seen. For example, a smaller facility may be better having people on site preparing

meals, but with a back up of the central facility for some more unusual items such as wheat-free, vegan or diabetic meals.

### No agreed standards

- 29.24 A key source of discontent in this field is that there is no agreement between NSW Health and its dieticians as to a state-wide standard for the nutritional requirements of menus. Pre-existing standards such as the Food and Nutrition Strategic Directions 1996–2000 are out of date.<sup>26</sup>
- 29.25 From the dieticians' point of view, I was told:
- The Dieticians Association of Australia and the Institute of Hospital Catering reached agreement on a range of dietary recommendations. The recommendations were supported by scientific evidence.<sup>27</sup> A menu template was developed, but was considered by NSW Health to be too costly.<sup>28</sup> The initiative floundered.
  - One clinical dietician emphasised the importance for agreed standards when she said:
 

"We have to have agreeance across the State on what is an acceptable food service. Not just the numbers of grams of protein, fat and carbohydrate, but what we value as clinicians, the choice, the range of food, how it will be provided, all of these things need to be there because we need to be able to measure quality service against what is being provided in health support."<sup>29</sup>
- 29.26 In April 2008, a clinical interface workshop was held with clinical representatives from NSW Health, Health Support Services and the area health services, including doctors, dieticians and speech pathologists, which agreed that:
- (a) a governance structure be established to support clinical involvement in food services;
  - (b) state-wide nutritional standards be introduced; and
  - (c) further work be done on defining the roles and functional relationships of the key stakeholders.
- 29.27 The workshop produced a draft paper highlighting food service and dietetic issues which mostly centred around the absence of agreed standards, variable food service quality and a lack of understanding of the impact of nutrition on patient outcomes. The paper outlined strategies to address these issues, by organising accountability and responsibility within the food services corporate structure. It was also noted that greater consideration was needed for cultural and allergy requirements and the compromised dexterity of frail and aged patients. We were informed that the paper will now be forwarded to the relevant department of NSW Health for consideration.<sup>30</sup> Since there is no one currently responsible for food in NSW Health, I assume this will be taken care of by Health Support Services.
- 29.28 The work of the clinical interface workshop seems a first step in resolving the unhelpful disharmony between Food Services and the dieticians working in NSW public hospitals.

### Food service

- 29.29 Whilst I was informed by NSW Health that nurses are responsible for serving meals to patients,<sup>31</sup> I could not find (nor was I provided with) any written policy confirming this

requirement. Given its importance I find this somewhat surprising. I was told Maitland Hospital is the only facility that specifically includes meal supervision in the role description of its nurses.<sup>32</sup>

- 29.30 Unsurprisingly, I received reports that nurses were often not involved in serving meals, due to time constraints.<sup>33</sup>
- 29.31 A 2007 study of 4 hospitals in the Northern Sydney Central Coast Area Health Service found that nurses did not adequately prepare many patients for meals or provide timely assistance with eating.<sup>34</sup> In addition, there was little encouragement to eat or drink and little monitoring of the amount of food and fluid consumed.<sup>35</sup> The main reasons nurses gave for these problems were lack of nursing time and in the context of time-rationing, a lower priority being given to nutritional care above other patient needs such as the administration of medications.<sup>36</sup>
- 29.32 In practice, the delivery and presentation of food to patients seems to be done by Food Services staff.
- 29.33 The NSW Health Patient Satisfaction survey conducted in May 2008 revealed that patients were generally happy with the food service in NSW Hospitals.<sup>37</sup> The survey produced the following results:
- 89.1% were happy with helpfulness of food staff;
  - 85.4% were happy with accuracy of food items ordered,
  - 75.2% were happy with the temperature of food; and
  - 68% were happy with the taste of food.
- 29.34 In some hospitals, nursing and food service staff were reportedly very helpful - opening packets, clearing tables and assisting people who cannot feed themselves. Some wards adjust meal breaks to maximise the staff presence during the patient mealtime.<sup>38</sup>
- 29.35 In other hospitals, the patients may not be prepared for meals when they arrive. Tray tables are cluttered, patients are not in a suitable sitting position to eat and they have not been offered a chance to wash their hands or visit the bathroom. This would be a source of frustration for many patients who have to wait until a nurse is available to assist them before they can start eating. Nurses said that they were given no notice of meal time. One nurse said:

"It may be 20 minutes before you realise the food has arrived."<sup>39</sup>

- 29.36 Other patients and their families reported seeing food delivered to patients and removed again, untouched, because there was no assistance to help them eat. In one hospital, a patient was left to manage his own meal tray even though he had one arm and hand incapacitated and couldn't open the packaging. The tray was left at the foot of his bed out of reach.<sup>40</sup>
- 29.37 Clearly, many patients, particularly elderly patients, need full assistance to eat their meals.
- 29.38 The Northern Sydney/Central Coast Area Health Service's *Nutrition Matters* Report revealed that patients who received assistance with their meals ate more.<sup>41</sup> Sadly, I understand it is too often the case that:

"No-one checks to see that old people actually eat meals."<sup>42</sup>

- 29.39 A study done by Wollongong University at Sutherland Hospital showed food intake increased by 30% when patients were assisted.<sup>43</sup>
- 29.40 There is presently no agreement as to whether it is the responsibility of the nurses or Food Service to provide such assistance.<sup>44</sup> This is most unsatisfactory. One report produced by the Northern Sydney/Central Coast Area Health Service concluded that without nurses having explicit instructions as to their role at mealtimes, there can be no consistent food management.<sup>45</sup>
- 29.41 Some hospitals have sought to overcome the lack of time nurses have to assist with meals by using volunteers. For example:
- The palliative care ward at Camden uses volunteers to help with patients eating meals;<sup>46</sup> and
  - At Sutherland Hospital there is a feeding project where volunteers are trained in this role.<sup>47</sup>
- 29.42 Relying on volunteers to provide a service, which is clinically important, does not seem to me to be a reliable solution given volunteers are not necessarily clinically trained and/or may not always be able to help.
- 29.43 The lines of responsibility between Food Services and nurses in respect of tasks associated with feeding patients are not clear, and need to be.

**Recommendation 127:** *Within 12 months, NSW Health should design and implement a policy which delineates clearly the respective responsibilities of Health Support Service staff, nursing and allied health staff (including clinical dietitians) with respect to all of the tasks associated with ordering and service of food to patients and consumption of food by patients, including monitoring an adequate food and drink intake by the patient.*

## Packaging

- 29.44 I heard evidence that patients frequently who have difficulty opening packaging go without food as a result. For example:
- A nurse at Liverpool hospital said the food is packaged in a way that is difficult to open, especially for geriatric patients.<sup>48</sup>
  - Some nurses at Wollongong Hospital told me a study found that 70% of geriatric patients required assistance to open their food packages.<sup>49</sup>
  - In the Northern Sydney/Central Coast Area Health Service's *Nutrition Matters* Report, it was recorded that patients were not getting the assistance they require to open packets.<sup>50</sup>





- 29.45 My staff obtained some samples of hospital packaged meals. I am told they found that a firm grip was needed to remove the coverings from meal containers, more so than was required to remove the top from, for example, a commercially available tub of juice, yoghurt or fruit.<sup>51</sup>
- 29.46 Food Services are required to ensure that food packaging meets with Australian standards for food safety. However, my understanding is that those standards do not specify the type of cover which must be used, nor the degree of adhesion between a food container and its cover.<sup>52</sup>
- 29.47 I note another interesting suggestion by a dietician – that packaging specifications should allow food still to be visible and to give patients cues and prompts on how to open them.<sup>53</sup>
- 29.48 I was told that an initial feasibility paper is being prepared for advice – due December 2008 – for an external provider to make up packages with a complete food portion for patients. The food would be provided to the receiving facility already plated with tamper proof packaging and stored ready for use.<sup>54</sup>

**Recommendation 128:** *Health Support Services prepare (or have a consultant prepare for them) specifications for the packaging and containers (including covers and seals) used on hospital food, so that the packaging and the containers:*

- (a) *comply with food standards; and*
- (b) *are able to be opened by frail, aged or unwell patients.*

## Malnourished patients

“Malnutrition in hospitals is a world wide phenomenon.”<sup>55</sup>

- 29.49 Malnutrition is the unintentional loss of weight from sub-optimal intake of food, resulting in loss of subcutaneous fat and/or muscle wasting.<sup>56</sup>

### Malnourished on arrival

- 29.50 Many patients, particularly the elderly, are malnourished on arrival at hospital. A dietician told me that one in 4 older people were malnourished when they come into the hospital system.<sup>57</sup>
- 29.51 It is important to identify these patients on arrival, as malnutrition needs to be treated as part of their medical needs. Malnourished patients take longer to recover and tend to spend twice as long in hospital.<sup>58</sup>
- 29.52 In Northern Sydney/Central Coast Area Health Service, the most common malnutrition screening comprises the following 3 simple questions:
- Has the patient lost weight recently?
  - How much weight has the patient lost?
  - Has the patient been eating poorly because of decreased appetite?

This could be completed when each patient is admitted, however understaffing and insufficient time were cited as reasons why screening was not routinely taking place on admission.<sup>59</sup>

## Malnourished during hospital stay

- 29.53 I was astonished to find that 1 in 4 older patients become malnourished during their stay in hospital.<sup>60</sup> It is imperative that hospitals be properly equipped to ensure that these patients are given enough of the right food to facilitate a speedy recovery.
- 29.54 Clinical dieticians at various hospitals reported malnutrition amongst the patients. Northern Sydney/Central Coast Area Health Service conducted a *Malnutrition Prevalence Audit*, finding:
- “67% of patients who had impaired nutritional status were estimated to have declined both before and during hospitalisation or during admission.”<sup>61</sup>
- 29.55 Four years ago, a study conducted at Wollongong and Port Kembla Hospitals, found that 45% of geriatric patients assessed were malnourished during their hospital stay.<sup>62</sup> A witness at Wollongong Hospital said:
- “... we have particular [dietary] concerns for patients who have longer length of stay or who have frequent admissions such as the elderly, rehab patients, renal patients, liver disease, oncology patients.”<sup>63</sup>
- 29.56 The following are some of the reasons why patients become malnourished during their hospital stay:
- Hospital meals are not designed to support the nutritional needs of patients long term, only for short stay 3 or 4 day patients.<sup>64</sup> Dieticians at Wollongong Hospital told me they wished to have access to supplements as well as additional nourishing food items to offer to long stay patients with special dietary requirements who are at risk of malnutrition.<sup>65</sup>
  - Patients who are unwell have poor appetites, and hospital food is not sufficiently tempting or available. Good meal presentation would encourage sick people to eat more. Unappealing packaging could make otherwise reasonable meal options unpalatable.<sup>66</sup> One witness said:
- “We can’t undervalue the importance of presentation and assistance and support ... I’m talking about how it presents to the patient that is sick, unwell, appetite-compromised.”<sup>67</sup>
- 29.57 Patients quite often don’t recognise the packaged item as food. A white plastic cup with a silver foil lid doesn’t look like desert to a patient, so it doesn’t get eaten.<sup>68</sup> This could be overcome if Food Services staff opened the packages when they delivered them.
- 29.58 There is a lack of choice of the meals available and also the portion size. Most patients interviewed in surveys had problems with their appetite and frequent, small, nourishing meals were what was required for these patients. Mid-meals, such as sandwiches, fruit snacks, packaged milkshakes, cake and biscuits, are needed to supplement patient meals.<sup>69</sup> This is necessary if the patient is undernourished or misses a meal.<sup>70</sup>
- 29.59 NSW Health assured me that mid-meals are readily available in NSW public hospitals.<sup>71</sup> Hospital staff disagreed with that notion, stating that there is little flexibility for patients to obtain food outside of mealtimes.<sup>72</sup> Nurses also expressed frustration stating there was no ready access to mid meals or other necessary foods. They also felt they wasted an inordinate amount of time chasing food items.<sup>73</sup>

*Problems with detection of malnutrition*

- 29.60 As members of the allied health profession, dieticians appear to suffer from the same problems as their allied health colleagues in terms of understaffing, recruitment restrictions, lack of backfilling and the like. This reduces the ability of our hospitals to address the nutritional needs of patients. To this end, one witness said:
- "We don't perform screening [of patients for malnutrition] at Westmead because we couldn't handle the referrals if we did."<sup>74</sup>
- 29.61 Consequently, the task of detecting malnourishment in patients tends to fall to nurses, who have many other tasks to attend to and are not trained to detect malnutrition. As a result, malnutrition is often missed.
- 29.62 For example, at Goulburn Hospital, only 25% of people had their weight recorded when they were in hospital.<sup>75</sup> And a very basic nutrition screening, which formed part of a nursing administration form, had only been completed for 50% of the patients. It was suggested to me that the reason for non-compliance is probably a combination of the limited nursing time for doing additional tasks and a lack of understanding of the importance of the questions.
- 29.63 During discussions with nurses as part of the Northern Sydney/Central Coast Area Health Service surveys, some nurses criticised their tertiary education saying that it did not cover certain aspects of patient care, namely nutrition.<sup>76</sup>

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- <sup>1</sup> Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1149.18-21.
  - <sup>2</sup> Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1147.30-37.
  - <sup>3</sup> Daniel Stiel, Royal North Shore Hospital hearing, 2 April 2008, transcript 1284.15-18.
  - <sup>4</sup> Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1149.18-21.
  - <sup>5</sup> Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1155.17-21.
  - <sup>6</sup> Margaret Holyday, Sydney Children's Hospital hearing, 19 May 2008, transcript 3063.33.
  - <sup>7</sup> Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1150.24-42.
  - <sup>8</sup> Confidential submission, 30 April 2008, SUBM.040.0094.
  - <sup>9</sup> NSW Health, *Special Commission of Inquiry Presentations: Shared Corporate Services*, 22 September 2008, p. 27.
  - <sup>10</sup> NSW Health, *Special Commission of Inquiry Presentations: Shared Corporate Services*, 22 September 2008, p. 30.
  - <sup>11</sup> NSW Health, *Special Commission of Inquiry Presentations: Shared Corporate Services*, 22 September 2008, p. 30.
  - <sup>12</sup> NSW Health, *Special Commission of Inquiry Presentations: Shared Corporate Services*, 22 September 2008, p. 33.
  - <sup>13</sup> NSW Health, *Special Commission of Inquiry Presentations: Shared Corporate Services*, 22 September 2008, p. 32.
  - <sup>14</sup> Information provided during visits to Macksville Hospital on 27 March 2008 and Cobar District Hospital on 8 May 2008.
  - <sup>15</sup> Food Standards Australia New Zealand, [www.foodstandards.gov.au](http://www.foodstandards.gov.au).

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- <sup>16</sup> NSW Health Briefing, 22 September 2008, transcript 78.
- <sup>17</sup> Letter from NSW Health to Special Commission of Inquiry, 12 September 2008.
- <sup>18</sup> Letter from NSW Health to Special Commission of Inquiry, 12 September 2008.
- <sup>19</sup> NSW Health, *Special Commission of Inquiry Presentations: Shared Corporate Services*, 22 September 2008, p. 28.
- <sup>20</sup> Brian Grant, Liverpool hearing, 17 April 2008, transcript 1840.36-38.
- <sup>21</sup> Information provided during visit to Dorrigo Multi-purpose Service on 26 March 2008.
- <sup>22</sup> Confidential Westmead hearing, 26 May 2008, transcript 29.2-4.
- <sup>23</sup> NSW Health, *Special Commission of Inquiry Presentations: Shared Corporate Services*, 22 September 2008.
- <sup>24</sup> NSW Health Briefing, 22 September 2008, transcript 78.11-25.
- <sup>25</sup> NSW Health, *Special Commission of Inquiry Presentations: Shared Corporate Services*, 22 September 2008, p. 30.
- <sup>26</sup> Letter from NSW Health to Special Commission of Inquiry, 12 September 2008.
- <sup>27</sup> Letter from Chairperson of Dieticians Association of Australia (NSW Branch) to Special Commission of Inquiry, 3 September 2008.
- <sup>28</sup> Letter from Chairperson of Dieticians Association of Australia (NSW Branch) to Special Commission of Inquiry, 3 September 2008.
- <sup>29</sup> Lynette Lace, Goulburn hearing, 16 April 2008, transcript 1804.8-16.
- <sup>30</sup> Letter from NSW Health to Special Commission of Inquiry, 12 September 2008.
- <sup>31</sup> Letter from NSW Health to Special Commission of Inquiry, 12 September 2008.
- <sup>32</sup> Letter from NSW Health to Special Commission of Inquiry, 12 September 2008.
- <sup>33</sup> Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project – Nursing staff focus groups - Report on Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0159).
- <sup>34</sup> Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Mealtime Observations and Nurse Interview Strategy - Report on Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0075 at 77).
- <sup>35</sup> Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Mealtime Observations and Nurse Interview Strategy - Report on Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0075 at 77).
- <sup>36</sup> Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Mealtime Observations and Nurse Interview Strategy - Report on Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0075 at 83, 84).
- <sup>37</sup> NSW Health, *Special Commission of Inquiry Presentations: NSW Health Patient Survey*, 22 May 2008, p. 30.
- <sup>38</sup> Letter from NSW Health to Special Commission of Inquiry, 12 September 2008; Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Mealtime Observations and Nurse Interview Strategy - Report on Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0075 at 80).
- <sup>39</sup> Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Nursing Staff Focus Groups - Report on Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as

part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0159 at 167).

- 40 Submission of Denise Young, March 2008, SUBM.068.0310.
- 41 Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Plate waste and patient interview strategy - Report of Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0118 at 111).
- 42 Submission of Catherine Harnack, 6 May 2008, SUBM.041.0269 at 270.
- 43 NSW Health Briefing, 22 September 2008, transcript 87.9-14.
- 44 NSW Health Briefing, 22 September 2008, transcript 86.
- 45 Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project – Mealtime Observations and Nurse Interview Strategy - Report of Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0075 at 86 and 87).
- 46 Information provided during visit to Camden Hospital on 16 April 2008.
- 47 Amy Haantjens, Allison Ferguson and Vanessa-Ann Allen, Wollongong hearing, 14 April 2008, transcript 1694.7-13.
- 48 Brian Grant, Liverpool hearing, 17 April 2008, transcript 1843.1-11.
- 49 Amy Haantjens, Allison Ferguson and Vanessa-Ann Allen, Wollongong hearing, 14 April 2008, transcript 1693.27-32.
- 50 Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project – Plate Waste and Patient Interview Strategy - Report of Key Findings* (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0094 at 109 and 110).
- 51 Inspection of food provided by NSW Health, 15 September 2008.
- 52 NSW Health Briefing, 22 September 2008, transcript 89.90.
- 53 Margaret Holyday, Sydney Children's Hospital hearing, 19 May 2008, transcript 3065.41-47.
- 54 NSW Health Briefing, 22 September 2008, transcript 89.90.
- 55 United Kingdom National Health Service, *Improving Nutritional Care*, COI for the Department of Health (UK), Report October 2008.
- 56 Letter from Chairperson of Dieticians Association of Australia (NSW Branch) to Special Commission of Inquiry 3 September 2008.
- 57 Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1147.36-37.
- 58 Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1149.18-21.
- 59 Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Nutrition Risk Screening Report - Current Processes and Future Options* (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0177 at 178 and 185).
- 60 Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1147.30-37.
- 61 Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Nutrition Status of In-Patients in NSCCAHS - Report of Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0118 at 119.)
- 62 Allison Ferguson, Wollongong hearing, 14 April 2008, transcript 1692.9-15.
- 63 Allison Ferguson, Wollongong hearing, 14 April 2008, transcript 1692.17-21.
- 64 Confidential Westmead hearing, 26 May 2008, transcript 29.6-14.

- <sup>65</sup> Amy Haantjens, Allison Ferguson and Vanessa-Ann Allen, Wollongong Hospital hearing, 14 April 2008, transcript 1696.20-47.
- <sup>66</sup> Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1150.34-37.
- <sup>67</sup> Joanne Prendergast, Royal North Shore Hospital hearing, 2 April 2008, transcript 1151.36-39.
- <sup>68</sup> Margaret Holyday, Sydney Children's Hospital Hearing, 19 May 2008, transcript 3065.20-22.
- <sup>69</sup> Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Nutrition Risk Screening Report - Current Processes and Future Options* (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0177 at 184).
- <sup>70</sup> Rhonda Matthews, Royal North Shore Hospital hearing, 2 April 2008, transcript 1153.26-37.
- <sup>71</sup> NSW Health Briefing, 22 September 2008, transcript 77.1-3.
- <sup>72</sup> Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project - Mealtime Observations and Nurse Interview Strategy - Report on Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.0075 at 11).
- <sup>73</sup> Rhonda Matthews, Royal North Shore Hospital hearing, 2 April 2008, transcript 1153.35-37.
- <sup>74</sup> Confidential Westmead hearing, 10 April 2008, transcript 26.19-22.
- <sup>75</sup> Lynette Lace, Goulburn hearing, 16 April 2008, transcript 1800.42-44.
- <sup>76</sup> Hall J, Matthews R and Bartlett L, Northern Sydney Central Coast Area Health Service, *Nutrition Matters - Patient Centered Nutrition Project – Nurse Staff Focus Groups - Report on Key Findings*, October 2007, Northern Sydney Central Area Health Service (provided as part of the submission of Judith Hall, Rhonda Matthews and Louise Bartlett, 2 April 2008, SUBM.006.00159).

 Food



## 30 Equipment

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- 30.1 In this chapter I examine the multitude of issues surrounding the equipment used in public hospitals in the provision of acute care.
- 30.2 The short story is that NSW Health's systems and processes have been difficult to use, inefficient and lacking in planning. However, I am satisfied that there are significant valuable processes which are either underway or at an advanced state of planning which ought significantly improve the existing processes.
- 30.3 I applaud and encourage these initiatives.

#### *Complaints about Equipment*

- 30.4 I heard numerous complaints during hospital visits and hearings about the standard of equipment in NSW public hospitals. It seems to me that these difficulties are a symptom of the immense financial constraints under which NSW public hospitals are operating. There were many submissions concerning old, broken or malfunctioning equipment or the general lack of equipment. For example, I was told that:
- The Bulli Hospital did not have an OCT machine for measuring glaucoma patients and retina patients with macular degeneration, with the consequence that patients had to be referred elsewhere;<sup>1</sup>
  - at The Children's Hospital at Westmead, most of the equipment was old (some of which was 12 years old);<sup>2</sup>
  - at the Wellington District Hospital Emergency Department, much of the equipment was old and needed replacing;<sup>3</sup>
  - at the Emergency Department at Braidwood, the X-ray facilities are particularly out of date, with staff having to use chemicals in freestanding containers, to develop films. Staff were required to handle the containers and dispose of chemicals by hand;<sup>4</sup>
  - at the Prince of Wales Hospital, I was told that the Emergency Department had 13 year old monitoring equipment, which should have been replaced 8 years ago and that the ICU had ventilators bought in 1992 for which they could not obtain spare parts;<sup>5</sup>
  - at the Bankstown Hospital, the equipment used in the recovery area section of the operating suite was more than 10 years old, it was difficult to get the equipment required, the blood warmers were no longer maintained and that it was difficult for an anaesthetist to keep the core body temperature of a patient regulated if the equipment is not available.<sup>6</sup> I was told by another witness that:
 

"We are used to working with less than adequate to adequate, but everything is a struggle."<sup>7</sup>
  - at the Coffs Harbour Hospital, I was told that:
 

"We run around half the shift wasting our time looking for equipment. That's a big issue that we find in our health system."<sup>8</sup>
  - by way of summary, according to a submission from the Australian Medical Association of NSW and the Australian Salaried Medical Officers' Federation, on average, 47.7 per cent of doctors and nurses found the level of equipment to undertake necessary clinical work to be poor and inadequate.<sup>9</sup>
- 30.5 Many hospitals rely heavily on the generosity of their local communities to fund the purchase of equipment,<sup>10</sup> as illustrated by the many submissions I received outlining the need for charitable fund raising. For example, I was told that:

- charity fund raising was used to help raise funds to replace anaesthetic equipment at a hospital ranging in age from 12 to 20 years old because replacement parts no longer existed;<sup>11</sup>
- at the Mullumbimby Hospital, they had 2 monitored beds with old equipment and the staff were involved with fundraising to upgrade the equipment;<sup>12</sup>
- at the RNSH, from 1990 it had been either getting money (hundreds of thousands) from the community or taking money from the general budgets to fund equipment, and that the problem was getting worse;<sup>13</sup>
- cake stalls were used to raise funds for basic physiotherapy equipment such as wheelchairs, pressure cushions and walking frames at a hospital;<sup>14</sup>
- at Goulburn Hospital, a local charity was asked for a grant of funds to enable the purchase of a number of replacement beds – the beds are old, frequently breaking, and are maintained insufficiently;<sup>15</sup>
- at the St George Hospital, the Emergency Department had problems getting funds for equipment and had to obtain funding by raising money locally;<sup>16</sup>
- in relation to the Prince of Wales Hospital:

"We have a number of bits of equipment that belong to Sydney Children's hospital because they have been donated however, they really are not ours. It is an act of grace that allows us to continue to use them in the adult hospital. Even basic surgical instruments, we really won't have enough of and requests don't always produce the desired results..."<sup>17</sup>

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- 30.6 It is wonderful to see the support of local communities but in my view the valuable time of health professionals would be better spent treating patients rather than raising funds. Some submissions pointed to an expectation by management that all such funding should be raised charitably.<sup>18</sup> However, this should be the exception rather than the norm, particularly given the stress the necessity of fundraising imposes on staff, as illustrated by the following comment to me by a witness:

" I say to staff that I prostitute myself to get money. I go out there begging. ... I have had enough."<sup>19</sup>

- 30.7 The problems with inadequate equipment are fairly obvious.

- 30.8 Firstly, it poses a threat to the safety and quality of services provided to patient. Problems with equipment can lead to a deterioration in the patient's health<sup>20</sup> or require patients to be moved to another place where the equipment is working.<sup>21</sup> Outdated, faulty or non-existent equipment can increase exposure to radiation and associated risks, as is demonstrated by the following evidence of Dr Arbuckle in relation to The Children's Hospital at Westmead:

"To have a hospital such as this ending up with instrumentation that is extraordinarily out of date, places patients at an increased radiation risk or other increased risk, which should be avoided."<sup>22</sup>

- 30.9 It can also necessitate choosing between patients for the allocation of functioning equipment by trying to determine which of them are more seriously ill than the other.<sup>23</sup> I was told that on one occasion a patient remained on a hospital floor all night, after falling out of bed, as there was no equipment to lift the patient back into bed.<sup>24</sup> Ultimately, inadequate, faulty or non-existent equipment can contribute to patient death, as is illustrated by submissions to me that:

- a root cause analysis showed that a lack of equipment contributed to the author's late husband's death;<sup>25</sup>

- a root cause analysis report determined that a Tocograph monitoring device was out of date and unable to give an accurate printout, contributing to brain damage and the death of the author's baby;<sup>26</sup>
- a lack of functioning equipment contributed to the death of the authors' daughter. No precision scales were available in operating theatre or recovery to measure blood loss from surgical sponges, pads and bed linen. Also, blood warming machines switched off by themselves and there was no machine in operating theatre to measure the patient's haemoglobin level;<sup>27</sup> and
- a case in which capnograph equipment failed several times, contributing to the death of a patient. The patient becoming cyanotic and bradycardic, eventually died.<sup>28</sup>

30.10 Second, it increases the level of stress health professionals are subject to when carrying out their work, and it is demoralising.<sup>29</sup> It can also create occupational health risks. For example, the lack of electric beds impact on a bed-ridden person's ability to sit up without help, which imposes a greater strain on hospital staff than would otherwise be the case were they available.<sup>30</sup> Machinery breakdown can also lead to delays in treatment and impact upon nursing care plans.<sup>31</sup> In contrast, new machinery can save staff time (as illustrated to me by a witness that new equipment would make redundant ten extra steps that were required to use old ventilator machines)<sup>32</sup> and hospital resources by reducing the necessity of chasing machines between wards.<sup>33</sup>

30.11 It is also reflected in the following comment by another witness:

"It's filtering down to the staff because they are not getting their equipment. They are not getting their education. All the good things we could do for our staff we say "no" because there is no budget. It's the same for all of us."<sup>34</sup>

30.12 Similarly, I was told:

"Another really great frustration that the staff find in the working environment is the difficulty in obtaining equipment ... we don't at the moment have one complete wheelchair."<sup>35</sup>

### Balancing demand with reality

30.13 Having described the problems associated with lack of equipment, it is also important to note that it is necessary to draw a distinction between what is needed with what is desired, and to take into account the reality of limited funding particularly in respect of the latter.

30.14 It is natural for clinicians and communities to want the best equipment and latest technology available in their local hospital. Modern equipment can save time, allow more patients to be treated<sup>36</sup> and decrease waiting lists.<sup>37</sup> It will usually make the task of the clinician much easier. I received numerous submissions and heard evidence from many witnesses as to their desire, for example, to have a Computerised Tomography (CT) scanner or Magnetic Imaging Resonance (MRI) scanner locally. For example, this desire was reflected in the submissions by Dr Steiner to me that:

"CT Scans are no longer an esoteric test but are now a basic radiology test."<sup>38</sup>

30.15 However, battles between hospitals and clinicians for new equipment can be fierce and based on desire rather than need. I was subjected to the unedifying spectacle of a dispute between doctors at Westmead Hospital and doctors at Blacktown Hospital

competing to have a cardiac catheterisation laboratory at their facility. I note the catheterisation laboratory finally went to Blacktown Hospital.<sup>39</sup> Planning for high cost equipment such as cardiac catheterisation laboratories, electro-physiology laboratories and interventional angiography suites takes place at both the area and state levels.<sup>40</sup> Where possible, it is important for suitable equipment to be available and allocated where it is most needed, that is where it will do the most good for the greatest number of patients.

- 30.16 It should be noted that there is a cost associated with a lack of equipment. A lack of equipment in some places can necessitate patients and accompanying hospital staff travelling greater distances in order to confirm diagnoses and receive appropriate treatment. This impacts on local staffing resources, increases transport costs and causes inconvenience to patients, especially in rural areas.<sup>41</sup>
- 30.17 I heard evidence of various examples of such inconveniences. For example, in the Greater Southern Area Health Service, when a local CT scan is not available, a patient may need to be transported to a hospital 3 hours away. This may, and often does tie up an ambulance for a full 8 hour shift.<sup>42</sup> Another example of the inconvenience caused by equipment shortages can be seen in the Moruya area, where the hospital does not have access to ultrasound or CT scans. Large sums of money are spent transporting patients and using privately owned and operated facilities.<sup>43</sup> Locally available equipment is also important where children are concerned, particularly where it may reduce the need for anaesthesia or sedation.<sup>44</sup>
- 30.18 The ongoing savings in staffing and transport costs in some areas may justify the purchase of suitable equipment.
- 30.19 A lack of equipment can also lead to an increase in a patient's length of stay in hospital, can increase waiting times to access treatment<sup>45</sup> and decrease overall staff efficiency.<sup>46</sup>
- 30.20 That said, the reality is that many pieces of medical equipment are prohibitively expensive and the public funds are, strictly limited. Replacement of equipment is thus delayed. A recent audit found that approximately \$300 million worth of equipment had exceeded its estimated replacement date.<sup>47</sup>
- 30.21 The purchase prices do not necessarily account for all the other costs associated with the placement of the machine such as, for example, the cost of a building site assessment report, available power supply and actual building work costs to house the machine safely which may also include the addition of consultation rooms. The determination of location and purchase of some high tech and high cost equipment, such as MRI machines and linear accelerators is planned at a State level and where possible the machines are purchased in bulk, or through an integrated procurement strategy available to all Area Health Services.<sup>48</sup> Medicare Benefits Schedule approval of the machine is sought in order that private patients may claim Medicare benefits for medical tests. This may reduce the hospital cost of performing the test.
- 30.22 In the most recent NSW Health budget, \$32.3 million was provided for new and replacement equipment. In addition, the Commonwealth Government has provided \$50.6 million to acquire equipment for elective surgery.<sup>49</sup>

### No central asset register

- 30.23 NSW Health tells me that there are more than 66,000 pieces of medical equipment in use in NSW public hospitals, which cost about \$840 million to acquire.<sup>50</sup>

- 30.24 A usual and rather basic requirement of business operation is to keep an accurate record of business assets, including equipment, which records the item and its description, its purchase date, its anticipated replacement date and any relevant maintenance details. It does not appear to me that such a record is maintained in respect of equipment in use in NSW public hospitals.
- 30.25 I am told by NSW Health that it requires assets valued at greater than \$10,000 on acquisition to be registered on the NSW Health ORACLE department system, which is maintained by Health Support Services. Assets below \$10,000 are meant to be registered separately in local Subsidiary Asset Registers.<sup>51</sup> However, the Area Health Services are responsible for managing and maintaining the local register of assets and medical equipment. Typically, the register is kept in area health services by the Finance or Biomedical Engineering areas respectively.<sup>52</sup> There is no state-wide register of equipment which cost less than \$10,000.
- 30.26 There were no witnesses from Finance or Biomedical Engineering at the hearings I conducted. I heard evidence from a number of witnesses whose main task was to purchase equipment, and it appeared to me from their evidence that there was a lack of central asset registers, even by Area Health Services.<sup>53</sup> Dr Arbuckle from Westmead Children's Hospital was not aware of any database in the hospital or the Area Health Service, which recorded equipment with an estimated life span. She said that there was a system of recording the acquisition of equipment in the Diagnostic Division and in Finance and whether it was purchased or leased. She said they have to register equipment once it is obtained and it is depreciated over time until it becomes obsolete. Some equipment is leased. Within the hospital, there may be several different departments with several independent recording systems for the equipment and its expected obsolescence. Dr Arbuckle thought it would assist to have a more uniform database across a hospital or Area Health Service to track these assets.
- 30.27 The asset registration practice appears to vary between Area Health Services and also between various hospitals.<sup>54</sup> Within each hospital, different departments keep their own asset registers (for example, biomedical engineering, cardiology, medical imaging, information services and pathology all keep separate asset registers). The officer responsible for updating the register also varies and there does not appear to be a uniform standard. To complicate matters further, NSW Health is trialling a Shared Corporate Services program that is aimed at pooling and standardising financial and procurement services and six of the eight area health services are in the process of implementing the service.<sup>55</sup> The Area Health Services are therefore in different stages of governing overall equipment needs and monitoring local budget availability.
- 30.28 In relation to the ORACLE system, when an asset is entered into it, the user must pick a category of asset, which pre-determines the depreciation of the asset according to a straight-line accounting method.<sup>56</sup> This works well for finance, and accounting purposes, but it does not necessarily estimate the life expectancy of the asset in terms of how long it will remain usable, when it will need to be replaced and whether there will be any budget to replace it. However, the latter information is important in terms of a useability and acquisition planning perspective.
- 30.29 When an asset is entered into a local Subsidiary Asset Register the date of supply is recorded. Some of the registers record life expectancy and some do not. Of the registers that recorded life expectancy for medical equipment, either a nominal life expectancy of 10 years was allocated or a life expectancy based on an American Society for Health Engineering publication<sup>57</sup> was allocated.

- 30.30 I am told assets are removed from the asset register upon disposal. I am also told that every year on a cyclical basis an asset stocktake is undertaken at nominated cost centres. It appears an asset audit is not performed at every cost centre, on a regular basis. There is also no suggestion that the functionality of the equipment is checked at the time of any asset audit.

**Recommendation 129:** *Within 24 months, NSW Health should establish a central State-wide equipment asset register recording details of fixed assets with an acquisition value greater than \$10,000 and attractive assets greater than \$1,000. Details recorded in the register should, as a minimum, include:*

- (a) *the purchase price;*
- (b) *the date of acquisition;*
- (c) *the estimated life expectancy (usability) or contract expiry date;*
- (d) *the half-life usability assessment date; and*
- (e) *the location of the asset.*

*Improvements underway*

- 30.31 NSW Health tells me it is introducing a computer programme to assist area health services to manage and maintain their equipment. The programme is called Health Asset Management and Maintenance System (HealthAMMS).<sup>58</sup> The newer system uses 2 software products to support property management, asset management and asset maintenance. It is supposed to identify area needs and maintenance expenditure.<sup>59</sup>
- 30.32 Newer MAXIMO software will be used as a maintenance management system for work orders, work requests, planned maintenance, job plans, equipment register, assets and locations, purchasing management, inventory control, condition auditing, mobile module and reporting modules.<sup>60</sup> There will be a finance interface between MAXIMO and ORACLE.
- 30.33 The new system will be located centrally within NSW Health and hosted by Health Technology. It is proposed the software will be accessed via the NSW Health Intranet and in the future via a remote access webFM system.
- 30.34 The first phase of HealthAMMS has been introduced to 3 area health services: Hunter New England, South Eastern Sydney Illawarra and Sydney West. Implementation began in the biomedical and engineering departments and will be expanded into other departments within the hospital. I have been told the 3 Area Health Services have found the system to be an improvement on previous systems, but the biomedical engineering services department have concerns. The system appears to be suitable to managing maintenance requests for non-medical equipment and building repairs. However, there are questions as to whether it can manage medical equipment. It is also reported that implementing the new system and running the system effectively is resource intensive and therefore more expensive than current systems.<sup>61</sup>
- 30.35 At one Area Health Service, the initial cost of implementation was \$1.4 million with expected ongoing costs of between \$237,000 and \$253,000 for upcoming years.<sup>62</sup> As the project progresses across other area health services, more modules of the software will be rolled out. It is intended that there be a support service bureau within each area health service to provide support with implementation at remaining sites.<sup>63</sup>



- 30.36 NSW Health is developing an implementation plan to accelerate the introduction of HealthAMMS to the remaining area health services *“based on their preparedness to implement and available resources.”*<sup>64</sup>
- 30.37 I am also told that in about 2010, Stage 2 of the Corporate IT Program being rolled out across NSW will provide an Asset Management System including the facility for a centralised asset register for NSW Health. Currently, a standard suite of integrated corporate IT applications is being designed to achieve this.<sup>65</sup> As can be seen from Recommendation 1 and 2 above, a centralised asset register is a desirable objective.

### No planned replacement

- 30.38 Medical science is a field of rapidly evolving technology. As often as not, a state-of-the-art piece of equipment is superseded as soon as it is installed. There is obviously a balance between having the latest technology in NSW public hospitals and financial responsibility. New technology can provide patients with better treatment,<sup>66</sup> cut waiting times for access to treatment and make better use of available staff resources. Patients should have access to some form of technology to enable proper and convenient diagnosis. As previously mentioned, I received many submissions outlining equipment being out of date, not working, not repaired, and beyond repair. Sometimes the machinery is so old that there are no longer any spare parts or guaranteed service.<sup>67</sup> There must be a balance between maintaining older but working equipment, replacing older equipment with more modern versions and purchasing state-of-the-art equipment. A balance also needs to be found between what is considered standard and necessary as opposed to ‘luxury’ machinery. These are, or at least should be, matters of every day standard management practices.
- 30.39 What concerns me is that there is no regime for the planned replacement of equipment.<sup>68</sup> In an industry where the state of equipment correlates closely to patient safety, it is important to review the equipment in use routinely and plan for the replacement of equipment as it comes to the end of its useful life or becomes unsuitable for use in the safe, modern practice of medicine.<sup>69</sup> This concern is reflected in the following statement made to me by a witness:

“We continue to use equipment that is really obsolete, that has reached its due by date and where there is much better instrumentation available.”<sup>70</sup>

“Modern medicine is very reliant on diagnostic services. ... You really need some sort of appropriate program to keep up with the latest in technology ... and to continuously upgrade and change your instrumentation as it’s required.... What really needs to be looked at is some sort of program across the state for the upgrading of instruments in all areas so that it is on a regular basis. ... If you don’t upgrade your instruments you fall behind the rest of the world and the rest of the state ...”<sup>71</sup>

- 30.40 To use a simple example, if a hospital acquires a cardiac monitor, I would expect the acquisition of that equipment to be centrally recorded, together with an estimate of its useful life. That lifespan may be 10 years. Once the cardiac monitor is 5 years old, I would expect the estimated lifespan to be reviewed, to see whether that estimate remains good given developments in medical technology. As the cardiac monitor comes within a year or two of expected redundancy, I would expect to see the cost of a new cardiac monitor being factored into the budget of the hospital, so that replacement equipment can be sourced and funded without unduly interrupting clinical activities.

- 30.41 However, this does not seem to be happening at all. Rather, it seems to come as something of a surprise when a piece of equipment needs replacement,<sup>72</sup> whether it is because of changes in medical technology,<sup>73</sup> or the equipment can no longer be repaired because the supplier has gone out of business or won't service models of that vintage,<sup>74</sup> or the equipment has become unreliable by reason of its antiquity.<sup>75</sup> It is only then that steps are taken to replace it, and there does not appear to be any routine budgeting for equipment replacement.<sup>76</sup> While some machines are awaiting replacement, simple upgrades are not permitted, compounding the problem.<sup>77</sup> I heard that it was difficult to locate the responsible person in the Area Health Service to ask when equipment would be replaced or repaired.<sup>78</sup> I have also been told one reason that equipment has not been identified for replacement is simply because there is no budget to pay for replacement.<sup>79</sup>
- 30.42 The problem is not isolated or minor but, rather, is widespread and potentially compromises patient safety, as illustrated by the following statement made to me by a witness:

"In one of my hospitals, virtually all of my equipment is beyond the standard use-by date. ... Even when equipment breaks down, there is still no attempt to procure funding to replace equipment... There needs to be some system of capital replacement in the accounting or at least a recognition of what your capital is, rather than just leaving it in the never-never and hoping a politician will come with the golden purse... The hospital system also needs to make allowances for these things."<sup>80</sup>

"I am also aware that cardiac monitoring systems in Prince of Wales including theatres are so old that parts are no longer available, and they urgently require replacement. The replacement cost would be \$4 million, but there are no funds available for these."<sup>81</sup>

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**Recommendation 130:** *NSW Health should ensure that each hospital performs equipment functionality assessments every 6 months to assess and predict the need for equipment replacement.*

### Cumbersome processes

- 30.43 I also heard numerous complaints by staff about the cumbersome process involved in procuring new medical equipment. For example, at Hornsby Hospital I heard:
- "If it is a broken piece of equipment, for example, if it is a broken electronic blood pressure machine, I need to get biomedical engineering from North Shore, they only come once a week on a Thursday. They, say, on a Thursday, take it away. A couple of weeks later they say they can't fix it. They write me a thing saying, "I can't fix it." I then need to approach a company, normally who ever is on government contract, and get two original quotes for that item. I then need to write a referral note with those two original quotes and take them to my divisional manager to get signed off on. In the referral note I need to say normally it can come from our trust fund."<sup>82</sup>
- 30.44 I heard from a witness that the procurement process varies depending on the price of the equipment to be procured, stating that:

"...any sort of equipment that needs to be purchased or borrowed or used seems to go through a very cumbersome approval process: several layers of approval."<sup>83</sup>

- 30.45 Some submissions discussed the need to submit an electronic purchase requisition for lower priced purchases. The requisition goes through a number of approval processes within or before reaching the area health service, partly dependant on which officers have the financial delegation to approve the purchase. Once the requisition has been approved for order, the area health finance system at the Area Health Service passes on the purchase order to the NSW Health hub, where the order is sent through to contractors. Once the goods have been received there is also a complicated receipting and invoicing procedure.<sup>84</sup>
- 30.46 In practice, there does appear to be some inconsistency between the hospitals. One example of this concerns the maintenance of low-price-stock levels. At some hospitals, stock levels were checked via once-a-week stock barcoding and automatically ordered. At other hospitals, emergency stock could be ordered over the phone, whereas at yet others, an electronic requisition through Maximo was required.<sup>85</sup>
- 30.47 For more expensive purchases, I heard there were additional procedures to be followed. A "request for quotes" must be made and a business case presented to support the required purchase of equipment. Sometimes a tender process was also required.
- 30.48 In the submissions I received, there appeared to be no assurance that equipment had actually been ordered, as there is no order confirmation or status update. For example, at one hospital I heard that an ultrasound machine was requested in June 2006 to ensure the safety of central venous access and also nerve blocks. A quote was obtained 1 to 2 months after the initial request. The matter was followed up one year later with further requests but the machine still did not arrive.<sup>86</sup> It was finally purchased with trust funds.<sup>87</sup>
- 30.49 I also heard evidence of orders being stopped at some stage in the purchasing process, having not received the requisite approvals.<sup>88</sup> Those placing the orders did not know where in the process they had been stopped and said that it was difficult to determine where in the approval process an order was. For instance, I received a submission which stated that:
- "Usually you are told to fill in a 'maximo'- a computer generated document that is meant to notify the workshop or stores re the equipment. The follow-up is either very slow or non-existent."<sup>89</sup>
- 30.50 Similarly, I received another submission which stated:
- "There are too many administrative steps to order supplies and no assurance the equipment is actually ordered. Frequent re-submission is required. Many requests, lengthy delays and no funds."<sup>90</sup>
- 30.51 The NSW Health Purchasing and Supply Manual for Public Health Organisations<sup>91</sup> states that ordering direct from State Government Contracts<sup>92</sup> should always be the first option for common-use items if the product and contract conditions meet requirements. Where there is no such contract, purchasing can be undertaken within the delegations established by NSW Health.<sup>93</sup> With respect to goods and services or work:<sup>94</sup>
- (a) up to \$1,500 inclusive of GST may be obtained without quotations subject to some conditions;
  - (b) over \$1,500 and up to \$30,000 inclusive of GST require at least one written proposal and are subject to certain conditions;

- (c) over \$30,000 and up to \$150,000 inclusive of GST require 3 quotations in writing;  
and
- (d) over \$150,000 inclusive of GST require a full tendering process.
- 30.52 These processes can be quite complicated. Understandably the ordinary clinician may not have time to learn about, and follow through with, the procurement process. The process may involve administration and management skills beyond the expertise of most staff.<sup>95</sup>
- 30.53 The new HealthAMMS system might help address some of these issues, as the system appears to have a newer version of the MAXIMO system and reporting facilities. However, despite there being an internet system listing the availability of inventory stock, the naming convention was not standardised, requiring the performance of time consuming searches to locate the item required to be ordered.<sup>96</sup> I understand though that, as part of the NSW Health Total Asset Management Plan 2007/2008 to 2017/2018,<sup>97</sup> a naming convention procedure will be developed with the intention of providing a consistent naming convention procedure to be extended to all medical equipment in the future.<sup>98</sup>
- 30.54 It appears to me that the complaint concerning cumbersome processes emanates from several problems:
- 30.55 First, the severe financial constraints under which hospitals are operating lead to many requests for equipment being rejected.<sup>99</sup> Many submissions stated that equipment had been identified for replacement but no equipment was forthcoming due to a lack of funds, and as illustrated by the following selection, it becomes a frustrating process for those seeking equipment:
- "I think people have become conditioned to expecting a negative response to requests for equipment and other changes. ... so they stop asking. It is easier for the bean counters then to say 'well nobody has asked me'."<sup>100</sup>
- "We actually put an order in for wheelchairs. It went through the health service manager, but then of course she only has the ability to sign off on a certain amount financially, so it then went up higher. I don't know where it got stopped, but it got stopped and we weren't allowed (sic) have them."<sup>101</sup>
- "I will put up the proposal and it is just an endless fight to get the money for the equipment I need."<sup>102</sup>
- 30.56 Hospital staff also said that they had not been told what the budget was or whether there were any funds to cover an equipment order, which would make it very difficult to plan services.
- 30.57 In terms of pricing, the State Government Contract for electro-medical equipment<sup>103</sup> mentions that:
- "an alternative to outright capital purchase [is] ...operating leases for the listed equipment."
- 30.58 I also heard at one hospital that some of the larger pieces of equipment were leased. They knew how long the lease was going to run and at the end of the lease the equipment was almost written off by the leasing company. Either the company would leave the equipment with the hospital, the lease could be renewed or a new piece of equipment could be leased.<sup>104</sup>

- 30.59 Considering the limited funds available to NSW Health, perhaps consideration could be given to leasing contracts to obtain the most up-to-date equipment without the need for a large capital commitment. I understand that State Government policy does not allow for broad based approval of finance leasing and that these can only be approved on a specific case-by-case basis by the Treasurer.<sup>105</sup> However, close consideration should be given to reviewing this policy where there is an urgent need for MRI and CT scanners, or other expensive machines, and there is currently no funds for the purchase of these machines and the leasing arrangement on its face appears to be of benefit.
- 30.60 A second reason contributing to the cumbersome procedure for ordering equipment is the low levels of financial delegation given to staff and managers, as discussed more widely in the Administration chapter (Chapter 31), as this means that equipment orders must go through many approvals before an item can actually be ordered,<sup>106</sup> which would to the difficulties concerning determining the stage at which an order was stopped.<sup>107</sup> In many cases the person who is able to approve the equipment order is far removed from frontline services and may not fully appreciate the necessity of the equipment ordered.
- 30.61 Thus I was told:
- in relation to St George Hospital, that all the stock ordered by the ICU required the approval of the general manager of the central area network since the end of 2005. This was to be contrasted with the situation prior to 2005, at which point it was possible for the purchase of goods up to the value of \$1,000 to be approved without general manager approval. This would lead to delays in the obtaining of the equipment;<sup>108</sup> and
  - in relation to the Sydney Children's Hospital, following the amalgamation of Area Health Services, more and more items were deleted from storage space, such that staff need to write orders to obtain equipment externally. Each purchase requisition requires 3 signatures and it would then be posted to the Materials Resource Division for an order number. Orders would get lost and have to be followed up and, on other occasions, were misdirected with incorrect delivery instructions. This could lead to the hospital being out of pocket; for example, on one occasion, two machines were ordered instead of one.<sup>109</sup>
- 30.62 The existing policy with respect to financial delegation is also confusing. The NSW Health Delegations Combined Manual<sup>110</sup> at Annexure B and page 6.2 lists a number of officers that are able to incur expenditure on services and stores. It is difficult to discern which officers/position holders are included within the 5 delegate rankings, number 1 being the highest ranking. At page 6.3 of the manual, a number of position titles are listed, but there is no definition of an "administration/executive officer". It is not clear whether the term applies directly to a hospital executive officer or an area health service executive officer or to some other management level. Nor is it clear who has the authority to approve the smallest order of stock. At page 8.2 only delegates 2, 3 and 4 can execute and accept documents relating to the performance of services or for the supply of goods, plant machinery or material.
- 30.63 A lack of financial delegation complicates and lengthens the ordering process, which is demonstrated by the following extracts of evidence from a witness:
- "Just as a very small example, that to me just typifies the nonsense that goes on here sometimes, I need to replace one of these plastic holders for my pager at a cost of \$5.90. This form, due to the new delegation policy, must be completed by third tier delegation level. It has to be signed by 3 people up the ladder before I

can get my piece of plastic and it usually takes 4 or 5 months."

"We needed some computer mice, they cost \$10 each. The initial request was put in, in May 2007 and I got delivery of the mice on 3 January 2008. That was after jumping up and down like a crazy woman."<sup>111</sup>

- 30.64 Indeed, many submissions were to the effect that, even where funding was available from charities, approval was still substantially delayed<sup>112</sup> or had been blocked somewhere along the approval path. In one submission I was told that hospital administration charged a handling fee for the approval process for a charity-funded piece of equipment.<sup>113</sup>
- 30.65 In terms of resolving this problem, it appears to be that improved financial delegation is required. Budgets should be allocated to each department head to enable the department heads to give the best service and buy adequate equipment in the provision of services relating to their department.<sup>114</sup> It is necessary for someone who is familiar with the particular needs of a department to be responsible in this regard.

"I think one of the key issues is a lack of delegation of decision making. The delegation of responsibility is still there. We still bear the responsibility for the clinical services and the quality and the safety, et cetera, but for people like me it's been very, very difficult ... I have observed the turnover of more than eight general managers and I've tried to work with all eight of them, but I've become increasingly aware of their feeling of impotency, their inability to make other than fairly small decisions, and during certain periods of time having to refer even really small decisions upwards."<sup>115</sup>

- 30.66 Third, the centralised decision-making processes involved in the 8 area health services, and the lack of devolved authority, as discussed more widely in the Administration chapter (Chapter 31), also seem to impede local processes. Some say that the Area Health Services are too big and that it results in one having to go up through several layers to obtain a decision,<sup>116</sup> assuming that the relevant person can be located.<sup>117</sup> I was told:

"The centralisation of decision-making at an area level results in long delays in approvals, and this impacts adversely on clinical services and also on morale. ...There also has to be an acknowledgement that there are economies of scale in adopting an area-wide approach in matters such as equipment purchase, service contracts..."<sup>118</sup>

- 30.67 Others witnesses told me that some hospital managers, who were also involved at the Area Health Service level, appeared to direct resources back to their own hospital and decisions appeared to have been made without consideration of what was perceived to be the area of largest need.<sup>119</sup>
- 30.68 There are of course economies of scale with the pooling of some resources, but there were also complaints that particular hospitals had saved a large amount of money but did not see the savings returned via their budget<sup>120</sup> and equipment was difficult to obtain from the relevant Area Health Service.<sup>121</sup> By way of example, I was told that, in relation to the Sydney Children's Hospital, although the neurosurgery department recently saved about \$700,000 by combining 5 neurological services in the Area Health Service to evaluate all the different companies supplying high speed turbine drills and going to tender. However, the savings "*went into a black hole*".<sup>122</sup> Unless there is an incentive to save the funds, such as by returning some part of the savings to the relevant



department, hospitals will always struggle to encourage proper equipment usage and ordering efficiency.

### Clinician involvement

30.69 As with the design of new buildings, clinician involvement is beneficial in deciding which equipment to buy. In some cases inappropriate equipment has been purchased as a result of lack of clinician involvement, which can lead to problems concerning spare parts, inefficiencies and confusion among staff when using a different apparatus.<sup>123</sup> Importantly, it leads to an under-use of the equipment.

30.70 These issues are reflected in the following extracts of evidence heard by me:

"The staff are saying why are they spending \$2.7 million opening up a fifth theatre, that probably will not be functional anyway, when we can't even have basic surgical instruments to run lists effectively? We are constantly going to the sterilising department and saying, "We need those instruments. Where are they?" It's a 2 hour turnaround from the time we use instruments to the time they are ready to be used again on a patient. It can quite significantly impact on the smooth running of your elective list."

"We say rather than spend money on that theatre, why not look at what people want the money spent on, what will be useful to the smooth running of an operating theatre, and indeed through the rest of hospital."

"We are concerned that there is irresponsible allocation of money for equipment that we don't need. For example the purchase of 5 new ventilators that were not needed. The director of ICU wasn't involved initially in the decision making process. "Isn't the decision of about what equipment to buy in the ICU made by the director of the ICU?"<sup>124</sup>

30.71 In contrast, I heard an example, which is worthy of detailed review, where the involvement of clinicians led to rectifying budgetary overruns in relation to equipment.<sup>125</sup> I discuss this in Chapter 31. In summary, the cost of prostheses used by surgeons in the same department at St Vincent's Hospital varied significantly. An analysis of the costs by the Program Director of Surgeon, Dr Maxwell Coleman, in consultation with the surgeons, resulted in prosthetic costs being reduced through standardising the procurement process. This was done in the context of GainShare, an initiative whose aim was to improve efficiency in specialised equipment procurement processes. I discuss GainShare in Chapter 31.

### No comprehensive equipment maintenance

30.72 As for equipment maintenance, there appears to be a lack of maintenance staff available to carry out equipment repairs in a timely manner.<sup>126</sup> One submission alleged that an area health service was too large and had insufficient staff, thus making it impossible for managers to manage maintenance, with the result that the preventative maintenance program had dropped off some years ago.<sup>127</sup> I was also told that some area health services withhold maintenance funds for other operational needs.<sup>128</sup> As noted above, many submissions alleged that equipment was old, malfunctioning, not regularly serviced or had incomplete servicing.

30.73 Machines need to be regularly checked and calibrated.<sup>129</sup> Breakdowns can lead to extended waiting lists and may have dire consequences. For medical equipment used



in patient transport, it was suggested that equipment should be checked twice per week and upon leaving and returning to the hospital.<sup>130</sup> I was told that, in desperation, equipment maintenance or repair was being performed by clinical or other hospital staff.<sup>131</sup> As stated by a witness from the Bourke Hospital:

"...the lighting and heating system on the top was perceived to be dysfunctional, so the fix it (sic) for that was to get an angle grinder and cut that fitting off and to get a stand with a lighting and heating unit and stand it over that table unit. ... It's not a very mobile unit."<sup>132</sup>

- 30.74 I heard that maintenance takes place in an Area Health Service workshop or, in some hospitals, onsite in the biomedical engineering workshop. Medical devices requiring maintenance are sent to the biomedical department for repair together with a request for repair. Where the equipment cannot be transported, a request is made over the phone or via facsimile transmission.<sup>133</sup> The need to transfer equipment offsite for repair also ties up hospital staff in transport.<sup>134</sup>
- 30.75 It is not clear how often equipment is maintained or tested for functionality and reliability. NSW Health tells me that local testing of equipment is to occur in accordance with Australian standards for the type of equipment. I am also told that once the expected life has passed, routine inspections are performed until the item is replaced.<sup>135</sup> There does not appear to be any indication as to how often those inspections really are. It appears that maintenance reports can be generated locally but are not generated at pre-determined periods. I heard that, due to a lack of funding, it may be that nothing is done until formal notification comes from the manufacturer that the equipment will no longer be supported.<sup>136</sup>
- 30.76 Some Area Health Services look at what needs to be replaced now, whereas others say that they plan for future equipment replacement. It appears some Area Health Services leave the hospital to spend within its own budget. However I heard many submissions alleging that the hospital was not told what the budget was. I have also been told by NSW Health that there is no strategic replacement plan in place as there is no budget to support it.<sup>137</sup>

### Improvements underway

- 30.77 NSW Health frankly acknowledged that there is scope to *"achieve process improvements and savings in the procurement and maintenance of medical equipment."*<sup>138</sup>
- 30.78 NSW Health's objectives are to implement a system with the following features (via HealthAMMS):<sup>139</sup>
- a whole of lifecycle costing approach to the management of medical equipment;
  - ensuring that all medical equipment is 'fit for purpose' and that the clinical requirements are used to define the specifications for the equipment;
  - a consistent approach to the procurement and maintenance of medical equipment across all area health services;
  - an improved understanding of the medical equipment assets held and their utilisation;
  - an integrated approach to the planning and management of equipment replacement needs;
  - an estimate of replacement liability; and

- a comprehensive equipment maintenance strategy across all area health services to minimise the unavailability of equipment.
- 30.79 The system also aims to:<sup>140</sup>
- create a standard definition of medical equipment and to assess naming conventions and asset descriptions;
  - use standard rules to calculate the useful life of an asset;
  - use a common medical equipment register;
  - improve the monitoring of leases;
  - manage the disposal of surplus equipment more effectively; and
  - use forward planning of maintenance contract requirements greater than 12 months.
- 30.80 I am told that NSW Health is calling for expressions of interest for the development of a business case to examine the options to establish a better asset management approach.
- 30.81 The business case will examine options for:<sup>141</sup>
- equitable and appropriate investment in medical equipment;
  - efficient and effective management of the recurrent costs (maintenance and consumables) for medical equipment;
  - appropriate and efficient disposal of medical equipment; and
  - provision of consistent information in relation to investment, maintenance and disposal of medical equipment across NSW.
- 30.82 I applaud these efforts. It is bad business not to know what assets you own, not to maintain your assets and not to plan for and replace equipment when it is needed.

<sup>1</sup> Confidential submission, 31 July 2008, SUBM.088.0089.

<sup>2</sup> Submission of The Children's Hospital at Westmead, 31 March 2008, SUBM.014.0253, page 4.

<sup>3</sup> Information provided during visit to Wellington District Hospital on 18 March 2008, HVH.002.0074.

<sup>4</sup> Information provided during visit to Braidwood Multi-Purpose Service on 15 April 2008, HVH.006.0057.

<sup>5</sup> Information provided during visit to Prince of Wales Hospital on 21 February 2008.

<sup>6</sup> Confidential Bankstown hearing, 13 May 2008, transcript 48.32 – 49.44,

<sup>7</sup> Confidential Bankstown hearing, 13 May 2008, transcript 48.32 – 49.44.

<sup>8</sup> Elisabeth Gay Allen, Coffs Harbour hearing, 27 March 2008, transcript 993.35 –993.39.

<sup>9</sup> Submission from the Australian Medical Association of NSW and the Australian Salaried Medical Officers' Federation, 20 March 2008, SUBM.016.0066 at 0081, 0087.

<sup>10</sup> Information provided during visit to Milton-Ulladulla Hospital on 15 April 2008; Debbie Skinner, Emma Coyle, Elizabeth White, Hornsby hearing, 11 March 2008, , transcript 252.7 –253.24; James Frederick Loneragon, Mudgee Hospital Hearing, 20 March 2008, , transcript 710.13 –710.30; Susan Henderson, Tracy Caroline Wittich, Margaret Webster, Royal North Shore Hospital, 14 March 2008, , transcript 392.28 – 394.15; Information provided on visit to Manly Hospital on 12 March 2008.

<sup>11</sup> Confidential Submission, 28 March 2008, SUBM.009.0150.

<sup>12</sup> Information provided during visit to Mullumbimby Hospital on 29 April 2008.

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- <sup>13</sup> Michael Cousins, Royal North Shore Hospital hearing, 14 March 2008, transcript 347.3-.349.3.
- <sup>14</sup> Submission of Barbara Lucas, Patricia Evans, Anne Osborne and Anne Heaton, 2 April 2008, SUBM.011.0297 and 011.0299.
- <sup>15</sup> Information provided during visit to Goulburn Hospital on 28 February 2008, [26].
- <sup>16</sup> Submission of Rozlyn Norman, 26 March 2008, SUBM.074.0087.
- <sup>17</sup> Janet Kay Ogden, Prince of Wales Hospital hearing, 1 May 2008, transcript 2566.20 – 2566.28.
- <sup>18</sup> Submission of Associate Professor Nick Evans, 20 May 2008, SUBM.040.0068.
- <sup>19</sup> Confidential Mudgee hearing, 20 March 2008, transcript 14.3 –15.43.
- <sup>20</sup> See for example the submission of Dr Robert Herkes, 28 March 2008, SUBM.007.0394.
- <sup>21</sup> Submission of Centre for Newborn Care Nurses, 1 May 2008, SUBM.074.007.
- <sup>22</sup> Dr Susan Arbuckle, Westmead Children’s Hospital hearing, 15 May 2008, transcript 2957.34-3957.44.
- <sup>23</sup> Submission of Rozlyn Norman, 26 March 2008, SUBM.074.0087.
- <sup>24</sup> Submission of Inverell Chamber of Commerce, 26 March 2008, SUBM.046.0063 at 0068.
- <sup>25</sup> Submission of Kate Walsh, 15 February 2008, SUBM.015.0209.
- <sup>26</sup> Submission of Ann Louise Moran, 26 March 2008, SUBM.027.0366.
- <sup>27</sup> Submission of Adrienne and Lewis Furner, 24 June 2008, SUBM.005.0244.
- <sup>28</sup> Submission of Michelle Lewis, 26 March 2008, SUBM.010.0211.
- <sup>29</sup> Dr Roderick Brooks, Hornsby hearing, 11 March 2009, transcript 270.36 – 271.3.
- <sup>30</sup> Submission of Julie Gibbs, 21 May 2008, SUBM.040.0226; Confidential submission, 18 April 2008, SUBM.031.0059.
- <sup>31</sup> Submission of Port Macquarie Base Hospital Nursing Unit Managers, 28 March 2008, SUBM.047.0202.
- <sup>32</sup> Confidential Submission, 28 March 2008, SUBM.009.0150; Confidential submission, 16 February 2008, SUBM.031.0059.
- <sup>33</sup> Submission of Dr Robert Herkes, 28 March 2008, SUBM.007.0394.
- <sup>34</sup> Confidential Mudgee hearing, 20 March 2008, TRAN.019.0001, transcript 14.3 –15.43.
- <sup>35</sup> Mary-Louise Davis, Bourke Hospital hearing, 9 May 2008, transcript 2683.5 - 2683.47.
- <sup>36</sup> Confidential submission, 14 May 2008, SUBM.009.
- <sup>37</sup> Submission of Stan Eggins, 26 April 2008, SUBM.023.0043.
- <sup>38</sup> Submission of Dr Hamish Steiner, 26 May 2008, SUBM.053.0092.
- <sup>39</sup> Confidential submission, 14 April 2008, SUBM.043.0223.
- <sup>40</sup> NSW Health Total Asset Management Plan 2007/2008 to 2017/2018, Version 9, December 2007, p.47; Letter from NSW Health to Special Commission of Inquiry, 18 November 2008.
- <sup>41</sup> Various examples of transport that would be rendered unnecessary were appropriate equipment available are found in: Submission of Dr Hamish Steiner, 26 May 2008, SUBM.053.0092; Submission of NSW Nurses Association Wagga Wagga Base Hospital Branch, 23 April 2008, SUBM.073.0093 at 0095; Submission of Michael Wawn, 3 February 2008, SUBM.031.0059; Confidential submission, Undated, SUBM.005.0023; Confidential Wagga Wagga Base Hospital Video-link hearing, 30 May 2008, Transcript 4.3–10.42.
- <sup>42</sup> Submission of Dr Hamish Steiner, 26 May 2008, SUBM.053.0092.
- <sup>43</sup> Submission of Southern General Practice Network, 11 March 2008, SUBM.002.0044.
- <sup>44</sup> Submission of Associate Professor Monica Rossleigh, 28 March 2008, SUBM.014.0057.
- <sup>45</sup> Submission of Dr Pdraic Grattan-Smith, 28 March 2008, SUBM.005.0535 at 2; Confidential submission, 14 May 2008, SUBM.009.0234 at 3; Submission of Associate Professor Monica Rossleigh, 28 March 2008, SUBM.014.0057 at 5.

- <sup>46</sup> Confidential submission, 28 March 2008, SUBM.014.0092, in relation to bedside ultrasound; and Dr Susan Arbuckle, Westmead Children's Hospital hearing, 15 May 2008, transcript 2955.1- 2958.10.
- <sup>47</sup> NSW Health Total Asset Management Plan 2007/2008 to 2017/2018, Version 9, December 2007 at page 13.
- <sup>48</sup> NSW Health Total Asset Management Plan 2007/2008 to 2017/2018, Version 9, December 2007 at page 47; Letter from NSW Health to Inquiry, 18 November 2008.
- <sup>49</sup> NSW Health Briefing, 2 June 2008.
- <sup>50</sup> Letter from NSW Health to the Special Commission of Inquiry, 6 June 2008, DOH.062.0056.
- <sup>51</sup> Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008.
- <sup>52</sup> Letter from NSW Health to the Special Commission of Inquiry, 6 June 2008, DOH.062.0056.
- <sup>53</sup> See for example Dr Susan Arbuckle, Westmead Children's Hospital hearing, 15 May 2008, TRAN.117.0001, transcript 2958.12 2960.30.
- <sup>54</sup> Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008.
- <sup>55</sup> Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008.
- <sup>56</sup> Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008.
- <sup>57</sup> Letter from NSW Health to the Inquiry, 25 September 2008; and American Society of Health care engineering of the American Hospital Association, *Maintenance management for Medical Equipment*, 1996.
- <sup>58</sup> Letter from NSW Health to the Special Commission of Inquiry, 6 June 2008, DOH.062.0056.
- <sup>59</sup> Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008; Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008.
- <sup>60</sup> Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008.
- <sup>61</sup> Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008.
- <sup>62</sup> Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008.
- <sup>63</sup> Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008; Letter from NSW Health to the Special Commission of Inquiry, 18 November 2008.
- <sup>64</sup> Letter from NSW Health to the Special Commission of Inquiry, 6 June 2008, DOH.062.0056.
- <sup>65</sup> Letter from NSW Health to the Special Commission of Inquiry, 6 June 2008, DOH.062.0056.
- <sup>66</sup> See for example the confidential submission, 27 March 2008, SUBM.023.0047 at 2; the Submission of Associate Professor Monica Rossleigh, 28 March 2008, SUBM.014.0057 at 1; and Confidential submission, 29 May 2008 SUBM.070.0273 at 3.
- <sup>67</sup> Submission of Jillian Skinner, 9 April 2008, SUBM.050.0211.
- <sup>68</sup> See, for example, the Submission of Associate Professor Richard Millard, 29 April 2008, SUBM.046.0100; Submission of Dr Brian Pezzutti, 25 March 2008, SUBM.028.0204, at p.3; Submission of Jillian Skinner, 9 April 2008, SUBM.050.0211; and Confidential submission, 29 May 2008, SUBM.037.0133.
- <sup>69</sup> For further examples of problems that arise as a consequence of using ageing equipment, see: Submission of Port Macquarie Base Hospital Nursing Unit Managers, 28 March 2008, SUBM.047.0202 at 3; Submission of Ann Louise Moran, 26 March 2008, SUBM.027.0366 at 1; Confidential submission, 14 May 2008, SUBM.009.0234 at 2; Confidential submission, 29 May 2008, SUBM.070.0273 at 3 - 5; Janet Ogden, Prince of Wales Hospital hearing, 1 May 2008, transcript 2566.8 - 2566.18; Submission of The Children's Hospital at Westmead Medical Staff Council to Minister for Health, 31 March 2008, SUBM.014.0260 at 4.
- <sup>70</sup> Dr Susan Arbuckle, Westmead Children's Hospital hearing, 15 May 2008, transcript 2958.12 - 2960.30.
- <sup>71</sup> Dr Susan Arbuckle, Westmead Children's Hospital hearing, 15 May 2008, transcript 2958.12 - 2960.30.
- <sup>72</sup> Submission of Dr Samuel Sakker, 6 April 2008, SUBM.029.0174.
- <sup>73</sup> Submission of Dr Stephen Adelstein and Dr Bev Rowbotham, 31 March 2008, SUBM.014.0121.
- <sup>74</sup> See for example, Submission of Dr Brian Pezzuti, 25 March 2008, SUBM.028.0204, at p.3.

- 75 See for example, Submission of Dr Brian Pezzutti, 25 March 2008, SUBM.028.0204.
- 76 See for example Debbie Skinner, Emma Coyle, Elizabeth White, Hornsby Hospital hearing, 11 March 2008, transcript 252.7 –253.24; and Information provided on visit to Liverpool Hospital on 26 February 2008.
- 77 Submission of Dr Brian Pezzutti, 25 March 2008, SUBM.028.0204
- 78 Submission of Rozlyn Norman, 26 March 2008, SUBM.013.0036 at p.2.
- 79 Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008.
- 80 Dr Lloyd Ridley, Concord Repatriation Hospital, 24 April 2008, transcript 2175.22- 2175.39.
- 81 Confidential Sydney Children's Hospital hearing, 19 May 2008 transcript 4.16 – 4.20.
- 82 Debbie Skinner, Emma Coyle, Elizabeth White, Hornsby hearing, 11 March 2008, , transcript 252.29-252.41.
- 83 Confidential Lismore Base hearing, 28 April 2008, transcript 21.15-22.16.
- 84 Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008.
- 85 Submission of Rozlyn Norman, 26 March 2008, SUBM.074.0087.
- 86 Confidential submission, 7 May 2008, SUBM.045.0122, at SUBM.046.0125 attaching, Plan for the Tweed Hospital, Department of Anaesthesia, 5 December 2007, p.139.
- 87 Confidential submission, 7 May 2008, SUBM.045.0122, at p.3.
- 88 Susan, Tracy Caroline Wittich, Margaret Webster, Royal North Shore Hospital hearing, 14 March 2008, transcript 392.29 – 393.10.
- 89 Submission of Rozlyn Norman, 26 March 2008, SUBM.074.0087.
- 90 Submission of Associate Professor Richard Millard, 29 April 2008, SUBM.046.0100.
- 91 NSW Health Purchasing and Supply Manual for Public Health Organisations, January 2006 at p.1.1.
- 92 The State Contracts Control Board assists the government in procurement practices. The Board organises State Government period contracts (State Government Contracts) with suppliers to secure contract prices for the procurement of certain goods and services. State Government Contracts exist for certain types of medical equipment.
- 93 NSW Health, *Purchasing and Supply Manual for Public Health Organisations, January 2006*, [http://www.health.nsw.gov.au/resources/policies/manuals/purch\\_supply.asp](http://www.health.nsw.gov.au/resources/policies/manuals/purch_supply.asp) (24 October 2008).
- 94 NSW Health, *Purchasing and Supply Manual for Public Health Organisations, January 2006*, [http://www.health.nsw.gov.au/resources/policies/manuals/purch\\_supply.asp](http://www.health.nsw.gov.au/resources/policies/manuals/purch_supply.asp) (24 October 2008).
- 95 Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008.
- 96 Debbie Skinner, Emma Coyle, Elizabeth White, Hornsby hearing, 11 March 2008, transcript 249.
- 97 Confidential NSW Health Total Asset Management Plan 2007/2008 to 2017/2018, Version 9, 7 December 2007. Medical Equipment Strategy, page 47.
- 98 Letter from NSW Health to the Special Commission of Inquiry, 18 November 2008.
- 99 Confidential submission, 2 April 2008, SUBM.011. 0338 at 4; Dr Jerry Koutts, Westmead hearing, 10 April 2008, transcript 1547.22-1547.45; Submission of Dr Stephen Adelstein and Dr Bev Rowbotham, 31 March 2008, SUBM.014.0121 at 8; Submission of NSW Nurses Association Wagga Wagga Base Hospital Branch, 23 April 2008, SUBM.073.0093 at 4 - 5; Submission of Patricia Mort, 20 March 2008, SUBM.074.0079 at 3; Confidential submission, undated, SUBM.076.0323 at 4; Submission of Australian Medical Association of NSW and Australian Salaried Medical Officers' Federation, 20 March 2008, SUBM.016.0066 at 2; Confidential Mudgee hearing, 20 March 2008, transcript 14.43-14.4.
- 100 Janet Ogden, Prince of Wales Hospital hearing, 1 May 2008, TRAN.080.0001, transcript 2567.10 – 2567.15.
- 101 Mary-Louise Davis, Bourke hearing, 9 May 2008, transcript 2683.21-2684.93.
- 102 Confidential Bankstown hearing, transcript 48.32 – 49.44.

- <sup>103</sup> NSW Department of Commerce, *Equipment available from electro-medical period contracts*, <http://www.dpws.nsw.gov.au/NR/rdonlyres/eazshxfnnz24wky6oo6nvlesv2hs57dfpyiugmqsg6f5kpic2ownukrijlzmqgwct4gl5g3xiddkbb67ijizismugc/EquipmentElectroMedicalContracts0608.pdf> (17 October 2008).
- <sup>104</sup> Dr Susan Arbuckle, Westmead Children's Hospital hearing, 15 May 2008, transcript 2958.36 - 2958.47.
- <sup>105</sup> NSW Health, *Purchasing and Supply Manual for Public Health Organisations*, January 2006, [http://www.health.nsw.gov.au/resources/policies/manuals/purch\\_supply.asp](http://www.health.nsw.gov.au/resources/policies/manuals/purch_supply.asp) (24 October 2008).
- <sup>106</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 8.5 -9.20.
- <sup>107</sup> Mary-Louise Davis, Bourke hearing, 9 May 2008, transcript 2683.5 -2683.20.
- <sup>108</sup> Confidential St George Hospital Hearing, transcript 2.35-6.19.
- <sup>109</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 8.5 -9.20.
- <sup>110</sup> NSW Health Delegations Manual, combined, Administrative Financial Staff, 1 January 1997, [http://www.health.nsw.gov.au/resources/policies/manuals/comb\\_delegations.asp](http://www.health.nsw.gov.au/resources/policies/manuals/comb_delegations.asp) (27 October 2008).
- <sup>111</sup> Confidential Westmead Hospital hearing, 10 April 2008, transcript 31.1 – 31.18
- <sup>112</sup> See for example Confidential Mudgee Hospital hearing, 20 March 2008, transcript 14.25-14.45; Debbie Skinner, Emma Coyle, Elizabeth White, Hornsby Hospital hearing, 11 March 2008, transcript 250.19, at 250.27; Confidential submission, 28 March 2008, SUBM.009.0150.
- <sup>113</sup> Confidential submission, 14 May 2008, SUBM.009.
- <sup>114</sup> Confidential submission, 28 March 2008, SUBM.014.0092.
- <sup>115</sup> Michael John Cousins, Royal North Shore Hospital hearing, 14 March 2008, transcript 342.42 –343.18.
- <sup>116</sup> Confidential Mudgee Hospital hearing, 20 March 2008, TRAN.019.0001, transcript 14.3 –15.
- <sup>117</sup> Note for example the Submission of Emergency Medical Consultants, 13 March 2008, SUBM.023.0202; and the Submission of Rozlyn Norman, 26 March 2008, SUBM.013.0036, page 2.
- <sup>118</sup> Dr Thomas Karplus, Concord Hospital hearing, 24 April 2008, transcript 2107.3 -2107.5; 2107.38-41.
- <sup>119</sup> Submission of Dr Samuel Sakker, 8 April 2008, SUBM.029.0174 – Royal North Shore Hospital management impacts on Ryde Hospital; and Confidential submission, 7 April 2008, SUBM.047.006.
- <sup>120</sup> Dr Warwick Stening, Sydney Children's Hospital hearing, transcript 3081.22-3081.40.
- <sup>121</sup> Confidential Submission, 15 April 2008, SUBM.021.0228
- <sup>122</sup> Dr Warwick Stening, Sydney Children's Hospital hearing, transcript 3081.22-3081.40.
- <sup>123</sup> Submission of Associate Professor Richard Millard, 29 April 2008, SUBM.046.0100 at 3; Confidential submission, 28 June 2006, SUBM.023.0081 at 9; Confidential submission, 7 April 2008, SUBM.047.0066 at 11.
- <sup>124</sup> Confidential Wagga Wagga Base Hospital Video-link hearing, 30 May 2008, Transcript 9.32–10.42
- <sup>125</sup> Dr Maxwell Coleman, St Vincent's Hospital hearing, 30 April 2008, transcript 2436.38 – 2443.14.
- <sup>126</sup> Confidential Submission, undated, SUBM.076.0323; Janet Kay Ogden, Prince of Wales Hospital hearing, 1 May 2008, transcript 2566.8 –2566.15.
- <sup>127</sup> Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 3.16 – 4.14.
- <sup>128</sup> Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008.
- <sup>129</sup> Submission of Dr Tristan Barnes, 31 March 2008, SUBM.002.0033.
- <sup>130</sup> Confidential submission, 28 April 2008, SUBM.025.0002
- <sup>131</sup> Confidential submission, 22 April 2008, SUBM.040.0136; and Submission of Dr Sue Ieraci, Dr Deniz Tek, 19 March 2008, SUBM.009.0001.



- <sup>132</sup> Mary-Louise Davis, Bourke Hospital hearing, 9 May 2008 transcript 2683.5 - 20.
- <sup>133</sup> Letter from NSW Health to the Special Commission of Inquiry, 24 September 2008.
- <sup>134</sup> Submission of Port Macquarie Base Hospital Nursing Unit Managers, 28 March 2008, SUBM.047.0202.
- <sup>135</sup> Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008.
- <sup>136</sup> Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008.
- <sup>137</sup> Letter from NSW Health to the Special Commission of Inquiry, 25 September 2008.
- <sup>138</sup> Letter from NSW Health to the Special Commission of Inquiry, 6 June 2008, DOH.062.0056.
- <sup>139</sup> Letter from NSW Health to the Special Commission of Inquiry, 6 June 2008, DOH.062.0056.
- <sup>140</sup> NSW Health Total Asset Management Plan 2007/2008 to 2017/2018, Version 9, December 2007 at p.47.
- <sup>141</sup> Letter from NSW Health to the Special Commission of Inquiry, 6 June 2008, DOH.062.0056.



Equipment

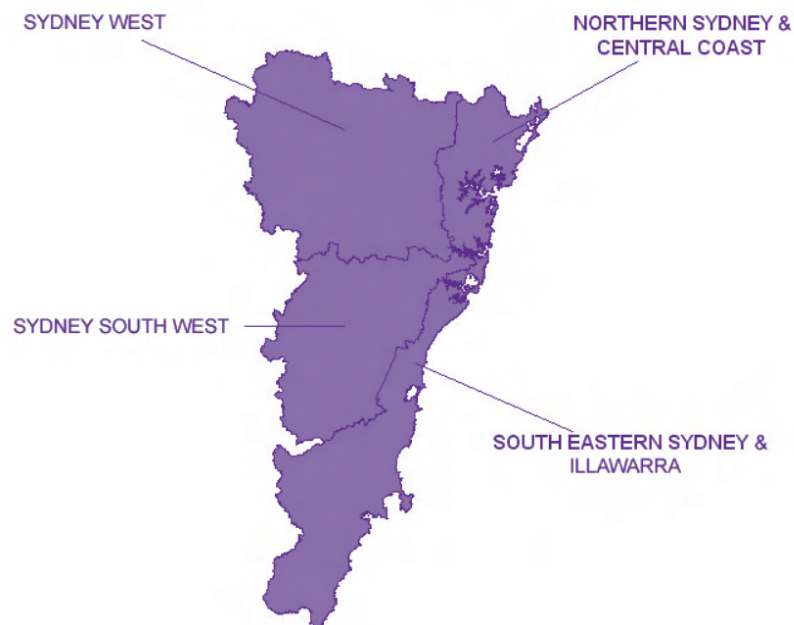
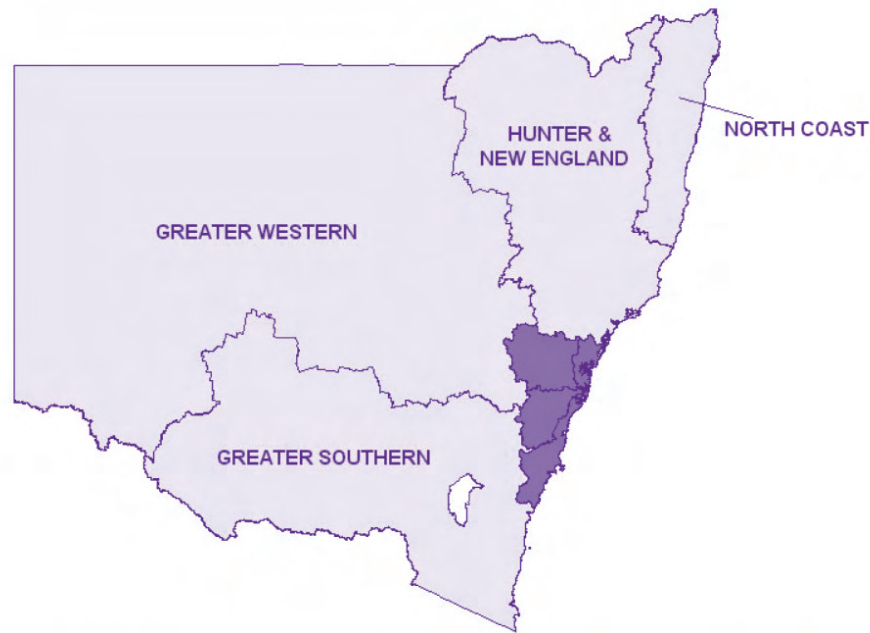
## 31 Administration & management

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- 31.1 During my Inquiry, a most frequent topic of complaint was the way in which the NSW public health system is administered.
- 31.2 In this chapter, I will examine:
- (a) the current area health service structure, and complaints about this structure;
  - (b) the current system of governance of area health services and complaints about this system;
  - (c) management practices and problems with them;
  - (d) the disengagement of clinicians from the public hospital system because of the poor relationship with management.
- 31.3 Finally, I will recommend some changes intended to improve the existing situation.
- 31.4 From the point of view the NSW government administration, the NSW public health system comprises:
- The Minister for Health (The Hon John Della Bosca MLC), together with two Ministers Assisting: Cancer, (The Hon Jodi Lynch MP) and Mental Health Services (The Hon Barbara Perry MP)
  - The Director General of NSW Department of Health
  - NSW Department of Health
  - Health Administration Corporation, which deals with land, services contracts and the like.
  - Ambulance Service of NSW
  - 8 Area Health Services
  - Other public health organisations such as Justice Health, the Children’s Hospital at Westmead and the Clinical Excellence Commission.
- 31.5 The Cancer Institute is a statutory body, largely independent of NSW Health, charged with improving cancer control in NSW.

## Area health services

- 31.6 Public hospitals, with the exception of The Children’s Hospital at Westmead, are operated by Area Health Services under the auspices of NSW Health.
- 31.7 There are 8 area health services, following a series of mergers and border changes in 2005, which reduced 17 area health services to the following:<sup>1</sup>
- Northern Sydney / Central Coast
  - South Eastern Sydney / Illawarra
  - Sydney South West
  - Sydney West
  - Greater Southern
  - Greater Western
  - Hunter / New England
  - North Coast
- 31.8 The borders of these area health services are shown in the following map:



- 31.9 The geographic areas concerned are immense. The Greater West Area Health Service is larger than Germany. The Hunter New England Area Health Service is the size of England. Indeed, the NSW Health System is one of the largest centralised health care systems in the world.<sup>2</sup>
- 31.10 The characteristics of each area health services are unique in terms of their geography, demography, service arrangements and in some of their governance structures.
- 31.11 However, whatever the precise boundaries of the area health services, the fact remains that the loyalty of clinicians and communities generally remains to hospitals or even wards and units within the hospitals, rather than to area health services.<sup>3</sup>

## Problems with the restructure of Area Health Services

- 31.12 Much disquiet was expressed during hearings and submissions in respect of the reduction of 17 area health services to 8. It is clear that the establishment of the 8 area health services has caused serious disruption and unrest.

### History of the restructure

- 31.13 In light of the concerns expressed, it is worth considering the rationale for the restructure which took effect on 1 January 2005, just three years before this Inquiry commenced.
- 31.14 The government's stated goal was announced at the time of the restructures in media releases:

"The goal of the restructure which was announced earlier this year was to unlock additional funds for frontline clinical services by reducing administrative duplication and streamlining processes," Mr Iemma said."

"The money we save from administrative duplication will be directed back into more beds, more doctors, nurses and allied health staff and more clinical services."<sup>4</sup>

and in Parliament:

"It is all about equity of access and the redistribution of health resources to areas of most need."<sup>5</sup>

- 31.15 The Second Reading Speech for the Bill which became the *Health Services Amendment Act 2004* which enacted the restructures contained, when delivered on 28 October 2004, in the Legislative Assembly by the then Minister for Health, the Hon Morris Iemma MP, this description of the purposes of the amalgamations:

"Area health service boundaries were drawn up almost 20 years ago and no longer reflect New South Wales's population distribution, make-up and growth, health work force distribution, and patterns of clinical referrals and patient flows. ...The new area boundaries have been developed to meet current and future health needs, with the key principle underpinning the area health service reforms being that more of NSW Health's resources should be spent on direct patient care and less on administration. The new area health service structure will reduce administrative duplication and inefficiencies and improve consistency in the way health services are delivered."<sup>6</sup>

It will encourage the building of better clinical networks and enhance academic and teaching links. The new structure will also assist in improving the distribution of the health work force....

The reforms to area health service boundaries and shared services arrangements are, over time, expected to free up \$100 million annually, with the savings being reinvested in additional frontline health services in the areas where they are realised."

- 31.16 The Independent Pricing and Regulatory Tribunal (**IPART**) undertook a review of the health system in 2003. The review considered the merits of merging the area health services and concluded that there was:<sup>7</sup>

"not a strong case for a system-wide boundary review at present."

- 31.17 IPART did not preclude minor changes in boundaries or "one off" amalgamations. It outlined some of the potential benefits and disadvantages of amalgamations. It noted that a reduction in the number of area health services might cause management to be too far removed from the population to adequately address all of its needs. On the other hand, it noted that area amalgamations might strengthen clinical networks to ensure a more equitable distribution of services and stimulate a cultural shift from clinicians' loyalty to individual hospitals to providing services across a wider geographic region. As noted above, this was one of the Government's stated purposes at the time of the restructures, which were announced in the year following IPART's report.

*What were the savings?*

- 31.18 Many clinicians gave evidence that they understood the purpose of the amalgamations to have been the removal of many of the "middle management" roles.<sup>8</sup> Some said that this happened initially but that there was then a "claw back" which increased the number of managers. Many others said that the result was to transfer responsibility for many administrative tasks to clinical staff which has taken them away from frontline clinical services.<sup>9</sup> I return to these issues below.
- 31.19 NSW Health informed the Inquiry that 1,108.69 FTE administrative positions (within prescribed Chief Financial Officer corporate services operating areas and related areas) were abolished as a result of the restructure. It said that this was the single biggest saving in achieving the efficiency target required to be met for 2005/2006 and the 2 following years.<sup>10</sup> As discussed in Chapter 25, since 2005 the NSW Government has imposed efficiency targets on all government departments in an attempt to reduce excessive spending. This required NSW Health to make a saving of \$91.3 million in 2005-2006 (with accumulated savings requirements each year thereafter).
- 31.20 I discuss the change to administrative positions below.
- 31.21 NSW Health provided the Inquiry with a copy of a review prepared by IAB Services, a NSW government business enterprise, in February 2008 relating to the savings made as a result of the amalgamation process.<sup>11</sup> The report notes that the objectives were to make overall amalgamation savings of 1,118.1 FTEs and total annual salary savings of \$70.5 million. The review identified that:
- 1,108.69 FTE reductions linked to the amalgamation process have occurred within the prescribed corporate services areas across all health services. These reductions were made by reason of resignations, transfers to non-CFO positions ('CFO positions' refers to the prescribed corporate services positions) and voluntary redundancies;
  - the total salary savings associated with these reductions, including 10% on-costs, was \$81.497 million; and
  - targets set by area health services for expenditure growth in nominated front line service areas were achieved. However, due to the complex nature of health recurrent expenditure and timing of the review, the review did not verify that FTE salary savings achieved from reductions in 'CFO' positions had in fact been 'redirected' towards front line service areas.
- 31.22 The review did not include analysis of expenditure or growth for the organisations (that is, area health services, the Children's Hospital at Westmead) as a whole or of the appropriateness of front line and CFO service activity or quality levels pre- and post-amalgamations.<sup>12</sup>

- 31.23 Although the restructure met the targets set by government, it has also generated significant complaints from clinicians and employees and staff of NSW Health.

### Size

- 31.24 There were complaints from a number of stakeholders that the sheer size of the area health services makes it difficult for them to function. I was told that the areas are too large for one Chief Executive to run effectively.<sup>13</sup>
- 31.25 The Inquiry received evidence that the larger size of area health services has meant that decision-makers are geographically removed from those who rely on them. I was told by one doctor that the administrative staff at most local facilities were “beholden to people in North Sydney...” who, I was told, are remote from “what is actually happening on the ground”.<sup>14</sup> I took this to be an expression used to emphasise the lack of decision-making power and discretion at local or hospital level and a statement condemning the excessive degree of centralised decision-making, which is a feature of the current restructured system.
- 31.26 Richard Western, who is regional director of the Maari Ma Health Aboriginal Corporation and based in Broken Hill, gave evidence that before formation of the Greater Western Area Health Service, he had access to the Chief Executive Officer of the Far West Area Health Service who was also located in Broken Hill.<sup>15</sup> The Greater Western Area Health Service is larger than Germany in geographical area. He said that he can no longer talk about issues face-to-face with decision makers as the Chief Executive is now located in Dubbo and responsible for a much larger area.
- 31.27 Mr Western said that the larger size of the area health service has also resulted in reduced access to, and support from, population health programs. He highlighted that the needs of Aboriginal people within the Greater Western Area Health Service are not homogenous and that they are unique from those of the rest of New South Wales.<sup>16</sup> Mr Western told the Inquiry that he is concerned that acute services in Broken Hill will become unstable as a result of the Area’s much larger size as this would undermine the work being done in Aboriginal health and the coordination of care which, he said, is vital to ensure equitable care to all Aboriginal communities.
- 31.28 I do not regard Mr Western’s evidence as being limited to an issue about Aboriginal health. I regard it as indicative of the evidence that I received about the larger size of area health services which has resulted in apprehension by smaller and more remote communities that their voice is no longer heard at Area level. Area health services need to be answerable to a genuine community.
- 31.29 Several other witnesses also expressed the view that the size of the Greater Western Area Health Service “makes it impossible to run”.<sup>17</sup>
- “The processes in trying to manage a system of the complexity we have across that sort of area are just incredibly difficult.”
- 31.30 Some said that greater support was needed from Dubbo.<sup>18</sup>
- 31.31 On the other hand, some say that sparsely populated areas of the State need to be part of large area health services to ensure that they have a capital base and patient numbers to function “on a fair basis”.<sup>19</sup> The Inquiry received a small amount of positive evidence about the size of the area health services. One witness said that the enlarged Northern Sydney Central Coast Area Health Service worked well because of the depth of clinician involvement across the network.<sup>20</sup>



- 31.32 The overarching problem, however, as many clinicians see it, was encapsulated in the following evidence:

"we feel one of the fundamental issues that we see as being a problem not only for us but across the health system is the inordinate disconnection between those of us at what one might call the coalface and the administration, particularly since the amalgamation of the areas that occurred a few years back when we have got administrators sitting, both geographically and functionally, an awfully long way from where things are meant to happen and we see a failure of the centralisation of so many of the functions that formerly seemed to work and now don't seem to."<sup>21</sup>

- 31.33 These concerns also relate to the other key change made in 2005 which was to abolish area health boards as the governance model for area health services. I discuss this further below.

- 31.34 The problem with the size of the area health services is also complicated by the centralisation of services<sup>22</sup>, as summarised in this evidence:

"previously when we had our own human resources, maintenance, finance and so on, we could get things done and we could get the answers and the greater the area health function, the less seems to be the connect and the less well do things seem to function."<sup>23</sup>

- 31.35 I was told by NSW Health that there is an inevitable tension between having areas that are large enough to be cost effective and having smaller areas with local responsiveness.<sup>24</sup>

- 31.36 Although I acknowledge the immense difficulties experienced by some area health services by reason of the sheer size of the geographic area of the health services, I do not recommend that the sizes be reduced or that the number of area health services be returned to original or modified levels. I consider that this would be too disruptive. I recommend however that appropriate and clear delegations be made to hospitals and health services to ensure that there is decision-making power and flexibility at a more local level, to ensure that health services respond to disparate community needs. I discuss this and make recommendations below.

### Increased bureaucracy

- 31.37 There is a powerful perception amongst clinicians that the restructure of the area health services has lead to an increase, rather than a decrease, in the number of administrative staff.<sup>25</sup>

- 31.38 For example, Professor Stewart of the NSW Medical Staff Executive Council told the Inquiry that during 25 of the 28 years that he has worked in public health, he has been able to speak directly with the person managing the facility in which he works. Now he says that there are 5 bureaucratic layers, across 3 geographical areas, between him and the decision-maker.<sup>26</sup> Many clinicians and managers made similar complaints. All of them powerfully illustrated the point. For example, another witness stated:

"Five years ago my position was a tier 3 in the organisation and it would answer directly to the director of clinical operations, who in those days was a clinician, and to the chief executive officer. Now my position is five or six layers down in the organisation. The clinicians are not seen as key or high-value people and it has a serious effect."<sup>27</sup>

- 31.39 Another witness said in response to my questions:<sup>28</sup>
- "Q. I get the sense from you that it wasn't like that with Macquarie Area Health Service.
- A. No, it was not.
- Q. What do you think the difference is?
- A. The layers of bureaucracy, we are too big. When we were part of the Macquarie Area Health Service, there was the area executive, and there was five of them, and then the health service managers. If I had an issue I could go to the director of finance and say "I have an issue", or I could go to the director of nursing. Now you can't, you go up through several layers. I don't have a delegation over \$1,000 per order."
- 31.40 Many written submissions to the Inquiry argued that extra layers of bureaucracy have been an impairment to running the hospital in simple things, such as stores or theatres running out of consumables over the weekend.<sup>29</sup> It has also affected recruitment. I was told by one witness that a medical appointment which has followed the required recruitment processes now has to be confirmed by an area medical advisory committee, when this was not required previously.<sup>30</sup> While proper screening of medical staff is obviously essential, I was told it provided no benefit and simply delayed the recruitment for 6 weeks.
- 31.41 Submissions said that the duplication of roles at hospital level and area level was made worse by the amalgamations as displaced staff had to find replacement jobs.<sup>31</sup> Submissions said that they "suspected" that their area's payroll for administration was now higher than it had been before the amalgamation.<sup>32</sup>
- 31.42 The concern is not only felt by clinicians, but managers as well. One General Manager of a cluster said to me in private session:
- "I think it did work a lot better under the former area health service...I can't see whether the restructure has achieved any administrative savings in terms of those savings being directed to frontline services. I can't see anything in the budget which tells me, "These are your savings which you can spend on clinical services." I'm sure that other people would probably say the same thing, clinicians especially."<sup>33</sup>
- 31.43 NSW Health provided the Inquiry with statistics on the growth in the administrative workforce. Between 2003 and 2007, there was a reduction of 20.3% in the number of corporate services staff. Corporate services consists of hospital executives, internal audit, public affairs, public relations, human resources, legal, work force, industrial relations, accounts, finance, purchasing, general records and information technology staff.<sup>34</sup>
- 31.44 Over the same period, there has been an 25.1% increase in scientific staff (for example, technical officers in pathology labs, radiation scientists), a 11.4% reduction in hotel services (for example, cleaning, linen staff), a 10.9% reduction in trade staff (for example, hospital engineers) and a 11.8% increase in hospital support (including IT support officers, project officers, planners and ward clerks). Overall "clinical support" staff, which includes all of those categories, increased by 0.7% between 2003 and 2007.
- 31.45 In June 2007, 65.5% of NSW Health employees were clinical staff, compared with 63.6% in 2003. Various statistics provided to the Inquiry show that NSW Health

compares favourably with other government agencies in terms of corporate service costs per full time employee. It is apparently the cheapest of all so-called super agencies. Super agencies have more than 10,000 full time equivalent employees. I was told that they include the Department of Health, the Department of Transport, NSW Police Force and the Department of Community Services.

- 31.46 Of course, the above figures do not specifically identify how the staffing levels changed as a result of the amalgamations, although they do show that overall there was a marginal increase in support staff to June 2007. The figures do not support the arguments advanced by many of the clinicians that the restructure has been accompanied by a significant increase in management and administration positions.
- 31.47 The figures provided do not show how reporting lines changed as a result of the restructures. As previously stated, the Inquiry was informed that approximately 1,100 FTE administrative positions were removed. Whether or not this be the net position, as at today, it is quite clear that the restructure of the workforce adversely affected the lines of authority, in some of the ways identified above.

### Reduced community involvement

- 31.48 Traditionally, community involvement was secured by representation on hospital boards. Since the amalgamation of area health services, I heard evidence that community involvement in hospitals has reduced. Some attribute this to the abolition of boards of directors at the hospital level, although such boards were abolished several years before the amalgamations.

- 31.49 One witness stated:<sup>35</sup>

"I just want to talk about the community interaction. This particular hospital has developed from a district hospital to the size it is today and it has continued to develop even more. It's my view that at various times during this stage, we now don't have the amount of community interaction that we used to have. This might seem a bit old fashioned, but when we had the board of directors, these are the people who were the community leaders, they were the people who really knew what went on in Liverpool, they were the people who were connected to all the support clubs, the council, ... So these people were powerful advocates for the hospital and the hospital was well, well connected even with the community at this time.

I think since the board of directors has actually gone, there's been less deep connection with the community, and I think that is something to be lamented."

- 31.50 Similarly, I was told:<sup>36</sup>

"[A]rea boards were introduced, and ever since - and it was forecast by senior clinicians and nurses that this would happen - there has been a failure of on-site management, which has led to all the breakdowns that you end up then hearing about.

...as a result of this altered management situation, there has been a collapse in community support. We happen today to be sitting at one of the very few hospitals in New South Wales which has still, for political reasons, been allowed to keep a board of directors, and it is only with the knowledge that the local community can trust what will happen at St Vincent's."

- 31.51 I discuss the governance structure at St Vincent's Hospital below, which is quite different from that existing in other hospitals around the State.
- 31.52 There can be no doubt that community involvement in the running of the NSW public hospital system is valuable.<sup>37</sup> There are many examples of this. Since the amalgamations, the principal forum for ensuring community input in public hospitals is the Area Health Advisory Councils in each area health service. I discuss these Councils in this chapter. In my view, community involvement is also important at the local hospital level. There are already various mechanisms for this, including by local participation forums, which I discuss below in the context of Area Health Advisory Councils.
- 31.53 I was impressed by the initiatives taken at Camden Hospital to secure community involvement in the hospital's management structure. I was told that 1 or 2 representatives of the local community are members of the hospital's committees, including technical operating committees such as the finance committee, the patient flow committee and the senior executive committee which includes senior management and senior clinicians.<sup>38</sup> Local managers told me that it is important to involve community members so that the word can be spread about how the hospital is meeting community needs. I was told that no restriction is placed on information so that the community representatives, clinicians and managers attending the meetings all have the same obligations with respect to what transpires at meetings, namely, to deal with information sensitively and appropriately.
- 31.54 I was told that from the hospital's perspective, the involvement of the community members at Camden mainly served to inform the community of the decisions and direction of the hospital, rather than rather than obtaining the benefit of specific expertise, although there is no reason why such expertise if available ought not be of benefit to the hospital executives.
- 31.55 Past community involvement in board governance structures was criticised because it often became the occasion for "political appointments" with the result that the effectiveness of the board was curtailed.<sup>39</sup>
- 31.56 Emeritus Professor Kerry Goulston submitted to the Inquiry how important it is to have community involvement in all hospital boards.<sup>40</sup> He said that local members of the public make a large contribution on such a board and assist in reorganising the traditional hospital "fiefdom" through their patient perspective. He said that this community involvement representation should be decided on the basis of advertisement and interview, rather than as "political" appointees.
- 31.57 In my view, there should be consumer representation on every principal hospital committee, as at Camden Hospital. One submission provided the Inquiry with the example of a decision by a hospital to have mixed-gender wards. The point was made that consumers would "bring the committee back to reality" and argue strongly against such a decision.<sup>41</sup>
- 31.58 At the Area level, consumer representatives already attend some area health service committee meetings. For instances, consumer representatives attended the Clinical Quality Meeting of the Sydney South West Area Health Service which I attended in July this year.
- 31.59 I note what IPART said in its report in September 2003 that the strength of local input may well depend on the quality of the community participation mechanisms, rather than the size of area health services.<sup>42</sup> This is because community allegiances probably tend to be facility-based rather than Area-based. I agree with this observation and this

is one of the reasons that I think it important that attempts be made to have community members involved in hospitals by making them part of hospital committees.

**Recommendation 131:** *NSW Health is to explore, in collaboration with the Health Care Advisory Council the implementation of a charter which enables community participation in the affairs of hospitals. The charter should:*

- (a) *Identify those committees, which would be appropriate for and which would benefit from, having community representation;*
- (b) *Identify whether in respect of any representation, any particular qualification, skill or experience would be desirable; and*
- (c) *Determining how the selection or appointment ought take place.*

### New referral patterns

- 31.60 The Inquiry received evidence that not all consequences of the restructure were adequately planned for. The restructure had the effect in some geographical areas of encouraging the referral of patients to hospitals to which they were not previously directed for care. Not all area health services were, or are, able to cope with this. Some area health service borders also present problems.
- 31.61 The Inquiry received submissions that in Hunter New England Area Health Service the effect of the amalgamation was to encourage referral to specialist services in Newcastle instead of the historical referral pattern to Sydney.<sup>43</sup> I was told that, despite increased utilisation of local specialist services, there was no change to the status quo with regard to funding, meaning there is now relative under funding of specialist services in Newcastle.
- 31.62 Similarly, in Tenterfield, which is part of the Hunter New England Area Health Service, the Inquiry was informed that patients are being referred to Tamworth and Armidale for care, whereas they are much closer to Lismore which is located within the North Coast Area Health Service. This creates real problems with transporting patients, particularly elderly patients, where public transport is non-existent. I was told that some facilities in the Tenterfield Local Government Area fall within the North Coast Area Health Service and that it would facilitate things if the town fell within that area.<sup>44</sup>
- 31.63 Because of the alteration of desired referral patterns to fit in with the new area health service boundaries, only some historical referral patterns have changed. The general result is a lack of clarity and consistency about referrals.
- 31.64 In my view, referral patterns need to be negotiated and established by clinicians principally on the basis of finding the appropriate clinical setting for the patient's treatment. If there is more than one option, then the treatment ought to be undertaken at the nearest appropriate facility. If that is within area health service boundaries, then that should be used where possible. If not possible, then one out of the area health service boundary should be accessed.

**Recommendation 132:** *Referral patterns should be made by clinicians on the basis of finding the appropriate clinical setting for the patient's treatment. If there is more than one setting, then the treatment ought to be undertaken at the nearest appropriate facility. If that is within area health service boundaries, then that should be used where possible. If not possible, then one out of the area health service boundary should be accessed. Funding should follow the patient.*

## Restructure fatigue

- 31.65 The most recent restructure follows a series of earlier restructures, each of which has taken time to 'bed down'. Each restructure has caused disruption to clinicians. From my observations, this has affected staff in every area health service. One witness complained that the restructures did not achieve their stated purposes.<sup>45</sup>

"Turning to the Greater Southern Area Health Service, the changes to health management each eight to 10 years since I have been here have failed to deliver functional administration. Having almost adjusted to the combination of Riverina and Greater Murray, we were then thrown into an amalgamation as the Greater Southern Area Health Service. Despite strong protests from Wagga Wagga, we have been forced to endure the problems of a massive geographical area with Canberra sitting near the centre and the largest hospital, being Wagga Wagga Base Hospital, removed from the decision making in Queanbeyan."

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- 31.66 I was told, and accept, that morale is low – many said that it was the lowest it has ever been – as a result of the restructures.<sup>46</sup> I was told that decision making and accountability have become very unclear. Again, this can be illustrated with an excerpt from the evidence, which was resonated around the State:

"A. Morale is really low, probably the lowest that I've ever experienced it.

Q. What's causing that, from your observation?

A. Look, I think it's largely the way the system has been restructured. As I said before, it's quite big and for our part of the region, our part of the sector, we really need to have access to a decision-maker and we need to be heard because we have a challenging environment to work in."<sup>47</sup>

- 31.67 I am conscious, however, of 'restructure fatigue' which appears to be afflicting the NSW public health system. The Inquiry received a significant amount of evidence of this fatigue. Again, the following evidence is indicative:<sup>48</sup>

"We have had at this hospital serial restructures over the last 10 years. We have had numerous general managers; we have had boards sacked and abolished; divisions have been eradicated; we've gone to a streamed structure; areas have been amalgamated ...

In this process roles have been abolished and redefined, and decision-making and accountability become very unclear. Part of this is the problem of communication, but there does seem to be many levels of bureaucracy. The perception is that these often serve to block and delay rather than facilitate the decision-making."

- 31.68 One of the consequences of either too many restructures, or too lengthy a process of almost continuous restructures is that an organisation doesn't have the chance to mature and to allow proper delegation of decision making. It is a feature of immature organisations, in my observation, that control, particularly financial control, is centralised until such time as positions are filled on a permanent basis, relationships are well established and reporting lines are demonstrated in practice to be effective. Once this occurs, then monetary delegations, and the matching of accountability and decision-making responsibility can occur.



- 31.69 On the other hand, the Inquiry received submissions that NSW Health should reverse the amalgamations of 2005 and devolve decision-making to areas of more workable size in order to re-involve and re-engage staff. Some of those same submissions stated, however, that “ceaseless reorganisation of the health system should stop” as “nothing drives long term staff away faster than endless change”.<sup>49</sup>
- 31.70 NSW Health told me that while the restructures are considered largely negatively, it is early days and the general view is that there should be a moratorium on change for the foreseeable future, to let the restructure settle.<sup>50</sup> I accept this position insofar as it concerns the area health service boundaries, as I saw the impact that the restructure has had on those working at the ‘front line’. I therefore do not recommend any change to the existing area health service boundaries.
- 31.71 At the same time, however, I accept the weight of evidence that the governance structure requires significant reform and I make recommendations about this below.

### Advantages of present area health services

- 31.72 I heard of 2 main advantages of the present restructured area health services.
- (a) It has increased the prospects of improving standards in hospitals across the area health service, by networking smaller hospitals to major hospitals,<sup>51</sup> and encouraging benchmarking between more hospitals across a bigger area.<sup>52</sup> I was told that a reduction in the number of area health services has enhanced the likelihood of success in standardisation and networking and collaboration in problem solving with regard to resource allocation and service planning.<sup>53</sup>
  - (b) It has improved the sharing of clinical expertise and clinicians across the area health service.
- 31.73 Further benefits are apparent to me:
- (a) It enables a more flexible role definition of each of the hospitals within the larger area. It enables a better combination of speciality units with an appropriate critical mass and volume of patient flow.
  - (b) It also allows for research to be undertaken on a wider scale than with smaller areas.
- 31.74 There does not appear to have been any clear communication of the benefits of the restructure. NSW Health told the Inquiry that there is a great lack of understanding of what was achieved by the amalgamations, what can be achieved, why things happened and the problems faced by administrators.<sup>54</sup> It said that people at the coalface can only see “I can’t get anything done any more”. It seems to me that that is a significant and real complaint that needs to be squarely addressed and resolved as far as possible. I discuss this below.

### Current governance structure

- 31.75 The key change of the restructures, which were enacted through the *Health Services Amendment Act 2004*, was to combine areas into larger organisations whilst at the same time abolishing Area boards, with new, enlarged area health services now being controlled and managed by a Chief Executive, supported by an executive management team.



- 31.76 While the new governance structure provides clear lines of accountability from the Chief Executive to the Director-General of NSW Health (who in turn is accountable to the Minister), the evidence received by the Inquiry overwhelmingly shows that clinicians and other 'frontline' staff perceive accountability in health administration to be worse now than it was before the restructures in 2005.

### Area health service administration

- 31.77 The affairs of an area health service are managed and controlled by a Chief Executive, supported by an Area Health Service executive. The Chief Executive is subject to the control and direction of the Director-General of Health, who reports to the Minister for Health.<sup>55</sup>
- 31.78 With the exception of the chief executive and executive team, the organisational structure of area health services is decided by each area health service. Accordingly, they are able to develop structures suitable to their geography, demography and service and staff profiles.
- 31.79 Prior to 2005, the affairs of an area health service were controlled by an Area board. The board was subject to the control and direction of the Minister.<sup>56</sup>

### *Chief executive*

- 31.80 The significant changes to the NSW public health system implemented in 2005 involved abolition of area health service boards and the establishment of a direct line of accountability between Chief Executives and the Director-General of NSW Health.
- 31.81 The duties of the chief executive's position, including performance criteria for the purpose of reviews of the executive's performance, are set out in a contract of employment between the Chief Executive and the Director-General.<sup>57</sup>
- 31.82 The term of appointment of Chief Executives can be for up to 5 years.<sup>58</sup>
- 31.83 The performance of Chief Executives is reviewed, at least annually, by persons nominated by the Director-General.<sup>59</sup> Reviews have regard to the agreed performance criteria for the position and any other relevant matters.
- 31.84 There are 2 types of performance criteria of Chief Executives. One type consists of the criteria set out in the performance agreement between the area health service and NSW Health. The second type consists of personal performance measures.<sup>60</sup> There is thus a direct link between the Chief Executive's contract of employment and achievement of the area health service's performance indicators. This is said to provide a means of aligning organisational objectives and priorities to the personal performance objectives of the Chief Executive.<sup>61</sup> That is, the Chief Executive has overall accountability for fulfilling and implementing the Government's policies.<sup>62</sup>
- 31.85 NSW Health provided the Inquiry with the generic accountabilities for chief executives in NSW Health which are set out in Chief Executive's contracts of employment.<sup>63</sup> They include:

#### **Leadership:**

- Providing leadership in the achievement of program targets and other matters;

#### **Effective management:**

- Implementing an effective system of corporate governance, including clinical governance, to enable the area health service to effectively fulfil its responsibilities;

- Implementation of the NSW Health Patient Safety and Clinical Quality Program;
- Ensuring achievement of allocated budgets and effectively managing organisational assets;
- Providing concise, accurate and timely advice to NSW Health and the Minister;

**Community and business relations:**

- Developing and implementing an effective working relationship with the Area Health Advisory Council and other community and clinician consultation bodies;
- Managing issues with external groups within and across Government;

**Other position specific accountabilities include:**

- Any strategies to deliver the commitments in the area health service Performance Agreement;
- Any other identified health priorities eg from State Plan and State Health Plan;
- Leadership

- 31.86 Chief executives are required to meet performance criteria contained in 5 further agreements covering:
- Sustainable Access
  - Mental Health
  - Population Health
  - Patient Safety and Clinical Quality
  - Disaster Preparedness
- 31.87 In a traditional model of corporate governance, there is a split between the function of a board and the function of the chief executive and managers. The board has the governance function of determining policy, overseeing the implementation of policy and checking the implementation of these decisions by the chief executive and managers. The model in the NSW public health system is that all ultimate authority and responsibility for performance of the organisation resides in the Chief Executive.<sup>64</sup>
- 31.88 The general perception of Chief Executives as expressed to the Inquiry was that they were inaccessible, and their decisions were not ordinarily explained to those who were affected by the decision. I heard that clinicians are often not informed about how a Chief Executive makes a particular decision, only what the decision was.<sup>65</sup> I was told that transparency in how decisions are made and how resources are allocated no longer exists.
- 31.89 Many say that Chief Executives appear to have “unfettered power and influence” as they answer only to the Director General.<sup>66</sup> They say that a partnership with medical staff is appropriate and needed so that there is some share of responsibility and decision-making capability.<sup>67</sup> These submissions were generally made by senior members of the medical profession of long-standing service to the NSW public hospital system.
- 31.90 It was suggested to the Inquiry that the Chief Executive may have too much responsibility under the current governance arrangements.<sup>68</sup>

“This chief executive officer in this particular area is running something like 16 health institutions, eight significant hospitals, five of them or so are in very severe distress... In addition, he is running three redevelopments, very substantive at the moment, a \$91m research and education building on this campus, the looming largest public infrastructure development in this

State ever... and I think all without substantive oversight in a management administrative sense."

"...health is possibly the most complex administrative and governance sector in the community, and yet we have no oversight - \$1.4 billion."

- 31.91 While Chief Executives have ultimate responsibility for the leadership and effective management of the area health service's human, material and financial resources, in reality, he or she undertakes that task with the assistance of and in conjunction with an executive committee. The Area Executive Committee has responsibility for overseeing the operation of the Area's business within the parameters of the functions conferred or imposed on the Chief Executive under the *Health Services Act 1997* (as amended).
- 31.92 NSW Health's *Corporate governance and accountability compendium for NSW Health (Compendium)* sets out the roles and responsibilities of agencies that constitute NSW Health, including area health services. The Performance Agreement between NSW Health and area health services requires area health services to have in place the structures and processes outlined in the Compendium<sup>69</sup>.
- 31.93 All Chief Executives are required to establish certain committees<sup>70</sup>:
- Audit and Risk Management Committee
  - Finance and Performance Committee
  - Health Care Quality Committee
  - Medical and Dental Appointment Advisory Committee
- 31.94 These committees do not have decision-making powers, as decision-making power resides in the Chief Executive. However they advise and assist the Chief Executive to perform his or her duties under the *Health Services Act*. The Compendium sets out the core responsibilities and duties of the different committees (which are in some cases further elucidated in policy directives of NSW Health) and highlights that one of the functions of the committees is to provide reasonable assurance to the Chief Executive about the matters within the committee's responsibilities.
- 31.95 Thus, in reality governance is maintained by way of an interaction between the Chief Executive, committees, policies, a consistent organisational structure and audit functions, together with annual assessments by, or at the direction of, the Director-General.
- Area health service executive*
- 31.96 The Chief Executive of each area health service is supported by an executive team. The constitution of executive teams differs slightly between area health services. A typical executive team comprises the following positions:
- (a) Director, Clinical Operations
  - (b) Director, Population Health, Planning and Performance
  - (c) Director, Workforce Development
  - (d) Director, Finance and Corporate Governance
  - (e) Director, Clinical Governance
  - (f) Director, Nursing and Midwifery.
- 31.97 In addition, NSW Health requires Chief Executives to create the committees identified in the previous section<sup>71</sup>.

- 31.98 The Compendium also states that the Chief Executive is accountable for establishing mechanisms to achieve successful governance of the range of clinical responsibilities, including:
- a Clinical Governance Unit as part of the Area structure (with the Director being a member of the area health service executive having direct reporting responsibilities to the Chief Executive);
  - a Medical Staff Council;
  - a Health Care Quality Committee; and
  - a Medical and Dental Appointment Advisory Committee.
- 31.99 The Compendium notes that “successful implementation of clinical governance requires:
- The development of strong and effective partnerships between clinicians and managers;
  - The identification of clear lines of responsibility and accountability for clinical care and ensuring these are communicated throughout a public health organisation”.
- 31.100 A huge number of submissions to the Inquiry sought to highlight that the present system has failed in regard to the first bullet point. I was told that there has been a shift from clinical governance of corporate matters, to corporate governance of clinical matters<sup>72</sup> and that there is a need for managers to look for a partnership with clinicians<sup>73</sup> and for a re-assertion of clinical issues<sup>74</sup>.
- 31.101 Clinical networks and clinical streams have become a favoured means of managing and organising services, particularly in metropolitan health services in NSW. Networks or streams function across institutional boundaries by linking a collaborating group of professionals or health service departments and facilities in a coordinated manner for the purpose of managing and organising services. The organisation of networks may be based on function (for example, critical care, pathology) or patient group (for example, children) or specialty (for example, vascular surgery).<sup>75</sup>
- 31.102 The advance of clinical streams raises questions of corporate governance. For example, whether a decision should be made by the network, the Area executive or General Manager at a hospital level. A recent report by Mr Alan McCarroll and Dr Denis King<sup>76</sup> noted that the introduction of clinical streams has meant that the decision making of hospital general managers, and of general managers of hospital networks, is constrained and has to be so.
- 31.103 That report summarises the structures adopted by the area health services. Some area health services have implemented a clinical stream management structure (Sydney South West, South Eastern Sydney Illawarra and Sydney West) in which clinical streams act as strategic management entities, while responsibility for operational management is retained by hospital general managers (Sydney South West) and network general managers (South Eastern Sydney Illawarra).<sup>77</sup> In Sydney West, clinical stream directors have both strategic and operational management responsibility for their respective clinical services. The rural area health services have adopted a strategy of progressive implementation of clinical streams (Hunter New England and the 3 other rural areas).
- 31.104 In contrast to a clinical stream management structure, Northern Sydney Central Coast Area Health Service has adopted a clinical networking structure in which clinical networks operate as consultative and advisory bodies. The networks do not hold budgets but have significant influence at the level of budget formulation.<sup>78</sup> The principal role of the Networks is to implement the Area Clinical Services Strategic Plan. Each

Network has a clinical director, who joins with the area executive team to form the Area Clinical Council, the peak governance body of the area health service advising the Chief Executive.<sup>79</sup>

- 31.105 Some say that clinical streams are too big and unwieldy and that they do not know the clinicians in charge of their Area clinical streams.<sup>80</sup> I was told that, although clinical streams designed to coordinate care within a particular specialty or group of specialties across areas is theoretically admirable, they are not in practice possible. I was told that with respect to particular clinical streams, the Director of the stream has the power to make recommendations concerning the whole Area without consultation with department heads. I was told that clinical streams have not solved the need for clinician involvement in local health service planning.
- 31.106 The report of Mr Alan McCarroll and Dr Denis King in May 2008 made interim recommendations that:<sup>81</sup>
- All area health services develop and implement a clinical stream management structure. This was seen as being fundamental to the engagement of clinicians in the management process;
  - Clinical management roles at all levels (clinical stream director, department head at the hospital level etc) be clearly defined in terms of their specific responsibilities and accountabilities and relationship to the broader management structure;
  - There be clearer definition of the role of hospital and hospital network general managers in the clinical stream environment. They say that in the context of the clinical stream environment, the concept of the hospital and hospital network general manager making substantive resource allocation decisions independent of the Area is untenable. The authority of the position of general manager should be developed such that it is perceived by clinicians as carrying the authority of the Chief Executive in the exercise of local delegation and decision-making;
  - The internal structure of the hospital and hospital networks should be consistent with the grouping of clinical services in the area clinical streams;
  - All areas establish an Area Clinical Council which brings together the Area executive, clinical stream directors and general managers of hospitals and hospital networks on a regular basis. The role of the Area Clinical Council would be to set the framework for strategic planning, determine priorities for service development, resource allocation and clinical policy development;
  - All areas ensure that there are effective forums at the hospital and hospital network level to promote clinician engagement, preferably multi-disciplinary forums;
  - The provision of appropriate administrative support and effective systems support to clinical managers as a priority;
  - All area health services develop a strategy for training and development of clinical leaders;
  - Reforms to the visiting medical officer appointment process.
- 31.107 I was told that formal action with respect to the recommendations has been held over until my report is released<sup>82</sup>.
- 31.108 It is said that clinical networks are less hierarchical than traditional management structures and reflect better the way clinicians function. In my view, to be effective, there needs to be a requirement for consultation by clinical stream directors with department heads at the hospital level. I do not think that clinical streams should take flexibility in decision-making away from managers at hospital level. I have seen in this Inquiry how important it is to clinicians at the 'frontline', particularly senior medical staff who are responsible for patient care, to have a sense of engagement and responsibility

for the direction of the institution to which they are attached. I make recommendations below.

### Area Health Advisory Councils

- 31.109 In the restructure, area health service boards were abolished. Area Health Advisory Councils (**AHACs**) were introduced in each area health service. NSW Health told me that AHACs were meant to be a replacement for the board, but this is not, in all senses, correct.<sup>83</sup> Their role is very different to that of an area health service board.
- 31.110 The stated role of the area health advisory council is to facilitate the involvement of providers and consumers of health services, and the local community generally, in developing the policies, plans and initiatives of the area health service.<sup>84</sup>
- 31.111 The functions of an area health advisory council include:<sup>85</sup>
- Advising and seeking the views of providers and consumers of health services, and other members of the local community, as to the area health service's policies, plans and initiatives for the provision of health services and advising the chief executive of them;
  - Conferring with the chief executive in connection with the operational performance targets set by any performance agreement to which the area health service is a party;
  - Advising the chief executive on how best to support, encourage and facilitate community, consumer and health service provider involvement in planning of health services by the area health service;
  - Liaising with other area health advisory councils in relation to both local and State-wide initiatives for the provision of health services;
  - Reporting about the above matters.
- 31.112 An area health advisory council must have between 9 and 13 members, appointed by the Minister, of whom:<sup>86</sup>
- (a) some must be persons having experience in the provision of health services, and
  - (b) the others must be persons who can represent the interests of consumers of health services and the local community, and
  - (c) at least one (who may be one of the members referred to in paragraph (a) or (b)) must be a person who has expertise, knowledge or experience in relation to Aboriginal health.
- 31.113 The law requires that the membership of an area health advisory council must maintain a reasonable balance between persons of the kind referred to in (a) and (b), so that at all times the persons of one kind do not outnumber persons of the other kind by more than 2. Membership cannot exceed 4 years.
- 31.114 In reality, AHACs have an advisory role only, with no power when it comes to decision-making or budget allocations.
- 31.115 The NSW Health Care Advisory Council is the peak clinical and community advisory group in NSW. The Council advises the Minister and the Director-General and draws upon the expertise of the 13 Health Priority Taskforces. These Taskforces include clinicians from a range of disciplines and consumers and community members.



- 31.116 The Inquiry received evidence that the North Coast AHAC has access to the area health service budget but does not have the ability to influence how the spending should be allocated.<sup>87</sup>
- 31.117 Some expressed this view about AHACS and the Health Advisory Council:<sup>88</sup>
- “It is irrelevant. There are several sorts of power in an organisation: the first one is money, the second one is space, and probably the third one is knowledge or expertise. Really, the Health Advisory Council has no control over any of those things, so is essentially not working.”
- 31.118 Submissions were made to the Inquiry that the statutory role of AHACs in the governance structures of health should be strengthened.<sup>89</sup> They said that AHACs are constituted by both clinicians and community and are therefore well placed to recognise and recommend either systemic or locally required changes in the delivery of health services to improve health outcomes. I generally agree with the thrust of these submissions and make recommendations below.
- 31.119 Concerns were expressed that the focus of AHACs is on metropolitan issues, and that representation is not equally distributed to reflect all parts of the area health service. I was told that the AHAC in the Northern Sydney Central Coast Area Health Service focussed disproportionately on the hospitals and health services “south of the Hawkesbury” and very little on the needs of the Central Coast.<sup>90</sup> Witnesses said that northern Sydney and the Central Coast have different issues and that this has not been reflected in the activity of the AHAC.
- 31.120 In some area health services, AHACs do not appear, from the evidence I heard, to have a particularly public face. Communities and clinicians did not feel that the committee was particularly useful. The Inquiry received evidence from a clinical nurse specialist at Liverpool Hospital for example that the AHAC was not particularly visible in the community or among clinicians and that it provided communities with less say in the running of their hospitals than boards did.<sup>91</sup> On the other hand, some AHACs have gone to great lengths to engage with the local community, as discussed below.
- 31.121 AHACs were not intended to replace already well-developed local health participation councils that have direct links with area management. Rather the Second Reading Speech to the *Health Services Amendment Act* (which enacted AHACs) stated that AHACs would build on their work and serve as a focal point for local health participation councils. It seems that AHACs have not replaced local health participation councils.
- 31.122 AHACs secure local participation in various ways. Some seem to have hit the ground running when it comes to putting in place structures for obtaining the participation of clinicians and their local communities. Others are still working out the process.<sup>92</sup>
- 31.123 In relation to the AHAC in the North Coast Area Health Service, for example, I was told by the Chair of the AHAC and one of its members that it rapidly put in place community and clinician participation structures including 4 geographically-based ‘local health participation forums’ that are centred around the base hospitals and their surrounding network of services (at Tweed and Lismore, Coffs, Clarence and Hastings/Macleay).<sup>93</sup> I was told that General Managers of the different networks in that area health service attend the meetings of the local health participation forums. I was told that appointments to the local health participation forums are made by the Chief Executive of the area health service.
- 31.124 I was told that the North Coast AHAC met in December 2005 to conduct a 2-day planning workshop and a series of community consultation meetings, following which it



established its relationship with the local health participation forums, with medical, nursing and allied health councils, with the overarching clinical councils, Aboriginal Health Councils, newly established health services forums and GP liaison committees. The witnesses said that members of the AHAC are represented on many of those bodies and that they attend the local health participation forums. This was described to me as being a collegiate approach which has allowed the AHAC to develop:

"a very strong idea of what the issues are in health service provision at a strategic level and also at a local level for the people of the North Coast."

- 31.125 I was told that the AHAC has had a strong role in communicating directly with members of the community in the 2 years since its inception but that it now acknowledged that it may be more effective for frontline contact with local communities to be the role of local health participation forums, at a network level, rather than the AHAC itself. It is therefore seeking to strengthen the activity of the health participation forums which, in the North Coast, meet yearly at a conference held near Lismore.
- 31.126 The North Coast AHAC is now seeking to strengthen engagement with clinicians.
- 31.127 The Inquiry also received evidence from the Chair of the Hunter New England AHAC. Associate Professor Fragar.<sup>94</sup> I was told that the Hunter New England AHAC meets at least 6 times a year in a different health service location each time.
- 31.128 I was told that Hunter New England AHAC took the view early in its work that its role would be one of ensuring that there are adequate systems for communities to have input into health administration, whether at the local health service level or in the area of planning. It specifically did not see its role as that of conduit for complaints. It also sees its role as being to ensure that clinicians know how to participate in decision-making, in particular so that they do not feel compelled to approach AHAC to resolve all issues with management.
- 31.129 The Hunter New England AHAC meets with local clinicians and the local health advisory committee at each the facility where it holds its meetings. Although it recognises that it is not a board of management, I was told that it takes up issues on behalf of clinicians where appropriate. I was told:<sup>95</sup>

"We can, if you like, be involved to some extent because we come from a background of experience in how systems operate and we are seeing how they operate around the area. ... we can also make comment and recommendations about process, where I think as a management board, you are actually more involved in the policy at the top and do not get involved in process.

We ran an area-wide seminar and out of that teased out a number of those issues, put that back on the table to the chief executive and the executive team ..and they have basically not modified what we recommended needed to be done ... but that's not easy with so many health services and so many committees."

- 31.130 That AHAC seeks the views of consumers through consultation with local health advisory committees. I was told that the local advisory committees have not been as effective as they might have been in providing community participation. Professor Fragar said:
- "local advisory committees... didn't really have the teeth that I think was the intent in putting them in place...that was a mix of issues about membership of them, a mix of them not understanding their role, but also of local

managers not using ...the good minds that are there sitting in those committees to really good effect."

- 31.131 With regard to clinician engagement, I was told that Hunter New England AHAC quickly discovered that clinicians did not have a clear idea about how management expects to communicate with clinicians or the processes by which clinicians should have input into management decisions. The following evidence indicated to me how valuable an AHAC can be in bridging the gap between clinicians and managers:<sup>96</sup>

"We went to some places where clinicians, the doctors and nurses, were quite comfortable with knowing how things ran and there are others where it was just all very disappointing in terms of people not knowing that.

Out of that there was a sharing of ideas on what people do, what would be a good communication system, an action plan has come out of that and the area health service is now working to, in the first instance, help local managers develop their own communication plans and processes to try to make that better

there are still things to be done, like being clearer about what decision making is delegated to what centre and that's still not clear to many people. What decisions can be made locally and what does need to be ticked off further up the line is not necessarily clear and those are things we will be still pressing them, working with, to try to test to see can the decision making come closer to home in some instances."

- 31.132 Although the AHAC has an advisory role, the above evidence shows that an advisory role can be significant as it involves seeking information from those affected by management decisions, identifying systemic issues and communicating them to managers in a coordinated fashion.
- 31.133 Although senior medical staff are active in some of the AHACs, some say that medical staff wish to have an influence on decision-making through avenues other than AHACs as they do not see AHACs as being the most effective forum for their concerns. I discuss the role Medical Staff Councils below.
- 31.134 In my view, the role of AHACs in the community and among clinicians and in the administration of the health system needs to be strengthened. The Second Reading Speech to the *Health Services Amendment Act* described AHACs as giving health professionals, health consumers and community representatives an "enhanced role in the administration of our health system and in setting directions for the delivery of health services" and "critical in keeping area management informed" of issues relating to patient care.
- 31.135 At the present time, although their role is evolving, I do not think that AHACs have given health professionals an "enhanced role" in the administration of the health system. Nor do I think that they have delivered robust clinical, consumer and community participation structures for area health services, in the way that was ostensibly intended.
- 31.136 It seems to me that it has taken some years for area health advisory councils to find their role, particularly how to go about securing the engagement of the local community and clinicians. This process is, indeed, not yet complete.
- 31.137 In my view, if AHACs are to provide "robust clinical, consumer and community participation structures for area health services",<sup>97</sup> as intended, area health services need to increase the engagement of AHACs in Area-wide processes. They need to provide AHACs with timely, meaningful performance and financial information and

request the AHACs for advice on strategic matters affecting clinicians and the community.

- 31.138 In my view, it would strengthen the role of AHACs in the administration of the health system and in setting directions for the delivery of health services to require an AHAC member, perhaps the Chair, to be part of the Area Executive, and appropriate Area Committees. Given that the committees which Chief Executives are required to establish are not ultimately decision-making committees, participation by AHAC would be compatible with the committees' functions. In my view, AHAC is well placed to provide advice about systemic and locally required changes in the delivery of health services to improve health outcomes, based on clinicians and community advice. This change would go part of the way to resolving the current complaints about the governance system, namely the lack of community and clinician input, and give to AHACs the enhanced role in administration that they were intended to have.

**Recommendation 133:** *A member of the Area Health Advisory Council, nominated by the chair of that Council, be entitled to attend and be present at meetings of the principal executive committee of the Area.*

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## Hospital administration

- 31.139 The administration of hospitals varies according to the hospital. Generally, they have a General Manager.
- 31.140 The role of the General Manager is today much more difficult and complex than it was in previous years. There are several reasons for this. One is that decisions made at the area health service level may affect several hospitals within the Area, meaning that the General Manager has little control of the process.<sup>98</sup> Another reason is that General Manager's participation in a decision to be made at hospital level may not be required at all. Thirdly, in general, expenditure delegations to General Managers are limited and there is no discretionary expenditure built into hospital budgets. These factors constrain the General Manager's power of decision-making. Many submissions to the Inquiry said that General Managers are nowadays given impossible parameters.
- 31.141 The General Manager nevertheless remains the "face" of the hospital and the point of access for 95% of the 8,000 senior medical staff employed by NSW Health.<sup>99</sup> In general, the evidence received by the Inquiry suggests that clinicians have enormous sympathy for General Managers as they perceive that they have been disempowered. I was told that if the General Manager lacks decision-making authority, then in a *de facto* sense the clinicians do too, because the General Manager is their point of contact.
- 31.142 My view is that General Managers need to be given back decision-making powers which are currently extremely circumscribed and in some cases irrelevant. There is a need for greater clarity in the role and responsibilities of General Managers. I discuss these issues and make recommendations below.

## Medical Staff Councils

- 31.143 All public hospital medical specialists (Staff Specialists and VMOs) belong, or are entitled to belong, to Medical Staff Councils. Each public hospital has its own Medical Staff Council and each area health service has a Medical Staff Executive Council. Members of Medical Staff Councils are selected by other specialists.
- 31.144 The NSW Medical Staff Executive Council is made up of the Chairs, or their delegates, of the Medical Staff Councils of all of the public hospitals in NSW. A submission from

the NSW Medical Staff Executive Council to this Inquiry noted that it provides an informed and unique view of hospital performance from the individuals who ultimately bear the responsibility for what happens to patients admitted to their institutions.

- 31.145 The role of Medical Staff Councils in the public hospital system is defined in model by-laws under the *Health Services Act 1997* (NSW). One witness highlighted that Medical Staff Councils are not committees as the members are not appointed by management but rather they are selected by other specialists.
- 31.146 Although the Inquiry received many submissions from Medical Staff Councils, particularly from rural hospitals, many say that their role has been sidelined since 2005 and that as a consequence there is now a reluctance by medical staff to participate in them.
- 31.147 I was told that, before the amalgamations of area health services in 2005, Medical Staff Councils had the ability to appoint a representative to area health service boards.<sup>100</sup> This was because in 2001, the then Minister for Health, Craig Knowles, agreed to appoint to each area health service Board as a full member a senior medical clinician selected by the Minister from a list of 5 put forward by each Area Medical Staff Executive Council. It is said that this representation assured senior medical staff that their views were represented at Board level.
- 31.148 I was told that since the major shift in governance in 2005, representation of senior medical staff in governance has been inconsistent and dependent on the local influence of individual staff members.<sup>101</sup> It is said that the opportunity to participate in the oversight of management has been lost and not replaced. I was told that Medical Staff Councils are no longer considered to be integral part of the running of the hospital,<sup>102</sup> and there is a lack of disclosure to the Medical Staff Councils compared to before the amalgamations.<sup>103</sup> Many doctors said that they would like to see that reversed.
- 31.149 I was told for example that the Medical Staff Council for Tamworth Hospital has basically disbanded:
- "because they don't believe there is a lot of point in meeting because no one wants to listen to them".<sup>104</sup>
- 31.150 I was told that another now has no facilities, no staffing and no lounge where people can talk and is "dispirited".<sup>105</sup> The Chairman of the Dubbo Medical Staff Council gave evidence that he proposed a 3 monthly meeting with the Chief Executive 18 months ago and is still waiting for the second meeting.<sup>106</sup> I was told that Medical Staff Councils need a protocol for the resolution of conflict between them and managers.<sup>107</sup>
- 31.151 In its submission, the NSW Medical Staff Executive Council advocates that the role of Medical Staff Councils be strengthened by amending the model by-laws for Medical Staff Councils so as to:
- Mandate regular meetings between each Area Medical Staff Executive Council and the Chief Executive supported by full information on the clinical and financial position of the area health service;
  - Mandate a process for dispute resolution in a timely fashion;
  - Provide for a reporting line for the Chair of the Area Medical Staff Executive Council to the Minister for Health to ensure that referral of unsolved disputes are seen as a matter of good governance rather than individual complaint;
  - Require regular consultation by the Chief Executive with the Area Medical Staff Executive Council and hospital Medical Staff Councils on all clinical matters, including the appointment of clinical advisory councils.

- 31.152 It says that adoption of these proposals would provide a safety valve in governance that was lost with the abolition of area health service Boards in 2005. It says that this would restore trust between frontline clinicians and management and make it easier to extract the much needed level of commitment and goodwill from the existing workforce.
- 31.153 The NSW Medical Staff Executive Council informed the Inquiry that an undertaking was given at the time of the amalgamations by government to the Chairs of the Medical Staff Councils that the role and influence of Medical Staff Councils should not diminish following abolition of the Area boards. I am unable to, and have not attempted to, determine whether this was so. In November 2007, the NSW Medical Staff Executive Council put forward to the Minister for Health proposed amended by-laws, which were discussed at two high level meetings in January and February 2008 with a promise by NSW Health of a response. It told the Inquiry that it is still awaiting a response.
- 31.154 The Second Reading Speech to the *Health Services Amendment Act* (which enacted the amalgamations in 2005) expressly envisaged the continued role of Medical Staff Councils. It said of Medical Staff Councils:<sup>108</sup>
- "Chief executives will continue to require the advice and support of committee structures and medical staff councils, similar to those currently established under existing by-laws. Accordingly the model area health service by-laws will be amended to ensure these committee and council structures are appropriately constituted under the new system."
- 31.155 The Inquiry received evidence that Medical Staff Councils do not see AHACs (Area Health Advisory Councils) as being the most effective avenue for having input into the governance of area health services.<sup>109</sup>
- 31.156 The *Review of Clinician Engagement in Clinical Management Structures* published in May 2008 noted that there was general agreement that Medical Staff Councils at Area and local level had become less relevant to the management and decision-making process within Areas. It noted that their relevance would continue to decline with the development of management structures and processes to engage clinicians as envisaged in that report.
- 31.157 Doctors generally told the Inquiry that there were potential benefits to having a clinical or general staff council to extend membership to nurses and allied health professionals but that doctors have a unique perspective into and overall responsibility for patient care which warrants a specifically medical staff council.<sup>110</sup>
- 31.158 In my view, Medical Staff Councils should be more effectively integrated in the consultation process as they have been functionally marginalised by the 2005 restructures. This can be done by Chief Executives attending meetings of Medical Staff Councils where possible, as should happen as part of good governance practices. I was told that this happens at St Vincent's Hospital<sup>111</sup> and it no doubt happens in other hospitals. It could also be done by allowing Medical Staff Councils to nominate a person to attend Area-level clinical operations committees, such as Area clinical councils. A process for consultation with Medical Staff Councils seems to me to be one way to ensure clinicians have input into the administration of their hospitals. In my view, it is the capacity of medical staff to contribute to the continuous improvement in their own hospital that is important to morale and quality and safety and it is the progressive loss of this influence that is the cause of many of the complaints identified in this chapter.

## Should there be a return to boards?

- 31.159 I have listened to and understand the submissions made by many people during the course of this Inquiry about the merits of returning to a system of governance by area health service boards and, in some submissions, by individual hospital boards. However, in my view, the removal of boards and the current structure is workable and should be permitted to work. I set out my reasons in this section. I also set out below my further proposals for improving the governance structure and the relationship between clinicians and management staff.

### *Individual hospital boards*

- 31.160 Individual hospital boards were by and large abolished in 1986.<sup>112</sup>
- 31.161 Several submissions to the Inquiry sought to draw a distinction between the small number of hospitals which have retained boards and the majority of hospitals which no longer have them. They said that there is a significant difference between those hospitals and other hospitals which favours the reintroduction of hospital boards.
- 31.162 It was submitted to the Inquiry that St Vincent's Hospital can be distinguished from other hospitals because it has a hospital board which provides governance and strategic direction for the hospital.<sup>113</sup> It is said that, although doctors in other hospitals feel demoralised and disenfranchised, this is much less so at St Vincent's Hospital.
- 31.163 Apart from having a board which does a lot more than merely control the public hospital services which it provides, St Vincent's Hospital has developed a program structure divided into 5 main clinical units which are governed by a doctor (called a program director) and a business manager who are responsible for the budget of those units. The units are Cancer, Heart/lung, Medical, Surgical, Mental Health, Population Health. I was told that this was a structure which provided sufficient decision-making flexibility to the local managers and ensured accountability and responsibility for the delivery of services.<sup>114</sup> One of the program directors who gave evidence to the Inquiry thought it was beneficial that program directors were doctors as they have some knowledge of what is reasonable when it comes to clinical matters, how the system works and how to communicate with medical colleagues.<sup>115</sup>
- 31.164 The real merit of the governance structure at St Vincent's Hospital seems to me be twofold: firstly, clinicians are involved in the direction and management of their clinical programs at a high level and secondly, they are given expenditure delegations and a discretion to allocate their budget as they see fit. In this process they are assisted by advice from the business managers. This is coupled with responsibility for those budgets. I do not see why a board needs to sit above that structure, as opposed to a Chief Executive.
- 31.165 I acknowledge that the St Vincent's Hospital board works within the parameters of a clinical services plan so that it cannot make decisions which adversely affect the overall distribution of resources across the area health service as decided at an Area level.
- 31.166 It was also submitted to the Inquiry that Westmead Children's Hospital has its own board of directors and as a consequence has no trouble raising money.<sup>116</sup> The Children's Hospital at Westmead does not have a board of directions. It is a chief executive governed statutory health corporation under section 41 of the *Health Services Act 1997*. It has a Children's Health Advisory Council and a Chief Executive. The Children's Hospital Advisory Council does not have an operational or management role



but has an advisory role in matters of strategic planning, priority setting, policy development, expenditure of donations and monitoring.

- 31.167 It was submitted that a hospital board ensures that there is a 'power base' at each hospital.<sup>117</sup> In contrast, presently, the 'power base' is off site, which I was told has an adverse effect on morale, trust, communication and co-operation of local clinicians. In particular, doctors feel that a board gives them an opportunity to feel they have input into decisions. Some say that the efficiencies that would be gained in each hospital if it had a return of high morale, high trust, good communication and good cooperation would more than account for the fact that some hospitals would seek a greater allocation of scarce resources. Community members also say that hospital boards allow the local community greater involvement and influence on their local hospitals.<sup>118</sup>
- 31.168 I do not recommend the return of individual hospital boards. Individual hospital boards are contrary to the intention of the development of area health services, in which hospitals are intended to operate within a clinical services network across the Area. Individual hospital boards compete for finite resources and do not engender a system of coordinated and efficient clinical care services to the community across a whole area.
- 31.169 Nevertheless, I accept that in the overwhelming majority of public hospitals in New South Wales at the present time there is very little delegation to hospital management for decision-making and that this has a tendency to demoralise and disenfranchise local management and clinicians. In my view, the lack of control of hospital management over human resources, clinical and financial matters must be addressed.

#### *Area Health Service Boards*

- 31.170 Area health service boards, first introduced in 1986,<sup>119</sup> were abolished at the time of the amalgamations in 2005.
- 31.171 I accept that the significant changes to the governance structure enacted in 2005, and other factors, have caused a serious loss of morale in senior medical staff, as well as hospital management. That loss of morale is, in my observation, palpable.
- 31.172 Regarding the removal of Area boards, many witnesses, predominantly senior clinicians, expressed their opinion to the Inquiry to similar effect as the following evidence:<sup>120</sup>
- "I would say that most of us are amazed that a corporation or an operation such as the Northern Sydney Central Coast Area Health Service with a budget of \$1.4 billion has no board of directors."
- "The CEO appears to answer only to the Director General, has except for that contact unfettered power and influence."
- "At the moment it is a servant and master relationship."
- "all without substantive oversight in a management administrative sense."
- 31.173 Some say that a board is necessary to ensure that frank advice is given to the Minister and department. At the present time, the Director-General is empowered under the *Health Services Act 1997* to dismiss the Chief Executive without notice or reason.<sup>121</sup> A board is perceived to ensure some sharing of power between the Chief Executive and Chairman of the Board which enhances the capacity of leaders to give advice to Government without fear or favour.<sup>122</sup>



- 31.174 On the other hand, I was told that decisions by Area boards were rarely effective because they were often overruled by NSW Health. One witness stated:<sup>123</sup>

"I can remember the extraordinary frustration of being a board member of one of the prior area health services where we had what we thought was a clear delegation of what we were responsible for as a board from the minister's office and the Department of Health, only to repeatedly have it usurped by the Department of Health: decisions were being made by the department that would overrule what was being done at the area board level."

- 31.175 Others said that area health service boards had some say about priorities but very little influence on the actual allocation of funds or the budgetary process. They were able to monitor expenditure, ask questions about it and participate in the audit process.<sup>124</sup> I do not see why clinicians and communities should not be able to monitor expenditure and ask questions about it. This does not, however, require that a board be involved to take that role.

- 31.176 It seems to me that the heart of the concern is that clinicians do not have access to a process for influencing decisions made by management, whether that be at Area level or departmental level, and therefore accountabilities are perceived to be unchecked. I make recommendations in this chapter aimed at returning local accountability as far as I think practicable. I do not recommend the return of area health service boards.
- 31.177 One of my recommendations is to introduce an Executive Clinical Director, who is a medical practitioner, in each area health service.

## Immature management practices

- 31.178 There are a number of ways in which the area health services are managed which, in my view, are far from mature management principles.

### Centralisation of decision making

- 31.179 Clinicians and managers complain that they have lost the ability to make decisions at the local level. Part of the problem is that the physical centre of administration is now largely located in, or near, one hospital within the area health service, leaving clinicians and managers working in other hospitals physically distant from the decision-makers.
- 31.180 Some say that off-site management has become gradually more remote from the coalface, that this process started many years ago when the Area boards were first introduced in 1986<sup>125</sup> and that the situation worsened dramatically after the restructures in 2005 when decision-making power was centralised in the Chief Executive.
- 31.181 Centralisation of decision-making at an Area level has meant that staff cannot rely on their local managers to make decisions. I was told that local managers have to turn to the Area for decisions and approval, even for routine matters. Staff feel that their local managers have been totally disempowered:<sup>126</sup>

"You almost feel that there is no point speaking to the guys locally, because they are not the ones who will make their decisions and say "yes" or "no"... so I think there has to be more local ownership of the issues and more local ownership of the solutions of the issues rather than a direction from upon high, not really knowing or understanding the local issues."

- 31.182 The Inquiry received a lot of evidence in the following vein:<sup>127</sup>
- “We have some very good managers here, but they are not enabled to manage the staff and to nurture them because it comes on high and we are devolved so far out that we are not able to make decisions as simple as organising morning tea.”
- “we have to write a brief now to get a morning tea for staff. It's International Midwives Day on 5 May, and I have to write a brief to get some money to celebrate that with staff.”
- 31.183 It was widely submitted that decision-making capacity should be devolved to hospitals:
- “which are the key functional, if you like, elements of the public system.”<sup>128</sup>
- 31.184 I was told that the larger the area health service and the further away the management is based, the greater the problems.<sup>129</sup>
- “I would like to see management come back to the facility, and the facility be responsible for its triumphs and its mistakes and be accountable to its staff population and community.”<sup>130</sup>
- 31.185 Even where decision-making capacity is devolved to hospital or network General Manager level, I heard that clinical managers cannot make routine purchases or decisions, which impedes patient care, particularly where urgent supplies are required.<sup>131</sup>
- 31.186 One of the examples of the failures of centralisation provided to the Inquiry related to pathology. With the restructures, pathology services were merged into 4 networks across the State. I was told that 3 years after the restructure, leadership positions in those networks have not been filled. I was told that some leaders have resigned because of slow progress. Dr Branley gave evidence that:<sup>132</sup>
- “We were the Nepean and Blue Mountains Pathology Service and we are now part of the ICPMR network, which is a vast network covering well over three-quarters of the state, but management has completely failed within that organisation, so much so that we need to buy machinery because it is constantly failing and we put up requisitions that disappear into complete management black holes because nobody can make a decision. It really is a joke trying to manage a small unit within the current structure.”
- 31.187 The loss of local management capacity has, I was told, resulted in a system that is “cumbersome”, “wasteful” and “inefficient”.<sup>133</sup> Clinicians informed the Inquiry that there has been a serious deterioration in the efficiency of management and the timeliness and decisiveness of management.<sup>134</sup>
- 31.188 I heard many complaints that it was difficult to get decisions made in a timely manner, and that requests or proposals often simply disappeared. The Inquiry was given examples of proposals which had been submitted to Area executives for approval, without response, or approved, without subsequent action, many months, and in some cases, years, before the evidence was given.<sup>135</sup> Staff told the Inquiry that they have no way of knowing how their request for a decision is tracking or where it has gone. All they know is that it has gone through several administrative layers and not met with a timely response.<sup>136</sup> One witness said that he would rather be told “no” than have his request disappear into the “ether”<sup>137</sup> or the “blackhole” as another witness put it.<sup>138</sup>

- 31.189 Some say that there is an opportunity cost of not making a management decision, which may often be very expensive. I was told, and agree, that this applies particularly to staff recruitment where inordinate delays in filling vacant positions mean that, as well as compromising patient care, a lot of money is spent on overtime and casual staff.<sup>139</sup>
- 31.190 Many clinicians complained that they no longer have direct access to the decision-makers to be able to physically meet with them. It is said, and quite reasonably, that face to face contact is the best way to achieve outcomes at senior management levels and far superior to telephones and emails.<sup>140</sup>
- 31.191 This physical removal of management has been coupled with an increase in administrative layers required to make decisions.<sup>141</sup> Many witnesses spoke about the layers of “bureaucracy” that are “unwieldy” and “remote”.<sup>142</sup> There is perceived to be duplication of administrative functions, such as approvals for recruitment, at the hospital and the Area level. I was told that these layers often seem to serve to block and delay, rather than facilitate decision-making.
- 31.192 I have discussed a specific example of the problems created by the centralisation of decision making in relation to the procurement of equipment in Chapter 30.
- 31.193 A survey undertaken by NSW Health recently identified perceptions shared by clinical managers of the centralised approval processes:<sup>143</sup>
- (a) Expenditure control is dominant in the decision making of the area health service.
  - (b) There are excessive delays in responding to proposals.
  - (c) There is lack of access to decision makers.
  - (d) Clinicians are powerless to influence policy and practice.
- 31.194 Words used by clinicians to this Inquiry to describe these problems were “disheartening”, “demoralising”, “dysfunctional” and “inefficient”.<sup>144</sup>

#### *Hospital committees*

- 31.195 Similarly, the Inquiry received evidence that local committees have lost importance in the decision making processes of the area health services. A witness at Wagga Base Hospital testified, for example, that action plans from hospital committees are often lost in transit between the local committee and the Area power base which is required to consider and enact them.<sup>145</sup> Alternatively, decisions of some hospital committees do not feed into any Area committee, such that valuable advice from clinicians is not channelled anywhere.<sup>146</sup> Clinicians say, and I accept, that this is a waste of their expertise. I have discussed elsewhere in this chapter the importance of an effective committee structure at hospital level.
- 31.196 At the same time, I was told that Area committees might make decisions seemingly without consultation. Clinicians said that they were often not informed about how decisions were made, only what the decision was.<sup>147</sup> An example given to the Inquiry was the introduction of a new form by an Area Committee, that in the clinicians’ collective opinion omitted important sections (that was described as “like a car without a steering wheel”).<sup>148</sup> I was told that there needs to be greater consultation and sharing of expertise before decisions are made.
- 31.197 In large area health services, the hospital style of management where all relevant staff can gather in a timely fashion in a room and have a broad-based meeting about a particular matter of central interest is obviously not feasible. Therefore, the planning and processes of Area committees have to be attended by careful visiting to various

facilities and consultation with the local clinicians. Area committees will only receive the support of clinicians when they are in touch with the clinicians at facility level. I accept that consultation as a general principle is simple to mandate, but complex as a practical matter. Every person affected by a decision cannot be consulted. However, a concerted effort has to be made to visit hospitals and know what is happening at the frontline of clinical services.

### *Micromanagement*

- 31.198 I also heard many complaints about micromanagement by the central administration.<sup>149</sup> I was told that micromanagement “has been elevated to an art by NSW Health that beggars the imagination”. It is said that this has a lot to do with the size of the area health services:<sup>150</sup>

“Now we have got these mega areas which you can only manage if you micromanage because there is no devolution and subsidiarity has been abolished.”

- 31.199 Some say that this might reflect a parent/child relationship between NSW Health and local leaders which needs to be changed to an adult relationship.<sup>151</sup> Releasing autonomy to local leaders, together with clarity of accountability, builds trust and reduces the need for micromanagement. Experts say that an emphasis on external and compulsory measures gives you compliance but not high performance, whilst successful organisations run on voluntary and internal measures and are self-improving.<sup>152</sup>

- 31.200 Whilst authority is not delegated to the local level, responsibility is still at the local level. This must be immensely frustrating for clinical managers to bear responsibility but to lack the authority to effect change. Senior medical officers told me that they are still responsible for clinical services and the quality and safety of patient care, but have little or no delegation to make decisions. They said that this has caused a progressive and increasing erosion of morale, commitment and loyalty to the institution. Many senior doctors expressed their disappointment and frustration at having reached such a position after many years of enormous commitment to the public hospital system. For example, Professor Cousins gave evidence:<sup>153</sup>

“I would like to say that after 50 years of observing this hospital, I'm sad to say that over the last 10 to 12 years there has been a progressive and, I would have to say, increasing erosion of morale, commitment and loyalty to the institution, and that's despite a large number of individuals having demonstrated an enormous commitment over the many years that I've been associated with the hospital.

So I'm very sad to have to say that, but I think we have to face up to facts...

My present position is that I, like many others, are on a knife edge, of feeling that we've just about tolerated as much as we can and we are considering leaving. If I did that, I would feel an enormous sense of loss - not loss for myself, but a sense of loss for what might happen to the service that I have tried so very hard to build...

I think one of the key issues is a lack of delegation of decision making. The delegation of responsibility is still there. We still bear the responsibility for the clinical services and the quality and the safety... The problem is from my point of view it's been very difficult to get a decision.”

- 31.201 I was told that day-to-day administrative tasks that would have been performed by previous managers now have to go through a chain before they are approved and signed off. Staff see this as micromanagement.<sup>154</sup> Witnesses gave the Inquiry examples of this in their testimony: If a mobile phone is broken, it takes 5 months to replace the handset; requests to replace broken doors or latches or for more envelopes or badges are said to be “... micromanaged from Sydney ...”<sup>155</sup>; a number of VMO psychiatrists remained unpaid for up to 5 months<sup>156</sup>.
- 31.202 A by-product of micromanagement from a central administration is a lack of willingness to take risks or make innovations in “outlying” hospitals.<sup>157</sup> Witnesses said that a supportive, flexible, imaginative executive which is prepared to take some risks is needed. I heard that some models of care have been successfully implemented that involved a degree of risk to the budget.<sup>158</sup>
- 31.203 I should comment briefly on the rationale which underlines the “need” to micro-manage: to instil budget discipline and protect expenditures. There is no compelling evidence that modern management requires centralised decision-making of the kind which prevails in NSW Health. The recent over-run of \$300 million in the health budget should not result in an attempt to exercise ever tighter control from the central office. Instead it should lead to a rethink of how to be more efficient and more economical. The evidence suggests that, in a mature management structure, this is best achieved by delegating serious decision-making from the area level to the hospital level whilst requiring the general managers to answer for compliance with their share of the Area budget. Monitoring can occur as frequently as necessary.

### *Solution*

- 31.204 The disconnection which the evidence reveals is between a centralised management structure designed to control finite resources as closely as possible and a frontline clinical staff whose overriding concern is patient care. Frontline staff are or consider themselves (as the case may be) best placed to decide what resources patient care requires. This was expressed in the following evidence:<sup>159</sup>

“We in recent years, in my view, have focused an incredible lot on management and management by numbers and figures and somewhat defensive sort of strategies about the way we approach care. I think some of that has been at the expense of leadership and empowering people at relatively low levels in the hierarchy of health. I would like to see a reversal of that trend where smaller unit focus is re-established and ownership and decision making is re-established at a smaller level.

Part of the way I see that is that as human beings working in health, we have a loyalty to perhaps two concepts, and I would suggest that those concepts are the hospital we work in and the ward or the unit that we work for.”

- 31.205 It seems to me that centralisation has caused the following problems:
- A failure of management to make timely and decisive decisions;
  - An over-centralisation of fund-holding and decision-making capability, coupled with an absence of local support for clinical managers;
  - An overwhelming perception by clinicians that they have no voice or power to influence decisions at the local level.
- 31.206 It seems to me that the clinicians will always identify most strongly with their hospital, ward or unit, and that they therefore require some reassurance that there is local

management capacity to respond to the patient care needs that they identify at the frontline. The restructure made in 2005 has clearly not delivered this and has made the position much worse. In my view, there has been sufficient time since the restructures took place to enable an accurate assessment of its impacts. During the course of the experts' conference, Bill Bowtell who was involved in the design of the restructure to eight area health services made a frank appraisal of the results of area amalgamation and concluded that the centralisation of decision making had not achieved its original intent and needed to be reviewed.<sup>160</sup>

31.207 Others agreed:<sup>161</sup>

"In terms of governance, over my 25 years, early on as a clinician and then more recently as an executive, both in this country and in other countries, there has been a palpable shift of governance towards the centre. I agree with the previous speaker; I have seen enough of this now to believe that it has been an abject failure."

31.208 Unless change is made, I do not think that the concerns raised by clinicians to this Inquiry (and by some managers) will go away.

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31.209 As I have previously noted, the disruption of attempting yet another change to the area health services is simply unacceptable. However the inherent weaknesses of the system as *it is* must be recognised: 2005 created an over-centralised management structure which has alienated clinicians who are the heart of the public hospital system. The remedy is for the area chief executives to devolve power and give managers at the hospital level more autonomy, thereby putting management back in touch with clinicians and responsive to their expertise and vision for the public system.

31.210 The solution to this is to devolve decision-making capacity to health services. There is a lack of clarity about the extent of authority of general managers of hospitals. This needs to be clearly defined.

31.211 Nepean Hospital has established a Senior Clinical Council to address the problem of centralised administration, which appears to be effective.<sup>162</sup> This group meets every week with a local facility manager so that senior clinicians can tackle problems at a local level. For problems which need to be dealt with higher in the network, the local facility manager is responsible for progressing that issue. I was told that this has led to a big improvement and has been effective in solving problems, many of which are local, because it is a forum for senior management and senior clinicians to communicate with each other.

31.212 In my view, this should be emulated. I also received evidence about a robust hospital committee system at Concord Hospital which is worthy of consideration and emulation (which I discuss below).

### Inadequate spending delegations

31.213 Many complained of inadequate spending delegations at a local level. This is at odds with the ability of clinicians to authorise medical tests and procedures worth thousands of dollars. I was told that the area health service restructures have caused a gross overcentralisation of fund-holding and decision-making processes.<sup>163</sup>

31.214 Dr Chapman at Westmead Hospital told me, for example, that he is responsible for a network with a budget of \$50 million a year but is not permitted to authorise a replacement pager for a junior staff member costing \$169.<sup>164</sup> The Inquiry received evidence to similar effect from many other clinical and facility managers. A General



Manager of both a hospital and hospital network complained about the inability to authorise the purchase of a floor polisher costing about \$1200 to enable hospital floors to be cleaned, despite being responsible for a hospital budget of around \$100 million and a network budget of an even greater amount.<sup>165</sup>

- 31.215 Many examples were given to the Inquiry, including from a Director of ICU who said that he was not empowered to make administrative decisions except to order photocopying, despite the authority to order expensive ICU tests and drugs.<sup>166</sup> Other heads of department also said that the delegation to order items up to an artificially low monetary amount was anomalous with the unlimited delegation in clinical matters.<sup>167</sup>
- 31.216 Clinical managers said that their lack of delegation to order routine items without General Manager approval impeded patient care, particularly where planned orders were required urgently (such as dialysis fluid and dialysis consumables).<sup>168</sup> Some felt that this was due to a financial crisis in the area health services which had led to micromanagement.<sup>169</sup>
- 31.217 Managers told the Inquiry that they use various devices to get around these limits, such as dividing orders into lots so as not to exceed delegations based on the dollar amount of each order.<sup>170</sup>
- 31.218 In some cases, it seems that there is confusion among staff about the extent of the authorities granted to local managers:
- "What decisions can be made locally and what needs to be ticked off further up the line is not necessarily clear."<sup>171</sup>
- 31.219 NSW Health informed the Inquiry that most heads of department of public hospitals are given a delegation to spend from between \$1,000 and \$5,000 provided that the expenditure did not exceed the budget.<sup>172</sup> These decisions do not have to be submitted for approval to the General Manager of the hospital. The extent of the delegations varies between area health services and is determined by the Chief Executive or the Director of Clinical Operations to whom the Chief Executive delegates functions<sup>173</sup>. NSW Health said that there is no explicit financial delegation limits for similar size hospitals.
- 31.220 I was told that sometimes, the person with the delegation does not have the funds due to lack of budget, and blames lack of delegation rather than the lack of budget. However, in some cases, although there is a delegation to make a certain decision, say to recruit staff or purchase certain equipment, there is a genuine absence of funds for the local manager, be it the General Manager of the hospital or head of a department, to do so.
- 31.221 I have also discussed the problems posed by lack of financial delegations in relation to the procurement of equipment in Chapter 30.
- 31.222 As I discussed above, this lack of authority must be immensely frustrating to staff who bear responsibility but lack the authority to effect change. In short, responsibility, authority and accountability must travel together. I have made recommendations in this regard above.

### No local budget

- 31.223 I heard numerous clinicians and community members complain that the budget for local services is no longer available for scrutiny.



- 31.224 I was told that this has happened since the amalgamations:<sup>174</sup>
- "We actually used to have very good financial systems here before the areas were amalgamated. Clinical directors could actually access their budget and understand it, there was a finance person you would work with, and you actually had some sense of responsibility and a little bit of control."
- 31.225 Many say that budgets at both hospital and Area level are not transparent:<sup>175</sup>
- "The funding at the moment is very opaque, as far as we are concerned, and the budgetary process is not always very clear as to how these decisions are made."
- 31.226 In contrast, clinicians are told about budgets when they are exceeded:
- "The only time I hear about the budget is when I have exceeded it."<sup>176</sup>
- 31.227 I was also told by members of the community that before the amalgamations in 2005 they had access to budgets. One witness described having access to information about the resources available to mental health programs in her geographic area, including staffing levels, and the benefits of knowing what resource limitations and opportunities existed.<sup>177</sup> I was told that since the amalgamation there is much less transparency and "a community concern that there is inequity" in the distribution of resources across the area: "we seem to have developed a culture of haves and have-nots".<sup>178</sup> Other witnesses, including clinicians also said that the funding and budgetary process is not clear.<sup>179</sup>
- 31.228 NSW Health says that there are large areas in western Sydney where the clinicians effectively have budgetary control and are intimately involved in the running of the service. On the other hand, in some area health services, almost no clinicians, or local managers, have control over the budget. I observed this in operation in, and the Chief Executive of the Northern Sydney Central Coast Area Health Service confirmed this to the Inquiry.<sup>180</sup>
- 31.229 It seems that it would help if the organisational structure of the area health services and their budgets were more transparent. The general view is reflected in this evidence.<sup>181</sup>
- "It's very clear that the CEO is in charge and the next level down, the general managers [of the health services] are in charge of those hospitals, but getting below that level it is not clear who is responsible for what and who controls the budget and who is answerable to who"
- "I would like to see that it was clear that the person who was in charge also carried financial responsibility and to be able to see who each person was answerable to"
- 31.230 The next important step would seem to be to devolve some level of participation in the planning and budgetary processes to clinicians. The Inquiry received evidence of a survey by the Liverpool Medical Staff Council in which 39 of 40 respondents considered it important that their department be responsible for the allocation of its budget and resources. They would like to see funding decisions made at a local level to try to reduce the levels of bureaucracy which are perceived to be redundant.<sup>182</sup>
- 31.231 Many clinicians were keen to be involved in the management of the budgets for their clinical services, but did not know what the budget was and did not have any authority to participate in how the budget was expended. In my observation, clinicians are aware of budget limitations and the need to make responsible financial decisions.

"I am very interested in saving money because it will allow us to do the things we need to do. Clinicians will come on side and do want to be on side"<sup>183</sup>

- 31.232 Many clinician managers testified that their expertise would be valuable, some say essential, to the planning and budgetary processes and said that clinicians need advice and support with finance, data and business management.<sup>184</sup> I was told that with those tools, they can make effective decisions.
- 31.233 I was told that clinician involvement in management is critical to the effective running of a health service and that it often leads to savings being made.<sup>185</sup>
- "So we are able to look at a budgetary problem and resolve it frequently with a clinical decision, with a change in patterns of care or models of care which enables you to do things a little better for less cost, but there is a finite end to that. You do get to a point where you are squeezed and you can't go on. I suppose the point I'm trying to come to is that clinical involvement in management is critical to the effective running of this health service. The higher those clinicians rise within that organisational structure, whether it be site, area, or the department itself, the better run it will be."
- 31.234 This is already happening in some areas. For instance, at St Vincent's Hospital clinical programs are managed by a senior doctor supported by a business manager, who have budgetary responsibility. The Inquiry received evidence from one of the Program Directors, a senior surgeon Dr Max Coleman, who considered leadership by a senior doctor to be a benefit to the running of the program. One of the most useful things, I was told, was to have a relatively senior business manager as an integral part of the program.<sup>186</sup>
- 31.235 I was told that business manager and data manager positions were removed at the time of the amalgamations, due to a need to make cost savings.<sup>187</sup>
- 31.236 I consider that senior doctors need to be engaged more in clinical management roles and supported in these roles by appropriate business managers. It seems to me that senior doctors who are looking to downsize their clinical practice are a potential resource for these types of roles. They are usually highly experienced in their area of specialty and, with training and support, suitable to take on roles in clinical management.
- 31.237 In my view, there needs to be an articulation of such roles and the value of them, as well as an effort to identify those with an interest, or willingness to develop an interest, in moving their career in that direction. I spoke to several senior clinicians who have found themselves selected for such management roles in the late years of their careers, without much forewarning or any training.
- 31.238 I also agree with the views expressed to me that clinical managers at the low levels ought to be given more responsibility for planning and budgetary processes, as well as education to manage resources. The current system does not encourage or train clinicians to take responsibility for budgets and essentially communicates a distrust to them about the decisions that they may make.
- 31.239 Many clinicians expressed their disappointment and frustration at not being involved in planning or in decisions about the distribution of funding. They felt that they were well placed to report on the function of the hospital and its capacity to serve its purposes.<sup>188</sup>

"If a clinician nowadays does make an attempt to point out a shortfall or a deficiency, it seems to me that we have largely been disempowered and there are a lot of obstructions to us sometimes preventing, if not a deterioration in services, outright catastrophes or crises that then really have terrible effects for those individuals involved but reflect badly on the system as a whole."<sup>189</sup>

- 31.240 Concerns were also raised about the transparency of budgets managed at area health service level, and the decisions by chief executive officers in relation to the budget. There needs to be greater transparency about area health service budgets. In my view, financial and quality information should be fed back to all relevant clinicians. This information should be easy to review and analyse. Currently, such information is non-existent or at best very difficult for clinicians to obtain or understand. This may be improved by requiring chief executive to report on 6 to 8 parameters regularly on a website. I make recommendations at the end of this chapter about budget transparency.

### No incentive or reward

- 31.241 The present method of managing does not incentivise clinicians to keep within a budget, or to save money in the way that they practise medicine. I was told quite often that doing a job well attracts more patients without necessarily the funding to go with it. Furthermore, I was told regularly that coming in under budget simply means that your budget will be cut:<sup>190</sup>

"If you produce a saving it disappears into the general fund and historically the following year you get 10% less of what you already saved, so you are actually penalised by being productive and efficient."<sup>191</sup>

- 31.242 I was told for example that although Sydney Children's Hospital won an award for the best performing hospital in NSW last year, this did not translate into any other financial or resource awards but meant that it missed out on some new initiatives because it apparently did not need them.<sup>192</sup> Similarly, a senior doctor gave the following evidence about applying for and obtaining a Commonwealth subsidy of \$96,000 for placing an Area of Need doctor in his hospital:

"We never saw a cent of that. Where is the incentive for people to try and find ways to improve the financial management of their institution?"<sup>193</sup>

- 31.243 Clinicians lamented that there are no incentives built in to reward good performance.
- 31.244 In my view, this should change, as it has in the United Kingdom, to involve clinicians in the management of budgets by entitling them to keep some part of the savings which they have made, within their units to fund further programmes or acquisitions of equipment. This seems to me to be a very effective way to create incentives for efficiency. If responsibility for managing a budget was devolved down to the department head level, and she or he was able to retain some part of any savings within the department, there would be an incentive to be a lot more efficient in the use of resources and raising revenue. Senior clinicians expressed this view to the Inquiry.<sup>194</sup>
- 31.245 I heard of an example which is worthy of detailed review, where the involvement of clinicians led to rectifying budgetary overruns in relation to procurement of surgical appliances.

- 31.246 Dr Coleman gave evidence<sup>195</sup> that when he took up the job of Director of the Surgery Program at St Vincent's Hospital he had been in the job about 4 to 5 months when the finance department informed him that his program was \$500,000 over budget. He found that half of the excess consisted of salaries and wages and the other half was in orthopaedic prostheses. He sought a list of the hip and knee joints that had been replaced in the hospital over a 12 month period and determined, having received a costing from the surgery department, how much joint prostheses cost per surgeon. With 7 surgeons, the prosthetic cost per patient varied from \$4,300 to \$7,900.
- 31.247 Dr Coleman gave evidence that surgeons in general do not know the cost of the equipment that they use and that the cost of different brands can vary widely, notwithstanding that the surgeons expect identical outcomes in patient care. Dr Coleman presented this data to the department within the hospital and it was determined, in consultation with the surgeons, that the budget would be achieved if the cost per patient could be reduced by \$1,000. Dr Coleman said that has essentially been achieved in conjunction with a trial carried out by NSW Health called Gainshare<sup>196</sup>.
- 31.248 Gainshare is a description given to projects led by NSW Health with the aim of improving efficiency in specialised equipment procurement processes. Under the projects, local management agreed with their local clinical unit or service to share in any savings achieved through improved procurement processes that could be attributed to their efforts. The Orthopaedic Gainshare Pilot was limited to total knee and total hip replacement prostheses and involved 4 metropolitan hospitals: St Vincent's, Sutherland, Fairfield and Royal North Shore<sup>197</sup>. It commenced in February 2007 and was completed in August 2007. I was told that not all sites achieved savings but an evaluation of the projects supported the potential of the Gainshare model. I was told that the challenges identified related to rewarding clinical areas that were already over budget, aligning local procurement processes with the Gainshare model and the need for stronger commercial expertise for effective negotiation with vendors.
- 31.249 In his evidence, Dr Coleman considered that Gainshare was an important element in making clinical processes more cost effective but in his view the result would also have been achieved without Gainshare<sup>198</sup>. He said that it was a "carrot" for the surgeons as it ensured their ability to have patients on their operating list each week.
- 31.250 NSW Health informed the Inquiry that other projects have been carried out to streamline procurement activity<sup>199</sup>. I was told that a trial is currently underway based on the "Basket of Goods" approach used in Sweden. Using a clinically verified treatment planning approach, South Eastern Sydney Illawarra Area Health Service approaches the market for a selective tender, engaging preferred suppliers for an area wide volume-based supply contract for an agreed range of products. I was told that this is expected to generate significant savings with regard to purchase prices and also improve efficiency along the supply chain by reducing invoicing for individual orders, invoice matching and sourcing supplies. It is expected that this process will reduce waste from surgical pre-packs and may serve to enhance clinical outcomes by standardising treatment with identified procedures. I was told that an approach to market was being prepared for release in November 2008 and that clinicians would be engaged in the implementation phase regarding developing standardised procedural guidelines to complement the streamlined procurement activity.
- 31.251 In my view, there is a potential for significant savings to be made by NSW Health in the area of procurement. At the present time, procurement, especially with regard to surgical equipment and appliances, as well as medications, is done on a fairly ad hoc basis. Streamlining and standardising procurement processes not only removes the significant discrepancy between costs of the same type of surgery according to the

surgeon, it also has the potential to improve patient care by achieving greater equity in the delivery of services. Because the potential of impeding clinical choice exists, there is a need for close consultation with clinicians. Consultation provides an opportunity for partnership between clinicians, hospital and Area management in an effort to reduce costs, improve patient care and share in resulting savings.

## Challenges facing management staff

- 31.252 NSW Health informed the Inquiry that there are 4,467.6 FTE health service managers (as at June 2008)<sup>200</sup>. This number includes clinical managers who perform both hands on clinical care and management duties.
- 31.253 The Australian College of Health Service Executives submitted to the Inquiry that there is no definition within NSW Health to define the competencies required for persons entering into a management role<sup>201</sup>. It submitted that the role of health services manager needs to be better defined so as to identify the persons considered to be managers, the preparation required for the role and the requisite competencies.
- 31.254 In its submission, the Australian College of Health Service Executives indicated that health service management is a highly qualified workforce<sup>202</sup>. It said that in its most recent survey, 95% of respondents held a degree, 78% held a management degree and 52% held a clinical qualification. This is an increase from only 19% of respondents with a clinical qualification in 1990.<sup>203</sup> It said that this reflects a trend in Australia towards 'clinician managers'.
- 31.255 NSW Health provided the Inquiry with information about the various programs available for training health service managers<sup>204</sup>. Some area health services offer their own management programs (such as Hunter New England Area Health Service and Sydney South West Area Health Service) which vary depending on the area of health service management. Other programs are funded by the NSW Government and available to the entire NSW public sector (such as the ANZOG Executive Masters and the Executive Development Program) or by NSW Health (such as the Clinical Leadership Program which is delivered by the Clinical Excellence Commission). Six universities in NSW offer degree courses in health services management<sup>205</sup>.
- 31.256 The Australian College of Health Service Executives receives funding from NSW Health to operate a graduate health management program<sup>206</sup>. The College takes 15 new graduates each year for a 2 year program. Trainees are placed in a management position in area health services over 2 years and undertake formal studies at Charles Sturt University. The University of Technology Sydney also offers a health services management program which takes approximately 4-6 trainees per year. The Australian College of Health Service Executives submitted to the Inquiry that the need for new, well-experienced and trained managers in the NSW health system far exceeds the total number of places in these 2 programs and that the programs could be substantially expanded.<sup>207</sup>
- 31.257 It was submitted to the Inquiry that there is a lack of career path for hospital managers and a lack of continuing education for them<sup>208</sup>. It is said that there is a need to require health services managers to:
- undertake continuous professional development;

- demonstrate commitment to their profession by membership of an appropriate professional body. In NSW, the major professional bodies associated with health services management are the Royal Australasian College of Medical Administrators and the Australian College of Health Service Executives;
- hold formal qualifications in management before qualifying for appointment to senior management positions<sup>209</sup>.

31.258 I do not consider it within my terms of reference to make specific recommendations about these matters. It is a matter which ought be left to NSW Health and the area health services to address. It is clear, however, that within the existing management structure, individual managers face a number of challenges. I discuss some of these below. I have discussed elsewhere the loss of support staff to assist managers.

### Turnover of management staff

31.259 I heard evidence that there is a frequent turnover of management staff, with resultant loss of corporate memory.

31.260 In some hospitals, in particular, there has been a high turnover of General Managers, including Royal North Shore Hospital<sup>210</sup> and Wagga Base Hospital.<sup>211</sup> Clinicians attribute this to some of the issues identified above, namely, the General Managers' lack of authority to make decisions and to control a budget. For example, in relation to Wagga Base Hospital, it was said:

"...we have had a succession of general managers, usually lasting less than a year at a time and one of the frustrations they find, I've heard repeatedly, is lack of discretionary funding. So despite being nominally in charge of a budget of over \$100m, they may have to seek permission for spending more than \$1,000. This leads to discontent, rapid turnover of staff, lack of responsibility, loss of corporate memory and impacts on recruitment."<sup>212</sup>

31.261 In relation to Royal North Shore Hospital, I was told:<sup>213</sup>

"I have observed the turnover of more than eight general managers and I've tried to work with all eight of them, but I've become increasingly aware of their feeling of impotency, their inability to make other than fairly small decisions, and during certain periods of time having to refer even really small decisions upwards."

31.262 Short tenures in key management roles leads to a lack of corporate memory and perceived lack of accountability for decision-making.<sup>214</sup> It is a weakness in any system.

31.263 I was told, and accept, that it makes it difficult for clinicians, the vast majority of whom are extremely stable in their roles, to function as a team with managers given such turnover.<sup>215</sup>

31.264 It also means that staff's needs are less likely to be met:<sup>216</sup>

"With a succession of acting managers in almost all of the departments and a reduction in medical administrators across the GSAHS, the Area is far less responsive to the needs of the medical staff."

31.265 Many say that hospital managers have a difficult task because the requirement to stay within budget is emphasised over everything else.<sup>217</sup> The Inquiry received evidence that:<sup>218</sup>



"Their main boss is the area health service and the Health department. The main outcome that is emphasised is staying on budget."

- 31.266 Although several witnesses had praise for managers, at both hospital and Area level, they said that effort needs to be made to bring some stability to managerial positions. I agree.

"There is no doubt that their lack of corporate knowledge and perceived lack of accountability for decision making in their short tenures is disheartening for those who battle on for years at the coalface. If NSW Health is seen as the head coach in this regard, then it would be well served and highly appropriate if they facilitated some stability in these key positions so that those teams could be given a chance at least to develop and succeed."<sup>219</sup>

### Security of tenure

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- 31.267 Some say that a move to short term contracts for management staff has reduced the ability of managers to provide independent views to those above them about the operation of hospitals and how things should be improved. It is said that the lack of security of tenure of chief executives and senior management staff means that it is difficult for them to give advice without hear or favour<sup>220</sup>.

### Data for management

- 31.268 The data needed by managers to manage does not seem to be readily available. An effective managerial system depends on good data. Although almost all of the needed data is collected across the State, it is not readily accessible, even at the highest levels of health administration. I heard that some Chief Executives have been able to build up data repositories to assist them in their functions.<sup>221</sup> Some say that a good data system is not difficult to implement.<sup>222</sup>
- 31.269 I heard that the Children's Hospital at Westmead and the Greater Southern Area Health Service use software "CareView" to assemble data.<sup>223</sup> This enables managers to delegate down, without fear that a budget will be exceeded. I was told that this data is oriented to operational managers, the use of incentives and the close monitoring of expenditures. It is not the same data that policy administrators require, for example, to monitor elective surgery waiting times or emergency department triage times. It is essential that Chief Executives have effective systems for monitoring expenditure so that appropriate delegations can be made to clinical managers.
- 31.270 Some say that care is needed to ensure that the data upon which major decisions are made is reliable and that the parameters are clear:
- "I think we need to take care that the data that we're collecting and basing major decisions on is very solid data and that we understand what that data means and where it comes from before we have major commitments based on it, because we could go down a path that's clearly not quite right."<sup>224</sup>
- 31.271 I detected a strong scepticism by many clinicians who gave evidence in private session that the data collected, particularly with regard to key performance indicators, reflected the true position.<sup>225</sup> I discuss some aspects of this in Chapter 17.



- 31.272 They also expressed concerns that the emphasis by management on collection of data of interest to managers has meant a lack of concern for patient care:

"financial people can tell you how many tea bags were paid for a ward, but no one comes and asks about patient care."<sup>226</sup>

- 31.273 While this statement was obviously rhetorical, it reflects a perception held by many frontline clinicians that financial performance prevails in importance over patient care. Regardless of whether the perception is accurate (which I would find difficult to accept), clinicians find it demoralising.

- 31.274 Data collection is part of the overall performance monitoring and management policy of NSW Health. I make recommendations in Chapter 17.

## The divide between clinicians and management

- 31.275 I heard quite sad evidence about senior doctors disengaging from the administration of their hospitals due to the problems with the existing management structure discussed above.

- 31.276 Very senior doctors told the Inquiry that they have serious concerns about the management of their hospitals and administration of the health system at Area level. They expressed concern at the loss of senior colleagues to the private hospital system:

"Money is not the issue. It's about that the wards that we go to don't have a coat of paint, the blood pressure machine doesn't work, the nurses are despondent... the patients are sitting there and they're telling us all these things. The relatives ring us, they don't ring the hospital and they say it was terrible for these reasons ..."<sup>227</sup>

And:

"Without mentioning names, they are people for whom I have the greatest respect, they were major leaders in various disciplines. Their prevailing sentiments were, "I've had enough of this place. I'm so angry with this place." They could not get the sort of infrastructure resources they needed to do the quality of work they wanted to do. The loss of that leadership is profound. It is perhaps part of the reason why the divide between management and leadership, clinical leadership has become so deep."<sup>228</sup>

- 31.277 Many say that the amalgamation of the area health services has led to senior doctors feeling frustrated that they have no decision-making role.<sup>229</sup> I was told that the new management structure has not allowed the same input by clinicians as the previous structure and has diminished interaction between management and clinicians.<sup>230</sup> Clinicians feel disempowered and unable to contribute to hospital or Area health management.<sup>231</sup>

- 31.278 Clinicians are worried that Area management is only concerned about meeting budgets and the performance criteria imposed by NSW Health:

"So I think there's a disconnect between the need for management to obtain numbers and figures which demonstrate what management is doing and the need for clinicians and people at the bedside to feel empowered

and that they can make decisions that really relate to them.”<sup>232</sup>

- 31.279 I was told that planning and operational meetings with management staff are often perceived by doctors to be a waste of time due to the fact that medical input is felt to be ignored.<sup>233</sup> Clinicians say that decisions are made by senior managers or the Chief Executive with little feedback to those involved as to how their views were considered. I was told that statements are then frequently made that clinician consultation occurred at all stages of the process. I was told that clinicians then resile from engaging in a process which may result in an outcome with which they disagree but which is attributed to them.<sup>234</sup>
- 31.280 It is obvious to me that clinicians participate in management processes in anticipation of being able to achieve something. It became clear to me, throughout the course of the Inquiry, that unless doctors perceive that they have a consultative role and there will be some progress, they become frustrated with the system and revert to their primary care role. I was told that there are many good clinical managers who have given up their management role and gone back to practice or left the public system altogether. Some say doctors prefer to retreat to the clinical management of patients, where they feel they can make a difference.
- 31.281 I was told that clinicians are feeling disengaged from the whole feeling of belonging and feeling proud of their hospital.<sup>235</sup>
- “And if I’m not feeling part of it, I think I am one of the proudest members of the public hospital system and its biggest supporter for 20 years, so if I’m not feeling proud of it, I know my colleagues are not proud of it”<sup>236</sup>
- And:
- “now we are just part of this monstrous Area Health Service. I don’t even know the name of the director of my clinical stream in the area.”<sup>237</sup>
- 31.282 Clinicians are withdrawing from giving their time to improving the system because of the other demands on their time. I discuss this also in Chapters 7 and 10.
- 31.283 Dr David Williams gave evidence at John Hunter Hospital that one of the things that goes when clinicians are busy and feel that they cannot promote their values is the engagement they have in the system. He suggested that when confronted with multiple responsibilities, as most senior medical practitioners are, there is a:
- “...tendency to devote effort to those things which are either most important or most rewarding, and for many practitioners what happens I think is that those aspects of contribution to improving system processes tends to be relatively unrewarding, and has been for a long time, because they feel that they are not able to promote the sorts of changes that they see as being valuable. When there are many other pressing things to do, it is easy enough to say, okay I will concentrate more efforts on these other areas. So I think that is part of the problem.”<sup>238</sup>
- 31.284 There is a corresponding loss of morale by medical staff councils, whose role is substantially diminished in the restructure. I discuss this above in the section on Medical Staff Councils.
- 31.285 Clinicians expressed disquiet about a lack of consultation by managers who are making decisions affecting patient care.<sup>239</sup> During the course of the Inquiry, I was told regularly

that managers do not listen to clinicians' opinions and protests about decisions<sup>240</sup>. One example was as follows:<sup>241</sup>

"There is this perceived thing at the moment that cheap is better. We are constantly asked to use instruments, material in theatre without being asked to trial it. An example is recently, two years ago, they had calf compressors, which help prevent clots in the legs. The hospital brought in a company "You have got this, bad luck". I had significant clinical issues with that... After 12 months of arguing and showing the data, evidence based medicine, the hospital changed to the appropriate machine."

31.286 Clinicians told the Inquiry that they are not invited to attend meetings at which decisions are made that bear directly on clinical work:

"On Monday, there will be a meeting of the Western Pathology Cluster Management Committee which is the peak committee for managing the pathology service. There will not be a pathologist invited to attend".<sup>242</sup>

31.287 They feel unsupported.<sup>243</sup>

"there is a feeling that clinicians just aren't involved with decision making. We're told what will happen to our services. The classic one is, "We've decided that this is how you are going to manage this automation." "We don't think that's the appropriate way to run it." "No, this is the way you'll run it."

31.288 Some midwives gave evidence about a lack of communication between management and midwives to similar effect.<sup>244</sup> They said that they are never asked their opinion about things or given reasons as to why decisions affecting them were made. This must be quite demoralising.

31.289 There is considerable distrust by clinicians of managers. The Australian Salaried Medical Officers Federation (NSW) undertook a survey jointly with the Australian Medical Association (NSW) and the NSW Nurses' Association in March 2008. 69% of doctors did not believe that managers at their workplace can be trusted "to tell things the way they are".<sup>245</sup> A similar number of doctors who responded to the survey do not consider that managers consult employees about issues affecting staff. Witnesses gave evidence that there is a worsening disconnection between administrators and clinicians over the last 5 to 6 years.<sup>246</sup>

31.290 Some say that managers are not to blame because the conflict is driven by the imperatives imposed by Area and Department of Health administration.<sup>247</sup> They said that the decreasing level of trust between clinical staff and their managers is due to the pressures that managers have upon them to reach certain goals and the fact they do not have the resources to provide for the needs on the ward.<sup>248</sup> They praised managers and Chief Executives who consulted staff and communicated with them about what the plans for the area health service were<sup>249</sup>.

31.291 It certainly seems to me that there are difficulties inherent in the clinician-manager relationship because of their different roles, responsibilities and accountabilities. Pressure on managers from the hierarchy above makes it more difficult for managers to share the same values and perspectives as clinicians.

31.292 Some hospitals have involved clinicians in the running of the hospital more successfully than others. I heard for example that Concord Hospital has fewer problems with regard to clinician-management engagement than other hospitals due to good communication

and management. Clinicians feel as though they are listened to by management. Concord Hospital has a committee structure at various levels, which involves clinicians at a clinical level, and an administrative level. In Concord, there is a governance committee which includes many clinicians, committees for each division of medicine and surgery, a staff consultative committee and various other committees involved with the hospital's management. Membership of those committees is rotated. I was told that in a good committee structure such as this:

"people are given a sense of involvement. If you are given a sense of involvement, you are given a sense of empowerment, it makes you relate more to the hospital and it gives management the tools and the feedback they can use to make the system work better."<sup>250</sup>

- 31.293 This sense of involvement is very important to the public health system. The above committee structure is simply a communication structure which (a) ensures that clinicians acknowledge the role of managers and (b) requires managers to work with clinicians. This sort of communication needs to be emulated in all hospitals and accompanied by a clear delineation of responsibilities.
- 31.294 I have already discussed above the management structure at St Vincent's Hospital, where the Inquiry also received evidence about a more constructive relationship between clinicians and management than exists in many other hospitals.
- 31.295 NSW Health has also made some effort to improve clinician engagement. Earlier this year, the Director General of Health, Deborah Picone, established the Clinical Engagement Group to support a team reviewing clinical engagement in clinical management structures. Alan McCarroll and Dr Denis King submitted an interim report *Review of Clinician Engagement in Clinical Management Structures* in May 2008, whose recommendations are summarised earlier in this chapter. The recommendations have been submitted to area health services and I was told that formal action with respect to the recommendations has been held over until my report is released<sup>251</sup>.
- 31.296 In 2004, the Minister asked the Greater Metropolitan Clinical Taskforce to help to define the issues regarding the relationships between hospital management and clinicians in NSW.<sup>252</sup> The Greater Metropolitan Clinical Taskforce formed a working party which analysed the issues and set out potential solutions. The issues identified were the same as those identified by this Inquiry, including that:
- Clinicians identify with hospitals rather than with area health services, senior Area management or NSW Health;
  - Pressures on administrative managers including performance agreements, budget and hierarchical expectations contributed to the disconnection;
  - The need for transparency, provision of data that are relatively contemporaneous and honesty in discussions preceding decision-making was fundamental in restoring trust between administrators and clinicians;
  - A perception that managers approach decision-making from the perspective of budget and clinicians from a clinical imperative meant that it was necessary to determine common ground.
- 31.297 A consultative process resulted in potential solutions, including:
- Recognising that the major forces for discord between clinicians and managers lie outside their control: pressure on managers is largely from Area administration and NSW Health;

- Acknowledging the essential role played by clinician goodwill in holding together the public hospital system and develop clear strategies to protect and nurture it. This involves working on removing current barriers and an active program of rewards;
- Acknowledging the skills of managers in holding together the public hospital system and develop clear strategies to protect and nurture this;
- Empowering clinicians and managers so that they can make change;
- Reconsidering the ways managers are dealt with and held accountable. Hospital and service managers need to be responsible for the performance of their part of the system, not unduly micromanaged, and need to be supported and provided with long-term contracts;
- Ensuring a clearer delineation of responsibilities;
- Ensuring clarity, certainty and predictability of funding, meaning at least 3 to 4 years of certainty around funding levels and the opportunity for enhancements;
- Addressing the problems associated with day to day contact between NSW Health and clinicians. These include the stress of reporting up within the system at all levels, poor communication, direction and mandates from the Department and the time spent in providing information and data collection with little reference to patient care.

31.298 This 2004 report identifies many of the pertinent issues and solutions. Yet the same issues and problems, and potential solutions, have been identified to this Inquiry some 4 years later by many medical clinicians and managers, across the State. It is time that NSW Health made a concerted effort to solve the clinician-management divide by requiring area health services to ensure effective processes for consultation and engagement with clinicians. This needs to be a 'ground up' approach so that clinicians at the front line have an opportunity *through their own hospital* to be informed and participate in the planning and decision-making, under an organisational structure that guarantees that their views will be passed up the line to the Area hierarchy and which permits of some level of flexibility of decision-making and budgetary control at hospital level.

### Clinician representatives

31.299 There needs to be representation of clinicians at management level. The Inquiry received a huge amount of evidence expressing similar sentiments to the following statement:

"clinical involvement in management is critical to the effective running of this health service. The higher those clinicians rise within that organisational structure, whether it be site, area, or the department itself, the better run it will be."

31.300 In my view, each area health service should have an Executive Clinical Director who is a qualified medical practitioner. The South Eastern Sydney Illawarra Area Health Service already has such a position. The occupant of the position ought maintain an ongoing clinical practice. The functions of this appointment should be to:

- (a) provide independent advice on all matters relating to clinical practice directly to the Chief Executive of the area health service or functional health authority;
- (b) provide independent advice on any matter relating to the medical workforce directly to the Chief Executive of the area health service or functional health authority;

- (c) provide oversight of, to be responsible for, and to champion enhancements to ongoing clinical practice, clinical practice improvement and safety and quality improvement programs;
  - (d) act as the public spokesperson, where required, for the area health service on all matters relating to clinical practice, and the safety and quality of patient care in the facilities in the Area;
  - (e) conduct regular forums (or similar consultation processes) with all clinicians (including with Medical Staff Councils) to ensure that clinicians are kept aware of all health systems and clinical practice improvements and enhancements and to enable clinicians to provide timely feedback to the Area on such matters.
- 31.301 The appointment should be governed by a detailed position description setting out the above functions.
- 31.302 The Executive Clinical Director ought be part of the Area Executive and sit on all appropriate Area committees, such as Health Care Quality Committee, Finance and Performance Committee and Audit and Risk Management Committee.
- 31.303 The Executive Clinical Director would be appointed by the Chief Executive in the ordinary way, but I would expect, in order for the occupant of this position to command the necessary widespread respect, that there would need to be a number of clinicians for the area health service involved in the various steps in the selection process. One suggestion which is also worthy of consideration, but about which I will not make a recommendation because it is ultimately a matter for personal leadership style, is that the Executive Clinical Director ought provide reasons to clinicians where he or she departs from their majority view about clinical practice. My recommendations are set out below.
- 31.304 Many doctors expressed the need for clinical leadership. I discuss this in Chapter 7. In short, clinical leadership and clinical champions are vital.

### Clinicians becoming managers

- 31.305 Clinicians told the Inquiry that they consider it important that the managers of clinical programs are clinicians. They said that there are too many non-clinicians in key senior clinical operations management positions in the area health services.<sup>253</sup> For example, some say that the Directors of Clinical Operations at Area level should have a medical background, rather than a financial and accounting background. I was told that appointing a non-doctor is like appointing an accountant to be the conductor of an orchestra:
- "the third movement is essentially variations on a theme from the first movement, so we can make efficiency savings by dropping the third movement out. You can laugh at that, but that is actually what is happening in health".<sup>254</sup>
- 31.306 Many submissions received by the Inquiry said that managers with a clinical background are valuable and too few and far between.<sup>255</sup> I was told that clinicians generally lose money when they become involved in clinical management and need to be supported in those roles.
- 31.307 The opportunities for doctors to take up managerial roles should be increased, with greater opportunities to attend training to develop the necessary skills. Clinical managers gave evidence to the Inquiry that they found the 3-day Clinical Excellence Commission course which teaches them to understand the issues faced by managers



with regard to financial and human resources to be useful. Clinicians said that this was helpful in giving them some insight into the issues that are important to managers higher up the chain.<sup>256</sup>

31.308 Many senior clinicians said that managers with a clinical background are valuable and agreed that there is a need to clearly articulate a career stream which embraces a managerial role. There is a particular need to draw on the experience and expertise of senior doctors who are approaching the end of their careers as clinicians and who may be interested in taking up a clinical management role.

31.309 As a senior surgeon said:<sup>257</sup>

"I think with people such as myself who are getting older in the community, sooner or later as a neurosurgeon I have to say to myself, "Should I continue to operate and do these very complex operations?", and when I don't do that, do I still have a value to the system?"

31.310 There seems to be a consensus that clinical managers should be good clinicians to ensure that they have credibility with their peers. There also seems to be a consensus that doctors who take on those roles require some degree of training in management to convert from being a full-time clinician to carrying out clinician management roles. They need to know the basics of accounting, leadership and performance management.<sup>258</sup> In my view, a training course for clinician managers would show that the system is investing in these individuals. At the present time, insufficient encouragement to, and recognition of the value of their role, is given to clinician managers.

### The way forward

31.311 In my view, there is a clear opportunity to regain the allegiance of senior clinicians by an inclusive approach to policy and the decision-making process.

31.312 I would like to see an alteration to the process of almost complete centralisation that has resulted from the restructures in 2005. Governance needs to be devolved to a more local level by:

- greater delegation to hospital and unit or ward level; and
- greater involvement of clinicians in management decisions; and
- strengthening the structures, including committee structures at hospital level, for communication between management and clinicians

31.313 In my view, a model of health care where a team approach is emphasised is needed. Managers are, and need to consider themselves and be viewed by clinicians as, part of a patient care team. This sentiment is encapsulated in the following evidence:

"I think we have to get back to a model of this, [which] is about patient care, and this is about working together, healthcare is about a team approach on any level. It's about working with nurses. It's about working with physios and OTs and porters and ambulance officers to achieve good outcomes for patients. We need to put the administrators into this team approach. They need to see themselves as part of a patient-care team, and not just running an organisation; as I try to run a business, I am just focussing on the business but not what the business actually does. They need to be part of a team and they need to take that on board as "I am also looking at patient care here".<sup>259</sup>



31.314 The divide between management and clinicians (which I regard as being a modern analogue of the Great Schism which divided medieval Christendom in 1054) needs to be overcome by reminding everyone and continuously emphasising that clinicians and managers are working towards the same goals with respect to patient care. Managers are not simply required to achieve compliance with processes and budgets. Clinicians are not simply to treat patients in any they wish without regard to budgetary obligations and systemic requirements.

31.315 My recommendations are as follows:

**Recommendation 134:** *I recommend that, but for the institution of NSW Kids, there be no other alterations to the current area health service governance structure.*

**Recommendation 135:** *I do not recommend that there be reinstated boards of directors whose task it is to govern the various area health services as board governed health corporations within the meaning of the Health Services Act 1997.*

**Recommendation 136:** *In order to improve governance, no later than 1 July 2009, the following changes take place within area health services and functional health authorities:*

- (a) *(a) that the Chief Executive be required to publish to all staff no later than four weeks after the delivery of the NSW State budget, the details of the budget for the entire health service, for each hospital and for each ward, unit or separate component part within the hospital;*
- (b) *(b) the Chief Executive institute procedures for, and publish guidelines which describe the matching of responsibility for delivering of patient care performance, the accountability for that performance and the authority, within proper budgetary constraints, to take any steps necessary to achieve the high standards of performance.*
- (c) *(c) that the Chief Executive publish to all staff on a monthly basis, the patient care performance status of each of the units or wards, hospitals and the entire area, in accordance with the criteria earlier recommended.*

**Recommendation 137:** *Within 3 months, NSW Health is to create within each area health service, a position entitled "Executive Clinical Director" which would be occupied by a qualified medical practitioner. That position would include, but not be limited to, the following functions:*

- (a) *the provision of independent advice on all matters relating to clinical practice directly to the Chief Executive of the area health service or functional health authority;*
- (b) *the provision of independent advice on any matter relating to the medical workforce directly to the Chief Executive of the area health service or functional health authority;*
- (c) *provide oversight of, to be responsible for, and to champion enhancements to ongoing clinical practice, clinical practice improvement and safety and quality improvement programs;*

- (d) *act as the public spokesperson, where required, for the area health service on all matters relating to clinical practice, and the safety and quality of patient care in the facilities in the Area;*
- (e) *conduct regular forums (or similar consultation processes) with all clinicians, including with Medical Staff Councils, to ensure that clinicians are kept aware of all health systems and clinical practice improvements and enhancements and to enable clinicians to provide timely feedback to the Area on such matters.*

**Recommendation 138:** *Within 18 months, NSW Health is to design and introduce a defined career path and structure for senior clinical leadership, and for senior clinician participation in senior administration and management roles.*

## State border problems

- 31.316 There are some real problems with the provision of medical services in towns near state and territory borders. In such towns, patients may routinely access services in Queensland, Victoria, South Australia, the Australian Capital Territory and the territory of Jervis Bay. Alternatively, patients come across the border from these states and territories to access services in New South Wales.
- 31.317 In some cases, geographic isolation means that hospitals find it difficult to access appropriate care in either New South Wales or the bordering State. I was told at Tweed Hospital for example that:<sup>260</sup>
- "the North Coast Area Health Service, in particular the northern component of that, is very isolated in the sense that we cannot rely on our tertiary and quaternary colleagues in Sydney. We have to look north, and they are at times not particularly receptive to our demands for critical care access, simply because of the overwhelming demands they already have within their system. It has put an imperative on us to become far more self-sufficient in terms of provision of that critical care service."
- 31.318 I was informed that, as a consequence, critical care doctors in Tweed Hospital's Emergency Department are often under enormous pressure caring for critically unwell patients for prolonged periods of time while they await a high dependency or intensive care unit bed. I was told that a lot of valuable time is wasted making telephone calls to Queensland hospitals and that the level of assistance received from 'north of the border' depends on individual personalities.
- 31.319 In some areas, hospitals near State borders seem, de facto, to belong to the neighbouring State's public health system. I was told in Corowa, for example, that the traditional referral pattern is to Wangaratta in Victoria and then to Melbourne.<sup>261</sup> There has been very little referral through to Albury Base Hospital. I heard that the hospital uses the Victoria Ambulance Service where retrieval is necessary and that patients are rarely, if ever, sent to Sydney or any NSW tertiary referral hospital. Similarly, in Broken Hill, patients are routinely sent to Adelaide.<sup>262</sup>
- 31.320 These cross-border movements cause funding pressures, where NSW is effectively funding treatments for say Queensland patients, and no doubt the funding pressures work in the other direction too. I was told at Tweed Hospital, for example, that the

hospital provides a large number of services to Gold Coast residents which has a severely depleted health service and that Tweed is not sufficiently funded to do this.<sup>263</sup>

- 31.321 State borders present some real practical difficulties. Some of the problems I heard about were that:
- Some health professionals who work in both New South Wales and the neighbouring State need to ensure that they are registered in both jurisdictions. This is particularly pertinent for the prescribing of medication where pharmacies may not be able to fill and dispense prescriptions if the prescriber is not registered in both states;<sup>264</sup>
  - Different legislation can create problems, such as for mental health patients who are scheduled in New South Wales but not in Queensland, and who are transferred between the mental health units located on both sides of the border. I was told about difficulties in transferring patients scheduled in New South Wales to Queensland's mental health facility across the border (and vice versa) without change to their scheduled status;<sup>265</sup>
  - The requirement for doctors in training to undertake terms in other hospitals may require them to travel as far away as Sydney, despite the fact that a term attachment in a hospital in the neighbouring State could provide equivalent training and lead to less disruption to their family lives;<sup>266</sup>
  - Daylight saving can be a challenge when running a hospital a couple of streets away from the Queensland border, in particular for organising patient discharges where community health services are involved. This can affect the hospital's performance against access block benchmarks;<sup>267</sup>
  - Staffing levels and resources can be adversely affected when the neighbouring State offers more competitive remuneration.<sup>268</sup>
- 31.322 Attempts have been made in some border towns to reach agreements with hospitals across the border in respect of a sensible provision of health services to their shared population. By and large, the Inquiry was told that such agreements were unfinalised and imperfect. For instance, I was told by several witnesses at Albury Hospital that the process of integrating the Wodonga and Albury Hospitals has not been transparent and very little had been communicated to staff, which has affected staff morale.<sup>269</sup> Staff expressed a concern that changes to service provision would have consequences for staffing levels and the distribution of resources.<sup>270</sup> The lack of transparency about cross-border arrangements was also of concern in Queanbeyan where I was told that secrecy has caused uncertainty about the delineation of services available to patients in NSW and in Canberra.<sup>271</sup> I was told at Tweed Hospital that attempts have been made to reach agreements with Queensland health services, particularly with the Gold Coast Hospital, but without success.<sup>272</sup> I was told both hospitals are "bursting at the seams".

**Recommendation 139:** *NSW Health examine how health services, which are regulated by State legislation, including mental health and like legislation, can best be delivered so as to ensure the efficiency and quality of patient care between differing legislative regimes in different but adjoining States and Territories.*

- 1 New South Wales Parliament, Legislative Council, Joint Select Committee on the Royal North Shore Hospital (Revd Hon Fred Nile MLC, Chair), *Report on Inquiry into the Royal North Shore Hospital*, December 2007, New South Wales Parliament, Sydney, NSW, p. 6.
- 2 NSW Health briefing, 13 March 2008, transcript 7.27-29.
- 3 Dr Thomas Karplus, Concord hearing, 24 April 2008, transcript 2112.17-36; Dr James Branley, Nepean hearing, 8 April 2008, transcript 1336.41-47
- 4 NSW Health, Media release, *Area Health Service amalgamations take effect today*, 1 January 2005.
- 5 New South Wales, Legislative Assembly 2004, *Debates*, 24 June 2004, p. 10188.
- 6 New South Wales, Legislative Assembly 2004, *Debates*, 28 October 2004, p. 12284.
- 7 Independent Pricing and Regulatory Tribunal (IPART), *NSW Health—Focusing on Patient Care*, September 2003, Independent Pricing and Regulatory Tribunal, Sydney, at p. 91.
- 8 For example, Julie Gibbs, Jodie Bancroft, St George Hospital hearing, 14 May 2008, transcript 2856.40-42.
- 9 Confidential hearing at the Inquiry's offices via video link from Tweed Heads, 29 May 2008, transcript 9.29.
- 10 NSW Health briefing, 13 March 2008.
- 11 IAB Services, NSW Department of Health *Review of Health Services' Amalgamation Savings (Consolidated Report)*, IAB Job No. 08620, February 2008.
- 12 IAB Services, NSW Department of Health *Review of Health Services' Amalgamation Savings (Consolidated Report)*, IAB Job No. 08620, February 2008.
- 13 Dr William Scott Monroe, Gosford hearing, 10 March 2008, transcript 119.17-30
- 14 Dr William Scott Monroe, Gosford hearing, 10 March 2008, transcript 119.17-30
- 15 Richard Western, Broken Hill hearing, 7 May 2008, transcript 2621.22-2622.17.
- 16 Richard Western, Broken Hill hearing, 7 May 2008, transcript 2621.22-2622.17.
- 17 Louise Christie, Orange hearing, 18 March 2008, transcript 542.25-31.
- 18 Confidential Bourke hearing, 9 May 2008, transcript 6.39.
- 19 Dr Flecknoe-Brown, Broken Hill Hospital hearing, 7 May 2008, transcript 2660.9-16.
- 20 Dr Michael Glynn, Sydney Children's Hospital hearing, 19 May 2008, transcript 3084.39-3085.18.
- 21 Dr Michael Bennett, Prince of Wales Hospital hearing, 1 May 2008, transcript 2597.32.
- 22 Associate Professor Graeme Richardson, Wagga Wagga hearing, 22 April 2008, transcript 1964.1
- 23 Dr Michael Bennett, Prince of Wales Hospital hearing, 1 May 2008, transcript 2598.16-20.
- 24 NSW Health briefing, 21 April 2008, transcript 39.40-43.
- 25 Confidential Tamworth hearing, 25 March 2008, transcript 11.30-34; Information provided during visits to Mona Vale Hospital on 12 March 2008 and Manly Hospital on 12 March 2008.
- 26 Meeting with the NSW Medical Staff Executive Council, 26 June 2008.
- 27 Professor Jerry Koutts, Westmead hearing, 10 April 2008, transcript 1551.18-35.
- 28 Confidential Mudgee hearing, 20 March 2008, transcript 15.07-19.
- 29 Submission of Dr Franko Sardelic, 20 March 2008, SUBM.014.0165 at 2.
- 30 Dr Ian Incoll, Gosford hearing, 10 March 2008, transcript 51.16-29.
- 31 Submission of Alan W Noble, 28 April 2008, SUBM.047.0060 at 1.
- 32 Dr Dean Fisher, Dubbo hearing, 19 March 2008, transcript 661.14-662.16.
- 33 Confidential Bourke hearing, 9 May 2008, transcript 7.15.
- 34 NSW Health briefing, 13 March 2008, transcript 11.12-22.
- 35 Brian Grant, Liverpool hearing, 17 April 2008, transcript 1844.12-37.
- 36 Dr John Graham, St Vincent's Hospital hearing, 30 April 2008, 2420.16-39.

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- 37 Dr Stephen Flecknoe-Brown, Broken Hill hearing, 7 May 2008, transcript 2658.44-46.
- 38 Information provided during visit to Camden Hospital on 16 April 2008.
- 39 Meeting with the Hospital Reform Group, 23 May 2008.
- 40 Meeting with the Hospital Reform Group, 23 May 2008.
- 41 Meeting with the Hospital Reform Group, 23 May 2008.
- 42 IPART, *NSW Health—Focusing on Patient Care*, September 2003, IPART, Sydney, at p. 92.
- 43 Submission of Dr David Williams, Chair Medical Staff Council, John Hunter Hospital, 25 March 2008, SUBM.015.0285 at 4; Fran Hodgson, Newcastle Hospital hearing, 12 May 2008, transcript 2808.21.
- 44 Harry Bolton, Armidale hearing, 26 March 2008, transcript 901.37-903.37.
- 45 Associate Professor Graeme Richardson, Wagga Wagga hearing, 22 April 2008, 1963.39-1964.2.
- 46 For example, Submission of the NSW Medical Staff Executive Council, 28 March 2008, SUBM.034.0088 at p. 8.
- 47 Richard Western, Broken Hill hearing, 7 May 2008, transcript 2625.42-2626.03.
- 48 Dr Peter Collett, Liverpool hearing, 17 April 2008, transcript 1818.24-39.
- 49 Statement of Therese Mary McGee, Appendix B to the Submission of the Australian Medical Association (NSW) Limited and the Australian Salaried Medical Officers' Federation, 28 March 2008, SUBM.016.0015.
- 50 NSW Health briefing, 21 April 2008, transcript 39.44-46.
- 51 Professor Lynnette Fragar, Armidale Hospital hearing, 26 March 2008, transcript 981.10-41.
- 52 See for example, Dr Flecknoe-Brown, Broken Hill hearing, 7 May 2008, transcript 2659.15-22.
- 53 Dr Michael Brydon, Sydney Children's Hospital hearing, 19 May 2008, transcript 3048.18-27.
- 54 NSW Health briefing, 21 April 2008, transcript 11.35-37.
- 55 Sections 24 and 25, *Health Services Act 1997* (NSW).
- 56 Section 25, *Health Services Act 1997* (NSW).
- 57 Section 121F, *Health Services Act 1997* (NSW).
- 58 Section 121D, *Health Services Act 1997* (NSW).
- 59 Section 121G, *Health Services Act 1997* (NSW).
- 60 NSW Health, *Executive Performance Management*, PD2006\_083.
- 61 NSW Health, *Executive Performance Management*, PD2006\_083 at 6.
- 62 NSW Health, *Executive Performance Management*, PD2006\_083 at 7.
- 63 Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- 64 Section 24, *Health Services Act 1997* (NSW); NSW Health, *Executive Performance Management*, PD2006\_083 at 7.
- 65 Dr Peter Rankin, Lismore hearing, 28 April 2008, transcript 2219.9-23.
- 66 For example, Professor Stephen Hunyor, Royal North Shore Hospital hearing, 14 March 2008, transcript 296.4-297.15.
- 67 Professor Jerry Koutts, Westmead hearing, 10 April 2008, transcript 1551.18-35; Professor Stephen Hunyor, Royal North Shore Hospital hearing, 14 March 2008, transcript 296.4-297.15.
- 68 Professor Stephen Hunyor, Royal North Shore Hospital hearing, 14 March 2008, transcript 296.38-297.07, 296.19-21.
- 69 Letter from NSW Health to Cate Follent, Special Commission of Inquiry, 5 November 2008.
- 70 Under the direction of the Director-General, through the *2005 Standard By-Laws for Health Services*, as set out in the Compendium.
- 71 Under the *Health Services Act*, the Chief Executive may establish such committees and councils as he or she considers appropriate to assist the area health service in the exercise

of its functions: section 29B, *Health Services Act 1997* (NSW). However, this is subject to the Compendium.

- <sup>72</sup> Dr Denis King, meeting with NSW Health, 21 April 2008, transcript 39.26.
- <sup>73</sup> Professor Jerry Koutts, Westmead Hospital hearing, 10 April 2008, transcript 1551.18-35; Professor Stephen Hunyor, Royal North Shore Hospital hearing, 14 March 2008, transcript 296.4-297.15
- <sup>74</sup> Briefing with NSW Health, 21 April 2008.
- <sup>75</sup> See for example, GWAHS Clinical Networks, revised May 2007, GW.001.0009.
- <sup>76</sup> NSW Health, King, D and McCarroll, A, *Review of Clinician Engagement in Clinical Management Structures*, interim report, May 2008, DOH.062.0035.
- <sup>77</sup> NSW Health, King, D and McCarroll, A, *Review of Clinician Engagement in Clinical Management Structures*, interim report, May 2008, DOH.062.0035.
- <sup>78</sup> NSW Health, King, D and McCarroll, A, *Review of Clinician Engagement in Clinical Management Structures*, interim report, May 2008, DOH.062.0035.
- <sup>79</sup> Northern Sydney Central Coast Area Health Service, *Referral Note: NSCC Area Executive Team Meeting*, 12 June 2008; Material provided by the Northern Sydney Central Coast Area Health Service in response to summons, NSCC.020.0042-3.
- <sup>80</sup> Confidential submission, SUBM.016.0003 at p.2.
- <sup>81</sup> NSW Health, King, D and McCarroll, A, *Review of Clinician Engagement in Clinical Management Structures*, interim report, May 2008.
- <sup>82</sup> Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- <sup>83</sup> NSW Health briefing, 13 March 2008.
- <sup>84</sup> Section 27, *Health Services Act 1997* (NSW).
- <sup>85</sup> Section 28, *Health Services Act 1997* (NSW).
- <sup>86</sup> Section 26, *Health Services Act 1997* (NSW).
- <sup>87</sup> Scott Wagner, Hazel Bridgett, public hearing at the Inquiry's offices via video link from Lismore, 30 May 2008, transcript 3272.07-42.
- <sup>88</sup> Dr Suzanne Hodgkinson, public hearing at the Inquiry's offices via video link from Liverpool, 17 April 2008, transcript 1862.47-1863.06.
- <sup>89</sup> Confidential submission, 13 March 2008, SUBM.028.0225 at p. 1; Scott Wagner Lismore video conference, 30 May 2008, transcript 3266.37-3267.04 expressed the view that the role of AHACs should be strengthened;
- <sup>90</sup> Dr Simon Roger, Gosford hearing, 10 March 2008, transcript 125.19-26; Dr William Monroe, Gosford hearing, 10 March 2008, transcript 119.43-120.39.
- <sup>91</sup> Brian Grant, Liverpool hearing, 17 April 2008, transcript 1845.14-19.
- <sup>92</sup> Associate Professor Fragar, Armidale hearing, 26 March 2008, transcript 892.16-26; NSW Health briefing, 13 March 2008, transcript 25.37-26.1.
- <sup>93</sup> Scott Wagner and Hazel Bridgett, Lismore hearing, 30 May 2008, transcript 3267.06-17.
- <sup>94</sup> Associate Professor Lynette Fragar, Armidale hearing, 26 March 2008, transcript 888.44
- <sup>95</sup> Associate Professor Lynette Fragar, Armidale hearing, 26 March 2008, transcript 890.34-41, 892.28-34.
- <sup>96</sup> Associate Professor Lynette Fragar, Armidale hearing, 26 March 2008, transcript 893.41-894.11.
- <sup>97</sup> New South Wales, Legislative Assembly 2004, *Debates*, 28 October 2004, p. 12284.
- <sup>98</sup> NSW Health briefing, 21 April 2008.
- <sup>99</sup> NSW Health briefing, 21 April 2008.
- <sup>100</sup> Submission of the NSW Medical Staff Executive Council, SUBM.034.0056 at 12.
- <sup>101</sup> Submission of the NSW Medical Staff Executive Council, SUBM.034.0056 at 12.
- <sup>102</sup> Dr David Williams, Newcastle hearing, 12 May 2008, transcript 2760.24-2761.09.
- <sup>103</sup> Confidential Westmead hearing, 26 May 2008, transcript 78.43-79.45.



- <sup>104</sup> Confidential Tamworth hearing, 25 March 2008, transcript 11.37-40.
- <sup>105</sup> Professor Stephen Hunyor, Royal North Shore Hospital hearing, 14 March 2008, transcript 296.32-36.
- <sup>106</sup> Dr Dean Fisher, Dubbo hearing, 19 March 2008, transcript 658.40-659.04.
- <sup>107</sup> Confidential Westmead hearing, 26 May 2008, transcript 74.41-44.
- <sup>108</sup> New South Wales, Legislative Assembly 2004, *Debates*, 28 October 2004, p. 12284.
- <sup>109</sup> Scott Wagner, Hazel Bridgett, public hearing at the Inquiry's offices via video link from Lismore, 30 May 2008, transcript 3271.14-20.
- <sup>110</sup> Confidential Westmead hearing, 26 May 2008, transcript 74.41-44; Dr David Williams, Newcastle hearing, 12 May 2008, transcript 2760.24-2761.09..
- <sup>111</sup> Dr John Latham Harkness, St Vincent's Hospital hearing, 30 April 2008, transcript 2429.28-34.
- <sup>112</sup> Dr John Graham, St Vincent's Hospital hearing, 30 April 2008, transcript 2419.41-42.
- <sup>113</sup> Dr John Latham Harkness, St Vincent's Hospital hearing, 30 April 2008, transcript 2427.24-2428-42.
- <sup>114</sup> Dr John Latham Harkness, St Vincent's Hospital hearing, 30 April 2008, transcript 2428.34-42.
- <sup>115</sup> Dr Max Coleman, St Vincent's Hospital hearing, 30 April 2008, transcript 2441.04-13.
- <sup>116</sup> Dr John Graham, St Vincent's Hospital hearing, 30 April 2008, transcript 2420.29-32.
- <sup>117</sup> Dr John Graham, St Vincent's Hospital hearing, 30 April 2008, transcript 2422.31-38.
- <sup>118</sup> Dr John Graham, St Vincent's Hospital hearing, 30 April 2008, transcript 2420.18-25.
- <sup>119</sup> Section 12, *Area Health Services Act 1986* (NSW), which commenced operation on 1 July 1986.
- <sup>120</sup> Professor Stephen Hunyor, Royal North Shore Hospital hearing, 14 March 2008, transcript 295.18-21, 296.23-25, 296.26-27, 297.06-07. Many others recommended that boards be returned, including Dr Suzanne Hodgkinson, Liverpool hearing, 17 April 2008, transcript 1862.20-23.
- <sup>121</sup> Section 121N(1) *Health Services Act 1997* (NSW).
- <sup>122</sup> Dr Suzanne Hodgkinson, Liverpool hearing, 17 April 2008, transcript 1862.10-23.
- <sup>123</sup> Experts' Conference, 15 September 2008, transcript 17.02-10.
- <sup>124</sup> Hazel Bridgett, Lismore video hearing, 30 May 2008, transcript 3273.02-07.
- <sup>125</sup> Section 12, *Area Health Services Act 1986* (NSW), which commenced operation on 1 July 1986; Dr John Graham, St Vincent's Hospital hearing, 30 April 2008, transcript 2420.02-14.
- <sup>126</sup> Dr Kathryn Porges, Gosford hearing, 10 March 2008, transcript 70.23-33.
- <sup>127</sup> Susan Betts-Hendy, Nepean hearing, 8 April 2008, transcript 1355.04-08.
- <sup>128</sup> Doctor Thomas Karplus, Concord hearing, 24 April 2008, transcript 2107.04-31.
- <sup>129</sup> Karen Fernance, Bankstown hearing, 13 May 2008, transcript 2842.11-14.
- <sup>130</sup> Karen Fernance, Bankstown hearing, 13 May 2008, transcript 2842.11-14.
- <sup>131</sup> Confidential St George Hospital hearing, 14 May 2008, transcript 3.24-04.15.
- <sup>132</sup> James Branley, Nepean Hospital hearing, 8 April 2008, transcript 1336.34-39.
- <sup>133</sup> Professor Michael Fearnside, Westmead hearing, 10 April 2008, 1553.43-1554.39; Confidential Bankstown hearing, 13 May 2008, transcript 74.19-75.01.
- <sup>134</sup> For example, Dr Rod Bishop, Nepean Hospital hearing, 8 April 2008, transcript 1384.27-34.
- <sup>135</sup> For example, Dr Jennifer Chambers, Port Macquarie hearing, 28 March 2008, transcript 1084.10-20; Doctor John Pardey, Nepean Hospital hearing, 8 April 2008, transcript 1421.24-38; Confidential Mudgee hearing, 20 March 2008, transcript 14.25-30.
- <sup>136</sup> Confidential Bankstown hearing, 13 May 2008, transcript 74.19-75.01.
- <sup>137</sup> Dr Roderick Bishop, Nepean Hospital hearing, 8 April 2008, transcript 1386.24-43.
- <sup>138</sup> Dr Peter Flynn, Nepean Hospital hearing, 8 April 2008, transcript 1472.27-36.



- 139 Dr Roderick Bishop, Nepean Hospital hearing, 8 April 2008, transcript 1386.24-43.
- 140 Professor Michael Fearnside, Westmead hearing, 10 April 2008, 1553.43-1554.39.
- 141 Confidential Mudgee hearing, 20 March 2008, transcript 15.12-18; Meeting with the Australian Health Policy Institute, 11 April 2008; Professor Katherine Brown, Wollongong hearing, 1601.06-1602.07.
- 142 For example, Dr Peter Collett, Liverpool hearing, 17 April 2008, transcript 1818.38-39.
- 143 NSW Health briefing, 21 April 2008.
- 144 Confidential Bankstown hearing, 13 May 2008, transcript 74.19-75.01; Professor Gerard Carroll, Wagga Wagga hearing, 22 April 2008, transcript 2003.18-2005.06.
- 145 Professor Gerard Carroll, Wagga Wagga hearing, 22 April 2008, transcript 2003.18-2005.06.
- 146 Professor Gerard Carroll, Wagga Wagga hearing, 22 April 2008, transcript 2003.18-2005.06.
- 147 Dr Peter Rankin, Lismore hearing, 28 April 2008, transcript 2219.15-19.
- 148 Professor Gerard Carroll, Wagga Wagga hearing, 22 April 2008, transcript 2003.18-2005.06.
- 149 Professor Katherine Brown, Wollongong hearing, 1601.06-1602.07; Confidential submission, 28 April 2008, SUBM.039.0009 at p. 4.
- 150 Meeting with the Australian Health Policy Institute, 11 April 2008, transcript 14.5-19.
- 151 Meeting with Helen Bevan, Specialist in Health Care Improvement, NHS, UK, 14 March 2008.
- 152 Meeting with Helen Bevan, Specialist in Health Care Improvement, NHS, UK, 14 March 2008.
- 153 Professor Michael Cousins, Royal North Shore Hospital hearing, 14 March 2008, transcript 342.13-343.17.
- 154 Confidential Wollongong hearing, 14 April 2008, transcript 6.22-27.
- 155 Confidential Wollongong hearing, transcript 06.24-27.
- 156 Confidential Wollongong hearing, transcript 7.11.
- 157 Meeting with the Australian Health Policy Institute, 11 April 2008, transcript 14.43-45; Dr Theresa Beswick, Coffs Harbour hearing, 27 March 2008, transcript 1044.21-24.
- 158 Dr Susan Kurrle, Hornsby hearing, 11 March 2008, transcript 261.30-41.
- 159 James Branley, Nepean hearing, 8 April 2008, transcript 1336.34-39.
- 160 Mr Bill Bowtell, Experts' conference, 15 September 2008, transcript 42.37-47.
- 161 Dr Michael Walsh, Experts' conference, 15 September 2008, transcript 45.43-46.02.
- 162 Dr Peter Flynn, Nepean hearing, 8 April 2008, transcript 1473.16-24.
- 163 Professor Gerard Carroll, Wagga Wagga hearing, 22 April 2008, transcript 2002.26-45.
- 164 Confidential Westmead hearing, 26 May 2008, transcript 78.30-36.
- 165 Confidential hearing at the Inquiry's offices via video link, transcript 10.41-11.17.
- 166 Dr Adam Purdon, Wollongong hearing, 14 April 2008, transcript 1671.44-1672.28.
- 167 Confidential Prince of Wales Hospital hearing, 1 May 2008, transcript 27.25-28.26; Confidential Bankstown Hospital hearing, 13 May 2008, transcript 76.02-77.16; Confidential Lismore hearing, 28 April 2008, transcript 22.10-19.
- 168 Confidential St George Hospital hearing, 14 May 2008, transcript 3.09-25.
- 169 Confidential Bankstown hearing, 13 May 2008, transcript 76.02-77.16..
- 170 Confidential Mudgee hearing, 20 March 2008, transcript 15.22-43.
- 171 Associate Professor Lynette Fragar, Armidale hearing, 26 March 2008, transcript 894.5-8.
- 172 NSW Health briefing, 21 April 2008, transcript 20.07-09.
- 173 Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- 174 Dr Suzanne Hodgkinson, Liverpool hearing, 17 April 2008, transcript 1862.02-08.
- 175 Dr Peter Collett, Liverpool hearing, 17 April 2008, transcript 1818.42-44.
- 176 Dr Greg Keogh, Experts' Conference, 15 September 2008, transcript 21.26-28.

- 177 Janette du Buisson Perrone, Liverpool hearing, 17 April 2008, transcript 1885.09-1886.01.
- 178 Janette du Buisson Perrone, Liverpool hearing, 17 April 2008, transcript 1885.09-1886.01.
- 179 Meeting with the NSW Medical Staff Executive Council, 26 June 2008; Dr Gary Baker, Armidale hearing, 26 March 2008, transcript 872.45; Dr Dean Fisher, Dubbo hearing, 19 March 2008, transcript 661.05-06.
- 180 NSW Health briefing, 21 April 2008, transcript 42.9-14.
- 181 Dr Peter Roberts, Hornsby hearing, 11 March 2008, transcript 197.6-11; 197.33-35.
- 182 Dr Peter Collett, Liverpool hearing, 17 April 2008, transcript 1815.40-1816-31.
- 183 Dr Christopher Arthur, Royal North Shore Hospital hearing, 2 April 2008, transcript 1243.01-03.
- 184 Dr Maxwell Coleman, St Vincent's Hospital hearing, 30 April 2008, transcript 2444.04-13 gave evidence of the benefits where a program director is a doctor; Dr Michael Mc-Glynn, Sydney Children's Hospital hearing, 19 May 2008, transcript 3086-46-3087.04.
- 185 Dr Michael Mc-Glynn, Sydney Children's Hospital hearing, 19 May 2008, transcript 3086-41-3088.34.
- 186 Dr Maxwell Coleman; Dr John Latham Harkness, St Vincent's Hospital hearing, 30 April 2008, transcript 2427.41-2428-42.
- 187 Dr Michael Mc-Glynn, Sydney Children's Hospital hearing, 19 May 2008, transcript 3086-41-3088.34.
- 188 Dr David Logan, Newcastle hearing, 12 May 2008, transcript 2811.22-44.
- 189 Dr David Logan, Newcastle hearing, 12 May 2008, transcript 2811.22-44.
- 190 Confidential Bankstown hearing, 13 May 2008, transcript 78.28-31.
- 191 Confidential Prince of Wales Hospital hearing, 1 May 2008, transcript 9.30-42.
- 192 Confidential Sydney Children's Hospital hearing, 19 May 2008, transcript 42.20-41.
- 193 Dr Warwick Stening, Sydney Children's Hospital hearing, 19 May 2008, transcript 3082.07-10.
- 194 Dr Warwick Stening, Sydney Children's Hospital hearing, 19 May 2008, transcript 3082.07-10.
- 195 Dr Maxwell Coleman, St Vincent's Hospital hearing, 30 April 2008, transcript 2437.05-2438.07.
- 196 Dr Maxwell Coleman, St Vincent's Hospital hearing, 30 April 2008, transcript 2437.05-2438.1.
- 197 Letter from NSW Health to Special Commission of Inquiry, 24 September 2008.
- 198 Dr Maxwell Coleman, St Vincent's Hospital hearing, 30 April 2008, transcript 2443.05-17.
- 199 Letter from NSW Health to Special Commission of Inquiry, 24 September 2008.
- 200 Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- 201 Dr Sarah Mott and Richard Baldwin, Westmead Hospital hearing, 26 May 2008, transcript 3171.39-47; Submission of the Australian College of Health Service Executives, 1 May 2008, SUBM.046.0288 at 8.
- 202 Submission of the Australian College of Health Service Executives, 1 May 2008, SUBM.046.0288 at 12.
- 203 Submission of the Australian College of Health Service Executives, 1 May 2008, SUBM.046.0288 at 12.
- 204 Meeting with NSW Health, 28 May 2008, transcript 39-40.
- 205 Dr Sarah Mott and Richard Baldwin, Westmead hearing, 26 May 2008, transcript 3171.39-47; Submission of the Australian College of Health Service Executives, 1 May 2008, SUBM.046.0288 at 17.
- 206 NSW Health briefing, 28 May 2008, transcript 39-40.
- 207 Dr Sarah Mott and Richard Baldwin, Westmead hearing, 26 May 2008, transcript
- 208 Confidential Bankstown hearing, 13 May 2008, transcript 99.06-20.

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- 209 Submission of the Australian College of Health Service Executives, 1 May 2008, SUBM.046.0288 at 15.
- 210 Professor Stephen Hunyor, Royal North Shore Hospital hearing, 14 March 2008, transcript 303.19-25.
- 211 Associate Professor Graeme Richardson, Wagga Wagga hearing, 22 April 2008, transcript 1964.08-13.
- 212 Professor Gerard Carroll, Wagga Wagga hearing, 22 April 2008, transcript 2002.26-45.
- 213 Professor Michael Cousins, Royal North Shore Hospital hearing, 14 March 2008, transcript 343.11-17.
- 214 Dr Simon Rogers, Gosford hearing, 10 March 2008, transcript 123.27-3; Professor Stephen Hunyor, Royal North Shore Hospital hearing, 14 March 2008, transcript 303.19-25; Dr Michael Brydon, Sydney Children's Hospital hearing, 19 May 2008, transcript 3048.45-3049.05.
- 215 Dr Michael Brydon, Sydney Children's Hospital hearing, 19 May 2008, transcript 3048.45-3049.05
- 216 Dr Graeme Richardson, Wagga Wagga hearing, 22 April 2008, transcript 1964.02-06.
- 217 Dr Ruth Arnold, Orange hearing, 18 March 2008, transcript 25-37.
- 218 Dr Ruth Arnold, Orange Base Hospital hearing, 18 March 2008, transcript 25-37.
- 219 Dr Michael Brydon, Sydney Children's Hospital hearing, 19 May 2008, transcript 3048.45-3049.05.
- 220 Dr Suzanne Hodgkinson, Liverpool hearing, 17 April 2008, transcript 1862.10-17.
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- 222 Meeting with Professor Katherine McGrath, 7 April 2008.
- 223 Meeting with Professor Katherine McGrath, 7 April 2008.
- 224 Dr Theresa Beswick, Coffs Harbour hearing, 27 March 2008, transcript 1045.43-1046.01.
- 225 Confidential Tamworth hearing, 25 March 2008, transcript 03.46-07.09.
- 226 Confidential Tamworth hearing, 25 March 2008, transcript 03.46-07.09.
- 227 Meeting with the IMET, 3 April 2008, transcript 84.8-15.
- 228 Dr Gregory Purcell, Royal North Shore Hospital hearing, 14 March 2008, transcript 416.01-10.
- 229 Dr Therese McGee, Westmead hearing, 10 April 2008, transcript 1532.02-13.
- 230 Dr Simon Rogers, Gosford hearing, 10 March 2008, transcript 123.41-43; Meeting with Alan McCarroll, 19 February 2008.
- 231 Meeting with the GMCT, 7 March 2008.
- 232 Dr James Branley, Neapan hearing, 8 April 2008, transcript 1336.41-47.
- 233 Submission of Dr Peter Rankin, 2 April 2008, SUBM.0140014 at 5.
- 234 Submission of Dr Peter Rankin, 2 April 2008, SUBM.0140014 at 5.
- 235 Meeting with the IMET, 3 April 2008.
- 236 Meeting with the IMET, 3 April 2008.
- 237 Meeting with the IMET, 3 April 2008.
- 238 Dr David Williams, Newcastle hearing, 2 May 2008, transcript 2758.34-46.
- 239 Confidential Prince of Wales Hospital hearing, 1 May 2008, transcript 25.27-36; Dr Kathryn Porges, Gosford hearing, 10 March 2008, transcript 69.05-19.
- 240 Dr Dean Fisher, Dubbo hearing, 19 March 2008, transcript 658.03-33.
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- 242 Professor Jerry Koutts, Westmead hearing, 10 April 2008, transcript 1550.25-28.
- 243 Dr Kathryn Porges, Gosford hearing, 10 March 2008, transcript 69.05-19.
- 244 Confidential Wollongong hearing, 14 April 2008, transcript 44.22-33.

- <sup>245</sup> Working Conditions of Doctors and Nurses in NSW Public Hospitals, Workplace Research Centre, University of Sydney, 20 March 2008; Dr Anthony Sara, Prince of Wales Hospital hearing, 1 May 2008, transcript 2544.37-43.
- <sup>246</sup> Confidential Lismore hearing, 28 April 2008, transcript 15.44-47.
- <sup>247</sup> Dr Simon Battersby, Gosford hearing, 10 March 2008, transcript 164.13-16.
- <sup>248</sup> Lorraine Fitzgerald, Bankstown hearing, 13 May 2008, transcript 2841.20-24.
- <sup>249</sup> Dr Sarah Smith, Royal North Shore Hospital hearing, 14 March 2008, transcript 427.11-430.22.
- <sup>250</sup> Dr Thomas Karplus, Concord hearing, 24 April 2008, transcript 2112.22-2113.21.
- <sup>251</sup> Letter from NSW Health to Special Commission of Inquiry, 5 November 2008.
- <sup>252</sup> Greater Metropolitan Clinical Taskforce, *The medical clinician-management connect in greater metropolitan public hospitals in Sydney, consultative meetings*, Final Report, NSW Health, Sydney, October 2004.  
[http://www.health.nsw.gov.au/resources/gmct/clinician\\_connect\\_pdf.asp](http://www.health.nsw.gov.au/resources/gmct/clinician_connect_pdf.asp) (11 November 2008).
- <sup>253</sup> Dr Dean Fisher, Dubbo hearing, 19 March 2008, transcript 660.47-661.04; Professor Jerry Koutts, Westmead hearing, 10 April 2008, transcript 1549.23-45; Confidential submission, 28 April 2008, SUBM.039.0009 at 11.
- <sup>254</sup> Professor Jerry Koutts, Westmead hearing, 10 April 2008, transcript 1549.38-45.
- <sup>255</sup> Dr Warwick Stening, Sydney Children's Hospital hearing, 19 May 2008, transcript 3082.41-46 who highlighted the value of the clinician manager; Dr Dean Fisher, Dubbo hearing, 19 March 2008, transcript 660.47-661.04.
- <sup>256</sup> Dr James Maurice Branley, Nepean Hospital hearing, 8 April 2008, transcript 1338.31-42.
- <sup>257</sup> Dr Warwick Stening, Sydney Children's Hospital hearing, 19 May 2008, transcript 3082.41-46.
- <sup>258</sup> NSW Health briefing, 21 April 2008.
- <sup>259</sup> Dr Ruth Arnold, Orange hearing, 18 March 2008, transcript 614.22-34.
- <sup>260</sup> Dr Barry Rigby, Tweed Heads hearing, 29 April 2008, transcript 2340.23-39, 2344.06-7
- <sup>261</sup> Information provided during visit to Corowa Hospital on 23 April 2008.
- <sup>262</sup> Dr Flecknoe-Brown, Broken Hill hearing, 7 May 2008, transcript 2661.16-29
- <sup>263</sup> Confidential Tweed Heads hearing, 29 April 2008, transcript 22.15-23.06.
- <sup>264</sup> Confidential Tweed Heads hearing, 29 April 2008, transcript 23.09.
- <sup>265</sup> Confidential video hearing, 29 May 2008, transcript 6.14-40.
- <sup>266</sup> Confidential video hearing, 29 May 2008, transcript 8.14.
- <sup>267</sup> Confidential video hearing, 29 May 2008, transcript 7.14.
- <sup>268</sup> Confidential Tweed Heads hearing, 29 April 2008, transcript 22.15-23.06.
- <sup>269</sup> Confidential Albury hearing, transcript 21.7
- <sup>270</sup> Confidential Albury hearing, 23 April 2008, 21.27, 22.25, 24.15.
- <sup>271</sup> Kevin Anthony Grainger, Queanbeyan hearing, 15 April 2008, 1777.13-1777.32.
- <sup>272</sup> Dr Barry Rigby, Tweed Heads hearing, 29 April 2008, transcript 2345.28.





**Special Commission of Inquiry**

**Acute Care Services in NSW Public Hospitals**

# Part G

## Ensuring Change





## 32 Ensuring Change

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## Change

32.1 In their seminal text published in 2006, "Re-defining Health Care", Professor Michael Porter of the Harvard Business School and Associate Professor Teisberg of the Darden Graduate School of Business at the University of West Virginia said:

"Health care is on a collision course with patient needs and economic reality. Without significant changes, the scale of the problem will only get worse."<sup>1</sup>

32.2 Although writing about the health system in the United States of America, those words are equally apposite to the situation, which I have found in NSW.

32.3 What I have identified in my report is a system of health care, which has much to admire about it. The outcomes of the system are very good. It is amongst the best in the world.

32.4 But, it is under strain, and unless significant change occurs then I fear for the future health of the people of NSW.

32.5 It is very easy to suggest change. It is harder to implement it. Implementation requires funding and resources, it requires strong leadership, it requires seeking and obtaining the collaboration and goodwill of those who have to work in the changed system and it requires the confidence of those about whom a health care system is centred, namely the patients and more generally, the public.

32.6 Ordinarily the function of a Special Commissioner engaged in such an Inquiry as mine is, conformably with the Letters Patent to inquire into and report on those matters specified in the Letters Patent.

32.7 The method by which the government chooses to implement such recommendations as it may accept is a matter, I emphasise, entirely within the hands of the government. It forms no direct part of my Terms of Reference.

32.8 In short, implementation is a matter for government and not me.

### Terms of Reference

32.9 However, of significance in my Letters Patent is Term of Reference 1. It permits me to report on:

"Any systemic or institutional issues in the delivery of acute care services in NSW public hospitals raised in submissions you receive that you consider appropriate for you to inquiry into and recommend any changes..."

### Submissions

32.10 A number of confidential submissions which I received drew attention to these matters:

- the large number of reports which had been obtained in the last 10-15 years about health issues which had made recommendations which have never been acted upon;
- a wide-spread perception amongst clinicians that any change that occurs within NSW Health does so either, at a glacial pace, or alternatively as a matter of undetectable incrementalism;
- a lack of good communication between senior managers and NSW Health and frontline clinicians about matters of importance, including plans for change; and

- a complete lack of trust that the government and/or NSW Health will, notwithstanding my report, actually carry out any change and that they will do so in a transparent and measurable way.

- 32.11 Whether these submissions be correct or not, and I have no need to embark on any detailed investigation of that question, they do reveal a deep seated and wide-spread malaise which may significantly affect the success of the implementation program for any of the reforms which I propose and which the government wishes to accept.
- 32.12 Given that clinicians will, together with administrators and managers, be the individuals primarily concerned with implementation, and their cooperation with a reform process is essential, I am persuaded that I should set out my views about the implementation of any reforms suggested by my report.

### Implementation Process

- 32.13 Implementing, managing and ensuring change requires thought, consultation and support. It requires a brisk impetus but not undue haste. It is possible unless there is true transparency to the process of change. It requires time, patience and determination. It requires commitment and leadership.
- 32.14 I have considered various suggestions for a reform model. As well, I have examined the process followed in the United Kingdom with the reform of the National Health Service. I hope that I am the beneficiary of past experience.

### NSW Health

- 32.15 My view is that given the system of parliamentary democracy in which this state is steeped, it is appropriate at the outset to identify that the Government, and in particular, the Minister for Health is the person responsible for ensuring change. Ultimately, it is the Minister for Health who is accountable to Parliament and the people of the State for what will occur.
- 32.16 He will be assisted in that task, not by the creation of a new bureaucratic style change agency which will impose change on the health system but rather, by planned, resourced, monitored, assured and transparent achievement of change milestones. To this end, in my view, any change, which flows from my report needs to be resourced, monitored, assured and charted.
- 32.17 As the first step in the implementation process, the government as a whole and NSW Health as the relevant agency, will need a period of time in which to consider my report and its recommendations, and provide publicly a response to it, indicating clearly which recommendations, if any, they wish to accept and implement.
- 32.18 At that time, NSW Health should be able to provide the outline of an implementation plan indicating the following information:
- Which recommendation is to be implemented;
  - What the principle steps are which need to be taken to implement the recommendations;
  - Who is responsible and accountable for the particular implementation steps; and
  - A realistic time period for the implementation of the recommendations.

- 32.19 This implementation plan needs to have the endorsement of and be accepted by government and the Minister for Health.
- 32.20 A reasonable period, so it seems to me, for the taking of that step, namely a response by the government and NSW Health to my report would be 3 months.
- 32.21 I would regard the time period, which I include in any recommendation for reform as commencing from the date, acceptance and publication of the implementation plan.
- 32.22 A public reporting scheme is essential. An appropriate reporting scheme is one which, in my opinion, commences with the publication by NSW Health on its website of the improved and endorsed implementation plan in a prominent place on that website.
- 32.23 Thereafter, for the first 2 years, NSW Health should report progress against the implementation plan on a quarterly basis. The report should relate to progress as measured up to one month prior to the reporting date.
- 32.24 The progress report ought be submitted to the NSW Minister for Health and ought, at the next appropriate time, be tabled by the Minister in the Parliament.
- 32.25 After the initial period of 2 years, it will be a matter for the Minister to determine with what regularity until the reform process is completed the minimum number of reports issued each year ought be 2. That is to say, a period of no longer than 6 months should elapse without a public report.

## Assurance and Oversight

- 32.26 Because the NSW Minister for Health is ultimately responsible for any reforms, and the progress of reform as reported by NSW Health, there needs to be a process of independent assurance and oversight. The reason that such a process is necessary is that all those participants in the reform and the public at large are entitled to be independently satisfied that the progress of reform as asserted by NSW Health to have occurred, has in fact occurred.
- 32.27 As well, the NSW Minister for Health as the person responsible for the reform process is entitled to have a degree of real assurance that what is being reported by NSW Health is accurate.
- 32.28 The key element in this assurance and oversight process is independence. The reform process will have no credibility unless the public and those involved in the reform process are satisfied that the reports made of progress by NSW Health are true and accurate.
- 32.29 There are a number of possible models for this assurance process. Which model is selected is a matter entirely for the NSW Minister for Health.
- 32.30 One possible model is for the Minister to constitute a time limited (say 3 years) reform oversight panel which consists of no more than 3 individuals of good standing in the community whose task would be to determine an audit plan to be applied the NSW Health reform process, engage independent external auditors to undertake the checks which are planned for and to obtain from those independent external auditors a report which is to be provided to the Minister assuring the Minister about the relevant progress.
- 32.31 Another possible model is, assuming the government accepts the recommendation and establishes it in good time, to give to the Bureau of Health Information the task of assurance and oversight. That Bureau would need to follow much the same course as

the reform oversight panel, namely, to fix a plan, engage independent external auditors, to ensure that the audit process occurs and to report that to the Minister.

- 32.32 It may be that a third model is for the Minister to merely to engage independent external auditors directly to undertake audits of the progress, which the Minister considers appropriate.
- 32.33 As I said earlier, and I repeat, the matter of the assurance and oversight model is a matter for the Minister. There may be other models, which are acceptable to the Minister. The key to any other model must be the independence and veracity of those carrying out and overseeing the audit process.
- 32.34 The Minister ought, at the first available opportunity, table the reports of the assurance and oversight process in the Parliament as well as insist that the reports are displayed on the NSW Health website.
- 32.35 It is in this way that I believe, sustainable change can occur and be seen transparently as occurring.

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<sup>1</sup> Michael E Porter, Elisabeth Olmsted Teisberg, Re-Defining Health Care: Creating Value Based Competition on Results”, Harvard Business School Press, 2006 at 381.





**Special Commission of Inquiry**

Acute Care Services in NSW Public Hospitals

# Appendices





## Appendix 1 Terms of reference

### NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

To Mr Peter Richard Garling SC.

By these Our Letters Patent, made and issued under the authority of the *Special Commissions of Inquiry Act 1983*, We hereby, with the advice of the Executive Council, authorise you as Commissioner to inquire into and report to Our Governor of the said State on the following matters concerning the delivery of acute care services in public hospitals in New South Wales:

1. any systemic or institutional issues in the delivery of acute care services in NSW public hospitals raised in submissions you receive that you consider appropriate for you to inquire into and recommend any changes which should be made to address them;
2. identify existing models of patient care used in the delivery of acute care services in NSW public hospitals with particular regard to case management including supervision of junior clinical staff, clinical note-taking and record-keeping, and communication between health professionals involved in the care of a patient;
3. recommend any changes which should be made to the existing models of patient care identified under paragraph 1 to improve the quality and safety of patient care in NSW public hospitals;
4. identify any systemic impediments to the implementation of changes recommended under paragraph 2;

ENTERED on Record by me, in REGISTER OF PATENTS, No. 89 Page 371, this 24<sup>th</sup> day of January, 2008

  
DIRECTOR GENERAL  
DEPARTMENT OF PREMIER AND CABINET

5. recommend any changes which NSW Health should make to overcome any impediments identified under paragraph 3; and
6. recommend any changes which NSW Health should make to ensure that its workforce policies and practices support improved models of patient care.

You may have regard to developments arising from the National Health and Hospitals Reform Commission and other Commonwealth-State reforms in relation to Australian health care delivery, to the extent that they arise before the date for the delivery of your report.

You are to refer any individual patient complaints identified in the course of your inquiry to the Health Care Complaints Commission.

You may seek the advice of such eminent persons as you choose to engage who have expertise in any one or more of medical practice, nursing practice, allied health practice, hospital management and such other areas as you consider appropriate. If you so desire, you may engage any such eminent persons from other States or the Territories or from outside Australia. This does not limit your ability to employ any other assistance under section 13 of the *Special Commissions of Inquiry Act 1983*.

AND hereby establish a Special Commission of Inquiry for this purpose.

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 31 July 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney.

AND pursuant to section 21 of the *Special Commissions of Inquiry Act* it is hereby declared that sections 22, 23 and 24 shall apply to and in respect of the Special Commission the subject of these Our Letters Patent.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

WITNESS Her Excellency  
Professor Marie Bashir,  
Companion of the Order of  
Australia, Commander of the  
Royal Victorian Order, Governor  
of the State of New South Wales  
in the Commonwealth of  
Australia.

Dated this 29<sup>th</sup> day of January 2008.



Governor

By Her Excellency's Command,

Premier. 



NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

To Mr Peter Richard Garling SC.

WHEREAS BY Letters Patent issued in Our name by Our Governor of Our State of New South Wales on 29 January 2008, WE appointed you as sole Commissioner to inquire into and report to Our Governor on various matters concerning the delivery of acute care services in public hospitals in New South Wales.

AND WHEREAS it is desirable that those Letters Patent be varied to correct cross references to certain paragraphs.

NOW THEREFORE WE do, by these Our Letters Patent issued in Our Name by Our Governor of Our said State, with the advice of the Executive Council, and pursuant to s6 of the *Special Commission of Inquiry Act 1983*, DECLARE that the Letters Patent constituting your Commission shall have effect as if the following paragraphs:

- “3. recommend any changes which should be made to the existing models of patient care identified under paragraph 1 to improve the quality and safety of patient care in NSW public hospitals;
4. identify any systemic impediments to the implementation of changes recommended under paragraph 2;
5. recommend any changes which NSW Health should make to overcome any impediments identified under paragraph 3; and”

were deleted and replaced with the following paragraphs:

ENTERED on Record by me, in REGISTER OF PATENTS, No. 29 Page 5/3, this 30<sup>th</sup> day of January, 2008

DIRECTOR GENERAL  
DEPARTMENT OF PREMIER AND CABINET



- “3. recommend any changes which should be made to the existing models of patient care identified under paragraph 2 to improve the quality and safety of patient care in NSW public hospitals;
4. identify any systemic impediments to the implementation of changes recommended under paragraph 3;
5. recommend any changes which NSW Health should make to overcome any impediments identified under paragraph 4; and”

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

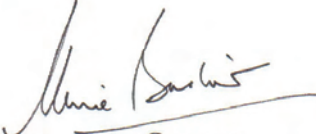
Page 1117

IN TESTIMONY WHEREOF, WE have caused, these Our Letters to be made Patent, and the Public Seal of Our State to be hereunto affixed.

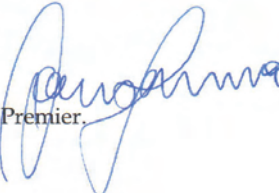


WITNESS Her Excellency  
Professor Marie Bashir,  
Companion of the Order of  
Australia, Commander of the  
Royal Victorian Order, Governor  
of the State of New South Wales  
in the Commonwealth of  
Australia.

Dated this 31<sup>st</sup> day of January 2008.

  
Governor

By Her Excellency's Command,

  
Premier.





## Appendix 2 Written submissions

The Inquiry received submissions from individuals and organisations. The two tables below detail those individuals and organisations that have indicated that their contribution to the Inquiry can be publicly recognised. A large number of individuals and organisations have asked that their submissions remain confidential.

657 individuals and organisations have submitted 692 submissions that can be identified. They are listed in the 2 tables below:

- Table A2.1 Written submissions from organisations
- Table A2.2 Written submissions from individuals

238 individuals and organisations made submissions that they have asked to remain confidential.

**Table A2.1 Written submissions from organisations**

Organisation	Date of Submission
Acute Surgical Unit Nepean Hospital	22 February 2008
Allied Health Alliance of NSW	28 March 2008
Area Directors of Allied Health Council	28 March 2008
Area Health Advisory Council of the Northern Sydney Central Coast Area Health Service	13 March 2008
Auburn Hospital Medical Staff Council	28 March 2008
Australasian College for Emergency Medicine	22 April 2008, 01 May 2008, 01 March 2008
Australian and New Zealand College of Anaesthetists	01 September 2008
Australian Association of Pathology Practices Inc.	24 April 2008
Australian Association of Social Workers	27 March 2008
Australian Centre for Health Research	28 March 2008
Australian College and New Zealand College of Anaesthetists	28 March 2008
Australian Confederation of Paediatric & Child Health Nurses (NSW) Branch	27 March 2008
Australian Doctors' Fund	19 March 2008
Australian Health Policy Institute	28 March 2008
Australian Institute of Radiography	02 April 2008
Australian Medical Association (NSW); Australian Salaried Medical Officer's Federation	02 April 2008
Australian Nurse Practitioner Association	27 March 2008
Australian Physiotherapy Association, NSW Branch	31 March 2008
Australian Pituitary Foundation	24 May 2008
Australian Society Of Independent Midwives	02 April 2008
Avant	31 March 2008
Bega Valley Community Health Staff	26 February 2008

Organisation	Date of Submission
Blacktown Mt Druitt Hospital Staff, Medical Council	31 March 2008
Board of Directors, North West Slopes Division of General Practice	04 April 2008
Broken Hill Health Council	07 May 2008
Cancer Voices NSW	27 March 2008
Carers NSW	27 March 2008
Centre for Clinical Governance Research	25 March 2008
Charles Sturt University, Faculty of Science	21 April 2008
Clinical Excellence Commission	28 March 2008
Coffs Clarence Health Participation Forum	27 March 2008
Combined Pensioners and Superannuants Association of NSW	17 March 2008 and 26 March 2008
Concord Hospital Clinical Nurse Consultants, Nursing Unit Managers and Clinical Nurse Educators	24 April 2008
Council of Social Service of NSW	26 March 2008
Council on the Ageing NSW Inc	28 March 2008
Deans of all Medical Schools in NSW and the ACT	28 March 2008
Department of Diving and Hyperbaric Medicine, Prince of Wales Hospital	25 March 2008
Division of Obstetrics and Gynaecology, John Hunter Hospital	01 April 2008
Executive Committee of the Royal Prince Alfred Hospital Resident Medical Officers Association	31 March 2008
Executive of the Newborn and Paediatric Emergency Transport Service (NETS)	10 June 2008
General Practice NSW Ltd	28 March 2008
General Surgeons Australia	31 March 2008
GOWEST (Growing Opportunities on the West of NSW)	06 May 2008
Health Services Association NSW	18 June 2008, 18 June 2008 (Supplementary), 28 March 2008
Homebirth Access Sydney	01 May 2008
Hope Healthcare	04 March 2008
Hornsby Kuringai Hospital Medical Staff Council	27 March 2008
Hospital Equity and Access Lobby (HEAL) Committee	25 March 2008
Hospital In The Home Society (NSW)	19 May 2008
Hospital Reform Group	27 March 2008, 28 March 2008, 5 June 2008
Hunter and Northern Kidney Association	11 May 2008
Hunter New England Area Health Service Area Allied Health Committee	20 May 2008
Hunter New England Area Medical Staff Executive Council	07 March 2008
Hunter Resident Medical Officers' Association	28 March 2008
Inverell Chamber of Commerce	26 March 2008
John Hunter Hospital Medical Staff Council	28 March 2008
Kempsey District Hospital Action Group	21 March 2008

Organisation	Date of Submission
Kempsey District Hospital Medical Staff Council	28 March 2008
Lismore Base Hospital Emergency Department Staff	28 March 2008
Liverpool Hospital, Department of Neonatal Intensive Care	16 April 2008
Maari Ma Aboriginal Corporation	07 May 2008
Management of Cardiac Function Program	22 April 2008
Medical Indemnity Industry Association	29 July 2008
Mental Health Coordinating Council	04 April 2008
Mental Health Workers Alliance of NSW	14 March 2008 and 28 March 2008
Menzies Centre for Health Policy	28 March 2008
Ministerial Taskforce on Emergency Care in NSW	25 March 2008
Murwillumbah District Hospital Support Committee	28 April 2008 and 24 April 2008
Neonatal Family Support Program	14 April 2008
Neonatal Intensive Care Units NSW and ACT	20 May 2008
NETHTA - National E-Health Transition Authority	27 March 2008
Newcastle Bone and Joint Institute	26 March 2008
North Coast Maternity Action Group	27 March 2008
Northern Illawarra Hospitals Group, Medical Staff Council	14 April 2008
Northern Rivers General Practice Network	28 March 2008
NSW Branch of the Australasian Faculty of Rehabilitation Medicine (Royal Australasian College of Physicians)	27 April 2008
NSW Branch of the Australian College of Health Service Executives	26 May 2008
NSW Commission For Children And Young People	28 March 2008
NSW Consumer Advisory Group	26 March 2008
NSW Health	14 April 2008
NSW Medical Staff Executive Council	28 March 2008
NSW Midwives Associations	28 March 2008 and 19 May 2008
NSW Nurses' Association	04 April 2008
NSW Nurses Association (Calvary Mater Newcastle branch)	09 May 2008
NSW Nutrition and Dietetics Advisors Group; Committee on Nutrition for Older Australians Department of Nutrition	02 April 2008
NSW Ombudsman	27 March 2008
NSW Operating Theatre Association	02 April 2008 and 03 October 2008
NSW Rural Doctors Network	28 March 2008
NSW State Committee of The Royal Australasian College of Obstetricians and Gynecologists	26 March 2008
NSW Therapeutic Advisory Group	23 May 2008
Nurse Unit Managers, Lismore Base Hospital	24 April 2008
Nursing and Midwifery Unit Managers' Society of NSW (Inc)	30 May 2008
Nursing Unit Managers, Port Macquarie Base Hospital	28 March 2008
Orthopaedic Association of Australia	31 March 2008
Palliative Care New South Wales	02 April 2008
Perioperative Managers' Committee, South Eastern Sydney Illawarra Health	28 March 2008

Organisation	Date of Submission
Port Macquarie Base Hospital Medical Staff Council	28 March 2008
Pharmaceutical Society of NSW	28 March 2008
Psychiatrists Peer Review Group 600	24 April 2008
Regional Community Watch	28 April 2008
RESNET - The City of Sydney Residents' Network	18 March 2008
Riverina Division of General Practice & Primary Health	14 May 2008
Royal Australasian College of Physicians	28 March 2008
Royal Australasian College of Surgeons NSW	31 March 2008
Royal Newcastle Centre Medical Staff Council Executive	27 March 2008
Royal North Shore Hospital - Physiotherapy Department	02 April 2008 and 09 April 2008
Royal Prince Alfred Hospital, Division of Surgery	02 April 2008
Royal Prince Alfred Hospital Medical Board	28 March 2008
Senior Medical Staff Council, Royal Hospital for Women	27 March 2008
Senior Medical Staff Council, Sydney Children's Hospital	31 March 2008
Southern General Practice Network	18 March 2008
St Vincent's Hospital Campus Medical Council	11 April 2008
Sutherland Emergency Department Staff Specialists	13 March 2008 and 24 April 2008
South Western Area Health Service Mental Health Network	07 April 2008
Sydney West Area Health Service Mental Health Consumer Network	01 April 2008
The Children's Hospital at Westmead	02 April 2008
The Children's Hospital at Westmead, Medical Staff Council	03 April 2008
The Chiropractors' Association of Australia (NSW) Ltd	08 May 2008
The College of Nursing	27 March 2008
The Natural Birth Education and Research Centre Inc	28 April 2008
The NSW Association of Directors of Pharmacy, University Teaching Hospitals	12 March 2008
The Official Visitors' Program - <i>Mental Health Act 2007</i> (NSW)	27 March 2008
The Peel Cluster Community Forum on Health	23 April 2008
The Royal Australian and New Zealand College of Psychiatrists	28 March 2008
The Royal College of Pathologists of Australia	31 March 2008
The Society of Hospital Pharmacists of Australia, NSW	28 March 2008 and 2 July 2008
University of Technology Sydney, Faculty of Nursing, Midwifery and Health	27 March 2008
Westmead Hospital Medical Staff Council	08 August 2008
Westmead Hospital, Nursing unit Managers	20 May 2008
Workplace Research Centre, University of Sydney	20 March 2008
Wyong Hospital Medical Staff Council; Gosford Hospital Medical Staff Council	31 March 2008

**Table A2.2 Written submissions from individuals**

Author	Date of Submission
Airey, Ronald	25 March 2008
Antonio, Geraldine and Cullen, Dr John	09 May 2008
Apokourastos, Leanne	07 May 2008
Arthur, A	28 March 2008
Arthur, Dr Christopher	28 March 2008
Astles, Dawn	02 April 2008
Axford-Brooks, Janice	15 May 2008
Bailey, Lynton	29 April 2008
Baker, Dr Gary	26 March 2008
Baker, Paul	30 June 2008
Baldwin, Frank Jeffery	26 March 2008
Bancroft, Jodie	02 June 2008
Banerjee, Dr Ashoke	04 October 2008
Baradine Mult Purpose Service staff	04 April 2008
Barham, Marian	28 March 2008
Barnett, Betty	16 April 2008
Barratt, Dr Stephen	30 March 2008
Batty, Julia	19 May 2008
Baumann MP, Craig	28 April 2008 and 29 April 2008
Beaumont, Dr Graham	18 March 2008
Beckett, Jacqueline	15 April 2008
Benasic, Safronia	17 April 2008
Bennett, Imelda	15 April 2008
Bennett, Pamela	01 April 2008
Bennett, Paul; Jones, Debra; Petersen, Janie	04 April 2008
Beresford, Dr Arthur	28 May 2008
Bethwaite, Carolyn	28 April 2008
Bilski, Dr Arthur	28 April 2008
Bisits, Dr Andrew	12 May 2008
Blair, Gordon	04 April 2008 and 06 April 2008
Bottom, Irene	28 March 2008
Bourke, Kathryn	20 May 2008
Bowen, Allison	28 April 2008
Bowers, Dave	25 April 2008
Bowtell, Bill	26 March 2008
Boyce, Neville	26 March 2008
Boyle, Associate Professor Michael	09 May 2008
Breen, Mrs Lyndal	29 May 2008
Brock, Dr David	28 April 2008
Brothers, Ian	28 February 2008
Brown, Karen	10 April 2008

Author	Date of Submission
Brown, Robin	28 April 2008
Bruce, Dr Warren	16 April 2008
Brydon, Dr Michael	24 April 2008
Buchanan, Dr John	27 March 2008
Bullmore, Dr Michelle; Brownlow, Dr Amanda	28 March 2008
Burn, Dr Ray	16 May 2008
Burns, Margaret	29 April 2008
Burrell, Dr John	21 April 2008
Burton, Adrienne	28 March 2008
Caines, Justine	30 March 2008 and 30 April 2008
Campbell, Dr Diane	22 April 2008
Campbell, Marion	24 April 2008
Campbell, Peter	16 May 2008
Cansdell MP, Steve	28 April 2008
Cappadonia, Dorothy	25 July 2008
Carmichael, Kathryn	29 April 2008
Carpenter, Cheryl	25 March 2008
Carr, Vaughan	08 May 2008
Carrall, Merrilyn	28 March 2008
Carroll, Alan; Carroll, Lois	28 April 2008
Carroll, Dr Gerard	22 April 2008
Carter, Robyn	10 April 2008
Cass, Dr Daniel	15 May 2008
Cechner, Sue	28 April 2008
Ceeley, Brad; Wade, Fiona	15 May 2008
Chambers, Dr Jennifer	27 March 2008
Chivers, Diana	29 May 2008
Cintio, Dr Vittorio	08 April 2008
Clark, Dr Peter Telford	10 April 2008
Coglin, Dr Michael	06 May 2008
Collett, Dr Peter	17 April 2008
Conway, Richard	26 May 2008
Cooke, Robyn	29 July 2008
Courtney, Judy	16 June 2008
Cracknell, Richard	03 March 2008
Craven, Paul	04 June 2008
Cregan, Patrick	23 February 2008
Crew, Neville	19 March 2008
Cullen, Tracey	18 March 2008
Cunningham, Paul	16 June 2008
Dangar, Gerard	09 April 2008
Davidson, Fergus	28 March 2008

Author	Date of Submission
Davidson, Les	04 April 2008
Davidson, Professor Trish	27 March 2008
Davis, Jan-Maree	14 May 2008
Davis, Ms Phyllia Mary	01 May 2008
Day, Jacqueline	24 April 2008
De Bernadi, Shirleyann	22 May 2008
Deane, Professor Stephen	21 May 2008
Deegan, Michael	26 May 2008
Devlin, Kathleen	18 April 2008
Dignam, Professor Denise	27 March 2008
Dillon, Frank	25 April 2008
Dolan, Chris	11 June 2008
Donohue, Terry	13 February 2008
Donovan, Lexie	14 April 2008
Donovan, Jennifer	14 April 2008
Dossetor, David	15 May 2008
Douglas, Rosemary	16 May 2008
Dubavs, Mrs Janice	15 April 2008 and 15 May 2008
Duggan, Professor John	31 March 2008
Duguid, Margaret; Crane, Jenny	25 March 2008
East, Benjamin	28 March 2008
Eagle, Trevor	04 April 2008
Edmonds-Wilson, Ellen	29 July 2008
Edwards, Tom	28 February 2008
Efthymiades, Christina	06 April 2008
Eggs, Stan	26 April 2008
England, Dr John Dacre Fontayne	20 March 2008
Evans, Dr Simon	19 March 2008
Fallon, Chris	22 March 2008
Faithfull, Samantha	30 May 2008
Fataar, Dr Shadley	27 March 2008
Faulkner, Stephanie	15 May 2008
Fearnside, Professor Michael Robert	09 April 2008
Ferguson, Frances	17 March 2008
Fergusson, Sara	26 March 2008
Fernandez, Sally	21 April 2008
Field, Greg	Undated
Fitter, Marshall	28 April 2008
Fletcher, Janice	08 April 2008
Foltyn, Dr Peter	30 April 2008
Fonseca, Dr Bob; Mifsud, Dr Geoff	14 May 2008
Ford, Jacqueline	30 April 2008



Author	Date of Submission
Forrester, Jeanette	20 June 2008
Foy, Associate Professor Aidan	27 March 2008
Fraser, Professor John	25 March 2008
French, Sylvia	14 February 2008
French, Robert James	14 February 2008
Frost, Barry	16 April 2008
Fulcher, Dr Jordan	26 April 2008
Fulham, Dr Michael	20 May 2008
Furner, Adrienne; Furner, Lewis	17 March 2008
Gaffney, Jamie	01 April 2008
Gale, Dr Peter	12 May 2008
Gallo, Dr John	09 April 2008
Gallur, Dr Luis	09 April 2008
Gander, Kenneth	01 April 2008
Gendron, Sandra	15 April 2008
George MP, Thomas	18 April 2008
Gibbs, Julie	26 May 2008
Gleeson, Tania; Sheehy, Sherylle	23 April 2008
Glykis, Marie	07 April 2008
Godhard AM, Tonia	10 October 2008
Goldstein, Dr Greg	02 April 2008
Good, Kerrie	31 March 2008
Graham, John	14 February 2008
Grainger, Kevin Anthony	22 April 2008
Grant, Denis; McCalla, Eileen	16 June 2008
Gratten-Smith, Dr Padraic	28 March 2008
Gray, Phillip	16 April 2008
Griffin, Mary	Undated
Grimshaw, Wendy	28 April 2008
Grove, Robyn	03 April 2008
Grover, Kathrine	07 April 2008
Gupte, Vijay	03 July 2008
Gyaneshwar, Associate Professor Rajat	16 April 2008
Hahn, Jan; Hume, Helen	27 March 2008
Hall, Judith; Matthews, Rhonda; Bartlett, Louise	02 April 2008
Hamilton, Jill	11 April 2008
Handcock, Robyn	29 Feb 08
Harland, Marie	26 May 2008
Harman, Paula; Hills, Rose	14 March 2008
Harnett, Professor Paul	10 April 2008
Harris, Clinical Professor Phillip	27 March 2008 and 10 April 2008
Harris, Professor David Charles	10 April 2008

Author	Date of Submission
Harris, Professor Ian	21 April 2008
Harvey, Dr Michael	30 March 2008
Hasler, Jane	02 April 2008
Hathway, Jillian Doris	30 April 2008
Hawke, Dr Anna	25 March 2008
Healy, Barbara	25 February 2008 and 03 April 2008
Heaphy, Dr Linda	20 June 2008
Hefner, Dr P.A	11 April 2008
Hempel, David	25 February 2008
Herkes, Dr Robert; Williams, Linda; Jacques, Associate Professor Theresa; Burrell, Dr Tony; Reece, Dr Graham; Lambert, Dr John; Raper, Dr Ray	28 March 2008
Hickey, Paul	28 April 2008
Hicks, Dr Henry Douglas	11 April 2008
Hicks, Pat	28 March 2008
Hill, Dr Kim	12 May 2008
Hill, Wendy	14 May 2008
Hodgkinson MP, Katrina	16 April 2008
Hodgson, Fran	12 May 2008
Hogan, Narelle	24 April 2008
Hogg, Veronica	18 April 2008
Hollis, Donna	26 March 2008
Holloway, Jocelyn	14 May 2008
Holloway, Simon	14 May 2008
Hooper, Dr Andrew	02 April 2008
Hooper, Mayor Robert; Weyland, Ian	17 March 2008
Horton, Marilyn; Horton, Chris	10 April 2008
Howen, Alexander	20 August 2008
Huenerbein, Margaret	05 April 2008
Hutson, Ronald Geoffrey	30 April 2008
Hyde Page, Dr Murray	09 April 2008
Hyland, Wayne	14 February 2008, 03 February 2008, 26 May 2008
Hylton, Rose	13 April 2008
Ieraci, Dr Sue; Tek, Dr Deniz	08 April 2008
Ingall, Dr Christopher	24 April 2008
Ireland, Des	01 May 2008
James, Colin	29 May 2008
Jankovic, Rodna	25 March 2008
Jenkins, Bronwyn	20 August 2008 and 21 August 2008
Johnson, Peter	28 April 2008
Johnson, Robert	02 April 2008 and 16 April 2008
Johnston, Adam	18 March 2008

Author	Date of Submission
Johnstone, Patricia	25 March 2008
Jones, Associate Professor Martin	23 April 2008 and 12 June 2008
Joseph, Dr Tony	14 March 2008
Karja, Lorna	28 March 2008
Keenan, Robin; Keenan, Bruce	28 April 2008 and 12 May 2008
Keith, Stephen	27 March 2008
Kellett, John	27 March 2008
Kelly, Victor	02 April 2008
Kemp, Professor Andrew	22 May 2008
Kennedy, Karen	28 April 2008
Kercher, Jennifer	18 April 2008
Kerrigan, Alan	18 March 2008
Khatri, Sonja	24 April 2008
Kincaid, Greg	09 June 2008
Klower, Pam	18 April 2008
Koldras, Isabella	20 April 2008
Kovoor, Associate Professor Pramesh; Thomas, Dr Stuart; Thiagalingam, Dr Aravinda	27 March 2008 and 14 April 2008
Kozaki, Tressa	09 May 2008
Kurrle, Associate Professor Susan	11 March 2008
La Greca, Maria	02 April 2008
Lane, Elizabeth Helen	28 May 2008
Lane, Ralph Bede	30 April 2008
Larcombe, Bernard	05 May 2008
Laurent, Dr Roger	02 April 2008
Lawrie, Dr Charles; Clarke, Dr Anne; Ferguson, Mrs Ros	11 March 2008
Lawson, Emeritus Professor James	01 February 2008
Lay, Janet	07 May 2008
Leach, Barbara	28 March 2008, 23 April 2008, 24 July 2008
Learmont, Janine	22 April 2008
Lennane, Jean	28 March 2008
Leslie, William	21 July 2008, 11 May 2008, 30 June 2008, 11 September 2008, 29 September 2008
Lewis, Michelle	28 March 2008
Lewis, Wayne; Lewis, Glendah	16 April 2008
Lindley, Professor Richard	10 April 2008
Lips, Dr Frederik	28 March 2008
Lipski, Associate Professor Peter	03 March 2008 and 31 March 2008
Lobegeier, Mark	28 April 2008
Logan, Dr David; Deane, Professor Stephen	22 May 2008
Loveday, Clare	14 May 2008

Author	Date of Submission
Lucey, Adrienne	13 May 2008
Lucire, Dr Yolande	11 April 2008, 19 August 2008, 10 November 2008
Lynn, Richard	27 March 2008
Macdonald, Don	29 April 2008
Mackay, Therese	08 February 2008, 28 March 2008, 07 April 2008, 30 May 2008, 03 June 2008
Mackinnon, Dr Ronald	04 April 2008
Madden, Anthony	18 April 2008
Maguire MP, Daryl	24 April 2008
Maider, Patricia	25 March 2008
Major, Dr Gabor	03 April 2008
Marinucci, Dr Phillip	27 March 2008
Marley, Dr Rosemary	27 March 2008
Marley, Professor John	24 March 2008
Marosszeky, Associate Professor Jenó Emil	10 April 2008
Marriott, Clifford	28 March 2008
Marroun, Hanaan	28 March 2008
Martin, Christine	13 February 2008
Matthews, Councillor Greg	27 March 2008 and 13 May 2008
Matthews, I K	22 May 2008
Mawbey, Pamela	06 May 2008, 09 May 2008, 24 May 2008, 25 May 2008
May, Geoff	16 April 2008
McCall, Liz	28 April 2008
McCaskill, Dr Mary	15 May 2008
McCauley, Mark	09 April 2008
McCusker, Elizabeth	24 March 2008
McMaster, Richard	14 March 2008
McNeill, Suzanne Margaret	Undated
Medway, Sharyn	15 May 2008
Melocco, Terry; Campbell, Gillian; Welch, Susan; Brown, Maree	05 June 2008
Menadue, John	25 March 2008 and 05 May 2008
Merchant, Cathy	28 April 2008
Millard, Associate Professor Richard	29 April 2008
Miskell, Dr Sharon	01 April 2008, 02 April 2008, 02 May 2008
Mitchell, Pauline	25 March 2008
Model, Albert	24 March 2008
Moehead, Anne	25 March 2008
Mohanlal, Dr Lisa; Murphy, Dr Paul; Brown, Dr Daniel; McPhee, Dr Ian	07 May 2008
Molloy, Dr William	21 April 2008

Author	Date of Submission
Moore, Betty	15 May 2008
Moore MP, Clover	28 March 2008
Moran, Ann-Louise	28 March 2008
Moran, Thomas; Moran, Margaret	27 March 2008
Morgan, June	07 April 2008
Morgan, Rachel	28 March 2008
Morris, Gerald	04 May 2008
Morris, Professor David	05 March 2008
Morrison, Ms Barbara	28 April 2008
Mort, Patricia	20 March 2008
Moskal, Steve	06 May 2008
Mukhar, Debbie	27 March 2008
Mullen, Glenda	19 May 2008
Munro, Dr Andrew Russell	27 March 2008
Nade, Professor Sydney	22 February 2008
Nash, Senator Fiona	29 April 2008
Nelson, Dr Gregory	09 March 2008 and 14 March 2008
Newcombe, Dr Jim	07 May 2008
Newrick, Barbara-Ann	23 April 2008, 23 May 2008
Nicholas, Ian	10 April 2008
Noble, Alan	08 April 2008
Norman, Rozlyn	26 March 2008 and 28 March 2008
Novak, Barbara	07 April 2008
Oates, Emeritus Professor Kim	14 April 2008
O'Callaghan, Dr John	23 April 2008
O'Connor, Dr Gerard	28 March 2008
O'Donnell, Carol	28 June 2008 and 30 June 2008
Oliver, Barbara	Undated
Oliver, Duncan Graham	Undated
O'Mara, Brian	29 May 2008
O'Mara, Rosemary	06 April 2008
O'Rourke, Cecilia	23 April 2008
O'Ryan, Dr Nicholas	07 May 2008
O'Toole, Laurie	25 March 2008
Pascoe, Mayor Kerry	22 April 2008
Passey, Catherine	26 March 2008
Patrick, Professor Jon	31 March 2008
Pauperis, V	24 April 2008
Pederson, Christine	25 April 2008
Perkins, Mrs Jon	30 April 2008
Perry, Lynda	22 May 2008
Peters, Elizabeth	11 June 2008

Author	Date of Submission
Pettersson, Linda	06 May 2008
Pettigrew, Evelyn	27 March 2008
Pezzutti, Dr Brian	19 March 2008 and 25 March 2008
Piccoli MP, Adrian	15 April 2008
Pickering, Michael	29 April 2008
Piscoe, Dr Aitkin	22 April 2008
Porter, Dr Robert	07 May 2008
Potter, Dr David Harry	12 June 2008
Poulos, Dr Christopher	14 April 2008
Prideaux, Rita	10 June 2008
Prineas, Stavros	17 March 2008
Proctor, Kenneth	28 March 2008
Provest MP, Geoff	28 April 2008, 25 March 2008, 29 April 2008
Puckeridge, Nina	19 May 2008
Purcell, Dr Greg	14 March 2008
Quinn, Denis Joseph	22 April 2008
Radonjic, Ms Vera	17 April 2008 and 25 May 2008
Raine, Robyn	26 May 2008
Randall, Greg	07 February 2008
Rankin, Peter	31 March 2008
Reddel, Dr Stephen	21 April 2008 and 24 April 2008
Reid, Professor Sandy	17 April 2008
Reimer, John	23 February 2008
Rivers, Alexandra	13 June 2008
Roberts, Dianne	29 April 2008
Robertson, Brent	10 April 2008
Robinson, Matthew	04 April 2008
Rosonakis, Judith	10 April 2008
Rossleigh Associate Professor, Monica	28 March 2008
Rowling, David	03 March 2008, 29 May 2008, 02 June 2008, 12 June 2008, 24 July 2008
Rushbrook, Danielle	28 July 2008 and 18 August 2008
Russell, Kate	04 February 2008
Ryan, Elizabeth	19 May 2008
Saddler, Sylvia	22 April 2008
Sadiq, Larissa	07 April 2008
Sakker, Dr Samuel	06 April 2008
Sardelic, Dr Franko	20 March 2008
Satherley, Zoe	14 April 2008
Schauffer, Elizabeth	24 April 2008
Schmike, Paul	14 April 2008
Schofield, Claire; Riley-Ward, Rebecca	22 February 2008

Author	Date of Submission
Schofield, Paul	28 March 2008
Scholl, Connie	14 April 2008
Schweizer, Nadia	28 March 2008
Scott, Lorna	Undated
Scurry, Susanna	17 March 2008
Seebach, Anne; Robards, Anne	01 May 2008
Shaw, Deb	28 March 2008
Sheedy, Jim	18 March 2008
Shepherd, Ms Muriel	14 April 2008
Shoesmith, Marilyn	17 April 2008
Shortis, George	07 May 2008
Sinclair, Anne	14 April 2008
Sinclair, Jonine May	Undated
Singh, Baljinda	29 April 2008
Skinner, Clare	14 March 2008
Skinner, Jillian MP	26 February 2008, 05 March 2008, 06 March 2008, 10 March 2008, 19 March 2008, 25 March 2008, 09 April 2008, 11 April 2008, 29 April 2008, 10 June 2008, 12 June 2008
Slade, Professor Diana; Iedema, Professor Rick	19 March 2008
Smith, Councillor Allan John	19 March 2008
Smith, Dr Denis	07 May 2008
Smith, Dr Ross	02 April 2008
Smith, Dr Sally	16 March 2008
Smith, Dr Tony	27 March 2008
Smith, Mayor Toby	18 March 2008
Smith, Mrs Julia	28 April 2008
Smith, Nicola	30 April 2008
Snodgrass, Helen	19 March 2008
Soncini, Lidia	10 April 2008
Sonnabend, Professor David	02 April 2008
Southwood, Mr Roger	22 April 2008
Stafford, Billy	07 May 2008
Standen, Greg	28 March 2008 and 19 May 2008
Stander-Challender, Sigrid	15 April 2008
Steiner, Dr Hamish	26 May 2008
Stephens, Christopher	20 March 2008 and 08 April 2008
Stephens, Dr Glenn	20 May 2008
Stephens, Ron	28 April 2008
Stephenson, Dr Nicholas	22 April 2008
Stirling, Jim	14 March 2008
Stocker, Maxwell; Stocker, Jennifer	12 May 2008



Author	Date of Submission
Stone, Mrs Lynette	31 March 2008 and 20 May 2008
Stoner MP, Andrew	03 April 2008
Storman, Mr James	01 May 2008
Strang, Meredith	05 July 2008
Stubley, Ann	30 April 2008
Sultan, Dr Aamer	02 May 2008
Summersell, Dr Peter	28 March 2008
Surbey, E B	03 April 2008
Swaddling, Carin	07 April 2008
Swan, Armelle	12 June 2008
Swan, Judy	30 April 2008
Swann, Kevin Peter	23 April 2008
Tan, Dr Andrew	02 April 2008
Tankel, Dr Alan	31 March 2008 and 27 March 2008
Telfer, Dr James	26 March 2008
Thomas, David	01 May 2008
Thomas, Lorraine	12 May 2008
Thompson, Bronwyn	07 April 2008
Todd, John	05 March 2008
Torbay MP, Richard	31 March 2008
Transit Department Employees	14 April 2008
Trevan, Elizabeth	28 March 2008
Tuite, Phyllis	28 March 2008
Turton, Elva	21 April 2008
Uche, Patrick Friday	18 April 2008
Van Asperen, Professor Peter	15 May 2008
Vaughan, Ronald	12 May 2008
Verbeek, Dr Miriam	28 April 2008
Vethanayagam, Dr Frederick	04 April 2008
Vote, Robert Harold	28 March 2008 and 16 May 2008
Vromans, Robyn	14 April 2008
Wagstaff, Patricia	20 March 2008
Walden, Stan	20 February 2008
Wallington, Kathleen	13 June 2008, 27 July 2008, 29 August 2008, 19 August 2008
Walsh, Beverley	25 March 2008
Walsh, Genevieve	31 March 2008
Walsh, Kate	15 February 2008
Walsh, Ted	17 March 2008
Wand, Tim	15 February 2008
Ward, John	21 April 2008
Wardell, Jennifer	14 April 2008

Author	Date of Submission
Warden, R	21 April 2008
Waters, Skye	26 March 2008
Watters, Charmaine Patricia	28 April 2008
Watterson, Dr Janet	14 April 2008
Watterson, Dr Leonie	14 March 2008
Wawn, Michael	01 May 2008
Weaver, Margaret	24 April 2008 and 26 May 2008
Webster, Ian	26 March 2008
Wheelhouse, Mrs Catherine	27 March 2008
White, Albert	27 April 2008
White, Ann May	19 March 2008
White, Professor Les; Davidson, Professor Trish	14 April 2008
Whitehouse, Kathryn	20 February 2008
Willesee, Amy; Wilesee, Joanna	14 April 2008
Williams, John	16 March 2008
Wilson, Associate Professor Stephen	30 April 2008
Wines, Dr Robert	04 May 2008
Wisman, Joy	20 March 2008
Witt, Susan; Troy, Jo-Anne	21 April 2008
Wittekind, Dr Carola	14 March 2008
Wodak, Dr Alex	14 April 2008 and 30 April 2008
Wood, Anna	26 March 2008 and 08 May 2008
Wood, Catherine	30 April 2008
Woods, Bernadette	16 April 2008
Woods, Sonya	28 March 2008
Woodward, Therese	23 April 2008
Wright, Annette	14 April 2008
Wright, John	07 April 2008
Wyllie, Dr Mac	28 March 2008
Zalewski, Trudy	14 April 2008
Ziegler, Associate Professor John	31 March 2008

## Appendix 3 Hospital Visits

Date	Hospital
14 February 2008	Royal Prince Alfred Hospital
19 February 2008	St Vincent's Hospital
21 February 2008	Concord Hospital
21 February 2008	St George Hospital
21 February 2008	Prince of Wales Hospital
26 February 2008	Liverpool Hospital
28 February 2008	Goulburn Base Hospital
10 March 2008	Wyong Hospital
11 March 2008	Macquarie Hospital
12 March 2008	Ryde Hospital
12 March 2008	Mona Vale and District Hospital
12 March 2008	Manly District Hospital
17 March 2008	Oberon Multi Purpose Service
17 March 2008	Bloomfield Hospital
18 March 2008	Wellington Hospital
18 March 2008	Wellington Aboriginal Medical Corporation
19 March 2008	Royal Flying Doctor Service, Dubbo
19 March 2008	Dubbo Private Hospital
20 March 2008	Gulgong District Hospital
20 March 2008	Rylstone Multi Purpose Service
25 March 2008	Muswellbrook District Hospital
25 March 2008	Quirindi District Hospital
26 March 2008	Dorrigo Multi Purpose Service
26 March 2008	Bellinger River District Hospital
27 March 2008	Macksville District Hospital
27 March 2008	Kempsey Hospital
14 April 2008	Wollongong Hospital
14 April 2008	Shoalhaven and District Memorial Hospital
15 April 2008	Milton and Ulladulla Hospital
15 April 2008	Braidwood Multi Purpose Service
16 April 2008	Kenmore Hospital
16 April 2008	Bowral and District Hospital
16 April 2008	Camden Hospital
17 April 2008	Liverpool Hospital, Mental Health Unit
22 April 2008	Holbrook District Hospital
23 April 2008	Corowa Multi Purpose Service
24 April 2008	Concord Hospital, Mental Health Unit
28 April 2008	Lismore Base Hospital
28 April 2008	Ballina Hospital

Date	Hospital
29 April 2008	Mullumbimby and District Hospital
7 May 2008	Broken Hill Base Hospital
8 May 2008	Wilcannia Multi Purpose Service
8 May 2008	Cobar District Hospital
8 May 2008	Bourke Multi Purpose Service
9 May 2008	Walgett District Hospital
9 May 2008	Walgett Aboriginal Medical Service
12 May 2008	James Fletcher Hospital
13 May 2008	Cumberland Hospital
14 May 2008	Sutherland Hospital
15 May 2008	The Children's Hospital, Westmead
19 May 2008	Sydney Children's Hospital
20 May 2008	Royal Prince Alfred Hospital, Maternity Unit
29 May 2008	NSW Ambulance Service Headquarters
3 June 2008	Justice Health
7 July 2008	Mt Druitt HealthOne
7 July 2008	Mt Druitt Hospital
7 July 2008	Blacktown Hospital
10 July 2008	Sydney Medical Simulation Centre
3 September 2008	Wollongong Community Mental Health
3 September 2008	St George Community Mental Health
3 September 2008	Ryde Community Mental Health
27 October 2008	The Children's Hospital, Westmead

## Appendix 4 Hearings and public witnesses

witnesses	position
<b>10 March 2008</b>	
<b>Gosford Hospital</b>	
Dr Ian Incoll	VMO orthopaedic surgeon
Dr Kathryn Porges	Acting Director of Emergency Services
Prof Peter Lipski	Conjoint Associate Professor in Geriatric Medicine
Veronica Croome	Director of Nursing; Acting Area Director of Nursing and Midwifery
Dr Scott Whyte	Head of Division of Neurosciences
Dr William Monroe	Chairman of Medical Staff Council
Dr Simon Roger	VMO specialist renal physician
Angela Monger	Acting Divisional Manager for Women's, Children's and Family Health
Louise Waymouth	Operational Nurse Manager for the Division of Anaesthesia, Surgery and Intensive Care
John Alchin	Acting Operational Nurse Manager for Medicine, Patient Flow Nurse Manager
Dr John Death	Staff specialist physician
Dr Simon Battersby	Chairman of Medical Staff Council
<b>11 March 2008</b>	
<b>Hornsby and Ku-Ring-Gai Hospital</b>	
Dr Rebecca Kozor	Registered Medical Officer, Post Graduate Year 2
Peg Hibbert	Clinical nurse specialist
Dr Peter Roberts	Area Director for Emergency Medicine; Councillor for the Australasian Society for Emergency Medicine
Dr Robert Reed	Secretary of Medical Staff Council
Dr Charles Lawrie	Emergency physician
Rosalyn Ferguson	Nursing Unit Manager (Accident & Emergency)
Diana Gomes	Registered nurse
Debbie Skinner	Nursing Unit Manager (Paediatric)
Emma Coyle	Nursing Unit Manager (Acute)
Elizabeth White	Infection control clinical nurse consultant
Dr Susan Kurrle	Clinical Director of the Division of Rehabilitation and Aged Care; Chair in Health Care of Older People
Dr Roderick Brooks	VMO specialist orthopaedic surgeon
<b>14 March 2008</b>	
<b>Royal North Shore Hospital</b>	
Paula Harman	Senior Discharge Planning Consultant
Rose Hill	Nursing Unit Manager (Orthopaedic)
Prof Stephen Hunyor	Professor of Medicine; cardiologist
Jan Tweedie	Acting Director of Nursing and Midwifery
Nicholas Marlow	Area Manager for Acute Post Acute Care (APAC) service; Fellow of the College of Nursing
Dr Russell Brereton	Head of Cardiothoracic Surgery

witnesses	position
Prof Michael Cousins	Director and Head of the Department of Anaesthesia and Pain Management
Ronald Mawhinney	Intensive care paramedic
Prof Alan Rosen	Director of clinical services; psychiatrist
Dr James Telfer	Psychiatrist
Susan Henderson	Nursing Unit Manager (Surgical Short Stay)
Tracey Wittich	Nursing Unit Manager (Acute Aged Care)
Margaret Webster	Nursing Unit Manager (Oncology and Haematology)
Anthony Humphrey	President of the Australian Mental Health Suicide Consumer Alliance ("Speranza"); member of Acute Services Advisory and Planning Committee
Dr Gregory Purcell	VMO Anaesthetist
Dr Sarah Smith	Senior cancer information manager
Dr Leonie Watterson	Director of Sydney Medical Simulation Centre

**17 March 2008****Bathurst Base Hospital**

Dr Christopher Halloway	Chair of Medical Staff Council
David Hempel	Private citizen
June Darke	Member of Bathurst and District Health Watch Committee
Lewis Furner	Private citizen
Adrienne Furner	Private citizen
Heather Dunn	Member of Daffodil Cottage voluntary palliative care group
Aileen Hulbert	Private citizen
Julie Maher	Member of the Bathurst Health Council; physiotherapist
Genevieve Croaker	Member of Bathurst volunteer palliative care
Irene Bottom	Private citizen
Margaret Wilson	Senior psychologist
Beverley Walsh	Private citizen
Rodney Gibbs	Private citizen
Robert Hoop	Mayor of Oberon
Ian Weyland	Chairman of the Oberon Aged Care Committee
Dr Stavros Prineas	Anaesthetist
Dr Bruce McGarrity	VMO physician; gastroenterologist and generalist
Donna Hollis	Private citizen
Katalyn Visolit	Private citizen

**18 March 2008****Orange Base Hospital**

Louis Christie	Director of Medical Services; specialist emergency physician
Allan Kerrigan	Network Director of Women, Children and Family Health
Kenneth Gander	Private citizen
Deborah Osborne	Private citizen
Karen Rauert	Midwife
Dr Brian Masters	Former Medical Superintendent
Dr Frances Gearon	Director of Aged Care and Rehabilitation

witnesses	position
Dr Ruth Arnold	Chair of Medical Staff Council
<b>19 March 2008</b>	<b>Dubbo Base Hospital</b>
Alan Smith	Councillor and former Mayor of Dubbo City Council
Malcolm Bryan	Private citizen
Valia Mallouhi	Private citizen
Sally Honfi	Private citizen
Dr Randall Greenberg	Director of Critical Care
Geoff Sherring	Private citizen
Dr Dean Fisher	Chairman of Medical Staff council
Ann White	Private citizen
Sandra Thomas	Private citizen
Jenny Mann	Nursing Unit Manager (Ambulatory Care)
Doreen Dawson-Heywood	Private citizen
Roger Parker	Enrolled Nurse
Dawn Fardell	State Member of Parliament
John Palmer	Private citizen
<b>20 March 2008</b>	<b>Mudgee District Hospital</b>
James Loneragon	Chair of Health Council for the Mudgee District; member of the local Greater Midwestern Council
Jodie McAlpine	Physiotherapist
Helen Harwood	Nurse Unit Manager (Operating Theatre); Nurse Services Manager
James Thompson	Mayor, Midwestern Regional Council
Dr John England	Consultant physician and cardiologist
Dr Aryatilak Dissanayake	Committee member of Rural Directors Association; Board member of Rural Doctors network
Jennifer Kiddle	Registered Nurse
Dr Charles Alpren	VMO general medicine and obstetrics
Maree Nott	Health Information Manager
Dr Michael Nicholson	GP
Kerry Shanahan	Nursing Unit Manager (Acute Care Ward)
Margo MacKenzie	Registered Nurse and Midwife
Joy Wisman	Private citizen
<b>25 March 2008</b>	<b>Tamworth Base Hospital</b>
Prof John Fraser	Head of the School of Rural Medicine of the University of New England
Dr Harold Noble	Retired dental surgeon
Justine Caines	Private citizen; past member of Maternity Coalition
David Smith	Nursing Unit Manager (Operating Theatres)
Cheryl Harris	Private citizen
Rozlyn Norman	Secretary of NSW Nurses Association branch
Dr Catherine Hawke	Director of Anaesthesia
Dr Gerard O'Connor	VMO anaesthetist
Gerard Jeffrey	Clinical nurse specialist (Operating Theatres)



witnesses	position
Dr Peter Finlayson	Director of Medical Services
Iris Mahoney	Private citizen
Dr Phillip Hungerford	Director of Clinical Care
Phillip Hodges	Chairman of Peel Cluster Forum on Health
Cheryl Jacob	Director of local Chamber of Commerce
Matthew Hooley	Private citizen
Glenda Hooley	Private citizen
Janet Hahn	Private citizen
<b>26 March 2008</b>	<b>Armidale and New England Hospital</b>
Dr Gary Baker	VMO general physician
Lynette Appleby	Private citizen
Keith Appleby	Private citizen
Prof Lynette Fragar	Chair of the Area Health Advisory council
Harry Bolton	Business Service Officer of Tenterfield Shire Council
Dr Robert French	Specialist surgeon
Marilyn Miller	Private citizen
Dr Ronald Hawkesford	Director of Accident & Emergency
Catherine Passey	Renal social worker
Dr Mark Henschke	VMO general practitioner obstetrician
<b>27 March 2008</b>	<b>Coffs Harbour Base Hospital</b>
Dr Shadley Fataar	Head of Medical Imaging Department
Amanda Short	Registered nurse (surgical ward)
Paul Scofield	Director of Nursing
Claire Simmonds	Member of Coffs Coast Maternity Action Group
Donald Coleshill	Private citizen
Paul McIntosh	Private citizen
Raymond Munro	Representative of Coffs-Clarence Health Participation Forum
Susan French	Clinical nurse educator (Surgical Unit)
Elisabeth Allen	Registered Nurse; acting Clinical Nursing Unit Manager (Surgical Ward)
Dr Paul Moran	VMO anaesthetist
Susan Saunders	Clinical Nursing Unit Manager (Medical Ward)
Dr Andrew Munro	Staff specialist of emergency medicine
Steven Rodwell	Director of Nursing
Dr Theresa Beswick	Director of Medical Services
<b>28 March 2008</b>	<b>Port Macquarie Base Hospital</b>
Therese Mackay	Private citizen
Kenneth Proctor	Cancer Care Coordinator at the North Coast Cancer Institute
John Bowell	Councillor of Kempsey Shire Council; Chairman of Kempsey Hospital Action Group
Paul Mesher	Enrolled Nurse; delegate of Nurses Association (Mental Health)
Dr Jennifer Chambers	VMO vascular surgeon

witnesses	position
Allan Anderson	Clinical psychologist
Kylie Brett	Private citizen
Elizabeth Green	Mayor of Kempsey Shire Council
Jennifer Baroutis	Nursing Unit Manager (Surgical Ward)
Kathryn Hodgman	Registered Nurse (Medical Ward)
Robert Kiddle	Private citizen
Alan Pretty	Nursing Unit Manager (Accident & Emergency)
Russell Pilcher	Private citizen
Dr Stephen Begbie	Chairman of the Medical Staff council
Dr Henry Cumberland	VMO orthopaedic surgeon
Sandra Eadie	Nursing Unit Manager (Maternity Unit)

### 2 April 2008 Royal North Shore Hospital

Warren Anderson	Private Citizen
Joanne Prendergast	Manager of Department of Nutrition and Dietetics
Rhonda Matthews	Dietitian
Donald Kennedy	Hospital volunteer
Patricia Heaton	Senior orthopaedic physiotherapist
Barbara Lucas	Paediatric physiotherapist
Dr Martin Laurent	Head of Department of Rheumatology
Dr Susan Rutowski	Retired Director of Spinal Cord Injuries
Prof John O'Grady	Chair of Language Technology; previous Chair of Information Systems
Peter Campbell	Clinical Nurse Consultant (Burns and Plastic Surgery)
Alan Grochulski	Clinical Nurse (Emergency Mental Health)
Joe-Anne Bendall	Clinical Nurse Consultant (Infection Control)
Jennifer Kinsella	Manager of Ryde Diabetes Service; Clinical Nurse Consultant (Diabetes)
Julia Weston	Private citizen
Dawn Astles	Registered Senior Pharmacist
Sally Nicolson	Registered Senior Pharmacist
Dr Christopher Arthur	Haematologist
Jenny Edge	Clinical Nurse Educator (Maternity)
Gail Aldenhoven	Clinical Nurse Educator
Dr Sharon Miskell	Director of Medical Services
Julia Poole	Clinical Nurse Consultant (Aged Care)
Dr Daniel Stiel	Clinical Director of the Division of Medicine and Aged Care
Evelyn Kelly	Registered Nurse (Psychiatry)
Julie Hartley-Jones	Director of Clinical Operations
Margaret Bramwell	Director of Social Work
Helen Ganley	Registered Nurse

### 8 April 2008 Nepean Hospital

Kevin Griffey	Private citizen
Christine Griffey	Private citizen

witnesses	position
Kim McCall	Private citizen
Jill Desmond	Team Leader of Midwifery in the Home (Post-natal)
Dr James Branley	Staff specialist physician and clinical microbiologist
Prof Michael Cox	Professor of surgery
Janet Long	Clinical Nurse Specialist (Maternity)
Susan Betts-Hendy	Clinical Midwifery Consultant
Jason Mullavey	Enrolled Nurse (Accident & Emergency)
Vittorio Cintio	Clinical Leader for Social Work
Dr Roderick Bishop	Director of the Accident & Emergency; Co-chair of the Emergency Care Taskforce
Demaris Wickham	Nurse Unit Manager (Acute Interventional Medicine and Cardiology)
Suzanne Samuels	Cardiac Services Manager
Sally Brown	Midwife
Glenis Geldard	Continuing Care Coordinator
Dr Andrew Keegan	President of the Australian Medical Association (NSW)
Dr John Pardey	Clinical Director of Obstetrics and Gynaecology
Geoffrey Oakley	Acting Nurse Manager (Surgery and Anaesthetics)
Kellie Lyn Thomas	Acting Nursing Unit manager (Orthopaedics)
Sylvia O'Malley	Nursing Unit Manager (Day Surgery)
Pauline Barber	Team Leader of Social Work (Acute Care Services)
Prof Anthony McLean	Director of Intensive Care Unit
Kathleen Gradidge	Patient Flow Manager
Dr Peter Flynn	Chairman of Medical Staff Council
<b>10 April 2008</b>	<b>Westmead Hospital</b>
Zareen Nisha	Private citizen
Dr Timothy Tan	Registrar physician
Dr Lisa Phipps	Registrar
Dr Jeremy Hsu	Registrar general surgeon
Nicole Scott	Private citizen
Dr Roslyn Crampton	Director of pre-vocational education and training
Dr John Gallagher	Staff specialist of intensive care
Dr Peter Clark	Senior staff specialist of intensive care
Dr Andrew Pesce	Clinical Director for Women's Health
Dr Therese McGee	Staff specialist in obstetrics and gynaecology
Pror Paul Harnett	Director of the Sydney West Cancer Network
Prof Jerry Koutts	Acting Clinical Director of Pathology Services
Prof Michael Fearnside	Director of surgery for Area Health Service; Chairman of the Area Health Advisory Council
Prof David Harris	Associate Dean and Head of Western Clinical School
Prof Anthony Cunningham	Network Director for Research in area health service; Director of the Westmead Millennium Institute
Prof Jenó Marosszeky	Director of Sydney West Area Health Service Rehabilitation Service
Marguerite Cullen	Nursing Unit Manager (Operation Suite)

witnesses	position
Lidia Soncini	Private citizen
Prof Richard Lindley	Chairman of the GMCT Aged Care Network Committee; member of the NSW Physicians Taskforce

### 14 April 2008 Wollongong Hospital

Prof Katherine Brown	Clinical Stream director of Population Health and Primary Health Care; Chair of Hospital Medical Staff Council
Grant Solomon	Patient Transport Officer
Amy Willesee	Private citizen
Joanna Willesee	Private citizen
Dr Liam Grundy	anaesthetist
Robyn Alexander	Speech pathologist (Stroke Unit)
Emma Ramirez	Speech pathologist
Anne Frew	Nurse Unit Manager (Medical Unit)
Susan Tait	Nurse Unit Manager
Dr Christopher Poulos	Specialist rehabilitation physician
Anne Sinclair	Principal nurse educator
Dr Adam Purdon	Acting Director of Intensive Care Unit
Prof Philip Clingan	Director of Medical Oncology
Dr Clair Langford	Staff specialist geriatrician
Amy Haantjens	Dietitian
Alison Ferguson	Dietitian
Vanessa Allen	Dietitian
Justine Dwyer	Nurse Unit Manager (Cardiac/High Dependency)
Dr Simon Leslie	Medical Director of Accident & Emergency; Secretary of Illawarra Association of Multi-skilled Medical Officers
Angela Pridham	NSW Nurses Association Representative for Mental Health

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### 15 April 2008 Queanbeyan District Hospital

David Erskine	Registered Nurse
Bronwyn Taylor	Clinical Nurse Specialist (Palliative Care)
Elizabeth Dee	Private citizen
Dr Margerie Cross	Representative of the Southern Division of General Practice
Gordon Reed	Private citizen
Andrew Constance	Member of the NSW Legislative Assembly
Matthew Mason-Cox	Member of the NSW Legislative Council
Janice Dubavs	Private citizen
Kevin Grainger	Chair of Local Area Health Advisory Committee

### 16 April 2008 Goulburn Base Hospital

Robert Johnson	Retired Ambulance Officer
Jeanelle Slater	Private citizen
Elizabeth Matheson	Private citizen
Zoe Vaughan	Private citizen
Lynette Lace	Delegate Advisor for Area Health Service for Dietetics

witnesses	position
David White	Electoral Officer for Member of Parliament
John Barburton	Private citizen
<b>17 April 2008</b>	<b>Liverpool Hospital</b>
Dr Sundaram Rachaiconda	Staff specialist of intensive care
Dr Peter Collett	Chair of Medical staff Council; Director of Respiratory Medicine
Wendy Smith	Nurse Educator
Brian Grant	Clinical Nurse Specialist; Cardiac Liaison Nurse
Dr Richard Cracknell	Director of the Accident & Emergency; Network Director
Dr Suzanne Hodgkinson	Clinical academic in neurology
Prof Ian Harris	Head of the Department of Orthopaedic Surgery
Dr Eric Farmer	Vascular surgeon
Dr John Smoleniec	Director of Feto-maternal Medicine
Janette Perrone	Private citizen
Andrea Delprado	Executive Manager of the Institute of Trauma Education; Registered Nurse
Dr Marianne Levey	Gastroenterologist
<b>22 April 2008</b>	<b>Wagga Wagga Base Hospital</b>
Prof Alexander Reid	Past Head of the University of NSW Clinical School, Wagga Wagga; past Assistant Dean for Medical Education at University of Newcastle; Department Director of Accident & Emergency
Francis Dillon	Private citizen
Sylvia Saddler	Private citizen
Heather Cregan	Private citizen
Kerry Pascoe	Mayor of the City of Wagga Wagga
Erwin Richter	Private citizen
Trevor Cocks	Clinical psychologist
Dr Atkin Pitsoe	Obstetrician and gynaecologist
Danette Watson	Private citizen
Susan Watson	Private citizen; retired radiographer
Prof Graeme Richardson	Associate Professor of Surgery at the University of NSW Rural Clinical School; Hospital Director of Postgraduate Training; Chairman of the Department of Surgery; Rural Representative for the Surgical Council for IMET
Owen Southwood	Former Regional Director of Agriculture
Susan Fowler	Mental Health Cluster Manager
Dr Rodney Juratowitch	Clinical Director of Psychiatry
Mary Saligari	Manager of Aged and Extended Care
Kirsty Matthews	Private citizen
Marie Heath	Representative of the Australian Society of Independent Midwives
Janet Jamieson	Manager of Community Mental Health Services
Professor Gerard Carroll	Chair of the Medical Staff Council
Dr Nicholas Stephenson	VMO radiologist
Denis Quinn	Manager of Primary and Community Health Services

witnesses	position
Charlene Brown	Acting Nurse Manager (Inpatient Mental Health Unit)
<b>23 April 2008</b>	<b>Albury Base Hospital</b>
Diana Knagge	Trainee Enrolled Nurse Program Coordinator for Area Health Service
Robyn Raine	Private citizen
Lorna Martin	Private citizen
Joseph Martin	Private citizen
Dianne McKillop	Student of Undergraduate Nursing
Helen Whyte	Enrolled Nurse
Kevin Swan	Chairman of No More Bandaid Solutions Inc
Paul Hickey	Private citizen
<b>24 April 2008</b>	<b>Concord Hospital</b>
Jacqueline Day	Private citizen
Sandra Gendron	Private citizen
Dr Thomas Karplus	Staff specialist in vascular medicine
Dr Stephen Reddel	Member of patient care committee; neurologist
Dr Neil Phillips	Psychiatrist
Susan Monaro	Clinical Nurse Consultant (Vascular)
Sonja Khatri	Clinical Nurse Consultant (Colorectal and Oncology)
Christine Parker	Nursing Unit Manager (Burns Unit)
Dr Jean Lennane	Representative of Friends of Callan Park
Thomas Edwards	Private citizen
Prof Leonard Kritharides	Head of Department of Cardiology
Sonya Jones	Acting Nurse Manager (Special projects); Nurse educator
Kay Robins	Clinical Nurse Educator (Surgical/Medical/Upper Gastrointestinal Tract)
Dr Lloyd Ridley	Head of Department of Radiology
Prof Saul Freedman	Professor of Cardiology; cardiologist
Sato Hacopian	Private citizen
Dr Judith Trotman	Director of Bone Marrow Transplant Services
<b>28 April 2008</b>	<b>Lismore Base Hospital</b>
Dr Christopher Ingall	VMO paediatrician
Karen Kennedy	Acting Director of Pharmacy
Thomas George	Member of NSW Legislative Assembly
Dr Peter Rankin	Senior staff specialist haematologist
Dr Martin Chase	Director of Accident & Emergency
Mary Fraser	Nurse Unit Manager (Accident & Emergency)
Dr Daniel Ewald	General Practitioner
Chris Clark	Chief Executive Officer of Northern Rivers General Practice Network
Elizabeth Lane	Private citizen
Deirdre Lane	Private citizen
Elizabeth McCall	Nursing Unit Manager (District Hospital – Emergency; Acute; Recovery)

witnesses	position
Carol Thurgate	Facility Manager of Aged Care Facility; Registered Nurse
Margaret Loong	Private citizen
Stephen Cansdell	Member of NSW Legislative Assembly
Marshall Fittler	President of Regional Community Watch
Lois Carroll	Private citizen
Janelle Saffin	Member of House of Representatives

**29 April 2008****The Tweed Hospital**

Donald McDonald	Project Officer for Pottsville Community Association
Dr David Brock	Career Medical Officer
Kathryn Carmichael	Deputy Clinical Information Manager
Michael Holloway	Director of the Pharmacy Department
Carol Murphy	Private citizen
Ian Ross	Chairman of Murwillumbah Hospital Support Committee
Desmond Ireland	Member of Murwillumbah Hospital Support Committee
Lynton Bailey	Private citizen
Judith Bailey	Private citizen
Prof Leslie Burnett	Director of Pathology Services
Dr Barry Rigby	Director of the Intensive Care Unit
Michael Shnukal	Nursing Unit Manager (Mental Health)
Joseph Lockley	Acting Nurse Unit Manager (The Tweed Valley Clinic)
Emily Hunston	Registered Nurse (Coronary Care Unit)
Madeleine Green	Registered Nurse (Coronary Care)
Leila Berak	Registered Nurse (Operating Theatre)
Mary Daly	Registered Nurse (Palliative Care; Dementia)
Geoffrey Provest	Member of NSW Legislative Assembly
Margaret Watherston	Nurse Unit Manager (Maternity Unit)
Jan Stephenson	Midwife
Sharna Jackson	Midwife
Pamela Barrett	Nurse Unit Manager (Medical; Coronary Care)
Prof Ehtesham Abdi	Medical oncologist
Susanne Brooks	Clinical Nurse Consultant; Manager of Oncology
Alison Jux	Registered Nurse (Surgical Ward)
Dr Dennis Pisk	Director of Medical Services

**30 April 2008****St Vincent's Hospital**

Dr John Graham	Chairman of Department of Medicine; Sydney Hospital
Dr John Harkness	Chairman of the Medical Council
Laura Leonoff	Private citizen
Dr Maxwell Coleman	Program Director of Surgery
Catherine O'Brien	Casual music therapist, mental health and palliative care
Dr Peter Foltyn	Consultant dentist
Andrew Driehuis	Clinical Nurse Consultant (Community Health Service)



witnesses	position
Paula Varnier	Clinical Nurse Consultant (Community Health Service)
Dr Alexander Wodak	Director of the Alcohol and Drug Service
Dr Judith Branch	VMO anaesthetist
Dr Anthony Dodds	Director of Haematology in Bone Marrow Transplant; Co-chair of the NSW Bone-Marrow Network
Dr Robert Wright	Director of Intensive Care Unit
Dr Steven Faux	Specialist rehabilitation physician
Dr Stephen Wilson	Director of Population Health Program
Diana Baird	Registered Nurse
Jillian Hathway	Social worker
Bernadette Crawford	Clinical Nurse Consultant
<b>1 May 2008 Prince of Wales Hospital</b>	
Phyllis Davis	Nursing Director of Operating Suite
Dr Robert Buist	VMO obstetrician
Mary-Anne O'Donnell	Director of the Kiloh Centre; psychiatrist
Dr Anthony Sara	President of NSW Branch and Vice-President of Federal Branch of Australian Salaried Medical Officers Federation
Antoinette Martin	Private citizen
Dr Philip Truskett	Chair of the College of Surgeons NSW; President of General Surgeons Australia; Member of the Safe Working Hours Working Party of the College of Surgeons
Janet Ogden	Registered Nurse (Ophthalmology)
Thomas Lim	Registered Nurse (Mental Health)
Barbara Daley	Senior Nurse Unit Manager (Accident & Emergency)
Dr Sally McCarthy	Director of Accident & Emergency
Prof Peter Maitz	Director of the Burns Unit
James Stormon	Physiotherapist
Prof Julian Bennett	Chairman of Medical Staff Council
Dr Danny Beran	Medical Director of the Eastern Suburbs Medical Service
Dr Yahya Shehabi	Co-director Medical for the Acute and Complex Community Clinical Service Program; Director of Intensive Care Services and Research
Dr James Mackie	Director of the Program of oncology, Emergency and Medicine
<b>7 May 2008 Broken Hill Base Hospital</b>	
Richard Western	Regional Director of the Maari Ma Aboriginal Health Corporation
Dr Denis Smith	Acting Director of Medical Services; Member of the NSW Medical Board
Captain Clyde Thompson	Executive Director of the Royal Flying Doctor Service, South-East Section
Pamela Tucker	Broken Hill Health Council
Dr Stephen Flecknoe-Brown	VMO physician
Lyndall Morris	Patient Safety and Clinical Quality Officer
<b>9 May 2008 Bourke Multi Purpose Service</b>	
Dianne Johnson	Private citizen

witnesses	position
Dr Merennege Salgado	Senior consultant in geriatrics
Anthony Cook	Area Trauma Nurse Coordinator
Dr Bob Fonesca	Director of Paediatrics
<b>15 May 2008</b>	<b>The Children's Hospital, Westmead</b>
Dr David Baines	Clinical Associate Professor and Head of the Department of Anaesthesia
Robert Vote	Private citizen
Dr David Dossetor	Area Director of Mental Health
Prof Andrew Kemp	Professor of Paediatric Allergy and Clinical Immunology
Dr Mary McCaskill	Head of Emergency Medical Services
Prof John Christodoulou	Director of Western Sydney Genetics Program
Dr Daniel Cass	Chief Executive Officer of the Institute of Trauma and Injury Management; Director of Trauma
Dr Susan Arbuckle	Chair of the Division of Diagnostic Services
Bradley Ceely	Nurse Practitioner (Intensive Care Unit)
Fiona Wade	Clinical Nurse Consultant (Neurology and Neurosurgery)
Dr George Margellis	Board Member for the Health Informatics Society of Australia
Prof Peter van Asperen	Head of the Department of Respiratory Medicine
Lyn Biviano	Manager of Social Work Services
Alison Jones	Head of the Occupational Therapy Department; Chair of Allied Health
<b>19 May 2008</b>	<b>Sydney Children's Hospital</b>
Dr Gina Watkins	Emergency physician
Jocelyn Holloway	Private citizen
Julia Batty	Physiotherapist
Dr Hannah Dahlen	Secretary of the NSW Midwives Association
Prof Sally Tracey	Professor of Women's Health, Nursing and Midwifery
Ann Stublely	Pharmacy Technician
Prof Gideon Caplan	Director of Post-Acute Care Services and Geriatric Medicine; President of the Hospital in the Home Society of NSW
Dr Nicholas Collins	Director of the Macarthur Ambulatory Care Service; Chair of the NSW Hospital in the Home Society's Conference Organising Committee
Dr Michael Brydon	Director of Clinical Operations
Prof Leslie White	Executive Director of Hospital
Margaret Holyday	Manager of Nutrition and Dietetics
Kylie Stark	Nurse Unit Manager of Accident & Emergency
Glenda Mullen	Nurse Practitioner (Accident & Emergency)
Dr Warwick Stening	Clinical Stream Director for Neuroscience, Spine and Rehabilitation; Chairman of the Department of Paediatric Neurosurgery
Dr Michael McGlynn	Chair of the Clinical Council; Chair of Clinical Strategy Group; Clinical Manager
<b>20 May 2008</b>	<b>Royal Prince Alfred Hospital</b>
Dr Paul Stalley	Clinical Director of Neuroscience and Bone Joint Trauma; Chairman of Operating Theatre Committee

witnesses	position
Mary-Louise Davis	Registered Nurse
Kelly Lienesch	Enrolled Nurse
Dr Heather Dalgety	VMO obstetrician
Judith Johnson	Chief Executive Officer of Bourke Aboriginal Health Service
Vera Honeyman	Acting Executive Assistant to the General Manager of Mitchell Cluster
Peter Tognetti	Manager of Ochre Health
Ellysa Brennan	Assistant Service and Operation Manager; Outback Eye Service
Dr Sally Torr	Health Service Manager
Stuart Gordon	Chief Executive Officer of the Outback Division of General Practice of NSW

**12 May 2008****John Hunter Hospital**

Melissa Lintott	Clinical Nurse Educator (Intensive Care)
Rachel Crook	Registered Nurse (Intensive Care)
Robin Keenan	Private citizen
Bruce Keenan	Private citizen
Susan McNeill	Clinical Nurse Consultant (Orthopaedic)
Lorraine Thomas	Private citizen
Dr David Williams	Chairman of the Medical Staff Council
Leanne Crittenden	Coordinator of the Northern Child Health Network
Wendy Goodman	Nurse Unit Manager (Orthopaedic)
Maxwell Stocker	Private citizen
Jennifer Stocker	Private citizen
Georgina Douglas	Private citizen
Dr Michael Pollack	Chairman of the Medical Staff Council
Katy Locock	Private citizen
Dianne Wells	Private citizen
Ellen Georgakopoulos	Private citizen
Kim Hill	Director of Clinical Governance
Fran Hodgson	Director of Social work for Greater Newcastle Acute Network
Dr David Logan	General oncological surgeon
Leonard Garrity	Representative of Bonells Bay Progress Association
Kathleen Cridland	Private citizen

**13 May 2008****Bankstown/ Lidcombe Hospital**

Lorraine Fitzgerald	President of Bankstown Branch of Nurses Association
Karen Fernance	Secretary of Bankstown Branch of Nurses Association

**14 May 2008****St George Hospital**

Jodie Bancroft	Trainee Enrolled Nurse
Julie Gibbs	Acting Manager of Staff Education
Lisa Metcalfe	Consumer representative on two midwifery practice steering committees
Caroline Shields	Registered Nurse (Surgery)
Prof Theresa Jacques	Director of the Intensive Care Unit

witnesses	position
Karen Bowen	Nursing Unit Manager (Neuroscience)
Rosemarie Lambert	Private citizen
Mark Lambert	Private citizen
Alan Gardo	Nurse Unit Manager (Intensive Care)
Dr Geoffrey White	Head of the Department of Vascular Surgery
Dr Richard Waugh	Head of the Department of Radiology
Karen Priest	Registered Nurse
<b>26 May 2008</b>	<b>Westmead Hospital</b>
Kathleen Dempsey	Clinical Nurse Consultant (Infection Control)
Kathleen Harrison	Network Director of Access and Patient Logistics
Claudia Graham	Social Worker
Sarah Mott	NSW State Director of the Australian College of Health Service Executives
Richard Baldwin	Registered Nurse
Eleanor Langley	Private citizen
Clarisa Vulas	Network Director of the Multicultural Health Network
Rosemary Douglas	Head of the Audiology Department
Jane Morley	Midwife
Julie-Anne Lahache	Registered Nurse and Midwife
Dr Elizabeth McCusker	Director of the Huntington's Disease Service
<b>29 May 2008</b>	<b>Witnesses by video link</b>
Frank Balwin	Hospital volunteer
Terry Sharples	Private citizen
Ronald Taylor	Private citizen
Wayne Russell	Private citizen
<b>30 May 2008</b>	<b>Witnesses by video link</b>
Justyn Cook	Quality and Safety Improvement Officer
Christopher Dolan	Clinical Nurse Specialist (Paediatric)
Dr Benjamin East	Representative of Hunter Resident Medical Officers Association; Resident Medical Officer, Post Graduate Year 2
Dr Ksenia Katyk	Representative of Hunter Resident Medical Officers Association; Resident Medical Officer, Post Graduate Year 2
Scott Wagner	Chair of the Area Health Advisory Council
Hazel Bridgett	Member of the Area Health Advisory Council
David Bowers	Hospital Volunteer
<b>13 June 2008</b>	<b>Other witnesses</b>
Dr Robert Gribble	Head of Consultation-Liaison Psychiatry Service
Alexandra Rivers	Vice-President of the Schizophrenia Fellowship of NSW

## Appendix 5 Meetings

No.	Date	Organisation and Attendees
1	29 January 2008	<b>NSW Minister for Health</b> <ul style="list-style-type: none"> <li>Reba Meagher MP</li> </ul> <b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> </ul>
2	5 February 2008	<b>Premier of NSW</b> <ul style="list-style-type: none"> <li>Morris Iemma MP</li> </ul>
3	7 February 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Deputy Directors-General</li> <li>Chief executives of area health services</li> </ul>
4	12 February 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Leanne O'Shannessy, Acting General Counsel</li> </ul>
5	12 February 2008	<b>Clinical Excellence Commission</b> <ul style="list-style-type: none"> <li>Prof Cliff Hughes, Chief Executive Officer</li> </ul>
6	19 February 2008	<b>NSW Opposition</b> <ul style="list-style-type: none"> <li>Barry O'Farrell MP, Leader of the NSW Liberal Party</li> <li>Greg Smith SC MP, Shadow Attorney General</li> </ul>
7	19 February 2008	Alan McCarroll
8	25 February 2008	<b>Health Care Complaints Commission</b> <ul style="list-style-type: none"> <li>Kieran Pehm, Commissioner</li> <li>Kim Swann, Executive Officer</li> </ul>
9	6 March 2008	Dr Peter Slezak, Physician, Hornsby & Ku-Ring-Gai Hospital
10	7 March 2008	<b>Greater Metropolitan Clinical Taskforce</b> <ul style="list-style-type: none"> <li>Prof Peter Castaldi, Chief Executive</li> <li>Dr Kate Needham, Executive Officer</li> </ul>
11	7 March 2008	Warren and Michelle Anderson
12	13 March 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Dr Richard Matthews, Deputy Director-General – Strategic Development</li> <li>Prof Katherine McGrath, Deputy Director-General, Health System Performance</li> <li>Karen Crawshaw, Deputy Director-General, Health Systems Support</li> <li>Ken Barker, Chief Financial Officer</li> <li>Mike Rillstone, Chief Information Officer</li> <li>Kathy Meleady, Director, Statewide Services Development</li> <li>David Gates, Director, Asset and Contract Services</li> <li>Prof Patrick Cregan, Chair, Surgical Services Taskforce</li> <li>Kelvin Genn, Director, Quality and Safety</li> </ul> <b>Sydney South West Area Health Service</b> <ul style="list-style-type: none"> <li>Michael Wallace, Chief Executive</li> </ul> <b>Clinical Excellence Commission</b> <ul style="list-style-type: none"> <li>Prof Cliff Hughes, Chief Executive Officer;</li> </ul>

No.	Date	Organisation and Attendees
		<b>NSW Ambulance Service</b> <ul style="list-style-type: none"> <li>• Greg Rochford, Chief Executive Officer</li> </ul> <b>South Eastern Sydney and Illawarra Area Health Service</b> <ul style="list-style-type: none"> <li>• Prof Denis King, Executive Clinical Director NSW Critical Care Council</li> <li>• Dr Tony O'Connell, Chairman</li> </ul>
13	14 March 2008	<b>National Health Service, U.K</b> <ul style="list-style-type: none"> <li>• Helen Bevan, Senior Specialist of Healthcare Delivery and Improvement</li> </ul>
14	31 March 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Prof Deborah Picone, Director-General</li> <li>• Dr Richard Matthews, Deputy Director-General – Strategic Development</li> <li>• Prof Katherine McGrath, Deputy Director-General, Health System Performance</li> <li>• Mike Rillstone, Chief Information Officer</li> <li>• David Gates, Chief Procurement Office, Health Systems Support</li> </ul> <b>NSW Ambulance Service</b> <ul style="list-style-type: none"> <li>• Greg Rochford, Chief Executive Officer</li> </ul>
15	1 April 2008	<b>Health Care Complaints Commission</b> <ul style="list-style-type: none"> <li>• Kieran Pehm, Commissioner</li> <li>• Kim Swan, Executive Officer</li> <li>• Sasha Shearman, Investigator</li> <li>• Detective Inspector Brett Coman</li> </ul>
16	3 April 2008	<b>NSW Institute of Medical Education and Training</b> <ul style="list-style-type: none"> <li>• Prof Mark Brown, Director</li> <li>• Assoc Prof Simon Willcock, Deputy Director</li> <li>• Dr Gregory Keogh, Deputy Director</li> </ul>
17	4 April 2008	Jim Murray
18	4 April 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Prof Deborah Picone, Director-General</li> <li>• Dr Richard Matthews, Deputy Director-General – Strategic Development</li> <li>• Karen Crawshaw, Deputy Director-General – Health Systems Support</li> <li>• Deborah Hyland, Director, Special Commission Response Unit</li> <li>• David Dixon, Acting Director, Workforce</li> <li>• Trevor Craft, Acting Director, Employee Relations</li> <li>• Prof Deborah Thoms, Chief Nursing and Midwifery Officer</li> <li>• Brenda McLeod, Chief Allied Health Officer</li> <li>• Dr Linda MacPherson, Medical Adviser, Workforce</li> </ul> <b>South-Western Sydney &amp; Illawarra Area Health Service</b> <ul style="list-style-type: none"> <li>• Terry Clout, Chief Executive</li> </ul> <b>Sydney South West Area Health Service</b> <ul style="list-style-type: none"> <li>• Prof Brian McCaughan, Clinical Associate Professor</li> </ul> <b>Institute of Medical Education and Training</b> <ul style="list-style-type: none"> <li>• Prof Mark Brown, General Manager</li> </ul> <b>Greater Metropolitan Clinical Taskforce</b> <ul style="list-style-type: none"> <li>• Prof Peter Castaldi, Chief Executive</li> </ul>
19	7 April 2008	Prof Carol Pollock, Chair of Medicine at Royal North Shore Hospital

No.	Date	Organisation and Attendees
20	7 April 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Katherine McGrath, Deputy Director-General, Health System Performance</li> </ul>
21	8 April 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Patrick Cregan, Chair, Surgical Services Taskforce</li> </ul>
22	9 April 2008	Neville Boyce
23	11 April 2008	<b>NSW Opposition</b> <ul style="list-style-type: none"> <li>Jillian Skinner MP, Opposition Spokesperson for Health</li> <li>James Rudder-Boland, Advisor to the Opposition Spokesperson for Health</li> </ul>
24	11 April 2008	<b>Department of Premier and Cabinet</b> <ul style="list-style-type: none"> <li>Graham Head, Deputy Director-General, Performance Review</li> </ul>
25	11 April 2008	<b>Australian Health Policy Institute</b> <ul style="list-style-type: none"> <li>Prof Steven Leeder, Director</li> <li>Dr Cathie Hull, Institute Associate</li> </ul>
26	21 April 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Dr Richard Matthews, Deputy Director-General, Strategic Development</li> <li>Ms Karen Crawshaw, Deputy Director-General, Health Systems Support</li> <li>Deborah Hyland, Director, Special Commission Response Unit</li> <li>Alan McCarroll</li> </ul> <b>South West Area Health Service</b> <ul style="list-style-type: none"> <li>Prof Steven Boyages, Chief Executive</li> </ul> <b>Northern Sydney Central Coast</b> <ul style="list-style-type: none"> <li>Matthew Daly, Chief Executive</li> </ul> <b>South Eastern Sydney and Illawarra Area Health Service</b> <ul style="list-style-type: none"> <li>Prof Denis King, Executive Clinical Director</li> </ul>
27	29 April 2008	John Greville
28	2 May 2008	<b>NSW Attorney-General, Minister for Justice, Minister for Industrial Relations, former Minister for Health</b> <ul style="list-style-type: none"> <li>John Hatzistergos MLC</li> </ul>
39	6 May 2008	Jana Horska and Mark Dreyer
30	6 May 2008	<b>Children's Hospital, Westmead</b> <ul style="list-style-type: none"> <li>Roger Corbett AM, Chairman of Advisory Committee</li> <li>Wendy Haigh, Director of Finances and Corporate Services</li> <li>Dr Ralph Hanson, Director, Information Services</li> </ul>
31	16 May 2008	<b>Smart Health Solutions</b> <ul style="list-style-type: none"> <li>Jon Hughes, Director</li> </ul>
32	22 May 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Dr Richard Matthews, Deputy Director-General – Strategic Development</li> <li>Karen Crawshaw, Deputy Director-General – Health Systems Support</li> <li>Prof Patrick Cregan, Chair, Surgical Services Taskforce</li> <li>Prof Donald MacLellan, State Director of Surgery</li> <li>Jane Gray, Senior Manager, Patient and Carer Experience Health Services Performance Improvement</li> </ul> <b>North Coast Area Health Service</b>



No.	Date	Organisation and Attendees
		<ul style="list-style-type: none"> <li>• Chris Crawford, Chief Executive Officer</li> </ul> <b>South East Sydney Illawarra Health Service</b> <ul style="list-style-type: none"> <li>• Terry Clout, Chief Executive Officer</li> </ul> <b>Clinical Excellence Commission</b> <ul style="list-style-type: none"> <li>• Prof Cliff Hughes, Chief Executive Officer</li> <li>• Prof Bruce Barraclough, Chair</li> </ul> <b>Sustainable Access Health Priority Taskforce</b> <ul style="list-style-type: none"> <li>• Dr Tony O'Connell, Acting Deputy Director-General, Health System Performance</li> </ul> <b>South Eastern Sydney and Illawarra Area Health Service</b> <ul style="list-style-type: none"> <li>• Prof Denis King, Executive Clinical Director</li> </ul>
33	22 May 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Prof Deborah Picone, NSW Health Director-General</li> <li>• Dr Richard Matthews, Deputy Director-General, Strategic Development</li> <li>• Karen Crawshaw, Deputy Director-General – Health Systems Support</li> <li>• Deborah Hyland, Director, Special Commission Response Unit</li> <li>• Jane Gray, Senior Manager, Patient and Carer Experience Health Services Performance Improvement</li> <li>• Chris Crawford, North Coast Area Health Service Chief Executive Officer</li> <li>• Dr Tony O'Connell, Acting Deputy Director-General, Health System Performance</li> <li>• Terry Clout, South West Sydney Illawarra Area Health Service Chief Executive Officer</li> <li>• Prof Cliff Hughes, Clinical Excellence Commission Chief Executive Officer</li> </ul>
34	23 May 2008	<b>Hospital Reform Group</b> <ul style="list-style-type: none"> <li>• Prof Kerry Goulston, Convenor</li> <li>• Prof Brad Frankum, Clinical Dean, University of Western Sydney</li> <li>• Dr Ross Kerridge, Anaesthetist and Peri-operative Specialist, John Hunter Hospital</li> <li>• Dr Clare Skinner, Emergency Medicine Trainee, Royal North Shore Hospital</li> </ul>
35	28 May 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Prof Deborah Picone, Director-General</li> <li>• Dr Richard Matthews, Deputy Director-General, Strategic Development</li> <li>• Deborah Hyland, Director, Special Commission Response Unit</li> <li>• Janet Anderson, Director, Inter-Governmental and Funding Scheme</li> </ul> <b>Department of Premier and Cabinet</b> <ul style="list-style-type: none"> <li>• Robyn Kruk, Director-General</li> </ul> <b>Greater Southern Area Health Service</b> <ul style="list-style-type: none"> <li>• Heather Gray, Chief Executive</li> </ul> <b>Sydney West Area Health Service</b> <ul style="list-style-type: none"> <li>• Michelle Bernardo, ACHSE Management Trainee, Westmead Hospital</li> <li>• Angela Barker, ACHSE Management Trainee, Napean Hospital</li> </ul> <b>Sydney South West Area Health Service</b> <ul style="list-style-type: none"> <li>• Mike Wallace, Chief Executive Officer</li> <li>• Tim Sinclair, Manager, Operational Initiatives</li> <li>• Paul Miles, Executive Officer to Director, Corporate Services</li> <li>• Lavena Ramdutt, Executive Officer to Chief Executive</li> </ul>

No.	Date	Organisation and Attendees
36	2 June 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Prof Deborah Picone, Director-General</li> <li>• Ms Karen Crawshaw, Deputy Director-General, Health Systems Support</li> <li>• Ken Barker, Chief Financial Officer</li> <li>• Deborah Hyland, Director, Special Commission Response Unit</li> </ul>
37	5 June 2008	<b>Sustainable Access Health Priority Taskforce</b> <ul style="list-style-type: none"> <li>• Brian McCaughan, Co-Chair</li> <li>• Dr Tony O'Connell, Acting Deputy Director-General, Health System Performance</li> <li>• Raj Verma, Acting Director, Health Services Performance Improvement</li> </ul>
38	13 June 2008	Dr Brian Pezzutti, Anaesthetist, Lismore Hospital
39	18 June 2008	<b>Avant Mutual Group Ltd</b> <ul style="list-style-type: none"> <li>• Helen Turnbull, Legal Manager, Disciplinary</li> </ul> <b>MDA National Insurance Pty Ltd</b> <ul style="list-style-type: none"> <li>• Deborah Jackson</li> <li>• Dr Sarah Bird, Medico-Legal Claims Manager</li> </ul> <b>Medico Legal Society of NSW</b> <ul style="list-style-type: none"> <li>• Dr Malcolm Stuart, Medical Vice President</li> </ul> <b>NSW Bar Association</b> <ul style="list-style-type: none"> <li>• Anna Katzman SC, President</li> <li>• Dr Helen Havryk</li> </ul>
40	23 June 2008	Dr Vasco de Carvalho, Medical Administrator
41	23 June 2008	<b>Australian Medical Association</b> <ul style="list-style-type: none"> <li>• Dr Fiona Davies, Chief Executive Officer NSW Branch</li> <li>• Dr Brian Morton, President NSW Branch</li> <li>• Dr Andrew Keegan, Immediate Past President NSW Branch</li> </ul> <b>Australian Salaried Medical Officers Federation</b> <ul style="list-style-type: none"> <li>• Sim Mead, Chief Executive Officer</li> <li>• Dr Tony Sara, President</li> </ul> <b>The University of Sydney</b> <ul style="list-style-type: none"> <li>• Dr John Buchanan</li> </ul>
42	23 June 2008	<b>Royal Australian and New Zealand College of Radiologists</b> <ul style="list-style-type: none"> <li>• Don Swinbourne, Chief Executive Officer</li> <li>• Lucy Cheetham, Director of Strategic Policy</li> </ul>
43	23 June 2008	<b>Mental Health Review Tribunal</b> <ul style="list-style-type: none"> <li>• The Hon Greg James QC, President</li> </ul>
44	24 June 2008	<b>Royal Australasian College of Physicians</b> <ul style="list-style-type: none"> <li>• Dr Greg Rowell, President</li> <li>• David Puls, Solicitor</li> </ul>
45	24 June 2008	<b>Australian and New Zealand College of Anaesthetists</b> <ul style="list-style-type: none"> <li>• Prof Barry Baker, Director of Professional Affairs</li> <li>• Dr Joanna Sutherland, Chairman of the NSW Region</li> <li>• John Biviano, Director of Policy</li> <li>• Dr Tracey Tay, Member of the NSW Committee and NSW Education Officer</li> </ul>
46	24 June 2008	<b>Australasian Society of Career Medical Officers</b> <ul style="list-style-type: none"> <li>• Dr Michael Boyd, President</li> </ul>

No.	Date	Organisation and Attendees
		<ul style="list-style-type: none"> <li>• Dr Mary Webber, Secretary</li> <li>• Dr Ross White, Industrial Officer</li> </ul>
47	25 June 2008	<b>Centre for Clinical Governance Research</b> <ul style="list-style-type: none"> <li>• Prof Jeffrey Braithwaite, Director</li> <li>• Dr Angus Corbett, Senior Law Lecturer, The University of New South Wales</li> </ul>
48	25 June 2008	<b>General Surgeons Australia</b> <ul style="list-style-type: none"> <li>• Dr Philip Truskett, President</li> </ul> <b>Royal Australasian College of Surgeons</b> <ul style="list-style-type: none"> <li>• Prof Ian Gough, President</li> <li>• Dr David Hillis, Chief Executive Officer</li> <li>• Dr Peter Holman, Chairman</li> <li>• Ms Lindley</li> <li>• Mr McAdam</li> </ul>
49	25 June 2008	<b>Royal Australasian and New Zealand College of Psychiatrists</b> <ul style="list-style-type: none"> <li>• Dr Adrian Keller, Chair</li> </ul>
50	26 June 2008	<b>NSW Medical Staff Executive Council</b> <ul style="list-style-type: none"> <li>• Prof Graham Stewart</li> <li>• Prof John Dwyer</li> </ul>
51	26 June 2008	<b>NSW Nurses Association</b> <ul style="list-style-type: none"> <li>• Brett Holmes, General Secretary</li> <li>• Bob Whyburn, Solicitor</li> </ul>
52	26 June 2008	<b>Royal College of Pathologists Australasia</b> <ul style="list-style-type: none"> <li>• Dr Deborah Graves, Chief Executive Officer</li> <li>• Dr Stephen Adelstein, NSW State Councillor</li> </ul>
53	27 June 2008	<b>Australasian College of Emergency Medicine</b> <ul style="list-style-type: none"> <li>• Dr Tony Joseph, Chair NSW Faculty</li> <li>• Dr Sally McCarthy, Vice President</li> </ul>
54	27 June 2008	<b>NSW Health, University of Technology, Sydney</b> <ul style="list-style-type: none"> <li>• Prof Mary Chiarella, Chief Nursing Officer of the Department of Health, Professor of Clinical Development Practice</li> </ul> <b>Hospital Reform Group</b> <ul style="list-style-type: none"> <li>• Prof Kerry Goulston, Convenor</li> </ul> <b>Greater Metropolitan Clinical Taskforce</b> <ul style="list-style-type: none"> <li>• Prof Peter Castaldi, Chairman</li> </ul>
55	27 June 2008	<b>Society of Hospital Pharmacists of Australia</b> <ul style="list-style-type: none"> <li>• Yvonne Allinson, Chief Executive Officer</li> <li>• Helen Dowling, Area Director of Pharmacy Services, Hunter New England Area Health Service</li> <li>• Alistair McDougall, Director of Pharmacy, St George Hospital and Community Health Services</li> <li>• Liz Perks, Pharmacy Board Member, NSW Therapeutic Advisory Group Inc</li> <li>• David Maxwell, Executive Officer</li> </ul>
56	27 June 2008	<ul style="list-style-type: none"> <li>• Assoc Prof Alan Rosen</li> <li>• Assoc Prof Roger Gurr</li> <li>• Assoc Prof Paul Fanning</li> </ul>
57	27 June 2008	<b>Rural Doctors Association, NSW</b> <ul style="list-style-type: none"> <li>• Dr Les Woollard, President</li> </ul>

No.	Date	Organisation and Attendees
58	1 July 2008	<b>NSW Institute of Medical Education and Training</b> <ul style="list-style-type: none"> <li>• Prof Mark Brown, Director</li> <li>• Dr Greg Keogh</li> <li>• Ms Louise Rice</li> </ul>
59	2 July 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Prof Deborah Picone, Director-General</li> <li>• Karen Crawshaw, Deputy Director-General, Health Systems Support</li> <li>• David McGrath, Acting Deputy Director-General, Strategic Development</li> <li>• Dr Tony O'Connell, Acting Deputy Director-General, Health System Performance</li> <li>• Dr Kerry Chant, Acting Deputy Director-General, Population Health</li> <li>• Deborah Hyland, Director, Special Commission Response Unit</li> <li>• Janet Anderson, Director, Intergovernmental Funding and Strategies Branch</li> <li>• Sarah Thackaway, Director, Centre for Epidemiology and Research</li> </ul> <b>Sydney West Area Health Service</b> <ul style="list-style-type: none"> <li>• Prof Steven Boyages, Chief Executive Officer</li> </ul>
60	2 July 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Prof Deborah Picone, Director-General</li> <li>• Karen Crawshaw, Deputy Director-General, Health Systems Support</li> </ul>
61	3 July 2008	<b>Independent Pricing and Regulatory Tribunal</b> <ul style="list-style-type: none"> <li>• Dr Michael Keating, Chairman</li> <li>• Alison Milne, Program Manager</li> <li>• Eric Groom, Principal Advisor</li> </ul>
62	3 July 2008	<b>Royal Australasian College of Physicians</b> <ul style="list-style-type: none"> <li>• Prof Geoffrey Metz, President</li> <li>• Prof John Kolbe, President Elect</li> <li>• Prof Kevin Forsyth, Dean</li> <li>• Dr Mel Miller, Chief Executive Officer</li> <li>• David Puls, Executive Officer to the Board and Chief Executive Officer</li> </ul>
63	4 July 2008	<b>Royal Australian College of General Practitioners</b> <ul style="list-style-type: none"> <li>• Assoc Prof Diana O'Halloran, Chair of the NSW and A.C.T Faculties</li> <li>• Richard Lawrence, State Manager</li> </ul>
64	11 July 2008	<b>The University of Sydney</b> <ul style="list-style-type: none"> <li>• Prof Kim Oates, Faculty of Medicine</li> </ul>
65	15 July 2008	<b>Greater Metropolitan Clinical Taskforce</b> <ul style="list-style-type: none"> <li>• Prof Peter Castaldi, Chairman</li> <li>• Dr Kate Needham, Executive Officer</li> </ul>
66	15 July 2008	Prof Judith Meppem, former Chief Nurse of NSW Health
67	15 July 2008	<b>Health Services Union</b> <ul style="list-style-type: none"> <li>• Dennis Ravlich, Manager Industrial Relations</li> <li>• Glenn Tyrrell, Industrial Officer</li> <li>• Karin Thompson, Junior Medical Officer, Professional Officer</li> </ul>
68	18 July 2008	<b>NSW Medical Staff Executive Council</b> <ul style="list-style-type: none"> <li>• Prof John Dwyer</li> <li>• Assoc Prof Graham Stewart</li> </ul>
69	25 July 2008	<b>Sydney Children's Hospital</b>

No.	Date	Organisation and Attendees
		<ul style="list-style-type: none"> <li>Prof Les White, Professor of Paediatrics, The University of New South Wales</li> </ul>
70	28 July 2008	<b>Kaleidoscope Hunter Children's Health Network, Hunter New England Area Health Service</b> <ul style="list-style-type: none"> <li>Prof Patricia Davidson, Area Director</li> </ul>
71	30 July 2008	<b>Clinical Excellence Commission</b> <ul style="list-style-type: none"> <li>Prof Cliff Hughes, Chief Executive Officer</li> <li>Dr Peter Kennedy</li> </ul>
72	31 July 2008	<b>The Children's Hospital, Westmead</b> <ul style="list-style-type: none"> <li>Dr Antonio Penna, Chief Executive Officer</li> </ul>
73	1 August 2008	<b>NSW Minister for Health</b> <ul style="list-style-type: none"> <li>Reba Meagher MP</li> </ul>
74	5 August 2008	<b>Department of Premier and Cabinet</b> <ul style="list-style-type: none"> <li>Graham Head, Chief Executive and Director of the Performance Review Unit.</li> </ul>
75	7 August 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Dr Richard Matthews, Deputy Director-General – Strategic Development</li> <li>Karen Crawshaw, Deputy Director-General – Health Systems Support</li> </ul>
76	11 August 2008	<b>NSW Minister for Health</b> <ul style="list-style-type: none"> <li>Reba Meagher MP</li> </ul>
77	12 August 2008	<b>College of Nursing</b> <ul style="list-style-type: none"> <li>Tracey Osmond, Chief Executive</li> <li>Prof Judith Meppem, former Chief Nurse of NSW Health</li> </ul>
78	13 August 2008	<b>Medical Deans of Australia and New Zealand</b> <ul style="list-style-type: none"> <li>Prof Bruce Robinson, Dean, Faculty of Medicine, The University of Sydney</li> <li>Prof Peter Smith, Dean, Faculty of Medicine, The University of New South Wales</li> <li>Prof Neville Yeomans, Foundation Dean of Medicine, University of Western Sydney</li> <li>Assoc Prof Victor Nossar, Associate Dean of Medicine, University of Notre Dame (Sydney)</li> </ul>
79	13 August 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Dr Elizabeth Murphy, Senior Clinical Advisor, Maternal and Child Health Unit</li> </ul>
80	19 August 2008	<b>University of Newcastle</b> <ul style="list-style-type: none"> <li>Prof Graham Vimpani, Head of Discipline of Paediatrics &amp; Child Health</li> </ul>
81	21 August 2008	<b>Clinical Excellence Commission</b> <ul style="list-style-type: none"> <li>Prof Cliff Hughes, Chief Executive Officer</li> <li>Dr Peter Kennedy, Deputy Chief Executive Officer</li> </ul>
82	1 September 2008	<b>Sax Institute</b> <ul style="list-style-type: none"> <li>Prof Sally Redman, Chief Executive Officer</li> <li>Deborah Frew, Director, Policy Impact Program</li> </ul>
83	2 September 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Prof Deborah Thoms, Chief Nursing and Midwifery Officer</li> <li>Deborah Hyland, Director, Special Commission Response Unit</li> </ul>

No.	Date	Organisation and Attendees
		<ul style="list-style-type: none"> <li>Sue Hawes, Project Manager, Nursing Unit Manager Project</li> <li>Anna Thornton, Project Manager, Nursing and Midwifery</li> </ul>
84	4 September 2008	<b>Greater Metropolitan Clinical Taskforce</b> <ul style="list-style-type: none"> <li>Prof Peter Castaldi, Chief Executive</li> </ul>
85	11 September 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Ronald Penny AO, Senior Clinical Advisor; Commissioner for National Health and Hospital Reform Commission; Co-Chair of Community Health Priority Task Force</li> </ul>
86	11 September 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Deborah Hyland, Director, Special Commission Response Unit</li> <li>Karen Crawshaw; Deputy Director-General – Health Systems Support</li> </ul> <b>Greater Southern Area Health Service</b> <ul style="list-style-type: none"> <li>Heather Gray, Chief Executive</li> </ul>
87	11 September 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Karen Crawshaw; Deputy Director-General – Health Systems Support</li> </ul>
88	18 September 2008	<b>Clinical Excellence Commission</b> <ul style="list-style-type: none"> <li>Prof Cliff Hughes, Chief Executive Officer</li> <li>Prof Bruce Barraclough, Chair</li> </ul>
89	19 September 2008	<b>NSW Treasury</b> <ul style="list-style-type: none"> <li>Philip Mussared, Deputy Secretary, Operations</li> <li>Mark Ronsisvalle, Deputy Secretary, Budget and Financial Management</li> <li>Caralee McLiesh, Deputy Secretary, Human and Social Services</li> <li>Joshua Shrubbs, Acting Director, Human Services</li> </ul>
90	22 September 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Dr Richard Matthews, Deputy Director-General – Strategic Development</li> <li>Karen Crawshaw, Deputy Director-General – Health Systems Support</li> <li>Deborah Hyland, Director, Special Commission Response Unit</li> <li>John Roach, Chief Executive, Health System Support</li> <li>Robert Lagaida, General Manager, Health System Support</li> <li>Carmen Rechbauer, Shared Business Services</li> </ul> <b>Hunter New England Area Health Service</b> <ul style="list-style-type: none"> <li>Dr Nigel Lyons, Chief Executive Officer</li> </ul>
91	23 September 2008	<b>Sax Institute</b> <ul style="list-style-type: none"> <li>Prof Sally Redman, Chief Executive Officer</li> <li>Dr Louisa Jorm, Director of Research</li> </ul>
92	24 September 2008	<b>NSW Minister for Health</b> <ul style="list-style-type: none"> <li>John Della Bosca MP</li> </ul>
93	25 September 2008	<b>University of Newcastle</b> <ul style="list-style-type: none"> <li>Prof Graham Vimpani, Head of Discipline of Paediatrics &amp; Child Health</li> </ul>
94	8 October 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>Prof Deborah Picone, Director-General</li> <li>Deborah Hyland, Director, Special Commission Response Unit</li> </ul> <b>Sydney South West Area Health Service</b> <ul style="list-style-type: none"> <li>Amanda Larkin, Acting General Manager for Clinical Council</li> </ul>

No.	Date	Organisation and Attendees
		<b>Concord Hospital</b> <ul style="list-style-type: none"> <li>• Sharne Hogan, Acting Director of Nursing, Concord Hospital</li> </ul>
95	15 October 2008	<b>Children's Hospital, Westmead</b> <ul style="list-style-type: none"> <li>• Dr Antonio Penna, Chief Executive</li> </ul>
96	20 October 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Prof Deborah Picone, Director-General</li> <li>• Karen Crawshaw, Deputy Director-General – Health Systems Support</li> </ul>
97	21 October 2008	<b>North Sydney Central Coast Area Health Service</b> <ul style="list-style-type: none"> <li>• Matthew Daly, Chief Executive</li> <li>• Dr Stephen Nolan, Chair, Manly Medical Staff Council</li> </ul>
98	22 October 2008	<b>Royal Australasian College of Physicians</b> <ul style="list-style-type: none"> <li>• Dr Mel Miller, Chief Executive Officer</li> <li>• Prof Kevin Forsyth, Dean</li> <li>• David Puls, Solicitor</li> </ul>
99	23 October 2008	<b>NSW Health</b> <ul style="list-style-type: none"> <li>• Mike Rillstone, Chief Information Officer</li> <li>• Dr Tim Smyth, Deputy Director-General, Performance</li> </ul>
100	24 October 2008	<b>Cancer Institute and NSW Health</b> <ul style="list-style-type: none"> <li>• Prof John Bishop, Chief Executive Officer</li> </ul>
101	27 October 2008	<b>Children's Hospital, Westmead</b> <ul style="list-style-type: none"> <li>• Dr Antonio Penna, Chief Executive</li> <li>• Dr Ralph Hanson, Director, Information Services</li> </ul>
102	4 November 2008	<b>Clinical Excellence Commission</b> <ul style="list-style-type: none"> <li>• Prof Clifford Hughes</li> </ul> <b>Greater Metropolitan Clinical Taskforce</b> <ul style="list-style-type: none"> <li>• Prof Carol Pollock</li> </ul>
103	13 November 2008	<b>Sydney South West Area Health Service</b> <ul style="list-style-type: none"> <li>• Assoc Prof Richard West</li> </ul>



## Appendix 6 Expert panels

### Experts Conference, 15 and 16 September 2008

Over two days, 15 and 16 September 2008, the Inquiry convened a conference of experts to consider issues relevant to the terms of reference in the Letters Patent.

The purpose of convening the conference was to ensure that the Inquiry was provided with independent expert opinion based on current international and interstate experience and practice.

Attendees at the conference were drawn from a pool of international, interstate and intrastate clinicians and academics.

#### List of Attendees

name	position
Professor Bruce Dowton	Vice President and Chief Operating Officer, Partners Harvard International, Boston, USA.
Dr Michael Walsh	Chief Executive, National Health Authority, Qatar.
Dr Bernard Lawless	Provincial Lead, Critical Care and Trauma, Critical Care Secretariat, Ontario, Canada.
Professor David Mayer	Associate Dean for Curriculum, University of Illinois, Chicago, USA.
Professor Charles Vincent	Clinical Research Division of Surgery, Imperial College, London, United Kingdom.
Professor Kim Sutherland	Co-author of "Quest for Quality", a ten year review of the United Kingdom National Health Service (NHS), Cambridge, United Kingdom.
Mr Mark Jones	Chief Nurse, Sector Capability & Innovation Directorate, Ministry of Health, Wellington, New Zealand.
Associate Professor Caroline Brand	Centre for Research Excellence in Patient Safety (CREPS), Monash University, Victoria.
Professor Phillip Della	Head of School of Nursing and Midwifery, Curtin University of Technology, Perth, Western Australia.
Mr Alan Kinkade	Group Chief Executive, Epworth HealthCare Board of Management, Melbourne, Victoria.
Professor Paddy Phillips	Chief Medical Officer, Adelaide, South Australia.
Mr Bill Bowtell	Director, Lowy Institute, Sydney, NSW.
Dr Ian Reinecke	Immediate past CEO of the Australian National E-Health Transition Authority, Sydney, NSW.
Professor Anne-Marie Feyer	Leader of PriceWaterhouseCoopers (PwC) National Health Practice, Sydney, NSW.
Emeritus Professor Kerry Goulston AO	Faculty of Medicine, University of Sydney, Sydney, NSW.
Professor Mary Chiarella	Professor of Nursing, University of Sydney, Sydney, NSW.
Professor Peter Castaldi	Immediate past CEO of NSW Greater Metropolitan Clinical Taskforce, Sydney, NSW.
Professor Bruce Barraclough	Chairman of the Board of the NSW Clinical Excellence

name	position
AO	Commission (CEC), Sydney, NSW.
Professor Carol Pollock	Professor of Medicine, University of Sydney; Chair of Medicine, Royal North Shore Hospital, Sydney, NSW.
Dr Greg Keogh	Deputy Director NSW Institute of Medical Education and Training (IMET), Sydney, NSW.
Professor Clifford Hughes AO	Chief Executive Officer of the NSW Clinical Excellence Commission (CEC), Sydney, NSW.
Mr Bruce James	CEO, Australia Division, Transfield Services Ltd, Sydney, NSW.

## Paediatric Experts Conference 29 September 2008

On 29 September 2008, the Inquiry convened a second conference of experts to consider issues relevant to the terms of reference in the Letters Patent, particularly as they related to the provision of health care to children and adolescents.

The purpose of the second conference was to obtain independent expert opinion based on current international and interstate experience and practice.

As with the first conference, conference attendees were drawn from a pool of international, interstate and intrastate clinicians and academics.

### List of Attendees

name	position
Dr Phillip Crowley	Deputy Chief Medical Officer, Department of Health and Children, Dublin, Republic of Ireland.
Dr Emma Curtis	Clinical Director of the National Paediatric Hospital Development, Dublin, Republic of Ireland.
Professor Charles Irwin	Professor and Vice Chairman of Paediatrics; Director, Division of Adolescent Medicine, University of California, San Francisco, California, United States of America.
Professor Alan Isles	Acting CEO, Queensland Child Health Services District, Brisbane, Queensland.
Professor Les White	CEO, Sydney Children's Hospital, Randwick, NSW.
Dr Ralph Hanson	Acting Chief Executive and Executive Director, Information Services and Planning, Children's Hospital Westmead, NSW.
Professor Patricia Davidson	Area Director, Kaleidoscope, Hunter Children's Health Network, Newcastle, NSW.
Professor Graham Vimpani	Head of Paediatrics and Child Health, University of Newcastle; Co-Chair, Children & Young Peoples Health Priority Taskforce, NSW.
Gail Furness	Barrister and Counsel Assisting the Special Commission of Inquiry into Child Protection Services, NSW.
Dr Elisabeth Murphy	Clinical Consultant, Primary Health and Community Partnerships, NSW Department of Health, Sydney, NSW.
Professor Kay Wilhelm AM, MD, FRANZCP	Conjoint Professor, University of NSW, Director, Consultant Liaison Psychiatry Services, Sydney, NSW.
Dr Jackie Andrews	Paediatrician, Member of NSW Children & Young People's Health Priority Taskforce, Lismore, NSW.
Dr Andrew Berry	State Director, Newborn and Paediatric Emergency Transport

name	position
Professor Jonathon Gillis	Service, Westmead, NSW. Clinical Associate Professor, Paediatrics & Child Health, Children's Hospital, Westmead, NSW.
Dr Robyn Rosina	Clinical Director, Adolescent Health & Research, Justice Health, NSW.
Kylie Stark	Nurse Unit Manager, Paediatric Emergency Department, Sydney Children's Hospital, Randwick, NSW



## Appendix 7 Feedback Forums

### Participants in Feedback Forum with chief executives and senior NSW Health representatives

name	position	agency
Dave Hodge	General Manager, Clinical Development	NSW Ambulance Service
Greg Rochford	Chief executive	NSW Ambulance Service
Prof Clifford Hughes	Chief executive	Clinical Excellence Commission
Dr Peter Kennedy	Deputy chief executive	Clinical Excellence Commission
Roger Corbett	Chair, Health Advisory Board	Children's Hospital, Westmead
Dr Anthony Penna	Chief executive	Children's Hospital, Westmead
Prof James Bishop	Chief Health Officer and Deputy Director-General, Population Health	NSW Health
Trish Strachan	Director Population Health	NSW Health
Leanne O'Shannessy	General Counsel	NSW Health
Tony Dunn	Acting Deputy Director-General - Health System Performance	NSW Health
Dr Tim Smythe	Deputy Director General – Health System Performance	NSW Health
Deborah Hyland	Director, Special Commission Response Unit	NSW Health
Dr Richard Matthews	Deputy Director-General Strategic Development	NSW Health
Dr Greg Fulcher	Acting chief executive	Greater Metropolitan Clinical Taskforce
Dr Heather Gray	Chief executive	Greater Southern Area Health Service
Dr Ian Stewart	Chair, Area Health Advisory Council	Greater Southern Area Health Service
Dr Steve Flecknoe-Brown	Chair, Area Health Advisory Council	Greater Western Area Health Service
Dr Nigel Lyons	Chief Executive	Hunter New England Area Health Service
John Roach	Chief Executive	Health Support Services, NSW Health
Prof Mark Brown	Director	NSW Institute of Medical Education and Training
Julie Babineau	Chief Executive	Justice Health
Neil Wykes	Acting Chairperson, Justice Health Board	Justice Health
Dr Hazel Bridgett	Acting Chair, Area Health Advisory Council	North Coast Area Health Service
Chris Crawford	Chief Executive	North Coast Area Health Service
Matthew Daly	Chief Executive	Northern Sydney / Central Coast Area Health Service
Prof Malcolm Fisher	Executive Director Networks Staff Specialist Intensive Care Royal North	Northern Sydney / Central Coast


<b>name</b>	<b>position</b>	<b>agency</b>
	Shore Hospital	Area Health Service
Elizabeth Koff	Acting chief executive	South Eastern Sydney / Illawarra Area Health Service
Dr Denis King	Executive Clinical Director	South Eastern Sydney / Illawarra Area Health Service
Mike Wallace	Chief executive	Sydney South West Area Health Service
Assoc Prof Jeremy Wilson	Chair, Area Health Advisory Council	Sydney South West Area Health Service
Prof Steven Boyages	Chief executive	Sydney West Area Health Service
Rhonda Loftus	Assistant Director Clinical Operations	Sydney West Area Health Service

### Participants in Feedback Forum with frontline staff

<b>name</b>	<b>position</b>	<b>agency</b>
Sue Cruttenden	Paramedic	NSW Ambulance Service
Stephen Flanagan	Paramedic	NSW Ambulance Service
Sue Kanne	Paramedic	NSW Ambulance Service
Dr Ron Manning	Director, Aeromedical Unit	NSW Ambulance Service
Bradley Ceeley	Nurse	Children's Hospital, Westmead
Dr Deepak Gill	Department Head, Neurology	Children's Hospital, Westmead
Alison Jones	Chair, Allied Health	Children's Hospital, Westmead
Renata Kaldor	Children's Health Advisory Council	Children's Hospital, Westmead
Joanne Hoarty	Senior Project Officer, Special Commission Response Unit	NSW Health
Deborah Hyland	Director, Special Commission Response Unit	NSW Health
Kelly Benstead	Ward Clerk, Theatre Administrative Support, Albury Base Hospital	Greater Southern Area Health Service
Fay Campbell	Community Representative, Area Health Advisory Council	Greater Southern Area Health Service
Melinda Hewitt	Speech Pathologist, Wagga Wagga Base Hospital	Greater Southern Area Health Service
Megan King	Perioperative Nurse Manager	Greater Southern Area Health Service
Dr Patricia Saccassan Whelan	Director of Emergency, Goulburn Base Hospital	Greater Southern Area Health Service
Vicky Conyers	Clinical Nurse Consultant, Critical Care, Orange Base Hospital	Greater Western Area Health Service
Elizabeth Scott	Acting Dietetics Advisor	Greater Western Area Health Service
Dallas Balley	Clinical Nurse Specialist & Cardiothoracic Database Manager	Hunter New England Area Health Service
Damien Jackel	Registrar, Division of Medicine	Hunter New England Area Health Service
Dr Michael Pollack	Rehabilitation Medical Officer	Hunter New England Area Health Service
Kerrie Kelly	Administrative Coordinator, John Hunter Hospital	Hunter New England Area Health Service

<b>name</b>	<b>position</b>	<b>agency</b>
Phil Webster	Community Representative, Area Health Advisory Council	Hunter New England Area Health Service
Michael Bazaley	Allied Health Manager, Forensic & Prison Hospital Project	Justice Health
Kristie Brown	Council of Social Service of NSW	Justice Health
Cain Byrnes	Nurse Unit Manager, Dillwynia Correctional Centre	Justice Health
Dr Stephen Hampton	Children's Health Advisory Council	Justice Health
Catherine Walsh	Administration Officer, Governance Unit	Justice Health
Dr Hazel Bridgett	Acting Chair, Area Health Advisory Council	North Coast Area Health Service
Dr William Lancashire	Director, Intensive Care, Port Macquarie Base Hospital	North Coast Area Health Service
Jane Ramsay	Transitional Nurse Practitioner, Accident & Emergency, Lismore Base Hospital	North Coast Area Health Service
Jacqui Riding	Administrative Officer	North Coast Area Health Service
Dr Magdalen Campbell	GP Representative, Area Health Advisory Council	Northern Sydney / Central Coast Area Health Service
Kelly Cridland	Nurse Unit Manager, Intensive Care, Gosford Hospital	Northern Sydney / Central Coast Area Health Service
Juliette Papadopolas	Administration Officer, Royal North Shore Hospital	Northern Sydney / Central Coast Area Health Service
Dr Raymond Raper	Intensive Care Director	Northern Sydney / Central Coast Area Health Service
Robyn Bignell	Community Representative, Area Health Advisory Council	South Eastern Sydney / Illawarra Area Health Service
Deidre Kennedy	Executive Assistant to General Manager, Northern Hospital Network	South Eastern Sydney / Illawarra Area Health Service
Marianna Milosavljevic	Dietician	South Eastern Sydney / Illawarra Area Health Service
Dr David Murphy	Registrar, Prince of Wales Hospital, Accident & Emergency	South Eastern Sydney / Illawarra Area Health Service
Rhonda Wainwright	Registered Nurse, Accident & Emergency, Sydney Hospital	South Eastern Sydney / Illawarra Area Health Service
Dr Ruchir Chavada	Senior Medical Registrar, Gastro	Sydney South West Area Health Service
Belinda Hubbard	Nurse Unit Manager, Surgical Ward, Liverpool Hospital	Sydney South West Area Health Service
Adriana Navarro	Area Health Advisory Council	Sydney South West Area Health Service
Tim Sinclair	Administration: operational initiatives	Sydney South West Area Health Service
Lisa Spencer	Pulmonary Rehabilitation Physiotherapist, Royal Prince Alfred Hospital	Sydney South West Area Health Service
Dr Gary Cheuk	Chair of the Blue Mountains District Hospital Medical Staff Council	Sydney West Area Health Service



 Appendix 7 Feedback Forums

name	position	agency
James Nol	Chief Radiographer	Sydney West Area Health Service

## Appendix 8 Shellharbour Hospital inquiry

- 1.1 I received evidence during a public hearing of the Inquiry at Wollongong Hospital on 14 April 2008 about the creation and operation of a so-called ‘virtual ward’ at Shellharbour Hospital<sup>1</sup>. When a patient was expected to stay more than 8 hours in the Emergency Department, the patient was reclassified as being in an inpatient bed, although he or she remained in the same bed in the Emergency Department under the care of the same clinicians. I was told that this initiative was developed in an effort to meet the access block benchmark for the purpose of the key performance indicator.
- 1.2 Two months after receiving evidence about ‘virtual ward’, I received a submission from Dr Simon Leslie, the doctor who had given that evidence, to the effect that he had been removed from his position at Shellharbour Hospital and the virtual ward had been disbanded<sup>2</sup>. He also informed the Inquiry that since that time, the area health service had taken steps to meet the access block benchmarks, including by increasing staffing levels in the Emergency Department and directing the closure of 3 beds where adequate nursing staff could not be guaranteed.
- 1.3 The Inquiry thoroughly investigated these issues as they are relevant to systemic issues affecting the delivery of acute care services about which the Inquiry received a large number of submissions, namely:
- access block,
  - KPIs applied to the Emergency Department, including the utility and manipulation of same,
  - models of care used in the Emergency Department to deal with overcrowding, and
  - the divide between clinicians and management.
- 1.4 The Inquiry summonsed documents from the South Eastern Sydney and Illawarra Area Health Service relating to the creation and operation of a clinical decisions unit or virtual ward, however named, between 2006 and 2008 and obtained sworn evidence from the following witnesses:
- Dr Simon Leslie, emergency physician, Shellharbour Hospital;
  - Ms Sue Browbank, General Manager, Southern Hospital Networks;
  - Mr Michael Brodnik, who was Site Manager at Shellharbour Hospital in 2006;
  - Mr Frank Testa, nurse unit manager, Shellharbour Hospital emergency department;
  - Dr Raghu Murthy, Director of Clinical Services;
  - Professor Debora Picone AM who was the Chief Executive of the South Eastern Sydney and Illawarra Area Health Service..
- 1.5 I set out below the inquiry into the use of a ‘virtual ward’ at Shellharbour Hospital and my findings. I also set out below my findings concerning Dr Leslie’s complaint about events occurring after he gave evidence to the Inquiry.
- The Virtual ward concept*
- 1.6 At 2:24pm on Friday 28 April 2006, Michael Brodnik circulated an email to staff at Shellharbour Hospital notifying them about a decision made that day to immediately set up a Clinical Decision Unit (**CDU**), comprising 4 beds “conceptually down the right hand wall of ED but using the concept of ‘virtual beds’.” Mr Brodnik noted<sup>3</sup>:

"A decision has been made today (area) to set up an Emergency Medical type unit (EMU) in the Shellharbour Emergency Department today.

This unit will be called the CDUS - Clinical Decision Unit- Shellharbour and will be four beds, conceptually down the right hand wall of ED but using the concept of 'virtual beds'.

At the moment, the concept is that patients will present to the Emergency Department as usual and go through the same process as usual, If the patient is then identified as admission and cannot be transferred eg for monitored bed they will be admitted to this unit.

It has been made clear that this 'unit' is required to be set up this afternoon. I appreciate that this is not the best way to look at the implementation of a new system / structure but we have not been given a choice unfortunately.

In saying this, it really is a paper exercise at this and I would appreciate if we could give it a go over the weekend and document all the concerns/problems you may have. There should be no increase in workload in the ED due to this change and if we are pushed we will use our normal demand management strategies. The actual 'unit' has been set up and ready to go, IT/system wise (not EDIS at this stage). I would appreciate if the SNM over the weekend can review all patients at the 7 hour mark, as we do now, and if we have any for admission - with nowhere to go - they are 'discharged' off EDIS - admitted CDUS.

The aim identified is that there is to be no one going into access block over the weekend."

- 1.7 On the same day, Shellharbour Hospital's Nurse Unit Manager, Frank Testa, made comments about the setting up of the CDU in the emergency department communications book next to a copy of Mr Brodrik's email. Mr Testa used that book to communicate policy changes and important information to staff<sup>4</sup>. His comments included as follows<sup>5</sup>:

"This is a strategy that has been directed from Area executive for immediate implementation.

This is to address Access Block.

Effectively, nothing changes in the way that we see/treat patients. What we have to do is to be more conscious re patient's plans of care - if no bed is available, then they are admitted (on paper) to the CDU while they await a ward bed WITHIN 8 HOURS OF TIME SEEN. If a patient is going to stay in ED for a period greater than 8 hours undiagnosed or no definite decision to admit or discharge, then these should be transferred to the CDU as soon as identified."

- 1.8 Mr Testa's message set out a table to be completed for all patients admitted to the CDU, noting that it would be collected on Monday for Mr Brodrik. That table gave instructions to staff to "include:

"1. all admissions to SHH...awaiting inpatient bed availability

2. All ED overnight stays for morning review by ED doctor or medical registrar review exceeding 8 hrs from time seen

3. All long ED stays ("short stay admissions") for Diagnostics and/or Blood results exceeding 8 hrs after ED time seen, eg. Awaiting 2<sup>nd</sup> troponin results"

- 1.9 Mr Brodnik gave evidence that at the time he sent his email directing that the unit be set up, no final decision had been made about the admission criteria or how the unit would operate in detail<sup>6</sup>. He said that the unit was set up because a substantial number of patients were remaining in the emergency department for longer than 8 hours for the reason that they required further clinical review. No decision could yet be made about the care of those patients, namely, whether to discharge them or admit them to an inpatient bed, and the unit was set up with the idea of "capturing that group"<sup>7</sup>. Mr Brodnik said that he was given authority by Ms Browbank to determine the admission criteria and that he spent the following 4 weeks, together with others, looking at different models for optimising the operation of the 'unit'<sup>8</sup>. I outline below how this progressed. However, firstly it is necessary to explain the background to Mr Brodnik's direction of 28 April 2006.

*Background to creation of virtual ward*

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- 1.10 Mr Brodnik gave evidence that access block at Shellharbour Hospital had been problematic during most of 2006<sup>9</sup>. One of the factors contributing to access block at Shellharbour Hospital was that the hospital did not have timely access to some diagnostic services and relied on Wollongong Hospital for assistance<sup>10</sup>. This meant that there was an inevitable delay in the work-up and treatment of patients in the emergency department at Shellharbour Hospital who needed to be transported to Wollongong Hospital for those diagnostic services and then returned to Shellharbour Hospital<sup>11</sup>.
- 1.11 Ms Browbank, who was the General Manager of the Southern Hospitals Network which included Shellharbour Hospital and Wollongong Hospital among others, also gave evidence that Shellharbour Hospital's access block figures were of particular concern. She said that<sup>12</sup>:
- "There was a clinical redesign program taking place statewide. The basis of that Clinical Services Redesign Program was improving patient journeys and it was very much data driven. So people actually started to go back and look at what was the data relating to not only emergency departments, but theatre and weighted times, a whole range of KPIs, and Shellharbour just didn't make sense as to what was happening there."
- 1.12 An 'access and performance' meeting took place on or about 17 March 2006 at which Ms Browbank indicated to Mr Brodnik that access block at Shellharbour Hospital needed to be reduced to 20% by June 2006. This was confirmed in an email to Mr Brodnik, who forwarded it to the nursing unit manager of the emergency department, Mr Testa, on 10 April 2006<sup>13</sup>. Mr Testa gave evidence that at this stage the access block figures at Shellharbour emergency department were consistently high and above the benchmark required by NSW Health<sup>14</sup>.
- 1.13 On or about 27 April 2006, the Chief Executive of the area health service, who at that time was Professor Debora Picone, requested Ms Browbank, and the general managers of the other hospital networks within the area health service, to make a presentation at an upcoming area executive meeting (of 9 May 2006) on the strategies to be adopted by the general managers for addressing the anticipated increased demand on Emergency Departments and the hospitals generally during winter<sup>15</sup>.
- 1.14 On the same day, Ms Browbank attended a meeting by teleconference with senior officers from NSW Health, including Katherine McGrath, regarding the Sustainable

Access Program. During the course of that meeting, Ms Browbank sent an email to Mr Brodnik to the effect that she was getting “very bad vibes regarding access block” at Shellharbour Hospital and wanted “strategies to get patients out of EDs and daily measures of access”<sup>16</sup>.

- 1.15 On 28 April 2008, a meeting took place between Ms Browbank and Mr Brodnik for the purpose of discussing the management of access block at Shellharbour Hospital<sup>17</sup>. It appears that that meeting took place by telephone<sup>18</sup>.
- 1.16 Mr Brodnik gave evidence that he had conducted some research about strategies used in other hospitals to improve access block and that he presented these to Ms Browbank. Mr Brodnik’s recollection is that Ms Browbank told him that the strategies he had developed were not good enough and directed him to set up a virtual ward in the emergency department<sup>19</sup>.
- 1.17 While Ms Browbank did not initially recall that meeting during her evidence before the Inquiry<sup>20</sup>, she said later in her evidence that the strategies that Mr Brodnik came up with were not satisfactory<sup>21</sup>. Ms Browbank agreed that on 28 April 2006 Mr Brodnik did not bring to her for approval the concept of a unit within the emergency department of the kind described in his email to staff on the afternoon of 28 April 2006. Ms Browbank agreed that on 28 April 2006 she told Mr Brodnik to set up a 4-bed unit within the emergency department but did not agree that she indicated to him that it would only be “a paper exercise”<sup>22</sup>.
- 1.18 In written submissions to the Inquiry following her testimony, Ms Browbank said that her meeting with Mr Brodnik of 28 April 2006 covered many issues related to the management and performance of Shellharbour Hospital, in particular the strategies and findings arising from the Clinical Services Redesign Program as part of the NSW Health Sustainable Access Program. She said that there was no definitive solution directed to Mr Brodnik and that “he was provided with principles, direction as to the mechanisms that it would be necessary to invoke to record and document changes, and reminded of the necessity for local consultation and negotiation regarding the model”<sup>23</sup>.
- 1.19 At 2:24pm that day Mr Brodnik sent his email to staff (set out above) informing them of the decision to set up the CDU using the concept of “virtual beds”. Later that day, Mr Brodnik forwarded to Ms Browbank an email in which he confirmed that the CDU had been opened<sup>24</sup>. He explained that it would be:
- “four beds conceptually down the right hand wall of ED.”
- 1.20 He referred to some difficulties with the Emergency Department Information System (EDIS) which he anticipated, which entailed a process “to retrospectively discharge out of EDIS and into unit on Monday”. Ms Browbank replied in an email to the effect: “hopefully this will assist in alleviating some of the problems”<sup>25</sup>. Ms Browbank gave evidence that in providing that reply, she was referring partly to the problems with the access block key performance indicator and partly to improving access for patients who required monitored beds<sup>26</sup>.
- 1.21 Ms Browbank gave evidence that there were specific problems at Shellharbour Hospital regarding access block which primarily concerned monitored patients<sup>27</sup>. She said that the emergency department was the only area, outside the Special Care Unit, that had the physical resources, both in terms of equipment and staff, to manage patients requiring cardiac monitoring<sup>28</sup>. She said that the lack of monitored beds in the inpatient wards was one of the primary reasons patients remained in the emergency department for more than 8 hours and became ‘access blocked’. The ‘virtual ward’ was, she said, a way of declaring monitored patients to be admitted patients because they had no option

but to remain in the emergency department. Ms Browbank asserted that the purpose was to improve patient safety and quality of care because, upon 'admission' to the virtual ward, the patients would be cared for by an inpatient team. Ms Browbank's position was that 4 of the beds in the emergency department were being reclassified as monitored inpatient beds<sup>29</sup>.

- 1.22 In her written submissions, Ms Browbank said that this system was appropriate because Shellharbour Hospital's emergency department had excess capacity in 2006 in terms of available bed spaces. She provided the Inquiry with the number of total presentations to Shellharbour's emergency department in the 2005/2006 and 2006/2007 years (21,341 and 22,833 respectively) which she said were below the projections for those years (of 22,636 and 24,345). Ms Browbank said that capacity existed in the emergency department to create a maximum of 4 inpatient beds and that she put this to Mr Brodnik<sup>30</sup>. She said that the essence of the proposed model was the requirement that care be provided by the inpatient team (although the beds were located in the emergency department) and that patients suitable for admission were those requiring monitoring<sup>31</sup>.
- 1.23 I do not accept Ms Browbank's explanation about the rationale for the creation of the virtual ward. While there is evidence to support her position that one of the causes of access block in Shellharbour Hospital in 2006 was the insufficient number of monitored beds (as to which, see below), I do not accept that this was the clinical basis for the decision to institute a 'virtual ward'. Indeed, I do not consider that there was any clinical justification for the virtual ward. Based on the evidence received by the Inquiry, it is quite clear to me that it was a clerical exercise the sole purpose of which was to improve key performance indicator outcomes for access block.
- 1.24 Ms Browbank did not refer to the need to accommodate monitored patients in her emails to Mr Brodnik on either 27 or 28 April 2006 referred to above. The only comment made in her email of 27 April 2006 was that strategies for improving the hospital's performance against the key performance indicator for access block had to be developed. Nor is there any mention, in the email from Mr Brodnik to Ms Browbank on 28 April 2006 confirming the creation of the new 'unit', of a requirement that the beds in the new unit be monitored beds. Nor is it said in that contemporaneous documentation that the unit would consist of 4 designated beds that would be reclassified as inpatient beds. I also take into account that when Mr Brodnik advised Ms Browbank that the beds were conceptually down the right-hand side of the wall in the emergency department, her reply was: "hopefully this will assist in alleviating some of the problems".
- 1.25 Although Ms Browbank gave evidence that the monitored beds were in fact down the right hand wall of the emergency department<sup>32</sup>, she admitted, upon further questioning, that patients other than those requiring monitoring would be 'admitted' to this 'unit'<sup>33</sup>. I found Ms Browbank's answers to be obfuscatory and I reject her evidence that the ward was created to accommodate patients requiring monitoring, for reasons further set out below.
- 1.26 I accept the possibility that Ms Browbank contemplated that the unit may consist of designated beds in the emergency bed. However, I do not accept her explanation that she directed Mr Brodnik to use 4 beds in the emergency department as inpatient beds for the care of cardiology patients under an inpatient team<sup>34</sup>. I find that she directed Mr Brodnik to implement a unit using emergency department beds to which patients would be notionally transferred before reaching the 8 hour mark for the sole purpose of complying with the access block key performance indicator.

*Implementation of the ward*

- 1.27 Mr Brodnik said that there was to be a trial period of about 4 weeks to determine what the most appropriate admission criteria would be and how the ward could operate in practice. He said that Ms Browbank gave him authority to determine the admission criteria. Mr Brodnik gave evidence that he was concerned to ensure that a change in practices did not cause any adverse change to patient care<sup>35</sup>.
- 1.28 Mr Brodnik said that on or about 1 May 2006 he undertook a statistical analysis of the reasons patients were experiencing access block at Shellharbour Hospital<sup>36</sup>. He found that a substantial number of patients remained in the emergency department for more than 8 hours because they required further clinical review.
- 1.29 On Monday, 1 May 2006, Mr Brodnik circulated his statistical analysis to Shellharbour Hospital staff including Dr Leslie<sup>37</sup>. In that document, he suggested that based on his analysis, the patients who would be appropriate for admission to the Clinical Decision Unit were those who were likely to be admitted to the hospital as inpatients but for whom confirmation of admission was not yet possible, due to the need to continue clinical investigations. Mr Brodnik's analysis also shows that one of the reasons patients experienced access block at Shellharbour Hospital was the lack of available monitored beds at the time of admission. However, he decided to exclude that category of patient, and certain other categories, from the admission criteria at that stage.
- 1.30 Mr Testa gave evidence that he was concerned from the outset that the strategy was a "figure fudging" exercise to address statistics and that it "effectively changed nothing in the way we treat or see patients"<sup>38</sup>. Mr Testa gave evidence that he met with Mr Brodnik and clinicians on 1 May 2006 and that it was agreed that the unit should not be used solely as a device to improve access block statistics. He said that it was agreed that patients who were expected to spend a long time in the emergency department (because, for example, the hospital did not have timely access to diagnostic services) would be 'admitted' to this unit. He said that this was an attempt to give the model some legitimate clinical basis<sup>39</sup>.
- 1.31 On 5 May 2006, a meeting took place with staff at Shellharbour at which Mr Brodnik conveyed to Ms Browbank his research and analysis in relation to the unit. During the course of that meeting, Mr Brodnik explained that it was not proposed to admit to the unit patients who became access blocked by reason of an absence of monitored beds<sup>40</sup>.
- 1.32 In my view, this makes it very unlikely that Ms Browbank made it plain to Mr Brodnik in her initial instructions to him on 28 April 2006, as she asserted in her evidence, that the main purpose of the new unit was to accommodate patients requiring monitored beds. This was precisely the category of patient that was excluded from Mr Brodnik's admission criteria on or around 5 May 2006<sup>41</sup>.
- 1.33 Ms Browbank's evidence was that staff at Shellharbour Hospital were making the decisions about which patients to admit to the virtual ward. She said that she was unaware that the admission criteria was changing from time to time<sup>42</sup>. I consider it very unlikely that the staff would have changed the admission criteria so often if Ms Browbank had clearly communicated to them that the ward was intended primarily or solely for patients requiring monitored beds or that it involved a once and for all transformation of emergency beds to inpatient beds, as Ms Browbank contended. Ms Browbank put forward both of these arguments. The evidence supports the conclusion that Ms Browbank directed Mr Brodnik to implement a unit using 4 emergency department beds to which patients would be transferred before reaching the 8 hour mark for the sole purpose of complying with the access block key performance indicator.



*Area Executive meeting*

- 1.34 On 9 May 2006, an executive meeting of the area health service took place at which Ms Browbank made a presentation about the creation of an Emergency Medical Unit (**EMU**) at Shellharbour Hospital to deal with increased patient demand during the winter season. This was a reference to the 4 bed 'unit' in Shellharbour's emergency department<sup>43</sup>.
- 1.35 Ms Browbank testified that while she explained to those present at the meeting, including the Chief Executive Ms Picone, that patients admitted to the EMU would be admitted "under team in ED" as set out in her PowerPoint presentation, she was referring to the proposal that patients be admitted to the EMU under an inpatient team, rather than under the care of emergency department staff<sup>44</sup>. That is not clear to me from merely looking at the presentation.
- 1.36 In her evidence to the Inquiry, Ms Browbank acknowledged that although she referred to an "EMU" in her presentation, the features which typically apply to an EMU did not apply to the ward proposed for Shellharbour Hospital.
- 1.37 A typical EMU is a separate or self-contained area within the emergency department, with its own dedicated team of emergency department clinicians and funding, to which patients with an expected length of stay of less than 24 hours (or sometimes up to 48 hours) are admitted. Ms Browbank said that participants at the meeting understood that Shellharbour Hospital would not have a ward of that kind. She said that EMU may not have been the right term<sup>45</sup>. Instead, she said, she was reducing the number of beds in the emergency department from 15 to 11 on the basis that 4 beds would be used as inpatient beds<sup>46</sup>. She said that participants at the meeting understood this<sup>47</sup>. There is no mention in her presentation of the beds being intended for monitored patients.
- 1.38 Accepting Ms Browbank's recollection of what she told the senior executives of the area health service, the contents of this presentation contradict Ms Browbank's assertions that her instructions to Mr Brodnik were to convert 4 emergency department beds into inpatient beds for the care of patients requiring monitoring under an inpatient team. That conclusion can be reached with a comfortable degree of satisfaction.

*Another direction to implement the virtual ward / objections by clinicians*

- 1.39 An email to the nursing unit manager, Frank Testa, and other staff on 10 May 2006 from Mr Brodnik says that Mr Testa needs to be "watching the clock"<sup>48</sup> and asks the emergency department staff to "please review our access block figures for the week", reminding them that "we need to get to 20%. Currently, area is not accepting anything above this".
- 1.40 On or about 10 May 2006, 2 patients in Shellharbour Hospital's emergency department experienced access block<sup>49</sup>. On 10 May 2006, Ms Browbank wrote to Mr Brodnik as follows<sup>50</sup>:

"The results at SHH remain unacceptable and unexplainable. I have indicated previously that the Area and Department have a particular interest in local access block. There have been several occasions this week that you have had beds and yet the patients have breached...

It is my expectation that you are personally managing this issue. ...

...I am now dealing with the CE and DCops on a twice daily basis as to why SHH and WH are breached...I expect

you to ring me every day at 11:30am and provide me with a report on activity from the past 24 hours including all breaches."

- 1.41 Ms Browbank said that she intended by this email to place considerable pressure on Mr Brodnik to redress the access block statistics at Shellharbour<sup>51</sup>. However, her purpose was, she said, to make him comply with the usual processes for transferring patients out of the emergency department into inpatient beds, where inpatient beds were available<sup>52</sup>.

- 1.42 The following day, 11 May 2006, Mr Brodnik forwarded Ms Browbank's email to Dr Leslie, Mr Testa and other staff with a message:

"Thought I would share with you one of the many emails I receive on the subject of access block".

- 1.43 Later on 11 May 2006, Dr Leslie sent to Ms Browbank, Mr Brodnik and Dr Murthy, Director of Medical Services, an email defending Shellharbour Hospital's record on access block and stating that there were a number of valid clinical reasons why a patient may remain in the emergency department beyond the 8 hour timeframe. His email included the following statements<sup>53</sup>:

"This letter is to provide relevant information to inform, from a medical and patient care perspective, the current issue with access block...

Doing this sort of thing to maximise the benefit and to minimise the cost of health care to society takes more work for everyone in ED..

It now appears that that is what we are being asked to do. We are being asked to run our health service on the basis of the need to treat one statistic and to ignore these other important issues.

I would like everyone to be aware that I and other treating doctors have not been ignorant or uncaring of the need to manage our resources appropriately. We understand the issues and the pressure to treat our access block figure but are driven firstly by patient care and community needs not just access block figures."

- 1.44 Mr Brodnik sent an email later that day to clinicians, including Dr Leslie, asking them to review access block figures for the preceding week and reminding them of the key performance indicator. He said:

"We need to consider should we admit (around 10PM) if we have beds or definite admissions waiting for a bed admit to our 4 bed unit (EMU)."

- 1.45 The nursing unit manager of the emergency department, Mr Testa, gave evidence about the difficulties achieving the access block benchmark at Shellharbour due in particular to their lack of access to diagnostic services. He said that the staff were "in a very difficult position". He said<sup>54</sup>:

"our hands were tied... We were doing all we could. The access block at Shellharbour was dependent on a number of things, our bed base, our reliance on Wollongong Hospital. There were a number of different issues that really we were beating our heads against a brick wall on".

- 1.46 Witnesses who gave evidence to the Inquiry could not recall any discussions during this time of Shellharbour Hospital being provided with resources to fix the access block problem. They said that, while there was discussion about the need for a CT scanner,

this was an ongoing discussion that did not resolve in the delivery of new resources<sup>55</sup>. In contrast, Ms Browbank informed the Inquiry that in 2006 a 4<sup>th</sup> medical team equating to approximately 2.5FTE was created at Shellharbour Hospital to manage the medical workload and that a CT scanner was installed in 2005<sup>56</sup>. The totality of the evidence does not permit me to accept that Ms Browbank provided any additional resources to Shellharbour Hospital in 2006 specifically for the purpose of addressing the access block problem.

- 1.47 On 12 May 2006, Mr Testa sent a memorandum to the staff at Shellharbour Hospital on the subject "Immediate implementation of Shellharbour Continuing Assessment Unit (CAU)" to the effect<sup>57</sup>:

"All please be aware that we have been directed by executive to implement the Shellharbour CAU immediately. Compliance is compulsory, as a strategy to address access block."

- 1.48 Mr Testa's email explained how patients were to be admitted to the unit, now called a CAU, and tracked on the emergency department information system (**EDIS**). It also set out the criteria for admission to the Clinical Assessment Unit to include:
- all patients requiring admission to Shellharbour Hospital and
  - patients who were identified as requiring a stay in the emergency department of greater than 6 hours.

- 1.49 There was no mention in that memorandum of admitting patients requiring monitored beds. Nor is there any mention of moving patients from one bed to another. Indeed, Dr Leslie, Mr Brodnik and Mr Testa gave evidence that the patients did not change beds within the emergency department upon admission to the unit and that their care did not change<sup>58</sup>. Mr Testa gave evidence that he sent that memorandum following an instruction from Mr Brodnik who had been instructed by Ms Browbank that she would not brook any excuses for a failure to meet the access block key performance indicator<sup>59</sup>.

#### *Interference with EDIS*

- 1.50 Emergency department computer systems require emergency department staff to record a range of information in relation to a patient's treatment such as the time of presentation, the time of commencement of treatment and the time the patient is discharged from the emergency department, into the community or, alternatively, into an inpatient ward. This allows staff to safely track a patient's clinical progress and physical location within the hospital. In 2006, Shellharbour Hospital used EDIS, as noted above.
- 1.51 Witnesses examined gave evidence that because the patient did not physically change beds upon admission from the emergency department to the virtual ward, the computer system did not track the patient's clinical progress accurately. That is, when a patient was admitted from the emergency department into the virtual ward (howsoever it was called), the patient was not recorded in EDIS as having left the emergency department<sup>60</sup>. Instead staff recorded in the 'departure ready time' box the time of 'admission' to the virtual unit. I was told that it was necessary to do this because the patient physically remained in the emergency department and, for reasons of patient safety, the emergency department needed to maintain a record in EDIS of the patient's actual whereabouts<sup>61</sup>.
- 1.52 Once the patient could actually leave the emergency department and be admitted to an inpatient bed, emergency department staff recorded as the actual departure time the time that they had previously inserted as the departure ready time<sup>62</sup>. This retrospective

change to the computer record meant that EDIS recorded false information: the actual departure time from the emergency department was later than in fact recorded. The time shown in EDIS as the actual departure time is used for determining emergency department KPI outcomes<sup>63</sup>.

- 1.53 I was told that the only accurate record of when a patient physically moved from the emergency department to an inpatient ward is contained in paper clinical notes kept by emergency department staff, which show both the time of 'admission' to the virtual ward and the time of actual departure from the emergency department<sup>64</sup>.

*Further changes to admission criteria*

- 1.54 By around 19 May 2006, the sole criteria for admission to the virtual ward (then called the Continuing Assessment Unit) was that no inpatient bed was available. Mr Brodnik communicated this to staff in a memo<sup>65</sup>. On 19 May 2006, Ms Browbank sent an email to Mr Brodnik and Dr Leslie in which she said<sup>66</sup>:

"I understand there are difficulties with the strategies related to the establishment of a virtual EMU at SHH... Simon, you need to speak to me if you have issues...the agreed position last week was that 4 beds in the ED should be reclassified to inpatient beds (by whatever name you so desire)...this is based on advice that it is rare for all available beds to be used in the ED... the numbers in ED would therefore be 11 ED beds and 4 inpatient beds. Where it was not possible to admit patients direct to a ward bed, patients would be admitted to the 4 beds in ED and be managed by the inpatient team under whom they have been admitted.

There was discussion regarding Simon's position and the need for us to return to our original intent for that position which was as a senior registrar undertaking a clinical role... I have spoken to Simon...regarding this matter and will speak with them both in detail later today."

- 1.55 Mr Brodnik gave evidence that he was not involved in discussions relating to Dr Leslie's position and that he "was not sure" why Ms Browbank's message had "come through that way". He said that he had not reached an agreement with Ms Browbank that Dr Leslie was occupying the position of senior registrar<sup>67</sup>. Dr Leslie gave evidence that at this time he was occupying the position of Director of the emergency department. I discuss this matter below.
- 1.56 Ms Browbank submitted to the Inquiry that the above email evidences her understanding in 2006 that patients admitted to the ward were to be cared for by the inpatient team and that the creation of the ward was justified by the spare bed capacity in the emergency department<sup>68</sup>.
- 1.57 Mr Brodnik gave evidence that the capacity of the emergency department fluctuated, although he said that it was rare for all available beds in the emergency department to be used<sup>69</sup>. Dr Leslie said that like all emergency departments the capacity fluctuated but it was not rare for it to be fully used<sup>70</sup>. Mr Testa gave evidence that there were times when all 15 emergency department beds were not in use but said that on the majority of days, the department was at full capacity at some point in time<sup>71</sup>. Whether or not the emergency department had capacity for the 'roping off' of 4 beds as additional inpatient beds, I do not accept that this was the intended model at April 2006.
- 1.58 I also not accept that it was a feature of the model directed by Ms Browbank that the inpatient teams would provide care for the patients. The clinicians working at

Shellharbour who were examined by the Inquiry gave evidence that the care of patients did not change after admission to the virtual unit<sup>72</sup>. Mr Testa said that if the patient was admitted to the hospital but awaiting a bed, the patient was technically under the care of an inpatient team in the virtual ward but that in reality there was a shared arrangement between the emergency department clinicians and the inpatient teams.<sup>73</sup> If the patient had not been admitted as an inpatient yet, the team looking after the patient did not change. That is the patient remained under the care of the emergency department clinicians<sup>74</sup>. Mr Brodnik said that if a patient is admitted under an inpatient team but stays in the emergency department, the practicalities of care depend on the hospital's staffing levels, the emergency department's view of how care should be provided and the inpatient team's view of things<sup>75</sup>. Dr Leslie said that in reality the emergency department medical and nursing staff continued to care for the patients after they were admitted for administrative purposes to the virtual ward<sup>76</sup>.

*Meeting with the Chief Executive of SESIAHS*

1.59 Witnesses examined by counsel assisting gave evidence that a meeting took place on 22 May 2006 at Shellharbour Hospital with the then Chief Executive of the area health service, Debra Picone, to enable the clinicians to voice their concerns about the new 'virtual' ward. Attendees at that meeting included Ms Picone, Ms Browbank, Mr Brodnik, Mr Testa, Dr Leslie and other clinicians including Dr Max Osborne and Dr Patrick Gleeson.

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1.60 Ms Browbank sent a briefing note to Ms Picone in the lead-up to the meeting, on 19 May 2006, to the effect that Shellharbour Hospital was trialling "a Virtual EMU". In that briefing note, Ms Browbank listed the concerns of doctors<sup>77</sup>:

"Concerns by medical officers

- "General Manager trying to fudge the figures"
- "We don't want medical patients in our ED"
- "Making more work for ED"
- "No one else has EMUs in their ED"
- "Unethical"
- "Everyone is upset about it" "

1.61 Dr Leslie gave evidence that during that meeting he expressed the view that the virtual ward had the purpose and effect of falsifying figures relating to access block and that he did not consider it ethical<sup>78</sup>. Mr Brodnik and Mr Testa gave evidence that the clinicians raised their concerns at the meeting that the direction to implement the CDU in the emergency department was "an exercise in fudging the figures"<sup>79</sup>.

1.62 Dr Leslie testified that Ms Picone said:

"... that we had to implement this structure, but it was up to us to ... make the final details about it"<sup>80</sup>."

1.63 Dr Leslie said<sup>81</sup>:

"We came away from that meeting with the clear direction that this had to be implemented despite our concerns and against how we wished it to be implemented."

1.64 The other witnesses examined by the Inquiry also testified that the clinicians expressed their objections to the virtual ward at that meeting. Mr Brodnik gave evidence that Ms Picone said<sup>82</sup>:

"There are models like this around the State. This is a legitimate model and I hope you will help us in implementing it."

1.65 Another witness said that he:

"remember(ed) clearly Deb Picone saying that the beds in the department can be reassigned as we see fit, for whatever purpose we want, and that we were allowed to do that, and as far as the implementation of a EMU, CDU or CAU, that was up to the hospital to decide how that was to happen. It was a site issue"<sup>83</sup>.

1.66 When questioned about whether the clinicians were instructed to implement the unit in Shellharbour Hospital's emergency department during the course of the meeting, Ms Browbank said<sup>84</sup>:

"The outcome from that meeting, from my perspective, is that there had been discussion and there was no direction to me not to. Okay. ... At the end of the day it proceeded. It was not an unusual practice, and I'm sure you will find similar practices in other hospitals.

I don't know if there was a direct instruction it would go ahead, but there was no instruction to change it. It was proceeding. Their views were listened to."

1.67 The Inquiry sought a response from Professor Picone about her recollection of that meeting. In a sworn affidavit<sup>85</sup>, Professor Picone said that at 3 years distance she had no specific recollection of the meeting and cannot provide any specific account of what was said or who was present other than by reference to the accounts of the witnesses that the Inquiry provided to her. Professor Picone said that she believed that the ward in question was an EMU that would be introduced in accordance with applicable NSW Health policies and directives. Professor Picone said that her understanding of the general EMU model was that:

"there would be specific beds or places used for this purpose with appropriate staffing, admission and discharge criteria applied. The beds would be physically situated so that the patient could be monitored for a short/24 hour period, but physically away from the more intensive and active areas of the ED. In most instances, the EMU would either be at a physically separate location or adjoining the ED".

1.68 Professor Picone said that apart from the briefing note from Ms Browbank of 19 May 2006 she does not recall being provided with a more detailed outline of the proposal, nor would she have expected to be. As Chief Executive, she said that she considered matters relating to the establishment of units and related protocols to be issues of detail appropriate to be settled at local management level. However, having regard to her knowledge of Shellharbour Hospital, its size and staffing, she said that she considers it reasonable that the general EMU model could operate inside the hospital's emergency department footprint, provided the arrangements made clinical sense, were in accordance with NSW Health requirements and involved beds that were appropriately designated and subject to the relevant staffing, admission and discharge criteria.

1.69 Professor Picone said that she understood the term "virtual" to mean that the EMU beds were within the ED, rather than situated in a structurally separate physical space as some other EMUs. She said that she did not believe that the concept involved no separately designated actual beds and a process of switching to EMU status depending on the status or diagnosis of the patient. Ms Picone said that the word "virtual" is used



in the health system in many senses, for example, virtual beds for out of home care and virtual cots for stabilising and transferring very sick neonates.

- 1.70 The weight of evidence supports a finding that the clinicians expressed to Professor Picone, at the meeting of 22 May 2006, their objections to the creation of a ward the sole purpose of which in their view was to achieve access block figure benchmarks.
- 1.71 There is no evidence that either the clinicians or Ms Browbank told the Area Executive, or Professor Picone specifically, that patients admitted to the new ward did not change beds. That is, there is no evidence that they told Professor Picone that the creation of the 'ward' was a mere clerical exercise involving a change of status for administrative purposes (from being an emergency department patient to being admitted to a virtual ward) without any change to the patient's care. The evidence indicates that Professor Picone was told that an Emergency Medical Unit would be established, namely:
- Ms Browbank's presentation to Area Executive, including Professor Picone, on 9 May 2006 that the ward was an EMU;
  - Ms Browbank's briefing note of 19 May 2006 referring to a "Virtual EMU". Although the word virtual was used, there is no evidence that Professor Picone was told the sense in which it was virtual, which was that there was no designated set of beds to be used.
- 1.72 An EMU was then, and continues to be, an acceptable clinical solution for the treatment of patients who require to remain in hospital for short periods. In the circumstances where Professor Picone was briefed that an EMU was the model of the ward being installed at Shellharbour Hospital, and there is no evidence to suggest that she was told of the detail of what in fact had been occurring over the weeks before her meeting, then her responses to the meeting were appropriate.

*Further objection by clinicians to the virtual ward*

- 1.73 About one month later, on or about 23 June 2006, Dr Leslie sent an email to Mr Brodnik in which he set out a draft email to Professor Picone objecting to the virtual ward<sup>86</sup>. In the draft email, Dr Leslie says that he has:
- "developed this discussion paper following our meeting regarding implementation of the virtual short stay unit at SHH...I understand the dilemma you have with meeting your KPIs but unfortunately the proposed solutions for SHH conflict with our staff's ethical and professional responsibilities to patient care". In the attached discussion paper, he notes that the "unit was implemented without any change in patient care, resources, unit layout or staffing levels. Implementation has meant that patients who have had a decision to admit and were reaching 8 hours in ED are "virtually" (but not physically) moved out of ED by reclassifying their bed as a "clinical decision unit" bed".
- 1.74 He asked Mr Brodnik if he agreed with the substance of the email and requested Professor Picone's email address.
- 1.75 Dr Leslie also prepared and circulated his discussion paper to clinicians at the hospital, in response to which he received emails in support of his views. The Inquiry was provided with a copy of those emails<sup>87</sup>.
- 1.76 Dr Leslie then wrote to Mr Brodnik on 28 June 2006<sup>88</sup> to the effect that the admission criteria to the virtual unit would be changed to bring it into line with a short stay unit for patients with an expected length of stay of less than 24 hours. He also notified Dr



Raghu Murthy, Director of Medical Services at that time, and Mr Brodnik that he had renamed the unit the “Virtual Short Stay Unit.” Dr Leslie said that he purported to make these changes on the basis that he was Director of the Emergency Department and had authority to do so, although he knew that his position was uncertain, given that Ms Browbank had questioned his right to call himself Director of Emergency Services<sup>89</sup>.

- 1.77 Mr Brodnik gave evidence that he understood Dr Leslie to work in that role but that he understood authority to change the admission criteria for the virtual ward in this way to reside in the General Manager, Ms Browbank<sup>90</sup>.
- 1.78 Dr Leslie’s proposed admission criteria were not implemented<sup>91</sup>. Nor did he send his proposed discussion paper to Professor Picone. He sent his discussion paper to Ms Browbank who responded on 28 June 2006 that the issues had already been discussed, that she had no preference as to how the unit was named nor how the local executive determined the best model. Ms Browbank said in her email that the original concept of an EMU was not acceptable to emergency department staff as it meant that they would have responsibility for the patients and that the decision made was for the patients to come under the ward team.
- 1.79 Ms Browbank submitted to the Inquiry that this email corroborates her assertion about the reasons the ward was established. However, there is no mention in that email about the creation of a ward to accommodate patients requiring monitored beds or the transformation of emergency department beds into inpatient beds.
- 1.80 Dr Leslie gave evidence that in about August 2006, following discussions with Dr Gordian Fulde of St Vincent’s Hospital, and with the Shellharbour Hospital emergency clinicians, about whether to continue to express his opposition to the virtual ward, he decided that it was pointless to pursue his opposition to the virtual ward.
- 1.81 The unit operated until it was closed in April 2008 after Dr Leslie gave evidence about it at a public hearing of the Inquiry at Wollongong Hospital.
- 1.82 Mr Brodnik gave evidence that the creation of the unit was a paper exercise. He said, as did other witnesses including Dr Leslie<sup>92</sup>, that patients did not physically change beds within the emergency department but were recorded as having been admitted to the unit without any change to their clinical care. Mr Brodnik gave evidence that he set up the unit because he was directed to do so. He said that he “did not feel comfortable with” implementing something he “did not truly believe in”<sup>93</sup>. He also gave evidence that the creation of the virtual ward improved the access block figure, whereas in truth the hospital continued to have access block<sup>94</sup>. The witnesses told the Inquiry that once the unit was active, the patient was transferred for administrative purposes from the emergency department to the virtual ward before the 8<sup>th</sup> hour elapsed<sup>95</sup>.

*Findings about the creation and operation of the virtual ward*

- 1.83 In relation to the creation and operation of the virtual ward, I find as follows:
- (a) On 28 April 2006, Ms Browbank, General Manager of the Southern Hospital Network, instructed Michael Brodnik, Site Manager and Director of Nursing at Shellharbour Hospital, to establish a “virtual ward” in the Emergency Department at Shellharbour Hospital, comprising 4 beds ‘conceptually down the right hand wall’ of the Emergency Department. Ms Browbank’s instructions to Mr Brodnik were substantially those set out in Mr Brodnik’s email to staff at 2.24pm that day. The “virtual ward” was initially known as the Clinical Decision Unit (CDU) and later the Clinical Assessment Unit (CAU).

- (b) Prior to giving the instruction in (a), Ms Browbank failed to consult the clinicians and staff at Shellharbour Hospital about the “virtual ward”, including its appropriateness and potential impact on patient care.
- (c) On admission to the “virtual ward”, patients were merely transferred in the records of the Emergency Department to the CDU/CAU, but did not in fact change beds, leave the Emergency Department, or receive medical treatment, either by Emergency Department staff or inpatient medical teams, in any different way to that before the establishment of the ‘virtual ward’.
- (d) Emergency department staff were required to manipulate the EDIS system so that they could monitor a patient’s location in the hospital. If they had not manipulated EDIS in the way described above, patients admitted to the virtual ward would have disappeared from the EDIS system because their ‘admission’ time to the virtual ward would have suggested that they had physically left the emergency department.
- (e) Ms Browbank’s predominant purpose in establishing the “virtual ward” was to improve the performance of Shellharbour Hospital in respect of the key performance indicator for Access Block. Ms Browbank knew that there would be no change in the way that patients admitted to the ‘virtual ward’ would be medically treated, and that it was a ‘paper exercise’. Later efforts by Ms Browbank to attribute a legitimate clinical reason for the establishment of the ‘virtual ward’, including in her evidence to this Inquiry, were disingenuous.
- (f) The practical effect of the establishment of the “virtual ward” was to:
  - (i) conceal the true position of time spent by patients in the Emergency Department at Shellharbour Hospital awaiting admission to an inpatient bed; and
  - (ii) obscure the need for resources at the Emergency Department at Shellharbour Hospital including staff and diagnostic equipment.

1.84 I set out my further findings in relation to Dr Leslie’s opposition to the virtual ward and his employment at Shellharbour Hospital below.

*Bullying of Dr Simon Leslie*

- 1.85 The present section sets out another aspect of my investigation of the creation and operation of the virtual ward, namely the complaint by Dr Leslie that he was treated poorly by management as a result of his opposition to the virtual ward and decision to give evidence to this Inquiry about it. In particular, Dr Leslie claims that after he gave evidence to the Inquiry, the virtual ward was “disbanded” and he was removed from his position as Medical Director of Emergency at Shellharbour Hospital, under the guise of a “restructure”, as retribution for giving evidence at the Inquiry.
- 1.86 As noted above, the virtual ward was established on 28 April 2006.
- 1.87 On 27 June 2006, at Dr Leslie’s request, Mr Brodnik forwarded to Ms Browbank three emails he had received from Dr Leslie. In the email, Mr Brodnik complained to Ms Browbank:

“I’ve been having a tough time with moving forward with Simon [Dr Leslie] in his current role. I will send you a set of 3 emails to date that are confidential but explains where things are at. Through discussions I have moved him from the letter writing role to why don’t you take a leadership role but I’m now wearing the consequence of him being unreasonable and in a nutshell,

I've had enough ... I would appreciate your direction in terms of the SHH EMU [the 'virtual ward']. I'm happy to stand my ground but Simon and I are moving beyond discussions."

- 1.88 The emails from Dr Leslie were critical of the "virtual ward" at Shellharbour Hospital. In one of them he said:

"... I need to forewarn that we are likely to recommend disbanding this unit (that's easy because it doesn't actually exist) and work towards having a properly staffed and resourced Short Stay Unit."

- 1.89 On the afternoon of that same day, Ms Browbank sent the following email to Dr Leslie:

"Several weeks ago I indicated that you would no longer be required to function as a medical administrator for SHH/Bulli as Raghu [Dr Raghu Murthy] would be assuming that role on a part time basis. I also requested that you develop for me an outline of a job description that you believed would appropriately describe the duties of a senior medical registrar working between the ED and the SCNU. As yet I have not received the JD I am somewhat surprised to see that you have adopted the title of Director of Emergency Services. Clearly there is no such position at SHH.

Prior to becoming aware of this role you appear to have adopted, I had requested a meeting with you and Raghu to discuss the appointment of another part time medical administrator to the Illawarra. Clearly this appointment will affect management duties at SHH. Having seen what appears to be the creation of a position that has never been agreed, I believe we should bring forward this meeting and meet ASAP. Until that time, please be advised that the position of Director of Emergency Services does not exist and should not be used in correspondence."

- 1.90 Ms Browbank gave me<sup>96</sup> the following explanation for this email to Dr Leslie:

"I would have to say it would not be in my normal practice - my normal practice would not be to send off emails which people could link to retribution or see that as payback. That would not be my normal practice. What I believe I was saying here - and my concern would have been for Michael [Brodnik] and I believe that's what I was responding to. The information, what Simon [Leslie] was doing, what he was saying was all out there. I knew all that. That was not a cause for me to get angry with Simon and retaliate against Simon. It was a case of: I need to put some boundaries around this because clearly Michael is not managing this."

- 1.91 Ms Browbank did not agree that the thrust of her email would instill in Dr Leslie a sense of insecurity about his employment at Shellharbour Hospital. She denied her intention was to intimidate Dr Leslie to resile from his stance and return to being a compliant employee.<sup>97</sup>

- 1.92 However, Dr Leslie's email response to Ms Browbank on the evening of 27 June 2006 included the following:

"I am concerned that this harsh email you have sent me is in response to my assessment of the viability of our virtual ED unit which has resulted in misleading figures about access block. I have no agenda other than to care for patients in our area."

- 1.93 Dr Simon Leslie has been a medical practitioner since 1980. After holding positions at Wollongong and Bulli Coledale Hospitals, he became a Casual Medical Officer at Shellharbour Hospital in 1994. He later became an Multi Skilled Medical Officer at Shellharbour Hospital, with clinical and governance roles in the medical and special care unit, progressing to Medical Director of Emergency Department in 2006/2007.<sup>98</sup>
- 1.94 Dr Leslie's job description is contained in a document that he and Dr Raghu Murthy, Director of Medical Services at Shellharbour Hospital, signed in September 2007, although Dr Leslie told me he commenced in the position around 12 months before it was executed.<sup>99</sup> This was confirmed by Dr Murthy.<sup>100</sup>
- 1.95 Dr Leslie prepared the job description and emailed it to Dr Murthy for Dr Murthy's review and comments on 13 July 2006. Dr Murthy responded by email on 10 August 2006 with changes. The title of the position was "Medical Director of Emergency Department". Ultimately that description was adopted in the executed version that was signed by both Dr Leslie and Dr Murthy on 5 September 2007. The job description describes the role as a "fulltime" position.
- 1.96 On 23 August 2007, Dr Murthy sent an email to Dr Leslie notifying him that a 12 month review had been carried out. He told Dr Leslie:
- "We have agreed that the Director of ED role is a much more appropriate position for you than your previous role as DMS.
- Good progress has occurred in the past 12 months in ED team building (medical and nursing), addressing of complaints, follow up of pathology/radiology. The MMO group has been happy with your leadership. You will further develop (with advice from Dr Tom Carrigan) systems for reviewing performance of medical staff in the ED.
- You are keen for further training this year in advanced paediatric life support.
- Your clinical contribution at SHH is vital.
- Areas for further development include clear communication on your intended absences from SHH and [sic] well as continued improvement in electronic written communication.
- We have made minor modifications in your JD which we will both sign shortly.
- Thank you for your efforts over the past 12 months."
- 1.97 Ms Browbank told me that she had many "items of correspondence" from Dr Leslie in 2006 where he used his title, some of which she responded to by directing him not to use the title, others where she did not respond "because it was almost a daily event in some cases".<sup>101</sup>
- 1.98 Ms Browbank in evidence before me maintained the position that Dr Leslie was not entitled to describe himself as "Director Emergency Services". However, when taken through various extracts of the evidence given to me by others, Ms Browbank confirmed that she had asked Dr Murthy, as her representative, to negotiate a job description with Dr Leslie in 2006.<sup>102</sup> Ms Browbank admitted there was no restriction in Dr Murthy's capacity or ability to negotiate with Dr Leslie,<sup>103</sup> although she maintained that Dr Murthy knew it as NSW Health policy that he could not create a senior medical position of director without appropriate delegation, which he did not have.<sup>104</sup>

- 1.99 However, Ms Browbank also admitted to me that she had agreed with Dr Murthy's proposed changes to the job description, including the name of position "Medical Director of Emergency Department."<sup>105</sup>
- 1.100 On 14 April 2008 when he gave evidence at the public hearing of the Inquiry at Wollongong about the "virtual ward", Dr Leslie told me the "virtual ward" was a fiction to compensate for the fact that Shellharbour Hospital does not have a short-stay unit, yet it is compared against other hospitals that do. He told me the concept was devised so Shellharbour Hospital can meet the access block benchmark.<sup>106</sup>
- 1.101 On 6 May 2008, Ms Browbank sent an email to Dr Leslie in which she told him she had the previous week written to him informing him of the appointment of Dr Tom Carrigan as Southern Hospitals Network Director of Emergency Medicine.
- 1.102 Ms Browbank told me the idea of a director of emergency services for the Southern Network had come about following some clinician meetings in November 2007. A job description was prepared in early 2008 and the position was approved by NSW Health's Senior Medical Appointments Review Committee in March 2008. The position was advertised on 2 April 2008.<sup>107</sup>
- 1.103 Dr Leslie told me he was not informed that the position of Southern Hospitals Network Director of Emergency Medicine was being advertised. He said he was not aware of any discussions about creating such a position.<sup>108</sup>
- 1.104 In my view, the decision to recruit and fill the position of Southern Hospitals Network Director of Emergency Medicine effectively re-structured the coordination of medical services and clinical governance within the Emergency Department of Shellharbour Hospital. Both technically and in reality, it effected the abolition of Dr Leslie's position.
- 1.105 Dr Leslie was, understandably, upset about the re-structure and the abolition of his position. Dr Leslie complained to Ms Browbank in an email he sent to her on 6 May 2008 after Dr Carrigan had instructed him to stop referring to himself as the Medical Director of Emergency Department.
- 1.106 Ms Browbank replied by return email the same day. She said:
- "there has certainly been no 'manoeuvring' involved in the filling of this position [Southern Hospitals Network Director of Emergency Medicine] ... it has been discussed for several months, approved by SMARC and advertised several weeks ago...to the best of my knowledge, externally ... HR should be able to provide details of when and where."
- 1.107 In her letter to Dr Leslie (a copy of which was attached to her 6 May 2008 email), Ms Browbank encouraged Dr Leslie to apply for another position at Shellharbour Hospital as clinical co-ordinator in the Emergency Department. She informed Dr Leslie that under this new proposed role, his shifts would include one 8 hour non-clinical shift, two 8 hour clinical shifts and a regular after-hour hours medical registrar shift. I note from this that none of these constitutes a full-time position.
- 1.108 Ms Browbank told me she agreed that Dr Leslie has a legitimate sense of grievance as a result of the re-structure process; however in terms of the manner of responding to Dr Leslie's grievance, Ms Browbank said "I guess, if I am to be perfectly blunt, it has been a downhill track from there".<sup>109</sup> I took her answers to be an acceptance of the proposition that her treatment of Dr Leslie was, at least from that time, inadequate.

- 1.109 On 16 June 2008, Dr Leslie complained to the Manager Workforce Development, Roger Davey, about being "sacked" from his position; he posed a number of questions about the process, assertions he had appointed himself to the role of Medical Director of Emergency Department, and queried how the Shellharbour Hospital Emergency Department would operate without a full time director. He asked:

"It has been asserted by Sue Browbank and others that I self appointed myself to my current role. In the light of the fact I have a position description developed and signed by the DMS and the fact that I represent this department as its acknowledged director in numerous forums what is the basis of this assertion and slander ... How is it possible to remove me from the role for which I have a contract and in which I have been acknowledged and satisfactorily functioning in for over 2 years? I attach a recent memo from Terry Clout referring to me as the Director of Emergency."

- 1.110 Mr Davey responded by email on 18 June 2008:

"As you are aware SESIAHS has been involved in amalgamations and clinical reviews over the past 2 years. These processes have seen many services and structures reviewed resulting in change. In many cases roles and responsibilities have changed, staff displaced and new position description written. The vast majority of employees in the health system have already gone through this, we still have Community health and Allied health outstanding. As part of the process, it was deemed appropriate to revisit the structure & management of ED in the SHN. The new structure sees the establishment of Clinical Coordinators in both Shoalhaven and Shellharbour and to ensure a coordinated approach these functions are overseen by the Area Director. As you know Dr Carrigan was appointed to this new position. The General Manager has the responsibility for all services in the SHN and is accountable for the performance of these services. Ultimately it is her decision to determine the most appropriate structure. Your contribution in the role for the past 2 years has been acknowledged and you have been actively encouraged to apply.

If you would like me to organise a meeting with you and Dr Murthy to go through the structure I am more than happy to do so."

- 1.111 In a later email to Dr Leslie sent on 18 June 2008, Mr Davey said:

"I do not understand your email. You are still employed as a MMO and the title of the non clinical part is now called 'Clinical Coordinator'. As part of due process you are encouraged to apply for the role if you so wish. You are a valuable member of SHN clinical team and your contributions and efforts have been acknowledged.

It is my understanding that you have had a meeting with the General Manager and Ian Rewell regarding all this.

If the issue is the title and you are interested in the role but don't want to go through the recruitment process let me know and I will discuss with the General Manager. Other than that I don't believe I can add anything more."

- 1.112 Dr Leslie's email response on 18 June 2008 was:

"If I can make it clearer for you. I have asked some questions. Can they be answered. If not why not?"



If I am to function as the Director of this emergency [department] and other people in other emergency departments are referred to as the director of emergency why should it be different at SHH?

It is an offensive insult that you imply that I am just interested in the 'title'. I seek to be acknowledged for the effective work and role that I fulfil not to cop this malicious process which I can only interpret as retribution for advocating for the interests of staff and patients at SHH. Ie being instrumental in getting rid of the fraud that was the virtual ward, and in correcting lies that were said by senior management to cover up their involvement in implementing such fraud and for advocating on behalf of MMOs when attempts were made to unilaterally change the place and hours of work.

If this is all just paranoia on my behalf I need evidence of the clinical rationale for the change and how it will benefit patient care.

I took on this role because people asked me to do it as it was desperately needed. I do it because I want to make sure patients at SHH get good and appropriate care. This is not about me wanting a role or a title."

1.113 Mr Davey responded by email on 18 June 2008:

"The Management of Southern Hospital Network have made their decision in regards to the structure, they had a meeting with you, and have sent two letters. I have nothing further to say on the matter."

1.114 In evidence before me, Ms Browbank accepted albeit with some reluctance, that she took no step, or directed no step to be taken, to inform Dr Leslie of the restructure prior to the publication of the advertisement for, and Dr Carrigan being appointed as, the Southern Hospitals Network Director of Emergency Medicine.<sup>110</sup> She was correct to accept this position which was clearly demonstrated by the evidence.

1.115 The poor treatment of Dr Leslie did not end there, however.

1.116 On 9 May 2008, Dr Leslie's new boss, Dr Carrigan, sent an email to Dr Leslie and Dr Gina Watkins (copied to four other people) in which he said:

"All FACEM & FRACP Directors of ED departments in this Area commit to 50% clinical time in ED, and since you refuse to do such, then you are a maverick on this, and until you do so, I cannot support your self-imposed title. No-one doubts you are a very good hospitalist, medical registrar, and Multi-Skilled Medical Officer, and we need to work together to improve patient flow within and out of SHHED, and that is why you were offered the Clinical Co-ordinator role. There is a place for you at Shellharbour Hospital, and we are trying to work with you with difficulty."

1.117 Ms Browbank told me of a history of an unhappy relationship between Doctors Leslie and Carrigan which existed for some years. She agreed that from Dr Leslie's point of view, Dr Leslie had been put in a difficult position of having to report to Dr Carrigan. She acknowledged that, as Dr Leslie's boss, Dr Carrigan's language was entirely inappropriate in email communications between them.<sup>111</sup>

1.118 In September 2008, Dr Leslie suffered two further detrimental acts at the hands of his employers. He was told to return his pager and he was told he needed to vacate his



office<sup>112</sup>. These events occurred shortly after summonses were served on NSW Health in relation to matters raised with the Inquiry by Dr Leslie.

- 1.119 Dr Leslie told me that, in addition to a significant change to his working hours, he is now left out of the “information circle” in relation to communications relevant to the operations of the Shellharbour Hospital Emergency Department.<sup>113</sup>
- 1.120 In evidence before me, Ms Browbank agreed that Dr Leslie, in the light of his treatment over the past 3 years, could have the impression that someone at the Southern Hospitals Network is out to “get him”.<sup>114</sup>
- 1.121 In her written submissions<sup>115</sup> to me, Ms Browbank said:
- (g) In 2006 Dr Leslie was not appointed as Medical Director of Emergency Department; that position did not exist and there was no intention to create such a position.
  - (h) In 2006, the only role available to Dr Leslie was the temporary part-time position of Acting Director of Clinical Services. Dr Leslie was appointed to that position temporarily in July 2005.
  - (i) Dr Leslie’s role in 2006 was a senior medical registrar undertaking a clinical role.
  - (j) In negotiating a job description with Dr Leslie in 2006, Dr Murthy’s understanding was that the job description simply provided a list of the tasks Dr Leslie could be reasonably expected to perform as a senior registrar overseeing the day to day activities in Shellharbour Hospital Special Care Nursing Unit and Emergency Department.
  - (k) Ms Browbank was unaware of the 2007 review by Dr Murthy of Dr Leslie’s job description and performance in the role of Medical Director of Emergency Department.
  - (l) The existence of any job description for Dr Leslie as Medical Director of Emergency Department, signed or otherwise, was unknown to Ms Browbank prior to May 2008.
  - (m) The positions of Southern Hospitals Network Director of Emergency Medicine and Shellharbour Hospital Director of Clinical Services had existed within the organisational framework, establishment and budget of the Illawarra Area Health services and SESIAHS since 2004, but were vacant due to an inability to recruit. Accordingly, recruitment to those positions in 2008 did not amount to a restructure of positions in the Southern Hospitals Network.
  - (n) Health NSW’s restructuring procedures<sup>116</sup> do not apply to Dr Leslie. Dr Leslie is employed under the Multi Skilled Medical Officers Agreement, an arrangement unique to the Southern Hospitals Network. The local policy governing restructuring is derived from various awards, where it states under clause 34 “Any proposal to reorganize a Department or service that will significantly affect employees covered by the Union will be subject of genuine consultation with the Union.”
  - (o) Dr Leslie’s attendance on 30 November 2007 at a “Southern Hospital Network Emergency Department Workforce Plan Workshop” conducted by Mr Tony Farley, SESIAHS Director of Workforce Development constituted a consultative process concerning changes to the management structure of Southern Hospitals Network Emergency Departments.

- (p) Dr Leslie also knew about the potential change to his and other MMO's working arrangements by virtue of MMO wage claim negotiations taking place at that time, where Dr Leslie was representing MMO's.
- (q) In her letter to Dr Leslie informing him of Dr Carrigan's appointment, Ms Browbank encouraged Dr Leslie to apply for one of the two new Clinical Coordinator positions.
- (r) The appointment of Dr Carrigan himself was of greater concern to Dr Leslie than the appointment process, due to the poor relationship between them.

1.122 I note from the minutes of the 30 November 2007 Southern Hospital Network Emergency Department Workforce Plan Workshop<sup>117</sup> attended by Dr Leslie that Emergency Department governance models were discussed:

"Develop an effective Emergency Network Governance Model  
- there has to be someone who runs it, makes things happen and makes sure people feel valued. This could take a number of possible forms including (but not limited to):

- i. Network ED Director and then a Director at each site
- ii. THW ED Director and Deputy Directors at each site

There needs to be a review of the role that Leonie Shepstone does and how it can be backfilled in her absences and how to find efficiencies in rostering.

Question - 'How do we make it work?' It needs to be driven by the General Manager and have players such as Henry Kornacki/Sue Browbank, Chris Poulos, Tom Carrigan, Paul Allin and Raghu Murthy.

Agreed Principles:

- Network Structure
- Clinical Leadership
- Appropriate administrative support
- Connection/links with educational institutions
- Close links and ties with JMOs and rostering."

- 1.123 The minutes record that it was agreed at the workshop to establish a working party and appoint a project manager. Dr Leslie was not included in the working party.
- 1.124 I do not accept Ms Browbank's submission that Dr Leslie's attendance at the workshop constituted a consultative process concerning changes to the management structure of Southern Hospitals Network Emergency Departments, such that Dr Leslie could be aware his position was to be abolished. Indeed, the minutes note that a "Network Structure" was agreed in principle, which when read with the earlier extract from the minutes, indicates there will be an Emergency Department director at each site. As Dr Leslie had been working as Medical Director Emergency Department for more than 12 months at the time of the workshop, the appointment of a Network Director could not be seen at that time to have affected his role. There was not said by Ms Browbank to have been other consultation or notification to Dr Leslie of the restructure.
- 1.125 I accept Dr Leslie's evidence that he did not know, until after Dr Carrigan's appointment, of the decision to appoint a Southern Hospitals Network Director of Emergency Medicine and to create two new Clinical Coordinator positions, which had the effect of

abolishing the position he had been occupying since at least 2006 and for which he had a signed job description.

- 1.126 I consider Ms Browbank's submission that Dr Leslie was more concerned about the appointment of Dr Carrigan than the process by which the appointment had been made, to be without foundation. The emails between Dr Leslie and Mr Davey clearly reveal that Dr Leslie's concerns were that he had been "sacked" without notice from an agreed, documented position of Medical Director of Emergency Department that he had held for over 2 years, for which his performance had been favourably evaluated.
- 1.127 I reject Ms Browbank's submissions that there was no position of Medical Director of Emergency Department at Shellharbour Hospital and that Dr Leslie was not entitled to describe himself as such. Her submission flies in the face of the obvious facts revealed by the evidence and is wholly untenable. I note that in evidence before me, Ms Browbank admitted that she authorised and delegated responsibility to Dr Murthy to negotiate a job description with Dr Leslie and that she reviewed the draft document and agreed with Dr Murthy's proposed changes to the job description, including the name of position "Medical Director of Emergency Department."<sup>118</sup> I consider it is unreasonable for an employer, through its authorised staff, to negotiate a job description with an employee, review the employee's performance, sign the document, permit the employee to carry out the duties as set out in the agreed job description for 2 years, and then deny that the employee holds the position because, as submitted by Ms Browbank:

"The recruitment and appointment of staff to any position and at any level of the organisation is by way of a contract of employment. This is separate, and in addition to a position or job description. The process of appointment involves a written offer and acceptance, a document outlining the duties and responsibilities of the position together with details of the remuneration offered. Only properly delegated officers may make an offer of appointment. Records relating to all appointments are maintained on central file held in Human Resources."<sup>119</sup>

- 1.128 I find that Ms Browbank acted unreasonably in instructing Dr Leslie on 27 June 2006 to stop referring to himself as Medical Director of Emergency Department, after Dr Leslie had sent an email Mr Michael Brodnik, Site Manager and Director of Nursing at Shellharbour Hospital, criticising the "virtual ward", saying it should be disbanded and informing Dr Raghu Murthy that Dr Leslie had decided to change the admission criteria and rename the "virtual ward" the "Virtual Short Stay Unit".
- 1.129 The significant fact which leads me to the conclusion is that the email does not address any of the substantive concerns which Dr Leslie was expressing about the virtual ward. The email simply consisted of an *ad hominem* attack.
- 1.130 I find the following treatment of Dr Leslie unreasonable:
- (s) Derogatory comments made about Dr Leslie in emails from Mr Roger Davey and Dr Tom Carrigan.
  - (t) Attempts by Shellharbour Hospital staff to remove from Dr Leslie the use of his pager and office.
  - (u) Excluding Dr Leslie from receiving communications relevant to the operations of the Emergency Department.
- 1.131 In a submission to me, Dr Leslie said:

"I just wish you to understand that there are disincentives to clinicians speaking out about patient care issues because of the adverse impact on career development that can follow. There are numerous examples of clinical advocates who have been 'shut down' by this method.

A better process would be for managers to accept that there are differences of opinion from clinicians about relative needs, and that these differences in opinion should be acknowledged and respected and taken into account in decision making. We all understand that managers need to weigh up the imperatives and make the best decisions rejecting, accepting or modifying advice depending on the big picture. This management style would require an enormous cultural shift."<sup>120</sup>

- 1.132 I find that Dr Simon Leslie was unfairly treated by NSW Health staff for criticising the "virtual ward" concept in 2006, for continuing to express his concerns from a clinical perspective, and for seeking the support of fellow clinicians in his quest to replace the "virtual ward" concept with a workable "short stay unit" option.
- 1.133 Furthermore, because the unfair treatment of Dr Leslie was unreasonable, repeated, unwelcome, unsolicited, offensive, intimidating, humiliating and threatening, I find it amounted to bullying and harassment in accordance with NSW Health's own guidelines.
- 1.134 This discrete part of my Inquiry required evidence to be taken formally over 4 days. It required extensive analysis and consideration of a history of interaction between various individuals over a period of between 2 and 3 years. The matter could have, and should have, been dealt with promptly years ago. It was not. In my view, the principal reason for that failure was because the senior officers of the Southern Hospital Network did not demonstrate, in practice and in their every day work, the slightest knowledge or realisation of what constituted bullying and unacceptable behaviour. No attention was paid at all to the comprehensive NSW Health policy.

<sup>1</sup> Dr Simon Leslie, Wollongong Hospital hearing, 14 April 2008, transcript 1699.

<sup>2</sup> Confidential Submission of Dr Simon Leslie, 18 June 2008, SUBM.077.0210.

<sup>3</sup> Tab 5, Marked For Identification bundle of documents (MFI) 1.

<sup>4</sup> Frank Testa, 30 September 2008, Shellharbour transcript 122.

<sup>5</sup> Tab 6, MFI1.

<sup>6</sup> Michael Brodник, 30 September 2008, Shellharbour transcript 74.9.

<sup>7</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 74.25, 77.1.

<sup>8</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 74.

<sup>9</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 71.43.

<sup>10</sup> Frank Testa, 30 September 2008, Shellharbour transcript 127.24.

<sup>11</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 162.15.

<sup>12</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 156.22

<sup>13</sup> Tab 4B, MFI1.

<sup>14</sup> Frank Testa, 30 September 2008, Shellharbour transcript 115.25.

<sup>15</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 157

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- <sup>16</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 71.43; Sue Browbank, transcript 158.40, 170.9, 194.1; Tab 5B, MF11.
- <sup>17</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 165.21; Susan Browbank, 2 October 2008, Shellharbour transcript 192.4, 193.5.
- <sup>18</sup> Susan Browbank, 2 October 2008, Shellharbour transcript 191, 192.8.
- <sup>19</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 73-74.
- <sup>20</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 160, 161.19.
- <sup>21</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 163.40.
- <sup>22</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 163, 165.25, 167.15, 169.39, 170.25-35, 171.10, 177.25, 206.
- <sup>23</sup> Written submissions on behalf of Sue Browbank dated 29 October 2008, pages 6-7.
- <sup>24</sup> Tab 6B, MF11.
- <sup>25</sup> Tab 6B, MF11.
- <sup>26</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 173.32.
- <sup>27</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 168.28.
- <sup>28</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 168.28; Written submissions on behalf of Sue Browbank dated 29 October 2008, page 5.
- <sup>29</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 183; Susan Browbank, 2 October 2008, Shellharbour transcript 206.46.
- <sup>30</sup> Written submissions on behalf of Susan Browbank dated 29 October 2008, page 6.
- <sup>31</sup> Written submissions on behalf of Susan Browbank dated 29 October 2008, page 7.
- <sup>32</sup> Susan Browbank, 2 October 2008, Shellharbour transcript 197
- <sup>33</sup> Susan Browbank, 2 October 2008, Shellharbour transcript 199.38, 200-201.
- <sup>34</sup> Susan Browbank, 2 October 2008, Shellharbour transcript 211.5
- <sup>35</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 76.35
- <sup>36</sup> Tab 7, MF11.
- <sup>37</sup> Tab 8, MF11.
- <sup>38</sup> Frank Testa, 30 September 2008, Shellharbour transcript 123.41.
- <sup>39</sup> Frank Testa, 30 September 2008, Shellharbour transcript 124, 125.
- <sup>40</sup> Susan Browbank, 2 October 2008, Shellharbour transcript 202.12; Tabs 7 and 19, MF11.
- <sup>41</sup> Susan Browbank, 2 October 2008, Shellharbour transcript 203.
- <sup>42</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 176.43; Susan Browbank, 2 October 2008, Shellharbour transcript 207.43.
- <sup>43</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 179.
- <sup>44</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 179.
- <sup>45</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 180.39.
- <sup>46</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 181.
- <sup>47</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 181.35.
- <sup>48</sup> Tab 8C, MF11.
- <sup>49</sup> Frank Testa, 30 September 2008, Shellharbour transcript 129.12.
- <sup>50</sup> Tab 9, MF11.
- <sup>51</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 183.44.
- <sup>52</sup> Susan Browbank, 30 September 2008, Shellharbour transcript 183.41
- <sup>53</sup> Tab 10, MF11.
- <sup>54</sup> Frank Testa, 30 September 2008, Shellharbour transcript 127.
- <sup>55</sup> Dr Simon Leslie, 23 September, Shellharbour transcript 18, 36; Frank Testa, 30 September 2008, Shellharbour transcript 128.

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- <sup>56</sup> Written submissions on behalf of Susan Browbank dated 29 October 2008, page 13.
- <sup>57</sup> Tab 11, MF11; Frank Testa, 30 September 2008, Shellharbour transcript 128.
- <sup>58</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 87.19; Frank Testa, 30 September 2008, Shellharbour transcript 129.47.
- <sup>59</sup> Frank Testa, 30 September 2008, Shellharbour transcript 128-129, 133.24; Tab 10A, MF11.
- <sup>60</sup> Frank Testa, 30 September 2008, Shellharbour transcript 132.20.
- <sup>61</sup> Frank Testa, 30 September 2008, Shellharbour transcript 135, 137; Tab 13, MF11.
- <sup>62</sup> Frank Testa, 30 September 2008, Shellharbour transcript 130, 132.35; Tab 11, MF11.
- <sup>63</sup> Frank Testa, 30 September 2008, Shellharbour transcript 135.39.
- <sup>64</sup> Frank Testa, 30 September 2008, Shellharbour transcript 136.35-47; Tab 12, MF11.
- <sup>65</sup> Tab 16, MF11.
- <sup>66</sup> Tab 15, MF11.
- <sup>67</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 97.32, 97.20 and 98.12
- <sup>68</sup> Written submissions on behalf of Susan Browbank dated 29 October 2008, page 15.
- <sup>69</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 95.34
- <sup>70</sup> Dr Simon Leslie, 23 September, Shellharbour transcript 26.
- <sup>71</sup> Frank Testa, 30 September 2008, Shellharbour transcript 120.
- <sup>72</sup> Dr Simon Leslie, 23 September, Shellharbour transcript 23,
- <sup>73</sup> Frank Testa, 30 September 2008, Shellharbour transcript 131.17.
- <sup>74</sup> Frank Testa, 30 September 2008, Shellharbour transcript 131.14.
- <sup>75</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 94-95.
- <sup>76</sup> Dr Simon Leslie, 23 September 2008, Shellharbour transcript 28.
- <sup>77</sup> Tab 17, MF11.
- <sup>78</sup> Dr Simon Leslie, 23 September 2008, Shellharbour transcript 30.
- <sup>79</sup> Frank Testa, 30 September 2008, Shellharbour transcript 139.37.
- <sup>80</sup> Dr Simon Leslie, 23 September 2008, Shellharbour transcript 30.30.
- <sup>81</sup> Dr Simon Leslie, 23 September 2008, Shellharbour transcript 30.35.
- <sup>82</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 104.33.
- <sup>83</sup> Frank Testa, 30 September 2008, Shellharbour transcript 139-140.
- <sup>84</sup> Susan Browbank, 2 October 2008, Shellharbour transcript 227.36.
- <sup>85</sup> Affidavit of Professor Debora Picone sworn 30 October 2008.
- <sup>86</sup> Tab 20, MF11.
- <sup>87</sup> Tab 25, MF11.
- <sup>88</sup> Tab 27, MF11.
- <sup>89</sup> Dr Simon Leslie, 23 September 2008, Shellharbour transcript 38.
- <sup>90</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 106.35.
- <sup>91</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 107.
- <sup>92</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 87.17-32; Dr Simon Leslie, 23 September, Shellharbour transcript 12.19; Frank Testa, 30 September 2008, Shellharbour transcript 129.
- <sup>93</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 88.13, 103.22.
- <sup>94</sup> Michael Brodnik, 30 September 2008, Shellharbour transcript 102.27.
- <sup>95</sup> Frank Testa, 30 September 2008, Shellharbour transcript 130.
- <sup>96</sup> Sue Browbank, 2 October 2008, transcript 246.40.
- <sup>97</sup> Sue Browbank, 2 October 2008, transcript 246.15 and 246.23.
- <sup>98</sup> Dr Simon Leslie, 23 September 2008, transcript 2.46-4.45.

- <sup>99</sup> Dr Simon Leslie, 23 September 2008, transcript 4.38.
- <sup>100</sup> Dr Raghu Murthy, 14 October 2008, transcript 330.41.
- <sup>101</sup> Sue Browbank, 2 October 2008, transcript 253.37.
- <sup>102</sup> Sue Browbank, 2 October 2008, transcript 258.1.
- <sup>103</sup> Sue Browbank, 2 October 2008, transcript 258.47.
- <sup>104</sup> Sue Browbank, 2 October 2008, transcript 259.11.
- <sup>105</sup> Sue Browbank, 2 October 2008, transcript 261.44.
- <sup>106</sup> Dr Simon Leslie, Wollongong Hospital hearing, 14 April 2008, transcript 1708.17.
- <sup>107</sup> Sue Browbank, 2 October 2008, transcript 267.26.
- <sup>108</sup> Dr Simon Leslie, 23 September 2008, transcript 50.25-50.32.
- <sup>109</sup> Sue Browbank, 2 October 2008, transcript 267.26.
- <sup>110</sup> Sue Browbank, 2 October 2008, transcript 281.21.
- <sup>111</sup> Sue Browbank, 2 October 2008, transcript 284.37.
- <sup>112</sup> Dr Simon Leslie, 23 September 2008, transcript 57.19-57.45
- <sup>113</sup> Dr Simon Leslie, 23 September 2008, transcript 65.23-65.40.
- <sup>114</sup> Sue Browbank, 2 October 2008, transcript 290.8.
- <sup>115</sup> Submissions on behalf of Sue Browbank to the Commission of Inquiry into Acute Care Services, 29 October 2008.
- <sup>116</sup> NSW Health, *Restructure Procedures*, PD2005\_321.
- <sup>117</sup> Attachment (tab "S") to submissions on behalf of Sue Browbank to the Commission of Inquiry into Acute Care Services, 29 October 2008.
- <sup>118</sup> Sue Browbank, hearing at the Inquiry's office, 2 October 2008, transcript 261.44.
- <sup>119</sup> Written submissions on behalf of Sue Browbank, 29 October 2008, page 24.
- <sup>120</sup> Submission from Dr Simon Leslie, 18 June 2008, SUBM.077.0210.



