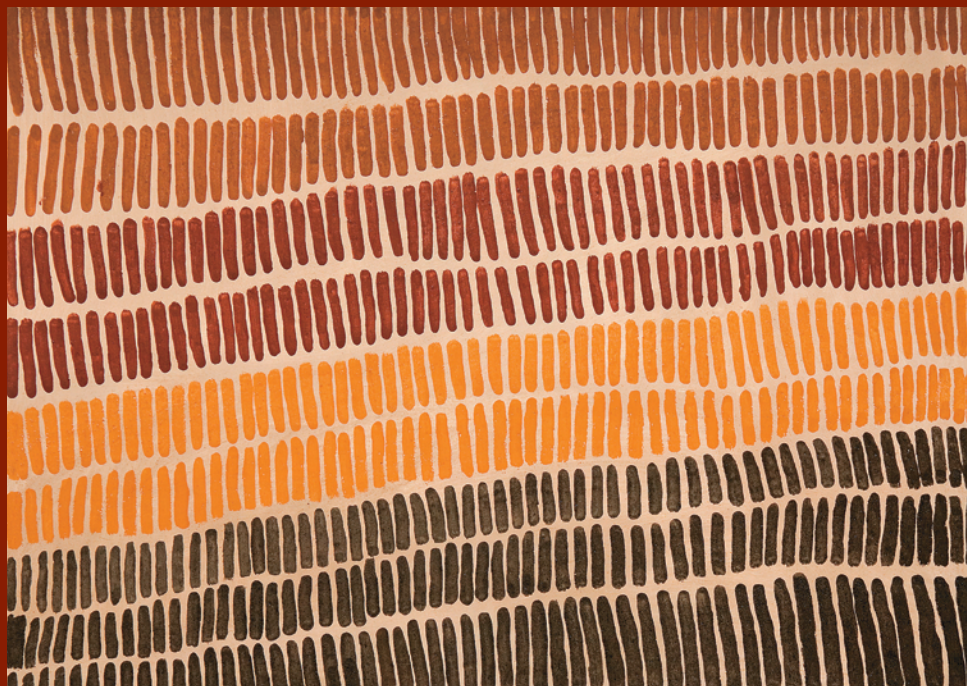




Special Commission of Inquiry
Acute Care Services in NSW Public Hospitals

Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals

Overview



Peter Garling SC
27 November 2008

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Acute Care Services in New South Wales Public Hospitals

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Overview

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Introduction

- 1.1 In this volume, I set out an overview of the work of my Inquiry and what my reflections are on the public hospital system in NSW. I draw attention to the principal recommendations which I make, and I include a comprehensive list of all recommendations made in my Report.
- 1.2 The detailed reasoning for my conclusions will be found in the Report itself. I intend this volume will enable those who have only limited time and interest to get an understanding of my views and recommendations.
- 1.3 Readers will see that some of my recommendations use terms and phrases which assume the acceptance of other recommendations. I caution that textual alterations may need to be made if not all of my recommendations are accepted.

Background

- 1.4 In the months before and since this Special Commission of Inquiry commenced, there has been public disquiet over the state of the NSW hospital system. This has been the result of highly publicised incidents which cast doubt in the public mind on how safe our public hospitals were and whether the quality of care they provided was what patients and their families and friends were entitled to expect.
- 1.5 During the course of this Inquiry, I have visited 61 public hospitals; heard evidence from 628 people including patients, community members, doctors, nurses and allied health professionals; received over 1200 written submissions from over 900 individuals and organisations; conferred with 27 peak bodies such as the specialist medical colleges, professional associations like the Australian Medical Association and the NSW Nurses' Association; and received extensive briefings from NSW Health and representatives of the 8 area health services which are the main organisational units which operate the hospital system. I have had the benefit of a 2-day conference with 22 experts from Australia and overseas on reforming the system and a one-day conference devoted to paediatric health issues.

NSW Health: A typical day

- 1.6 It is necessary for me to provide some context so as to allow a good understanding of the issues raised during the Inquiry. I thought that a sketch of some facts about a typical day for NSW Health would be helpful.
- 1.7 On a typical day for NSW Health across the state of NSW, there will be:
- an ambulance responding to an emergency 000 call every 30 seconds;
 - 6,000 patients arriving at Emergency Departments seeking treatment;
 - 4,900 new people being admitted as an in-patient at a hospital;
 - 17,000 people occupying a hospital bed of whom 7,480 are over 65 years old;
 - 7,000 separate procedures performed; and
 - \$34 million spent on providing care in public hospitals and for the health of the people of NSW.

NSW Health: A Paradox

- 1.8 The documents and the data confirmed the weight of the oral evidence and presentations on a number of points. The experts all agreed.
- 1.9 First, NSW still has one of the better public health care systems in the developed world. Measured by per capita spending on health care, by the number of beds per 1,000 of population, by clinician to patient ratios or by expectation of life, Australia's performance ranges from close to the average up to the top 4 or 5 of the 20 leading Organisation for Economic Co-operation and Development (OECD) nations. The Australia-wide figures hold good for NSW.
- 1.10 Secondly, the doctors, nurses and clinical staff are well-trained and skilled. They are caring and dedicated and are able to provide some of the most sophisticated medical care available in today's world. The public hospital system is equipped with modern diagnostic and procedural equipment and aids of a high standard to assist them in their work.
- 1.11 Thirdly, the community of NSW supports the investment in health care to the tune of over \$13 billion or 27% of the budget of the NSW state government. This amount includes a Commonwealth government contribution. Per capita spending across the whole system is close to the OECD average.
- 1.12 Fourthly, modern communications mean that those with grave injuries or illness can expect to be transported quickly to a centre of excellence such as one for burns, major trauma or intensive care. Those who require complex life saving procedures such as organ transplants can have them for free without travelling out of the State.
- 1.13 These facts suggest that applying the usual international criteria, Australia and NSW have a public hospital system of high standard. What then is the public to make of the alarming reports which regularly appear in the media and suggest quite the opposite?
- 1.14 One explanation is that even the best systems are not immune from crises and the public health system has entered one such period now.

NSW Health: On the Brink

- 1.15 There are several developments which support this view. More people are using the public hospital system than ever before - more than can be accounted for by population growth alone. Among these are increasing numbers of elderly patients with complex, chronic conditions which require longer stays in hospital and more specialist teams to treat them. The young also are presenting to public hospitals in greater numbers than was anticipated, especially to the Emergency Departments. Of them, a significant proportion may have mental health problems along with drug and alcohol dependence.
- 1.16 Demographic changes mean that Australia has an ageing population which will require proportionately more care as the age groups survive through their 70s and well into their 80s. In 2006-07, one-third of all public hospital patients were aged over 65 years, although that group made up only 13.5% of the state's population. By now, those aged over 65 years make up 45%, nearly one-half, of all public hospital patients.
- 1.17 Demographic changes also mean that the population no longer lives where the hospitals were built and have existed for many years. The skilled workforce, particularly

- doctors, are not evenly distributed amongst the population. The sandstone curtain of the Great Dividing Range provides a barrier which the skilled workforce finds hard to cross.
- 1.18 The costs of treatment are also rising along side the number of patients. Technological advances have made available expensive diagnostic tools such as colonoscopy, magnetic resonance imaging, computed axial tomography, surgical procedures such as angioplasty to unblock blood vessels and hip and knee replacements, expensive medications and much else.
- 1.19 These developments have also affected the make-up of the hospital workforce. Increasingly newly qualified practitioners have been attracted into work as proceduralists, where the rewards (which are in part driven by the Medicare schedule of fees) are greater, and away from work as generalists where the need is greatest but rewards are considerably less. The problem was made worse during the 1990s when the Commonwealth discouraged the entry of more doctors into the workforce through its control over undergraduate places. As a result there is a shortage of doctors, particularly general practitioners, which the experts predict will not be brought back into line for several years, if then.
- 1.20 The nursing workforce faces similar challenges with 22% of the entire profession in NSW qualifying for retirement in 2011 which is just 3 years away. The nurses in public hospitals are frequently junior nurses with insufficient senior nurses available to supervise them.
- 1.21 It is not surprising that, in this environment, the safety of the patient and the good quality of patient care have begun to suffer. But for the goodwill and dedication of the public hospital workforce, this would have happened sooner and been much greater.
- 1.22 If I were to sum up my conclusions about the performance of our public hospitals following ten months investigation, I would describe our hospitals as good by world standards, in many cases ranking towards the top, but too often unable to deal with the sudden increase in patients, the rising cost of treatment, and the pressures on a skilled workforce spread too thinly and too poorly supported in the dozens of administrative tasks which take them away from their patients.
- 1.23 Given the demographic changes and the rising costs, it is the case that we have entered into a period of crisis for a public hospital system which has always been free and accessible to all. If public hospitals are to survive as providers of free care for all, there will have to be some radical changes in the way they do business. We are on the brink of seeing whether the public system can survive and flourish or whether it will become a relic of better times.
- 1.24 To start with, a new culture needs to take root which sees the patient's needs as the paramount central concern of the system and not the convenience of the clinicians and administrators. It may seem a simple example, but were senior specialists to do their ward rounds before 10 o'clock in the morning and thus discharge their patients before noon and free up each of those beds for another patient, the hospital would save many, many bed days and shorten the waiting time for patients to get a bed. The failure to do morning rounds contributes to bed block, the daily traffic jam of the public hospital system. Ward staff need to plan discharges well in advance so that when the specialist signs off on the patient, he or she will have a home or aged care facility ready to go to with sufficient care assured. When they don't, the traffic jam only gets worse.
- 1.25 The doctors, nurses and allied health professionals will need to replace the old system where different specialists would see the patient but no one person would necessarily

take complete charge of the patient's care. A new model of teamwork will be required to replace the old individual and independent "silos" of professional care.

- 1.26 Furthermore, the rigid demarcation between what a doctor's job is, and what a nurse's job is, needs to be consigned to history. Once the concept of teamwork is accepted as the norm in treating a patient, it is easier to see why a qualified nurse practitioner should be able to do many jobs once reserved for doctors.
- 1.27 This report identifies many ways in which work practices can be streamlined and brought into the 21st century. This applies to how clinicians deliver their services and treat their patients. Most of the common practices and procedures in medicine could be performed according to a uniform, best-practice model of care. The evidence shows that patients are better cared for and are safer from mishaps where clinicians adopt uniform best-practice. There are 2 steps in this reform which must be taken.
- 1.28 The first step is to engage the dedication of clinicians in designing new models of care which are supported and actively championed by clinical leaders in the field, which are evidence-based best practice, and which can be monitored to track the degree of success. To achieve this, I have taken up the many existing networks of clinicians and recommended that they become part of a new, more comprehensive agency which will be tasked to coordinate and drive constant innovation across the whole system. I have suggested that it be called the Clinical Innovation and Enhancement Agency, and be responsible for continuing reform and improvement of clinical models of care and practices.
- 1.29 The second step is to implement the changes required by the new models of care at the clinical unit level. This requires the active support of clinical leaders to be the champions of the changes.
- 1.30 I have accepted the overwhelming evidence that this can only be achieved if NSW Health adopts a whole new approach to information technology:
- new targets must be set for completing the infrastructure and mining the existing data sets able to keep a day-to-day track on performance at the unit level;
 - the data must be made available in real time to the units in the hospital and their peers in other hospitals;
 - the clinical leaders of the units, the head doctor and head nurse, must sign off on all data relating to safety and quality issues in their units: such as infection rates, and the happening of adverse event and display their results proudly and publicly;
 - the data is to be directed to better patient safety and better care, and not just to administrative, process-driven information which does not improve the patient's lot.
 - the performance of every area health service including the chief executive, measured by up-to-date data, is to be assessed first and foremost by the quality of care and the safety of patients in the public system, and this should be expressly stated.
- 1.31 To achieve this reform, I have recommended that a Bureau of Health Information be established to access, interpret and report on all data relating to safety and quality of patient care and facilitate its interpretation and re-issue to the unit level on a regular basis. The information collected is to be directed to how well the patient has been treated, not to process-driven, often politically-driven, data which may make administrators more comfortable, but not the patients
- 1.32 This Bureau should be independent from NSW Health and would stand alone or else form part of the Clinical Excellence Commission which should continue its present tasks

in the area of safety and quality of patient care. I applaud the work of the Clinical Excellence Commission and suggest enhanced areas for its involvement.

- 1.33 The changing of a professional culture can only occur if the why and wherefore of reform is taught in the undergraduate and early clinical training years. The creation of a modern, well trained, flexible hospital workforce is a major objective of the recommendations I have made. In particular, I recommend that an Institute of Clinical Education and Training be established with a broad mandate to take charge of the training of a new generation of clinicians in inter disciplinary team-based treatment of patients, and to assess and evaluate the clinical training of junior doctors, nurses and allied health professionals.
- 1.34 I regard the Clinical Innovation and Enhancement Agency, the Clinical Excellence Commission, the Institute of Clinical Education and Training, and the Bureau of Health Information as the four pillars of reform of the public hospital system. They should at all times reflect in their work a number of principles: that redesign of clinical practices must be a bottom-up reform driven by clinicians; that information about the safety and quality of treatment at the unit level is the greatest guarantee of a quick change-over to evidence based best practice models of care; that the only way to avoid a slide of the present clinical standards into mediocrity or worse is by strengthening the training of new clinicians in better, safer treatments based on a patient centred team approach; that the safety and quality of public hospital care should be the highest priority of the public hospital system, and that its employees need to implement this at the individual patient level.
- 1.35 NSW Health has acquired a great deal of expertise over the years in shaping the policy direction of an organisation which by any standards is very large and very complex. If NSW Health was a publicly listed company, it would probably be the 15th largest company in Australia. In my opinion, the looming crisis for public hospitals has happened so quickly that it is not surprising that the organisation has been slow to implement radical reform.
- 1.36 However, the changes ahead are very far-reaching and will require managerial skills which may not be natural to a largely public policy body. In that regard, I think that it is likely that the changes which I have outlined to drive reform which should be implemented by NSW Health may require assistance from change managers in the private sector. The implementation of change such as I have recommended requires change management at the levels of the central office of NSW Health, the area health services, the hospitals and the units. All four levels need to be educated in change and helped in its day-to-day implementation. Too often in the past, innovation in the form of new information technology has failed dismally because the administrators failed to provide the practical guidance at the coalface. The reforms which I recommend will likewise founder without specialist expertise in operational change: after all, the changes must be made whilst the work of treating patients continues along side.
- 1.37 To implement change of the order which I have recommended should not be attempted by "decree". It cannot be done simply by issuing an order to the area health services and the units and the individual practitioners. They will need practical assistance from experienced change managers perhaps from outside NSW Health working in collaboration at all levels of the organisation.
- 1.38 The terms of reference, contained in the commission which Her Excellency the Governor of NSW issued, use the phrase "model of care" a number of times and I should say something at the outset as to its different usages. It has been used to describe the way health services are delivered. NSW Health state that:

"[A] model of care is a description of how care is managed and organised."

"...the model of care provides the clinical and organisational framework for the service".¹

- 1.39 An example of this use of the term "model of care" are models of care used in Emergency Department, such as, the use of Emergency Medicine Units (EMU), being short stay beds for Emergency Department patients who do not require inpatient admission; or the "Fast Track" initiative, which provides access to timely care for those with a minor injury or illness. The term "model of care" extends to the use of particular clinicians to undertake care: for example, the use of an Emergency Nurse Practitioner to diagnose and discharge patients within Emergency Department, is also captured by the term "model of care".
- 1.40 The term "model of care" has also been used to refer to what could be also described as a clinical protocol or clinical pathways. A clinical protocol is evidence-based best practice used at the ward level and intended to reduce unacceptable variation and deliver high quality, safe and cost effective treatment to patients. For example, a nurse or junior doctor delivers care to a patient according to a clinical protocol and is not empowered to depart from the steps set out there in other exceptional cases.
- 1.41 A "model of care" is also described as a consensus developed by a group of informed clinicians about a process of care that is applicable to their particular domain of activity: for example, the steps to be taken in the diagnosis and treatment of a patient who presents with symptoms of stroke.
- 1.42 I do not intend to be overly rigid in my interpretation regarding the term "model of care" since it covers both methods of care at the individual patient level and the clinical and organisational framework at the unit, the hospital, and even the state-wide levels.
- 1.43 It is not part of my functions to prescribe the treatment of patients, but rather to recommend the framework in which new models of care representing up-to-date best practice will be continuously proposed and implemented. It involves a program of ongoing innovation and an institutional framework, as set out above, which will ensure the involvement of clinicians at all stages.
- 1.44 To ensure that reform does take hold at the front-line, I have recommended that an assurance and oversight process be established to report quarterly to the Minister for Health on the progress of the reforms with a view to the report being presented to Parliament. The precise form of the process I will leave to the good sense of the Minister, but the process must be independent of NSW Health, transparent and rigorous. The process is intended to provide to the Minister, and, through the Minister, to the NSW Parliament and people of NSW, an independent running report card of whether and how well the recommendations are being implemented. These reforms will not happen overnight. They will take several years to implement. Everyone must be kept fully informed about what is happening.

¹ Submission of NSW Health, 14 April 2008, SUBM.075.0002 at 59, 72 and 92.

NSW Health: Back from the Brink

- 1.45 In outlining my recommendations in this section, I note again that in all cases they are based upon the principle that the safety of the patients and the quality of their care is paramount. A system must be designed to ensure that this value is translated into action where it matters, namely at the bedside.
- 1.46 The four pillars of reform that I have referred to will require NSW Health to change and adapt to the new. Because reform can only be driven by information which proves on the evidence the best models of care for the patient, I begin with the investment in information technology which must be made. Already NSW Health has made advances in introducing electronic medical records and digital systems for calling up medical imaging results. For budgetary reasons, however, these are spasmodic and patchy across the areas, and even within the hospitals.

Information Technology

Page 7

- 1.47 The adoption of a policy to introduce up-to-date information technology within 4 years in line with the deadlines set out below is necessary if NSW Health is to provide safe, quality care for patients. Just as a railway system becomes dangerous for passengers when the signal network is old and out-of-date, so too a public hospital system becomes dangerous for patients when information about risky practices is lost in the clerical maze. Passengers may never be aware of the signals system but their lives depend on it. The lives of patients depend upon clinicians seeing the risks and eliminating them. Because IT reform is largely hidden, there will be no feel-good moment which comes from cutting-the-ribbon to open a new facility. However, it will surely save many lives, and protect many, many more from harm.
- 1.48 A change will need commitment at a government level because of the experience needed and the size of the task for the whole state. Already NSW Health has embarked upon one of the largest IT projects in the country. My recommendation is to make this a priority of government so that it is completed quickly and efficiently. A full discussion appears in chapter 14 *Clinical records & information technology*.
- 1.49 My recommendations will require that the current NSW Health information technology program needs to be considerably accelerated so that it is entirely completed by end of financial year 2013. I propose the following revised time lines for the completion of the implementation across NSW of the NSW Health information technology program:

Stage 1: 12 months	Infrastructure
Stage 2: 18 months	Electronic medical record Patient Administration System
Stage 3: 24 months	Human Resources Information System Business information strategy Medical imaging Intensive care Hospital pharmacy system
Stage 4: 36 months	Community health system redevelopment Automated rostering Clinical Documentation Medication management
Stage 5: 48 months	State-wide roll out of the electronic health record

- 1.50 In addition to the initial funding provided for the provision of any information technology project, it is necessary for NSW Health to ensure that each of the systems are maintained, upgraded and continuously improved.
- 1.51 Because regional, rural and remote hospitals are unable to have all of the highly skilled specialists working in their hospitals, the only way to make those skills promptly available is by the use of e-Health technology. What needs to happen is that a high speed broadband network should be established within 18 months securely linking all public hospitals in NSW so as to enable the provision of specialist clinical services and support via the network from metropolitan-based clinicians and hospitals to regional, rural and remote clinicians and hospitals.
- 1.52 Until this network is installed, and metropolitan clinicians share the burden of regional, rural and remote clinicians in caring for their patients, there will always be two systems of hospital care in NSW.

Health Information

- 1.53 There is already a great reservoir of information available within NSW Health from which data are available to measure the quality of patient care and the safety of patients who receive care in hospitals.
- 1.54 The problem is not collecting information itself but rather gathering it, understanding its meaning and interpreting it for the practitioners down to the ward or clinical unit where the patients are cared for. It does not help if data which show a particular clinical procedure is risky are held in a computer at the headquarters of NSW Health in North Sydney until that data is interpreted and explained at the ward or unit level to the very people who carry out the procedure.
- 1.55 All of the leading world experts to whom I spoke, told me that understanding, analysing and publishing sensibly health information will lead to big improvements in health care. They are right. Information is the basis for knowing where health care in hospitals is at, where it has to go, and when it has arrived.
- 1.56 This reform, together with the Information Technology reforms, are of the highest priority.
- 1.57 A Bureau of Health Information should be established in accordance with the principles discussed more fully in Ch 16 Safety and Quality.
- 1.58 The substance of my recommendation is that within a very short space of time, 3 months, NSW Health should establish a Bureau of Health Information, which has is independent of the Department and which is either a stand alone body or else part of a stand alone body.
- 1.59 After the Bureau is established, my recommendations see that it is quite quickly to identify, develop and publish patient care measurements which are a much more comprehensive way of seeing how the patients in NSW public hospitals are being looked after. Rather than just asking how quickly the patients were seen, these criteria try and measure how well the patient got along and whether they were treated safely and properly. These are the measurements which I have in mind:
- (a) **Access:** Access to and availability of hospital services including timeliness of the provision of services and proximity to a patient's home or locality. Availability of

alternative community or home based services in lieu of the hospital services and whether and how far they were utilised;

- (b) **Clinical:** Clinical performance including patient outcome, appropriateness of clinical treatment method, the variation, if any, from protocols and models of care, and identified benefits or detriments to the health and wellbeing of the patient;
- (c) **Safety and Quality:** Safety and quality of the clinical care and the hospital attendance or admission;
- (d) **Cost:** All costs of and associated with the provision of the episode of the clinical care including amount elements of episode funding cost calculation, transport cost to and from hospitals if provided by NSW Health, cost of any clinical complication, eg., hospital acquired infection, re-presentation or re-admission cost, and error cost (including provision of additional care, medication, diagnostic tests and/or counselling services and any financial settlement including litigation costs);
- (e) **Patient:** Patient experience and satisfaction;
- (f) **Staff:** Staff experience and satisfaction;
- (g) **Sustainability:** System impact and sustainability.

- 1.60 I envisage, and make recommendations to this effect that after being in operation for a year the Bureau should start publishing quarterly reports, within 60 days of the end of the reporting period, which disclose the performance of each unit or ward, hospital, area (or functional) health service and NSW Health as a whole by reference to the patient care performance criteria which I have just set out above. It will then be important for NSW Health to decide a year later whether the time has come to continue with these measurements and leave behind the current regime which really only measures how quickly people are seen in the Emergency Department or else have their surgery. I hope by that time that NSW Health will be able to move on from the current processing indicators to the more sophisticated ones which I have suggested.

NSW Institute for Clinical Education and Training

- 1.61 The safety and quality of care provided to patients in public hospitals depends upon the skill of the whole hospital workforce which in turn depends upon how well they were trained before coming to the hospital, and how well they continue to be trained within the hospital after they join the staff.
- 1.62 The division of responsibility for the education of the professional staff is divided between the Commonwealth and the State. The undergraduate years are federally funded through university places whereas postgraduate training falls to the state and largely with the public hospital system. Specialist vocational training is provided by a complex mix of specialist medical colleges, both the public and private hospital systems and as well some Commonwealth government funding.
- 1.63 The period of post-graduate clinical training of doctors, nurses and allied health professionals is essential if safe models of care based on best-practice are to be provided always and everywhere to patients admitted to NSW public hospitals.
- 1.64 So far, training for everyone in the public hospital system has often been ad hoc rather than planned, too often cancelled if pressure of other business requires or money runs out. This is especially serious in circumstances where junior medical officers and junior nurses are frequently the only professionals on duty through the night to care for patients.

- 1.65 Like the railway signal system, the training of new clinicians is a down payment on a safe, good quality system of health care in public hospitals. To ensure proper clinical training of professional staff from new graduates to registrars, I have made a number of recommendations concerning training which are designed for the protection of patients whose treatment is in the hands of trainees.
- 1.66 However, it will be seen from the recommendations that they proceed on the basis that education and training needs to continue long after graduation. For example, the serious shortage of generalists among doctors, and the difficulties in managing the care of patients with chronic, complex conditions under several specialist doctors, has led to the trialling of a clinician position known as a hospitalist. The hospitalists have been drawn from, inter alia, the ranks of experienced career medical officers (CMOs) already well-established on hospital staffs. They are trained to “navigate” a patient through complex care and to co-ordinate the work of two or more staff specialist or consultants.
- 1.67 Similarly, many experienced doctors and nurses, in the latter years of practice, would welcome a career as clinical leaders and health system leaders. They are a resource of rich experience. But they would need to be trained to make the transition.
- 1.68 The remit of the NSW Institute for Clinical Education and Training is very wide and covers the on-going job of keeping learning and skills updated in an era of unprecedented change and progress in health care.
- 1.69 Whilst clinical training and education needs to be enhanced, I was, and I think the public would be, surprised to learn that from the time a person leaves school until they qualify as a medical specialist is often 17 or 18 years. The demands on the current system cannot tolerate this rather leisurely 19th Century approach and I have recommended that the Institute explore in collaboration with the relevant stakeholders how this can change for the better.
- 1.70 What I see as a part of the essential task for the Institute is to change training culture which labels only a handful of facilities as “teaching hospitals”. From now on, I would like to see every hospital in NSW be labelled a “teaching hospital” because ongoing education is at the heart of safe, good quality patient care.
- 1.71 My recommendations see the establishment of a statutory health corporation to fulfil the role of a NSW Institute for Clinical Education and Training. I envisage that the Institute is to have a number of roles, purposes and functions, but it ought to have, at least, the following principal purposes and functions:
- (a) to design, institute, conduct and evaluate a program for the postgraduate clinical education and training for all new postgraduate professional clinical staff employed in NSW public hospitals;
 - (b) to design, institute, conduct and evaluate leadership training for clinicians to enable clinicians to become clinical leaders and also health system leaders;
 - (c) to design, institute, conduct and evaluate training for clinicians to enable clinicians to become skilled teachers and trainers for the trainees in all of the programs conducted by the Institute;
 - (d) to design, implement and oversee an appropriate performance evaluation program for professional clinical staff whilst undergoing postgraduate clinical training; and
 - (e) to design, implement, conduct and evaluate clinical education and training to enable medical practitioners to be qualified, competent and capable of practising as hospitalists in NSW public hospitals.

- 1.72 I see it as very important for the Institute to adopt some guiding principles, including the following:
- (a) that clinical education and training should be undertaken in a multi-disciplinary environment which emphasises inter disciplinary team based patient centred care;
 - (b) that the education and training be delivered by the most appropriate and suitable person regardless of the profession or specialty of the individual, and including, where appropriate, non-clinically trained personnel;
 - (c) that all prevocational clinical staff enrolled in the Institute's programs be required to spend a minimum of 20% of their ordinary rostered time in Year One and a minimum of 10% of their time in Year Two participating in the training programs; and
 - (d) that the clinical education and training program for prevocational clinical staff include at least four different components, namely:
 - (i) Formal teaching to which currently employed and contracted senior clinical staff would contribute;
 - (ii) E-learning by self-completed modules;
 - (iii) Simulation training conducted by senior clinical staff at simulation centres and facilities;
 - (iv) and Clinical skill modelling where postgraduate clinical staff are supernumerary for the relevant mandatory time to enable observation of, and modelling of, clinical skills being demonstrated by senior clinicians.

The divide between clinicians and managers

- 1.73 During the course of this inquiry, I have identified one impediment to good, safe care which infects the whole public hospital system. I liken it to the Great Schism of 1054. It is the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system. If it continues, NSW will risk losing one of the crown jewels of its public hospital system : the engagement of the best and brightest from the professions who are able to provide world-class care in public hospitals free of charge to the patient.
- 1.74 So serious is this problem that I have approached it at each level of the public hospital system. At the state-wide level through a Clinical Innovation and Enhancement Agency. At the area level, through an Executive Clinical Director who should be a recognised clinical leader able to speak on behalf of doctors and other clinicians and who is to be consulted by the area chief executive on all matters affecting clinical procedure. At the hospital level by reconnecting clinicians with management through devolving more power from the area chief executive to local managers, including program, stream and unit leaders. At the clinical unit level by involving clinicians (along with allied health professionals and patient representatives) in the re-design of clinical practices and by involving them in the monitoring of all safety and quality of care data for the individual unit or ward.

Clinical Innovation and Enhancement Agency

- 1.75 To address clinician involvement at the state-wide level, my recommendations suggest that continual innovation and improvement must be driven from the bottom up by the

clinicians who are going to deliver the care. NSW Health should a Clinical Innovation and Enhancement Agency, which uses networks of clinicians to champion and drive change and improvements for the good of the patients. The Agency needs a central reservoir of skills to help these networks and my recommendations are quite specific about this.

- 1.76 As I see it, the Agency is to have, at least, the following principal purposes and functions:
- (a) to identify, review and enhance or else to research and prepare standard evidence based protocols or models of care guidelines for every unexceptional surgical intervention, and the common disease or syndrome treatment modalities encountered in NSW public hospitals;
 - (b) To investigate, identify, design, cost and recommend for implementation changes in patient care by way of enhancements or improvements in clinical practice, including the content and method of such practice, in order to ensure, on an ongoing state-wide basis, better, safer, more efficient and more cost-effective patient care;
 - (c) To provide advice to NSW Health, or any Area, or functional Health Service, on any matter relating to the enhancement or improvement of clinical practice.
 - (d) To liaise with change managers from the private sector retained to assist in the introduction of clinical re-design at the Area, hospital and unit levels and provide the point of contact between change managers and NSW Health.
- 1.77 Because there are a broad range of networks of clinicians throughout NSW Health, my recommendations see this as an opportunity to bring all of these networks together under the one umbrella to march forward together with the aim of improving and enhancing patient care with continual innovations.

Executive Clinical Director

- 1.78 The next step which I see as necessary to address the clinician and management divide at the area health service level is to create a position for a senior doctor to be a close adviser to the Chief Executive of the Area and so I recommend that within 3 months, NSW Health should create within each area health service, a position entitled "Executive Clinical Director". That position is intended to ensure that the Chief Executive is kept well and independently advised about clinical matters and to give doctors and other clinicians an assurance that their voice will be heard by the Chief Executive of an area.

NSW Kids

- 1.79 There is one further area where I have come to the conclusion that a major organisational change should be made to improve patient care. At present, care for seriously sick new-borns and children is provided in specialist children's hospitals at Westmead, Randwick and Newcastle.
- 1.80 We have to teach the children of NSW that being healthy allows them to do whatever they want to do when they grow up. We need to help them with early intervention programs like vaccinations which prevent them from becoming seriously ill. We need to educate them about healthy eating and exercise because obesity is a major looming crisis. When they get sick, they are often harder to cure and take more time to nurse

than adults do. Unless in a professional and focussed way we address the health of our children, the future cost to the whole of society would be very great indeed.

- 1.81 The children of NSW are our future. If we do not take especially good care of them we will always regret it.
- 1.82 The responsibility for acute care services for new-borns and children should be taken over by a newly created body which is a single health service for the whole state. I have called it NSW Kids. It has two early tasks. The first is to plan how best it can organise all of the hospital facilities wherever they are around NSW which look after children to make sure that the children of Walgett get as good care as do the children of Woollahra and Wollongong. The other important task which it will need to do sooner rather than later is the planning (which would be likely to take a decade or more to come to fruition) of a single new tertiary and quaternary level children's hospital to service the whole state.
- 1.83 Every action implemented by NSW Kids should adhere to the guiding principle that the paramount consideration in the provision of health care is the promotion of the health and well-being and the prevention, diagnosis, treatment and cure of the illnesses in a manner which best promotes the wellbeing of children and young people.
- 1.84 NSW Kids will need to establish and maintain close links with maternal and perinatal health services conducted throughout NSW to promote the health and well-being of unborn children, and simultaneously promote maternal health and well-being.
- 1.85 It will be important for NSW Kids to pay attention to these purposes which I recommend:
- (a) The striking of, and the maintenance of, a proper funding balance between the provision of community based services, including inter-agency co-operation and prevention measures, and the provision of acute care and related services in public hospitals;
 - (b) Ensuring that the standard of all health care provided to children and young people throughout public hospitals in NSW is consistent and is undertaken, so far as possible, in facilities or parts of facilities which are designated and set aside for such care and which do not include the provision of care for adults; and
 - (c) Ensuring that there are adequate services and facilities for the provision of mental health care to children and young people.

Deficiencies in present models of care in public hospitals

- 1.86 It would surprise many in the public to know that, as a rule, a person with an illness is often better off being treated outside rather than inside a hospital. Of course this does not apply to someone who suffered a serious accident or has taken the wrong medication or is suddenly struck with chest pains. But the bulk of chronic conditions are better dealt with in the home or in the community than in an acute care bed.
- 1.87 There are several high-risk areas in our public hospitals which relate to:
- (a) how hospitals organise the workforce and match it to patient care including how well the junior staff are supervised;
 - (b) how hospitals dovetail the work of one group treating the patient with other groups treating the same patient, including how notes are taken and the patient's clinical records are kept;
 - (c) how hospitals deal with the risks of human error, such as:

- (i) medication control;
 - (ii) infections;
 - (d) how hospitals ensure that a patient will spend in hospital only as much time as his or her treatment requires after which the patient will be discharged into proper after-hospital care:
 - (i) ward rounds and handover
 - (ii) planned discharge summaries;
 - (iii) transfer to community care.
- 1.88 They all bear upon how safe patients can expect to be in our public hospitals. I will deal with each of these in turn.

Supervision of Junior Doctors

- 1.89 The greatest barrier to good supervision is that by 6pm most senior clinical staff have emptied out of the hospital leaving the patients in the hands of the less experienced. As night time settles in and the registrars withdraw, the patients are given over to the care of the least experienced, most junior staff, with an occasional senior nurse visible at the end of the long corridors. Whilst hospitals largely operate on a 9am to 5pm routine from Monday to Friday, this is only about ¼ of the whole week. There remains 75% of the week which is regarded by hospitals as after-hours including the weekend. Illness has no respect for the clock or the day of the week however and much of the misadventure and adverse results occur after hours when experienced staff are hard to find.
- 1.90 In the course of my report, I have referred to cases where patients under the care of junior clinical staff have died, with all the burden of grief for the family and friends of the deceased, and the burden also carried by the inexperienced staff who were inadequately supervised, have failed to pick the signs of danger. The need for supervision is not limited to junior doctors and nurses. They are most often supervised by registrars who are around the hospital more of the time. Registrars also need supervision by specialists as they move up in the profession to become consultants themselves.
- 1.91 The need to create flexible hospital workforce flows from the in-built shortages of doctors and nurses under the present allocation of duties, coupled with the increased demands by an ageing population prone to complex, chronic diseases. Put simply, there is no way the present numbers of doctors and nurses and allied health professionals could cope with that demand. The problem will not be fixed simply by the influx of new medical and nursing graduates already in the pipeline.
- 1.92 A senior health bureaucrat summed up the challenge as follows:
- "Health needs to move from a craft based industry of many individual professionals practising independently to a managed business where the main goal is excellent patient care provided by multidisciplinary teams and assessed by patient outcomes and patient experience.
- The NSW health system needs to have a single direction, clear principles and standardised operating systems including standard models of care for common patient groups with key performance standard defined in performance agreements and implemented through a rigorous process of regular performance review with appropriate rewards and penalties.

Such an approach needs a strong management team capable of setting a clear direction and standards, forming constructive relationships with professional staff, involving them in designing the system of care delivery and ensuring adherence to that system by the whole team with consequences for those who do not function as a part of the team."

- 1.93 Quite so.
- 1.94 There will need to be two phases to this reform: the first is to change the allocation of tasks so that supervision can happen and the overall organisation of the workforce; the second is to introduce best practice across the system which will lead to new and often standardised, models of care which will be better for all patients.
- 1.95 The supervision of junior doctors is very important. Otherwise the patient can't be certain that they are going to be treated safely or well. My recommendations deal in some detail about how the supervision of junior doctors is to take place. Importantly, junior doctors must never be put in the position where they do not feel able to ask a more senior doctor for help and advice. Some senior doctors don't appreciate being disturbed at home or after hours and so discourage junior doctors from seeking their assistance. I hope that with my recommendations these difficulties should disappear. After all, if the patient needs help, then it should be given.
- 1.96 I think that it would be a good idea to get feedback from the junior doctors about what they think of their supervisors. That will soon tell us how well and diligently they are being helped.

Note taking & Clinical records

- 1.97 Any one patient in a public hospital is likely to be seen by at least three teams of nurses over the course of 24 hours, two or more junior doctors and registrars, as well as the consultant specialist. Allied health professionals will have a role to play as well. No one person will carry the information about the changes in the patient's condition, the medication that has been prescribed and often changed, the test results which have been ordered, and the treatment regimes instituted by the medical staff. All of this detail will be communicated as between nurses and nurses, nurses and doctors, specialists and registrars, registrars and senior doctors, clinicians and pharmacists and physiotherapists and dieticians and so on in 4 ways:
- (a) First, in clinical notes;
 - (b) Secondly, during multidisciplinary ward rounds;
 - (c) Thirdly, at handover;
 - (d) Fourthly by word of mouth.
- 1.98 There are many opportunities for mistakes and misinformation. Moreover clinicians are often tied to habit in the way they communicate and pay insufficient attention to the need to minimise the risk of error. Although it is 2008, doctors still write notes which cannot be read because of their poor handwriting. The following recommendations are made in the context of those earlier recommendations which look to the introduction of an electronic medical record for all public hospital patients by 2010. An electronic medical record will be legible, should contain alerts where there is an error in the dosage of drugs, or risk to the patient deduced from the observations, and can "follow" the patient in a way which paper records often fail to do. In the meantime, hundreds of thousands of patients will be treated using the old style clinical records, where the most

important requirements for their care, will not be read, or if they are they may not be legible. In Chapter 14, I make a series of recommendations which helps to deal with this subject.

Medication Control

- 1.99 I mention later that where possible a clinical pharmacist ought be included in the ward rounds. This derives from evidence of the high incidence of adverse results from medication errors. The coronial inquest into the death of Vanessa Anderson pointed to a clear medication error. It was not an isolated incident. I heard evidence that 26% of the 27,000 hospital related incidents reported on the Australian Incident monitoring Systems to 2002 were medication errors. The level at which medication causes harm and death within our hospitals has continued largely unabated. Clinical pharmacy reviews are known to reduce considerably these harms. Readmissions are materially reduced. The introduction of an electronic hospital pharmacy system would likewise be a major contribution to reducing the damage caused by medication error. But for a reason which escapes me, probably professional jealousy, the skills of clinical pharmacists are not being well used when they clearly should be. My recommendations in Chapter 9 are designed to reduce medication errors by improving medication control. I think that a clinical pharmacist should perform a clinical pharmacy review for each admitted patient. Such review has been shown to increase patient safety and reduce costs. Review should involve taking a patient's medication history, reviewing the patient's medical chart, and reviewing the patient's medications on discharge.

Hospital Acquired Infection

- 1.100 Along with medication errors, hospital acquired infections cause a great many deaths and illnesses within our hospitals. The estimates as to the cost in lost bed days in NSW in 2004-5 was 629,600.
- 1.101 The worst of these infections are from Methicillin Resistant Staphylococcus Aureus (MRSA). It is fatal for 35% of patients infected with MRSA in their bloodstreams. It is a ticking time-bomb and strong measures are needed. NSW has a very poor record of controlling this disease: Western Australia has 1.1 cases per 100,000 patients, Queensland 3.4, Victoria 6 and NSW 7.4.
- 1.102 One of the worst aspects is that clinicians, especially doctors are spreading infections from patient to patient largely because they do not practice hand hygiene before and after seeing each patient. A sizeable proportion of them trail infection around like sparks in a dry wheat field on the black soil plains at Mullaley bringing great risk to the patients.
- 1.103 In my opinion, the risks from MRSA are very large and it has the capacity to close down whole sections of our public system. . For this reason, I recommend that infection control be a NSW Health priority, not merely an individual objective. I recommend a stringent enforcement regime for hand hygiene protocols because I was astonished to find that often less than half of the doctors in our public hospitals wash their hands before or after seeing each patient. Washing hands is no harder than putting a seat belt on when getting into a car. But there really is an unacceptably low rate of hand hygiene practice in NSW public hospitals. I hope that my recommendations will very quickly turn that position around, but it will require leadership and commitment.
- 1.104 One really effective way to stop the spread of MRSA in hospitals is to have mandatory screening of vulnerable and high risk patients by standard or rapid screening technology for MRSA and all other significant pathogens across all area health services. I

recommend that it be done in the case of planned admissions before, and for all other cases immediately after, entry into the hospital. I think that such mandatory screening should commence as soon as practicable but must be fully operational no later than 12 months.

- 1.105 Because this is potentially a very costly problem, the government needs to adopt and to embrace as a matter of high importance a target which sees the reduction in MRSA rates in NSW hospitals by 50% from the present rate within a year. After that the reduction rate may vary. The best people for the government to listen to about that will be the Clinical Excellence Commission. Once the government adopts this target the chief executives of the area health services and statutory health corporation must achieve it.
- 1.106 One of the things which I learnt was that most professionals who work in public hospitals are proud of their professional skills and their reputations. And that is good. Because they are so proud of their reputations, they don't enjoy doing badly when compared with their peers, either as individuals or as part of a ward or unit.
- 1.107 In order to emphasise the importance of eradicating hospital acquired infection, I recommend that there be a public display in each ward or unit of a chart which shows how well the ward (or unit) is doing in keeping infection away from their patients. I am confident that this will significantly help improve infection control procedures.
- 1.108 I also recommend, because I think that it is fair and just that NSW Health should refund patients the net cost (if any) for medication necessary for the treatment of hospital acquired infection after they are discharged from hospital. Sometimes medication for patients can be quite expensive and I fail to see why the patient should pay for being infected whilst in hospital through no fault of their own.
- 1.109 I make a number of other recommendations which a part and parcel of the attack on hospital acquired infection and a real attempt to get rid of it.

Ward Rounds and handover

- 1.110 The evidence shows that a team-approach to treatment is likely to produce the best results. One proven technique is the multi-disciplinary ward round which includes the consultant and registrar, junior doctors, nursing staff, pharmacists and, where relevant, allied health professionals such as speech therapist or physiotherapist.
- 1.111 I am satisfied that NSW public patients will have much better outcomes from their stay in hospital where this model of care is adopted, because it gathers together everyone involved in the patient's care at one time and in the presence of the patient where communication is going to be most effective. So I recommend that there should be a state-wide policy for multi-disciplinary daily ward rounds be introduced. The policy should require that ward rounds occur in the early morning, be multi-disciplinary, that accurate and complete notes are taken which are approved by the supervising doctor 24 hours.
- 1.112 At the worst, I heard evidence of a handover between nursing staff where one shift simply recorded on a dictaphone, voice messages for the next shift to playback and hopefully listen to. It seemed to me to be just like hearing a voicemail message. Handover between one group of clinicians and the relieving team carries risks for the patient when information somehow falls between the two groups. A policy designed to "Mind the Gap" should be implemented quickly and so I recommend the institution of a mandatory shift handover policy, which should include:

- (a) a requirement that part of the handover occurs at the patient's bedside;
 - (b) a requirement that sufficient time designated for handover is built into the rostering system;
 - (c) a requirement for the information which is to be conveyed during handover; and
 - (d) a requirement that a record to be made of the handover.
- 1.113 In my view, unless the system-wide roll-out of the policy is accompanied by appropriate coaching and training there will be nothing to ensure the sustainability of this new policy. I think that the policy should be introduced within 12 months.

Discharge

- 1.114 When you stay overnight at a motel it is expected that you will check out and leave early the next morning, usually by 10am. That is so your room can be cleaned and prepared for the next guest. It makes good sense, otherwise the if you didn't leave until 3pm, or even later, there would be a queue of people waiting to get in and use the room you had been occupying.
- 1.115 Discharging patients from hospital is really no different in concept. Discharge has to take place before patients arrive seeking admission. But that doesn't seem to happen in public hospitals in NSW.
- 1.116 Rather, it is the reverse. The peak of people needing admission from the Emergency Department happens many hours earlier than the peak of people leaving the hospital and checking out. It makes no sense.
- 1.117 Peak time for discharging patients from hospital wards needs to be in the morning. To achieve this essential outcome, I recommend a number of steps which are significant changes in work practices, including:
- (a) establishing an estimated date of discharge on the first day a patient is admitted to a ward;
 - (b) establishing protocols which permit patients to be discharged in a planned way without the consultant necessarily seeing them to sign off on the discharge;
 - (c) have consultants do ward rounds in the first part of the morning so that they conclude before 10am;
 - (d) planning all of the processes for discharge needs to be done well in advance of the estimated date of discharge.

Workforce Reform

- 1.118 Over 60% of the whole of the health budget is spent on paying the salaries and wages, and all of the other costs of the workforce, of NSW Health. There are over 100,000 people who work for NSW Health although not all of them are full-time workers.
- 1.119 This very large workforce is not as well organised and structured as it could be. People are doing jobs that they are too well qualified for. Staff on higher wages are doing menial tasks which could be done much better by other staff and for less than half of the cost.
- 1.120 But the need to find budgetary savings over the years has meant that senior clinicians are rushed off their feet doing clerical work instead of using their skills and experience to care for patients.

- 1.121 Senior nurses, called Nurse Unit Managers, (who many years ago were called Matrons) now spend 70% of their time photocopying job applications, attending to payroll discrepancies and being away from their patients. Senior specialists in the Emergency Departments spend their time chasing up test results and answering telephone enquiries about lost property, because there is no-one else to do it, when it would be much better if they were looking after the patients.
- 1.122 A workforce organised like this is neither efficient nor cost effective. It actually costs much more than it should. In short, the workforce needs to be reorganised so that care is provided by teams in which each person has their specific role.
- 1.123 I make the following recommendations to reform work practices and create a modern hospital workforce by nominating these guiding principles:
- (a) each member of the clinical workforce should be prepared to work within a multi-disciplinary environment as a member of, or as a contributor to an inter-disciplinary team responsible for the delivery of patient centred care;
 - (b) patient centred care is to be provided by a team, which allocates in accordance with the principles of “shared care”, a component or components of care to a member of the team according to their qualifications and experience;
 - (c) where a component or components of care can be provided, without adversely affecting patient care as measured by the patient care criteria, by
 - (i) IT based remote support; or
 - (ii) by a less well, but nevertheless suitably, qualified member of the team; or
 - (iii) by a private provider of health services
 then NSW Health is free to designate one of these alternatives for the provision of care.
 - (d) a real need exists in times of a national health workforce shortage for clinical support staff to be employed to undertake tasks for which they are suitably qualified so as to allow senior clinicians, in particular, to be freed up to attend to those components of patient care which require their other skills.
- 1.124 Of very great importance is the need to review and redesign the role of the nurse unit manager (“NUM”) so as to enable the NUM to undertake clinical leadership in the supervision of patients and the enforcement of appropriate standards of safety and quality in treatment and care of patients in the unit or ward for which they are responsible. I recommend that this role redesign needs to encompass either the transfer of a range of duties from the NUM to other existing staff members or alternatively the creation of a role of clinical assistant to the NUM to undertake those tasks. The aim of the redesign is to ensure that at least 70% of the NUM’s time is applied to clinical duties and no more than 30% of the time is applied to administration, management and transactional duties.
- 1.125 The units and wards, and all of the clinicians need to be supported as well, and new and more cost effective members of the team need to be introduced into the workforce and so I recommend the creation of a position called a clinical support officer who can undertake roles presently fulfilled by senior and junior clinical staff but which can be undertaken by less, but nevertheless suitably, qualified individuals. The position will have to include doing after hours work, and on a 24 hour a day, 7 days a week basis, where the ward activity requires. The position would include those roles previously performed by communications clerks, ward clerks and wardsmen.

- 1.126 NSW Health spends, on the evidence which I heard very large sums of money hiring casual doctors who are called locums. Sometime area health services bid against each other to hire locums for a weekend and everyone ends up paying more than they should. I am sure that the locum workforce can be better organised and so I recommend that NSW Health should create its own casual workforce by instituting and maintaining a centralised register recording the details of all doctors, including their credentials and experience, who are available to fill casual shifts or to sit as locums for specified periods. The register should also include any currently employed or contracted specialists who are available to fill shifts on a casual basis. In this way, all areas which need a locum ought need to do is to consult the central registry to see who is available.

Clinical Staff Rosters

- 1.127 As I said earlier, the rostering and work practices which have existed for many years in NSW Health for senior and junior doctors and some senior nurses are largely based around the paradigm that the hospitals should be fully staffed for about $\frac{1}{4}$ of the week, and that there is a much smaller and less experienced staff available for the other $\frac{3}{4}$ of the week, including the weekends. Because this doesn't seem right when we all know that patients get sick or are injured at any time during the day or night and on any day during the week, I have recommended that within 6 months, NSW Health is to implement a project, the aim of which is to redesign rostering systems and practices for senior and junior doctors and senior nurses in a way which promotes safe patient care of good quality. In my view the aim of the project must be:
- (a) To ensure the presence of an appropriate number of these clinicians in all hospitals down to and including Peer Hospital Group Category C1 for 16 hours a day;
 - (b) To ensure the availability of the services of these clinicians for 7 days per week; and
 - (c) To ensure adequate coverage, whether by an on-call service or otherwise for the remaining 8 hour shift for each day.

Ward reorganisation

- 1.128 The nursing workforce on each ward needs to consider how it can best organise their workflow so that they can provide the best patient care possible. There are a number of projects both in the United Kingdom and in NSW at various hospitals which have successfully brought ward workflows and practices into the 21st century. My recommendations ask the Chief Nurse of NSW Health to oversee a state-wide program to achieve a noticeable improvement in the efficiency and design of nursing work practices.
- 1.129 These workplace reforms which I have recommended will have an impact on all health care professionals in the public hospital system in turn doctors, nurses and allied health professionals.

Doctors

- 1.130 For doctors, I have recommended that NSW Health design and implement a business information system that records current medical workforce according to speciality (if any), qualifications, location and stage of training, to enable workforce planning to be undertaken in a coordinated manner. This system should be available for all areas in NSW within 18 months.

- 1.131 Amongst other matters relating to doctors, I have made a specific recommendation about the medical workforce enhancement which involves:
- (a) Reviewing the number and adequacy of prevocational and vocational places in rural regional and outer metropolitan areas so as to ensure a secure career path for medical officers who wish to work in these areas;
 - (b) Identifying the extent of the current shortage of general physicians and taking steps to ensure that there are created appropriate number of training places so as to enable the current shortage of general physicians to be addressed; and
 - (c) creating the role of a clinical support officer for doctors who may be able to assist in the undertaking of their roles and ensuring that their time is dedicated to clinical tasks rather than non-clinical workload.

Nurses

- 1.132 In addition to the range of matters which I have discussed earlier about NUMs and nursing workplace practice improvements, I have recommended that NSW Health, in order to address the current shortages in the nursing workforce, consider and implement, if appropriate, the following:
- (a) the creation of a new clinical designation for registered nurses with over 10 years experience who continue to carry out patient clinical care, entitled "Senior Registered Nurse" with appropriate competency based increments;
 - (b) NSW Health allocate funding for more nurse practitioner positions across NSW, particularly in rural and remote areas, and in hospitals where it is hard to employ doctors. The NSW Government promulgate regulations as to the clinical decisions and procedures that may be made and undertaken by nurse practitioners. Implementation of this recommendation will provide certainty as to the scope of the nurse practitioner role, and promote acceptance of it. NSW Health instruct managers to ensure that nurse practitioners are directed to work in all areas for which they are qualified and that they are not to be used as if they were stop-gap or second-best clinicians; and
 - (c) A redesign of the General Workload Calculation Tool to take into account nurses' designation (clinical nurse specialist, registered nurse, enrolled nurse, trainee enrolled nurse, assistant-in-nursing) and years of experience.

Allied Health

- 1.133 For the allied health professionals, who are an important part of the workforce, I have made a specific recommendation that NSW Health address deficiencies in the workforce of and in the delivery of services by allied health professionals in public hospitals by considering and implementing a program which addresses the following matters:
- (a) The institution of policies which mandate timely action for dealing with vacancies of allied health professionals so as to ensure that replacements occur when allied health staff are on annual leave, maternity leave or long service leave;
 - (b) Enhancing allied health services in hospitals by providing for allied health staff either to be rostered for at least two shifts a day and to be on call for a third shift or else taking other steps to ensure that there is available an adequate supply of allied health services to inpatients – seven days a week;

- (c) Ensuring that when new models of care are introduced which require input by allied health professionals that the appropriate contribution by those allied health professionals is recognised, incorporated into the model of care and adequately provided for;
 - (d) Determining the appropriate means by which allied health professionals should receive adequate ongoing education.
- 1.134 At every hospital, it is necessary to ensure that the important services of the allied health professionals are not forgotten and ignored. So I think that it is necessary for each hospital to appoint a director or co-ordinator of allied health services who should be a senior allied health practitioner with knowledge of the range of all allied health roles.

Bullying in the workplace

- 1.135 Bullying is poisonous in any workplace, and it cannot be tolerated.
- 1.136 NSW Health has appropriately a “zero tolerance” policy about bullying in the workplace and so it should. It has a comprehensive suite of policies and guidelines designed to eliminate bullying from the workplace.
- 1.137 But, when I visited hospitals and took evidence, almost everywhere I went, I was told about incidents of bullying. Many witnesses asked to be allowed to give their evidence in private.
- 1.138 Why is this so? I am forced to conclude that the culture endemic in NSW Health, which has been around for a very long time, is an unhealthy one. Of course, there are exceptions to this. Some units had queues of staff waiting for a position to become vacant.
- 1.139 What is missing from this culture? I think it is respect. Different professional groups don’t sufficiently respect other professional groups. Culture is the product of the values of the workplace. Respect is an essential but absent value in NSW Health. It needs to make a prompt return.
- 1.140 I suggest a workplace culture improvement program and I draw attention to one model (of many possibilities) which seems to be working well in different places around the world. My recommendations deal with introducing a “Just Culture” policy. But NSW Health will need help to do it, and I make recommendations which will achieve this end.
- 1.141 The purpose of the introduction of a “Just Culture” policy, is to address the absence of respect in the workplace culture and to attempt to remedy the absence of proper standards of behaviour including bullying, inappropriate workplace behaviour and the inadequate grievance resolution practices.

Communications

- 1.142 Earlier in this overview, I discussed the way in which clinical notes are kept and used. I have looked at other issues about communication as well.
- 1.143 Hospitals are very strange and rather foreign places to patients and their families and carers, because largely they are unfamiliar with the terms that are used, what all the staff do and what is going on with their treatment.
- 1.144 As well, steps have to be taken to make sure that the important information about a patient, their condition and what has and is happening to them, needs to be given to the

general practitioner so that ongoing care can be provided in the community after they patient leaves hospital.

- 1.145 I have found it necessary to make recommendations designed to help with communication. One deals with wearing uniforms that easily identify what each person in the hospital does, when they are treating patients. I think that what is necessary is some places like being Emergency Departments is that all staff, including senior doctors, should, if they are not in uniform, put on a sleeveless vest called a tabard. It is the modern day equivalent of what was worn by knights and heralds as an outer garment so that everyone would know who they were. They are now in regular use all over the state. They work well because they can readily identify by colour and words the role which individuals are engaged in. This will surely help ease the lot of patients who often don't know, or else get confused about, what the staff do and who they are.
- 1.146 There has to be much better communication with general practitioners about their patients. I suggest that there is need for that to be done in a well organised and coordinated way. In fact, everyone in the hospital needs to work on good communication, otherwise complete chaos will descend on patients. I have made in Chapter 15 a number of recommendations intended to improve communication in hospitals.
- 1.147 The next sections of my Report deal with recommendations relating to different categories of patients namely, patients in general; elderly and other patients with chronic and complex illness; mothers, babies, children and young people; and patients in rural areas. I have already dealt with some of these recommendations. Many of the others are best understood in the context of the particular chapters. But I will highlight a few in this overview volume.

Patients in general

- 1.148 I was regularly told that one of the problems for NSW Health was that the value and worth of its work is largely unknown to the general public. In order to assist with having the value of its work better known, I have recommended that NSW Health consider whether in the interests of public education and information, it would be feasible to provide to patients upon discharge from public hospitals either an itemised listing of the cost of their care based on the relevant case-mix formula or else to make publicly available the average cost of typical interventions and treatments. In this way, the public may readily come to appreciate the benefits which the system provides.

Elderly and other patients with chronic and complex illnesses

- 1.149 As I have said earlier, one of the challenges for health care throughout Australia is the ageing of the population and the expansion in numbers of those who have chronic and complex illnesses.
- 1.150 My recommendations which I suggest are best read in the context of the full chapter in my Report are designed to encourage models of care which enable the delivery of as much care as possible in the home and not in the hospital which is a very alienating place for our older fellow citizens. They are also designed to provide assistance to patients in this group who need a hand to find their way around all of the healthcare services which they need and which will keep them out of hospital.

Mothers

- 1.151 I received a large number of submissions about maternity services and the need to give midwives more freedom and responsibility for being involved with helping mothers have babies.
- 1.152 This is a complex question because some of the matters I was asked to make recommendations about really belong in the Commonwealth sphere and don't fall within my Terms of Reference. As well, there quite complex issues about safety and quality which require careful thought. Nevertheless, I felt able, on the basis of the evidence which I received to make recommendations about enhancing the midwifery workforce, and seeing whether midwifery case-load models of care where the same midwife looks after the mother from their first appointment until about 4 weeks after the birth of the baby can be introduced to more hospitals than at present. I make a specific recommendation, in the interest of the safety of the mother and child which is that NSW Health only offer birthing facilities for low risk mothers in hospitals which satisfy the following criteria:
- (i) the hospital has an adequate number of health professionals qualified and trained to assist with the birth, such as midwives or VMOs with the necessary credentials; and
 - (ii) the hospital has, on-site, or else has the ability to transfer the mother within 30 minutes travel time to a hospital which has on-site, the workforce and facilities to perform an emergency caesarean section.

Rural patients

- 1.153 The hospital workforce which lies to the west of the sandstone curtain needs to be boosted. I make recommendations to try and achieve that aim by suggesting that NSW Health take immediate steps to enhance the supply of a skilled workforce of clinicians to rural areas by ways which include, at least:
- (a) Giving consideration to whether there is an available process by which there ought be made compulsory a rural training term for employed junior medical officers in their second and third year of employment with NSW Health, including reviewing which hospitals have the capacity to accept such trainees and what other steps are necessary to ensure the adequacy of the training of such junior medical officers undertaking a rural term;
 - (b) Reviewing the existence of and developing, as required, employment packages with features which would attract and retain skilled staff to work in rural communities. This may include developing formalised partnership structures between metropolitan hospitals and rural hospitals which facilitate the transition of clinicians between the hospitals.
 - (c) Developing education facilities which ensure that clinicians working in the rural and remote areas of NSW are provided with adequate education and training.

Key Performance Indicators

- 1.154 Key Performance Indicators, or KPIs as they are usually called, are the bane of clinicians. Many of them told me that they took a lot of work to collect, and that they were usually misunderstood or else used for inappropriate purposes. But NSW Health, as any system must, relies on them quite heavily for all sorts of purposes. The Commonwealth government demands that certain indicia are measured and reported if

the funding it provides is to be continued. I see no difficulty with this approach except inconvenience, but as I discussed earlier when discussing the role of the Bureau of Health Information, a whole rethink of KPIs is required to turn the concentration from processing and access indicators to measurements and indicia which are patient centred and attempt to determine not just how quickly the patient was treated, but how well. I have made a series of recommendations about some KPIs in Chapter 17.

Deteriorating patients

- 1.155 The detection and management of deterioration in a patient's condition by hospital staff can be problematic, particularly where the problems occur overnight when patients are under the care of junior clinicians who may lack the experience to deal with the problem or are reluctant to wake a consultant. The available data from NSW suggests that the issue of the deteriorating is prevalent. The Clinical Excellence Commission has suggested a plan to NSW Health which will assist to improve the care being provided for patients who may fall into this description. My recommendation endorses that plan and commends it to NSW Health for its consideration.

Emergency department

- 1.156 Despite the surge of patients presenting at Emergency Departments there have not been sufficient emergency specialists qualifying with the Australian College of Emergency Medicine to deal with the influx. The result has been overcrowding in the Emergency Department in most public hospitals. For reasons that I have already discussed, namely presentations by elderly patients with chronic, complex diseases in Emergency Departments and the large number of younger adults also presenting there, often with conditions usually treated by primary care doctors, there is almost no likelihood that demand will ease.
- 1.157 For this reason, the way has to be found to take the pressure off Emergency Departments, emergency specialists and the hospital staff. At the end of my long and detailed investigation I have concluded that the best way to do this is by taking steps to make sure that only those patients whose condition needs emergency treatment within 30 minutes of arriving at hospital should be seen by specialist emergency doctors. In my view, if it is alright for you to wait for an hour or more to be seen in an emergency department, then you probably didn't need to be seen by an emergency specialist. Many other well qualified doctors can help you.
- 1.158 This means that those patients who are in triage categories 1, 2 and 3 should be channelled through the Emergency Department, and the patients in categories 4 and 5 should be channelled to Primary Care Centres which I recommend should be set up within the public hospitals and staffed by medical practitioners such as a hospitalist, Career Medical Officers (CMOs) or general practitioners who are prepared to work part-time in these centres.
- 1.159 The Commonwealth should pay for all treatments in Primary Care Centres as this falls within its remit to look after and fund primary care. To complement the Primary Care Centres, Medical Assessment Units should be established in all hospitals of sufficient size to deal with patients with chronic, complex conditions presenting from homes and nursing homes. By this means the crisis in care within Emergency Departments can be overcome quickly.
- 1.160 When patients do present at busy Emergency Departments, they often find them confusing and intimidating. NSW Health should take steps to ensure that patients are

able to follow the journey through the department, for example, it should consider making available:

- (a) Figures which use only plain language words that are easily able to be understood. For example, "Triage" should be replaced as it is not easily able to be understood.
- (b) an information video accessible to the main language groups of the relevant geographic area explaining what is going on behind the doors, why patients need to be prioritised via the triage system, and the roles of the various hospital staff that they are likely to encounter; and
- (c) a screen containing information about the number and the severity of the condition of patients currently being treated in the Emergency Department. The screen ought to be automatically updated when new patients arrive.

1.161 Often a small effort to communicate can resolve a lot of the tension patients experience in the Emergency Department.

1.162 It is important for me to outline as I do in Chapter 20 the principles by which Emergency Departments operate which I say should include, but not be limited to: the fact that the provision of emergency care is to be determined by clinical condition, and is not one based on, or determined by, patient demand; a recognition that the performance of Emergency Departments is inextricably linked with the performance of the hospital as a whole; and that there needs to be broad acceptance that Emergency Departments are not necessarily the only portal for an unplanned admission to hospital.

Community Health

1.163 I have not dealt with this problem in detail because it relates to acute care services at one remove i.e. it is a necessary part of the overall strategy to control demand for acute care beds by treating patients wherever possible in the community. In making these recommendations, I am conscious of the danger that moving the focus from hospitals to the home can end with a policy of governmental neglect about which I was frequently told in the course of my Inquiry.

1.164 With this in mind, the best solution for delivery of community health (as it relates to demand upon the public hospital system) is to employ the concept of "the virtual hospital". This would require organisation of community health along the lines of admission-treatment-discharge as used in a public hospital, but without the building. Those in need of care for chronic, complex diseases (which almost inevitably lead to periodic admissions to acute care hospitals) would be admitted to care by the general practitioner or a designated community based nurse and assigned to a virtual ward of up to say 50 other patients. The treatment protocols for any one disease would be where possible standardised. The actual care would be delivered by an extension of the Hospital to the home. Where needed, teams including if necessary a specialist, would be available to visit the patient at home or in the aged care facility. The patient's progress would be recorded in the electronic medical record available to the general practitioner and at-home treating teams. Community health would thus be a structure which could make sure that all of the things which are good about hospital care can be replicated in the community..

1.165 In this way the move away from hospitalisation would be supported by a vigorous alternative model of care and patients would not "fall between the cracks".

Mental Health

- 1.166 Mental illness is responsible for 13.3% of the total burden of disease in Australia and, therefore, is clearly one of the most significant health problems of the nation.
- 1.167 My overall impression of the treatment of mental illness in NSW, at least by the public hospitals, is that it is an under-resourced, over-stretched part of the public hospital system which is presently in 'catch up' mode in terms of increasing funding, training and recruiting additional workforce, and building more facilities.
- 1.168 For the last few years, mental health services has accounted for about 8% of the total NSW Health budget. In the 2008-09, the amount was \$1,092 billion, being 8.3% of the budget.
- 1.169 However the evidence to this Inquiry was that there is still an overwhelming shortage of acute mental health inpatient beds in NSW. The lack is particularly acute in rural areas, as I have discussed in Chapter 6. A lot has been done in the last few years, and this progress needs to be kept up.
- 1.170 My recommendations include requiring hospitals to establish a safe assessment room (or rooms) at a location, if not adjacent to, then proximate to the Emergency Department and for the larger hospitals establishing a psychiatric emergency care centre (PECC) at a location, if not adjacent to, then proximate to the Emergency Department unless there is easy access to a PECC located at another hospital within a reasonable transfer distance.

Surgery

- 1.171 Roughly a quarter (23%) of public hospital surgical admissions (Australia-wide) are emergency cases needing to be undertaken within 24 hours. The rest are somewhat curiously described as "elective" surgery, meaning surgery that can be delayed for at least 24 hours. However most elective surgery is still urgent and crucial to a person's wellbeing, and I prefer to call it "planned" surgery.
- 1.172 I heard a considerable amount of evidence about problems occurring when planned surgery is interrupted by emergency surgery. In many hospitals in NSW there isn't a structure for providing rooms and resources to be used specifically for emergency surgery. Instead there is significant emphasis on the delivery of planned surgery and emergency surgery is essentially required to fit around it. I was told that this in fact is an impossible task.
- 1.173 I have concluded that a new surgical model of care needs to be implemented which includes an acute care surgery unit in most large hospitals and which involves these elements, where possible and appropriate:
- (a) The separation by facility, or operating list or otherwise, of planned or elective surgery from emergency or urgent unplanned surgery;
 - (b) The introduction of an Acute Surgery Unit, which is a consultant led unit, the purpose of which is to undertake all acute surgery at the hospital within the 12 hour day time period;
 - (c) Explores the availability for, and the engagement of smaller hospitals to provide the facilities for surgery to be undertaken there to supplement the principal surgery programs;
 - (d) Enables improvements to supervision of the kind referred to in Chapter 13.

Pathology & Medical Imaging

- 1.174 Pathology and medical imaging results should be available to clinicians on-line and accessible, both within the hospital and remotely, so that clinicians can view results away from the hospital, for example, at home after hours.
- 1.175 The state-of-the-art digital system for distributing medical imaging results to clinicians is the Picture Archiving and Communication System (“PACS”). PACS is a computer system that enables x-rays, MRIs, ultrasound and CT scans to be stored and archived electronically. Such a system when fully implemented will remove the need for x-ray films and can allow for remote access to the images and thereby remote analysis.
- 1.176 NSW not only needs a state-wide PACS system, but it needs to have all images created digitally and which have the capacity to be read centrally 24 hours a day 7 days a week. Part of this service should also be the provision of a means by which the clinicians are able to talk to the radiologist, if required.
- 1.177 I make recommendations which should make far more efficient and cost effective the present dispersed system for reading pictures and scans. I suggest that NSW Health should have the PACS system off and running within 18 months. This needs to be supported by the establishment of a central radiology service sufficiently staffed to read the results of medical images and provide medical imaging reports to public hospitals across NSW 24 hours a day, 7 days a week. I recommend that in establishing this service, NSW Health should compare the costs of providing this service itself with outsourcing it to the private sector. In the event that review proves that the service may be able to be provided by the private sector more cost effectively, NSW Health should consider seeking tenders for this service.

Funding

- 1.178 NSW Health receives a large proportion of the NSW state budget. There are many other meritorious claims to the state’s funds, including education, police and roads. Health cannot, in good conscience, expect much more. It is unreasonable to expect that spending on health can continue to consume a greater proportion of the Gross Domestic Product of Australia or of the NSW state budget. This is unsustainable. Efficiencies and rationalisations must occur.
- 1.179 In my view, it is essential that the individual hospitals within an area, and the individual units within each hospital, know precisely what amount of money is allocated for that hospital or unit under the budget and have unconditional access to the figures showing the on-going balance against the budgeted allocation. I recommend this should be adopted straight away. Budgets should be transparent, not hidden tools for management to pull out when the finances are under pressure.

Hospitals

- 1.180 It is natural that community leaders and representatives from the 3 tiers of government should be concerned about the local impact of the modernisation of the public hospital system. The issue which all must face is that there is a permanent shortage of professional staff in many rural and remote areas, and no amount of political debate is likely to be able to change that. A specialised workforce will always be attracted to facilities with “critical mass”, i.e., sufficient patients to enable clinicians to develop and keep up-to-date their skills.

- 1.181 The patients must now be got to the specialist workforce, since (in general) the specialist workforce does not choose to live and work in the dozens of small rural and remote communities which still boast a public hospital. The task of leadership in health is to educate public opinion to support a new model whereby the issue becomes *how quickly* the patient can get to the right hospital and not *how close* is a facility displaying a *Hospital* sign, regardless of what services it can deliver.
- 1.182 This is not just a problem for the rural and remote areas, because in the metropolitan areas of Sydney, Newcastle and Wollongong there are too many smaller hospitals each trying to offer a fully comprehensive array of services when, quite close by, another often much larger hospital is doing it better.
- 1.183 NSW Health will have to carefully review how all the services are configured across the State and make some hard decisions about the modernization of the network of public hospitals in NSW. They will need the support and goodwill of all in this role. I recommend that there be a full and 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.

Transport

- 1.184 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.
- 1.185 In order to meet the challenges of the increase in demand into the future, changes to the NSW Ambulance Service operations and work practices, which seek to engage existing resources more efficiently, are necessary.
- 1.186 Those paramedics, who are highly trained, can and ought to do more to treat patients without bringing them to hospital.
- 1.187 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.

- 1.188 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 Victoria. Another possibility is to expand the present non-emergency ambulance operation. A combination of any of these options may also be appropriate
- 1.189 The Ambulance Service Workforce, just like the rest of the hospital system, needs to modernise its workforce design and practices. I suggest that it start by introducing a paramedic assistant who can drive the ambulance and help the paramedic do their job.
- 1.190 And so in Chapter 27, I make a number of quite detailed recommendations about urgent and non-urgent transport.

Beds

- 1.191 Bed management plays a significant role in the overall NSW public hospital scheme. Approaches to bed management issues impact, amongst other things, upon patient flow through the health system.
- 1.192 These difficulties all have implications for patient length of stay, cancellations of planned surgery, patient safety and quality of care, and “bed block” or “access block” issues for the Emergency Department.
- 1.193 The recommendations I have made in this area of bed management are designed to ensure that hospital beds are used in the most efficient manner. The potential benefit to be realised through my recommendations is an improvement in the quality of care provided to patients: both those who are awaiting a hospital bed and those who will be in receipt of a more robust discharge practice. And my recommendations should make more beds available and reduce access block.
- 1.194 But even if the existing beds are used more efficiently, the population growth in NSW alone will require the addition of about 350 beds each year over the next few years.
- 1.195 One way in which some hospitals try and be more efficient with their bed usage is to put men and women in the same room in an inpatient ward. I think that this is undignified for the patients and I recommend that it must stop immediately.

Food

- 1.196 I received a lot of submissions about hospital food. It can be and has been the butt of many uncomplimentary jokes and remarks. But I have to say that NSW Health seems to me to be putting a lot of effort into improving the food in hospitals. In Chapter 29, I make a number of recommendations about what more can be done.

Equipment

- 1.197 In an industry where the state of equipment correlates closely to patient safety, it is important to routinely review the equipment in use 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. As a piece of equipment nears the end of its useful life, I would expect to see the cost of a replacement machine being factored into the budget of the hospital, so that it could be sourced and funded without interrupting clinical activities.

- 1.198 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, whether it is because of changes in medical technology or the equipment can no longer be repaired or the equipment has become unreliable by reason of its antiquity. There does not appear to be any routine budgeting for equipment replacement. I heard that it was difficult to locate the responsible area health service person to ask when equipment would be replaced or repaired. I also heard that while some machines were awaiting replacement, simple upgrades were not permitted.
- 1.199 I have made recommendations, which are mostly quite technical in Chapter 30 which I think should see this important subject matter be enhanced. Importantly, I suggest that NSW Health should ensure that each hospital performs six monthly equipment functionality assessments to assess and predict the need for equipment replacement.

Administration & Management

- 1.200 The greatest criticism of the new area health service's structure is that they are too big and the decision makers are too remote from the people affected by those decisions, usually the chief executive of the area health service from the managers and clinicians working at the hospital and unit level. One of the weaknesses which is apparent in the present organisation is the absence of necessary decision making authority and financial delegations which would enable hospital and unit managers to manage effectively. In order to make a system of delegated authority work properly, good performance monitoring systems are essential.
- 1.201 The public discussion encouraged by clinicians is all about too many administrators and what unhelpful individuals they are but the reality is they are as committed and hard working as clinical staff and as essential to good patient care delivery.
- 1.202 A change of the present culture of division between clinicians and managers is required. It should be replaced by a collaborative partnership between administrators and clinicians. In the past, senior doctors alone managed large public hospitals. The present day economics of health care make this no longer an automatic option. The health care system at the area and the hospital levels has to be managed those who are qualified with management skills. Ideally clinicians would be attracted to management roles, having spent the necessary time in education and training for such a role. Managers in the health care system equally need to be informed about medical issues. I have been told that often clinicians who do not wish to adopt new models of care resort to "shroud waving", the unassailable argument against the manager used by the clinician who is not willing to change a particular model of care.
- 1.203 It is in this debate that evidence-based innovation will win the argument. Time and again during the course of this inquiry I have been told of the use of data to convince clinicians as to the actual health outcomes of different models of care. For this reason I have concluded that information will prove to be the most significant driver of clinical innovation and enhancement. Statistically it is established that models of care can be standardised for more than 80% of patients who suffer from a condition in common. The data already proves that patients are safer and have better health outcomes where best practice is used. The point about best practice is not that it is "standardised" care but that it is "best" care.
- 1.204 Where the divide between clinicians and managers acts as an impediment to the introduction of modern, safe practices of medicine I regard its removal as a keystone of true reform.

- 1.205 The recommendations which I have made concerning the administration and management of the healthcare system should be understood with these principles in mind. I should add that in the course of the Inquiry I was impressed by the readiness with which very senior clinicians from all areas of health care acknowledged the valuable contributions made by patients' representatives in the work of formulating new models of care within clinical networks. In my view representatives of the community who are familiar with the hospital system can make important contributions to its reform.
- 1.206 At the moment the paradigm of medical care is that seen through the eyes of practitioners not of patients. A recognition of the role of patient representatives at all levels of the health care system would help to shift the paradigm and ensure that the primary concern becomes the welfare of the patient rather than the convenience of the doctor, nurse or allied health professional.
- 1.207 My most important recommendation in this subject, which I have not yet made reference to is the one where I recommend that in order to improve governance, in a period no longer than 6 months, the following changes take place within area health services and statutory health corporations:
- (a) 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) 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) 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, which I have earlier recommended
- 1.208 The other important recommendation in Chapter 31 is that within 12 months, NSW Health design and introduce a defined career path and structure for senior clinical leadership, and for senior clinician participation in senior administration and management roles. That way the divide between clinicians and managers will not be so great.

Summary

- 1.209 And so, this Overview of my Report, concludes with these remarks about change.
- 1.210 NSW Health will not be able to move forward to embrace system wide reforms without the support of the community. This necessitates leadership from all involved in the political process to accept that the good of all citizens in NSW, and the provision of health care in an orderly and systematic way, must prevail over individual, sectional or geographical interests whose motivation is largely, if not entirely, self interest. It necessitates strong leadership from all the clinicians and managers who work within, or as a part of, NSW Health.
- 1.211 Change requires time, patience and determination. It can only succeed if the central purpose is kept constantly in mind, namely that every person who comes to be cared for in a public hospital in NSW should be treated with respect by an appropriately skilled

clinician in a safe and cost effective way to achieve the best health outcome possible for the patient.

1.212 In Cicero's words: "*salus populi suprema lex esto*"

List of recommendations

page

Chapter 2 Patients recommendations

Recommendation 1: *NSW Health should consider whether in the interests of public education and information it would be feasible to provide to patients upon discharge from public hospitals either an itemised listing of the cost of their care based on the relevant case-mix formula or else to make publicly available the average cost of typical interventions and treatments.* 30

Recommendation 2: *In order to improve the availability of interpreting services in public hospitals for non-English speaking patients, each Area Health Service must investigate the sufficiency of, and ensure the adequacy of, the hands free communication equipment available in each hospital to maximise the opportunities for the use of the telephone interpreter service.* 35

Chapter 3 Chronic complex and elderly recommendations

Recommendation 3: *NSW Health's Severe Chronic Disease Management Program should be implemented and expanded to include all "very high risk" and "high risk patients" over the age of 18.* 50

Recommendation 4: *NSW Health should consider and develop a comprehensive plan for the expansion of Hospital in the Home programs of care for chronic and complex patients. The program should be implemented throughout NSW hospitals within 18 months.* 54

Recommendation 5: *NSW Health should liaise with the Guardianship Tribunal to ensure that patients within acute care services in NSW public hospitals who are medically fit for discharge be given the appropriate priority for a hearing by the Tribunal.* 60

Recommendation 6: *Aged Care Assessment Team assessments of inpatients should be planned to commence as early in a patient's stay in hospital as is possible so that they are completed at the time the patient is medically ready for discharge.* 61

Recommendation 7: *The Clinical Innovation and Enhancement Agency should as a matter of priority develop a model of care (a) that allows identification of those elderly patients for whom a hospital stay in the event of deterioration would be likely to result in adverse health outcomes; and (b) which outlines the appropriate treatment modalities for such patients out of hospital.* 65

Chapter 4 Mothers recommendations

Recommendation 8: *NSW health should address the following matters with respect to its maternity services:*

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- (a) *Within 12 months, NSW Health consider and determine whether area health services be permitted to enter into “fee for service” contracts with midwives, including determining what arrangements with NSW Treasury are necessary in relation to the extension of current indemnity to cover such midwives;*
- (b) *NSW Health, through the area health services, identify which hospitals would be appropriate for the introduction of a caseload model of maternity care in addition to, or in lieu of full-time maternity services. Following the review, NSW Health is to plan for the introduction of that model of care, where viable on a clinical needs basis and subject to available funding;*
- (c) *In the interests of patient safety, NSW Health only offer birthing facilities for low risk mothers in hospitals which satisfy the following criteria:*
 - (i) *the hospital has an adequate number of health professionals qualified and trained to assist with the birth, such as midwives or VMOs with the necessary credentials; and*
 - (ii) *the hospital has, on-site, or else has the ability to transfer the mother within 30 minutes travel time to a hospital which has on-site, the workforce and facilities to perform an emergency caesarean section.*

 Page 35

Chapter 5 Babies, children and young people recommendations

Recommendation 9: *Within 6 months, NSW Health should establish, as a chief-executive governed statutory health corporation pursuant to s.41 of the Health Services Act 1997, a Children and Young Peoples’ Health Authority (“NSW Kids”).*

120

The function and role of NSW Kids will be to provide all health care for children and young people, throughout NSW, whether in the community, or in a public hospital, commencing with neo-nates who require tertiary or higher level services and concluding with young people at the end of their sixteenth year of life.

The guiding principle of NSW Kids is that the paramount consideration in the provision of health care is the promotion of the health and well-being of the population and the prevention, diagnosis, treatment and cure of the illnesses of the population in a manner which best promotes the wellbeing of children and young people.

The principal purposes of NSW Kids are to include, at least:

- (a) The striking of, and the maintenance of, a proper funding balance between the provision of community based services, including inter-agency co-operation and prevention measures, and the provision of acute care and related services in public hospitals;*
- (b) Ensuring that the standard of all health care provided to children and young people throughout public hospitals in NSW is consistent and is undertaken, so far as possible, in facilities or parts of facilities which are designated and set aside for such care and which do not include the provision of care for adults; and*
- (c) Ensuring that there are adequate services and facilities for the provision of mental health care to children and young people.*

The secondary purposes of NSW Kids are to include, at least:

- (a) the provision of education and training to all clinicians about the health and well-being of children and young people;*
- (b) the provision, either alone or in conjunction with NSW Health and the Area Health Services, of public education, including preventative health and wellness campaigns, which promotes the health and well-being of children and young people throughout NSW; and*
- (c) the commissioning, conducting, supporting and supervision of research into the health and well-being of children and young people.*

Recommendation 10: *Within 12 months, NSW Kids should publish and implement, a strategic service delivery plan for the health care of children and young persons so as to ensure that appropriate treatment is delivered by appropriately skilled clinicians in the appropriate facility or else as a community based service. Such plan is to delineate clearly which health service is to be provided in which facility or class of facilities, including the criteria for transfer between facilities, and should, so far as clinically appropriate, avoid the duplication of services between facilities. In the development of the strategic service delivery plan, NSW Kids, determine whether it is in the best interests of the health of children and young people that all Sydney metropolitan area based intensive care units (providing tertiary and quaternary care for neo-natal and paediatric patients) should be combined into a single unit at a single facility and whether there should be established a similar facility at the John Hunter Children's Hospital.*

120

Recommendation 11: *Within 18 months, NSW Kids should investigate and report to NSW Health and the Minister for Health on the need for, the desirability of, and the possible locations of a new NSW Kids hospital providing quaternary and tertiary facilities. Any such report needs to include preliminary costings for and a business case which analyse the best options for a new NSW Kids hospital.*

121

Chapter 6 Rural recommendations

Recommendation 12: *NSW Health should take immediate steps to enhance the supply of a skilled workforce of clinicians to rural areas by ways which include, at least:*

139

- (a) *Giving consideration to whether there is an available process by which there ought be made compulsory a rural training term for employed junior medical officers in their second and third year of employment with NSW Health, including reviewing which hospitals have the capacity to accept such trainees and what other steps are necessary to ensure the adequacy of the training of such junior medical officers undertaking a rural term;*
- (b) *Reviewing the existence of and developing, as required, employment packages with features which would attract and retain skilled staff to work in rural communities. This may include developing formalised partnership structures between metropolitan hospitals and rural hospitals which facilitate the transition of clinicians between the hospitals.*
- (c) *Developing education facilities and programs which ensure that clinicians working in the rural and remote areas of NSW are provided with adequate education and training.*

 Page 37

Recommendation 13: *NSW Health should seek an amendment to the Mental Health Act 2007 to permit suitable remote facilities, specified in regulations to the Act, to operate safe assessment rooms for mental health patients on the basis that 3 hourly review of the patient may be undertaken by a senior nurse or psychiatrist over a video link.*

166

Recommendation 14: *NSW Health should address the transport problems associated with providing care for rural patients including:*

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- (a) *Abolishing the personal contribution and administration charge for all qualifying IPTAAS claims;*
- (b) *that there is a need to create a non urgent transport service to be responsible for the return transport of patients from metropolitan or rural hospitals to either their hospital of origin or alternatively to their homes, depending upon their clinical condition.*

Chapter 7 Doctors recommendations

Recommendation 15: *NSW Health design and implement a business information system that records current medical workforce according to specialty if any, qualifications, location and stage of training, to enable workforce planning to be undertaken in a coordinated manner. This system should be available within 18 months.*

199

- Recommendation 16:** *NSW Health ought review its policies and practices with respect to the recruitment of medical staff (other than junior medical officers) so as to require clear identification of the available senior medical officer positions by number and description which are unfilled and the date such positions became vacant, and which ensures that the recruitment of such medical officers occurs without any unnecessary or unintended delays. Each area health service should display, updated monthly, a complete list of all vacancies on the NSW Health intranet, together with the date when the position first became vacant.* 202
- Recommendation 17:** *NSW Health ought consider the enhancement of its medical workforce by:* 206
- (a) *Reviewing the number and adequacy of prevocational and vocational places in rural regional and outer metropolitan areas so as to ensure a secure career path for medical officers who wish to work in these areas;*
 - (b) *Identifying the extent of the current shortage of general physicians and taking steps to ensure that there are created appropriate number of training places so as to enable the current shortage of general physicians to be addressed;*
 - (c) *Creating the role of a clinical support officer for doctors, designed to be able to assist in the undertaking of their roles and ensuring that their time is dedicated to clinical tasks rather than non-clinical workload.*
- Recommendation 18:** *The NSW Minister for Health should consider, having regard to any advice from the NSW Medical Board, whether it would be appropriate to impose on all registered medical practitioners a mandatory obligation to undertake continuing professional education in each year of practice, and, if so, whether any amendments are necessary to the Medical Practice Act 1992 (NSW).* 216
- Recommendation 19:** *Within 12 months, NSW Health should create a casual medical workforce:* 221
- (a) *By instituting and maintaining a centralised register recording the details of all doctors, including their credentials and experience, who are available to fill casual shifts or to act as locums for specified periods;*
 - (b) *By including on the centralised register the details of any currently employed or contracted specialists who are available to fill shifts on a casual basis;*
 - (c) *Which is subject to appropriate performance reporting and performance management systems which are designed to ensure the continued competency of those on the list; and*
 - (d) *Which has access to and is encouraged to undertake education and training so as to ensure the maintenance of and improvements in their skills and competence.*

Recommendation 20: *NSW Health should review the current induction program which is undertaken for overseas trained doctors prior to them commencing employment in the NSW public hospital system, and enhance it so as to make more efficient and effective the employment of overseas trained doctors.* 224

Recommendation 21: *NSW Health should implement within 12 months a program which ensures that an annual performance review for each employed or contracted doctor, other than a doctor in training, is undertaken jointly by a senior clinician and a management representative.* 228

In order to enable an annual performance review program to occur, NSW Health should ensure there exists for each position to be reviewed a job description identifying:

- (a) roles and responsibilities for each designation and position held by a doctor;*
- (b) performance criteria for inclusion in contracts with respect to each position held by a doctor.*

Chapter 8 Nurses recommendations

Recommendation 22: *NSW Health should review the current induction program which is undertaken for overseas trained nurses prior to them commencing employment in the NSW public hospital system, and enhance it so as to make more efficient and effective the employment of overseas trained nurses.* 253

Recommendation 23: *NSW Health should, as a matter of priority, review and redesign the role of the nurse unit manager (“NUM”) so as to enable the NUM to undertake clinical leadership in the supervision of patients and the enforcement of appropriate standards of safety and quality in treatment and care of patients in the unit or ward for which they are responsible. This redesign needs to encompass either the transfer of a range of duties from the NUM to other existing staff members or alternatively the creation of a role of clinical assistant to the NUM to undertake those tasks. . The aim of the redesign is to ensure that at least 70% of the NUM’s time is applied to clinical duties and no more than 30% of the time is applied to administration, management and transactional duties.* 262

Recommendation 24: *All hospitals employing nurse unit managers report within 6 months to the Chief Nurse of NSW Health how they will re-allocate the duties currently being undertaken by the NUM in line with my earlier recommendation and all hospitals employing NUMs should complete the implementation of the redesigned role within 2 years.* 262

Recommendation 25: *I recommend that NSW Health, in order to address the current shortages in the nursing workforce, consider and implement, if appropriate, the following:* 277

- (a) The creation of a new clinical designation for registered nurses with over 10 years experience who continue to carry out patient clinical care, entitled “Senior Registered Nurse” with appropriate competency based increments.*

- (b) *The allocation of funding for more nurse practitioner positions across NSW, particularly in rural and remote areas, and in hospitals where it is hard to employ doctors.*
- (c) *A redesign of the General Workload Calculation Tool to take into account nurses' designation (clinical nurse specialist, registered nurse, enrolled nurse, trainee enrolled nurse, assistant-in-nursing) and years of nursing experience, together with the capacities created by a team-based nursing medical of care.*

Chapter 9 Allied Health & Pharmacy recommendations

Recommendation 26: *I recommend that NSW Health address deficiencies in the workforce of and delivery of services by allied health professionals in public hospitals by considering and implementing a program which addresses the following matters:*

301

- (a) *The institution of policies which mandate timely action for dealing with vacancies of allied health professionals so as to ensure that replacements occur when allied health staff are on annual leave, maternity leave or long service leave or any other period of leave which exceeds 5 working days;*
- (b) *Enhancing allied health services in hospitals by providing for allied health staff either to be rostered for at least two shifts a day and to be on call for a third shift or else taking other steps to ensure that there is available an adequate supply of allied health services to inpatients on all 7 days of the week;*
- (c) *Ensuring that when new models of care are introduced which require input by allied health professionals that the appropriate contribution by those allied health professionals is sought, recognised and incorporated into the model of care. It will be necessary to ensure adequate funding for such allied health participation;*
- (d) *Determining the appropriate means by which allied health professionals should receive adequate ongoing education and providing such education and training.*

Recommendation 27: *A director or co-ordinator of allied health services be appointed in each hospital or hospital facility. That person should be a senior allied health practitioner with knowledge of the range of all allied health roles.*

303

Recommendation 28: *NSW Health should ensure that there is developed standard guidelines which involve consultation by and the participation of clinical pharmacists in the care of patients at the earliest appropriate opportunity so as to enable a clinical pharmacist to take a patient's medication history, participate in ward rounds, review the patient's medical chart during their inpatient stay and review medications on discharge.*

306

- Recommendation 29:** *NSW Health consider the enhancement of the clinical pharmacists' work force in public hospitals by:* 308
- (a) *encouraging the obtaining of higher qualifications by clinical pharmacy staff;*
 - (b) *incorporating for clinical pharmacists a component relating to training time both of pre-registration pharmacists (or trainees), new graduates in the hospital, and by the provision of clinical pharmacy educator;*
 - (c) *fostering arrangements with community pharmacists so as to encourage a better exchange of pharmacists between the community and the hospital; and*
 - (d) *identifying the tasks which may be performed by a pharmacists assistant and designing a position for such an assistant in order to free up a clinical pharmacist to spend more time engaged in patient care.*

Chapter 10 Education & Training recommendations

- Recommendation 30:** *Benchmarks which adequately measure the extent of the delivery of postgraduate clinical education and training should be included in performance agreements between NSW Health and area health services and statutory health corporations.* 324
- Recommendation 31:** *NSW Health should review, develop if required and implement such policies as will clearly specify the roles and responsibilities of the Institute of Clinical Education and Training and the roles and responsibilities of area health services and relevant statutory health corporations in the delivery of training and education relevant to health services.* 333
- Recommendation 32:** *NSW Health should ensure that all hospital directors and supervisors of training for prevocational doctors are provided with protected time each week to carry out their duties in relation to training and formal teaching within the hospital. This time should be protected as part of the terms of employment and through the employment performance management process.* 339
- Recommendation 33:** *NSW Health should require all clinicians who are engaged in the teaching and/or supervision of postgraduate clinical staff to satisfactorily complete courses provided by the Institute of Clinical Education and Training directed to enhancing their skills as teachers, trainers and supervisors.* 339
- Recommendation 34:** *NSW Health should explore the opportunities for and develop programs which attract senior clinicians to become involved in or else increase their involvement in, the teaching and supervision of junior clinical staff, including by developing appropriate positions and career streams for such senior clinicians.* 339

Recommendation 35: *NSW Health should consider the enhancement of the training and education provided for allied health professionals, by, at least:* 348

- (a) *Considering the provision of funding directly, or else indirectly through payment of allowances for attendance at, and participation in external education and training courses relevant to the particular allied health specialty; and*
- (b) *Considering whether it would be appropriate and cost effective to create specific positions for the provision of education to the particular allied health specialties.*

Recommendation 36: *Within sixth months, NSW Health is to establish a chief executive governed statutory health corporation pursuant to s.41 of the Health Services Act 1997 to fulfil the role of a NSW Institute for Clinical Education and Training. The Institute is to have, at least, the following principal purposes and functions:* 353

- (a) *to design, institute, conduct and evaluate a program for the postgraduate clinical education and training for all new postgraduate professional clinical staff employed in NSW public hospitals;*
- (b) *to design, institute, conduct and evaluate leadership training for clinicians to enable clinicians to become clinical leaders and also health system leaders;*
- (c) *to design, institute, conduct and evaluate training for clinicians to enable clinicians to become skilled teachers and trainers for the trainees in all of the programs conducted by the Institute;*
- (d) *to design, implement and oversee an appropriate performance evaluation program for professional clinical staff whilst undergoing postgraduate clinical training; and*
- (e) *to design, implement, conduct and evaluate clinical education and training to enable medical practitioners to be qualified, competent and capable of practising as hospitalists in NSW public hospitals.*

The Institute is to have at least, the following secondary purposes and functions:

- (a) *to liaise with the College of Nursing so as to ensure that the postgraduate education and training programs are appropriately designed and delivered; and*
- (b) *to liaise with the Deans of tertiary education institutions which provide undergraduate education in the various Health Science disciplines at, or with the assistance of, NSW public hospitals in order to identify all synergies between the clinical education and training of undergraduates and post-graduate trainees and to seek to make more efficient the respective education and training regimes, including the delivery of the education and training; and*
- (c) *to liaise with the various medical colleges which provide vocational education and training for medical practitioners in order to ensure that:*
 - (i) *the most efficient and effective means of education and training are provided for vocational trainees in the employment of NSW Health; and*

- (ii) *the most appropriate placement program for vocational trainees in the employment of NSW Health having regard to both the health service delivery requirements of NSW Health and the training requirements of the respective Medical College.*

Recommendation 37: *The Institute in the provision of its programs adopt the following guiding principles:*

354

- (a) *that clinical education and training should be undertaken in a multi-disciplinary environment which emphasises inter disciplinary team based patient centred care;*
- (b) *that the education and training be delivered by the most appropriate and suitable person regardless of the profession or specialty of the individual, and including, where appropriate, non-clinically trained personnel;*
- (c) *that all prevocational clinical staff enrolled in the Institute's programs be required to spend a minimum of 20% of their ordinary rostered time in Year One and a minimum of 10% of their time in Year Two participating in the training programs; and*
- (d) *that the clinical education and training program for prevocational clinical staff include at least four different components, namely:*
- (i) *Formal teaching to which currently employed and contracted senior clinical staff would contribute;*
- (ii) *E-learning by self-completed modules;*
- (iii) *Simulation training conducted by senior clinical staff at simulation centres and facilities;*
- (iv) *and Clinical skill modelling where postgraduate clinical staff are supernumerary for the relevant mandatory time to enable observation of, and modelling of, clinical skills being demonstrated by senior clinicians.*

 Page 43

Chapter 11 Workplace Reform recommendations

Recommendation 38: *The Chief Nurse of NSW Health should supervise the preparation within 6 months of and ensure over a 2 year period the implementation of a program across all public hospitals in NSW which is designed to achieve an improvement in the efficiency and design of nursing work practices in each ward or unit having regard to the principles of shared care and team-based work practices. The NSW program should take into account the improvements made by the Productive Ward Program in the United Kingdom and the Essentials of Care Program.*

369

Recommendation 39: *The workforce at large of NSW Health be re-aligned so as to recognise the following principles:*

378

- (a) *each member of the clinical workforce should be prepared to work within a multi-disciplinary environment as a member of, or as a contributor to an inter-disciplinary team responsible for the delivery of patient centred care;*
- (b) *patient centred care is to be provided by a team, which allocates in accordance with the principles of "shared care", a component or*

components of care to a member of the team according to their qualifications and experience;

- (c) *where a component or components of care can be provided, without adversely affecting patient care as measured by the patient care performance criteria, by*
- (i) *IT based remote support; or*
 - (ii) *by a less well, but nevertheless suitably qualified member of the team; or*
 - (iii) *by a private provider of health services,*

then NSW Health is free to designate one of these alternatives for the provision of care.

- (d) *a real need exists in times of a national health workforce shortage for clinical support staff to be employed to undertake tasks for which they are suitably qualified so as to allow senior clinicians, in particular, to be freed up to attend to those components of patient care which require their other skills*

Recommendation 40: *Within 12 months, NSW Health should create a position called clinical support officer within public hospitals in NSW to be filled on a needs and activity basis to undertake roles presently fulfilled by senior and junior clinical staff which can be undertaken by less, but nevertheless suitably, qualified or experienced individuals. The position will include being rostered for after hours work and on a 24 hour a day 7 days a week basis where the need is identified and where the ward activity requires, and would encompass those roles previously performed by communications clerks, ward clerks and wardsmen.*

383

Recommendation 41: *NSW Health, within 6 months, is to implement a project, the aim of which is to redesign rostering systems and practice for senior and junior doctors and senior nurses in a way which promotes safety and good quality patient care. The aim of the project must be:*

383

- (a) *To ensure the presence of an appropriate number and range of skills of these clinicians in all hospitals down to and including Peer Hospital Group Category C1 for 16 hours a day;*
- (b) *To ensure the availability of the services of these clinicians for 7 days per week; and*
- (c) *To ensure adequate coverage, whether by an on-call service or otherwise for the remaining 8 hour shift for each day.*

Chapter 12 Bullying recommendations

Recommendation 42: *In order to implement meaningful and long-lasting improvement to its workplace culture, NSW Health, as a key priority, embark immediately on a workplace culture improvement program based on "Just Culture" principles, that clearly identifies acceptable behaviours in the workplace and that is linked to NSW Health corporate values.*

421

Recommendation 43: *NSW Health should:* 421

- (a) *engage external expertise to develop the "Just Culture" program;*
- (b) *ensure that all of its senior management personally champion "Just Culture" principles and regard the program as a key priority area for reform;*
- (c) *implement a comprehensive training program for all staff and managers in "Just Culture" principles, to be completed within 3 years;*
- (d) *introduce new procedures for the management of bullying complaints, characterised by fair and reasonable treatment of complainants and respondents, the introduction of timeframes within which complaints need to be resolved and reporting to senior management on the progress of conflict resolution processes;*
- (e) *review existing resources for the management of bullying complaints and implement steps to ensure sufficient numbers of staff are able to handle and resolve complaints in a timely manner;*
- (f) *formulate protocols for, and mechanisms to protect, confidentiality during investigations of bullying complaints, clearly identifying where confidentiality will not be kept (eg if a person discloses self-harm or a criminal offence); and*
- (g) *establish a grievance advisory service to provide independent, objective advice to complainants and respondents in relation to bullying complaints.*

Recommendation 44: *In order to ensure the successful implementation of the "Just Culture" program, I recommend that NSW Health:* 421

- (a) *implement annual audits to monitor the performance of complaint management systems and compliance with agreed targets; and*
- (b) *measure its success in implementation by reporting on its progress in its annual report.*

Chapter 13 Supervision of junior clinical staff recommendations

Recommendation 45: *NSW Health should ensure within 12 months there is developed and implemented State wide policies setting out a best practice model for the supervision of junior clinicians which:* 438

- (a) *defines supervision,*
- (b) *defines the objectives and content of supervision,*
- (c) *defines the supervisory relationship, including the roles and responsibilities of clinical supervisors (including consultants, registrars and nurse educators) and trainees,*
- (d) *sets out mechanisms for resolving difficulties relating to inadequate supervision,*
- (e) *recognises the importance of the supervisor's role;*
- (f) *requires area health services to stipulate the roles and responsibilities of supervisors (including consultants, registrars and nurse educators) in their job descriptions (whether as employee or independent*

contractor), including the time required to be allocated to supervision duties;

- (g) requires that supervisors (consultants, registrars and nurse educators) be allocated protected time each week for carrying out active supervision of junior medical officers and nurses.

Recommendation 46: *The Institute of Clinical Education and Training, if it becomes aware of any circumstances which it considers give rise to a significant risk to patient safety or a significant risk to the provision of good quality patient care arising from any inadequacy in the supervision and training being provided at any NSW public hospital for junior clinicians, must forthwith:*

439

- (a) Notify the chief executive of the area health service or statutory health corporation together with its recommendations for the appropriate remedial actions to be taken; and
- (b) If it considers that the remedial actions, if any, which have been taken are inappropriate or inadequate to remedy the identified significant risks within an appropriate timeframe, deliver a report to the Director General of NSW Health together with recommendations for action by the Director General.

Recommendation 47: *Within 24 months, NSW Health should undertake a review of, and examine the improvement options for the supervision of registrars undertaking surgery, including but not limited to:*

442

- (a) Whether it is appropriate, and if so how, to separate by facility or operating list or otherwise planned surgery from emergency and urgent unplanned surgery;
- (b) Whether any change in workplace rostering or practices is necessary to maximise supervision of surgeons in training and minimise risk to patient care from surgery being conducted after hours without supervisors present;
- (c) Developing systems for monitoring the extent of and adequacy of supervision of surgery being undertaken by registrars.

Chapter 14 Clinical Records and IT recommendations

Recommendation 48: *Within 6 months, NSW Health should design and implement a system of auditing the performance of all hospitals in the compilation of patient clinical records, for compliance with NSW Health policies regarding legibility and completeness of those records.*

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Recommendation 49: *Within 6 months, NSW Health should implement and audit compliance with a policy which specifies the obligations of the Admitting Medical Officers (AMOs) in the supervision of clinical notes relating to their patients which includes a requirement that the AMO read and initial, at regular intervals each patient's clinical notes which have been written by the junior medical officer.*

482

Recommendation 50: *NSW Health should cooperate with and support the National E-Health Transition Authority including in particular developing appropriate policies to and platforms which govern the manner of and the circumstances sufficient to permit general practitioners, specialists, allied health professionals and community health clinicians, who are located outside the hospital, to gain access to relevant parts of, and information from, the electronic medical record generated within NSW public hospitals.* 496

Recommendation 51: *Within 4 years NSW Health should complete the current information technology program including the following stages:* 501

Timing	
Stage 1: 12 months	Infrastructure
Stage 2: 18 months	Electronic medical record Patient Administration System
Stage 3: 24 months	Human Resources Information System Business information strategy Medical imaging Intensive care Hospital pharmacy system
Stage 4: 36 months	Community health system redevelopment Automated rostering Clinical Documentation Medication management
Stage 5: 48 months	State-wide roll out of the electronic health record

Recommendation 52: *A high speed broadband network should be established within 18 months securely linking all public hospitals in NSW so as to enable the provision of specialist clinical services and support via the network from metropolitan-based clinicians and hospitals to regional, rural and remote clinicians and hospitals.* 502

Chapter 15 Communication recommendations

Recommendation 53: *Within 18 months, NSW Health should introduce a mandatory policy for a form containing a checklist to be completed each time a patient is admitted as an inpatient to a hospital ward from the Emergency Department. The checklist ought require details including patient’s identification, provisional diagnosis, whether or not any tests and investigations have been carried out, and whether or not the inpatient consultant has been notified of the admission and accepted the admission (with the identity of the consultant under whose care the patient is admitted and the date and time of notification recorded). This form should be completed by a junior medical officer in the Emergency Department and the same form should be used throughout the State.* 522

- Recommendation 54:** *Within 6 months, NSW Health should introduce a mandatory policy which requires that when orders for pathology tests are made, the name of the ordering doctor and contact number be clearly printed (if written) or entered (if computerised) on the pathology form. The policy should include a protocol outlining the appropriate channel of communication where (a) the relevant details are incomplete or illegible and (b) the ordering doctor is not on duty or contactable.* 525
- Recommendation 55:** *Daily multi-disciplinary ward rounds should be introduced at which accurate and complete notes are taken which are approved by the supervising doctor within a specified timeframe.* 530
- Recommendation 56:** *Within 18 months, NSW Health should ensure that each hospital designs and introduces a mandatory shift handover policy, which includes, as a minimum:* 540
- (a) *a requirement that part of the handover occurs at the patient's bedside;*
 - (b) *a requirement that sufficient time designated for handover is built into the rostering system;*
 - (c) *a requirement for the information which is to be conveyed during handover; and*
 - (d) *a requirement that a written or electronic record be made of the handover.*
- Recommendation 57:** *Recommend that the function of liaison with general practitioners be undertaken as a designated role in every public hospital in NSW, either by the creation of one or more positions to undertake the function on a full time basis or alternatively the allocation, on a part time basis of the function, to an existing position.* 547
- Recommendation 58:** *In order to ensure compliance with the NSW Health policy on the mandatory provision of discharge summaries to a general practitioner the GP Liaison Officer in each hospital is to institute a regular process of checking and auditing:* 547
- (a) *the provision of a discharge summary;*
 - (b) *the accuracy of and the sufficiency of the discharge summary; and*
 - (c) *where appropriate, the legibility and readability of the discharge summary.*
- Recommendation 59:** *Within 24 months, NSW Health should investigate and establish a plan for the introduction of modern internet based systems (e.g. VOIP) for all communications within hospitals including portable communication devices for all appropriate clinical staff members from patients and their carers are addressed as soon as reasonably practicable.* 551

Recommendation 60: *NSW Health should encourage all hospital staff to take all reasonable measures to enhance their communication with patients including by making sure that:* 554

- (a) *patients and their carers are told who staff are and what their function is;*
- (b) *patients and their carers are kept informed of the nature and purpose of any treatment about to be delivered;*
- (c) *any questions and concerns from patients on their case are addressed as soon as is reasonably practicable.*

Recommendation 61: *On discharge from hospital unless clinically inappropriate, each patient or their carer should be provided with a document, in plain language, explaining:* 557

- (a) *what medications, if any, they are to take and the details related to those medications, including, for example, frequency, dosage and any medications which are contra-indicated;*
- (b) *what their care plan is;*
- (c) *an outline of resources available to assist them upon discharge (including contact details of patient support groups); and*
- (d) *a schedule of any follow up appointments.*

Recommendation 62: *Within 12 months, NSW Health implement a state-wide policy ensuring uniforms or vests are worn by each health professional, identifying in large print the role of the health professional. The state-wide policy should:* 567

- (a) *designate a colour to each professional role and ensure that the colour is consistently adopted;*
- (b) *include a requirement for posters to be prominently displayed throughout NSW Health facilities providing a chart to indicate which uniform or colour is assigned to which profession; and*
- (c) *NSW Health amend existing policy or develop additional policy to require the wearing of name badges (or similar, but not cards on lanyards) by each type of health professional, bearing in large print the person's name and title or role.*

Chapter 16 Safety and Quality recommendations

Recommendation 63: *NSW Health should encourage each facility to have a patient care committee which has, at least, the following features: monthly meetings; include nursing, medical, allied health and administrative staff; review all deaths in the facility; and review minutes of morbidity & mortality committee meetings and any other safety and quality committee meetings.* 602

Recommendation 64: *The improvement plan process set out by the Clinical Excellence Commission in the Quality Systems Assessment Statewide Report be implemented by all area health services within the time frames specified by the Clinical Excellence Commission.* 609

Recommendation 65: *NSW Health should review the functions, size and structure of the Quality & Safety Branch to determine if it has any functions which duplicate the work of, or else would more appropriately be undertaken by, the Clinical Excellence Commission. NSW Health needs to ensure that any duplication or unnecessary replication is eliminated with the intent that the Clinical Excellence Commission will become the body primarily responsible for safety and quality within NSW Health.* 617

Recommendation 66: *If the Clinical Excellence Commission identifies that the quality and safety processes or performance of an area health service, statutory health corporation or facility are inadequate, the Clinical Excellence Commission must:* 617

- (a) *Immediately notify the general manager of the facility, the chief executive of the area health service and the Director General of NSW Health.*
- (b) *The notification must specify:*
 - (i) *the quality and safety processes or performance which the Clinical Excellence Commission has identified as being inadequate;*
 - (ii) *what action, in the opinion of the Clinical Excellence Commission, should be taken by the facility, area health service and/or NSW Health to rectify the inadequacy;*
 - (iii) *the time frame in which the action should be taken; and*
 - (iv) *a date after which the Clinical Excellence Commission will again inspect or review the area health service, statutory health corporation or facility to monitor improvement.*
- (c) *The Clinical Excellence Commission is to inspect or review the area health service, statutory health corporation or facility after the date specified in the notification.*
- (d) *If, following the inspection or review by the Clinical Excellence Commission, the action specified in the Clinical Excellence Commissions notification has not been taken, the Clinical Excellence Commission is to notify the Minister for Health with a recommendation as to what action the Minister for Health should take.*

Recommendation 67: *Within 12 months, NSW Health is to establish a board governed statutory health corporation pursuant to s.41 of the Health Services Act 1997 known as the Clinical Innovation and Enhancement Agency.* 618

The Agency is to undertake its role according to these guidelines:

- (a) *establish new, or else incorporate within it the already existing-clinical networks, taskforces and other clinician practice groups as the operative networks by which it is to undertake its role;*
- (b) *establish within a central directorate of the Agency, a reservoir of the following skills:*
 - (i) *change management;*
 - (ii) *health economics expertise;*

- (iii) *business management; and*
 - (iv) *project design and support*
 - (v) *to be provided as necessary to the clinical networks, together with such other administration support as is appropriate, to enable the efficient functioning of the clinical networks;*
- (c) *use the existing clinical network model to involve clinicians and patient representations in continuous clinical redesign to deliver safer and better patient care.*

The Agency is to have, at least, the following principal purposes and functions:

- (a) *To identify, review and enhance or else to research and prepare standard evidence based protocols or models of care guidelines for every unexceptional surgical intervention, and the common disease or syndrome treatment modalities encountered in NSW public hospitals;*
- (b) *To investigate, identify, design, cost and recommend for implementation changes in patient care by way of enhancements or improvements in clinical practice, including the content and method of such practice, in order to ensure, on an ongoing state-wide basis, better, safer, more efficient and more cost-effective patient care;*
 - (i) *To provide advice to NSW Health, or any Area, or functional Health Service, on any matter relating to the enhancement or improvement of clinical practice.*
 - (ii) *To liaise with change managers from the private sector retained to assist in the introduction of clinical re-design at the Area, hospital and unit levels and provide the point of contact between change managers and NSW Health.*

The Agency is to report directly to the Minister for Health and the Director-General of NSW Health and is to prepare an annual report to the Minister on the progress of clinical innovation and enhancement in the public hospital sector.

Recommendation 68: *Each of the chief executives of the public health organisations is to report every six months to the Clinical Innovation and Enhancement Agency and the Director-General of NSW Health on the progress of implementation of all endorsed innovation and enhancement programs, and if any program has not been implemented the explanation for such failure.*

619

Recommendation 69: *The Clinical Excellence Commission, the Clinical Innovation and Enhancement Agency and the NSW Institute for Clinical Education and Training should jointly explore whether it would be more efficient and cost effective for their operations:*

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- (a) *to be physically co-located;*
- (b) *to share common facilities;*
- (c) *to share corporate support functions and support staff.*

- Recommendation 70:** *NSW Health is to ensure that quarterly reports for each unit and each facility containing the following information:* 625
- (a) *Data regarding the IIMS reports made by the facility during the period;*
 - (b) *Data regarding the IIMS reports made by the unit during the period;*
 - (c) *Data comparing the IIMS data for that facility and for that unit to the performance of the rest of the NSW health system, are prepared and distributed.*
- Recommendation 71:** *NSW Health should develop a process which ensures that upon the finalisation of each IIMS report, the results of the IIMS report are immediately reported back, by email where possible, to the person who made the initial report and their manager. If the IIMS report takes longer than one month to finalise, a monthly report regarding progress is to be provided to the reporter of the incident and their manager until the IIMS report is finalised.* 625
- Recommendation 72:** *The Clinical Excellence Commission to conduct regular audits of the accuracy of the data and the appropriateness of the SAC categories applied to the various incidents by reporting clinicians.* 627
- Recommendation 73:** *Within 3 months, the Clinical Excellence Commission to consider and advise the Director General of NSW Health whether the involvement by the chief executive in the approval of the Root Cause Analysis process requires amendment and if so in what respects.* 632
- Recommendation 74:** *Within 12 months the Clinical Excellence Commission to establish searchable intranet accessible to all NSW Health staff which contains all RCAs.* 633
- Recommendation 75:** *Within 3 months, NSW Health is to establish a Bureau of Health Information, which has the following characteristics:* 639
- (a) *It is to be independent from and not part of the Department of Health;*
 - (b) *It is to be established either as, or as a part of, a board governed statutory health corporation pursuant to s.41 of the Health Services Act 1997;*
 - (c) *It is desirable that it be co-located with a research facility or else a body with expertise in the collection, analysis and use of complex data.*
- Recommendation 76:** *The functions of the Bureau are to include, but not be limited to,* 639
- (a) *Present routinely collected data sets:*
 - (i) *Public Reporting:*
 - Review and develop indicators of Health System Performance for the State as a whole, each Area Health Service (including functional Health Services), hospitals and units or wards;*
 - Produce and publish regular and timely Reports of Health System Performance data according to relevant criteria;*

Provide an Annual Report on the Patient Care Performance criteria, together any other relevant performance criteria to the NSW Parliament on NSW Health;

(ii) Performance Monitoring:

Develop methods and systems for the analysis of routinely collected data;

Provide advice on the enhancement of routine data collections;

Identifying and undertaking benchmarking, reporting and feedback systems for all levels of NSW Health.

(iii) Data Access and Supply:

Analysing routinely collected data in response to user requests;

Developing and distributing tools to allow users to interrogate routinely collected data (e.g. data cubes).

(iv) Value-Added Analysis:

Undertaking analysis of routinely collected data sets to explore and report on specific issues.

(b) New data sets:

(i) Evaluation:

Undertaking, commissioning or advising upon the meaning of the cost and effectiveness of new policies and programs.

(ii) Research:

Commissioning research, as appropriate to support and renew its own functions;

Commissioning research into areas and issues, identified by or to it, concerning health system performance;

Commissioning or undertaking research for the developing of new analytic methods for both routinely collected data sets or else new data sets.

Recommendation 77: *Within 6 months, the Bureau of Health Information is to develop and publish patient care performance criteria which are adequate to enable measurement on a continuous basis of the performance in the provision of care to patients of each unit or ward, hospital, area (or functional) health service and NSW Health as a whole in the following areas:*

- (a) Access: Access to and availability of hospital services including timeliness of the provision of services and proximity to patient's home or locality. Availability of alternative community or home based services in lieu of the hospital services;*

- (b) *Clinical: Clinical performance including patient outcome, appropriateness of clinical treatment method, the variation, if any, from protocols and models of care, and identified benefits or detriments to the health and wellbeing of the patient;*
- (c) *Safety and Quality: Safety and quality of the clinical care and the hospital attendance or admission.*
- (d) *Cost: Cost of the clinical care including re-presentation or re-admission cost, and error cost (including provision of additional care, medication, diagnostic tests and/or counselling services and any financial settlement including litigation costs);*
- (e) *Patient: Patient experience and satisfaction;*
- (f) *Staff: Staff experience and satisfaction;*
- (g) *Sustainability: System impact and sustainability.*

Recommendation 78: *Within 12 months, the Bureau of Health Information is to start publishing quarterly reports, within 60 days of the end of the reporting period, which disclose the performance of each unit or ward, hospital, area (or functional) health service and NSW Health as a whole by reference to the patient care performance criteria.* 640

Recommendation 79: *Within 24 months, NSW Health is to review whether it is either necessary or appropriate to continue to measure hospital performance by the current key performance indicators or whether such measurement ought to be discontinued having regard to the quarterly reports of the Bureau of Health Information.* 641

Chapter 17 Key performance indicators recommendations

Recommendation 80: *NSW Health, if it has not fully implemented the next recommendation, should within 18 months provide either by consensual arrangement or changed technology that ambulance officers and the Emergency Department agree and determine jointly off stretcher time.* 656

Recommendation 81: *Within 18 months, the practice whereby ambulance officers remain with patients in the Emergency Department of hospitals until the patient has their definitive treatment commenced ought be abolished.* 657

Recommendation 82: *NSW Health should institute an audit program of waiting lists kept for each hospital in NSW, conducted by staff who are not associated with the relevant area health service or the hospital. The audits should examine all paperwork that the hospital is required to maintain for the waiting lists including correspondence with referring doctor, and should include the auditing of any reclassification of patients' clinical urgency category.* 659

Recommendation 83: *Any hospital which reclassifies the clinical urgency of a patient whose name is on, or is to be entered on, a surgical waiting list, is to inform the patient's referring doctor in writing within 7 days.* 660

- Recommendation 84:** *Within 12 months NSW Health should critically review this requirement for reporting against Key Performance Indicators required of Emergency Departments to determine whether:* 666
- (a) *The indicators are useful;*
 - (b) *The indicators are necessary; and*
 - (c) *Whether any undue burden is being imposed on Emergency Department staff by the existing regulatory requirements.*

Chapter 18 Hospital acquired infection recommendations

- Recommendation 85:** *NSW Health refund patients the net cost (if any) for medication necessary for the treatment of hospital acquired infection after discharge of the patient from the hospital.* 675

- Recommendation 86:** *The extent of hospital cleaning services be reviewed within 12 months so as to ensure that properly trained cleaners are available, at least:* 677

- (a) *In the principal referral group A and B hospitals and paediatric specialist hospitals on a 24 hour a day, 7 days a week basis*
- (b) *In major metropolitan and non-metropolitan hospitals, on a permanent 16 hour a day, 7 days a week basis and on call at other times.*

- Recommendation 87:** *I recommend that the Clinical Excellence Commission within 9 months, undertake a review of the evidence which exists about the appropriateness of a policy such as the "Bare Below the Elbows Policy" and develop a policy capable of ready implementation and evaluation about the appropriate clothing and accoutrements which ought be worn by health care workers when engaged in clinical care in public hospitals in NSW.* 6822

- Recommendation 88:** *Within 6 months, NSW Health develop a new policy which outlines an enforcement regime which includes the following as a minimum, for failing to comply with hand hygiene protocols for all staff who come into contact with patients.* 690

- (a) *Where the failure is unintentional:*
 - (i) *First occasion Counselling*
 - (ii) *Second occasion Completion of an online educational package*
 - (iii) *Third occasion Attendance at a public education lecture with other 'non-compliers' and a warning that any further failure will result in formal disciplinary action*
 - (iv) *Fourth occasion Disciplinary action*
- (b) *Where the failure is intentional or reckless, immediate disciplinary action is called for which may include, depending upon the seriousness of the conduct, counselling, supervision, or other disciplinary action including dismissal. 688*
- (c) *It should be mandatory for a Chief Executive to report professional staff including VMOs, to their relevant registration authority for*

unsatisfactory professional conduct in all cases where a failure has occurred on four occasions or else is intentional or reckless.

Compliance with the hand hygiene should become part of the contractual obligations of all health care workers.

An intentional or reckless failure to comply with hand hygiene precautions should be reported on IIMS and regarded, at a minimum, as a SAC 2 category incident.

Recommendation 89: *NSW Health ought mandate the screening of vulnerable and high risk patients by standard or rapid screening technology for MRSA and all other significant pathogens across all area health services in the case of planned admissions BEFORE and for all other cases IMMEDIATELY AFTER entry into the hospital. Such mandatory screening ought to commence as soon as practicable but ought be fully operational within 12 months.*

693

Recommendation 90: *NSW Health to consider PD2007-084 and if appropriate, to rewrite it, to include material about and requirements for infection prevention which needs to include as a minimum, the following:*

694

- (a) *each ward must undergo regular audits (at least monthly) and random audits. The audits should be undertaken by an infection control professional who is not part of the staff of the ward;*
- (b) *each ward must nominate either the nurse unit manager or in the alternative, an appropriate infection control officer whose tasks include education about infection control, enforcement of infection control standards, displaying leadership in the ward by their example and undertaking audits of performance in other wards or hospitals;*
- (c) *each ward must publicly display statistics and results compiled monthly and updated throughout the year showing, at least:*
 - (i) *the rate of hospital acquired infection per patient on the ward;*
 - (ii) *the rate of compliance with hand washing techniques (and any other applicable hygiene techniques) separately for each group of health care workers caring for patients.*

Chapter 19 Deteriorating patients recommendations

Recommendation 91: *Within 12 months, NSW Health is to implement a system in accordance with the recommendations of the Clinical Excellence Commission for the detention of deteriorating patients containing the following elements:*

712

- *a system for early identification of an at-risk patient in every hospital in NSW (this system will involve the implementation of a specifically designed vital signs/observation chart);*
- *escalation protocols to manage deteriorating patients, which would include a rapid response system;*
- *development and implementation of detailed education and training programs, aimed at recognising and managing the deteriorating patient;*
- *the ongoing collection and analysis of appropriate data to monitor the implementation and progress of the program;*

- a standardised process for the handover of patients which can be utilised on all occasions and can equally be done when all clinicians are not on site together;
- high level support from management and clinicians; and
- ongoing evaluation.

Chapter 20 Emergency Department recommendations

- Recommendation 92:** *NSW Health devise ways of ensuring that adequate and clear information is provided to all patients who attend at the Emergency Department.* 718
- Recommendation 93:** *Within 12 months, the role of the Clinical Initiatives Nurse should be introduced, if not already in existence, in the waiting room of Emergency Departments in all metropolitan areas and in major regional cities.* 722
- Recommendation 94:** *Triage should be carried out by a senior experienced registered nurse with emergency or critical care experience whenever possible and, without exception, in all tertiary hospitals, and in all like hospitals.* 725
- Recommendation 95:** *Within 18 months, each hospital within a peer group down to and including B2 – Major Non-Metropolitan Hospital and which operates an Emergency Department, ought also to establish a Medical Assessment Unit where enrolled chronic and complex patients will be assessed prior to admission.* 735
- Recommendation 96:** *Within 6 months, every hospital should adopt a policy which permits, subject to the conditions described above, the practice that where a patient is to be admitted to a hospital from an Emergency Department or else a Primary Care Centre, the determination of the ward to which the patient is to be admitted rests with the medical officer in charge of the Emergency Department or the Primary Care Centre, as the case may be, and not with the medical officer (or ward staff) of the department to which the patient is to be admitted.* 742
- Recommendation 97:** *All hospitals review their policies and work practices which affect patient discharge to ensure as far as practicable that the time and date of discharge is activated:* 746
- At the earliest possible opportunity; and*
 - In a way which is consistently with good patient care, maximises bed availability*
- Recommendation 98:** *The principles by which Emergency Departments should operate include, but are not limited to:* 753
- That the provision of emergency care is to be determined by clinical condition, and is not one based on, or determined by, patient demand;*
 - A recognition that the performance of Emergency Departments is inextricably linked with the performance of the whole of the hospital;*

- (c) *An acceptance that Emergency Departments are not the necessarily the only portal for an unplanned admission to hospital.*

Recommendation 99: *Within 18 months, Emergency Departments, so designated, ought be limited to providing care for only those in need of immediate or emergency care which requires the services of highly skilled emergency teams led by specialist emergency physicians. This will ordinarily include those presently in categories 1, 2 and 3 of the Australian Triage Scale, but not those ordinarily within categories 4 and 5.* 754

Recommendation 100: *Such patient care performance criteria as measure the timeliness of access to services in Emergency Departments do so by reference to only two categories namely the provision of immediate care (which is the existing category one of the Australasian Triage Scale) and a second category of emergency care (which combines the existing categories 2 and 3 of the Australian Triage Scale) being care which needs to be provided within a maximum of 30 minutes. The benchmark for both of these categories should be 100%.* 754

Recommendation 101: *Within 18 months, where a hospital has an Emergency Departments, it should establish a Primary Care Centre which would provide services for all patients who attend the hospital seeking urgent or unplanned care and who are not determined clinically to be in need of immediate or emergency care.* 754

Recommendation 102: *The current framework of collaboration between NSW Health and the Emergency Department Workforce Reference Group be continued in order to, by consensus:* 760

- (a) *Identify and publish current staffing levels and profiles for each existing Emergency Department;*
- (b) *A workload tool for determining appropriate staffing levels for Emergency Departments;*
- (c) *A plan identifying the appropriate number and location of emergency medicine trainees which ought be funded by NSW Health.*

Recommendation 103: *A clinical support officer be rostered for duty as a communications officer for no less than 16 hours per day at every Emergency Department.* 762

Chapter 21 Community Health recommendations

Recommendation 104: *NSW Health should articulate the goals of its out of hospital programs and make this information as well as information about how each program operates or what they are intended to achieve publicly available.* 784

Recommendation 105: *NSW Health should ensure that community health services are available as far as practicable on weekends and after-hours to facilitate discharge, improve the efficiency of the acute care system and patient care in both the hospital and community settings.* 784

Recommendation 106: *NSW Health within 18 months is to review and determine the most effective and appropriate structure for the governance in each area health service of the staff and programs delivering health services in the community.* 786

Chapter 22 Mental Health recommendations

Recommendation 107: *Within 18 months, each hospital which operates an Emergency Department should establish a safe assessment room at a location, if not adjacent to, then proximate to the Emergency Department.* 807

Recommendation 108: *Within 18 months, each hospital which does not have a psychiatric emergency care centre (PECC) within a peer group down to and including B2 – Major Non-Metropolitan Hospital and which operates an Emergency Department, ought also to establish a psychiatric emergency care centre (PECC) at a location, if not adjacent to, then proximate to the Emergency Department unless there is easy access to a PECC located at another hospital within a reasonable transfer distance.* 810

Page 59

Recommendation 109: *Mental health patients re-presenting to a mental health inpatient facility or psychiatric emergency care centre (PECC) be admitted to that facility without prior admission to emergency unless, in the opinion of a triage nurse or medical officer in emergency, that person requires specialist emergency medical care.* 810

Chapter 23 Surgery recommendations

Recommendation 110: *NSW Health, within 18 months, should ensure that there is implemented in each area health service for hospitals down to and including Category B2, Major Non-Metropolitan, a model of care for surgery which includes where possible and appropriate:* 844

- (a) *The separation by facility, or operating list or otherwise, of planned or elective surgery from emergency or urgent unplanned surgery;* 842
- (b) *The introduction of an Acute Surgery Unit, which is a consultant led unit, the purpose of which is to undertake all acute surgery at the hospital within the 12 hour day time period;*
- (c) *Explores the availability for, and the engagement of smaller hospitals to provide the facilities for surgery to be undertaken there to supplement the principal surgery programs;*
- (d) *Enables improvements to supervision of the kind referred to in Chapter 13.*

Chapter 24 Pathology & Medical Imaging recommendations

Recommendation 111: *NSW Health provide its hospitals with the tools to analyse requests for tests, so that the heads of medical departments can track the number and cost of tests by patient and health professional, and regularly publish the results within the hospital for all departments.* 860

Recommendation 112: *That the Department of Environment and Climate Change amend the conditions for licences under the Radiation Control Act*

1990 to include the requirement for a quality audit of remote operators who hold licences under the Act to perform x-ray radiology services. 863

Recommendation 113: *Within 18 months, every public hospital in NSW ought be fitted with a digital radiological imaging system, such as PACS, or a compatible system thereto, which will enable the electronic transmission of medical images to remote locations for use in clinical treatment, reading and interpretation.* 871

Recommendation 114: *NSW Health establish a central radiology service sufficiently staffed to read the results of medical images and provide medical imaging reports to public hospitals across NSW 24 hours a day, 7 days a week. In establishing this service, NSW Health should compare the costs of providing this service itself or outsourcing it to the private sector. In the event that it may be able to be provided by the private sector more cost effectively, NSW Health should consider seeking tenders for this service.* 869

Chapter 25 Funding recommendations

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.* 903

Chapter 26 Hospitals recommendations

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.* 943

Recommendation 117: *In my view, there needs to be a complete state-wide review undertaken by NSW Health which involves:* 947

- (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.*

Chapter 27 Transport recommendations

- 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.* 966
- Recommendation 119:** *The patient override function in the Matrix used by the NSW Ambulance Service should be abolished.* 969
- 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.* 971
- 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.* 971
- 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.* 972
- 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:* 977
- (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.*

Chapter 28 Beds recommendations

- 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.* 992

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.* 994

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.* 1000

Chapter 29 Food recommendations

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.* 1017

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:* 1018

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

Chapter 30 Buildings & Equipment recommendations

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:* 1031

- (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.*

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.* 1033

Chapter 31 Administration & Management recommendations

- 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:* 1057
- (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.*
- 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.* 1057
- 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.* 1069
- 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.* 1095
- 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.* 1095
- 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:* 1095
- (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) *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) *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:* 1095
- (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.* 1096
- 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.* 1097

