Volume Three

Final Submissions

Queensland Public Hospitals

Commission of Inquiry

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Queensland Nurses' Union

PRELIMINARY SUBMISSION TO THE BUNDABERG HOSPITAL COMMISSION OF INQUIRY ON BEHALF OF THE QUEENSLAND NURSES' UNION

The Queensland Nurses' Union (QNU) has extended its co-operation and that of its members to this Commission of Inquiry by way of provision of information, including statements of its members, to the Commission. The QNU will continue to co-operate with and assist the Commission in this regard. So as to further assist the Commission in its task and represent the interests of members, some of whom will be witnesses before the Commission, the QNU seeks leave to appear at Commission hearings by Counsel, John Allen, instructed by Roberts & Kane, Solicitors.

These submissions are preliminary only. The QNU has not yet finalised its inquiries in relation to matters the subject of the Commission's Terms of Reference. Nor is the QNU in possession of all of the information gathered by other parties. The Commission is yet to hear any evidence. At a later point, the QNU intends, through Counsel, to make full submissions in relation to each of the Commission's Terms of Reference.

ABOUT THE QNU

The QNU is the principal health union operating and registered in Queensland. In addition, the QNU operates as the state branch of the federally registered Australian Nursing Federation. The objects of the union are both professional and industrial in nature. Pursuant to the Rules of the QNU, the objects of the QNU are to foster high standards of nursing practice, promote the professional and educational advancement of nurses, and promote the economic and general welfare of nurses. The Rules provide that the QNU may take all steps to participate with all other agencies in promoting measures to meet the health needs of the public.

The QNU covers all categories of workers that make up the nursing workforce in Queensland: registered nurses, enrolled nurses and assistants in nursing, employed in the public, private and not-for-profit health sectors including aged care. QNU members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management.

Membership of the QNU has grown steadily since its formation in 1982 and as at May 2005 was in excess of 33,500 and still growing. The QNU represents the largest number of organised women workers of any union in Queensland. Like the nursing profession as a whole, the overwhelming majority of QNU members are women (93%).

The QNU has a democratic structure based on workplace or geographical branches. Delegates are elected from the branches to attend the annual QNU conference, which is the principal policy making body of the union. It is rank and file membership that drives the agenda of the QNU. In addition to the annual conference the QNU has an elected council and an elected executive, which have decision-making responsibilities between conferences. Council is the governing body of the QNU.

QNU members working for Queensland Health are employed under federal industrial instruments. Members in the private sector are employed under state industrial instruments. In addition, since 1994 when there were no enterprise agreements covering nurses, the QNU has become party to over 200 enterprise agreements which cover a diverse range of health facilities and other non-health establishments where nursing services are provided (for example, schools, prisons and factories). The QNU therefore has a clear and comprehensive understanding of the complexity of contemporary health service delivery and the diversity of locations where health services are delivered.

BUNDABERG BASE HOSPITAL ISSUES

The QNU expects that evidence to be presented before the Commission will establish that:-

- Dr Jayant Patel was permitted to perform surgery beyond his own clinical competence and beyond the scope of practice of the Bundaberg Base Hospital;
- hospital management were aware of serious concerns held by other doctors and nursing staff as to Dr Patel's clinical practice;
- hospital management failed to take appropriate action to address those serious concerns;
- Queensland Health officials threatened staff with serious reprisals for communicating such concerns to any person outside the Department; and
- Queensland Health's inaction contributed directly to unnecessary loss of life, serious injury and suffering of patients. It also caused nursing staff great anxiety and distress.

Surgery beyond Dr Patel's competence and beyond the scope of practice of the Bundaberg Base Hospital

A number of factors determine whether a particular surgical procedure can properly be performed at a particular hospital, for example the Bundaberg Base Hospital, or whether a patient should be transferred to another hospital. These factors include:-

- whether surgical staff and necessary medical and nursing staff of sufficient skill and experience are available to undertake such a procedure; and
- whether the hospital's surgical and post-operative facilities are appropriate for such a procedure.

In relation to appropriate post-operative facilities, the nature of available intensive care facilities is of utmost importance. The Intensive Care Unit (the "ICU") at the Bundaberg Base Hospital is a Level 1 Combined Intensive Care/ Coronary Care Unit. Because of the limited number of available appropriately qualified and experienced nursing staff, there are restrictions upon the number of acutely ill patients who can have their needs met in the unit at any one time.

The Joint Faculty of Intensive Care Medicine has published a Policy Document which outlines the minimum standards relating to work practice/caseload, staffing and operational requirements, design, equipment and monitoring for Level 1, 2 and 3 Intensive Care Units[1]. Level 3 units are well resourced units located in tertiary referring hospitals such as the Royal Brisbane and Princess Alexandra Hospitals. Level 1 Intensive Care Units, such as that at the Bundaberg Base Hospital, should generally only keep patients who require ventilation for between 24 and 48 hours before transferring them to a hospital with a higher level of intensive care.

The Bundaberg Base Hospital could only realistically deal with a maximum of 2 patients on ventilators at any one time because of nursing staffing levels. Also, the Bundaberg Base Hospital ICU does not have the services of a specialist Intensivist[2], unlike hospitals in Brisbane to which patients requiring high level of intensive care are appropriately referred.

Dr Patel was permitted to perform surgery which was beyond the scope of practice of the Bundaberg Base Hospital, namely, that which should have been performed at a hospital with a higher level of intensive care facilities. He was also permitted to perform surgery of a type beyond his own clinical competence.

Dr Patel ignored the concerns of other medical staff and nursing staff that patients should be transferred to Brisbane for a surgical procedure and/or after suffering post-operative complications. The farcical, but tragic, situation occurred whereby other medical staff and nursing staff would take steps to, in effect, hide patients from Dr Patel and organise the transfer of patients to Brisbane at times when Dr Patel was not present to intervene to prevent transfers.

Examples of adverse outcomes for patients and complaints by nursing staff and the QNU to management and other authorities

It is expected that the Commission will hear evidence as to a number of patients who have suffered unnecessary death or serious injury because of the circumstances at the Bundaberg Base Hospital. The QNU expects that such evidence will include evidence in relation to the following patients, who are referred to by way of examples of the tragic situation confronted by patients, medical staff and nursing staff. To protect the privacy of the living and the feelings of the loved ones of those deceased, these patients are referred to in this submission by way of a code used in preparation of statements from QNU members for submission to the Commission. The Commission has been supplied with a list of patients referred to by name, Queensland Health UR number where it is known, and the code.

[1] http://www.jficm.anzca.edu.au/publications/policy/ic1_2003.htm
[2] A medical director who is a Fellow of the Joint Faculty of Intensive Care Medicine

On 19 May 2003, **Patient P34** underwent the major surgical procedure of an oesophagectomy performed by Dr Patel. An anaesthetist reported to ICU staff that the patient had no obtainable blood pressure during the last 45 minutes of surgery. The patient was obviously critically ill when admitted to the ICU and ultimately died. During the course of the patient's time in the ICU, Dr Patel informed medical and nursing staff and the family of the patient that the patient was stable.

The ICU Nursing Unit Manager, Ms Toni Hoffman, spoke to the Director of Medical Services, Dr Darren Keating, on two occasions in late May or early June 2003 to voice her concerns about the treatment of this patient. At one of those meetings she was accompanied by the then Director of Nursing, Ms Glenys Goodman, and on another occasion by Dr Jon Joiner, a General Practitioner who would perform local anaesthesia for the hospital. Ms Hoffman expressed her concerns to Dr Keating as to surgery such as oesophagectomies being undertaken at the Bundaberg Base Hospital, which lacked appropriate intensive care facilities for post-operative care for patients undergoing such major surgery. She also expressed her concerns as to Dr Patel describing a patient as stable when they were obviously critically ill. Dr Keating's response was that Dr Patel was a very experienced surgeon with whom staff would have to cooperate. He told Ms Hoffman that there was an expectation that the Bundaberg Base Hospital would continue to provide surgery to the people of Bundaberg and that Dr Patel was experienced in performing this type of surgery.

On 6 June 2003 **Patient P18** underwent an oesophagectomy performed by Dr Patel. Despite post-operative complications that required returns on subsequent days for further surgery because of wound dehiscence (the wound coming apart), Dr Patel intervened to prevent the transfer of the patient to the Royal Brisbane Hospital and he was not ultimately transferred to the Royal Brisbane Hospital until 20 June 2003.

Ms Hoffman communicated her concerns in writing to the then Director of Nursing, Ms Goodman, and to the Director of Medicine, Dr Keating, in the period of time that Patient P18 remained in the ICU.

During 2003, every patient at the Bundaberg Base Hospital who had a peritoneal dialysis catheter placed by Dr Patel had complications with acute and chronic infections, migration of catheters requiring further surgery and incorrect external positioning of the catheters. On 17 December 2003 **Patient P30** underwent surgical intervention to address the migration of his peritoneal catheter. This additional surgery was required because of the incompetence of Dr Patel in inserting the catheter, yet was performed by Dr Patel. The patient died as a result of haemopericardium due to perforated thoracic veins during the insertion of a permacath by Dr Patel. The patient would not have required this additional procedure had his peritoneal catheter been positioned correctly in the first place.

As a result of concerns raised by nursing staff as to this death and the hundred percent complication rate regarding peritoneal dialysis catheters inserted by Dr Patel, hospital management eventually reached an agreement with a medical supply company and a local private hospital. Pursuant to this agreement, the medical supply company undertook to pay for insertion of such catheters into Bundaberg Base Hospital patients at the private hospital.

On 27 July 2004, Dr Patel intervened to prevent the transfer to Brisbane of **Patient P11.** He then took it upon himself to intervene in the care of the patient and insert a pericardial drain. Such a procedure involves the insertion of a tube with a needle on its end through the abdominal wall under the diaphragm and up into the pericardial sac which surrounds the heart. Such a procedure is one that can be accomplished by any reasonably competent surgeon on the first attempt. Dr Patel forcefully attempted to insert the pericardial drain. He was unable to do so on his first or many subsequent attempts, leaving the patient with multiple stab wounds in his upper stomach. Whilst doing so, Dr Patel made loud comments that the patient would die and did not need to go to Brisbane. These circumstances caused great distress to nursing staff attending to the patient and to the family of the patient, who were nearby. The patient died before he could be transferred to Brisbane.

Nursing staff prepared statements detailing their knowledge of the circumstances of this patient's treatment which were later communicated to hospital management. Ms Hoffman spoke to Bundaberg Base Hospital doctors, the local acting Coroner, an officer of the Queensland Police Service and the head doctor of the Royal Flying Doctor Service. It appears that no action was taken at this time to address these concerns.

Nursing staff communicated their concerns about Dr Patel to the QNU. Ms Kym Barry, a Professional Officer of the QNU, met with the Director of Nursing, Ms Linda Mulligan, on 6 October 2004 to discuss the concerns. Ms Mulligan expressed the view that there appeared to be a personality clash between Dr Patel and Ms Hoffman which might be resolved by mediation. Concerned that Ms Mulligan may be dismissing events as a mere personality clash, Ms Barry advised Ms Hoffman to put her concerns in writing to the District Manager and discussed other possible avenues of complaint to the Medical Board and the Health Rights Commission.

Ms Hoffman forwarded a letter dated 22 October 2004 to the District Manager, Mr Peter Leck, concerning **Patient P11** and other matters. Attached to the letter were written statements from other nursing staff. A short time later, three Queensland Health officers travelled from Brisbane and lectured senior Bundaberg Base Hospital nursing staff as to the constraints upon Queensland Health employees disclosing confidential information to others. Staff were specifically told that they were not permitted to tell their union about what went on at the hospital and that breach of such prohibition would result in loss of employment and liability to imprisonment.

On 20 December 2004, nursing staff became aware of a planned surgical procedure by Dr Patel of a gastro-oesophagectomy. The ICU already had two patients on ventilators and could not accommodate a third. Medical staff agreed with nursing staff that Dr Patel's surgery should be postponed. Dr Patel insisted that the surgery should proceed and that one of the patients already being ventilated in ICU (**Patient P44**) should have her ventilator turned off as she was 'brain dead'. Ventilation of Patient P44 was ceased at the direction of Dr Patel without the requisite brain death testing being carried out.

Dr Patel then commenced surgery of a gastro-oesophagectomy upon **Patient P21**. During surgery, despite the repeated concerns voiced by medical and nursing staff, Dr Patel ignored obvious signs of internal haemorrhaging by this patient. At the conclusion of surgery Dr Patel ordered that the patient be transferred to the ICU. Patient P21 died the following day due to blood loss. Nursing staff expressed verbal and written concerns to hospital management within the following days. They were subsequently indirectly informed that hospital management had determined that Dr Patel was not to be permitted to perform surgery of this type in the future.

On 23 December 2005 **Patient P26**, a fifteen year old boy who had been involved in a motor vehicle accident and had a possible femoral artery injury, was transferred to the Bundaberg Base Hospital by helicopter. Patient P26 underwent surgery by Dr Patel. Later that day he was returned to theatre to receive fasciotomies for compartment syndrome of his left leg. Dr Patel declined to order on table x-rays or an angiogram, which were suggested by nursing staff to ascertain why the patient was suffering from compartment syndrome. Dr Patel insisted that such further investigations were not necessary. Nursing staff and medical staff continued to have concerns about the condition of the patient's leg, which was mottled, extremely stiff and had no discernable pulse. Other doctors expressed concerns as to the patient's condition and agreed with nursing staff that he needed to be transferred to Brisbane. The patient was not transferred to Brisbane and received further surgery later that day. The patient continued to suffer from compartment syndrome of his left leg. Nevertheless, the patient was not transferred to Brisbane until his condition had deteriorated to such an extent that his leg required amputation. Nursing staff were understandably concerned about the treatment of this patient and expressed concerns to doctors and hospital management.

Dr Patel is permitted to continue as Director of Surgery

Despite the matters outlined above and other indications of post-operative complications that threw into question Dr Patel's clinical competence, and complaints about his misbehaviour towards women members of staff, he continued to perform his duties as Director of Surgery. Dr Patel claimed to be valued by management because of the money he made for the hospital. Staff believed Dr Patel when he suggested that he was immune from criticism due to his contribution to the finances of the Health District.

In February 2005, the District Manager, Mr Leck, instructed Theatre nursing staff that the rate of elective surgery at the Bundaberg Base Hospital was to be increased through to the end of the budget year (30 June 2005) so as to meet budget targets. In an email dated 8 February 2005 Mr Leck stated that "[a]ll cancellations should be minimal with these cases pushed thru as much as possible". By this time, the elective surgery targets had become unmanageable. The Theatre was under staffed, nursing workloads were excessive and nursing staff were becoming physically exhausted. Dr Patel told nursing staff that Mr Leck had told him to meet the elective surgery targets at any cost. When nursing staff raised with Dr Patel concerns about the size of some of his surgical lists and the effects that would have on nursing overtime, he became verbally abusive, raised his voice and said that "if the staff have to work back they have to work back". This often meant working late into the night as

the surgical lists were fully booked with no capacity for emergencies. Emergencies would push out the list and staff would often work well into the night to finish the elective surgery list and the non-life threatening emergency cases that had built up during the day. Nursing staff felt that they could not do anything about this situation as it appeared to be driven by management giving Dr Patel full support in achieving surgery targets regardless of the quality of care provided and the impact upon hospital staff.

In February 2005, nursing staff were informed of a Queensland Health investigation against Dr Patel, however, he continued to perform his duties as Director of Surgery.

The QNU makes further representations on behalf of its members

From October 2004, the QNU continued to communicate with Ms Hoffman and other nursing staff as to their concerns.

On 2 February 2005, QNU officials met with Ms Mulligan in relation to ICU nursing concerns. Ms Mulligan indicated that there would be an investigation into matters.

On 4 February 2005, QNU officials met with Mr David Kerslake, Health Rights Commissioner, and raised concerns based on particulars from Ms Hoffman's letter dated 22 October 2004. They indicated that it would be in the public interest for Mr Kerslake to investigate and asked whether there was anything that the Health Rights Commission could do to investigate such matters. Mr Kerslake indicated that he would have to be directed by the Minister for Health to undertake such an investigation. He advised that complaints relating to individual medical practitioners would be referred to the Medical Board. Mr Kerslake also stated that the Health Rights Commission did not have any direct links to the Coroner's Office in terms of receiving recommendations made by the Coroner relating to health systems and processes.

On 11 February 2005, QNU officials met with Queensland Health's Chief Medical Officer, Dr FitzGerald. Dr FitzGerald and his colleague, Ms Jenkins, confirmed that they were undertaking a clinical audit of surgical procedures at Bundaberg Base Hospital and that nurses who had provided statements would be interviewed.

On 15 February 2005, QNU officials met with Mr Jim O'Dempsey, Executive Officer of the Medical Board. They inquired of Mr O'Dempsey if Dr Patel in fact held surgical qualifications as his practice would seem to suggest otherwise. Mr O'Dempsey confirmed that the Health Rights Commission could refer a complaint to the Medical Board for investigation. He confirmed that providers and users of medical care could make a complaint to the Medical Board in relation to an individual doctor.

A nurse blows the whistle

By March 2005, no action had been taken to restrict the surgical practice of Dr Patel. He informed staff that his contract as Director of Surgery had been extended.

Also by March 2005, Ms Hoffman had, either personally or through the QNU, communicated concerns regarding Dr Patel's practice to:

- other doctors in the hospital including Dr Carter, Dr Miach, Dr Strahan and Dr Berens;
- the Director of Medical Services, Dr Darren Keating;
- the Director of Nursing, Ms Linda Mulligan;
- the District Manager, Mr Peter Leck;
- Dr Gerald Costello, the head doctor for the Royal Flying Doctor Service;
- senior nurses from the Royal Flying Doctor Service;
- the Chief Health Officer for the State of Queensland, Dr Gerald FitzGerald;
- the Queensland Police Service;
- the local acting Coroner;
- the Health Rights Commission; and
- the Medical Board of Queensland.

Yet Dr Patel continued to operate on patients.

By this time, Ms Hoffman had reached a point of desperation as to what could be done to prevent unnecessary death and suffering of patients under the hands of Dr Patel. She was aware that the Member for Parliament for the electorate of Burnett, Mr Rob Messenger, had expressed an interest in an industrial matter involving nursing staff at the Bundaberg Base Hospital. She spoke with Mr Messenger and provided him with a copy of her written complaint to Mr Leck dated 22 October 2004, asking that he de-identify the document by deleting patient names and nurses' names before doing anything further with it. She accepted an offer by Mr Messenger for her to anonymously claim "whistleblower status" before being interviewed by him.

Reprisals by Queensland Health

After Mr Messenger's statements in Parliament had been publicly reported, the Acting Director of Nursing called a meeting of ICU staff. This meeting was attended by the District Manager, Mr Leck, who expressed anger about nurses breaching the confidentiality provisions of Queensland Health's Code of Conduct. Mr Leck referred to a departmental Industrial Relations document to the effect that staff breaching confidentiality could be imprisoned for two years and lose their jobs. He stated that he was appalled that such a senior surgeon of the hospital could be treated in such a way that denied him natural justice. Nursing staff felt extremely intimidated by the comments by Mr Leck who failed to give any of them an opportunity to respond to his comments or to discuss their concerns about Dr Patel.

On 28 March 2005, the Bundaberg *News Mail* published a letter to the editor from Mr Leck. Mr Leck stated that:

- the fact that allegations had been made public was "reprehensible"
- he had received no advice that the allegations were substantiated
- "A range of systems are in place to monitor patient safety and the community can be assured that we constantly work to improve our service delivery."
- "Dr Patel is an industrious surgeon who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go."

On 7 April 2005, nursing staff attended a staff forum attended by the District Manager, Mr Leck, the Director-General of Queensland Health, Dr Steve Buckland, and Minister for Health, the Honourable Gordon Nuttall MP. Mr Nuttall and Dr Buckland told staff that, because of the release of material in Parliament by Mr Messenger and the departure of Dr Patel from Australia, results of the Queensland Health investigation that had been underway would not be released. Mr Nuttall stated that the only way staff could stop such rubbish was to vote Mr Messenger out at the next election. Dr Buckland said that no decent doctor would want to come to Bundaberg to work in these circumstances. Staff felt that they were being criticised as being disloyal and believed that the Department would not be further investigating matters regarding Dr Patel.

Queensland Health maintains QNU members cannot give information to the QNU without the express written authority of the Director-General

Even after this Commission of Inquiry was announced and the Crime and Misconduct Commission announced its own inquiries into a complaint by the QNU of official misconduct on the part of Queensland Health officials, Queensland Health continued to adopt an approach, relying upon the provisions of the *Health Services Act 1991*, which would have had the effect of inhibiting Queensland Health employees in communicating matters of concern to the Commission and the CMC through the QNU. It was not until 17 May 2005, after correspondence with the QNU's solicitors, that Queensland Health communicated its general authority for QNU members to communicate to the QNU and its legal representatives matters of relevance to official inquiries into the Bundaberg Base Hospital.

It would appear Queensland Health maintains that, in the absence of such written authority, members of the QNU who voice concerns as to hospital practices and administration to the QNU, could be in breach of confidentiality provisions and subject to disciplinary or criminal action. The QNU will, at an appropriate time, address submissions to the Commission as to legislative changes that may be required to leave it beyond doubt that QNU members will be able to raise such matters with the QNU, and other appropriate bodies, without the fear of disciplinary action or criminal prosecution. It is expected that such submissions may be addressed to necessary amendments of the *Health Services Act 1991* and the *Whistleblowers Protection Act 1994*.

QUEENSLAND HEALTH - CULTURAL ISSUES

A significant concern to the QNU is the dominant culture that pervades Queensland Health. This culture is one of an obsession with secrecy, a failure to embrace differences of opinion and critical analysis, intimidation of those who dare to question and entrenched power imbalances. This dysfunctional culture has contributed significantly to the circumstances giving rise to this Inquiry.

Queensland Health has a "shoot the messenger" culture: an obsession with secrecy and ensuring that the appearance that "all is well" is maintained at any cost; a failure to address medical dominance and arrogance; a failure to embrace different views and critical analysis; and perhaps most importantly an overemphasis on efficiency gains rather than effectiveness within the system. Coming in on budget and meeting elective surgery targets receive higher priority than the important objectives of ensuring optimal, appropriate and timely care. At Queensland Health what is valued most highly is the dollar bottom line.

The almost paranoid obsession with secrecy and failure to share meaningful data with "partner" organisations such as health unions (not to mention the community as a whole) are fundamental barriers to accountability. In the last ten years or so every effort has been made to get Queensland Health off the front page of *The Courier Mail* and this has resulted in those with a genuine interest in information that is required to enable proper scrutiny of the system being denied access to necessary information. The winding back of the Freedom of Information regime in this State has greatly facilitated this culture of secrecy and lack of accountability.

Queensland Health's dysfunctional culture is further entrenched by a "can't do" attitude and lack of appropriately functioning structures. In the last decade or so, the QNU has had to fight every step of the way to even achieve the lawful entitlements of its members. There is a fundamental lack of consistency of approach across the Department, with no one consistent view on human resource and industrial relations matters. Every Health Service District appears to be a "power unto themselves" in this regard – there is no one organisational position that is consistently applied.

Queensland Health employees, including nurses, experience the disparity between the publicly stated values espoused by the Department in documents such as the Vision Statement and strategic plans and those exhibited in their workplaces on a daily basis. Their real life experiences do not match their employer's rhetoric.

Team relationships suffer from a widespread culture of bullying and intimidation. Staff members are informed publicly that "you are either with us or against us – if you are against us you can leave". Reasonable critical analysis and debate is stifled. The level of bullying and intimidation that occurs in the Department is unparalleled in any other Queensland government agency, as confirmed by the findings of the *Queensland Government Bullying Taskforce* (2002).

There are great inconsistencies with regard to the way in which staff are treated within Queensland Health that arise from fundamental and longstanding power imbalances. The QNU notes that Dr Patel was able to continue to practice while the Department was investigating extremely serious allegations against him. The QNU's experience has always been that when a nurse is under investigation for practice concerns of a serious nature they are immediately suspended or moved to alternate, non-patient contact, duties. There is apparently one rule for doctors and another for all other health workers.

COMMENTS IN RELATION TO THE QUEENSLAND HEALTH INITIAL SUBMISSION TO THE BUNDABERG HOSPITAL COMMISSION OF INQUIRY DATED 16 MAY 2005

Generally speaking, the submission by Queensland Health demonstrates a remarkable lack of insight into the magnitude of the Department's failures. There is no doubt that these failures contributed to the tragic events at Bundaberg Base Hospital. The picture of systems and processes in place to safeguard patient outcomes, as described by Queensland Health, is in sharp contrast to the reality of what has occurred and continues to occur in public hospitals, including the Bundaberg Base Hospital. The tale of "The Emperor's New Clothes" is brought to mind in connection with Queensland Health's proud depiction of its current processes for maintaining and improving clinical standards, receiving, processing, investigating and resolving complaints and its systems of accountability. The contents of the submission are consistent with the experience of the QNU in that there is a wide gulf between Queensland Health's stated objectives and procedures and the reality of practices within the public health system.

Paragraph 1.4 of the submission purports to be a discussion of the "health workforce" but addresses only the medical workforce and makes no mention of the nursing workforce. This appears to be consistent with the position taken by Queensland Health in previous industrial negotiations and proceedings with the QNU, in that Queensland Health has maintained, despite all the evidence to the contrary, that there is no nursing shortage. The submission provides statistics as to the decrease in the medical practitioner rate. The Commission may wish to note that in 1995 the number of fulltime employed nurses per 100,000 population in Queensland was 988 (Australian average 1127) and in 2001 this number had decreased to 965 per 100,000 population (Australian average 1024).

In relation to paragraph 1.6 of the submission, evidence that will be presented before the Commission by QNU members and others which will demonstrate a stark difference between the reality of the administration of the public hospital system by Queensland Health and the admirable stated mission, vision and values of the Department.

In relation to paragraph 3.3 of the submission, the stated mechanisms for receiving, processing, investigating and resolving complaints about clinical practice and procedures at Queensland Health hospitals, particularly where such services result in adverse outcomes, do not provide for any process whereby medical or nursing staff concerned about the clinical practices of a doctor can do so in a reliable formal manner. Evidence that will be

put before the Commission will show that attempts by nursing staff to address to management concerns regarding the clinical practice of Dr Patel were met with inaction, discouragement and at times open hostility and threats of retribution. Once again, the systems and processes, as described by Queensland Health, stand in stark contrast to the reality of the situation.

In relation to paragraph 3.4 of the submission, the same comment can be made. The systems of accountability failed miserably to protect patients at the Bundaberg Base Hospital and will continue to do so without fundamental change to the administration and culture of Queensland Health.

In relation to paragraph 3.5 of the submission, Queensland Health fails to identify some obvious factors that currently impact upon the availability of medical practitioners across the State, such as:

- the restrictive practices of medical colleges in relation to entry into training programs, designed to heighten the demand for specialist practitioners and thus their earning capacity;
- the form of remuneration arrangements for medical practitioners; and
- the failure of governments at State and Federal level to address health matters in a comprehensive and concerted manner.

WIDENING OF THE TERMS OF REFERENCE OF THE COMMISSION OF INQUIRY

Since the establishment of this Commission of Inquiry, the QNU has been encouraged by public comments by the Premier and Minister for Trade, the Honourable Peter Beattie MP, indicating that issues extending beyond the Bundaberg Base Hospital will be investigated by the Commission. We also note recent media reports of the Commissioner to the same effect. The QNU supports any requisite widening of the Terms of Reference so as to allow the Commission to effectively investigate the wider issues of the malaise of the Queensland health system that have contributed to the tragic situation at the Bundaberg Base Hospital. The QNU hopes that the Commission is not inappropriately constrained in investigating and reporting upon any inadequacies of the Queensland public health system.

OTHER INQUIRIES OF RELEVANCE

Prior to the establishment of this Commission of Inquiry, the QNU lodged a complaint with the Crime and Misconduct Commission regarding the failure of Queensland Health officials to act upon complaints by nursing staff about Dr Patel. The QNU has co-operated with the subsequent CMC investigation by providing the CMC with relevant information and facilitating interviews by the CMC of nurses in Bundaberg. Such assistance to the CMC is ongoing.

The QNU intends to provide a detailed submission to the Systems Review of Queensland Health that is currently being conducted by Mr Peter Forster. The QNU has met with Mr Forster and outlined broad concerns relating to the terms of reference for his inquiry and also provided him with background materials that may be of assistance. The documents provided to Mr Forster are listed below. The QNU would be happy to provide all or any of these documents to the Commission of Inquiry upon request. As can be seen from the list below, the QNU has for many years been expressing concern about the structure and culture of Queensland Health. Unfortunately, there has been a distinct lack of action by governments of both political persuasions to address these issues. The QNU welcomes the opportunity to provide constructive input into the Bundaberg Hospital Commission of Inquiry, the CMC Inquiry and the Queensland Health Systems Review as these inquiries present a long overdue opportunity to design meaningful systemic change.

The following documents were provided to Mr Forster:

- QNU Submission to then Health Minister Hon Peter Beattie *Planning for the Future of Queensland Health* (February 1996);
- QNU *Issues of Concern to Nurses* Submission to Political Parties in the lead up to 1998 Queensland election (November 1997);
- QNU Submission to the Ministerial Taskforce on Recruitment and Retention (June 1999);
- Letter to then Health Minister Hon Wendy Edmond re Proposal for Second Phase of Nursing Recruitment and Retention Taskforce (29 October 2001);
- Letter to then Health Minister Hon Wendy Edmond re Disruption to health service delivery arising from shortage of health professionals (15 February 2002);
- QNU submission to the Senate Inquiry into Nursing (Feb 2002) – this is a detailed submission covering a wide range of concerns about the nursing workforce and although it is now a few years old many if not all of the issues raised still require attention;
- QNU Submission to the National Review of Nursing Education (Feb 2002) – this inquiry was held at the same time as the Senate Inquiry into Nursing so similar concerns were raised in this submission;
- QNU submission to Queensland Health – *Smart State 2020* (June 2002);
- University of Southern Queensland (USQ) summary of findings of research conducted on behalf of QNU – *Your Work, Your Time, Your Life* survey (July 2002) – please note this research was repeated at the end of 2004 and USQ is in the process of analysing this data at present and undertaking comparative analysis between 2001 and 2004 research. The QNU will be able to provide the Commission with findings of this new research on a confidential basis when a report is made available to the QNU;
- Affidavit of Elizabeth Mohle for Queensland Health EB 5 arbitration (November 2002) – information on staffing numbers, throughput and other issue of relevance contained in this document;
- QNU submission to Australian Council on Safety and Quality in Health Care on Safe Staffing (October 2003) – no further progress apparent from the Council on this taskforce;
- QNU publication explaining *The Business Planning Framework: Nursing Resources* (2003);

- QNU Briefing Document prepared for incoming Queensland Minister for Health - *Nurses: Worth looking after* (March 2004);
- QNU submission to Queensland Health on Qualifications Allowance for Nurses (June 2004);
- QNU submission to Queensland government prior to 2005-2006 Queensland Budget (December 2004); and
- Letter to Director General of Queensland Health on nursing strategy (April 2005).

The QNU also intends to provide a submission to the current Productivity Commission's *Health Workforce Study* and has already provided some relevant background materials to this inquiry to assist the preparation of a discussion paper. The QNU submission will concentrate on issues such as:

- Current inadequacies and inconsistencies in relation to the way in which work is valued in the health sector and the failings of our current systems (industrial and professional) to appropriately deal with this issue. This is linked with the manner in which productivity is assessed in the health sector and the undue emphasis placed on meeting efficiency indicators, and insufficient attention to issues of effectiveness and quality of care. The failures of enterprise bargaining in the health sector will also be addressed in the submission;
- Workload management in the health sector and the nexus between workloads and patient outcomes and how to ensure safe staffing levels;
- Current significant skills shortages in health (especially in nursing) and the failure of governments at the state and federal levels to adequately address these shortages;
- Issues of skill mix and substitution in the health and aged care sectors and concerns with current inadequacies in quality assurance systems and processes;
- Inconsistencies in health worker education in Australia and who bears the cost of this at present, especially with regard to post graduate studies and how this contributes to skills shortages. (For example, the differences in costs and arrangements for nurses undertaking post graduate studies compared to doctors);
- The need to significantly change the culture and power relationships in health in order to aid recruitment and retention of personnel and encourage genuine "consumer" involvement in health planning and decision making;
- Significant issues with respect to health and safety (and the impact on workers compensation) and other issues related to providing a safe and supportive workplace environment for health workers;
- The potential impact of demographic challenges on the health workforce and demand for health services;
- The need to review current remuneration arrangements for health practitioners (such as the fee for service funding arrangements for medical practitioners);
- The differential treatment of health workers with respect to government assistance for professional indemnity insurance;
- The need to promote innovation in models of health care such as multi-disciplinary primary health care teams and the role of nurse practitioners in these and other settings; and

- The lack of a coordinated, adequately resourced and nationally consistent framework for health workforce planning. The lack of political will to address this issue is of grave concern.

GENERAL ISSUES OF CONCERN

Nursing and its regulation

Many attempts have and continue to be made to define the practice of nursing. In October 1998 the Queensland Nursing Council published a document titled *Scope of Nursing Practice Decision Making Framework.* This document defines nursing practice as follows:

> *"Nursing practice incorporates the application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues. It focuses on the promotion and maintenance of health, the prevention of injury or disease and the care of the sick and disabled so that people with identified nursing needs may maintain optimal well being or achieve a peaceful death. Nursing practice is largely determined by the context in which it takes place."*

The role of the nurse is broad and at times difficult to specify. This is in large part due not only to the intensely personal nature of the work performed but also because historically the so-called "soft skills" innate to predominantly female occupations such as nursing, have not been adequately identified, or ascribed appropriate value. Such skills are often difficult to articulate and indeed at times, are not formally seen as skills but rather personal attributes. Recent pay equity inquiries in both New South Wales and Queensland have acknowledged this difficulty.

Certainly there is an appreciation at a certain level within the community that a nurse's job is a difficult one – emotionally, physically and intellectually challenging. Nurses are generally highly regarded because of this, consistently topping public opinion polls of the "most respected" occupation. However, most members of the general community do not receive an insight into the breadth and depth of a nurse's role and the skill that nurses require to perform their role competently until such time as they (or a loved one) require nursing care. It is at such times that the value placed on caring, safe and competent nursing practice is in sharp focus.

The Queensland Nursing Council (QNC) regulates nursing practice in Queensland. The QNC is a statutory body established under the *Nursing Act 1992* and is accountable directly to Parliament through the Minister for Health. It maintains registers of registered and enrolled nurses and, in consultation with the profession, consumers and others, develops implements and monitors standards for the regulation, education, practice and conduct of nurses. As such the QNC performs a vitally important role as such standards are essential for the protection of nurses and patients of health services in this State.

The active and strict regulation of nurses by the QNC may be contrasted with the degree of regulation of doctors by the Medical Board. The QNU will at an appropriate time address further submissions regarding this issue with respect to the first of the Terms of Reference of the Commission of Inquiry.

There are three categories that make up the nursing workforce in Queensland – registered nurses, enrolled nurses and assistants in nursing. Registered and enrolled nurses are licensed employees who are answerable individually to their professional registration body (the QNC) as well as being subject to industrial instruments and legislation as are all other employees. Registered and enrolled nurses are employed across a wide variety of health care settings. Assistants in nursing are unlicensed employees and are employed in the non-acute care setting, predominantly in the aged care sector in this State.

In 2004 there 47,375 nurses registered or enrolled with the QNC (40,102 Registered Nurses and 7,232 Enrolled Nurses and 41 Midwives only). However, this figure should not be confused with the number of employed nurses as some nurses continue to maintain their license when not in paid employment. In Queensland in 2001 (latest available data) there were 32,805 employed Registered Nurses and 6491 employed Enrolled Nurses (total 39,297). In 2001 it is estimated that there were 9,900 employed Assistants in Nursing/Personal Care Workers in Queensland.[3] (Further data on employment status of nurses can be found below.)

Recent trends in nursing

The following information is obtained from the Australian Institute of Health and Welfare's (AIHW) Nursing Labour Force publications. Some of this information relates to national data as breakdown by state is not available.

Nurses are a significant occupational group. Nurses are the largest occupational group in the Australian health workforce, representing 54% of the total employed health occupations in 2001[4] and just over 40% of the total Queensland Health workforce[5] in that same year. The QNU is well aware that because of the size of the nursing workforce there is often a reluctance by government to address nursing concerns, particularly because of budgetary implications. Nursing, after teaching and administrative personnel, is the third largest single occupational group employed by the Queensland government.

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[3] Shah C and Burke G (2002), *Job Growth and Replacement Needs in Nursing Occupations,* DEST (National Review of Nursing Education) Canberra, page 40.

[4] AIHW (2003), *Health and community services labour force, 2001*, Canberra page xiv.

[5] Queensland Health (2001), *Annual Report 2000/2001*, page 35.

Nursing remains a highly feminised occupation. Over 90% of nurses are women, although the proportion of male nurses in the profession increased by 1% between 1995 and 2001.[6] However the distribution of male nurses in job classifications and salary ranges is interesting to note with male nurses slightly under-represented in the lower levels (and salary ranges) and over-represented in the higher levels.[7]

The nursing workforce (like the health workforce and the community generally) is ageing. The average age of employed nurses was 42.2 years in 2001, having increased from 39.3 years in 1995.[8] The health and community services sector workforce is older and ageing more rapidly than the rest of the workforce. The number of employed registered and enrolled nurses under the age of 35 years decreased from 29.5% to 24.7% between 1995 and 2001 while the percentage aged over 45 years increased from 29.5% to 41.7% over the same period.

Over 50% of nurses are working part time. The number of nurses employed in a part-time capacity has steadily increased in recent years. In 1995 less than half (48.8%) of nurses worked part time and by 2001 this had increased to 53.7%.[9] At the same time the average number of hours worked per week has decreased from 32.4 hours in 1995 to 30.5 hours in 2001.[10]

Nursing numbers in Queensland are lower than the national average. Queensland continues to fall well below the national averages in terms of both the total number of employed nurses and total full time equivalent (FTE) employed nurses. The number of employed nurses (RNs and ENs) per 100,000 of population in Queensland was 1074 in 1995 and 1083 in 2001 compared to the Australian average of 1221 in 1995 and 1176 in 2001.[11] A more meaningful indicator of nursing supply is the number of FTE nurses per 100,000 population. In 1995 the number of FTE employed nurses per 100,000 population in Queensland was 988 (Australian average 1127) and in 2001 this number had decreased to 965 per 100,000 population (Australian average 1024).[12]Although there was a 12% growth in total RN and EN numbers in Queensland between 1995 and 2001, there was a 2.3% decrease in the number of FTE employed nurses per 100,000 population during this period. Significantly the growth in third level unlicensed personnel has been greater in Queensland than any other part of Australia, growing by 47.5% (3.9% per annum) between 1987 and 2001. (Total employment of this category of worker in Queensland in 2001 was 9900.)[13]

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[6] AIHW (2003), *Nursing labour force 2002*, Canberra, page 1. Note: AIHW nursing labour force reports only deal with numbers of regulated nurses – RNs and ENs, so this data does not capture unregulated workers performing nursing work.
[7] AIHW (2003), *Nursing labour force 2001*, Canberra, page 23.
[8] AIHW (2003), *Nursing labour force 2002*, Canberra, page 1.
[9] AIHW (2003), *Nursing labour force 2002*, Canberra, page 6.
[10] AIHW (2003), *Nursing labour force 2002*, Canberra, page 6.
[11] AIHW (2003), *Nursing labour force 2002*, Canberra, page 8.
[12] AIHW (2003), *Nursing labour force 2002*, Canberra, page 18.
[13] Shah C and Burke G, *Job Growth and Replacement Needs in Nursing Occupations,* DEST (National Review of Nursing Education) Canberra, page 40.

Pronounced skills shortages exist in all areas of nursing: According to the Department of Employment and Workplace Relations (DEWR) *National Skill Shortage Survey*, the depth and breadth of the skills shortages in nursing remains the greatest of all occupational groups. Workforce modelling commissioned by the recent National Review of Nursing Education predicts that there will be 31,000 nursing vacancies in Australia by 2006. Queensland Health continues to maintain that there is no nursing shortage in Queensland.

At the same time changes have also been occurring in the wider community and health sector that have impacted on nurses and nursing. Queensland's population growth is the highest of all states and territories in recent years - between 1995 and 2001 there was a population growth of 11%.[14] . This growth, which is predicted to continue, has put significant pressure on demand for health services. The Australian community as a whole is ageing, thereby increasing demand for health and aged care services. Technological advances and reform in the health sector in recent years has been significant and this has meant changes to care and work patterns. For example, length of stay in hospitals has declined and this has resulted in significant work intensification for nurses, as those they are caring for are more acutely ill while in hospital. There has been an increased level of acuity of patients across hospital, community and residential care settings. Community expectations of care and treatment have also increased significantly in recent years.
In a nutshell, the nursing workforce is ageing and although there are greater numbers of nurses the actual hours they worked has decreased. This means that there are fewer nurses caring for sicker and more demanding patients. This situation will only intensify given predicted population growth in Queensland, the ageing of the general population and the nursing workforce.

The nature of this crisis in nursing and its causes has been identified—all that is missing is the political will to address the issues in a comprehensive manner. Some work has been done within Queensland Health through the Nursing Recruitment and Retention Taskforce and subsequent bodies. However, some issues, especially establishing appropriate nursing workloads, require further urgent attention. There is also an urgent need to establish and support mechanisms to promote appropriate nursing workforce planning across all sectors in Queensland and at the national level.

Broader Context

Queensland's current strong economic position, and in particular the State's continued strong economic growth and higher than expected government sector operating surplus, places the Government in an enviable position compared to most other state and territory governments. In November 2004 the independent international ratings agency Standard and Poor (S and P) released its analysis of the Queensland Government's financial status, continuing its AAA credit rating. S and P concluded that Queensland's balance sheet is the strongest of all Australian states, with very low net financial liabilities. On releasing the rating S and P credit analyst Rick Shepard stated:

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[14] AIHW (2003), *Nursing labour force 2002*, Canberra, page 18.

The finances of the general government sector are exceedingly strong, with financial assets exceeding gross debt and superannuation liabilities combined; the only state where this is the case. The sector also regularly produces cash (after capital expenditure) surpluses. A large capital expenditure program will see the extent of the financial surplus decline a little in the next two years, but overall general government will remain extremely strong financially.[15]

In light of the demographic challenges of continued population growth, the ageing of the population, the decentralised nature of Queensland and changes in community expectations and demand for services, the QNU believes that Queensland's comparatively strong financial position means that the Government should place particular emphasis on making sustainable improvements in service delivery and infrastructure. The QNU welcomes the Premier's commitment following release of the S and P AAA credit rating that it "affirms our commitment to a large infrastructure program".[16]

Infrastructure and service needs have already been highlighted in documents such as the *Draft South East Queensland Regional Plan* and the *Queensland Health Strategic Plan 2004-2010*. What is needed are ongoing processes that involve community consultation and will coordinate and prioritise the funding of competing areas.

In light of the challenges confronting the Queensland community, the QNU considers that it is essential that the issues of community needs and expectations be examined in a coordinated and comprehensive way. This is especially important in the areas of health and aged care services because of the anticipated increase in demand for services as a result of the population aging, cost blow outs related to technological advances, increasing consumer demands, lack of integration of services and expectations and structural inefficiencies and duplication related to dual federal/state government responsibilities in this area.

The role that state and territory governments can play in facilitating a coordinated and evidence based approach assumes particular importance as momentum for the significant health reform agenda being pushed during negotiations for the last Australian Health Care Agreement (AHCA) has effectively been lost. Much needed health reform can only be delivered through proper community debate and engagement. QNU's preference is for this to be achieved on a national level through the establishment of a broadly representative National Health Reform Council. In light of the present attitude of the Commonwealth Government the QNU believes that state and territory governments must take up this challenge and fund the establishment of state based Health Reform Bodies. A properly constituted and representative Queensland Health Reform Council would inform the implementation of the Queensland Health Strategic Plan and other processes such as regional plans, in addition to future AHCA negotiations with the Commonwealth. For the QNU, such a body is a prerequisite to holistic health sector reform. It is essential that patient representatives and organisations such as the QNU be represented on any such body.

[15] Standards and Poor Media Release, 17 November 2004.
[16] Media Release from Premier Beattie, 17 November 2004.

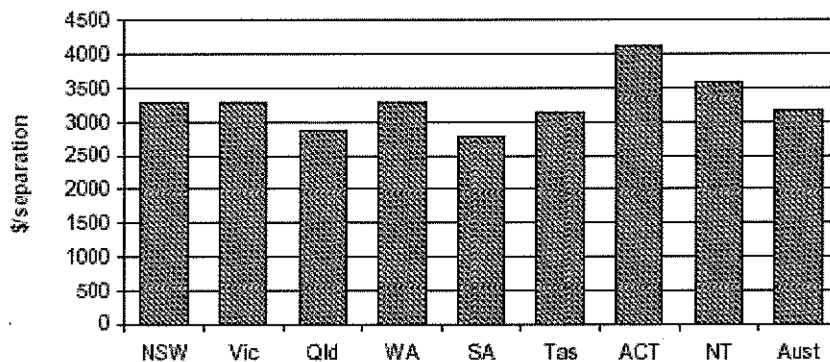
An undue emphasis placed on achieving efficiency related outcomes

Queensland public hospitals are the most economically efficient hospitals in the country. The annual *Report on Government Service* prepared by the Steering Committee for the Review of Government Service Provision has repeatedly highlighted the comparative efficiency of Queensland's public hospitals and its 2004 report is no exception. For example:

> *The recurrent cost per casemix-adjusted separation nationally in 2001-02 was $3017. Across jurisdictions it was highest in the ACT ($3769) and lowest in Queensland ($2741)*[17]

The specific dollar recurrent cost per casemix separation in 2002-2003 was not stated in the Report on Government Services 2005, but is represented graphically below[18]:

Figure 9.14 **Recurrent cost per casemix-adjusted separation, 2002-03**[a, b, c, d, e, f, g]



[a] Excludes depreciation and the user cost of capital, spending on non-admitted patient care, research costs and payroll tax. [b] Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights, from the National Hospital Morbidity Database, are based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2000-01 AR-DRG v4.2 cost weights (DHA 2003). [c] Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. [d] Excludes psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multipurpose services. [e] Data for NSW are preliminary. [f] NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT. [g] All hospitals in the NT, one very small hospital in Victoria and two very small hospitals in SA have had their inpatient fraction estimated using the HASAC ratio (see AIHW 2004a).

Source: AIHW (2004a); table 9A.4.

The 2003-2004 Queensland Health Annual Report quotes the average cost per weighted episode of care at $2631 whereas in 2002-2003 this figure was $2713[19].

In the previous ten to fifteen years there has been significant reform in the Queensland public health sector that has lead to efficiency gains. Significantly, these gains have been achieved in the context of either tight constraints on or actual decreases in (depending on

[17] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2004,* page 9.47, Canberra.

[18] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005,* page 9.49, Canberra.

[19] Queensland Health Annual Reports – 2002-2003 p 47 and 2003-2004 p21.

data relied upon) nurses employed by Queensland Health. (See section below on Queensland Health data difficulties).

These reforms have included but are not limited to:

- significant technological advances and broadening of the knowledge base of nurses and other health workers (this has coincided with the transfer of nurse education to the tertiary sector);
- decreased hospital length of stay – from 5.38 days in 1990/91 to 3.0 days in 2003/2004 (target for this year was 3.08 days)[20];
- increased throughput and patient acuity –

	1990-91	2002-03	2003-04
Total admitted episodes of care	514,635	734,107	749,949
Total day only patients	No data	348,038	352,385
Total non Inpatient Occasions of service	6,120,632	8,867,807	8,813,831[21];

- a significant capital works programme in the public sector that has also resulted in a decrease in available beds per 1,000 population from 3.3 in 1993-94 to 2.7 in 200-2001[22];
- significant changes to models of care;
- restructuring of health service delivery; and
- implementation of new career structures and roles for health workers and significant public sector

Hospital activity and patient acuity rates have increased over the last ten years. Associated with this increase is a decreasing length of stay. This means that a patient treated ten years ago who required a hospital bed for a number of days may now be treated as a day patient. A patient who may have been cared for in an intensive care unit ten years ago may be in a ward today.

Increased throughput and decreasing length of stay in public hospitals combined with significant health and information technology development over the last decade have resulted in work intensification for nurses. As patients are admitted for shorter periods of time, the level of patient dependency for the period of hospitalisation is higher. That is, patients are sicker—as they improve they are discharged for their recovery phase. Patients

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[20] Queensland Health Annual Reports.
[21] Queensland Health Annual Reports – note data for 2002-2003 and 2003-2004 come from the 2003-2004 Annual Report data pages 22-26.
[22] AIHW *Australia's Health* 1996 Table 5.6 and *Australian Hospital Statistics 2002-2003* Table 3.2, Canberra.

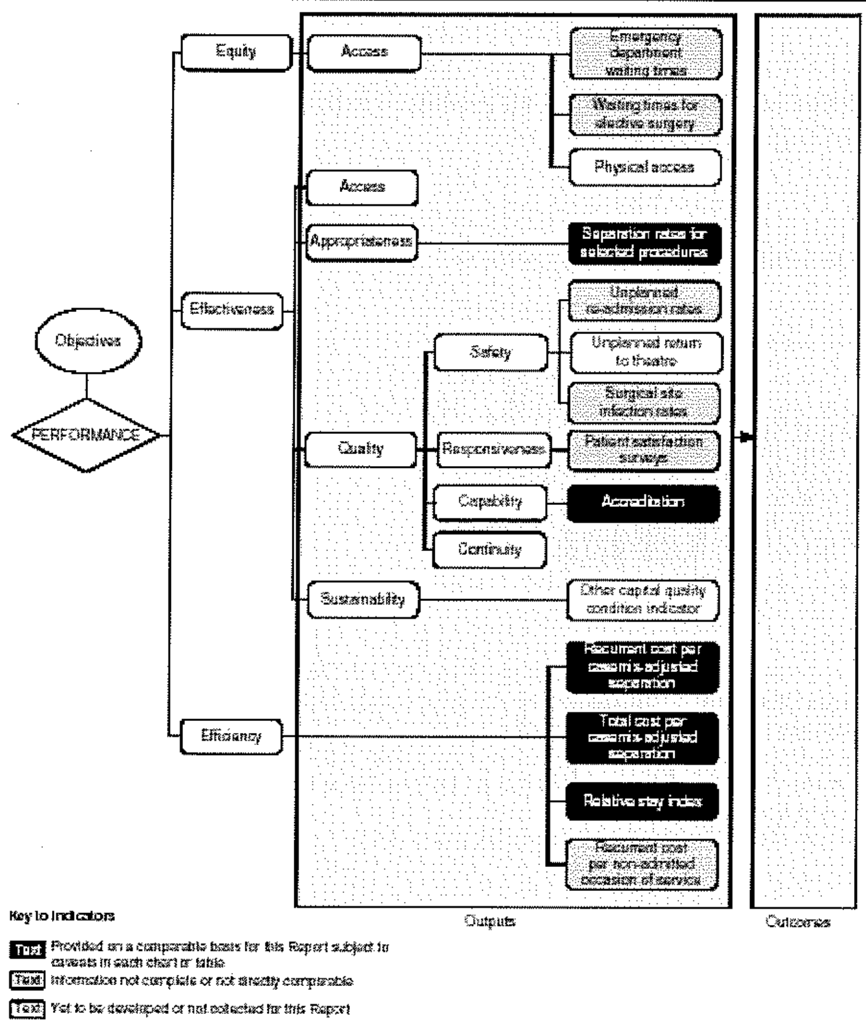
are discharged sicker and quicker. The implications for nurses and nursing are that nursing work has intensified and is much more complex.

Queensland Health has placed an undue emphasis upon achieving greater and greater efficiency outcomes. In contrast, insufficient emphasis is placed upon the quality of care provided and whether health outcomes are satisfactory. The QNU's members are increasingly experiencing that this emphasis on efficiency gains is having a negative impact on quality of care as nurses are placed situations where they are unable to deliver an optimal standard of nursing care. This results in nursing wastage as nurses leave the health system or decrease their hours of work because they can no longer cope with the unrealistic work intensification and the consequences this has for their ethical obligations as health professionals. The common complaint of nurses in the current climate is that that they love nursing but hate their job. Nursing is incredibly personally rewarding – nurses love nursing, and it is the context in which they work, one of budgetary constraints and insufficient resources and their often unsafe and conflict ridden work environment that is the source of angst for many nurses. This has, in part, resulted from the unsustainable drive for efficiency that must urgently be re-examined. The quality and effectiveness of services provided should be the primary focus of Queensland Health and form the background to any measures of efficiency.

Governments report progress towards the achievement of agreed performance indicators to the Steering Committee for the Review of Government Service Provision and this is reported in the annual *Report on Government Services.* The current performance indicator framework for public hospitals that is contained in *Report on Government Services 2005* is reproduced below.[23]

[23] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005,* page 9.20, Canberra.

Figure 9.11 **Performance indicators for public hospitals**



Historically Queensland has spent less on health services compared to other states and territories

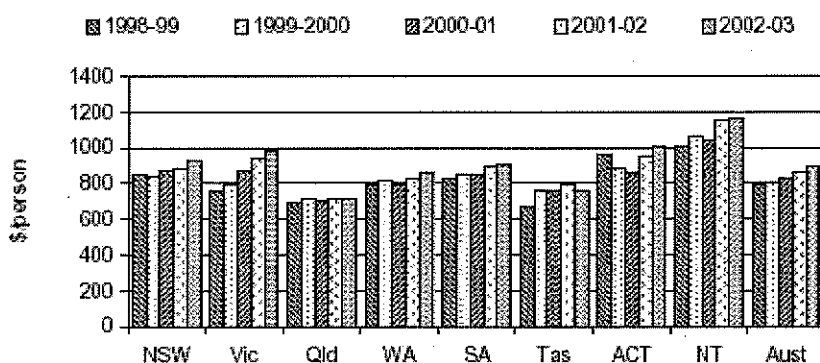
Queensland also continues to have the lowest per capita health expenditure in Australia. This lower level of expenditure is particularly striking considering the additional costs associated with delivering health services in Australia's most decentralised state. The 2005 *Report on Government Services* prepared by the Steering Committee for the Review of Government Service Provision repeatedly highlights this continuing trend:

> *In 2002-03, government real recurrent expenditure on public hospitals (in 2001-02 dollars) was $895 per person for Australia, up from $791 in 1998-99. It ranged from $1165 per person in the NT to $712 per person in Queensland in 2002-03.*[24]

[24] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.4, Canberra.

Government expenditure trends in public hospitals from 1997/98 to 2001/02 are represented graphically as follows[25]:

Figure 9.2 Real recurrent expenditure per person, public hospitals (including psychiatric) (2001-02 dollars)a, b, c



a Expenditure excludes depreciation and interest payments. **b** Data for 2002-03 for NSW are preliminary. NSW hospital expenditure recorded against special purposes and trust funds is excluded. NSW expenditure against primary and community care programs is included from 2000-01. **c** For 2001-02, Tasmanian data for two small hospitals are not supplied and data for one small hospital are incomplete. For 2000-01, data for six small Tasmanian hospitals are incomplete. For 2002-03, Tasmanian data for one small hospital were not supplied and data for five other small hospitals were incomplete.
Source: AIHW (2004a and various years); ABS (unpublished); tables 9A.2 and A.2.

A report released by the Federal Health Minister in June 2004 titled *The state of our public hospitals* claims that (based on AIHW and 1998-2003 Australian Health Care Agreement data) the Queensland government's recurrent expenditure per person on public hospitals in 2000-2001 was the lowest in Australia at $322. (Queensland and Tasmania tied for equal seventh place. The national average expenditure was $371)[26].

Increases in Queensland budget expenditure in the health area have failed to keep pace with significant population growth and increased demand for health services in recent years. The recent Queensland Health Capital Works program process for determining hospital bed numbers required significantly under-estimated future demand for services in many areas. This is clearly demonstrated through recent hospital activity data, for example hospital waiting list information. The response of the Government to the blow out in public hospital waiting lists appears in part to be to transfer demand to the private sector, be this through individual consumers taking out private health insurance, self funding health services in the private sector or Queensland Health contracting services out to private hospitals.

This approach is fraught with problems. The QNU expressed its many concerns about the waiting list strategy to the Minister for Health earlier this year. From an economic perspective the QNU believe that such an approach is inflationary and demonstrates the Queensland Government's tacit endorsement of a greater shift to a "user pays" system in health. The QNU questions the private sector's ability to perform services for public

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[25] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.5, Canberra.
[26] Australian Government (June 2004), *The state of our public hospitals*, page 17, Canberra.

patients at a cheaper cost than public hospitals and is extremely concerned about the lack of publicly available cost benefit analysis data on this strategy.

This strategy (along with vague references in the recently released Queensland Health strategic plan to increasing "partnering" with the private sector) are of concern to the QNU because of the apparent lack of accountability frameworks for such activities. It must be clearly and publicly demonstrated to the Queensland community that such activities are both cost effective and are of an appropriate standard. Although the QNU holds significant concerns about the availability of adequate data in the public sector, some data is nonetheless available. The community is not provided with sufficient information on private health sector activity given that the Freedom of Information regime is not applicable to the private sector and there is also no comprehensive performance indicator information available for this sector.

The current approach by Queensland Health also does nothing to address a significant cause of waiting list "blow outs" - namely control of waiting lists by medical specialists. Indeed, such a strategy could result in additional reward for specialists who manipulate waiting lists if they are paid more to undertake the procedure in the private system. It has been reported in the media that Queensland Health is taking action against the Royal College of Pathologists for the restrictions they place on entry to their training courses and other state governments are hinting at taking similar action against the Royal College of Surgeons. This long overdue examination of restrictions on medical specialist numbers will hopefully facilitate better public scrutiny of and debate on health service demand and supply issues.

The lack of access to meaningful data upon which to make informed decisions, encourage community debate, measure outcomes and ensure accountability

The lack of reliable publicly available data from Queensland Health in a range of areas should be the source of significant embarrassment to the Queensland Government. This is not only a source of frustration for the QNU. The QNU understands that other government agencies are also concerned about the lack of meaningful data, especially of a financial and human resource nature. Lack of openness and transparency is an issue for the whole of the Queensland Government (exemplified by the recent winding back of the FOI regime in this state) but is particularly a problem in relation to Queensland Health. Urgent action is required across the public sector and especially within Queensland Health to improve access to meaningful information so as to enhance transparency, planning and accountability.

By way of example, despite being one of the largest Queensland public sector agencies (with the second largest budget allocation), Queensland Health cannot state with any degree of accuracy its actual number of employees at any given time. Until very recently, Queensland Health was the only government department required to report MOHRI (Minimum Obligatory Human Resource Information) data that could not do so. Even though Queensland Health is reporting MOHRI data in the 2003-2004 Annual Report (as is prescribed by the Ministerial Portfolio Statements), the QNU has grave doubts that the data recorded is accurate as Queensland Health can not provide the QNU with data on actual numbers of nurses employed and current vacancy levels. It is not uncommon for a number of different figures to be given to the QNU by Queensland Health Districts in response to

requests for nursing numbers. The QNU therefore has no confidence in the data Queensland Health provides in respect to nursing employees.

Accurate workforce planning and reporting (for example, legislated Equal Employment Opportunity reporting against set government objectives) or proper budgeting can not take place in an information vacuum. Immediately addressing Queensland Health's information deficiencies, especially in relation to human resources, should be a top priority for the Queensland Government. The current situation represents a critical and ongoing risk for the Government and until such time that it is addressed a fundamental accountability flaw will continue. The community of Queensland is entitled to expect that such a significant Department has accurate and efficient systems for gathering data. Given the information systems that are now available it is difficult to comprehend why this issue has not been addressed.

Associated with the lack of human resources information is the lack of organisational will to implement standardised human resources and industrial relations practices and policies across Queensland Health. For some years now Queensland Health has been informing the QNU that a standardised HR/IR policy and procedure framework is proposed. However, the QNU has seen little progress towards achievement of this objective. Until such time as this issue is addressed, the QNU and other unions will continue to experience extreme difficulty in obtaining compliance with industrial instrument provisions. This is not only a source of frustration for health unions but also their members- the employees of Queensland Health - who are tired of the continual buck shifting between facility/district/zone and corporate office levels. The QNU's members simply want to cut through the bureaucracy and achieve their rightful entitlements. The current situation destroys relationships and good faith between Queensland Health and unions and Queensland Health and its employees.

The Government should exercise extreme caution in claiming it has created "extra" nursing positions in recent years. Not only is Queensland Health HR data notoriously unreliable, it should also be noted that it has been estimated by Queensland Health that demand for nursing services will increase by 30% between 2000 and 2010.[27] The number of nurses per 100,000 population in Queensland has decreased in recent years and Queensland Health has also significantly expanded services in some areas of particular population growth or demand growth due to other factors. Given these factors, and based on available information, the QNU believes it is safe to assume that the number of nurses employed by Queensland Health has been decreasing (or in a best case scenario has remained static), be this in numbers of full time equivalents (FTE) employed or actual head count of nursing employees.

There is broad nursing workforce data highlighting the increasing shift to part time work by nurses (over 50% of nurses are now working part time). The QNU has access to significant Queensland anecdotal evidence on the causes of this major shift through QNU membership research undertaken by the University of Southern Queensland in 2001, which is currently being repeated. National and Queensland evidence highlights that a significant contributing factor to this change in working patterns is work intensification. Nurses are decreasing the hours they work per week so they can better

[27] Queensland Health Workforce Planning Discussion Paper (2002), *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010, page 12.*

cope with excessive workloads. When nursing vacancies are not filled those left in the system are expected to cope as management refuses to cut services provided in order to match supply of nursing services with demand. Addressing the causes of decreasing nursing workforce attachment will be central to finding sustainable solutions to the growing demand for services evidenced by indicators such as lengthening waiting lists for elective surgery.

As stated above, extreme care needs to be taken when interpreting nursing workforce data. For example, the Government has stated that it has exceeded a 2001 election promise to employ an additional 1500 new nursing graduates over three years. (A similar promise was again made in the lead up to the 2004 state election.) Just over 1500 new graduates were employed in the three year period since 2001 and another 500 are expected to be employed in early 2005. (As of December 2004, 520 new graduates have been employed by Queensland Health during 2004.) However, these new graduates have only been employed into existing nursing vacancies and should not be interpreted as meaning that the Government has employed additional nurses. As has been acknowledged by Queensland Health officials, this simply has not occurred. An examination of the available data demonstrates that these "additional" nurses have not been employed. Queensland Health has admitted for example, that it is routine for nursing vacancies in the second half of the year not to be filled so that positions will be available for new graduates in the new year.

The QNU and its members continue to be extremely concerned and frustrated by the way in which they are forced to "do business" with Queensland Health. Lack of access to meaningful and timely information that would enable them to participate in a genuine partnership with Queensland Health to improve the health of Queenslanders is a major source of this frustration. The overly bureaucratised "can't do" ethos that pervades Queensland Health is also a problem. A new approach is required in order to properly address critically important issues such as nursing skills shortages and to improve access to high quality, appropriate and sustainable health services.

CONCLUSION

The issues confronting the Queensland public health system are many and serious.

However, it is essential that recognition be given to the overwhelming majority of employees of Queensland Health who are competent, dedicated, hardworking and steadfastly committed to delivering high quality public health services to the people of Queensland. Day in, day out, these employees do their utmost to provide the best care they can within the budgets allocated, often contributing additional unpaid hours so that public patients receive adequate care. Most Queensland Health employees provide the highest quality of care against the odds.

Every step must be taken to ensure that the morale of the Queensland Health workforce does not suffer as a result of the adverse publicity being generated as a result of the current inquiries. The health workforce is critical to the rebuilding of a positive culture in Queensland Health and to the community's faith in our public health system.

CONFIDENTIAL ATTACHMENTS

1. List of witnesses as per para 34.2 of the Practice Direction dated 18 May 2005
2. List of Bundaberg Base Hospital patients

QNU Submission to the Queensland Health Systems Review

July 2005

Nurses. Worth listening to.

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Full Terms of Reference

Objective:

To undertake a review of the performance of Queensland Health's administrative and workforce management systems with a focus on improving health outcomes for Queenslanders.

To specifically review:

1. Existing administrative systems and recommend improvements to support health service delivery, focusing on:
   - o District and corporate organizational structures and layers of decision making
   - o Corporate planning and budgeting systems
   - o Cost effectiveness of services compared to relevant jurisdictions
   - o Effectiveness of performance reporting and monitoring systems
   - o Organisation and delivery of clinical support services
   - o Risk management systems
   - o Quality and safety systems and
   - o Clinical audit and governance systems

2. Clinical workforce management systems to deliver high quality health services, with a particular focus on:
   - o Recruitment
   - o Retention
   - o Training
   - o Clinical leadership and
   - o Measures to assist in improving the availability of clinicians

3. Performance management systems including as they relate to:
   - o Asset management and capital works planning and delivery
   - o Information management
   - o Monitoring health system outcomes

Executive Summary

The Queensland Nurses' Union (QNU) believes that Queensland Health is at a critical crossroad. The recent revelations from the Bundaberg Hospital Commission of Inquiry and the staff and community consultations for this Systems Review of Queensland Health merely highlight what employees of Queensland Health and the health unions who represent them have known for some time—this department is in crisis.

We do not use this term lightly. In the past when concerns about this agency have been publicly raised by the QNU and other health unions we have been accused of hysteria and "shroud waving". We are also very mindful that public criticism can have the effect of under-mining community confidence in our public health system. As staunch advocates for public health services we are careful to ensure that criticism and concerns raised are placed in context and a positive problem solving approach is adopted.

The QNU wants to establish a meaningful partnership with government to address the issues in Queensland Health. We have been requesting this for some years now and again place on record our belief that this review is the only way forward that will rebuild staff and community confidence and pride in the system. It would be devastating for staff and community alike if these current reviews do not result in the needed change. Many members have expressed a cynicism that "things just won't change—they never do". It is imperative that things do change, and we all have a role to play to ensure that significant improvements are made within Queensland Health and that the change is managed well.

There are some issues that need to be acknowledged and addressed by government first before we can move forward. These include:

The culture in Queensland Health is unhealthy and requires urgent remedial action. Improving openness, transparency and accountability and establishing an environment where critical analysis is encouraged will be central to effecting the necessary cultural change within Queensland Health.

Queensland Health services are under-funded and this must be addressed as a matter of urgency. On any examination of the data, Queensland Health is the "leanest" public health system in the country. It is too lean. This spending on public health services in Queensland is even more astounding when you consider the additional costs associated with service delivery in the most decentralised state in the country. For example, in 2003-2004 the Queensland Government's public hospital recurrent per person expenditure was the lowest in the country at $440, with the Australian average being $552. Even though health budgets have continued to increase in the last ten to fifteen years this has been insufficient to keep pace with population growth, increasing community expectations and expanding technology. The sound financial position of Queensland enables us to considerably increase our spending on public health services. An active decision by government to make health its key priority needs to occur.

The public health system in Queensland is the most efficient in the country – but how effective is it? For too long there has been an over-emphasis on efficiency outcomes at the expense of effectiveness. What has been valued is "coming in on budget" and increasing through put of patients. Issues such as quality or effectiveness of care and equity of access are much lower order considerations.

Quality of care suffers as staff are continually forced to do more with less. Queensland Health staff also subsidise the operation of the public health system

through lower wages and working conditions and excessive and unsustainable workloads. Independent research shows that Queensland nurses are becoming increasingly distressed because they cannot deliver individualised quality nursing care due to workload pressures. An examination of nursing staffing numbers in public hospitals for 2002-2003 demonstrates that to reach the Australian average full time equivalent nurse (FTE) per 1000 population ratio Queensland public hospitals would have to employ an extra 1505 FTE nursing staff. To reach the Victorian and New South Wales ratios levels Queensland public hospitals would have required the employment of an additional 2258 FTE nurses. This data only refers to public hospital nursing staff numbers—more nurses are also required in community and other non-acute settings.

Not only are nurses subsidising the continued operation of the system through unsustainable workloads, they are paid far less than their interstate counterparts. Significant improvements in wages and working conditions (including workloads) are needed to stop the wastage of nurses from the system and to improve recruitment of nurses—a vitally important issue given the current nursing shortage and ageing of the population. For example, by the time the current Section 170MX Award for nurses expires in October 2005, a Level 1 Registered Nurse Paypoint 8 (the largest classification group of nurses employed by Queensland Health) will be paid $986.35 per week compared to their New South Wales counterparts being paid $1139.51 per week. This is a difference of $153.16 per week or over 15%.

The Queensland community must be genuinely involved in the debate about health needs and expectations and how these are best funded. This must include a discussion of whether taxes need to be increased to provide the type of health services the community expects. The days of the old paternalistic model of health care are over, as are the days of medical dominance. In future there must be a genuine partnership between the community and health care providers where health needs, policies, priorities and treatments are jointly determined and health services are delivered by a team of health providers. In our view a state wide Health Reform Council that includes representatives of all key stakeholders (including the community and health unions) must be established to drive the change and develop the framework for community input into health decision making processes at the local level.

There needs to be a shift in emphasis towards health promotion and disease prevention. The sustainability of our health system will be determined in large part by the success of strategies that aim to shift the emphasis on to health promotion and prevention. This will require additional emphasis and funding for these areas.

The innately political nature of health care must be publicly acknowledged and issues debated openly. For too long health has been viewed as a political hot potato and every attempt has been made to keep it off the front page of *The Courier Mail.* The obsession with secrecy in Queensland Health has largely been derived from a combined imperative to "put a lid" on controversy and dissent and at the same time manage the unrelenting drive to continue to do more with less. This secrecy has only served to entrench power imbalances in health. Politicians must demonstrate more trust in the community and health care providers to honestly debate the issues and find solutions. The finite nature of resources should underpin decision making but so too should community needs and expectations.

The climate of secrecy in health has enabled a toxic culture to flourish. Priority attention must be afforded to rebuilding a positive and supportive culture in health, one where health workers and patients are treated with dignity

and respect and as equal partners in health care. This will be a significant exercise and the government must acknowledge the magnitude of this task and fund it accordingly.

Abuse of the Queensland Health Code of Conduct must cease immediately. The Queensland Health Code of Conduct is used as a weapon to punish staff and shut down legitimate debate and discussion of concerns. Instead of being used to deal with ensuring privacy in relation to patient confidentiality, the Code of Conduct is utilised to attempt to stifle discussion about serious systems concerns and even stop nurses and other health workers from contacting their union about these concerns. This fundamental misuse of this document must be immediately ceased if we are to create a positive, problem solving and open culture in Queensland Health. It is the right of all Queensland Health staff and citizens to raise concerns in the public domain about the conduct of public institutions including hospitals and other health facilities. It is the department's role to deal with these concerns in a timely and appropriate manner or to refute them. It is not there role to silence criticism and debate through the misuse of documents such as the Code of Conduct. It is essential that the Code of Conduct be reviewed and amended to reflect this and for a penalty to be imposed for the inappropriate use of this document by management.

Attention must be paid to human resource management (HR) and industrial relations (IR) processes and policies. As health workers are the system's most valuable asset they must be properly valued and treated equally and fairly. A consistent HR/IR policy framework must be established within Queensland Health to ensure that this occurs. Adequate systems to provide timely and accurate data upon which to base decisions are a critical component of this framework. Currently Queensland Health cannot state with any degree of certainty the actual number of people it employees. This is a disgrace and must be addressed as a matter of urgency.

Lack of access to meaningful data upon which to make decisions is a fundamental flaw in the system. This systems problem can of course be convenient – how can there be proper scrutiny and debate on issues if the data is not available to inform this? Linked to this is the department's obsession with secrecy that results in those who should be viewed as partners in health care (the general community and groups such as health unions) being denied access to necessary information.

There is a need for a new partnership model in health. For there to be a genuine partnership between health service providers and government there needs to be a fundamental change in approach and this must be reflected in significant changes in industrial relations processes. In it imperative in our view that we recommence the "best practice" approach to health care reform that was abandoned by Queensland Health before it really commenced a decade ago. This approach is one based on a genuine partnership of staff and their unions and a "balanced scorecard" approach to measuring outcomes in health that must incorporate considerations beyond efficiency gains.

Establishing a sound governance framework will be essential to rebuilding community and staff confidence in Queensland Health. This will require significant cultural changes and sound leadership. Most importantly, it will require congruency between stated values and actions—what is said on paper in documents such as strategic plans and mission statements must be matched with behaviour and actions.

The problems in health are significant. But the government has willing partners to rebuild our public health system. The QNU is committed to a strong,

innovative, responsive, sustainable and high quality public health system. To us this is a fundamental feature of a fair society—as citizens we deserve no less. The issues under consideration are very much about values—what we value as citizens and workers in the health system—and the QNU believes that we must position the discussion about the future of Queensland Health within a framework of values.

We need a public health system where:

- The system is patient and staff focused—this requires a shift in focus to quality/effectiveness from efficiency and budget bottom lines.
- There is equity of access to health service and equality of health outcomes —where access to health services is determined by clinical need and not ability to pay.
- Services are integrated across settings and there is support for innovation and improved service delivery.
- A safe and supportive environment for staff and patients is provided.
- Community and staff have genuine input into decision making and health service planning.
- Openness, respect, transparency and accountability are the principles that underpin the operation of the system.
- Words are matched with action and expectations matched with appropriate funding.
- Evidence underpins all decision making and a culture of critical analysis and debate flourishes.
- There is consistency of approach and sound systems upon which to base decision making.
- Staff and patients are treated fairly and with respect and are valued for their contribution.
- Workloads of staff are fair and enable the delivery of high quality patient centred care.
- Health workers receive fair remuneration and conditions of employment—there is pay parity with interstate counterparts and work value is consistently and appropriately determined.
- There is a rigorous, simple and open complaints system established for staff and patients that enables concerns to be promptly and appropriately addressed.

The QNU is hopeful that this inquiry provides a critical watershed for Queensland Health and will enable us to focus on rebuilding the agency based on the above principles. We have made over 70 recommendations in our submission that we believe will help effect the necessary change and have provided significant detailed background to underpin these recommendations.

The QNU is committed to working with the Queensland government to rebuild community and staff confidence in Queensland Health.

Recommendations

Health Reform Council (page 23)

That the Queensland government fund the establishment and continued operation of a state based Health Reform Council that would draw up a framework to enable genuine community consultation on health policy decision making and the planning of service delivery at the state wide and local levels. Further to this, that this body be broadly representative of the Queensland community and include representatives from the QNU and consumer organisations.

Expanding health performance measures (page 27)

That specific funding is allocated to enable the further development of appropriate performance indicators that measure effectiveness and equity of access to health service delivery as agreed to in the Steering Committee for the Review of Government Service Provision (annual *Report on Government Services*) process.

Budget for and supply of health services (page 30)

The Queensland government continues to increase its budget allocation to the health portfolio in order that government per capita expenditure on health services reaches an acceptable level compared to other state/territory governments.

In light of population growth and current high levels of demand for public health services the Queensland government fund an urgent re-examination of demand and supply of public health services (including the number and distribution of public hospital beds, day procedure units and primary health care services) and that the outcome of this review form the basis for future budget allocations for health infrastructure and recurrent funding.

Access to meaningful data (page 30)

Specific funding is allocated to enable the further development of appropriate systems within Queensland Health that will enable timely access to reliable data for health bureaucrats and the broader community including health unions. This would facilitate better planning and accountability and evidence based decision making on clinical and non clinical matters.

Establishing a new partnership in health based on sound principles (page 32)

A new "partnership" approach be developed and adopted for the design and delivery of public health services in Queensland and that this be based on a health care team delivering health services to informed clients who have genuine input into decision making processes. Further to this, that at all times principles of universality, no cost at point of service, timely access, equity of access and equality of health outcomes underpin our public health services in Queensland.

Data on health and safety impact of system stress on health workers (page 33)

This inquiry pay particular attention to examining health and safety and WorkCover data from Queensland Health and from this make firm recommendations aimed at establishing safer systems of work for all Queensland Health employees.

Cultural change in Queensland Health (pages 34)

Specific funding be allocated for training and staff development necessary to affect the necessary change to build positive, supportive and patient and staff

focused culture within Queensland Health. In particular, that current educational programmes for middle and senior management within Queensland Health be reviewed to ensure appropriate content on matters such as encouraging participation, critical analysis and debate, the need for openness, transparency and accountability, the role of the public service, the government's overarching policy framework and the role of unions as legitimate representatives of employees.

The Queensland Health Code of conduct be reviewed and amended as required to ensure that this cannot be used by management to prevent legitimate criticism and debate about health system concerns by employees and citizens and enable staff to contact their union or other relevant institutions in society to discuss their concerns. Further to this, that a penalty be imposed on management representatives who use the Code of Conduct inappropriately to close down discussion and debate.

Establishing a standardised HR/IR framework in Queensland Health (page 35)

As a matter of urgency a standardised organisational HR and IR policy framework be developed in consultation with health unions for the whole Queensland Health that will prevent district by district interpretation of industrial and other related legislative obligations.

Review and improvement to policies and processes relating to public sector management (page 37)

There be an urgent review of human resource policies and processes within Queensland Health and that these are improved to ensure the consistent application of fair and equitable processes, especially in relation to recruitment and selection processes, performance planning and review, management of diminished performance, training and development and fair treatment of employees and other standards applicable to public sector management.

Workplace Health and Safety and Employment Equity considerations (page 38)

Close consideration be given to the prominence of and resourcing for Workplace Health and Safety and Equal Employment Opportunity initiatives when implementing the required cultural change within Queensland Health.

Measuring of work value and establishing consistency of recognition (page 39)

An urgent review of the methodologies used to assess work value be conducted within Queensland Health to ensure consistency between occupational streams and appropriate recognition of the skills and qualifications required.

HR reporting systems (page 40)

As a matter of urgency specific tied funding be allocated to Queensland Health to enable the agency to implement an appropriate standardised HR information reporting system and that the agency be closely monitored to ensure timely and appropriate implementation of this system. Such a system will facilitate the provision of accurate data to better match supply and demand of services, adhere to enforceable award provisions such as those relating to nursing workload management, undertake accurate costings for budgetary and enterprise bargaining negotiations processes and facilitate agency compliance with legislative and policy requirements (e.g. Equal Employment Opportunity reporting and achievement of target group employment targets).

Establishing a new framework for consultative arrangements with health unions (page 43)

Consultative arrangements for the health portfolio be reviewed and amended as required and that an oversight mechanism be established under the auspices of the Department of Premier and Cabinet that involves all relevant agencies and key stakeholders including health unions.

Increasing nursing numbers in Queensland Health (page 45)

As a matter of urgency there be an increase in Full time equivalent registered and enrolled nursing numbers to bring nursing staffing numbers across all settings in Queensland Health up to the national average as an interim measure and then to levels employed in Victoria and New South Wales. For public hospitals alone this equates to an additional 1505.6 FTE registered and enrolled nursing positions to bring Queensland public hospital staffing levels up to the national average. (An additional 2258.4 FTE positions would be required to bring Queensland public hospital nurse staffing levels up to Victorian and New South Wales numbers.)

Improving pay and working conditions for nurses and other employees (page 45)

Urgent action is taken to significantly improve the pay and working conditions (most notably workloads) of Queensland Health employees.

Adoption of new approach to deal with nursing issues (page 47)

Prior to the commencement of the next round of enterprise bargaining with Queensland Health government enter into discussions with QNU regarding the adoption of a new holistic approach to nursing workforce and industrial relations issues.

Analysis of staffing numbers by occupational group (page 48)

There is an urgent analysis of Queensland Health's staffing numbers by occupational group, including a comparative analysis of HSD and corporate office numbers. This must also include a gap analysis of areas of need with respect to support provided in clinical services.

Review of Queensland Health risk management framework (page 50)

There be a review of Queensland Health's risk management framework and that it is amended as necessary to ensure efficacy and staff confidence in it. In particular, there need to be urgent enhancements to the current risk management framework to ensure that all risks are appropriately identified, treated and monitored (eg security and health and safety risks to staff).

Improving safety and quality (page 53)

It is recommended that this review makes specific recommendations aimed at improving safety and quality within Queensland Health. In particular, strategies must be implemented to:

- build a supportive culture within Queensland Health where critical analysis is encouraged;
- provide adequate human and physical resources to ensure that safe care can be delivered and quality can continually improve;

- review current tools used to assess quality and amended as necessary to ensure adequacy;
- encourage genuine teamwork and valuing of the skills and contribution of all team members;.
- directly link safety and quality to the agency's industrial relations processes;
- better integration of the multitude of existing agenda that relate to safety and quality;
- address existing inconsistencies in approach with regards to the current regulatory policies and processes for health professionals;
- extend the current regulatory regime for health workers to ensure that all who are delivering health services are appropriately regulated;
- encourage better coordination and consistency between activities regarding safety and quality at the state and national level to ensure that this receives the appropriate level of priority.

Appropriate consultation with health unions on proposed changes in Queensland Health (page 55)

This inquiry recommends that health unions be at first briefed and then consulted about the organisational and governance structures in Queensland Health as soon as possible/practicable given that this review may recommend changes in these areas.

Further consultation with QNU prior to finalisation of systems review (page 57)

The Queensland Health Systems Review team meets with representatives of the QNU as soon as possible to discuss the findings of the University of Southern Queensland research into QNU membership and other matters relating to our submission so that the issues highlighted and possible strategies to address them can be discussed prior to the finalisation of your report.

Strategies to improve nursing recruitment and retention (page 59)

The funding for existing nursing recruitment and retention being progressed by the Peak Nursing Body be continued and that specific additional funding be allocated to address serious deficiencies with respect to:

- establishing appropriate enforceable nursing workloads across all practice settings;
- enabling nurses to access required education, training and development;
- providing adequate support to new nursing graduates and improved coordination of new graduate employment;
- extending the implementation of innovative care models (e.g. Nurse Practitioners) across all practice settings and ensuring appropriate nursing skill mix;
- continue to expand the school based Youth Health Nurse Programme and investigate other innovative primary health roles for nurses such as nurse health and safety screening and immunisation in child care centres;
- reviewing the nursing classification structure to address longstanding anomalies with other like occupational groups (e.g. Professional Officer stream) and include Enrolled Nurses and Assistants in Nursing in the structure;

- improving the Remote Area Nurse Incentive Package both in terms of localities and categories of nurses included (extend to include Enrolled Nurses and Assistants in Nursing);
- extending funding for nursing research to facilitate the development of innovative patient centred models of care;
- undertaking new research on issues on nursing turnover, absenteeism and morale within Queensland Health;
- improving succession planning for nurses.

Addressing nursing workload concerns (page 62)

Queensland Health be directed to use the complete Business Planning Framework: Nursing Resources tool to determine appropriate allocation of budgets for nursing services within Queensland Health.

Specific funds be provided to facilitate the urgent development of a workload management tool for those areas where it is not possible to implement the Business Planning Framework: Nursing Resources in its current form (e.g. community health settings, Emergency Departments and Outpatient Departments, Intensive Care Units, Integrated Mental Health Units, Operating Theatres and Day Surgery Units).

The Business Planning Framework be used to supplement the minimum care hours model used for determining nursing staffing in State Government Nursing Homes.

Resourcing the reform process in Queensland Health (page 64)

The government allocate sufficient funds to fully meet the costs of "reforming" Queensland Health and also to fully meet the cost of necessary improvements in nurses' wages and conditions for the enterprise bargaining negotiations scheduled for the second half of 2005.

Staff education and development and workforce planning (page 68)

The planning and development of future education, training and development programmes for Queensland Health employees be informed by the establishment of an appropriate consultative mechanism involving key stakeholders such as health unions.

Proxy allocations used within the Business Planning Framework: Nursing Resources (e.g. for new graduate support, training leave, other forms of leave) be urgently reviewed to ensure they adequately cover the true costs incurred particularly at peak times of demand; further, that following review of such proxy allocations and necessary amendment of the tool, sufficient budgetary allocation be provided by Treasury to ensure the appropriate and consistent implementation of Business Planning Framework: Nursing Resources across all of Queensland Health.

The Australian Institute of Health and Welfare be commissioned to undertake a Queensland nursing labour force study that will inform nursing workforce planning for Queensland Health.

The Queensland government fund scholarships for undergraduate and post graduate nursing students (based on the recently announced arrangement between the Queensland Government and Griffith University School of Medicine) in order to begin to address nursing skills shortages. Further to

this that the Queensland government enters into urgent discussions with the federal government with respect to health workforce issues and shortages and in particular seeks to address the current inequities that exists with respect to the funding of post graduate health qualifications.

Queensland Health introduce an ongoing staff education, training and development programme (based on the programme for staff at the Department of Child Safety) where all staff are released and backfilled to attend and that all categories of staff receive equitable treatment with regard to access to such ongoing education, training and development.

Funding is allocated to pay the Competence Assessment Fee for all participants in nursing reentry programmes as is the case in other states.

Funding to increase the number of EN course places offered in TAFE should be increased to 400 per year from 2006. Further this this, that at least 50 scholarships that meet the full course costs be funded by government each year and made available to applicants from specific targeted disadvantaged groups.

That there be no further proliferation of new certificate courses for new categories of health workers until such time that there is a comprehensive and evidence based assessment of the training needs of the health and community services sector and whether these needs can instead be met by amending/extending the educational preparation of existing categories of employees. Further to this, that the Department of Employment and Training ensure that the QNU and relevant nursing bodies are invited to participate in course development advisory committees of any proposed health care qualification;

Funding is allocated to enable existing unlicensed care workers in Queensland such as Assistants in Nursing to complete their Certificate level qualification as was provided to child care workers to enable them to meet legislated minimum educational qualifications. Further to this, that at least 50 scholarships that meet the full course costs be funded by government each year and made available to applicants from specific targeted disadvantaged groups who wish to obtain a qualification in order to secure employment in the health and aged care sector.

Specific ongoing funding be allocated for research and consultation with industry regarding important threshold issues for nursing education in the VET sector, including but not limited to examining issues such as articulation, recognised prior learning and evaluating an evaluation of utilising the VET in Schools Programme for the health and aged care sectors.

Priority attention be given to funding workforce education and training needs for nurses.

The QNU be involved in the development any course proposals that involve nursing work.

Specific funding be allocated to establish a broadly representative health and aged care sector industry body (including representation from the QNU) to inform workforce planning for this sector in Queensland.

Work and Family issues (page 70)

Funding be provided to:

- introduce 14 weeks paid maternity leave for Queensland public sector employees;
- establish a broadly representative Queensland Work and Family Forum;

- develop and implement a Queensland "whole of government" portal on work and family matters;
- facilitate a coordinated approach to improving child care services for shift workers across all Queensland government agencies.

Health and safety concerns (page 72)

Adequate funding be provided to ensure the full implementation of all the recommendations arising from the Violence against Nurses Steering Committee review process.

Funding be allocated for a review and a detailed analysis of the initiatives in place relating to manual handling to ascertain their effectiveness and whether any modification is required. Further to this, that funding is allocated for regular servicing, preventative maintenance, maintenance and replacement of equipment necessary for safer manual handling.

The advisory standard relating to workplace harassment is made mandatory and that Queensland Health Districts be allocated funding to enable the development of plans for the implementation of the standard and the provision of mandatory training for all staff on the code within 12 months.

Queensland Health be directed to adopt *Directive 4/99 Medical Deployment and Redeployment*. Further to this, that funding is allocated to properly investigate fitness for work issues for Queensland Health employees and plan strategies to encourage continued workforce attachment given the ageing of the health workforce and significant shortages that exist in nursing and other health occupations.

Workplace amenities (page 73)

Queensland Health pay particular attention to ensuring that appropriate workplace amenities are provided for staff and that all staff receive equitable treatment with regard to the provision of workplace amenities. Particular attention must be paid to ensuring the provision of appropriate and safe accommodation for all staff (where this is provided), safe and free/affordable car parking, reasonably priced high quality and healthy meals for staff on all shifts and adequate other amenities such as separate meal areas, shower, toilets and change facilities and facilities that promote the health and wellbeing of staff.

Nursing leadership (page 73)

The Office of the Chief Nursing Adviser within Queensland Health be restructured so that it is consistent with the model for the Office of the Chief Nursing Officer in New South Wales. Further to this, additional resources be provided to ensure that the office of the Chief Nursing Adviser within Queensland Health can carry out the functions of their New South Wales counterpart.

Reporting relationships between the Office of the Chief Nurse Adviser and the Minister and Director General for Health be reviewed and amended as necessary to ensure consistency with the reporting relationship applying in New South Wales.

There is clear delineation between Chief Nursing Adviser and Principal Nursing Adviser roles, which will be especially important going forward given the importance of nursing leadership if we are to change the culture of Queensland Health. Further to this, that a merit selection process takes place to permanently fill the position of Chief Nursing Adviser but this cannot take place until such time that matters relating to whole of agency responsibility for nursing leadership

and reporting relationships between the Chief Nursing Adviser and Principal Nursing Adviser roles are clarified.

The Office of the Chief Nursing Adviser be directly involved in negotiations on workforce restructuring within Queensland Health and that this office ensures the establishment of appropriate consultative mechanisms to ensure the ongoing involvement of the QNU in adequate negotiations of such changes.

Capital works and maintenance (pages 79, 80)

Nurses be always included in consultations for the initial design and ongoing commissioning phases of all new capital works and redevelopments to ensure that workplace designs are both patient and health worker friendly.

A consistently applied, equitable and transparent whole of agency approach to prioritising of the development of staff accommodation refurbishment and rebuilding projects and a fair process for determining access to accommodation be developed.

Funding be allocated to facilitate the development of minimum design guidelines for Queensland Health facilities.

Queensland Health urgently review its policies regarding the contacting out of maintenance services in Queensland Health with a view to increasing the direct employment of tradespeople to undertake maintenance in house and be available to supervise apprentice tradespeople within the agency. Further to this that Queensland Health subsequently significantly increase the number of apprentices that it employs to assist the state to address the significant skill shortages that currently exist.

System performance (pages 85, 86, 87)

In consultation with other key stakeholders there be further development of appropriate performance indicators within Queensland Health, especially indicators that relate to equity and effectiveness within Queensland Health.

As a matter of urgency an appropriate and comprehensive framework is developed for the monitoring and implementation of coroner's recommendations regarding deaths in public and private sector health and aged care facilities in Queensland.

The *Clinical Services Capability Framework for Public and Licensed Private Health Facilities*' (SCF) is reviewed as a matter of priority in consultation with the QNU and other stakeholders and amended to include minimum staffing levels and skills mix **required** to ensure safe practice in all service areas.

Any Queensland Health policy related to medication management in residential aged care facilities reference the legislated requirements under the *Health (Drugs and Poisons) Regulation* that dispensed medications are administered by a registered nurse, or by an endorsed enrolled nurse under the supervision of a registered nurse, to any resident in residential aged care facilities who does not have capacity to request help from an assistant in nursing/carer to take their dispensed medication/s.

Introduction

The Queensland Nurses' Union (QNU) welcomes the opportunity to provide a submission to the Queensland Health Systems Review (2005). To us this review represents a significant opportunity to bring about much needed and long overdue improvements to the structure and culture of Queensland Health. We have attempted to provide such feedback in the past—the background materials we have already provided to this review testify to years of concerted activity on our part.

In summary we have been successful at achieving necessary reform only at the margins. This has largely occurred through the activities of the Ministerial Nursing Recruitment and Retention Taskforce processes. To say that the union and our members have been frustrated by lack of progress is an understatement. Through the Taskforce and other processes such as enterprise bargaining (EB) any initiative we have recommended that would have budgetary implications or would threaten existing power relationships within Queensland Health or would result in enhanced transparency, openness and accountability have largely failed to be adequately addressed.

In particular we have been frustrated by the tactic of denial used by Queensland Health. This has manifested itself in many ways. The agency has a longstanding response of denial to nurses because they represent the largest occupational group in Queensland Health (and indeed one of the largest occupational groups employed by the state government as a whole) and therefore granting of claims by nurses has significant budgetary implications for government. It does not matter that inequity exists and that other occupational groups (within Queensland Health and outside of Queensland Health) may already receive what we seek for our members.

Not only is there a denial at the level of initial claim but there is also denial at the implementation level once a claim has been argued, bargained for (or arbitrated) and achieved. When we are finally successful at achieving an enhancement for nurses we then have to continue to fight for the proper and consistent implementation of such lawful entitlements.

Perhaps the most astounding example of denial by Queensland Health in recent years is their position during EB 5 negotiation and arbitration when they steadfastly denied the existence of a nursing shortage in Queensland despite independent evidence to the contrary. The Department of Employment and Workplace Relations (DEWR) annual *National Skill Shortage Survey* has shown for some years (and continues to show) the breadth and depth of the nursing skills shortage in Queensland. Although a Ministerial Taskforce into Nursing Recruitment and Retention was established in the late 1990s in Queensland to deal with anticipated worsening nursing shortages, the agency was of the belief that this process had adequately addressed nursing shortages and wastage

There has in recent years been a refusal on the part of Queensland Health to accept the accuracy of DEWR data on the nursing shortage (despite it being accepted by the 2002 Senate Inquiry into Nursing and the National Review of Nursing Education) as it suited their purposes not to do so given that they obviously had reached the conclusion that to accept the existence of a shortage would "cost them" in enterprise bargaining negotiations. So Queensland Health continued to insist repeatedly in an Orwellian manner that a nursing shortage did not exist. They argued this line despite the fact that Queensland Health's own workforce data is notoriously inaccurate, with the agency being unwilling or unable to state with any degree of certainty how many people they actually do employ.

Government did not have the same difficulty accepting the existence of skills shortages in the Queensland electricity industry not do they deny the existence of a national and international doctor shortage. Only in recent times has Queensland Health acknowledged that a nursing shortage exists. It is our hope that the current reviews into Queensland Health will finally provide the impetus to comprehensively address the nursing shortage. Further inaction will continue to compromise the provision of safe nursing care for the community of Queensland.

About the QNU

The QNU is the principal health union operating and registered in Queensland. The QNU also operates as the state branch of the federally registered Australian Nursing Federation.

The QNU covers all categories of workers that make up the nursing workforce in Queensland—registered nurses, enrolled nurses and assistants in nursing, employed in the public, private and not-for-profit health sectors including aged care. Our members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management.

The union has both industrial and professional objectives. We firmly see nurses and nursing as being situated within a societal context—nurses being both providers and "consumers" of health services. In recent years we have attempted to lead and contribute to the debate within nursing and the wider community about the role and contribution of nursing through the development, implementation and regular review of a *Social Charter of Nursing in Queensland*. The QNU and the Queensland Nursing Council (QNC) are co-sponsors of this charter and we see this document as forming an important foundation for responsive and innovative nursing practice that is based on community needs and expectations and mutual respect and trust.

Membership of the QNU has grown steadily since its formation in 1982 and in June 2005 was in excess of 33,000 and still growing. The QNU represents the largest number of organised women workers of any union in Queensland. Like the nursing profession as a whole, the overwhelming majority of our members are female (93%). As nurses are the largest occupational group within health (nurses make up over 50% of the total employed health workforce and over 40% of the Queensland Health workforce), the QNU is the principal health union operating in Queensland. We estimate our membership density within Queensland Health to be around 90%.

The union has a democratic structure based on workplace or geographical branches. Delegates are elected from the branches to attend the annual QNU conference which is the principal policy making body of the union. As such it is rank and file membership that drives the agenda of the QNU. In addition to the annual conference the QNU has an elected council and an elected executive, which in turn have decision-making responsibilities between conferences. Council is the governing body of the union.

QNU members working in Queensland Health are employed under federal industrial instruments and in the private sector are employed under state industrial instruments. In addition, since 1994 when no enterprise agreements were in place covering nursing workers, the QNU has become party to over 300 enterprise agreements which cover a diverse range of health facilities and other non-health establishments where nursing services are provided (e.g. schools, prisons and factories). We therefore have a clear and comprehensive understanding of the complexity of contemporary health service delivery as well as the diversity of locations where health services are delivered.

Recent trends in nursing

The QNU has already provided background information to this inquiry on recent trends in nursing. However we will briefly summarise the major trends now in order to provide a context for this submission.(The following information is obtained from the Australian Institute of Health and Welfare's (AIHW) *Nursing labour force* publications.).

Nurses are a significant occupational group. Nurses are the largest occupational group in the Australian health workforce, representing 54% of the total employed health occupations in 2001[1] and just over 40% of the total Queensland Health workforce[2] in that same year. Health professionals account for 43% of employment in the health industry (other workers include administrative staff, cleaning, catering and other operational staff and trades people) and nurses are the largest professional group, accounting for just over one quarter of total health industry employment.[3]

Nursing remains a highly feminised occupation. Over 90% of nurses are women.

The nursing workforce (like the health workforce and the community generally) is ageing. The average age of employed nurses was 42.2 years in 2001, having increased from 39.3 years in 1995.[4] The health and community services sector workforce is older and ageing more rapidly than the rest of the workforce.

Over 50% of nurses are working part time. The number of nurses employed in a part-time capacity has steadily increased in recent years. By 2001 this had increased to 53.7%.[5] At the same time the average number of hours worked per week has decreased from 32.4 hours in 1995 to 30.5 hours in 2001.[6]

Nursing numbers in Queensland are lower than the national average. Queensland continues to fall well below the national averages in terms of both the total number of employed nurses and total full time equivalent (FTE) employed nurses. The number of employed nurses (RNs and ENs) per 100,000 of population in Queensland was 1074 in 1995 and 1083 in 2001 compared to the Australian average of 1221 in 1995 and 1176 in 2001.[7] A more meaningful indicator of nursing supply is the number of FTE nurses per 100,000 population: In 1995 the number of FTE employed nurses per 100,000 population in Queensland was 988 (Australian average 1127) and in 2001 this number had decreased to 965 per 100,000 population (Australian average 1024).[8] Although there was a 12% growth in total RN and EN numbers in Queensland between 1995 and 2001, there was a 2.3% decrease in the number of FTE employed nurses per 100,000 population during this period. Significantly the growth in third level unlicensed personnel has been greater in Queensland than any other part of Australia, growing by 47.5% (3.9% per annum) between 1987 and 2001. (Total employment of this category in Queensland in 2001 was 9900.)[9]

1 AIHW (2003), *Health and community services labour force*, 2001, Canberra page xiv
2 Queensland Health (2001), *Annual Report 2000/2001*, page 35.
3 Duckett, S "Health Workforce Design for the 21st century, *Australian Health Review* May 2005 Vol 29 No 2, page 201.
4 AIHW (2003), *Nursing labour force 2002*, Canberra, page 1.
5 AIHW (2003), *Nursing labour force 2002*, Canberra, page 6.
6 AIHW (2003), *Nursing labour force 2002*, Canberra, page 6.
7 AIHW (2003), *Nursing labour force 2002*, Canberra, page 8.
8 AIHW (2003), *Nursing labour force 2002*, Canberra, page 18.
9 Shah C and Burke G, *Job Growth and Replacement Needs in Nursing Occupations*, DEST (National Review of Nursing Education) Canberra, page 40.

Pronounced skills shortages exist in all areas of nursing. According to the Department of Employment and Workplace Relations (DEWR) *National Skill Shortage Survey*, the depth and breadth of the skills shortages in nursing remains the greatest of all occupational groups. Workforce modeling commissioned by the recent National Review of Nursing Education predicts that there will be 31,000 nursing vacancies in Australia by 2006.

At the same time changes have also been occurring in the wider community and health sector that have impacted on nurses and nursing. Queensland's population growth is the highest of all states and territories in recent years. This growth, which is predicted to continue, has put significant pressure on demand for health services. Ageing of the Australian community, technological advances and reform in the health sector in recent years have all significantly contributed to changes to care and work patterns. For example, length of stay in hospitals has declined and this has resulted in significant work intensification for nurses, those they are caring for being more acutely ill while in hospital. There has been an increased level of acuity of people across all care settings be this in the hospital, community or residential care. Community expectations of care and treatment have also increased significantly in recent years.

What does this all mean for nursing? In a nutshell the nursing workforce is ageing and although there are greater numbers of nurses the actual hours they work has decreased which means there are fewer nurses caring for sicker and more demanding patients. This situation is only going to intensify given predicted population growth in Queensland and the ageing of the general population and the nursing workforce. The nature of this crisis in nursing and its causes has been identified—all that is missing is the political will

to address the issues in a comprehensive manner. Some work has been done within Queensland Health through the Nursing Recruitment and Retention Taskforce and subsequent bodies though some areas (especially in relation to establishing appropriate nursing workloads) require further urgent attention. Also, there is an urgent need to establish and support mechanisms to promote appropriate nursing workforce planning across all sectors in Queensland and at the national level.

The nature of nursing work

Many attempts have been made to define the practice of nursing. In October 1998 the Queensland Nursing Council published a document titled *Scope of Nursing Practice Decision Making Framework*, which defines nursing practice as follows:

Nursing practice incorporates the application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues. It focuses on the promotion and maintenance of health, the prevention of injury or disease and the care of the sick and disabled so that people with identified nursing needs may maintain optimal well being or achieve a peaceful death. Nursing practice is largely determined by the context in which it takes place.

The role of the nurse is broad and at times difficult to specify. The multi-dimensional nature of nursing work – to be a nurse requires increasingly complex technical knowledge and skills that are balanced and complemented with well-developed interpersonal, written and verbal communication, problem solving and conflict resolution skills. Many of the so-called "soft skills" required by nurses are often not "visible" and therefore are not adequately acknowledged and ascribed value accordingly. Technical skills are more visible and therefore easier to measure than the equally important emotional intelligence component of nurses' work. (Recent pay equity inquiries in both New South Wales and Queensland have acknowledged this difficulty.)

The context in which a nurse does their work is also highly variable – working as an independent professional agent who at any one time can be caring for a number of individuals (and their families) but doing so within a team structure. Multiple transactions between individuals occur during the course of a shift, a complex range of activities are undertaken and the working environment is often unstable. The condition of patients can rapidly deteriorate, in most areas you have a number of patients in your care (all with different needs and health status) so your clinical assessment and reaction skills must be finely tuned. You must have the ability to prioritise and respond appropriately. As they work 24/7 nurses perform the principal surveillance role in the health system – it is nurses who keep patients safe.

There has also been significant work intensification in the last 10-20 years, as evidenced by decreasing length of stay, increased throughput and an increase in the level of patient acuity. Given this changing context the breadth and depth of knowledge required by nurses to perform their role has expanded considerably.

Apart from concern regarding the context of nursing work there are some inherent features of the work that are challenging. The work is physically and emotionally demanding, the rigours of shift work (the performance of work 24 hours a day seven day a week) being just one example of this. It is also personally dangerous work, given the prevalence of blood borne diseases and the incidence of physical and verbal assault on nurses.

It is hard to describe the richness and complexity of nursing easily and succinctly. It is more often than not the case that many do not want to hear what it is that nurses do because it is of such a personal nature. People are embarrassed to listen. Their own sense of physical or personal security may be fundamentally threatened by the very nature of the work that nurses do. Most healthy people do not want to think about being sick - many prefer not to think that they will ever be so vulnerable that they will require nursing care. Giving up such personal power can be confronting. Nurses are aware of this dynamic so their actions seek

to normalise abnormal situations – to make people who are ill feel as physically and emotionally comfortable as possible under the circumstances. It is the very act of normalisation, through reassurance or "down playing" of seriousness that in turn masks the importance and complexity of nursing skills. This complex dynamic is central in our view to the longstanding under valuing of nursing work. The very nature of nursing work and the difficulty in "translating" this for non-nurses perpetuate the inequity.

It is the source of considerable frustration to many nurses that the complexity and richness of their work continues to be undervalued by health bureaucrats and government alike. Nursing is incredibly personally rewarding: nurses love nursing. It is the context of in which they work, one of budgetary constraints and insufficient resources, and their work environment that is the source of angst for many nurses. So many nurses *love nursing* but *hate their jobs*.

The QNU strongly believes that past examinations of the work value of nurses have failed to adequately identify and measure the full range of skills employed by nurses in their work. This is in large part due to a fundamental gender based bias that we believe exists in current job evaluation methodologies. As a result we feel the depth and range of nurse's skills have not been adequately acknowledged and rewarded. This fundamental inequity is compounded by an adversarial wage fixing system based on industrial conflict. Such a framework is counter productive in a system such as health care where cooperation and teamwork are central to achieving outcomes. Relationships are central to the work of nurses, so when these fundamentally break down, as is the case with the current systemic disconnect between nursing and Queensland Health, it is especially frustrating and distressing.

Overall objective of the Systems Review of Queensland Health

To undertake a review of the performance of Queensland Health's administrative and workforce management systems with a focus on improving health outcomes for Queenslanders.

Broader Context

Give that the overall focus of this review is "improving health outcomes for Queenslanders" the QNU believes there are a number of contextual issues that need to be considered before addressing the specific terms of reference of this inquiry.

Queensland's budgetary position enables funding of necessary change

Queensland's current strong economic position, to not only meet the considerable infrastructure needs of the state but also address the particular needs of the Queensland public health system that are being highlighted through this review and the Commission of Inquiry into Bundaberg Hospital. Addressing deficiencies in the structure, culture and funding of public health services in Queensland is now the undisputed priority of the Queensland government. There is an urgent need for additional funding for health services as well as the need to ensure existing services are adequately resourced to meet community needs and expectations. We welcome the Premier's stated commitment following release of the 2005/2006 Queensland Budget to fund initiatives arising from the reviews of Queensland Health from the state's surplus.

Other significant factors impacting on health service delivery

The QNU believes that Queensland's comparatively strong financial position enables us to place particular emphasis on making sustainable and evidence based improvements in health service delivery and infrastructure at this time. This is particularly important given the demographic challenges of continued population growth, the ageing of the population, the decentralised nature of Queensland and changes in community expectations and demand for services. The issues of community needs and expectations should be examined in a coordinated and comprehensive way in view of the challenges confronting us. This is especially important in the areas of health and aged care services given factors such as the potential increase in demand for services because of the ageing population, cost blow outs related to technological advances, increasing consumer demands, lack of integration of services and expectations and structural inefficiencies and duplication related to dual federal/state government responsibilities in this area.

The importance of the Queensland public health system

The history of the Queensland public health system is a long and proud one. Our public health system is an important cornerstone of our universal health system. This is increasingly so given that the federal government is undermining universal health care by shifting emphasis to a "user pays" model for health funding. More and more, those who cannot afford spiralling out of pocket expenses in the private medical system are relying on public health services. This reliance is particularly acute in regional and rural areas, where it is usually the case that the only hospital services (and often primary health services) are public ones. There are no private hospitals west of the Great Dividing Range (i.e. in most rural and all remote areas of Queensland). Given the decentralised nature of Queensland this is a critical point that underscores the significance of our public health system in ensuring equity and access to essential health services.

The QNU is steadfastly committed to the establishment and improvement of the Queensland public health system. The provision of timely, quality, publicly funded health services to all in our community determined on clinical need and not ability to pay is, to us, an essential hallmark of a civil and fair society. Although private health care providers are an important component of the health care system, it should only ever be seen as complementary to the public system.

There needs to be better interface between the public and private systems to ensure better integration of services and improved continuity of care for clients of the health system. This is because clients of health services can and usually do move across sectors. Currently coordination across care settings within and between sectors is inadequate. This is not to say that improvements have not been made in recent years (for example, relationships between the public hospital sector and general practice have improved, especially with the advent of new technologies). But much more needs to be done to ensure seamless care. Some of this fragmentation arises from state and federal government funding and accountability arrangements and these will only be truly addressed by a national coordinated approach to genuine health reform in this country. However more can and must be done as an interim measure to improve the interface between public and private sector health care providers in Queensland.

In our view an important step in achieving this end is the establishment of a state based Health Reform Council which has responsibility for establishing processes to ensure genuine community consultation on health service planning and delivery as well as improving the interface between public and private health sectors. The QNU does not support an *ad hoc* approach to the "restructure" of Queensland Health. The formation of new local health councils or boards in the absence of a coordinated and consistent policy framework will fail in our view.

It is essential to also remember that any consideration of health reform in Queensland must be undertaken in full cognisance of current developments with respect to the national health reform agenda. Most importantly, it is also vitally important that any reform that takes place within Queensland Health must also achieve the objectives that underpin of our universal health system – that of ensuring universal access, access based on need and not ability to pay, equity of access and equality of health outcomes, efficiency and effectiveness. In particular, every effort must be made to ensure that any changes to structures do not adversely affect the achievement of objectives in health priority areas such as indigenous health, mental health and cancer services.

The QNU believes a state wide "peak body" such as a Health Reform Council must be established first to provide a framework for local level community and stakeholder engagement on health reform. Ensuring consistency of approach is paramount in our view and firm guidelines must be established to ensure appropriate community and stakeholder representation on local health advisory services. For example, the QNU also does not support a model whereby there is formal private sector input into the running of public health services unless a similar arrangement is established that enables direct public sector input into the running of private health services (be these hospitals, aged care facilities, general practice or community based not for profit services). We are sure that such direct public sector input into the running of private services would be strenuously resisted and therefore cannot see how an argument for private sector input into the running of Queensland Health could be sustained.

The best model for achieving better coordination and input into decision making is through the initial establishment of a statewide Health Reform Council (with sub working groups dealing with specific priority areas requiring attention). This

group would then be responsible for drawing up a consistent and appropriate model of local consultative arrangements. (Such local consultative arrangements must be rational and consistent with Queensland Health's service delivery geographic boundaries that may change as a result of current reviews.)

It is recommended that:

RECOMMENDATION (Health Reform Council)

That the Queensland government fund the establishment and continued operation of a state based Health Reform Council that would draw up a framework to enable genuine community consultation on health policy decision making and the planning of service delivery at the state wide and local levels. Further to this, that this body be broadly representative of the Queensland community and include representatives from the QNU and consumer organisations.

This review and the concurrent Commission of Inquiry into Bundaberg Hospital are central to rebuilding community confidence in the Queensland public health system. The QNU will play whatever role we can in contributing in a positive way to achieving this end. We are well aware that the continued undermining of the public health system suits the purposes of some players. It is therefore essential that we keep in mind that the systems and cultural problems highlighted by the Morris and Forster inquiries into Queensland Health are also common problems in the private system. It is just that these issues are not currently being exposed there due to the decreased availability of mechanisms for public scrutiny of the private health system.

Although the QNU has serious concerns about the lack of openness and transparency of our public health system it is the case that the public system is more accountable than the private health sector. This is because Freedom of Information (FOI) legislation (deficient though it is in this state) and many public reporting arrangements do not extend to the private sector.

Health and education are the two largest state government portfolio areas and as such account for a significant proportion of government funding. These are two very important areas of government service provision and as such Queensland taxpayers have a clear stake in ensuring both appropriate administration and service delivery. It is also the case that Queensland Health is one of the state's largest employers and therefore fulfils an essential economic function in regional and rural communities in particular. Our public health system also provides an essential training function. Overwhelmingly it is the case that specialist medical officer training occurs in the public sector. Our public system is the primary provider of critical high cost and medical emergency treatments and often is the first provider of "cutting edge" technology. As such, it fulfils many vitally important functions that highlight the many reasons why it is essential to rebuild community trust and confidence in Queensland's public health system.

Decentralised nature of Queensland

The decentralised nature of this state provides particular challenges to government. Not only is it more expensive to deliver services in a highly decentralised state such as Queensland but also geography greatly influences equitable access to appropriate services.

In our 1996 submission to the then Health Minister Hon Peter Beattie the QNU highlighted the need for more rational and consistent service delivery models. We argued at that time (and still hold this view) that it is a nonsense to have inconsistencies between government agencies with regard to geographical boundaries for service delivery. Why is it that the geographical "district" boundaries for all government agencies are not consistent, especially with regard to large service delivery agencies such as Queensland Health and Education Queensland? The aim of the Shared Services Initiative (SSI) was to at least in

part address issues of duplication of effort and service across the agency and public sector as a whole and to improve service standards in rural and remote areas. Unfortunately this has not been achieved and confusion now exists about the relationships and responsibilities between the overall Queensland Health organisational structure and that of the shared services initiative. If this initiative was to be a genuine attempt to ensure consistency of approach and reduce duplication of effort then from the outset a consistent HR/IR policy framework for the whole of Queensland Health should have been established rather than allow the continuance of the existing Health Service District (HSD) autonomy on HR/IR issues. This is a key issue for consideration by this review and therefore will be dealt with in greater detail later in this submission.

Informed community debate

Much needed health reform can only be delivered through proper community debate and engagement. The existing mechanisms for this are obviously inadequate. A new paradigm is needed whereby a holistic approach to health sector reform is adopted, based on a genuine community dialogue about health needs and expectations and how these are best funded. This will not be achieved by retreating back in time to the era of Hospital Boards – a new approach is required. Similarly it is essential that a new approach is required for health service delivery, one founded on a partnership with the staff delivering the services (who are also citizens). The QNU believes that the time has well and truly come to adopt a new approach/culture in health – one based on sharing of information, engagement and debate, openness, transparency and accountability. We are confident that citizens, the staff who provide the service and government are capable of such a shift in approach. It is appreciated that this shift is significant and achieving it will not be without difficulty. However if we are to ensure the delivery of sustainable, evidence and needs based, quality health services into the future then this must occur. The need for this shift will be a recurring theme of this submission.

Undue emphasis on achieving efficiency related outcomes

The Queensland government frequently reminds us that Queensland public hospitals are the most efficient hospitals in the country. This point is reinforced each year by the annual *Report on Government Service* prepared by the Steering Committee for the Review of Government Service Provision. The comparative efficiency of Queensland's public hospitals is highlighted in the 2004 and 2005 reports. For example in 2004 the report highlighted that:

The recurrent cost per casemix-adjusted separation nationally in 2001-02 was $3017. Across jurisdictions it was highest in the ACT ($3769) and lowest in Queensland ($2741)[10]

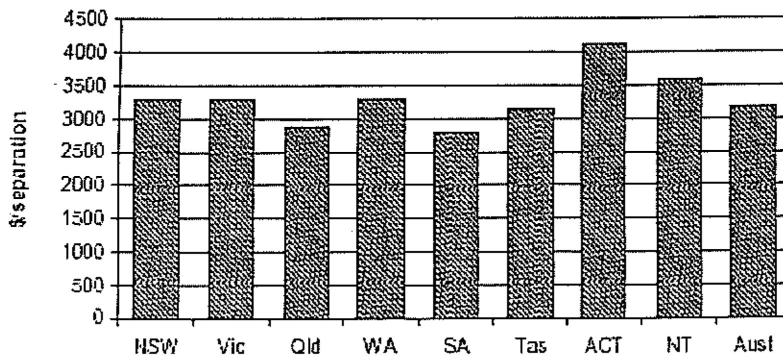
The 2005 report quotes the total recurrent cost per casemix-adjusted separation as being $2885 in Queensland compared to the national average of $3184. [11] This is represented graphically below[12]:

10 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2004*, page 9.47, Canberra.

11 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, Table 9A.4, Canberra.

12 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.49, Canberra.

Figure 9.14 **Recurrent cost per casemix-adjusted separation, 2002-03**[a, b, c, d, e, f, g]



[a] Excludes depreciation and the user cost of capital, spending on non-admitted patient care, research costs and payroll tax. [b] Casemix-adjusted separations are the product of total separations and average cost weight. Average cost weights, from the National Hospital Morbidity Database, are based on acute and unspecified separations and newborn episodes of care with qualified days, using the 2000-01 AR-DRG v4.2 cost weights (DHA 2003). [c] Excludes separations for which the care type was reported as 'newborn with no qualified days', and records for hospital boarders and posthumous organ procurement. [d] Excludes psychiatric hospitals, drug and alcohol services, mothercraft hospitals, unpeered and other hospitals, hospices, rehabilitation facilities, small non-acute hospitals and multipurpose services. [e] Data for NSW are preliminary. [f] NT data need to be interpreted in conjunction with the cost disabilities associated with hospital service delivery in the NT. [g] All hospitals in the NT, one very small hospital in Victoria and two very small hospitals in SA have had their inpatient fraction estimated using the HASAC ratio (see AIHW 2004a).

Source: AIHW (2004a); table 9A.4.

The 2003-2004 Queensland Health Annual Report quotes the average cost per weighted episode of care at $2631 whereas in 2002-2003 this figure was $2713[13].

In the last 10-15 years there has been significant reform in the public health sector in Queensland that has lead to efficiency gains. [Significantly these gains have been achieved in the context of either tight constraints on or actual decreases in (depending on data relied upon) nursing numbers employed by Queensland Health. See section below on data difficulties in Queensland Health].

These reforms have included but are not limited to:

- Significant technological advances and broadening of the knowledge base of nurses and other health workers (this has coincided with the transfer of nurse education to the tertiary sector)
- Decreased hospital length of stay – from 5.38 days in 1990/91 to 3.0 days in 2003/2004 (target for this year was 3.08 days)[14]
- Increased throughput and patient acuity –

	1990-91	**2002-03**	**2003-04**
Total admitted episodes of care	514,635	734,107	749,949
Total day only patients	No data	348,038	352,385
Total non Inpatient Occasions of Service	6,120,632	8,867,807	8,813,831[15]

13 Queensland Health Annual Reports – 2002-2003 p 47 and 2003-2004 p21.

14 Queensland Health Annual Reports.

15 Queensland Health Annual Reports – note data for 2002-2003 and 2003-2004 come from the 2003-2004 Annual Report data pages 22-26.

- A significant capital works programme in the public sector that has also resulted in a decrease in available beds per 1,000 population from 3.3 in 1993-94 to 2.7 in 200-2001[16]
- Significant changes to models of care
- Restructuring of health service delivery
- Implementation of new career structures and roles for health workers and other significant public sector reforms

Hospital activity and patient acuity rates (degree of how ill patients are) have increased over the last ten years. Associated with this increase is a decreasing length of stay. This means that patients treated ten years ago who required a hospital bed for a number of days may now be treated as a day patient. A patient who may have been cared for in an intensive care unit ten years ago may be in a ward today.

Increased throughput and decreasing length of stay in public hospitals combined with significant health and information technology development over the last decade have resulted in work intensification by nurses. As patients are admitted for shorter periods of time, the level of patient dependency for the period of hospitalisation is higher. That is, patients are sicker—as they improve they are discharged for their recovery phase. Patients are discharged sicker and quicker. Nursing work has intensified and is much more complex than what it has been.

In our view an undue emphasis has been placed upon achieving greater and greater efficiency outcomes and insufficient emphasis is being placed upon the quality of care provided or effectiveness of health outcomes. Our members are increasingly reporting that this emphasis on increased efficiency gains is having a negative impact on quality of care as nurses are placed insituations where they are unable to deliver an optimal standard of nursing care. This results in nursing wastage as nurses leave the health system or decrease their hours of work because they can no longer cope with the unrealistic work intensification and the consequences this has for their ethical obligations as health professionals.

The common complaint of nurses today is that that they love nursing but hate their job. (This is backed up by independent research involving QNU members conducted by University of Southern Queensland (USQ) in 2001 and 2004 – findings of research detailed later in this submission.) This has resulted from the unsustainable drive for efficiency that must urgently be re-examined and placed in the context of the expected quality and effectiveness of services provided.

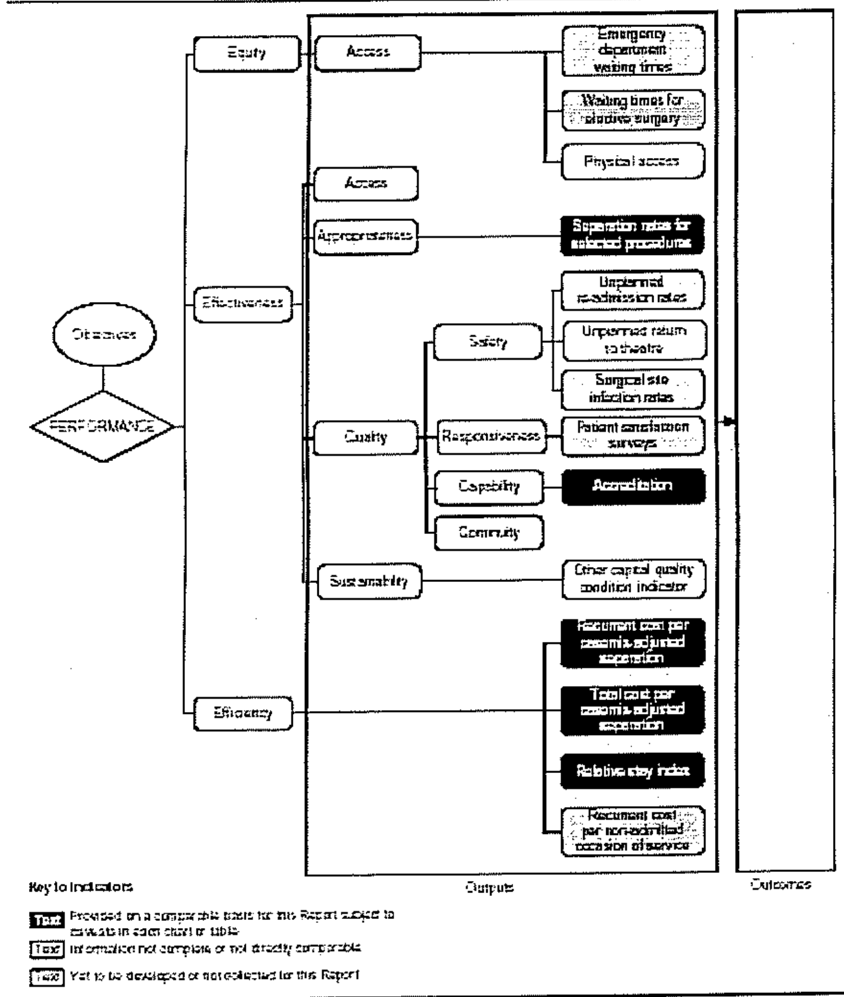
For years now governments have pushed for greater efficiency in areas of service delivery such as health and as a result have failed to develop a truly balanced approach to measuring performance. One mechanism through which governments report progress towards the achievement of agreed performance indicators is to the Steering Committee for the Review of Government Service Provision. This is reported in the annual *Report on Government Services.* Performance indicator frameworks have been designed for all major areas of government service delivery. The current performance indicator framework for public hospitals contained in *Report on Government Services 2005* is reproduced below.[17] It should be noted that the efficiency indicators of this framework were developed first and have been

16 AIHW *Australia's Health* 1996 Table 5.6 and *Australian Hospital Statistics 2002-2003* Table 3.2, Canberra.

17 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005,* page 9.20, Canberra.

the most refined over time. The development of indicators in the areas of equity and effectiveness still require much more work. Some indicators that are currently utilised to assess quality (for example accreditation) are also seriously deficient in our view. The over emphasis on meeting crude efficiency targets (e.g. elective surgery targets) can and does have serious effects on quality and appropriateness of care. You need look no further than recent experience at Bundaberg Hospital to be reminded that the consequences of taking an unbalanced approach can indeed be dire.

Figure 9.11 Performance indicators for public hospitals



It is recommended that:

RECOMMENDATION (Expanding health performance measures)

That specific funding is allocated to enable the further development of appropriate performance indicators that measure effectiveness and equity of access to health service delivery as agreed to in the Steering Committee for the Review of Government Service Provision (annual *Report on Government Services*) process.

Lower spending on health in Queensland

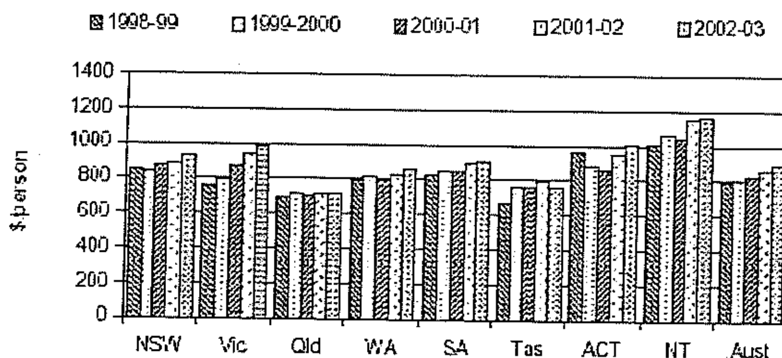
Queensland also continues to have the lowest per capita health expenditure in Australia, despite "record" expenditure in the health portfolio each year. This lower level of expenditure is particularly striking considering the additional costs associated with delivering health services in Australia's most decentralised state. The 2005 *Report on Government Services* prepared by the Steering Committee

for the Review of Government Service Provision repeatedly highlights this continuing trend:

In 2002-03, government real recurrent expenditure on public hospitals (in 2001-02 dollars) was $895 per person for Australia, up from $791 in 1998-99. It ranged from $1165 per person in the NT to $712 per person in Queensland in 2002-03.[18]

Government expenditure trends in public hospitals from 1997/98 to 2001/02 are represented graphically as follows[19]:

Figure 9.2 Real recurrent expenditure per person, public hospitals (including psychiatric) (2001-02 dollars)a, b, c



a Expenditure excludes depreciation and interest payments.

b Data for 2002-03 for NSW are preliminary. NSW hospital expenditure recorded against special purposes and trust funds is excluded. NSW expenditure against primary and community care programs is included from 2000-01.

c For 2001-02, Tasmanian data for two small hospitals are not supplied and data for one small hospital are incomplete. For 2000-01, data for six small Tasmanian hospitals are incomplete. For 2002-03, Tasmanian data for one small hospital were not supplied and data for five other small hospitals were incomplete.

Source: AIHW (2004a and various years); ABS (unpublished); tables 9A.2 and A.2.

A report released by the federal health minister in June 2004 titled *The state of our public hospitals* claims that (based on AIHW and 1998-2003 Australian Health Care Agreement data) the Queensland government's recurrent expenditure per person on public hospitals in 2000-2001 was the lowest in Australia at $440. (Next lowest was South Australia at $487.) The national average expenditure was $552.[20]

The low level of expenditure on health care in Queensland extends beyond expenditure on public hospitals. According to the 2005 *Report on Government Services* (our emphasis added in extract below)[21]:

18 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.4, Canberra.

19 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page 9.5, Canberra.

20 Australian Government (June 2005), *The state of our public hospitals*, page 14, Canberra.

21 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005*, page E8-E9, Canberra.

Health expenditure per person in each jurisdiction is affected by different policy initiatives and socioeconomic and demographic characteristics. Nationally, total health expenditure (recurrent and capital) per person in 2002-03 was $3652, rising by 32.9 per cent in nominal terms in the five years since 1998-99 (when it was $2748). Across jurisdictions, it was highest in the NT ($4126 per person) and ***lowest in Queensland ($3392 per person) (table*** *EA.5).*

The most recent data on recurrent health expenditure per person by jurisdiction are for 2001-02. Real recurrent health expenditure per person in Australia increased from $2637 (in 2001-02 dollars) in 1997-98 to $3142 in 2001-02. In 2001-02, total recurrent health expenditure per person was highest in the NT ($3437) ***and lowest in Queensland*** *($2885) (figure E.4 and table EA.6). If spending on high level residential aged care is removed from these data, then total recurrent health expenditure per person ranged from $3383 in NT to $2659* ***in Queensland in*** *2001- 02 (table EA.7). Government real recurrent health expenditure per person in Australia increased from $1776 in 1997-98 to $2112 in 2001-02 (in 2001-02 dollars). In 2001-02 it was highest in the NT ($2658)* ***and lowest in Queensland*** *($1972) (figure E.4 and table EA.6). If spending on high level residential aged care is removed from these data, then government recurrent health expenditure per person ranged from $2614 in the NT to* ***$1784 in Queensland in 2001-02*** *(table EA.7).*

It is also our firmly held view that increases in the Queensland budget expenditure in the health area have failed to keep pace with the significant population growth and increased demand for health services seen in recent years. Indeed the QNU believes the recent Queensland Health Capital Works program process for determining the hospital bed numbers required has significantly under-estimated future demand for services in many areas. This is clearly demonstrated through recent hospital activity data, for example hospital waiting list information.

The government response to the blow out in public hospital waiting lists appears in part at least to transfer demand to the private sector, be this through individual consumers taking out private health insurance (or self funding health services in the private sector) or by Queensland Health contracting services out to private hospitals. The QNU believes this knee jerk approach is fraught with potential problems and we have expressed our concerns about the waiting list strategy to the Minister for Health.

Staying within budget (while at the same time having to meet unrealistic performance objectives) is the overriding imperative in Queensland Health – all else appears to take second place to this. The primacy of the budget bottom line is demonstrated again and again. In 1999 the whole District Executive at Toowoomba Health Service District (HSD) were removed for failing to come in on budget. Not long after that the District Manager in Cairns HSD was dismissed for reportedly failing to come in on budget. These dismissals were powerful symbols for the rest of the system and helped achieved better budget compliance by instilling fear of job loss in senior management across the agency, a fear that was in turn passed down to middle management and beyond. It was strange that these particular districts were singled out for this particular form of harsh treatment, especially when there were other districts that were in greater budgetary difficulties.

It is also disappointing (to say the least) that a similar level of decisive action was not shown towards management at the Bundaberg Health Service District (HSD) when such significant systems failures manifested themselves this year. We are not arguing such draconian dismissal action against the management at Bundaberg HSD but highlight that an obvious and clear double standard exists in this agency. Failure to come in on budget will result in dismissal but failing

to act to correct significant systems failures that result in death and injury to patients results in you being asked to consider whether you should stand aside "while matters are investigated". No one within the system (or outside of it for that matter) is left in any doubt about what is more highly valued when such clear messages are sent. The budget dollar bottom line is paramount.

It is our firm view that the historic under funding of public health services in Queensland has in large part contributed to the current crisis we are experiencing. As the health budget is insufficient to meet public demand for services something has to give. Although it is appreciated that health funding in Queensland has been increasing in recent years this increase has not been sufficient to ensure consistent access to timely and high quality health services. We have argued in our recent budget submission to the Queensland government for the need to increase Queensland's spending on health to the national per capita average, and continue to argue for this outcome. There is a concurrent need to develop improved effectiveness and equity indicators (in addition to existing efficiency indicators) to ensure that additional funding is contributing to achieving desired outcomes.

RECOMMENDATIONS (Budget for and supply of health services)

It is recommended that:

The Queensland government continues to increase its budget allocation to the health portfolio in order that government per capita expenditure on health services reaches an acceptable level compared to other state/territory governments.

In light of population growth and current high levels of demand for public health services the Queensland government fund an urgent re-examination of demand and supply of public health services (including the number and distribution of public hospital beds, day procedure units and primary health care services) and that the outcome of this review form the basis for future budget allocations for health infrastructure and recurrent funding.

Lack of access to meaningful data

The lack of reliable publicly available data from Queensland Health in a range of areas should be a source of significant embarrassment to the Queensland government. This is not only a source of frustration for the QNU - we are advised that other government agencies are also concerned about the lack of meaningful data, especially of a financial and human resource nature. In our view lack of openness and transparency is an issue for the whole of the Queensland government (exemplified by the recent winding back of the FOI regime in this state) but is particularly a problem in Queensland Health. Urgent action is required across government but especially within Queensland Health to improve access to meaningful information to enable better transparency, planning and accountability. Even if reliable data is available it often is not released to key stakeholders such as unions. Issues relating to data are of central significance to this review and will be elaborated on later in this submission.

RECOMMENDATIONS (Access to meaningful data)

It is recommended that:

Specific funding is allocated to enable the further development of appropriate systems within Queensland Health that will enable timely access to reliable data for health bureaucrats and the broader community including health unions. This would facilitate better planning and accountability and evidence based decision making on clinical and non clinical matters.

Politics of health

The entrenched power imbalances within health care make it inherently political and add to the complexity of dealing with issues within the portfolio. The failure of successive administrations to appropriately "manage" the politics of health

has in large part related to their failure to appropriately and openly deal with these power relationships. Openness is the key issue here in our view – if the issues were examined and debated in an open manner then we believe the "politics" would also be subject to greater scrutiny and there would be a far greater potential for resolution of the power imbalances.

The health portfolio provides perhaps the greatest opportunities to cause the downfall of governments. Received wisdom is that the Goss government was brought down because of "reforms" they introduced to the public sector, especially in the health portfolio. However rather than subject the reasons for discontent to proper analysis, admit that mistakes were made and then develop strategies to address problems identified, the response (at least in health) has been knee jerk and punishing. The aim is to shut down critical analysis and debate in health rather than encourage it—to neutralise opponents by playing the person and not the issue (a very entrenched strategy in Queensland political culture). This response has only served to entrench power imbalances and create greater dissatisfaction and a sense of hopelessness. (Successive surveys of our members demonstrate this very clearly.)

Despite attempts in recent years to restructure the culture of health to a team based approach the hierarchies remain. Perhaps it is naive to believe that this will not always be the case, but in our view it is illogical to not acknowledge their existence openly, discuss them and develop appropriate strategies to mitigate against power imbalances. Similarly, it is imperative in our view that a new approach be adopted to genuinely engage citizens in the debate about health needs and expectations and how these should be funded.

It is of particular concern to the QNU that some are now arguing for a return to the "good old days" of a medical model for Queensland Health. We have well and truly moved beyond a time when health care policy and service delivery is determined by the most powerful occupational group in the health industry. Those who fail to realise this are doomed to failure in our view—stuck in an old world paternalistic paradigm of "doctor knows best" that is not an appropriate health care model for the twenty-first century. This is not to say that doctors are not very important service providers in the health system—of course they are. So too are other health professionals and those workers who provide support to clinical services. To have a new sustainable model of health care we must adopt a team approach that acknowledges the contribution of all players.

It must also be remembered that despite recent claims to the contrary by some, it remains the case that medical officers continue to play key leadership roles at the corporate office and HSD levels. For example, over the last 15 years plus all Directors General of Queensland Health bar one (Mr Dick Perrson) have been medically qualified. There are also a number of medically qualified officers holding senior positions within Queensland Health including the Office of the Chief Health Officer (legislation requires that this person be medically qualified) and many other medical officers hold positions at very high levels within corporate office. It is also the case that Medical Directors/Superintendents at the HSD and facility levels continue to form a central role in the Executive of the health service.

Typically the Executive of a HSD comprises the District Manager (who may or may not be a medical officer), the Director of Corporate Services, the Director of Medical Services and the Director of Nursing Services. The QNU fails to see how a sustainable argument can be run that medical officers have been frozen out of decision making and leadership positions at the highest level. There may or may not be issues with the perceived performance of individuals holding these positions but it is essential that the personalities be removed from the

examination and we instead focus on the positions. (If there are performance issue for the incumbents in these positions then deal with that problem – it is nonsensical to create new positions/layers because of a lack of performance management processes or failure in accountability mechanisms. Any problems must be addressed at the source – it is inappropriate to merely treat symptoms.) Medical officers have always had and continue to have appropriate representation at senior levels of Queensland Health at the corporate office and local facility/ HSD level.

Most importantly however the old medical model misses the salient point – the focus should be on "health" services" (in all its forms) not "medical" services. The aim is to promote the optimal health and wellbeing of the community and this is achieved through many mechanisms, one of which is the provision of services by medical officers. The focus must shift to community needs and expectations—the system should not be designed around the particular needs of any provider, though of course the needs and expectations of all health service providers must be adequately met if we are to provide services at all. The key here is a partnership approach—one where there is a genuine partnership between health service providers and a genuine partnership between providers and the community as a whole. Obviously from the rhetoric of some key stakeholders of recent times we are some way from achieving this end. However it is nonetheless essential that this remain the objective and that changes that result from the current review of health services in Queensland do not result in a further entrenchment of the power imbalances that have been a longstanding feature of the health system.

It is nonsense to continue with the pretence that our current approach to health system design and funding is either appropriate or sustainable. To continue to publicly claim year after year that government has provided another record health budget in the absence of a genuine debate on community needs and expectations is simply ludicrous. State and federal governments have a key role to play in generating such a debate by putting aside the fear of political ramifications of "telling it like it is" and showing leadership on what is one of the key challenges confronting us: ensuring an equitable, high quality and sustainable health system for all. This is fundamentally a debate about the values that underpin our society, how health care is best provided and funded and what are our mutual rights and responsibilities. Without providing these underpinnings explicitly we cannot optimally effect a shift towards a preventative (and hence more sustainable) model of health care. A holistic approach is required, one that necessitates a rethinking of our multiple relationships within our health system.

RECOMMENDATION (Establishing a new partnership in health based on sound principles)

It is recommended that:

A new "partnership" approach be developed and adopted for the design and delivery of public health services in Queensland and that this be based on a health care team delivering health services to informed clients who have genuine input into decision making processes. Further to this, that at all times principles of universality, no cost at point of service, timely access, equity of access and equality of health outcomes underpin our public health services in Queensland.

Cultural issues

The QNU believes that the dominant culture that pervades Queensland Health is one of an obsession with secrecy, a failure to embrace differences of opinion and critical analysis, intimidation of those who dare to question and entrenched power imbalances. There is no doubt these are complex and inter-related issues. In our view it is this dysfunctional culture that has largely lead to this review.

The almost paranoid obsession with secrecy and failure to share meaningful data with "partner" organisations such as health unions (not to mention the community as a whole) are seen by us as fundamental barriers to accountability. In the last ten years or so every effort has been made to get Queensland Health off the front page of *The Courier Mail* and this has resulted in those with a genuine interest in information that is required to enable proper scrutiny of the system being denied access to necessary information. The winding back of the Freedom of Information regime in this state has greatly facilitated this culture of secrecy and lack of accountability. The result has been that Queensland Health is well and truly back on the front page of *The Courier Mail* in an unprecedented way. The system has failed the people of Bundaberg and in a wider sense the people of Queensland given the battering of public confidence in our public health system.

The current culture and unrelenting quest for greater efficiencies is unsustainable and must be changed. It is a nonsense for this agency to be charged with a mission of "promoting a healthier Queensland" while at the same time the way those delivering health services are treated contributes to the diminution of their health and wellbeing through the culture of bullying and intimidation and unsustainable workloads. We believe an examination of Queensland Health's WorkCover and health and safety data would demonstrate that significant problems exits in this agency and strongly recommend that this review pays particular attention to ensuring the establishment of a safe system of work for Queensland Health employees.

It is recommended that:

RECOMMENDATION (Data on health and safety impact of system stress on health workers)

This review pays particular attention to examining health and safety and WorkCover data from Queensland Health and from this make firm recommendations aimed at establishing safer systems of work for all Queensland Health employees.

Staff members see this disconnect between the publicly stated values espoused by the department in documents such as their Vision Statement and strategic plans and the behaviour that is actually modelled in their workplaces on a daily basis. It is important that these words on paper are actually given effect. This requires a switch in mindset on behalf of Queensland Health, with staff being truly viewed as an asset rather than a liability.

The real life experiences of employees of Queensland Health do not match their employer's rhetoric. There are great inconsistencies with regard to the way staff are treated within Queensland Health and some of these arise from fundamental and longstanding power imbalances. Why is it, for example, that Dr Patel was able to continue to practice while serious allegations were being investigated by the department earlier this year? Our experience has always been that when a nurse is under investigation for practice concerns of a serious nature they are immediately suspended or moved to alternate (non-patient contact) duties. There appears to be one rule for doctors and another for all other health workers such as nurses.

Another significant cultural problem exits within Queensland Health. In many areas a culture of cronyism exists—enclaves of like personalities and approaches are established. This could of course be positive if the attitudes that dominate are positive ones. Sadly this is often not the case and such negative cultures become entrenched and hard to break down. It is frequently the case that where such a culture exists there is a "play the person not the issue" approach. In such environments there is also not a strong understanding of the proper role of the public service or the overarching government policy objectives/framework. There also is not an acceptance or understanding of the legitimate role of unions

as representatives of their employees. In our view there is a great need for education of middle and senior management within Queensland Health of these matters if we are to be successful in breaking down such negative cultures.

RECOMMENDATION (Cultural change in Queensland Health)

It is recommended that:

Specific funding be allocated for training and staff development necessary to affect the necessary change to build positive, supportive and patient and staff focused culture within Queensland Health. In particular, that current educational programmes for middle and senior management within Queensland Health be reviewed to ensure appropriate content on matters such as encouraging participation, critical analysis and debate, the need for openness, transparency and accountability, the role of the public service, the government's overarching policy framework and the role of unions as legitimate representatives of employees.

The Queensland Health Code of Conduct is used as a weapon to punish staff and shut down legitimate debate and discussion of concerns. Instead of being used to deal with ensuring privacy in relation to patient confidentiality, the Code of Conduct is utilised to attempt to stifle discussion about serious systems concerns and even stop nurses and other health workers from contacting their union about these concerns. This fundamental misuse of this document must be immediately ceased if we are to create a positive, problem solving and open culture in Queensland Health. It is the right of all Queensland Health staff and citizens to raise concerns in the public domain about the conduct of public institutions including hospitals and other health facilities. It is the department's role to deal with these concerns in a timely and appropriate manner or to refute them. It is not there role to silence criticism and debate through the misuse of documents such as the Code of Conduct. It is essential that the Code of Conduct be reviewed and amended to reflect this and for a penalty to be imposed for the inappropriate use of this document by management.

RECOMMENDATION (Cultural change in Queensland Health)

It is recommended that:

The Queensland Health Code of Conduct be reviewed and amended as required to ensure that this cannot be used by management to prevent legitimate criticism and debate about health system concerns by employees and citizens and enable staff to contact their union or other relevant institutions in society to discuss their concerns. Further to this, that a penalty be imposed on management representatives who use the Code of Conduct inappropriately to close down discussion and debate.

How did we end up in this current mess? There are many reasons – a dysfunctional "shoot the messenger" culture: an obsession with secrecy and ensuring that the appearance that all is well is maintained at any cost; a failure to address medical dominance and arrogance; a failure to embrace different views and critical analysis; and perhaps most importantly an overemphasis on efficiency gains rather than effectiveness within the system. The importance of coming in on budget and meeting elective surgery targets receive higher prominence than the equally (or more) important objectives of ensuring optimal, appropriate and timely care. It is the case that what is measured is what is valued and the message is received loud and clear within Queensland Health that what is valued more highly is the dollar bottom line. The current crisis within Queensland Health is a crisis of values as much as anything. Nurses and other health workers can no longer continue to function in a system in which their professional values/obligations are compromised – where they can no longer deliver the care they want to deliver. Responses of QNU members to our most recent survey conducted by USQ in 2004 reinforce our assertion that nurses feel fundamentally compromised by the way in which the system currently functions.

Terms of Reference for this inquiry:

To specifically review:

1. Existing administrative systems and recommend improvements to support health service delivery, focusing on:

- *District and corporate organizational structures and layers of decision making*
- *Corporate planning and budgeting systems*
- *Cost effectiveness of services compared to relevant jurisdictions*
- *Effectiveness of performance reporting and monitoring systems*
- *Organisation and delivery of clinical support services*
- *Risk management systems*
- *Quality and safety systems and*
- *Clinical audit and governance systems*

District and corporate organizational structures and layers of decision making

Queensland Health is a large and complex agency and as such there is bound to be some problems related to structure and decision making processes arising from sheer size alone. There are going to be some layers of bureaucracy. However there are issues that must be addressed regarding organisational structures and decision making within Queensland Health. These include:

The need for a consistently applied policy framework for the agency, especially relating to human resource (HR) and industrial relations) policies and practices. There is not one consistent HR/IR policy framework within Queensland Health. There are 37 Health Service Districts (HSD) within Queensland Health and one Corporate Office. This means that there are 38 different interpretations of HR and IR matters (39 if you include the Mater Public Health Service in Brisbane). Despite the existence of a Industrial Relations Manual policy framework we are advised that Corporate Office only has the ability to "advise" not direct HSD on their HR/IR obligations. This results in significant inconsistency of approach (very much dependent on personalities and the level of expertise at each HSD), duplication of effort on the part of Queensland Health and health unions alike and extreme frustration on the part of health unions and their members with regard to enforcement of lawful entitlements. This is a significant issue must be addressed once and for all through this review. There is not room for flexibility in interpretation of such matters in our view.

It is recommended that:

As a matter of urgency a standardised organisational HR and IR policy framework be developed in consultation with health unions for the whole Queensland Health that will prevent district by district interpretation of industrial and other related legislative obligations.

RECOMMENDATION (Establishing a standardised HR/ IR framework in Queensland Health)

Our experience with each of the HSDs (and the Mater) is summarised in feedback we have obtained from QNU officials provided at Attachment 1 to this submission. As you can see, there are great discrepancies with regard to management and the functioning of consultative mechanisms across the state. This information is provided to this inquiry in confidence and we request that this information not be released either to Queensland Health or the general public. These reports do not identify any individual but do identify situations and/or experiences. We provide this information to give an overview of the broad impressions of eleven QNU officials who have responsibility for dealing with Queensland Health at the Corporate Office and HSD levels. To highlight

examples of inconsistent or poor practice by Queensland Health we have also provided a number of Case Studies at Attachment 2. These case studies should not be viewed as exhaustive: rather they exemplify the general approach taken to the management of HR and IR issues by Queensland Health and highlight the frustration felt by the QNU about inconsistencies, lack of standardised process and the "can't do" approach to nursing matters.

Issues relating to the arrangements for the Mater require further attention. There needs to be consistency of approach with regard to that service as well given that the Queensland government totally funds the public service. This goes beyond HR and IR arrangements to fundamental accountability issues such as the need to make Mater Public Health Services subject to Freedom of Information (FOI) and other public sector legislative arrangements. This will not doubt involve complex negotiations between government and the Mater Health Services but the issues at stake are relevant to this review and therefore must be given due consideration.

Confusion also exists about the relationship between the Queensland Health organisational chart (and responsibilities and reporting relationships therein) and that of the Shared Service Initiative (SSI) Provider. There still remains duplication of effort and uncertainty about who handles what types of issues, especially from the perspective of a key stakeholder such as a union.

There is also significant concern about the implementation of functions within the SSI. An example of this is using call centre arrangements for handling unexpected nursing staff leave replacement. The role that nurse managers have traditionally played in this area cannot and should not be replaced by a remote call centre arrangement—it is unfair for the nursing staff being contacted to be "cold called", it is unfair for call centre staff to have to handle an often complex negotiation using a standard script. Such negotiations with casual/pool staff cannot be adequately covered in a standard script—they are complex and require specific knowledge. This includes knowledge of patient conditions and clinical care required as well as knowledge of the skills and personal circumstances (eg family responsibilities) of the nurses being contacted. It certainly does make sense to rationalise support services such as those contained in the SSP but it is nonsensical to do so without a consistently applied organisational policy framework, especially in relation to HR and IR issues. Just why this new structure stopped short of bringing about meaningful reform through establishing such consistency is a mystery to the QNU.

The need for appropriate devolution of authority and accountability within a consistent policy framework. Adequate accountability mechanisms must be in place to ensure achievement of clear, agreed and achievable objectives. This must occur within a consistent policy framework and be underpinned by the provision of adequate training for relevant staff. Currently there is no openness regarding the requirements contained in contracts for District Managers and other Senior Executive staff nor generally is there knowledge of the details of service level contracts entered into by HSDs. Yet it is the case that budgetary and other devolved authority flow from this. How can congruency be ensured if this information is not known?

Some years ago (under the first enterprise bargaining agreement with Queensland Health) this information was made available at consultative forums at the local and central office levels and used to develop strategies to match supply with demand for services. (There was examination of long standing areas of budget blow out, for example in areas such as medical officer overtime payments and restrictive or inefficient work practices.) This was part and parcel of a new "best practice" approach to health service delivery – an approach that was underpinned

by a genuine partnership with staff and their representatives, the health unions. Authority was to be devolved as far as appropriate and (then) PSMC standards ensure a consistent public sector standard of operation based on principles of merit and equity.

These standards helped greatly to ensure consistency of approach and were especially important in ensuring fair and equitable processes, particularly in relation to recruitment and selection, fair treatment, performance planning and review, training and development and management of diminished performance. A number of significant problems with the current unfavourable culture within Queensland Health can be traced back to the demise of the PSMC standards. It is our strong view that the current policies and processes relating to these issues be reviewed as a matter of urgency and that improved human resources policies be implemented to ensure consistent and fair treatment for all employees of Queensland Health and address concerns relating to nepotism and favouritism that are currently levelled against Queensland Health.

It is recommended that:

RECOMMENDATION (Review and improvement to policies and processes relating to public sector management)

There be an urgent review of human resource policies and processes within Queensland Health and that these are improved to ensure the consistent application of fair and equitable processes, especially in relation to recruitment and selection processes, performance planning and review, training and development, management of diminished performance and fair treatment of employees.

It has been our experience that insufficient authority is devolved (within an established policy framework) to decision makers on HR and IR issues within Queensland Health. For example, it is often the case that consultative forums at the central office and HSD levels do not have sufficient authority to adequately deal with matters that should be uncontroversial (e.g. compliance with government policy) and therefore significant time and energy is wasted deferring matters until further advice or an organisational position is obtained. This inefficiency could in large part be addressed through the adoption of a standardised policy framework for HR/IR matters.

Many of the public sector reforms that arose from the Fitzgerald Inquiry have been slowly eroded over time and this slippage in regards to accountability mechanisms must be addressed if the necessary cultural change is to occur and be sustained in Queensland Health. There is not currently a culture of giving frank and fearless advice within the agency. (A culture of bullying and intimidation discourages this, to say the least). Although key selection criteria (KSC) for positions may on the surface appear appropriate, just how adequately is performance against these criteria measured (especially for those in management positions)? For example, it is standard practice that most position descriptions for Queensland Health jobs contain a KSC (usually the last one) on contemporary HR practice. For management positions this usually reads something like: *Demonstrated ability to manage staff in line with contemporary human resource management policies, procedures and practices including anti-discrimination, ethical behaviour and occupational health and safety.* For non supervisory positions the KSC may read: *Demonstrated ability to participate in a working environment supporting quality human resource management practices including employment equity, anti-discrimination, occupational health and safety, and ethical behaviour.*

The QNU firmly believes that these KSCs need to be strengthened (especially for managerial and supervisory positions) and also reprioritised so they become one of the primary essential selection criteria rather than an afterthought that languishes at the end of a position description that applicants pay lip service to

in their application and at interview. For example, the KSC could be reworded along the following lines: *Demonstrated ability to identify, promote, and maintain a working environment free from all forms of discrimination, sexual harassment and workplace harassment (workplace bullying).* But it is insufficient to merely reword and re-prioritise KSC—there also needs to be annual review of performance against such criteria in performance and development reviews. The objective would be to break down the unhealthy culture in Queensland Health and it would follow that if failure to meet this criteria is demonstrated then corrective action is taken. There is of course a current problem related to incumbency—just how do we break down the existing culture when it is already established? The culture perpetuates itself as those on selection panels recruit "like" personalities into subordinate promotional positions.

The provision of adequate resourcing to ensure compliance with legislative requirements that promote a safe working environment. There are a number of areas of activity within Queensland Health that contributs greatly towards the creation and maintenance of sa afe work environment and supportive culture for staff that need close examination. Legislative requirements relating to workplace health and safety (WH and S) and equal employment opportunity (EEO, also known as employment equity) are particular examples. Some years ago these activity areas were promoted quite heavily within Queensland Health and provided with specific resources at corporate office and local facility/district level. A decision was made in 1996 to mainstream these functions within HRM processes for the department, with resources being cut accordingly. The QNU protested these cuts at the time, pointing out to the then Director General how important these areas were to promoting a safe and supportive work environment for Queensland Health employees and thus creating a positive workplace culture. The response from the agency was that these functions would remain mainstreamed but we should rest assured that responsibility for these two areas of activity would be specifically included in the performance contracts for all senior executives including District Managers. (We could never confirm their inclusion in such contracts as they are not made public and are therefore not able to be held up to scrutiny or open monitoring.)

EEO has fared worse than health and safety with regard to resourcing cuts in recent years and has largely stayed on the organisational agenda through the commitment of a small number of HRM staff who have a personal commitment to EEO. It is obvious to the QNU that decision makers within the agency see these areas of activity as "non core" or "soft" functions whereas QNU holds quite the contrary view.

RECOMMENDATION (Workplace health and safety and employment equity considerations)

It is recommended that:

Close consideration be given to the prominence of and resourcing for Workplace Health and Safety and Equal Employment Opportunity initiatives when implementing the required cultural change within Queensland Health.

Ensuring consistent and appropriate remuneration and reward is provided commensurate with the level of responsibility. The QNU firmly believes that inconsistencies exist in relation to the appropriate valuing of work of Queensland Health staff - for example, an examination of the level of responsibility devolved to nurses in management positions at Nursing Officer (NO) Levels 3-4 compared to their counterparts in other streams (such as Professional Officer and Administration Officer streams). The lack of recognition of nurses with management and leadership qualifications in Queensland Health's interpretation of the award's qualifications allowance provisions has also demonstrated that Queensland Health does not value the management and leadership skills demonstrated by these nurses. (Such skills

will be essential if we are serious about achieving the required cultural change in Queensland Health and yet qualifications in these areas are not recognised and appropriately rewarded by Queensland Health. Please see our submission to Queensland Health on the qualifications allowance previously provided to this review for further information on this fundamental lack of valuing on the part of Queensland Health.) There has also been a longstanding anomaly, for example, between nurses in team leader positions within mental health areas compared to Professional Officers in the same area. Nurses must relinquish their nursing classification to take up a team leader position. Also, an anomaly exists between these team leader classification and the Clinical Nurse Consultant and Nurse Unit Manager Classifications in the nursing stream. The QNU recommends that there be an urgent review of the methodologies used to assess work value within Queensland Health to ensure consistency between occupational streams. This is required to ensure that there is equity and devolved responsibility is consistently rewarded.

It is recommended that:

RECOMMENDATION (Measuring of work value and establishing consistency of recognition)

An urgent review of the methodologies used to assess work value be conducted within Queensland Health to ensure consistency between occupational streams and appropriate recognition of the skills and qualifications required.

Whether the layers that currently exist add value and how should this be evaluated. The QNU has been concerned for some time now about the proliferation of positions especially middle to senior level Administration Officer (AO) positions, within Queensland Health, especially those within Corporate Office including those "hidden" Corporate Office positions that are attached to HSDs. This is not an exercise of AO bashing by QNU, far from it. We recognise and value the contribution that administrative staff make to the functioning of Queensland Health. Indeed we frequently argue for additional administrative support in clinical areas. Rather we question whether the volume of positions is needed at such high levels and ask what assessment is made of whether these positions add value to clinical operations. It is extremely difficult to make an assessment of actual numbers as Queensland Health refuses to release such information to us. (When asked they say that such information is not available only later to see data released in other forums.)

Reports of the proliferation of positions at Corporate Office level is of particular concern to the QNU. We have been advised recently of the creation of seventeen AO7 positions within the Workplace Innovation area within Corporate Office (though attached to the Royal Brisbane and Women's HSD). We cannot state whether this represents value adding or not. Nor can we make an assessment of whether these positions are part of a wider proliferation of non-clinical positions within the agency as we cannot get an accurate current picture of the workforce of Queensland Health. With respect to these seventeen positions in particular we do question why these are AO positions given that we are advised that their focus is on innovative clinical practice. Why cannot nursing (or other clinical positions) rather than AO positions be created with remuneration being equivalent to the AO7 level of remuneration if it has been determined that is the appropriate level of pay? We know of nurses who have applied for these positions and if successful they will be forced to relinquish their nursing position and put at risk their ongoing registration with the Queensland Nursing Council because of this change. If the job has been assessed as being worth AO7 equivalent remuneration that is what should be paid, but surely the applicants should not be forced to move outside their clinical stream to take up the role.

An examination of staffing numbers by occupational groups within Corporate Office starkly highlights a disconnect between clinical and administrative

functions and resourcing within the agency. For example, an assessment of a "head count" of positions (not full time equivalent (FTE) positions) within Corporate Office of Queensland Health[22] stated that there are a total of 1301 staff attached to Corporate Office. The breakdown of this "head count" is as follows: Administrative 928, Professional 191, Technical 112, Operational 42, Medical 22 and Nursing 6. Although nursing staff constitute over 40% of Queensland Health staff how can it be that only 0.46% of corporate office staff (by head count) are nurses? A response to that may be that there are nurses in AO positions but we ask why is this the case? Why are nurses converting to AO (or PO) positions if there is appropriate valuing of nursing skills and this is recognised through sufficient promotional positions being available through equitable career structures?

As stated elsewhere in this submission, the lack of data of this nature is a source of considerable frustration to the QNU. Before we can make an assessment of whether any positions are actually needed to support the delivery of clinical services we must start by establishing a reliable mechanism for the open and ongoing analysis of staffing numbers and employment arrangements (permanent employment versus temporary or casual engagement) within Queensland Health. When a major Queensland public sector entity cannot state with any certainty how many staff they employ this should cause significant embarrassment to government as it represents a fundamental lack of accountability to the taxpayer of Queensland. The QNU highlighted this issue in our recent budget submission to the Queensland government and we will rephrase the recommendation contained in that document again here:

RECOMMENDATION (HR reporting systems)

It is recommended that:

As a matter of urgency specific tied funding be allocated to Queensland Health to enable the agency to implement an appropriate standardised HR information reporting system and that the agency be closely monitored to ensure timely and appropriate implementation of this system. Such a system will facilitate the provision of accurate data to better match supply and demand of services, adhere to enforceable award provisions such as those relating to nursing workload management, undertake accurate costings for budgetary and enterprise bargaining negotiations processes and facilitate agency compliance with legislative and policy requirements (e.g. Equal Employment Opportunity reporting and achievement of target group employment targets).

As we have stated previously, there are significant cultural problems that impact upon decision making within Queensland Health. Queensland Health's dysfunctional culture is further entrenched by a "can't do" attitude and lack of appropriately functioning structures. Our experience in the last decade or so is that we have had to fight every step of the way to even achieve the lawful entitlements of our members. This may be due to a number of factors – that nurses are a large occupational group and granting benefits to them will therefore "cost" government or that just saying no is a successful stonewalling tactic (and survival technique) developed to cope with the many unreasonable demands being placed upon the bureaucrats who manage an under resourced system.

It is a significant source of frustration to the QNU and other health unions that the automatic response from Queensland Health with regard to HR and IR issues is to find as many different ways as possible to say "no". The default policy position appears to act from a position to refuse all requests/demands. The alternative rational approach of assessing the merits of each case and seeing if the issue can be acceded to or not is rarely used. The assumption seems to be

22 Provided to the QNU on 8 June 2005 as part of a report on staff who have undertaken Workplace Harassment training.

that there is far less work involved in saying "no" from the outset, despite the consequences of adopting such a position. This is not to say that there are not individuals working within the system who operate from a positive problem solving approach where merit and equity underpin their decision making. There are such individuals (and there have been many past employees of the agency who attempted to operate from such a position) – but they are working against the odds in a crisis ridden system and dominant culture lacking a consistent organisational policy framework.

Team relationships suffer from a widespread culture of bullying and intimidation. Staff members are advised publicly that "you are either with us or against us – if you are against us you can leave". Reasonable critical analysis and debate is stifled. Staff are advised routinely that they should not advise or consult their union about concerns they may have, a strategy aimed at decreasing legitimate external scrutiny of the agency. The level of bullying and intimidation that occurs in this agency is unparalleled in any other Queensland government agency – confirmed by the findings of the *Queensland Government Bullying Taskforce* (2002). There is something seriously wrong with the culture of this agency. There is a significant disconnect between stated and actual values and this results in significant additional stress for employees. If an overall objective of this review is to focus on improving health outcomes of Queenslanders then this must surely include paying particular attention to improving the health of Queensland Health employees.

In our view bringing about necessary cultural change within Queensland Health is a prerequisite to the success of any other reform that takes place within the agency. A new culture must be built based on mutual trust, respect, valuing and inclusiveness. The building of a genuine partnership is required for the successful functioning of a human services agency such as health. This must involve the legitimate representatives of the workers within the system, the QNU and other health unions.

We wish to make one final comment about the structure of the agency. The QNU was concerned to hear that one recent proposal by the Premier to address this issue was to divide the agency in two departments – a Hospitals Departments and a Department of Primary Care and Health Service Integration. Although on the surface it may appear to be an attractive proposition to create two more manageably sized organisations we are fundamentally concerned that such a split would serve to further undermine continuity of care through the creation of two separate "silos". In our view it could be potentially much more difficult to achieve better integration of services in such a structure. It is acknowledged that the current structure of the agency is problematic and also very importantly that primary and preventative care are still the "poor cousins" to the hospital sector within the current system design and budget allocation. However we do not believe that these issues are best addressed by splitting the agency in the manner that has been flagged by the Premier. In our view the priority areas for attention in the structure of the agency relate to its entrenched culture and the lack of a standardised policy framework and approach (especially in relation to human resource and industrial relations matters).

Corporate planning and budgeting systems

The QNU's comments on corporate planning and budgetary systems are constrained by our lack of access to meaningful data and lack of input into genuine consultative processes. In the past, during the brief window of opportunity of the first enterprise bargaining (EB) Agreement with Queensland Health there was indeed the potential for a new era of partnership via a best practice approach that

would underpin the planning and delivery of health services within the budget provided. This approach was not sustained and the agency, its employees, the government and health unions have been paying the price for this failure ever since. The cost has been significant—ten years have been lost and significant damage to relationships and trust has been done as well.

There is an urgent need for far greater openness and transparency and this must be underpinned by a genuine commitment for this to occur from government. Insufficient information is made public at present for an assessment to be made of the adequacy or appropriateness of current planning and budgetary systems. For example, currently the only information that is known about the 2005-2006 Queensland Budget is that provided in the budget papers. The Ministerial portfolio statement for health does not "drill down" adequately to the local or programme areas for us to make an adequate assessment of to what extent the issues raised in our budget submission to government have been addressed. For many years now there has not been a budget briefing provided at the agency level that would facilitate a proper analysis. (The QNU attends the pre budget briefing provided on a whole of government basis on budget day but this is a "higher level" briefing and does not get down to agency specifics.)

A primary concern of the QNU is what is publicly acknowledged and valued in budgetary compliance and achieving set activity/efficiency targets (for example elective surgery waiting lists or decreasing length of stay). As effectiveness indicators are often more difficult to quantify they fail to adequately factor in what us measured. This was perhaps most bluntly demonstrated in recent times by the removal of the entire Executive of the Toowoomba HSD on the grounds of failing to stay within budget. This must be changed if we are to bring about necessary cultural change and rebuild staff and community confidence in the system.

The only way forward as we see it is to attempt to restart the "best practice" approach of the first EB and to have this underpinned by a new empowered consultative framework. (Two documents outlining the approach taken during EB 1 are attached for your information at Attachment 3: *Best Practice and Organisational Change* and *Measuring Productivity in Health Care*.)

In our view there is the need to establish an oversight mechanism in at least the short to medium term and this should occur at the level of Department of Premier and Cabinet. The Premier, Treasurer, Health Minister and the Minister for Industrial Relations (or their representatives if they are empowered with the necessary authority) should participate in this oversight committee as well as all key stakeholders including heath unions. (Indeed there is merit we believe in this mechanism being established on a permanent basis given the challenges confronting this portfolio not only with respect to cultural changes but also external challenges going forward for health with respect to demographic challenges and population growth in Queensland.)

This would create a mechanism to provide the impetus for change and to ensure that the required changes are indeed occurring. It would provide the primary vehicle for raising issues of concern—the days of one on one meetings and dealing with the issues of one group without input from or knowledge of others must cease. This is not to say that there needs to be mechanisms to address issues that may only affect one particular group but rather that in future this must occur within an open and transparent framework. In our view this body should meet quarterly or more frequently as determined appropriate/necessary.

At the agency (Queensland Health) level there is a need to restructure the consultative mechanisms at central office and HSD/local level to ensure these

arrangements must be adequately empowered to drive corporate planning and budgetary processes. This will need to be the subject of further detailed discussion between the parties in the lead up to the next round of enterprise bargaining.

RECOMMENDATION (Establishing a new framework for consultative arrangements with unions)

It is recommended that:

Consultative arrangements for the health portfolio be reviewed and amended as required and that an oversight mechanism be established under the auspices of the Department of Premier and Cabinet that involves all relevant agencies and key stakeholders including health unions.

Cost effectiveness of services compared to relevant jurisdictions

The QNU believes there is no doubt that overall Queensland Health's services are the most cost efficient in Australia. However cost efficiency does not equate to cost effectiveness. The emphasis within Queensland has been unduly on cost containment, so much so that factors such as wages cost and staffing numbers have been kept at unsustainably low levels. This has been at a cost to the quality of health services provided.

Previously in this submission we have highlighted the comparative efficiency of Queensland Health. Queensland spends the lowest amount per capita on public hospital in Australia. (Recurrent expenditure per person for public hospitals (including psychiatric hospitals in 2001-2002 dollars for 2002-2003 in Queensland was $711.80 compared to a national average of $895.2.[23])

This assessment is based on data contained in the annual *Report on Government Services*. The 2005 edition of this report "drills down" to uncover the sources of comparative efficiency by looking at data pertaining to recurrent costs per casemix adjusted separation for public hospitals. The information below is an extract from Table 9A.4, with Queensland and Australian average data only extracted.

Recurrent cost per Casemix adjusted separation, selected public hospitals 2002-2003[24]

Non-medical labour costs per casemix adjusted separation		
	Qld	Aust. Average
Nursing	$ 772	$838
Diagnostic/allied health	$186	$237
Administrative	$199	$235
Other staff	$255	$196
Superannuation	$175	$178
Total non-medical labour costs	$1587	$1683

23 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005,Table 9A.25*, Canberra.

24 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005, Table 9.A.4*, Canberra.

Other recurrent costs per casemix-adjusted separation

Domestic services	$84	$85
Repairs/maintenance	$59	$74
Medical supplies	$299	$265
Drug supplies	$167	$164
Food supplies	$23	$36
Administration	$155	$171
Other	$26	$104
Total other recurrent costs	$814	$899
Total excluding medical labour costs	$2400	$2582

Medical labour costs per casemix-adjusted separation

Public Patients Salaried/sessional staff	$374	$391
VMO payments	$65	$119
Private patients (estimated)	$46	$90
Total medical labour costs	$485	$601
Total recurrent cost per casemix-adjusted separation	**$2885**	**$3184**

An examination of the number of full time equivalent staff per 1000 persons in this report also identifies that staffing numbers in Queensland are lower than the Australian average for every occupational group bar one (Domestic and other staff).

Extract from Table 9A.7 Average Full Time Equivalent (FTE) staff per 1000 persons, public hospitals (including psychiatric hospitals) 2002-2003[25]

Category of Staff	Qld	Aust Average
Salaried Medical Officers	0.9	1.0
Nurses (all registered and enrolled)	3.9	4.3*
Other personal care staff	0.2	0.1
Diagnostic and Allied Health	0.9	1.4
Administrative and Clerical	1.2	1.6
Domestic and other	1.7	1.5
TOTAL	**8.7**	**9.8**

(Totals do not add up - reproduced as presented in table)

*In Victoria where there is a mandated 1 to 4 nurse/patient ratio in all major public hospitals the number of nurses per 1,000 population is 4.5. This is a significant difference. Resident population for 2003-2003 financial year (i.e. as at 30 June) was 3764000 for Qld and 4894000 for Vic. And the number of nurses employed in Queensland public hospitals can therefore be calculated as 3764 x 3.9 for Qld = 14679.6 FTE and 4894 x 4.5 for Vic = 22023 FTE. To bring Queensland public hospitals to the nurse staffing levels provided in Victorian public hospitals would require an additional 2258.4 FTE and to bring Queensland to the national average in terms of nursing staffing an additional 1505.6 FTE positions would be required. Note, NSW data was not provided for 2002/2003, but according to data provided for 2001/2002 there were 4.5 nurses employed in public hospitals per 1000 population in NSW in that year.

25 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2005, Table 9.A.7*, Canberra.

It is essential that the significant deficiency in nursing numbers employed by Queensland Health across all settings be addressed as a matter of urgency to enhance the quality of services provided within the agency and stem the wastage of nurses from the system. Although data that highlights the magnitude of the nursing staffing deficiency in Queensland Health is only available for public hospitals, it is our strong view that similar deficiencies exist across all practice settings, most notably in community health and other non acute care settings. There has been a failure on the part of Queensland Health to devise an appropriate tool for workload management that can be applied in non acute settings such as community health. (This issue will be addressed later in the submission in the section dealing with nursing workload matters.) For some years now there has been an agreed model for establishing nursing staffing numbers (Minimum Care Hours Model) in State Government Nursing Homes and we assume that this is still being appropriately implemented. This does only represent a minimum standard however and we strongly believe that as part of an examination of nursing staffing numbers for the whole of Queensland Health an assessment be made of the Minimum Care Hours Model to ensure adequacy of nursing staffing numbers in that setting.

RECOMMENDATION (Increasing nursing numbers in Queensland Health)

It is recommended that:

As a matter of urgency there be an increase in Full time equivalent registered and enrolled nursing numbers to bring nursing staffing numbers across all settings in Queensland Health up to the national average as an interim measure and then to levels employed in Victoria and New South Wales. For public hospitals alone this equates to an additional 1505.6 FTE registered and enrolled nursing positions to bring Queensland public hospital staffing levels up to the national average. (An additional 2258.4 FTE positions would be required to bring Queensland public hospital nurse staffing levels up to Victorian and New South Wales numbers.)

So in terms of both labour costs and labour numbers Queensland Health costs are much lower than other jurisdictions. These lower staffing cost and numbers are all the more astounding given that additional costs are incurred because of the decentralised nature of Queensland as minimum staffing numbers are required to provide such services in rural and remote Queensland. It is Queensland Health's employees that are subsidising the operation of the system through lower wages and higher workloads. It is our strong view that this is not only inequitable, it is unsustainable and must be addressed as a matter of urgency. This is especially the case when significant shortages exist in nursing and other categories of health workers and attachment to the workforce of those remaining in the system is diminishing because of the increasing incidence of part time work. It is our strong view that one significant strategy of those remaining in the system in coping with unmanageable workloads and the unsatisfactory work environment is by decreasing working hours.

RECOMMENDATION (Improving pay and working conditions for nurses and other employees)

It is recommended that:

Urgent action is taken to significantly improve the pay and working conditions (most notably workloads) of Queensland Health employees.

As we have stated previously in this submission, insufficient attention has been paid to date to the development of appropriate indicators of effectiveness given the undue emphasis paid to the development of efficiency indicators in health. Some effectiveness indicators that do exist (for example, accreditation of health facilities or services) are deficient in some significant aspects and require urgent review and improvement. The QNU believes that particular attention must be paid to the development of more relevant indicators of effectiveness and that much more work is required in this area. This area alone requires significant resources and careful thought and a nationally consistent approach is required.

The impetus for further national reform in health care as promoted by the Australian Health Care Reform Alliance may provide an important opportunity for progress. (QNU is represented on this Alliance by our national union the Australian Nursing Federation.) For example, we believe there is no reason why there cannot be an extension of the methodology utilised to assess cost effectiveness and efficacy of drugs in the Pharmaceutical Benefits Scheme process can not be extended to analyse cost effectiveness and efficacy of other forms of health treatment (such as surgical procedures). In the absence of such a comprehensive and consistently applied approach it is difficult to make an assessment of comparative effectiveness. Yes, assessments can be performed with regard to health outcomes for the population (and the *Report on Government Services* and other reports provide significant data on this) but without a holistic approach that involves examination of the appropriateness of health services provided, it is difficult to fully measure cost or clinical effectiveness or educate the community on such issues in order to engage them in a debate about health service prioritisation.

Effectiveness of performance reporting and monitoring systems

As we have already indicated, we have serious doubts about the effectiveness of current performance reporting and monitoring systems within Queensland Health. This arises from our direct experience of the standard of information that has been provided to us, the difficulty that we constantly experience gaining access to meaningful and timely data from Queensland Health and the over emphasis placed on data that measures efficiency rather than effectiveness.

The adequate measurement of effectiveness is a critically important issue for health unions. The QNU and its members continue to be extremely concerned and frustrated by the way in which we are forced to "do business" with Queensland Health. Lack of access to meaningful and timely information prevents us from participating in a genuine partnership with government to improve the health of Queenslanders. This is a major source of frustration as is an overly bureaucratised "can't do" ethos that pervades the agency. A new approach is required if we are to properly address critically important issues such as nursing skills shortages and improving access to high quality, appropriate and sustainable health services. It is going to become even more critical that we find creative ways to address these challenges given the demographic issues confronting Queensland.

A new paradigm is also required in health given the nature of the work performed and the failings to date of our current systems to appropriately bring together the industrial relations and clinical/quality imperatives at play.

It is especially important that we find mechanisms to adequately capture the contribution made by nurses and other health workers to the effectiveness and quality of health service delivery. With the abandonment of a best practice approach within the enterprise bargaining framework the "quality" agenda within Queensland Health was retained under the guise of its Quality Improvement and Enhancement Program (QIEP) and more recently its Integrating Strategy and Performance (ISAP) Program as well as other programs such as the Clinician Development Program. Effectively this agenda has been taken out of the industrial arena and situated in the "quality" area of the agency. This has significant ramifications for nurses and other "knowledge workers".

It is our firm view that their contribution to the improvement of health services in Queensland Health has not be adequately captured and hence nurses have not been sufficiently rewarded for this contribution. One interpretation of this

change in approach is that this has certainly assisted in the containment of costs and hence sustaining of Queensland's comparatively low spending on public health services.

There has been a multiplicity of agendas and mechanisms within health that in part impinge upon or attempt to amend the work of nurses but there has been a failure to adequately link or consolidate these avenues. For example, we have been heavily involved in recent years in the Ministerial Nursing Recruitment and Retention Taskforce and the implementation of strategies arising from that process. The inter-relationship between this process and established industrial relations consultative processes and the quality improvement agenda have been at times difficult to reconcile because of Queensland Health's reluctance to see the links between the agendas . Indeed parallel processes have in fact been operating and it has not yet been possible to capture everything under one umbrella. The QNU believes that a significant opportunity to integrate approaches was missed when Queensland Health decided to move away from the "best practice" framework that was identified under the first enterprise bargaining agreement. The result has been a lack of integration, piecemeal approaches, duplication of effort, frustration with flawed processes, loss of trust (resulting in damaged relationships) and frustration with lack of progress by all parties. A fresh approach is required prior to embarking on our next round of EB negotiations.

It is recommended that:

RECOMMENDATION (Adoption of new approach to deal with nursing issues)

Prior to the commencement of the next round of enterprise bargaining with Queensland Health government enter into discussions with QNU regarding the adoption of a new holistic approach to nursing workforce and industrial relations issues.

Organisation and delivery of clinical support services

Comment has been made earlier in this submission about the provision of support services to clinical areas, especially with regard to the perception that there has been a proliferation of administrative positions in recent years (in particular those situated in or attached to corporate office). An analysis of Queensland Health's *Finance and Activity Statements* for Public Hospitals, Residential and Related Facilities was conducted as part of the QNU's preparation for the arbitration for EB5. Analysis of data for the period 1991/92 to 1999/2000 shows that employment of staff by Queensland Health in total grew by 9.8% during that period. However, when you look at employment numbers by categories of staff this data indicates that during this period nursing numbers decreased by 0.4%, salaried medical officer numbers increased by 67.8% and administrative staff numbers increased by 59.1%. We do not have access to data beyond 1999/2000 to enable us to extend this comparison to the present time but believe such analysis is essential. Although we have significant reservations about the accuracy of Queensland Health's employment data limited information is available to us upon which to make a judgement.

There is also a critical need for an agency wide analysis of existing gaps in support services. For example, members of the QNU in some areas of Queensland Health complain about inadequate administrative support at the clinical unit level that results in nurses being diverted from clinical duties to undertake administrative work. When this issue is raised with local management the response is often that such support can be provided if it comes out of nursing staffing numbers – that is, nursing numbers have to decrease to provide this support. Nurses are usually reluctant to agree to this given their workload pressures – they cannot afford to

give up needed human resources required for clinical service delivery. There have been similar disagreements over the years with regard to operational staff support, but this usually relates to role boundaries and task demarcations. (We are able to provide numerous examples of role boundary and task demarcations that require further attention. For example, there has been a longstanding problem at Royal Brisbane and Women's HSD about some wards persons refusing to "tie off" linen bags prior to removal from the ward area.)

Given the issues about workforce needs and skill mix outlined in documents such as the Queensland Health strategic plan and *Health 2020* policy documents it is imperative that we have sound data upon which to plan for the future needs of Queensland Health. This must include an ongoing evaluation of the appropriateness of skill mix and numbers to support clinical service delivery.

RECOMMENDATION (Analysis of staffing numbers by occupational group)

It is recommended that:

There is an urgent analysis of Queensland Health's staffing numbers by occupational group, including a comparative analysis of HSD and corporate office numbers. This must also include a gap analysis of areas of need with respect to support provided in clinical services.

Risk management systems

The QNU does not have concerns about the resource materials that we have sighted regarding Queensland Health's Integrated Risk Management Policy. From what we have seen the written documentation appears consistent with Australian and New Zealand Standards on Risk Management.

We are however most concerned about the application of the policy and the level of organisational commitment to the proper implementation of this policy. Despite the fact that the approach aims to achieve good practice with regard to the management of risk it is not surprising to the QNU that staff would view this framework as another management fad (and a complex and lengthy one at that). It can be viewed as management attempting to "force downwards" another responsibility for staff in the absence of a genuine commitment "from above" to resource the process or act on deficiencies in a timely and meaningful way when problems are identified. You need to look no further than the spectacular risk management failures currently being identified through the Bundaberg Hospital Commission of Inquiry to see that there are problems with the implementation of this framework.

Particular issues of concern relating to the implementation of Queensland Health's risk management framework include:

- The complexity of the risk management environment within Queensland Health and the need to make this more "manageable" for staff (and hence "owned" by them) and avoid unnecessary duplication of effort. There needs to be truly one integrated program for quality and risk management – they must not be seen as separate from each other;
- There must be a truly integrated approach to risk management that addresses risks for both patients and staff who work in the system. For example, security and workplace health and safety risks are not captured adequately under the current framework. It is our understanding that clinical systems risks are captured in PRIME and then fed into the Enterprise System. This is funded and managed by Queensland Health and it is compulsory for staff to utilise the system. On the other hand security and workplace health and safety risks (while reported via the IMS system) are then not captured in the Enterprise System. Therefore proper data is not available for review. This means that

serious incidents that affect staff are not being captured and addressed appropriately, resulting in a serious deficiency in the risk management framework. For example, the very recent death of a nurse following an assault by a patient at the Gold Coast Hospital was not reported to Corporate Office of Queensland Health as this is not required under the current system because it involved only one death. This is an extremely serious deficiency that must be addressed as a matter of urgency. As it stands now Queensland Health is failing to meet Australian Standards. The current double standard also sends a clear message that the safety of patients has a higher value to Queensland Health than the safety of their staff;

- The need for significant cultural change within Queensland Health to facilitate the establishment of a culture of risk management. The need for cultural change is paramount given that quality and risk management are primarily workforce activities. Management must demonstrate their support for genuine staff participation in such processes through the provision of sufficient time and resources;

- The need for more resources to be provided for risk management (e.g. the appointment of additional specialised senior staff dedicated to risk and quality, establishment of meaningful feedback mechanisms, provision of ongoing staff awareness and training etc);

- Management must demonstrate a clear commitment to acting promptly and appropriately to address risk for there to be staff confidence in and commitment to risk management;

- There needs to be a more sophisticated and diversified approach to the development of strategies to treat risk—at present there appears to be a tacit acceptance of many risks because alternative (and more appropriate) responses are either too costly or seen as being too complex to address. (Rather than this being a conscious/active decision to accept the risk it is often the case that risk can be accepted for want of making an active decision to do otherwise. In such instances the "doing nothing" option equates to risk acceptance);

- Improvements need to be made to existing policies and processes if there is to be faith in the risk management system. For example, a clear and unambiguous policy regarding staff complaints about clinical practice concerns must be implemented and adhered to. This must include the provision of adequate protections for "whistle blowing" staff;

- More support must be provided to the development of policies and procedures that facilitate the reporting of adverse clinical incidents so these can be quickly identified and addressed appropriately. The QNU is very concerned that recent events at Bundaberg Hospital do not hinder the genuine reform of the health system so that adverse events are appropriately dealt with through the adoption of a genuine "no blame" culture and proper patient/client empowerment;

- There needs to be a much clearer understanding of the responsibilities with respect to risk management, especially regarding accountability areas and the relationship between these areas within the agency;

- It is essential that robust systems be developed to assess compliance and whether those risk management strategies in place are actually resulting in the better management of risk.

To date Queensland Health's risk management policies are in large part viewed as window dressing—documents that look good on paper. They must be given effect if we are to rebuild public (and staff) confidence in Queensland's public health system.

RECOMMENDATION (Review of Queensland Health risk management framework)

It is recommended that:

There be a review of Queensland Health's risk management framework and that it is amended as necessary to ensure efficacy and staff confidence in it. In particular, there need to be urgent enhancements to the current risk management framework to ensure that all risks are appropriately identified, treated and monitored (eg security and health and safety risks to staff).

Quality and safety systems

There are a significant number of concerns that the QNU has regarding current quality and safety systems within Queensland Health, some of which have already been highlighted in this submission. In our view this area requires particular and careful attention by this review given that "Promoting a healthier Queensland" is the reason for Queensland Health's existence and quality and safety systems are central to achieving this objective.

The significant quality and safety systems failures identified in the Bundaberg Hospital Commission of Inquiry highlight significant problems that need to be addressed. There are fourteen separate programs within Queensland Health dedicated to improving the quality and safety of services: Clinical Audit, Clinical Information Systems, Clinical Pathways, Clinician Development, Credentials and Clinical Privileges, Collaborative for Healthcare Improvement, Infection Control, Informed Consent, Integrated Risk Management, Measured Quality, Measuring Quality in the Non-Government Health Sector, Pressure Ulcer Prevention and Wound Management, Queensland Health Medication Management Services and Telehealth. (The Bundaberg investigation is likely to identify issues of concern relating to ten or more of these program areas.) There are also specific projects operating at the Zonal, HSD and facility levels.

These safety and quality programs are essential—indeed we would argue for them to be extended. However, they all amount to nought if the culture and resources are not provided throughout the whole organisation to meet their stated objectives of these programmes. The primary focus of the system should be that of the provision of quality care for the "clients" of Queensland Health. To the QNU the issues that need to be urgently addressed to facilitate a genuine client focus and culture of continuous improvement include:

Cultural changes within the organisation: There is a need for openness and transparency within the agency and a culture that values critical analysis, not dissuades it. Health professionals should be encouraged to think and debate issues. Indeed it is their professional obligation to do so. Adequate human resources and systems at the clinical level must be provided if we are to move beyond a "tick the box" approach to quality and safety.

Provision of adequate human and other resources: Quality health services cannot be provided if there is insufficient staff at the clinical level to do so. Inadequate nursing numbers remains an ongoing serious concern for the QNU and its members.

The level of member concern about this issue is highlighted by the research undertaken by the University of Southern Queensland for the QNU in 2001 and 2004. Nurses are frustrated and angry because they cannot consistently provide a standard of care to their professional satisfaction.

Previous evidence provided in this submission highlights that nursing numbers in public hospitals alone would have to increase significantly to reach the national average or the numbers currently in place in Victoria and New South Wales.

Review of adequacy of current tools to assess quality: The QNU has held concerns for some time now about the adequacy of tools such as ACHS accreditation. In our view this tool does not adequately address issues such as workloads and appropriateness of skill mix for example. There is a requirement that a process is in place to monitor workloads but there is not an examination of the efficacy of such processes. Accreditation is held out to the public to be an indication of quality and we fear that this can be misleading and give a false sense of security. Bundaberg HSD is ACHS accredited.

Genuine teamwork that includes acknowledgement of the contributions made by various team members must be in place: It is crucial that an environment of valuing is established. The twenty first century health system must be based on a genuine model of team work. There is no place for medical dominance (or dominance by any other occupational group) of the system. This is not to say that the contribution of medical officers to the system is not important, but it should not be assumed that they, by pure virtue of their qualification, must always assume the leadership or top management role.

The recent offensive criticism by the AMA about nurses holding the position of District Manager and Head of the Division of Surgery at the Royal Brisbane and Women's HSD highlight the anachronistic attitudes that must be overcome. Just because someone holds a medical degree does not means that they have the necessary skills or aptitudes to hold a management position.

Although there is some commonality, different skill sets are required for clinical and administrative functions. This is not to ascribe a higher or lower value to either—just to acknowledge the difference and value the contribution that each makes. Central to this is the issue of the wielding of power within the system and the need for improved accountability —two significant issues that must be brought out into the open and tackled head on.

Quality and safety initiatives and improvements must be linked to industrial relations processes: As stated previously, the quality and safety enhancements achieved within Queensland Health must be captured for industrial relations purposes. As "knowledge" workers such outcomes are the fruits of the labours of health workers. We must re-establish the best practice approach to such matters that was briefly commenced in EB1. This is of course inextricably linked to improving openness, transparency and accountability mechanisms as well as establishing properly functioning and valued teams.

Processes must be better integrated within Queensland Health and there must be clarity about agendas and linkages: The QNU is concerned that there is no clarity going forward about where responsibility for quality and safety will lie. For example, how does this link in with ISAP (Integrating Strategy and Performance) initiatives arising from the *Smart State Health 2020* directions statement? The philosophy underpinning ISAP is supported but again it is not integrated with other areas of activity.

Health unions are not integrally involved in driving the strategy and it appears (from the outside) that it is being imposed from above rather than being built from below. (Resources are required at the grassroots level to drive genuine reform of the kind envisaged in ISAP.)

The importance of getting this issue back on track cannot be overstated—this is about ensuring sustainable, quality, patient centred health care into the future.

The *Smart State Health 2020* and the resultant current Queensland Health Strategic Plan were mismanaged from the outset and this has resulted in a lack of faith in these important documents by staff and health unions. You can have all the fine words in the world but they must be backed up with actions that are consistent with them.

Inconsistency in approach must be addressed: The inconsistency that exists regarding issues such as processes for the regulation of health professionals within Queensland has been a source of serious concern for the QNU for some time now. Differences between the way in which doctors and nurses are currently regulated in Queensland (the comparative processes/policies of the Medical Board of Queensland and Queensland Nursing Council) have been highlighted at the current Morris inquiry.

Another discrepancy that has recently come to our attention is inconsistency regarding processes to ensure compliance with legislation requiring mandatory criminal history checks for health professionals. We are advised that the Queensland Nursing Council (QNC) has introduced policies and procedures to give effect to this legislation but this has not occurred for other health professionals. Ensuring compliance with such fundamental legislative requirements that impact directly on safety and quality must be urgently addressed.

Existing regulatory mechanisms that underpin safety and quality must be strengthened: In our view there are currently significant systemic inadequacies in the overall regulation of health professionals that seriously impact upon the provision of safe and high quality health services. One such deficiency is the failure of the QNC to regulate so called "third level" nursing workers—those people who are providing nursing services but are currently not licensed to do so by the QNC. These workers may be employed as Assistants in Nursing or under other titles such as Personal Care Workers or Carers. These workers may or may not hold qualifications and they may or may not work under the direct or indirect supervision of a registered nurse. They are primarily employed in the aged care sector in Queensland but in recent years their numbers have been increasing in public and private hospitals and public and private community based services.

For many years now the QNU has argued that these workers must be regulated by the QNC—failure to do so provides a real opportunity for the undermining of standards of care. It has been our experience that substitution of licensed workers with unlicensed personnel has been increasing in recent years as a response to budgetary pressures and workforce shortages. This lack of appropriate regulation of all people who provide nursing services is a serious deficiency that must be addressed as a matter of urgency.

Quality and safety initiatives must regain prominence at the national level: It appears that the national agenda for safety and quality in health care has stalled in recent times. For example, the Safe Staffing Project of a few years ago conducted by the Australian Council for Safety and Quality in Health Care appears to have gone nowhere. A consultation paper was produced, organisations like the QNU made submissions and participated in local consultations and since that time have heard no more.

It appears to us that issues such as staffing levels are too politically contentious and therefore are placed in the too hard basket. Similarly the safety and quality movement nationally has to us at least, not appeared to have responded adequately to serious systems issues highlighted by the McArthur Health Service issues in NSW and now the Bundaberg Hospital Inquiry in Queensland. The QNU has always been a strong supporter of the work and objectives of the Australian Council for Safety and Quality in Health Care but now we fear that

confidence in their work could be being undermined by perceived inaction on vitally important issues.

RECOMMENDATION (Improving safety and quality)

It is recommended that:

This review makes specific recommendations aimed at improving safety and quality within Queensland Health. In particular, strategies must be implemented to:

- build a supportive culture within Queensland Health where critical analysis is encouraged;
- provide adequate human and physical resources to ensure that safe care can be delivered and quality can continually improve;
- review current tools used to assess quality and amended as necessary to ensure adequacy;
- encourage genuine teamwork and valuing of the skills and contribution of all team members;
- directly link safety and quality to the agency's industrial relations processes;
- better integrate the multitude of existing agenda that relate to safety and quality;
- address existing inconsistencies in approach with regards to the current regulatory policies and processes for health professionals;
- extend the current regulatory regime for health workers to ensure that all who are delivering health services are appropriately regulated;
- encourage better coordination and consistency between activities regarding safety and quality at the state and national level to ensure that this receives the appropriate level of priority.

Clinical audit and governance systems

The QNU does not claim to have detailed knowledge of Queensland Health's clinical audit and governance system. This arises in large part from the disconnect that has existed for some years now between industrial relations processes and the clinical activities of the agency. While we see these issues as inextricably linked, there has in large part been a failure by management in Queensland Health to acknowledge this.

These concerns have been dealt with in some depth in this submission. The main point that we wish to reiterate is that we cannot be expected to have a detailed position on such issues given that we have been effectively excluded from deliberations about these matters and denied access to meaningful information about them. We will however make some broad points about what we believe constitutes good governance and how this can be improved in Queensland Health.

It is the case that defining the principles of good governance is difficult and can be controversial. There are some models that appear to be almost universally accepted, one of these being principles espoused in the United Nations Development Program (UNDP "Governance and Sustainable Human Development, 1997"). The five principles of good governance contained in this document have been summarised is the table below.

Five Principles of Good Governance[26]

The five good governance principles	The UNDP text on which they are based
1. Legitimacy and Voice	**Participation** – all men and women should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their intention. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. **Consensus orientation** – good governance mediates differing interests to reach a broad consensus on what is in the best interest of the group and, where possible, on policies and procedures.
2 Direction	**Strategic vision** – leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded.
3 Performance	**Responsiveness** – institutions and processes try to serve all stakeholders. **Effectiveness and efficiency** – processes and institutions produce results that meet needs while making the best use of resources.
4. Accountability	**Accountability** – decision-makers in government, the private sector and civil society organizations are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organizations and whether the decision is internal or external. **Transparency** – transparency is built on the free flow of information. Processes, institutions and information are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.
5. Fairness	**Equity** – all men and women have opportunities to improve or maintain their wellbeing. **Rule of Law** – legal frameworks should be fair and enforced impartially, particularly the laws on human rights.

The QNU believes that Queensland Health falls short of exhibiting good governance with respect to each of the five areas detailed above. This is not to say that improvements in governance have not been made in the past 10-20 years, but rather that much more needs to be done.

The deficiencies with regard to governance arise primarily from problems with culture (discouraging critical analysis, debate and genuine input into decision making), lack of openness and transparency and lack of consistency of approach

26 Graham, J, Amos, B and Plumptre, T, *Principles for Good Governance in the 21st Century* Policy Brief No. 15. - Institute on Governance, Ottawa, Canada, page 4.

that relates in large part from the failure to establish one policy framework, especially in relation to management of the agency (e.g. the handling of HR and IR matters). We cannot see any way that this can be improved until there is one accountable employing entity established for the agency rather than the plethora of HSD decision makers that currently exist. Although we support the devolution of authority and the promotion of innovation at the local level this must occur within a consistent policy framework.

Our concerns outlined above in the section on quality and safety are also of relevance to the consideration of clinical governance matters. Queensland Health appears to have greater success at devising clinical protocols that should be consistently implemented (although the extent to which there is compliance with these is unknown by QNU) but the same cannot be said in relation to HR/IR matters. There are HR/IR policies that are devised at the corporate office level but these are subject to interpretation at the local level. There is no mechanism to ensure compliance.

Recently the QNU became aware that a "Board" has been established at Corporate Office level. It is our understanding this is a large board of over 20 members that reports directly to the senior management team in corporate office and therefore is a key influencer of policy and direction and would obviously fulfill an important governance function. (To our knowledge there is no nursing representation on this board.)

The QNU has not been formally advised (let alone consulted) of the function and terms of reference for this group. This is of concern to us as this is obviously a key group. The lack of consultation with the QNU on the establishment of such an important body highlights to us the extent to which our relationship with the agency has broken down. This is despite one of the strategic intents of the current Queensland Health strategic plan being to "build healthier partnerships", including partnerships with health unions. In recent times the QNU has made numerous requests to representatives of Queensland Health for a briefing on their new organisational structure and governance structures as we do not have a clear understanding of this. To date these requests have not been met.

It is appreciated that this systems review of Queensland Health may recommend changes to the structure and governance of Queensland Health. In any case, health unions will need to first be briefed and then consulted on any proposed structure (even if the structure remains unchanged). Given that we have not been able to secure such a briefing and consultation to date we request that this inquiry recommends that this occurs.

It is recommended that:

This inquiry recommends that health unions be at first briefed and then consulted about the organisational and governance structures in Queensland Health as soon as possible/practicable given that this review may recommend changes in these areas.

RECOMMENDATION (Appropriate consultation with health unions on proposed changes in Queensland Health)

Terms of Reference for this inquiry

To specifically review:

2. *Clinical workforce management systems to deliver high quality health services, with a particular focus on:*
   Recruitment
   Retention
   Training
   Clinical leadership and
   Measures to assist in improving the availability of clinicians

In recent years the QNU has been particularly active in campaigning on nursing recruitment and retention issues. Our campaign started in earnest with the production of a detailed submission *Issues of Concern to Nurses (1997)* prepared as a political lobbying document in the lead up to the 1998 Queensland election. It was through lobbying around this document that the QNU secured a commitment from the then Labor opposition to establish a Ministerial Nursing Recruitment and Retention Taskforce. This taskforce and its successor (the Peak Nursing Body) have improved coordination between various key stakeholders in nursing in Queensland and have facilitated the implementation of a variety of strategies that have in some ways improved the recruitment and retention of nurses in this state. However, it is our firm view that strategies implemented to date have been insufficient to adequately stem wastage from nursing from the health and aged care sectors in Queensland. More urgent attention is required.

Recruitment and retention activities have been greatly undermined by Queensland Health's continued insistence (until recent times) to deny the very existence of a nursing shortage in Queensland. This has been despite irrefutable independent evidence to the contrary. The significance of the impact of this denial cannot be overstated. The impact has been felt in a number of ways. Firstly, it has resulted in nurses and the QNU feeling as if they inhabit a parallel universe to Queensland Health. The department's stated position (that there is no nursing shortage because the Nursing Recruitment and Retention Taskforce had addressed all the issues and there was no need for further action) was diametrically opposed to the daily lived experience of nurses.

This has had a powerful demoralising effect and resulted in a fundamental breakdown in trust. How can you trust someone who constantly denies your reality, especially given the obvious reason for this is to contain costs as the shortage happened to coincide with a bargaining period for nurses? How can trust be rebuilt when the acrimony arising from this denial has been so sustained? The damage to the relationship with those nurses who remained in the system while their employer repeatedly denied that there was any problem will be hard to repair. Of course some have been lost from the system totally or have decreased their hours of work in order to cope with the work intensification arising from the refusal to address such an obvious problem. Many of those remaining in the system suffer from extreme cynicism. A response that the QNU has heard from many members about this inquiry is "why should we bother to have a say as nothing ever changes".

Nurses interpreted the subtext of the denial of the nursing shortage as being a denial of the contribution and worth of nurses. The other important consequence of this denial is that valuable time has been lost for the development and implementation of strategies to aid recruitment and retention. This will require additional resources to repair relationships and damage done by failing to acknowledge the very existence of the problem.

The impact of the failure to implement adequate strategies to improve nursing recruitment and retention of nurses across all sectors in Queensland is highlighted by the findings of the latest research on QNU members conducted by the University of Southern Queensland (USQ). The first USQ research project was conducted late in 2001. (The QNU has already provided you with a copy of the summary of findings from this research.) The latest research was conducted in October 2004 and the report from this research has only recently been finalised and will be launched at the QNU conference on 13 July 2005.

When we met with Mr Forster shortly after the announcement of his inquiry he advised us that he was keen to be provided with a copy of the research findings as soon as it is available. We are therefore providing this inquiry with a copy of the full report prior to its public release **on the proviso that it be treated in strict confidence and not provided to Queensland Health.** The full report of this research can be found at Attachment 4. The department is keen to receive a copy of the findings of this research and we wish to determine when this is provided to them. It certainly will not be provided to Queensland Health prior to it being presented to members at conference. We request the opportunity to meet with the inquiry separately to discuss the findings of this research and how it may be incorporated into this review.

RECOMMENDATION (Further consultation with QNU prior to finalisation of Systems Review)

It is recommended that:

The Queensland Health Systems Review team meets with representatives of the QNU as soon as possible to discuss the findings of the University of Southern Queensland research into QNU membership and other matters relating to our submission so that the issues highlighted and possible strategies to address them can be discussed prior to the finalisation of your report.

This research supports the QNU's contentions that serious problems exist that impact upon the recruitment and retention of nurses in Queensland Health. These problems include, but are not limited to the following:

- unsustainable workloads impact upon the ability of nurses to deliver quality individualised care;
- unsupportive and unsafe work environments (especially the current high levels of workplace violence) must be addressed as a matter of urgency;
- remuneration and conditions of employment must be improved and inequities addressed;
- deteriorating morale of nurses that contributes to wastage of nurses from the system;
- ensuring access to appropriate ongoing education and development for nurses.

Please refer to the attached research report for further details of the findings of this important research. The report includes an excellent literature review that provides a comprehensive summary of the issues affecting contemporary nursing and the recruitment and retention of nurses. It should be noted that the USQ research findings are supported by other independent Queensland research on nursing recruitment and retention conducted by Dr Gary Day from Queensland University of Technology (*The determinants of staff morale among registered nurses in a convenient sample of acute health care facilities*). We have a copy of Dr Day's research findings and would be happy to provide this to you should you experience difficulty accessing this.

It is obvious to us that the work environment of nurses must be fundamentally changed if we are to address nursing shortages by improving the recruitment and retention of nurses. Central to this is changing the existing culture of

Queensland Health, an issue that has already received considerable attention in this submission. It is of extreme concern to the QNU that it appears that Queensland Health continues to deny the root causes for the wastage of nurses from the system. For example, the recently released paper prepared by Queensland Health for the Morris Inquiry titled "Enhanced Clinical Roles" refers to unidentified "research" that indicated *"that nurses were leaving the profession due to a lack of opportunities to fully utilise skills, experience and knowledge gained through their university training."*[27] Some nurses may be leaving nursing for this reason, but our research indicates that the principal reason for nurse wastage is unsustainable workloads and nurses feeling unable to deliver high quality individualised patient care. Wastage of nurses will not be addressed until such time as this is acknowledged and addressed.

Likewise, talk of expanded roles for nurses is premature until deficiencies in the actual number of nurses employed by Queensland Health are first addressed. As we have demonstrated earlier in this submission, for Queensland public hospitals alone to reach the nursing FTE staffing numbers of Victoria and New South Wales it would require an additional 2258.4 FTE nurses and to reach the national average an additional 1505.6. FTE nurses must be employed. Genuine role expansion for nurses cannot occur until this is rectified.

Some of the specific issues highlighted above will be elaborated on in more detail later in the report. Firstly however, we wish to provide some background information on the Peak Nursing Body and specific strategies that can be progressed through that body to improve the recruitment and retention of nurses.

The QNU wishes to place on record our support for the continued operation of the Peak Nursing Body (PNB) and funding of those existing initiatives that have been implemented under its auspices. The issue of the relationship between the PNB and other consultative mechanisms (e.g. those associated with enterprise bargaining) need further close examination and should be the subject of further negotiations. This will certainly be required if Queensland Health proceeds down the path of interest based bargaining. Linkages to other (potential external) mechanisms will also be required if nurses are to play, as has been suggested recently by the Premier, a key role in the re-building of Queensland Health.

It is our strong view that although the Nursing Recruitment and Retention Taskforce has been in many ways successful, the funding allocated to date for recruitment and retention strategies has not been sufficient. The actual structure of the Taskforce process and collaborative approach this engendered meant that some very good and important work was undertaken jointly between Queensland Health and the QNU. Most of the work that has been done to date through this process has largely related to improving processes or HR matters. These required little funding but improved functioning.

When it has come to the implementation of recommendations that would require funding (such as addressing workload pressures through the employment of more nurses or reducing services to match demand with supply of nurses) then progress has been inadequate in most Queensland Health workplaces. We strongly believe that significant improvements will not be made in recruiting and retaining nurses until this is adequately budgeted for.

Importantly a number of recommendations of the Queensland Nursing Recruitment and Retention Taskforce (which reported in 2000) have only in part been implemented and some have not implemented at all. We therefore

27 Queensland Health (2005) *Enhanced clinical roles* (paper provided to Morris Inquiry), page 4.

believe it is essential that specific targeted funding aimed at improving nursing recruitment and retention be provided. This should include the allocation of funding to address areas of particular priority including strategies to:

- ensure the maintenance of appropriate nursing workloads for nurses in all practice settings, with particular attention being paid to the funded backfilling of nurses for periods of planned and emergent leave and the appropriate allocation of non-clinical time for nurses;
- provide sufficient resources to enable nurses to access in-service training, education and professional development (e.g. the backfilling of nurses to enable them to be released from their wards/units to attend education and training as well as the provision of appropriate ongoing clinical support at the ward/unit level);
- plan and implement appropriate nursing skill mix and workforce redesign, with particular emphasis on the expansion of innovative roles such as Nurse Practitioners (in all practice settings) and other advanced practice roles for both Registered Nurses, Midwives and Enrolled Nurses;
- continue to expand the number of school based Youth Health Nurse Programmes and investigate other innovative primary health roles for nurses such as nurse health and safety screening and immunisation programmes in child care centres;
- improve the level of clinical support provided to new graduates;
- better coordination of the employment of new graduates;
- undertake a review of the current classification structure with particular emphasis on comparative analysis of roles and responsibilities with other occupational streams in health (in particular there is an urgent need to address the longstanding anomaly that exists between Nursing Officer 3 and Professional Officer 4) and the appropriate integration of Enrolled Nurses and Assistants in Nursing into the current Nursing Career Structure in conjunction with the review of skill mix and workforce redesign foreshadowed by the *Queensland Health Strategic Plan 2004-2010;*
- extend the Remote Area Nurse Incentive Package both in terms of including new locations and extending coverage to include Enrolled Nurses and Assistants in Nursing;
- extend funding allocated for nursing research projects to aid the development of innovative patient focused models of care;
- specific funding be allocated to undertake new research on issues on nursing turnover, absenteeism and morale within Queensland Health given that research on these matters was undertaken some years ago under the auspices of the Nursing Recruitment and Retention Taskforce and that this data is now not current;
- improve succession planning for nurses (This cannot be addressed adequately until such time as deficiencies in the areas of training and skill development for nurses are addressed.).

It is recommended that:

RECOMMENDATION (Strategies to improve nursing recruitment and retention)

The funding for existing nursing recruitment and retention being progressed by the Peak Nursing Body be continued and that specific additional funding be allocated to address serious deficiencies with respect to:

- establishing appropriate enforceable nursing workloads across all practice settings;
- enabling nurses to access required education, training and development;
- providing adequate support to new nursing graduates and improved coordination of new graduate employment;

- extending the implementation of innovative care models (e.g. Nurse Practitioners) across all practice settings and ensuring appropriate nursing skill mix;
- continue to expand the school based Youth Health Nurse Programme and investigate other innovative primary health roles for nurses such as nurse health and safety screening and immunisation in child care centres;
- reviewing the nursing classification structure to address longstanding anomalies with other like occupational groups (e.g. Professional Officer stream) and include Enrolled Nurses and Assistants in Nursing in the structure;
- improving the Remote Area Nurse Incentive Package both in terms of localities and categories of nurses included (extend to include Enrolled Nurses and Assistants in Nursing);
- extending funding for nursing research to facilitate the development of innovative patient centred models of care;
- undertaking new research on issues on nursing turnover, absenteeism and morale within Queensland Health;
- improving succession planning for nurses.

Nursing workloads

Work intensification and the need to establish safe nursing workloads continue to remain the principal issues of concern for QNU members in all sectors. The recent findings of research conducted by the USQ confirm this. Data from the *Report on Government Services 2005* quoted earlier in this submission highlighted starkly that the number of FTE nurses employed in Queensland public hospitals per 1000 population (data was only provided for public hospitals) falls well below the numbers provided interstate.

This data indicates that to bring Queensland public hospitals to the nurse staffing levels provided in Victorian public hospitals in 2002/2003 (and in 2001/2002 for NSW) would require an additional 2258.4 FTEpositions. To bring Queensland to the national average in terms of nursing FTE staffing an additional 1505.6 FTE positions would be required. As there are no significant Casemix or activity differences in Queensland this must mean that Queensland nurses are working much harder than their interstate counterparts. We fear that quality of care and nursing morale is suffering because of work intensification. This gross inequity could be easily addressed if Queensland Health would appropriately implement the agreed nurse staffing tool.

Despite the fact that we reached agreement with Queensland Health some years ago now on a tool that would facilitate the matching of supply with demand for nursing services, the issue of appropriate workload management for nurses has not been satisfactorily resolved for the whole agency. Queensland Health has repeatedly failed to show good faith in negotiations with the QNU regarding the implementation of an agreed mechanism to manage nursing workloads—the Business Planning Framework: Nursing Resources (BPF:NR). In particular there has been a reluctance to consolidate "whole of agency" data that would enable the matching of nursing resources with demand for nursing services within Queensland Health. The BPF:NR requires each unit/ward where it can be applied (there are some limitations to its application) to draw up a service profile which should incorporate the matching of demand for services with supply of nursing personnel and thus safely manage nursing workloads.

Unfortunately we have experienced widespread difficulties with the implementation of the BPF:NR. In some cases senior management at the facility level have refused to sign off on many individual service profiles. We have also experienced difficulty in accessing all service profiles. There is also

no consolidation of this information into one document (or if it is, the QNU is not provided with it) that would facilitate meaningful discussions on required nursing staffing numbers on a "whole agency" basis that could then feed into budget submissions to Treasury.

Although Queensland Health should be acknowledged for the resources provided to date to train nursing staff on the implementation on the BPF:NR, a fundamental issue of concern remains—the level of commitment from Queensland Health to the actual implementation of this agreed workload management tool. The approach from most District Health Services is to use the tool to ensure that they stay within budget for nursing resources rather than match demand for nursing services with supply of nursing personnel. Again, it appears to our members that the rhetoric espoused during the training provided by Queensland Health is not matched with the management response when it comes to actual implementation of the tool. The cynicism of nurses that results from this failure to yet again appropriately implement an agreed tool has significant potential to undermine the confidence of nurses in it and therefore pressure will increase for the implementation of blunt tools such as a 1 to 4 patient nurse ratio that has been introduced in major Victorian public hospitals.

Components of the tool are also utilised in isolation and this results in the objective—establishment of safe nursing workloads—not being achieved at most Queensland Health facilities where it is applied. This results in our members, who have received education on how the tool should be utilised, becoming increasingly despondent and cynical as they see the management manipulation of this tool. In summary our major concerns about the inappropriate implementation of the BPF:NR are:

- the lack of preparedness of management at many facilities to "sign off" on the service profiles that have been developed at unit level;
- delays in implementation, selective utilisation of aspects of the tool and the creation of deliberate confusion by some in management positions;
- lack of adequate provision for backfilling to allow for mandatory training for nurses—to our knowledge no facility or district has allocated sufficient hours in their calculation of "non-productive nursing hours" to cover even the mandatory education/in-service that nurses are required to attend each year (a minimum of five days);
- in some Districts nurses cannot take annual leave or long service leave because there is no capacity to provide backfill;
- the backfilling of nurses taking emergent sick leave is becoming an increasing problem. This is because budgetary restrictions do not enable the engagement of casual/agency staff (e.g. insufficient allocation has been made to cover sick leave in non-productive nursing hours calculations);
- there are also increasing reports of attempted manipulation of the BPF-NR process through creative rostering. For example, we are seeing more "swiss cheese rosters", a phenomena whereby the roster is produced with the correct number of nurses for the bed occupancy but many of the nurses on the roster are not actually available to present to work due to other commitments. This is a slightly different scenario to the general problem with backfilling where it is assumed that the roster was prepared with the intent of everyone being available. In the case of "swiss cheese rostering", it is known beforehand that many of the shifts won't actually be worked.

Since 1999 minimum nursing staffing levels at State Government Nursing Homes have been calculated with reference to the 'entitled hours per day by resident

category' model that was in place for all nursing homes prior to enactment of the *Aged Care Act 1997*. The minimum rostered care hours for residents are:

RCS Category 1	3.857hrs
RCS Category 2	3.357hrs
RC3 Category 3	2.786hrs
RC4 Category 4	1.857hrs

The number of residents at each RCS category is multiplied by the minimum hours provided for that category to calculate the total minimum care hours for a roster period. **Given that this model has been in place for some years now we believe that it is appropriate for it to be enhanced by utilising other agreed workload management tools. It is our view that** the Business Planning Framework processes **should**/may be used to supplement the minimum care hours to be rostered.

RECOMMENDATIONS (Addressing nursing workload concerns)

It is recommended that:

Queensland Health be directed to use the complete Business Planning Framework: Nursing Resources tool to determine appropriate allocation of budgets for nursing services within Queensland Health.

Specific funds be provided to facilitate the urgent development of a workload management tool for those areas where it is not possible to implement the Business Planning Framework: Nursing Resources in its current form (e.g. community health settings, Emergency Departments and Outpatient Departments, Intensive Care Units, Integrated Mental Health Units, Operating Theatres and Day Surgery Units).

The Business Planning Framework be used to supplement the minimum care hours model used for determining nursing staffing in State Government Nursing Homes.

Funding for future increases in wages and conditions of employment

There is general acceptance, both nationally within Australia and internationally, that there is a current shortage of nurses willing to work in the nursing profession.

The only exception to this was, until recently, Queensland Health, as they consistently refuse to recognise any nursing shortage in Queensland. This is even despite the finding of the Australian Industrial Relations Commission (AIRC) in its arbitration under Section 170MX of the *Workplace Relations Act 1996* regarding Queensland Public Health nursing (Print PR931289) in which the Commission found that "... our acceptance that there are shortages and there are consequences of these shortages causes us to also accept that public interest and industrial merits considerations are raised by the circumstances of this case" (PR931289 at [58]).

In considering the necessary funding for wages and conditions for nurses in the lead up to the imminent enterprise bargaining negotiation, government must be mindful that the recognised nursing shortage is projected to be exacerbated over time. Government must also be mindful of the movements in wages and conditions throughout Australia that will result in Queensland public sector nurses falling significantly behind their interstate colleagues by October 2005. (The Section 170 MX Awards covering nurses employed by Queensland Health and the Mater Public Hospitals in Brisbane expire on 25 October 2005.)

It is useful to observe the views expressed by the AIRC in relation to interstate comparisons of wage rates as a relevant consideration. The AIRC stated: *It is appropriate, almost necessary, to have regard to the market rates applying*

to nurses as reflected in the enterprise bargains which cover them. This is especially so in circumstances where there is a national shortage of nurses and some mobility and transference of skills and qualifications. (PR931289 at [93])

While at the time of this arbitration the Commission believed it was placing Queensland in a relatively competitive position in the national market as far as wage rates were concerned (PR931289 at [95]), the following tables strongly indicates that this position will have changed substantially by October 2005. Three tables (EN highest pay point, RN Level 1 highest pay point and RN Level 3 highest pay point) have been compiled by the QNU from the various applicable certified agreements in each state/territory. For the sake of brevity only three examples have been selected. These are representative of the majority of Queensland Health's nursing employees. Comparisons of nursing positions can be provided to this inquiry upon request.

INTERSTATE COMPARISON

INTERSTATE COMPARISON – 1 October 2005
Enrolled Nurses Pay Point 5

State	$ per wk	$ diff/wk	% diff/wk	Rank
QLD	697.85			7
NSW	778.91	81.06	11.6%	4
VIC	790.00	92.15	13.2%	3
SA	790.45	92.60	13.3%	2
WA	NA			
TAS	721.80	23.95	3.4%	6
ACT	814.84	116.99	16.8%	1
NT	778.23	80.38	11.5%	5

INTERSTATE COMPARISON – 1 October 2005
Level 1 Registered Nurse Pay Point 8

State	$ per wk	$ diff/wk	% diff/wk	Rank
QLD	986.35			7
NSW	1139.51	$153.16	15.53%	1
VIC	1040.40	$54.05	5.48%	4
SA	1041.07	$54.72	5.55%	3
WA	1,034.86	$48.51	4.92%	5
TAS	975.59	-$10.76	-1.09%	8
ACT	1106.50	$120.15	12.18%	2
NT	1029.59	$43.24	4.38%	6

INTERSTATE COMPARISON - RN L3.4 as at 1 October 2005

State	$ per wk	$ diff/wk	% diff/wk	Rank
QLD	1233.35			8
NSW	1537.67	304.32	24.7%	1
VIC	1328.90	95.55	7.7%	5
SA	1394.00	160.65	13.0%	3
WA	1420.37	187.02	15.2%	2
TAS	1242.90	9.55	0.8%	7
ACT	1351.50	118.15	9.6%	4
NT	1282.40	49.05	4.0%	6

As at 1 October 2005, an Enrolled Nurses Pay Point 5 in Queensland will rank seventh in Australia – the lowest in the country. (Please note: no strictly comparable data is available for Enrolled Nurses in WA as they are not covered by one nursing award/agreement in that state. However, the weekly rates of pay for

ENs in WA as at 1 October 2005 are: EN Point 4 - $751.10 and Advanced Skills EN - $801.00. [28]) As at 1 October 2005 a Registered Nurse Level 1 Pay Point 8 in Queensland will rank seventh on a national wage comparison, marginally ($10.76) in front of Tasmania. Similarly, as at 1 October 2005 a Level 3 Pay Point 4 Registered Nurse will rank eighth on a national comparison. It is evident throughout Queensland Health that the differential wage increases awarded by the AIRC in their arbitration relating to Queensland public health nurses has resulted in relativities between nursing classifications being significantly disturbed and that pre-existing anomalies between the Clinical Nurse classification (NO2) and those nursing classifications at the NO3 level have been exacerbated. The outcome of this compression of relativities has been a significant increase in the inability of Queensland Health to attract Clinical Nurses into higher positions, either through higher duties arrangements or through open merit selection.

It is in the interests of both nursing and the Queensland Government to correct these wage inequities created by the compression of these relativities to ensure that the incentive for career enhancement is maintained throughout the nursing career structure. Funding will need to be specifically earmarked in the budget to address these inequities and anomalies.

The creation of the Enrolled Nurse (Advanced Practice) classification has also resulted in an impediment for Enrolled Nurses progressing to the Advanced Practice level. Unfortunately, Queensland Health, at facility level, has failed to embrace this classification by creating sufficient numbers of positions to allow all Enrolled Nurses deserving of movement to this level the ability to advance. This is despite the minimal wage differential between the top paypoint of the Enrolled Nurse classification and that of the Enrolled Nurse (Advanced Practice). The artificial cap placed upon the number of Enrolled Nurse (Advanced Practice) positions has created significant disenchantment amongst Enrolled Nurses that is unnecessary and avoidable.

Just as it is appropriate, indeed necessary, to have regard to market rates applying to nursing rates of pay, such consideration needs to expand to nursing conditions of employment also. It is in the interests of both the nursing profession and the Queensland Government to ensure that in the current environment, both the wages and the conditions of employment applicable to nurses in Queensland are such that Queensland maintains a competitive position to ensure that we can attract and retain highly skilled nurses into the Queensland public health system. This includes key entitlements such as qualifications entitlements being applied equitably across nursing classifications.

RECOMMENDATION (Resourcing the reform process in Queensland Health)

It is recommended that:

The government allocate sufficient funds to fully meet the costs of "reforming" Queensland Health and also to fully meet the cost of necessary improvements in nurses' wages and conditions for the enterprise bargaining negotiations scheduled for the second half of 2005.

Funding for nursing education

It is appreciated that the bulk of responsibility for the funding of registered nurse education lies with the federal government given the transfer of this to the university sector some years ago. The state government can however make a significant difference in some discrete areas of nursing education by providing targeted strategic funding.

Three particular areas requiring targeted funding are ongoing education and training for employees of Queensland Health; refresher and re-entry courses

28 AG 290 of 2004, *LHMU Enrolled Nurses and Nursing Assistants Department of Health Industrial Agreement 2004*, clause 15 (2).

for nursing; Enrolled Nurse and Assistant in Nursing education. Although the responsibility for some of this will fall to the TAFE sector it is relevant that the issues be raised in this submission as it is hoped that this review can make recommendations to government on issues that will improve the functioning of Queensland Health even though responsibility for delivering the strategy will lie with another agency. The QNU made recommendations to the Queensland government on these matters in the budget submission we provided in the lead up to the 2005/2006 state budget. As we cannot determine from the budget papers whether the government has decided to act upon our recommendations, we believe that it essential for us to restate these issues now given that the budget may not have allocated funding to address these issues. (We have requested clarification of the status of our recommendations from the Minister for Health.)

Queensland Health has a responsibility for skill enhancement and ongoing education and training for its existing employees. This will be particularly important given the significant agenda for workforce reform pre-empted in the *Smart State Health 2020* document and Queensland Health's current strategic plan. It is essential that this education, training and development be based on identified areas of skill shortage yet at the same time seek to bring about the necessary cultural change required within Queensland Health. Given that it is likely there will be some potentially significant role changes or enhancements or an increase in the number of advanced practice roles (for example the introduction of more Nurse Practitioner positions) it is essential that health unions be involved in the planning of the education, training and development agenda from the outset. It is therefore essential that mechanisms be established to facilitate adequate consultation with health unions.

Better use of the skills of existing nursing personnel will be critical to the future health service delivery in Queensland Health. It is therefore extremely important that research of existing and needed skills underpins the health workforce planning process. The lack of available data to accurately plan future nursing workforce needs has been acknowledged by the Victorian government. They commissioned the Australian Institute of Health and Welfare (AIHW) to undertake a Victorian nursing workforce study to underpin future workforce planning, especially in relation to existing skill levels and skill gaps. This study (*Nursing Labour Force Victoria 2003*) was released in late 2004 and is available from the AIHW website. The QNU strongly believes that such independent research is required in Queensland and recommends that the AIHW be commissioned to undertake a Queensland nursing labour force study.

It is our understanding that current budgetary processes allow for the inclusion of "proxy" funding amounts to cover issues such as provision of support to new graduates to facilitate an appropriate transition to work. The allocation that is determined at central office level for built in funding for support of new graduate nurses is now insufficient. It has not been increased from the amounts initially determined some years ago ($1500 for metropolitan based new graduates and $3000 for rural/remote based new graduates). Insufficient funding has also been allocated for support of nursing students while on clinical placement. Current levels of support for new graduates and nursing students are woefully inadequate. Queensland Health has been advised repeatedly of our concerns on this issue at both the facility and corporate office level and yet insufficient action has been taken to address these concerns.

We have no doubt that significant resources will need to be allocated by Queensland Health towards education and ongoing development of their staff. Queensland Health's staff are, after all, their most valuable asset. Longstanding

inequities between health occupational groups regarding access to ongoing development and training must be addressed as a matter of urgency. It is often difficult, for example, for nurses with a clinical case load to be released to attend training and education, especially if there is no established standard entitlement to leave for this purpose. Often they are forced to do this in their own time and at their own expense by accessing external education providers.

Why is it, for example, that the majority of the cost of obtaining a post graduate nursing qualification is met by the individual nurse through the PELS scheme whereas medical officers undertaking post-basic specialty education have the majority of their educational expenses paid for by tax payers as Queensland public hospitals remain the primary setting for ongoing medical specialty training and development? The cost burden for ongoing education for nurses is largely borne by them whereas this expense for ongoing medical education is largely met by government. How can this inequity be sustained, especially given the longstanding nursing skills shortages? In the past we have often argued unsuccessfully that PELS fees for post graduate nursing qualifications in areas of nursing skills shortage be ceased until such time as the shortages are addressed. The federal government has refused to implement this option, instead implementing a small number of part and full scholarships.

The state government has recently acknowledged the need to address the shortfall in undergraduate medical student numbers when they announced the bonded scholarship arrangement with Griffith University School of Medicine. The QNU strongly believes that such a scholarship arrangement is also warranted for both undergraduate and postgraduate nursing positions. Now that the precedent has been set for medicine in Queensland we eagerly await a similar response from the Queensland government to address the nursing skills shortage.

There is also a precedent for the Queensland Government acknowledging and funding the ongoing training, education, development and support needs of staff in other government departments (see the recommendations arising from the review of child safety in Queensland).

Frontline staff in the Queensland Department of Child Safety now receive a comprehensive orientation and annual specified minimum time "off line" each year to undertake ongoing staff development and education. We understand that funding for this staff support is factored into the budget for this department and it is our strong view that a similar minimum entitlement must be introduced for Queensland Health staff. Like the contact front line staff in the Department of Child Safety, frontline clinical staff in Queensland Health must be backfilled to enable them to attend such education, training and development and this backfilling must be adequately factored into budgets.

Re-entry and refresher courses

There are thousands of qualified nurses in Queensland who are currently not employed in nursing who may be able to be attracted back into the profession if adequate recruitment and retention strategies are put in place. One strategy utilised successfully by other state governments is to meet the costs associated with refresher and re-entry courses for registered and enrolled nurses. Queensland Health facilitates the placement of re-entry programmes for nurses absent from the workforce for more than five years but does not meet costs of the Competence Assessment Service Fee for participants as other states do. Instead Queensland Health offers interest free loans to participants to meet this cost. We believe this cost impost provides an unreasonable barrier and should be waived until such time as nursing shortages within Queensland Health are fully addressed.

EN education

The role of the Enrolled Nurse (EN) in Queensland has expanded significantly in recent years (e.g. the course curriculum has been expanded to include medication endorsement) and yet we believe that insufficient use is currently being made of ENs in this state. This is in part due to reluctance by some in management to fully utilise the expanded role and also because Queensland is in our view producing insufficient numbers of ENs at present.

We firmly believe that nursing shortages could in part be mitigated by better skill mix of nursing staff and increasing the number of funded places for EN training would go a long way to achieving this. (We understand there certainly is the demand for such courses to justify additional places being offered.) Queensland Health and the Department of Employment and Training jointly fund 150 places for EN training per year. QNU believes the number of funded EN training places offered should be increased to 400 per year from 2006.

The fee for service costs of EN courses ranges from $8000 to more than $10,000 and are full fee paying as HECS does not apply. Given the significant demand for these courses we believe the government will easily be able to fully recover costs associated with increasing place numbers. However increasing place numbers is only part of the solution and targeted scholarships that pay full course costs should be provided for particularly disadvantaged groups (e.g. Aboriginal and Torres Strait Islander people, long term unemployed and low income earners) to enable them to undertake the study. The QNU is Currently involved in discussions in relation to a proposal for a pilot Enrolled Nurse cadetship program to be funded by the Department of Employment and Training and is fully supporting this initiative.

Training for Assistants in Nursing

The nationally endorsed Community Services Training Package and Health Training Package include a range of qualifications that have been developed for unlicensed health care workers. For example, an area requiring particular funding attention is that of Certificate courses for Assistants in Nursing (AINs). These are offered by the TAFE sector and private training providers.

The *National Nursing Education Review Report* released in 2004 has recommended that all currently unlicensed nursing workers be required to attain a mandatory minimum qualification (at Certificate 3 level) and undergo criminal history checking by police. Given that it is likely that state and territory governments will soon be called upon to demonstrate how they intend to address this recommendation we believe that the necessary funding be allocated to meet this requirement as soon as possible.

There is a precedent for this in Queensland: when changes to the *Child Care Act* mandated similar requirements the then Minister secured funding to meet the cost of providing the necessary minimum educational requirement for all existing child care workers in Queensland. We believe similar funding is now required for all existing unlicensed workers in aged care, including AINs. Although Queensland Health has allocated funding to some of its existing employees to enable them to undertake certificate courses, there is a need for such support to be provided for those AINs employed in the private and not-for-profit sectors in Queensland, especially in aged care. Just as a community safety issue exists for children in Queensland a similar community safety issue also exists for similarly vulnerable older Queenslanders in care. A scholarship programme should also be established to meet the full course costs for those from targeted disadvantaged groups not already in the health and aged care workforce who wish to obtain a qualification to secure employment in that sector.

We welcome the fact that the Queensland government is committed to addressing areas of significant skill shortages through its Smart VET programme. This has been exhibited by the recent release of the Green Paper *Queensland's proposed responses to the challenges of skills for jobs and growth.* There certainly is potential to address skills shortages in nursing through innovative educational programmes that provide for a pathway into nursing. However further specific attention must be paid to a number of issues that will need to be addressed before this can be properly facilitated such as articulation, recognised prior learning issues and an evaluation of utilising the VET in Schools Programme for the health and aged care sectors. The depth and breadth of the skills shortages in nursing remains the greatest of all occupational groups. In view of the predicted increased demand for nursing personnel arising from population growth and the general ageing of the population, we strongly urge the government to give priority attention to funding workforce education and training needs for nurses.

The QNU is particularly concerned about the introduction of new vocational education and training qualifications which involve nursing work that are being approved by the Department of Employment and Training without adequate consultation with the QNU. For example, a diploma in medical assisting qualification has recently been approved by the Department of Employment and Training. This qualification incorporates nursing activities into the role of receptionists in medical centres. The course was developed and approved without consultation with the QNU, and we understand that there was no consultation with any nursing body in Queensland in relation to the course content.

It appears that courses are being developed and then rolled out in a very *ad hoc* manner. There is an urgent need for this to be better coordinated and based on unambiguous and cogent evidence from the health and community services sector on actual workforce skills needs rather than anecdotal and one off advice. Why should new courses be developed when there are existing categories of health personnel (such as Assistants in Nursing) that currently are not supported in achieving existing certificate based qualifications? The QNU recommends that this Union be involved in the development of any course proposals that involve nursing work.

Separate work has and is being done within Queensland Health and outside it to address workforce concerns in the health and aged care sectors. We believe tere is an urgent need for government to facilitate a coordinated approach to this issue through funding the establishment of a representative industry body involving all key stakeholders. (There is a precedent for this in other sectors: the Queensland Child Care Forum facilitated workforce planning and the development of a strategic plan for the child care sector.) Such a body would also facilitate the achievement of the broad objective of improving partnerships and coordination of services across sectors as is envisaged in the current Queensland Health Strategic Plan.

RECOMMENDATIONS (Staff education and development and workforce planning)

It is recommended that:

The planning and development of future education, training and development programmes for Queensland Health employees be informed by the establishment of an appropriate consultative mechanism involving key stakeholders such as health unions.

Proxy allocations used within the Business Planning Framework: Nursing Resources (e.g. for new graduate support, training leave, other forms of leave) be urgently reviewed to ensure they adequately cover the true costs incurred particularly at peak times of demand; further, that following review of such proxy allocations and necessary amendment of the tool, sufficient budgetary

allocation be provided by Treasury to ensure the appropriate and consistent implementation of Business Planning Framework: Nursing Resources across all of Queensland Health.

The Australian Institute of Health and Welfare be commissioned to undertake a Queensland nursing labour force study that will inform nursing workforce planning for Queensland Health.

The Queensland government fund scholarships for undergraduate and post graduate nursing students (based on the recently announced arrangement between the Queensland Government and Griffith University School of Medicine) in order to begin to address nursing skills shortages. Further to this that the Queensland government enters into urgent discussions with the federal government with respect to health workforce issues and shortages and in particular seeks to address the current inequities that exists with respect to the funding of post graduate health qualifications.

Queensland Health introduce an ongoing staff education, training and development programme (based on the programme for staff at the Department of Child Safety) where all staff are released and backfilled to attend and that all categories of staff receive equitable treatment with regard to access to such ongoing education, training and development.

Funding is allocated to pay the Competence Assessment Fee for all participants in nursing reentry programmes as is the case in other states.

Funding to increase the number of EN course places offered in TAFE should be increased to 400 per year from 2006. Further this this, that at least 50 scholarships that meet the full course costs be funded by government each year and made available to applicants from specific targeted disadvantaged groups.

There be no further proliferation of new certificate courses for new categories of health workers until such time that there is a comprehensive and evidence based assessment of the training needs of the health and community services sector and whether these needs can instead be met by amending/extending the educational preparation of existing categories of employees. Further to this, that the Department of Employment and Training ensure that the QNU and relevant nursing bodies are invited to participate in course development advisory committees of any proposed health care qualification;

Funding is allocated to enable existing unlicensed care workers in Queensland such as Assistants in Nursing to complete their Certificate level qualification as was provided to child care workers to enable them to meet legislated minimum educational qualifications. Further to this, that at least 50 scholarships that meet the full course costs be funded by government each year and made available to applicants from specific targeted disadvantaged groups who wish to obtain a qualification in order to secure employment in the health and aged care sector.

Specific ongoing funding be allocated for research and consultation with industry regarding important threshold issues for nursing education in the VET sector, including but not limited to examining issues such as articulation, recognised prior learning and evaluating an evaluation of utilising the VET in Schools Programme for the health and aged care sectors.

Priority attention be given to funding workforce education and training needs for nurses.

The QNU be involved in the development any course proposals that involve nursing work.

Specific funding be allocated to establish a broadly representative health and aged care sector industry body (including representation from the QNU) to inform workforce planning for this sector in Queensland.

Work and family issues and the impact on recruitment and retention

Given that the majority of Queensland Health employees are women, strategies that facilitate the balancing of work and family are particularly important to ensure ongoing workforce attachment for employees of this agency. The QNU has argued for many years that the implementation of a comprehensive work and family strategy for Queensland Health is vitally important if this agency is to recruit and retain staff. Rather than this being a "non core" activity (as family friendly initiatives such as child care have been presented by some in the past) this constitutes a core HRM function for the agency. As such significantly more attention must be provided to the implementation of work and family initiatives, especially if Queensland Health is to adequately meet the challenges that are being posed by the ageing of the health workforce.

There are a number of glaringly obvious priority issues requiring attention. These were highlighted in the QNU submission to the Queensland government prior to the 2005-2006 budget and we will briefly restate these in this submission. These are whole of government issues in the main, but are of particular importance to the functioning of Queensland Health given its gender and age profile. To maintain momentum that has been recently lost with regards to progressing the work and family agenda for Queensland, the QNU believes that the following priority areas require attention:

- immediately increasing the paid maternity leave entitlement for public sector employees from six to fourteen weeks , as has recently been granted to public sector employees in New South Wales;
- establishing a representative Queensland Work and Family Forum to continue to drive necessary work and family reform and encourage community debate. This Forum be constituted under the auspices of the Department of Premier and Cabinet so that a "whole of government" approach is taken to this issue;
- establishing a "whole of government" information portal (one stop shop) on services and support available to assist Queenslanders balance their work and family commitments. This would bring together information on services, legislation and helpful information from all relevant state government departments;
- establishing a coordinated approach across all public sector agencies employing shift workers to assist these employees to better meet their child care needs. (This is necessary because the needs of shift workers are largely inadequately met by the existing child care system. It is also an essential strategy to retain those nurses in the 25 to 35 age group, a critical demographic to retain if we are to begin to address the ageing of the nursing workforce.)

RECOMMENDATION
(Work and family issues)

It is recommended that:

Funding be provided to:

- introduce 14 weeks paid maternity leave for Queensland public sector employees;
- establish a broadly representative Queensland Work and Family Forum;
- develop and implement a Queensland "whole of government" portal on work and family matters;
- facilitate a coordinated approach to improving child care services for shift workers across all Queensland government agencies.

Safe working environment
The provision of a safe and supportive working environment for Queensland Health staff should be a priority objective of this review. There are significant issues of concern relating to violence towards nurses and other health workers, be this from patients or visitors, management or other workers within Queensland Health. The culture is a sick one and it will take a concerted effort and significant resources to turn it around. The recent research conducted by the USQ on nursing in Queensland highlights the critically important nature of this issue. This review should pay particular attention to the section of this report pertaining to workplace violence towards nurses. Urgent action is required to address this dangerous state of affairs. The importance of this issue cannot be overstated.

Violence
It is acknowledged that the Minister for Health had previously accepted our concerns about the current unacceptable level of violence towards nurses and established a Violence Against Nurses Steering Committee to investigate this issue and report by the end of 2004. The report is still in the process of finalisation and the final recommendations were not publicly available to us at the time of writing. As the QNU is represented on this group we are confident that our concerns will be highlighted in the final report or through a minority report submitted by the union should we be unable to reach agreement on all recommendations. We therefore recommend that adequate funding be provided to ensure full implementation of all the recommendations arising from this review process. It is also likely to be the case that other issues relating to workplace violence will be highlighted through this review, so it may be necessary to augment the recommendations of the Violence Against Nurses Steering Committee report in light of this.

Manual tasks
Queensland Health has invested substantial resources in this area which remains the predominant hazard within the health care environment. While manual tasks still contribute to injuries, anecdotal evidence indicates that the severity of the injuries appears to be decreasing. We believe there is a need for a review and a detailed analysis of the initiatives in place to see if they are working and see if any modification is required. Consideration should be given to funds being made available for regular servicing, preventative maintenance, maintenance and replacement of equipment necessary for safer manual handling.

Workplace harassment
Workplace harassment or workplace bullying is also a major issue for nurses and is no doubt a significant focus of your review. As stated previously, the dominant culture within Queensland Health is one of bullying and intimidation. A "shoot the messenger" attitude is common place and, in general, positive critical analysis is discouraged. There are policies and procedures in place within Queensland Health but these are generally seen as ineffectual, especially given that some in management positions operate from a mindset of bullying and intimidation. Positive behaviour is often not modeled by those in management positions and this has the effect of such behaviour becoming the norm and therefore replicated throughout the system.

Although Queensland Health has a training programme to address the issue of workplace harassment, minimal numbers of nursing staff have received training in this area despite its introduction nearly two years ago. As stated above, clinical demands often make it difficult for nurses to be released to attend such training. If we are to change the culture of Queensland Health much more will need to be done to ensure that all staff access appropriate training and support. All

areas within the department must be instructed to address this issue as a matter of priority and they should all be directed to develop training and development plans to ensure that all staff receives the required training and support within 12 months. The department must demonstrate clearly and unambiguously that workplace harassment will not be tolerated. We believe that one mechanism to help demonstrate this commitment is through the mandatory adoption of the code of practice relating to workplace harassment.

Fitness for work issues

The way in which nursing continues to be treated as a "disposable" workforce is of significant concern to the QNU. This is clearly demonstrated by the number of nurses being retired from Queensland Health Districts because of ill health. The reason given is that they cannot carry out the *full duties* required of them even though many have carried out a meaningful role up until the time they are retired. The QNU intends testing this requirement with the Anti Discrimination Commission in the near future. We do not believe that the issues of general occupational requirements and reasonable adjustment have been sufficiently investigated by this agency. The unfitness from work may result from a work related illness or injury or it may not. If the affected nurse is in the WorkCover system the only avenue available to them is to lodge a claim against Queensland Health under common law and instigate this action if applicable.

It is significant that Queensland Health has not yet adopted *Directive 4/99 Medical Deployment and Redeployment*. (This is unacceptable in our view given Queensland Health's lead agency status and their aim to improve the health of all Queenslanders, including their own employees.) This directive would allow for ill or injured nurses who are able to work to be appropriately deployed to another area with required support. We believe these issues need to be further investigated. As the average age of nurses is now over 42 years and it is become increasingly important to retain older workers in this workforce, particular urgent attention to this matter is required.

RECOMMENDATIONS (Health and safety concerns)

It is recommended that:

Adequate funding be provided to ensure the full implementation of all the recommendations arising from the Violence against Nurses Steering Committee review process.

Funding be allocated for a review and a detailed analysis of the initiatives in place relating to manual handling to ascertain their effectiveness and whether any modification is required. Further to this, that funding is allocated for regular servicing, preventative maintenance, maintenance and replacement of equipment necessary for safer manual handling.

The advisory standard relating to workplace harassment is made mandatory and that Queensland Health Districts be allocated funding to enable the development of plans for the implementation of the standard and the provision of mandatory training for all staff on the code within 12 months.

Queensland Health be directed to adopt *Directive 4/99 Medical Deployment and Redeployment*. Further to this, that funding is allocated to properly investigate fitness for work issues for Queensland Health employees and plan strategies to encourage continued workforce attachment given the ageing of the health workforce and significant shortages that exist in nursing and other health occupations.

Other issues relating to the workplace environment

There are a number of basic workplace amenity issues that continue to be the source of frustration and anger for nurses in Queensland Health. These

relate to issues of inconsistent treatment of staff and failure of Queensland Health to introduce a standardised and equitable response to the concerns of staff. The concerns may not exist at every workplace, but it is the case that a significant number of Queensland Health workplaces do have concerns about basic workplace amenities that are the source of great anger and frustration for staff and hence greatly contribute to deteriorating morale. In our view these issues are easy to fix—there may be some small costs involved but the costs the agency through deteriorating staff morale is a far greater cost to bear (though often difficult to quantify in dollar terms). This should be a high priority for Queensland Health if it is committed to the stated strategic intent of its current strategic plan of supporting the health of their staff.

Commonly areas of particular concern are the provision of:

- appropriate and safe accommodation be provided to staff on an equitable basis where Queensland Health provides this (e.g. in rural and remote areas);
- safe and free/affordable car parking for Queensland Health staff and the equitable treatment of staff with regards to the provision of safe and appropriate car parking. (This may not be a significant problem for all Queensland Health facilities but is a significant issue for many, especially for larger metropolitan hospitals.);
- reasonably priced, high quality and healthy meals for staff, especially ensuring that these are available for shift workers;
- adequate other amenities for staff such as separate meal areas, changing, toilets and showering facilities and access to facilities that assist stress reduction and promote the health of staff (such as access to quiet area, gyms and swimming pools etc);

It is recommended that:

RECOMMENDATION (Workplace amenities)

Queensland Health pay particular attention to ensuring that appropriate workplace amenities are provided for staff and that all staff receive equitable treatment with regard to the provision of workplace amenities. Particular attention must be paid to ensuring the provision of appropriate and safe accommodation for all staff (where this is provided), safe and free/affordable car parking, reasonably priced high quality and healthy meals for staff on all shifts and adequate other amenities such as separate meal areas, shower, toilets and change facilities and facilities that promote the health and wellbeing of staff.

Nursing leadership

The QNU strongly believes that nursing leadership is going to be central to the rebuilding of a positive culture in Queensland Health that will in turn assist recruitment and retention. It is critically important that nurses are lead by strong and innovative nurses. It is especially important that nurses continue to control nursing resources in the system. We are concerned that a view may have formed that the number of nurses in management positions could be decreased and some roles currently performed by nurses in management/coordinating positions (such as rostering of nurses) can be transferred to other categories of staff to perform as this "frees" up nurses to perform a clinical role. Such a view demonstrates a fundamental knowledge deficit about the complexity and variability of the roles that nurses perform in the health system and why career structures have been developed to encompass the richness and complexity of nursing roles.

Nursing encompasses clinical, management, research and educational skills and our career structure has been developed to reflect this. It is disappointing and frustrating in the extreme that nurses must continually be forced to defend the

integrity of our career structure and the multi-dimensional nature of the nursing role. We had this battle in the 1990s when the Goss government attempted to unilaterally dismantle the management stream of the career structure. The arguments have been raised again recently with the lack of recognition provided to nurses with management and leadership qualifications in our dispute with Queensland Health over the payment of qualifications allowance. In the very recent past non-nursing organisations such as the AMA have publicly denigrated the role nurses play in management of the health system. This constant requirement of nurses to justify their roles within the system is indicative of a fundamental lack of valuing of the contribution that nurses make, the multi-dimensional nature of this contribution (beyond the "hands on" clinical role) and the complexity of their roles. Nurses must continue to manage nurses and nursing in the totality. This is fundamental to the delivery of quality nursing services.

Take the example of rostering of nurses. It may appear on the surface that this is a mere scheduling function that can be provided by administrative support officers. It is the case that administrative support and IT systems can assist the performance of this function. However it is vitally important that nurses retain control of this function overall as it is the nursing knowledge of the skill mix and numbers required that are essential to the provision of adequate numbers of nurses with sufficient skills to undertake safely the nursing work required.

There are issues of concern to members about their career structure but these relate to issues such as lack of promotional opportunities and inequities of remuneration compared to other occupational groups rather than a fundamental problem with the career structure itself. Nurses are autonomous health professionals and like other autonomous health professionals they should be the ones to determine if any changes should be made to their career structure and nursing roles. It is not that nurses are not amenable to change, especially if it can be demonstrated that the change results in improved health services or outcomes. Again and again nurses have demonstrated their responsiveness.

Prior to the announcement of this review we wrote a detailed letter to the Director General of Queensland Health expressing our concerns about lack of an integrated and comprehensive nursing strategy and requested that this be addressed as a matter of urgency. The Secretary of the QNU met with the Director General after he received this letter and had a general introductory discussion on the matters raised in our letter. However, shortly after this the Systems Review of Queensland Health was announced and so no further action has been taken to address our concerns.

Although we have provided this review with a copy of the letter sent to the Director General on nursing strategy, we believe it is important that we restate the contents of this correspondence again now given that the issues raised are of direct relevance to the terms of reference for this review. In this letter (dated 20 April 2005) the QNU raised the following concerns with the Director General of Queensland Health which remain of concern to the QNU and must be considered by this inquiry:

1. Model for the office of Chief Nursing Adviser

The QNU has stated on numerous occasions in the past that we favour a restructuring of the office of Chief Nursing Adviser based on the New South Wales Chief Nursing Officer (CNO) model. In New South Wales the CNO is the professional link between the Minister for Health, the Director General and the public, private and education sectors of the nursing and midwifery professions. This position is supported by a number of staff in the Nursing and Midwifery Office (NaMO). Currently there are seventeen staff employed in this unit,

including the CNO, Adjunct Professor Kathy Baker. The role of the CNO and NaMO is to provide advice on professional nursing and midwifery issues and on policy issues, monitor policy implementation, manage state-wide nursing and midwifery initiatives, represent the department on various committees and allocate funding for nursing and midwifery initiatives. Specifically, the CNO and NaMO:

- provide advice on professional nursing and midwifery issues and on policy issues that impact on nurses and midwives, and their practice
- provide advice to the nursing and midwifery professions on the implications of health policy
- manage statewide nursing and midwifery initiatives, for example:
  - promotional activities and career advice
  - recruItment and retention strategies
  - a number of education strategies
  - a number of research projects
  - strategic planning
  - Nurse Practitioner Project
- monitor policy implementation
- manage Nursing DOHRS (Department of Health Reporting System)
- develop and analyse policies on a broad range of nursing and midwifery issues
- provide a resource on nursing, midwifery and related issues to other divisions/ branches within the Health Department
- facilitate effective consultation and communication channels
- represent the NSW Health Department and the nursing and midwifery professions on national and state committees. [29]

This role is much wider than the current role of the Nursing Advisory Unit within Queensland Health. It is our firm view that the role and function of the Chief Nursing Adviser and Nursing Advisory Unit must be expanded along similar lines to the New South Wales model. It will be particularly important that this change takes place to ensure the success of the ambitious agenda for workplace reform and health service delivery (especially managing the inter-relationship between the public and private and not for profit health sectors) outlined in the Queensland Health Strategic Plan and the *Health 2020* Strategy.

2. Reporting relationships

In our view it is essential that the reporting relationships for the Chief Nursing Adviser and their office are clear and unambiguous. Not only is it essential that this position report directly to the Minister for Health and the Director General for Health in the same manner that their NSW counterpart does, it is also essential that nurses within the health system are able to report concerns they may have about critical local nursing matters to the Chief Nursing Adviser if they are unable to resolve concerns with local management. Such a reporting relationship would in our view would help to prevent (or at least more promptly address) systems failures such as those highlighted in the recent Bundaberg Base Hospital debacle.

3. Delineation between Chief Nursing Adviser and Principal Nursing Adviser roles

There currently exists great confusion about the role delineation between the Chief Nursing Adviser and Principal Nursing Adviser roles. The QNU is unsure about who we should contact and in which circumstances and there also appears

29 Source NSW Health NaMO website.

to be similar widespread confusion within Queensland Health and the nursing community at the state and national levels about this issue. This confusion must be resolved as a matter of urgency.

4. Merit selection process for permanent appointment of Chief Nursing Adviser position

In our view it is also essential that the Chief Nursing Adviser position be filled on a permanent basis through an open merit selection process as soon as possible. It is not only the QNU that is concerned about the need for this to occur, many nurses have contacted us to express their concern about this issue. The process for permanent appointment must be open and transparent if there is to be confidence in the independence and integrity of this position. It is noted that this position has recently been advertised locally and nationally. However, confusion still exists with regard to the reporting relationships for the Chief Nursing Adviser and Principal Nursing Adviser roles. This must be clarified as a matter of urgency. It is of great concern to the QNU and our members that the Chief Nursing Adviser position is being permanently filled given the current uncertainty with regard to Queensland Health's structure and in the absence of any review of the current functions and relationships of roles with responsibility for whole of agency nursing advice and leadership. It is therefore recommended that the position of Chief Nursing Adviser not be permanently filled until such time that these matters have been clarified.

5. The provision of adequate resourcing for the Nursing Unit

It is our strongly held view that resources allocated to date to the Nursing Advisory Unit have been woefully inadequate. We have expressed this view in multiple submissions to government in recent years. Our most recent submission to the Queensland government provided late last year in advance of the 2005-2006 state budget preparation outlines our current views with regard to priority resourcing issues for the Nursing Advisory Unit and more widely. Much more can be achieved in terms of the implementation of a rational and sustainable nursing strategy for Queensland if even a modest increase in resourcing were to be provided.

Although progress has been made in recent years as a result of the Ministerial Nursing Recruitment and Retention Taskforce established by the previous Minister more resources must now be provided to properly progress nursing workforce issues in Queensland. The QNU remains extremely concerned that significant momentum has been lost in recent years with regard to the implementation of strategies to address the significant longstanding nursing shortages that currently exist. Inaction and "short-termism" in health and nursing policy are creating self-perpetuating downward spirals of shortages that threaten not only the quality of care provided to the community of Queensland but also the very future of quality nursing services. For this to be addressed there needs to be a clear strategy developed in consultation with all key stakeholders (including the QNU) and adequate resources must be allocated to ensure accountability for the achievement of nursing objectives. This must be properly coordinated and driven by an adequately resourced Nursing Advisory Unit.

6. The role of the Nursing Unit with regard to health workforce restructuring

As the largest single occupational group within Queensland Health and the health workforce generally nurses have a critical role to play in developing innovative, responsive and sustainable models of health care for the community of Queensland. This is even more critical given the demographic challenges confronting us. There is no doubt that there will be a need for new ways of doing things. This has been identified in both the current Queensland Health

strategic plan and the *Health 2020* strategy document. Nurses are committed to providing high quality nursing services now and into the future. Likewise the QNU is keen to collaborate closely with Queensland Health and other providers of health and aged care services in this state to ensure the provision of high quality, appropriate and responsive nursing services.

To do this we need to be closely involved in consultations about the changes that will be required to health service delivery going forward. We are concerned however that the space does not exist for us to do so in a meaningful and ongoing manner. We are concerned that changes in service delivery are occurring without an appropriate framework being in place to ensure adequate input from both nursing services within Queensland Health and the QNU. For example, in recent times it appears that a significant number of clinical service coordination positions have been created at the AO7 level within Queensland Health. To our knowledge there has been no consultation with health unions about these new positions. This is of concern to the QNU as we believe this may point to a more widespread "genericisation" within health that would in our view undermine both the provision of quality health services and the nursing career structure. It is therefore essential that wider issues of health workforce reform feature prominently in our discussions about Queensland Health's nursing strategy and the role of the Nursing Services Unit.

RECOMMENDATIONS (Nursing leadership)

It is recommended that:

The Office of the Chief Nursing Adviser within Queensland Health be restructured so that it is consistent with the model for the Office of the Chief Nursing Officer in New South Wales. Further to this, additional resources be provided to ensure that the office of the Chief Nursing Adviser within Queensland Health can carry out the functions of their New South Wales counterpart.

Reporting relationships between the Office of the Chief Nurse Adviser and the Minister and Director General for Health be reviewed and amended as necessary to ensure consistency with the reporting relationship applying in New South Wales.

There is clear delineation between Chief Nursing Adviser and Principal Nursing Adviser roles, which will be especially important going forward given the importance of nursing leadership if we are to change the culture of Queensland Health. Further to this, that a merit selection process takes place to permanently fill the position of Chief Nursing Adviser but this cannot take place until such time that matters relating to whole of agency responsibility for nursing leadership and reporting relationships between the Chief Nursing Adviser and Principal Nursing Adviser roles are clarified.

The Office of the Chief Nursing Adviser be directly involved in negotiations on workforce restructuring within Queensland Health and that this office ensures the establishment of appropriate consultative mechanisms to ensure the ongoing involvement of the QNU in adequate negotiations of such changes.

Terms of Reference for this inquiry

To specifically review:

3. Performance management systems including as they relate to:

Asset management and capital works planning and delivery
Information management
Monitoring health system outcomes

We have addressed many performance management issues previously in this submission. We will therefore not provide detailed comment on issues relating to this specific term of reference. Rather, we will briefly restate concerns already raised and highlight other relevant issues that have not yet been covered.

Performance management is vitally important, and it is an area where the QNU believes there is room for considerable improvement. Appropriate performance management is made virtually impossible in our view where there is a culture of secrecy and a fundamental lack of openness and transparency as is the case with Queensland Health.

Changing the culture and governance of Queensland Health to ensure that it is open and therefore much more accountable is of critical importance. This is not going to occur easily if there is not a wider systemic change of approach on behalf of government with regard to improving the openness of government in Queensland. Both sides of politics have failed to achieve an adequate degree of openness in our view and it is time for the blaming and buck passing between the parties to stop. When in government political parties try to limit openness and disclosure and when in opposition they cry for more openness and disclosure. The time for political point scoring is over. The problems in Queensland Health demonstrate clearly to us at least what happens when openness and transparency are eschewed and critical analysis and debate discouraged. This is not only dangerous to democracy itself, it can also result in loss of lives when this is the culture in a vitally important public service such as health.

Asset management and capital works planning and delivery

Given the size and complexity of Queensland Health issues such as asset management and capital works are going to present particular challenges. The QNU has certainly noticed some improvements in recent years with regard to asset management by Queensland Health. The government must also be congratulated for the significant capital works programme of the last 15 years. This has been one of the most comprehensive health system capital works programmes in Australia's history. The health service stock had been neglected for decades under National Party rule, so the capital works programme was long overdue.

The Goss and now Beattie governments must be acknowledged for undertaking such a significant rebuilding of public infrastructure, and, importantly, for achieving this through appropriate public borrowings rather than through alternative funding arrangements such as Public Private Partnerships (PPPs). (The experience both in Queensland and interstate has shown that PPPs in health have proved to be a spectacular failure and an expensive exercise for government.) It must also be acknowledged that this capital works programme is continuing and will be boosted further through infrastructure programmes recently announced for south east Queensland. The critical issue for nurses with respect to capital works programmes is that we have early and ongoing input into facility design and commissioning processes.

There are a number of concerns that we wish to highlight regarding capital works planning and delivery and asset management. These relate to the problems that QNU has experienced with regard to building design and the contracting out of maintenance services for many Queensland Health facilities in recent years, and the impact this has had on adequacy of ongoing maintenance and the maintenance of an appropriate number of tradesperson positions and apprenticeships within Queensland Health.

Building design

Our strong view is that it is essential to involve nurses in a meaningful and ongoing way in the design of new buildings and refurbishments. This should occur from the initial planning phases and continue until final commissioning. It has been our experience that when this does occur problems are minimised and the final result is better design and a more user friendly working environment for nurses and care environment for patients. When this does not occur then we encounter sometimes significant problems.

Over the past few years the QNU has spent considerable time negotiating on behalf of members for building designs to be modified or fixed because of health and safety concerns. Examples of issues that have required our intervention include: amenities for staff, redesigning toilets to allow a toilet chair to fit over the bowl, suitable wheels for trolleys that don't require excessive force when pushed over carpet, modifications to plumbing and air-conditioning where chemicals were being drawn through the system, and significant modifications to building design at Bundaberg, Gold Coast and Logan Mental Health Units, to name a few.

Another issue of concern to the QNU is that it appears there is not a consistently applied process for determining and prioritising capital works projects. This specifically applies to rebuilding and refurbishment works for staff accommodation in rural and remote areas. The QNU receives frequent contact from members in these locations about priority afforded to projects and the inequitable treatment of staff with respect to access to staff accommodation. This situation contributes to problems recruiting and retaining nursing staff to work in remote and rural locations. A consistently applied and transparent policy and process for determining access to accommodation is required.

It is important to note that the Beattie government amended the *Workplace Health and Safety Act 1995* in 2003 to extend the obligations of various parties including "designers of buildings or other structures used as a workplace". The aim was to prevent injuries caused by inappropriate design. We believe that minimum design guidelines should be developed specifically for Queensland Health facilities in order to prevent design related hazards.

RECOMMENDATIONS (Capital works and maintenance)

It is recommended that:

Nurses be always included in consultations for the initial design and ongoing commissioning phases of all new capital works and redevelopments to ensure that workplace designs are both patient and health worker friendly.

A consistently applied, equitable and transparent whole of agency approach to prioritising of the development of staff accommodation refurbishment and rebuilding projects and a fair process for determining access to accommodation be developed.

Funding be allocated to facilitate the development of minimum design guidelines for Queensland Health facilities.

Maintenance at Queensland Health facilities

The QNU has been concerned for some time now about the trend within Queensland Health to contract out maintenance services. We fear that this may not be a cost effective practice in the long term and are also concerned that there has not been adequate monitoring or review of the appropriateness of this action. It is especially important that close attention be paid to the adequate maintenance of assets, especially when such a significant amount has been expended on capital works in Queensland Health in recent years.

It is also of significant concern that Queensland Health appears to not be meeting its obligations with regard to the training of new tradespersons in recent years. It is extremely important that Queensland Health, as one of the largest if not the largest employer in Queensland, plays a role in the training and employment of new apprentices. Government agencies play a key role in this regard (especially in rural and remote communities) and have an essential part to play in helping to address the current and projected shortages of tradespeople in this state. The QNU was shocked and dismayed to discover recently that of the total Queensland Health workforce (head count as at December 2004) of **49,327** there were only **169** tradespeople employed by Queensland Health. This is, in our view, a disgrace. Queensland Health must urgently review the employment of tradespeople and proactively plan to contribute to addressing tradespeople skill shortages in Queensland by engaging more tradespeople to carry out asset maintenance "in house" which would in turn facilitate the agency playing a more active role in the training and employment of trades apprentices in this state. The state government has a key role to play in the training of tradespeople. State agencies (such as Queensland Health) have in recent times taken a short term view on training and development needs and the needs of the community as a whole in relation to skills shortages. By refusing to acknowledge they have an important role to play in this regard they have contributed to the current skill shortages.

RECOMMENDATION (Capital works and maintenance)

It is recommended that:

Queensland Health urgently review its policies regarding the contacting out of maintenance services in Queensland Health with a view to increasing the direct employment of tradespeople to undertake maintenance in house and be available to supervise apprentice tradespeople within the agency. Further to this that Queensland Health subsequently significantly increase the number of apprentices that it employs to assist the state to address the significant skill shortages that currently exist.

Information management

Lack of adequate information management by Queensland Health has been a long-standing source of frustration to the QNU. Some of our concerns regarding our inability to access meaningful information upon which to base decisions and our general concern about a culture of secrecy within Queensland Health have already been highlighted in this submission. This is a critically important issue to the QNU. A genuine partnership with Queensland Health is required to re-establish confidence of both staff and the community and this cannot occur until these issues are addressed. One clear example of the long term difficulty we have experienced in accessing information relates to a simple issue such as ascertaining the number of nurses employed by Queensland Health.

Despite being one of the largest Queensland public sector agencies (with the second largest budget allocation) Queensland Health cannot state with any degree of accuracy its actual number of employees at any given time (unless they do a manual head count). It is our understanding that Queensland Health

until very recently was the only government department required to report MOHRI (Minimum Obligatory Human Resource Information) data that could not do so. Even though they are reporting against MOHRI data in the 2003-2004 Annual Report (as is prescribed by the Ministerial Portfolio Statements) we have grave doubts that the data recorded is accurate as they cannot provide us with data on actual numbers of nurses employed and current vacancy levels. It is not uncommon for a number of different figures to be given to us by HSDs when we ask for nursing FTE numbers. We therefore have no confidence in the data Queensland Health provides us with in respect to nursing employees and we wonder whether it is convenient for the agency to not have accurate data available for public scrutiny as this would clearly demonstrate the efficiency gains in recent years by nurses and other health workers and the extent of excessive workloads in that agency.

The QNU receives mixed messages about Queensland Health's capacity to provide accurate workforce data. We are frequently advised by some when we request information from Corporate Office HR/IR Policy and Strategy Centre about nursing numbers (head count and FTE) and nursing vacancies across the state that this information cannot be provided. And then when we attend meetings with other Queensland Health officials we are provided with information on employment numbers. An example of this was that a document was tabled at a meeting of the Queensland Health Workplace Harassment Project Meeting on 8 June 2005 that detailed the number of Queensland Health employees who had attended training about this issue. This document also provided a total "head count" of employees by occupational category for each HSD as at 31 December 2004. We totalled the numbers provided in this document to reveal the following total headcount of employees of Queensland Health by occupational group:

Occupational Category	QH Total Number by Occupation
Professional	5009
Medical	4353
Operational	9555
Administrative	7872
Nursing	21039
Technical	862
Trades	169
Dental	468
TOTAL	49327

Note: It appears from data provided that Northern Downs HSD provided FTE data rather than head count.

Our question is: if one part of the agency can gather and supply this sort of information why can't all areas? It is difficult to determine with accuracy whether it genuinely is the case that Queensland Health's IT and HR systems do not allow them to provide unions with meaningful data or whether they use systems inadequacies as an excuse for not releasing the information to us. For the purposes of this submission we will assume system deficiencies.

How can accurate workforce planning and reporting (e.g. legislated Equal Employment Opportunity reporting against set government objectives) or proper budgeting take place in such an information vacuum? In our view immediately addressing Queensland Health's information deficiencies, especially in relation to human resources, should be a top level priority for the Queensland government.

The current situation represents a critical and ongoing risk for government and until it is addressed a fundamental accountability flaw will continue. Surely this is of great concern to central government agencies. The community of Queensland is entitled to expect that such a significant government agency has accurate and efficient systems for data gathering. Given the IT systems that are now available it is hard to comprehend why this issue has not been addressed by now, unless it is the case that the agency somehow benefits from maintaining the status quo of information ignorance.

Associated with the lack of HR information is the lack of organisational will to address standardised HR and IR practices and policies across Queensland Health. We have been advised for some years now that a standardised HR/IR policy and procedure framework is proposed but have seen little progress towards achievement of this objective. Until this issue is addressed the QNU and other unions will continue to experience extreme difficulty in obtaining compliance with industrial instrument provisions. This is not only a source of frustration for health unions but also their members - the employees of Queensland Health - who are tired of the continual buck shifting between facility/district/zone and corporate office levels. They simply want to cut through the bureaucracy and achieve their rightful entitlements. The current situation destroys relationships and good faith between the agency and unions and the agency and its employees. Surprisingly one Queensland Health official advised us that we should have included our request for the implementation of a standardised HR/IR policy and procedure framework in our last EB claim. This is not a bargaining issue - it represents standard (not even best) HR/IR practice.

The government needs to exercise extreme caution when they state they have employed "extra" nursing positions in recent years. Not only is Queensland Health HR data notoriously unreliable, it should also be noted that it has been estimated by Queensland Health that demand for nursing services will increase by 30% between 2000 and 2010.[30] The number of nurses per 100,000 population in Queensland has decreased in recent years and Queensland Health has also significantly expanded services in some areas of particular population growth or demand growth due to other factors. Given these factors and based on available information we believe it is safe to assume that the number of nurses employed by Queensland Health has been decreasing (or in a best case scenario has remained static), be this in number of full time equivalents (FTE) employed or actual head count of nursing employees. Evidence provided earlier in this submission clearly demonstrates that Queensland Health public hospitals employ far less nurses per 1000 population than the rest of Australia.

There is broad nursing workforce data highlighting the increasing shift to part time work by nurses – over 50% of nurses are now working part time. We also have access to significant Queensland anecdotal evidence on the causes of this major shift through USQ research undertaken in 2001 and 2004. National and Queensland evidence highlights that a significant contributing factor to this change in working patterns is work intensification. Nurses are decreasing the hours they work per week so they can better cope with excessive workloads. When nursing vacancies are not filled those left in the system are expected to cope as management refuses to cut services provided in order to match supply of nursing services with demand. Addressing the causes of decreasing nursing workforce attachment will be central to finding sustainable solutions to the growing demand for services evidenced by indicators such as lengthening waiting lists for elective surgery.

30 Queensland Health Workforce Planning Discussion Paper (2002), *Towards a sustainable supply for Queensland Health's nursing workforce: Recruitment and planning issues for 2000-2010, page 12.*

As stated above, extreme care needs to be taken when interpreting nursing workforce data. For example, the government has stated that they have exceeded their 2001 election promise to employ an additional 1500 new nursing graduates over three years. (A similar promise was again made in the lead up to the 2004 state election.) Yes, it was the case that just over 1500 new graduates were employed in the three year period since 2001 and another 500 are expected to be employed in early 2005. (As of December 2004, 520 new graduates have been employed by Queensland Health during 2004.) However these new graduates have only been employed into existing nursing vacancies and should not be interpreted as the government employing **additional** nurses. This simply has not occurred and has been acknowledged by Queensland Health officials as having not occurred. An examination of the available data demonstrates that these "additional" nurses have not been employed. Queensland Health has admitted for example that it is routine for nursing vacancies in the second half of the year not to be filled so that positions will be available for new graduates in the New Year.

The information we have access to about the number of nurses employed by Queensland Health is based on the actual number of nurses balloted in various EB ballots and Queensland Health Annual Reports and other materials:

Enterprise Agreement	Number of nursing employees Balloted
No 2 – 1996	19,429 (RN, EN and AIN)
No 3 – 1998	23,000 (RN, EN and AIN)
No 4 – 2000	21,062 (RN, EN and AIN)
Qld Health Est for No 5*	19,338
As at Dec 2004**	21039

* If ballot had been conducted
** Based on information tabled at Queensland Health Workplace Harassment Project meeting on 8 June 2005)

Qld Health Annual Report Year	No of FTE Nursing Staff Employed[31]
1998/99	17,048 (RN, EN and AIN)
1999/2000	16,141 (RN, EN and AIN)
2000/2001	16,171 (RN, EN and AIN)
2001/2002	16,280
2002/2003	over 16,000 – no precise figure given
2003/2004	16,831[32]

The QNU strongly believes that this ridiculous situation regarding the lack of availability of meaningful data within Queensland Health must be addressed as a matter of urgency. This is simply an embarrassment for government for this to continue and it must be a particular concern to them given the significant resources previously allocated to Queensland Health for IT systems and staff. We have already provided a recommendation about this issue in an earlier section of this submission.

31 Queensland Health Annual Reports 1998/99 page 8, 1999/2000 page 29, 2000/2001 page 35, 2001/2002 page 28 and 2002/2003 page 37.
32 Queensland Health Annual Reports – Note: 2003-2004 Annual Report FTE figure uses MOHRI data that they say excludes contract/agency staff data.

Monitoring health system outcomes

The issue of national reporting frameworks for public hospitals (and the deficiencies we see regarding lack of development of indicators of equity and effectiveness) has already been discussed previously in our submission. Queensland Health contributes to a number of other health system outcome reporting processes to organisations such as Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics, the Commonwealth Department of Health and the Productivity Commission (for the *Report on Government Services*). It is our understanding that work is under way to achieve better standardisation of data required and provided.

The QNU would support the development of a standardised comprehensive reporting framework for health given that this would help decrease duplication of effort with regards to reporting requirements. The critical point for the QNU are that any performance indicator framework/s for health must be balanced and include robust indicators of equity and effectiveness. Community needs and expectations about health care must always underpin the development of such indicators. To date, undue emphasis has been placed on the development of efficiency indicators and now a concerted effort must be made to develop comprehensive and robust indicators of equity and effectiveness. We also strongly believe that much more can and should be done on the development of tools to promote "evidence based practice" so that informed decisions can be made by consumers and clinicians alike about available treatment options. The work of the international Cochrane Collaboration provides an invaluable starting point for this. To date this resource is largely utilised by clinicians. Much more work is required to further develop the application of evidence based practice by clinicians and increase community awareness of the need to base decisions about treatments on the best available evidence.

The current Queensland Health Strategic Plan provides details (at page 20) of their proposed performance measures. A mixture of measures of health status indicators and health systems performance measures are listed. The health status measures are relatively straightforward and represent a good starting point to reportage on health status and the vast majority of these are already broadly reported on. (No doubt more health status performance indicators will be developed over time. There must however be a rational number of such indicators so that we do not end up reporting for the sake of it, hence the importance of reaching agreement at the national level about what constitute appropriate measures for inclusion.) The measures of health system performance could prove to be more problematic in our view. For example, how can factors such as "Community confidence in Queensland Health" and "Whole of government action that supports health" be accurately measured? We believe that further careful consideration of the "systems performance measures" is required. Why is it not possible, for example, to measure and report upon the perceptions of the performance of Queensland Health by key stakeholders including unions? Also, why aren't measures of the success of Queensland Health's broader role of regulating all health services (including private health and aged care facilities) included? This is a significant deficiency in our view.

It is also of great concern to the QNU that there currently is no overall monitoring of coroner's cases in Queensland. Implementation of recommendations from coroner's cases are not monitored or coordinated effectively. This is a significant deficiency given that the coroner's court is a critically important safety and quality surveillance mechanism. The QNU only becomes aware of cases if our members are involved in them; however this does not capture all matters that may be of interest to us. When we recently contacted the coroner's court to attempt to ascertain how we could monitor cases coming up that may be of interest to the

QNU we were advised that these are publicised in the Law List in *The Courier Mail*. There are a number of problems with attempting to monitor the cases by the Law List in the Courier mail. Firstly, it is difficult to track cases given that they are not listed routinely. Also, very little information is readily available on the nature of the cases. Other deficiencies with regard to coroner's court processes will no doubt be highlighted by the Bundaberg Hospital Commission of Inquiry. We believe that it is vitally important that a simple and transparent monitoring mechanism for coroners' matters must be devised as a matter of urgency.

RECOMMENDATIONS (System performance)

It is recommended that:

In consultation with other key stakeholders there be further development of appropriate performance indicators within Queensland Health, especially indicators that relate to equity and effectiveness within Queensland Health.

As a matter of urgency an appropriate and comprehensive framework is developed for the monitoring and implementation of coroner's recommendations regarding deaths in public and private sector health and aged care facilities in Queensland.

Monitoring health systems outcomes in the private sector

Queensland Health's legislative responsibility to protect the health and wellbeing of Queenslanders includes responsibility for establishing standards and requirements to ensure high quality and safe health services for all Queenslanders. The Union believes there currently exist significant deficiencies regarding the monitoring of health outcomes in the private sector in Queensland. By way of example, the QNU wishes to provide comment about two specific issues of concern in relation to Queensland Health's monitoring of privately provided health care services in this State.

These issues are:

i) the current standards for staffing in private health facilities; and
ii) the proposed changes in Queensland Health policy in relation to administration of medications in residential aged care facilities.

i) Current standards for staffing in private health facilities

In July 2004 Queensland Health published the *Clinical Services Capability Framework for Public and Licensed Private Health Facilities* (SCF). The stated purpose of the document is to 'provide a standard set of capability requirements for most acute health facility services provided in Queensland by public and private health facilities'. The SCF, amongst other things, provides minimum levels of qualifications, skills and experience of medical, nursing and allied health staff required to ensure a safe service.

Of major concern to the QNU is that the SCF does not set minimum staffing levels for all services. For example, while the SCF requires that there is a minimum of two registered nurses on duty at all times when there is a patient in an intensive care unit, the SCF provides for staffing in an acute surgical unit to be determined at the local service/facility level. The QNU is constantly receiving reports from members in private hospitals that nursing staffing levels are inadequate, and in some cases, unsafe. Members, particularly from smaller acute care private hospitals, also regularly report concerns about inadequate access to medical officers in emergency situations.

RECOMMENDATION (System performance)

It is recommended that:

The *Clinical Services Capability Framework for Public and Licensed Private Health Facilities* (SCF) is reviewed as a matter of priority in consultation with the QNU and other stakeholders and amended to include minimum staffing levels and skills mix **required** to ensure safe practice in all service areas.

ii) Proposed changes in Queensland Health policy in relation to administration of medications in residential aged care facilities

The legislative framework that provides for administration of medications in all Queensland health services, along with other standards and controls for scheduled drugs and poisons, is established by the *Health (Drugs and Poisons) Regulation 1996*. The Regulation is made pursuant to the *Health Act 1937 (Qld)*. The Regulation is administered by Queensland Health and operational issues are managed by the Queensland Health Environmental Health Unit. The stated role of the Environmental Health Unit is to develop policies in relation to the management of medications that promote, safeguard and maintain the health and wellbeing of the people of Queensland.

In September 2004 Queensland Health released a draft Policy pursuant to the Health (Drugs and Poisons) Regulation 1996 *Guidelines for the Use of Carers in Helping with Medications (Residential Care Facilities)* for consultation. It is proposed that this document will replace the current Queensland Health policy (Circular No. 03/98). Currently only registered nurses and endorsed enrolled nurses may administer medications to residents who are unable to request assistance to take their medications. The proposed policy allows aged care providers to direct assistants in nursing/other unlicensed staff to give medications to *all* residents in residential aged care facilities.

The QNU opposes the introduction of the proposed Queensland Health policy. The union believes that implementation of the proposed policy would create serious risks to the health and safety of residents, and impose excessive and unreasonable responsibilities on unlicensed nursing staff in residential aged care facilities. The union also believes that the proposed policy does not reflect the legal requirements of the Health (Drugs and Poisons) Regulation 1996.

The carers' provisions in the Health (Drugs and Poisons) Regulation 1996 were introduced prior to changes in Commonwealth legislation that have resulted in dramatically increasing numbers of high care (nursing home) residents in low care aged care facilities (hostels). At the time the Regulation was introduced on 1 January 1997, all hostel residents in Queensland were classified as requiring low levels of care. In September 2000 approximately 29% of all hostel residents in Queensland were classified as high care residents. As at September 2004 approximately 40% of all residents in low care hostels in Queensland were nursing home type residents requiring high levels of care.

The majority of residents classified as requiring high levels of care do not have the capacity to ask for help to take their drugs and are not able to self manage their medications. These residents require their medications to be administered by a registered nurse, or an endorsed enrolled nurse under the supervision of a registered nurse.

The current Queensland Health policy stipulates that licensed nurses with endorsements under the Regulation must administer medications to residents in residential aged care facilities with only high care residents (nursing homes). Despite a statement excluding residential aged care facilities with only high care places from the proposed policy, Queensland Health has not confirmed that aged care providers could be prevented from directing assistants in nursing to give

drugs to residents in facilities/parts of facilities with only high care residents if the proposed policy is implemented.

A survey of QNU members working in aged care facilities has shown that licensed nurses currently administer medications in residential aged care facilities that care for at least 83% of all aged care residents in Queensland. The survey results also confirmed that the endorsed enrolled nurse role is under-utilised in low care facilities (hostels). The proposed policy confers authority on aged care providers to determine whether or not a licensed nurse will be 'available' to administer medications. The Union believes it is not appropriate for Queensland Health to permit aged care providers to decide who will administer drugs to residents in aged care facilities.

Ensuring that appropriate policies remain in place for medication management in residential aged care services is a matter of public interest as it affects some of the most vulnerable citizens of our community. The QNU believes that it is the responsibility of Queensland Health to ensure public safety in relation to the legal requirements for management of drugs and poisons in residential aged care facilities in this State. The proposed policy provides for persons without endorsements required under the Regulation to administer medications to totally dependent residents in aged care facilities. The proposed policy should not be implemented. A copy of the QNU submission to Queensland Health in response to the draft policy has been provided to this inquiry.

It is recommended that:

RECOMMENDATION (System performance)

Any Queensland Health policy related to medication management in residential aged care facilities reference the legislated requirements under the *Health (Drugs and Poisons) Regulation* that dispensed medications are administered by a registered nurse, or by an endorsed enrolled nurse under the supervision of a registered nurse, to any resident in residential aged care facilities who does not have capacity to request help from an assistant in nursing/carer to take their dispensed medication/s.

Conclusion

Thank you again for the opportunity to provide input into this important review. We view this process as a rare opportunity to bring about positive systemic change for health care in Queensland. We place on record again our eagerness to be involved in ongoing consultations during this review process. In particular, we would like to meet with the review team to discuss the contents of this submission, especially the USQ research provided with it, prior to the finalisation of your report.

The QNU is committed to a genuine partnership with government and our members to bring about the improvements needed to health service delivery in this state from both the perspective of nurses as workers in the system and citizens who hold legitimate concerns about current health policy and service delivery.

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Attachments

Attachment 1 – Confidential reports on Individual Health Service Districts and Corporate Office of Queensland Health

Attachment 2 – Case Studies of Queensland Health Culture and Behaviour

Attachment 3 – Background Materials on Best Practice Approach to Enterprise Bargaining in Health

Attachment 4 – Confidential Report on University of Southern Queensland Research conducted in 2004 into Nursing in Queensland

APPENDIX 3

QUEENSLAND
Nurses' Union
IN ASSOCIATION WITH AUSTRALIAN NURSING FEDERATION QLD. BRANCH
ADDRESS ALL CORRESPODENCE TO THE SECRETARY, G.P.O. BOX 1289, BRISBANE, Q, 4001.

IN REPLY PLEASE QUOTE: 14 May 1999

All enquiries regarding this correspondence should be directed to: ____________

Ms Kerryn Newton
Research Director
Legal, Constitutional and Administrative Review Committee
Parliament House
George Street
Brisbane Q 4000

Dear Ms Newton,

Re: Review of *Freedom of Information Act 1992* (Qld)

Please find attached a submission from the Queensland Nurses' Union (QNU) into the review by the Legal, Constitutional and Administrative Review Committee of the *Freedom of Information Act 1992*.

The QNU represents in excess of 26,000 nurses employed in both the public and private (for profit and not for profit) sectors in Queensland.

The union has a keen interest in Freedom of Information (FOI) matters and has made a number of submissions in the past on the issues of FOI and privacy. The QNU has utilised both state and federal FOI legislation to advance the collective and individual interests of membership. In our submission we will draw on this past experience to highlight particular issues of concern.

Officials of the QNU are willing to appear before public hearings held by the committee.

Should you require any additional information or clarification of issue raised in our submission please do not hesitate to contact QNU Project Officer Beth Mohle or QNU Industrial Officer Steve Ross on (07) 3840 1444.

Yours sincerely,

Gay Hawksworth
SECRETARY

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Registered under the Industrial Conciliation Arbitration Act 1990

Queensland Nurses' Union

Submission on the Review of the *Freedom of Information Act 1992*

Submitted 14 May 1999

A. *Whether the basic purposes of the freedom of information legislation in Queensland have been satisfied, and whether they now require modification.*

> *"A popular government, without popular information, or the means of acquiring it, is but a prologue to a farce or a tragedy; or perhaps both. Knowledge will forever govern ignorance: and a people who mean to be their own governors, must arm themselves with the power which knowledge gives." US President James Madison – 1822*[1]

Access to information relating to decision-making processes is essential to the appropriate functioning of a healthy democracy. Freedom of Information (FOI) legislation is pivotal to ensuring openness, accountability and responsibility in government and meaningful participation by the public in the political process. Indeed, following the Fitzgerald Inquiry the Electoral and Administrative Review Committee (EARC) correctly identified FOI as a "foundational matter" that needed to be addressed as a matter of priority. The introduction of such legislation was central to the Fitzgerald reform process and the democratisation of this state.

The FOI Bill was introduced to State Parliament on 5 December 1991 by the then Attorney General Hon Dean Wells. In his second reading speech the Attorney General stated:

> *"The Bill enables people to have access to documents used by decision-makers and will, in practical terms, produce higher level accountability and provide a greater opportunity for the public to participate in policy-making and government itself."*[2]

Attorney General Wells concluded the second reading speech:

> *"... this Bill will effect a major philosophical and cultural shift in the institutions of Government in this State. The assumption that information held by government is secret unless there are reasons to the contrary is to be replaced by the assumption that information held by Government is available unless there are reasons to the contrary. The perception that Government is something remote from the citizen and entitled to keep its processes secret will be replaced by the perception that Government is merely the agent of its citizens, keeping no secrets other than those necessary to perform its functions as an agent. Information, which in this modern society is power, is being democratised."*[3]

In the absence of any meaningful performance data on the operation of the Act, it is difficult to actually measure to what extent the implementation of FOI legislation has increased accountability and public input into the policy-making process. There is no disputing that improvements have been made but the base from which comparisons can be made was a very low one. It must also be remembered that, although important in itself, FOI legislation was merely one plank of a significant public sector reform agenda implemented by the Goss government. It is difficult therefore to ascertain with any certainty the part that FOI alone has played in bringing about cultural shifts within the government departments.

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[1] Quoted in *Freedom of Information Report by the Senate Standing Committee on Constitutional and Legal Affairs on the Freedom of Information Bill 1978, and aspects of the Archives Bill 1978* - Australian Government Publishing Service, Canberra 1979, page 23.
[2] Queensland Legislative Assembly *Hansard*, 5 December 1991, page 3848.
[3] Queensland Legislative Assembly *Hansard*, 5 December 1991, page 3850.

Given the difficulty experienced accessing meaningful performance data, our submission to this review of the Queensland FOI legislation will be based on the experiences of the Union and our observations of the operation of the Act.

The existence of FOI legislation certainly has improved access to information, especially information relating to the personal affairs of an applicant. For example, Queensland Health has made great efforts since the implementation of the FOI Act to assist individuals to obtain access to their medical records held by the department. This information is now usually provided by less formal administrative access arrangements. In the vast majority of cases it is no longer necessary to utilise FOI legislation to obtain access to personal medical records. While there is still some resistance on the part of individual health care providers, by and large there has been a significant attitudinal change on the part of health care providers in the public sector with regard to this issue in recent years. Unfortunately, in our opinion, the same cannot be said for the approach to providing access to information that is not of a personal nature. Much more needs to be done to promote a "pro-disclosure" culture within the Queensland public sector.

The Queensland Nurses' Union (QNU) has used FOI legislation while acting in the individual and collective interests of membership. When the union has assisted members to use FOI to access information of a personal nature there has generally been no difficulty in gaining accessing this information. For example, the Union has in the past advised members to gain access to their WorkCover files via both administrative access arrangements and FOI processes when appealing a decision of that body. In these cases recourse to FOI is required because under administrative access arrangements information relating to internal decision making processes is not provided. There are also inconsistencies relating to the timeframes that apply to the processing of FOI applications (generally up to 45 days in these cases) and the timeframes for lodging WorkCover appeals (28 days). Administrative access to files (excluding information that is often of particular relevance in appeal processes) is usually granted within 28 days. In our view there is an urgent need for bodies such as WorkCover to adopt a more "pro-disclosure" approach and grant access to complete information via administrative access arrangements in the first instance. This information is currently being obtained under FOI anyway. If this information were made available via administrative access then unnecessary duplication of effort would be avoided.

The QNU has also successfully assisted members to use FOI to amend false or misleading information contained on personnel files. In these cases members were unable to gain access to their files via administrative access arrangements and therefore were forced to utilise FOI processes to amend records. Although members have been satisfied with the outcome in these instances, it seems time wasting for both parties to resort to the formality of FOI in these circumstances. Again, in our opinion a "pro disclosure" culture needs to be promoted and adopted within the Queensland public sector.

The QNU has however experienced difficulty in obtaining access to information in the collective interests of our members. This information can usually be categorised as information that is not of a personal nature and relates to the policy decision making processes of government. In our view this is where the basic purposes of the FOI Act are not being met. There is still an assumption that information relating to the decision-making processes must be kept secret. This reluctance to provide information is a serious impediment to open and accountable government in this state.

The way in which FOI legislation is an essential accountability tool not only for the public but also for government ministers was highlighted in the 1979 Senate Standing Committee report on Freedom of Information:

> *"Freedom of information legislation is a means not only of ensuring the more direct accountability of public servants to the public, but also of ensuring greater accountability of public servants to their ministers. It is in the interests of ministers themselves to expose the advice of their officials to wider public scrutiny so as to improve the quality of that advice and ensure that all possible options have been canvassed. Freedom of information legislation can be in the interests of the public services and agencies whose processes are opened up to the public gaze too, for it will lead to more adequate recognition of the effectiveness of the public service."* [4]

Based on our experience with departments such as Queensland Health, the QNU believes however that the cultural shift required of public servants that would ensure greater public accountability for advice given and decisions made has not occurred to a great extent. Certainly the Administrative Law sections within departments have a greater understanding of this essential rationale for the implementation of FOI legislation. This appreciation unfortunately often does not extend beyond FOI practitioners within departments. (This sometimes results in considerable tension and frustration within agencies when the FOI decision makers have to deal with resistance from other sections of their department who are reluctant to act in accordance with the spirit of the FOI legislation.) There is not, in our view, the general promotion of a "pro-disclosure" culture within many departments. More needs to be done in the area of training of all staff (from Director General level down) on the philosophical foundations and appropriate application of FOI legislation in order to promote the adoption of a "pro-disclosure" culture.

Difficulties in affecting cultural change can not be attributed to attitude alone. It is however important to also consider the impact that information management practices and policies have on the administration by agencies of the FOI Act. The QNU is unaware of a consistent approach to information management across agencies. From our experience it certainly appears that there is no consistent approach. The manner in which information is stored and retrieved by agencies often makes the job of the FOI decision-maker more difficult. We therefore believe that it would be appropriate to review information management processes and policies to ensure that these facilitate the release of information via FOI or administrative arrangements. The way in which agencies communicate information about their FOI processes also needs to be reviewed. A simple examination of departmental websites, for example, reveals that there is no consistent approach to the advertising of agency FOI processes.

[4] *Freedom of Information Report by the Senate Standing Committee on Constitutional and legal Affairs on the Freedom of Information Bill 1978, and aspects of the Archives Bill 1978* – Australian Government Publishing Service, Canberra 1979, page 26.

The QNU has experienced (and continues to experience) considerable difficulty in accessing meaningful information on Queensland Health decision making processes. We have sought access to information pertaining to issues that are of direct relevance to our membership but are seen, in the eyes of Queensland Health officials, as being in some way "controversial". The department has in these cases exhibited extreme reluctance to release all the relevant information. The QNU has been most dissatisfied with the extreme secrecy exhibited and the reluctance to open up their decision-making processes to public scrutiny. Examples of QNU FOI applications of this nature include our application for access to information about the 1993 decision to slash nursing career structure positions, our 1993 and 1994 applications (under both state and federal FOI legislation) for information about to the privatisation of Greenslopes Repatriation Hospital and most recently our late 1998 (pending) application relating to the collocation of public and private health facilities. In all of these instances we encountered extreme reluctance on the part of Queensland Health to release meaningful information in the context of the established industrial relations consultative processes. We were therefore forced to utilise FOI processes in order to scrutinise the deliberative processes of the department and the advice given to the Minister and Cabinet on these matters.

Our most recent pending application for information about collocation arrangements should be of particular interest to members of this committee given its relevance to the current inquiry by the Parliamentary Public Works Committee into the Noosa and Robina hospitals projects. The QNU is still awaiting the outcome of our FOI application on this matter. We relayed our experiences with respect to undue secrecy by Queensland Health in relation to this matter to the Public Works Committee. This Committee also who appeared to be experiencing difficulty in accessing meaningful information from the department in relation to the contractual arrangements for the Noosa and Robina projects. We expressed to that committee our fear that they may experience the same difficulty accessing information that was experienced by a South Australian parliamentary committee investigating the privatisation of Modbury hospital. The health department in South Australia had consistently refused to provide relevant information to the parliamentary committee, thereby placing these contractual arrangements above the scrutiny of the parliament and the public. We await with considerable interest the report of the Public Works Committee on the Noosa and Robina projects. These could be of relevance to the deliberations on the review of the FOI Act.

These types of examples are now quite familiar given the grossly inappropriate trend of governments across Australia to "contract out" the provision of government services. Unfortunately governments have largely failed to put in place the necessary legislative framework to meet the significant challenges posed by the blurring of the boundaries between public and private sectors. (Later in this submission we will make specific recommendations pertaining to the extension of FOI provisions in circumstances where government services have been contracted out to the private sector.)

Before concluding this section of our submission we wish to briefly comment on one particular issue of concern that we believe is central to the consideration of whether the basic purposes of the Act have been satisfied – the issue of the abuse of the Cabinet processes to ensure that documents are excluded from public scrutiny. This activity has been facilitated by the 1993 and 1995 amendments to the FOI legislation that resulted in a broadening of the Cabinet/Executive Council exemption provisions of the Act. Governments of both major parties in recent times have in our opinion, abused these provisions.

The Information Commissioner has commented in a number of his annual reports on the need to wind back the overly broad exemption provisions of the Act. The QNU supports the concerns raised by the Information Commissioner in his 1995-96, 1996-97 and 1997-98 Annual Reports relating to these issues. We welcome the initiative of Premier Beattie when he introduced in 1998 (as Opposition Leader) a private member's bill aimed at preventing the abuse of Cabinet secrecy provisions. To quote from his second reading speech:

> *"This Bill amounts to a legislative promise that my Government will not sneak documents into Cabinet meetings as a device to hide them from the public. The Bill makes it clear that the Cabinet exemption from FOI does not arise when material is submitted to Cabinet for the improper purpose of avoiding FOI access."*[5]

We wholeheartedly welcome the spirit of this initiative of the Premier. Considerable cynicism exists within the general community at present given the often blatant past abuses of the Cabinet exemption provisions. There are far too many examples of documents literally being "wheeled in" to the Cabinet room (but not being genuinely considered by Cabinet) in order to qualify for the exemption provisions. Is it any wonder that there is an estrangement of the community from the political process and a general lack of faith in the openness and accountability of government in this state? We believe it is essential that the faith that the public has lost with respect to the efficacy of FOI legislation be restored as a matter of urgency.

The QNU believes that it is essential that urgent action be taken to address this issue. We believe there is a need for bipartisan support of legislative amendments to restore community faith in the efficacy of FOI legislation. We believe the government must demonstrate their commitment to FOI by "winding back" the current exemption provisions relating to Cabinet processes so they can not be abused. The QNU would defer to administrative law practitioners with respect to the best mechanism for achieving this desired outcome. We therefore refer the committee to Chapter 3 of the 1997-98 Sixth Annual Report of the Information Commissioner and the recommendations contained therein relating to the winding back of Cabinet exemption provisions.

To conclude our submission on this section of the inquiry we wish to place on record that we believe certain significant purposes of the FOI Act have not been met. Some of these deficiencies have been highlighted above. The QNU believes it is necessary to strengthen aspects of the current legislation so that a consistent "pro-disclosure" culture is promoted across the public sector. Suggested amendments to the relevant sections of the legislation will be made later in this submission. The QNU also wishes to make some recommendations relating to strategies that may assist to promote a "pro-disclosure" culture within the Queensland public sector. These recommendations are as follows:

Recommendation 1: **That a whole of government approach be adopted to develop strategies aimed at promoting an open and accountable culture within government agencies. This should include improved training for departmental officials at all levels on the philosophy underpinning FOI legislation and the importance of such legislation as an accountability mechanism.**

[5] Queensland Legislative Assembly *Hansard*, 4 March 1998, page 119.

Recommendation 2: **That performance criteria for Director Generals/CEOs and agencies be reviewed to ensure that these include a commitment to the principles of openness and accountability.**

Recommendation 3: **That as a matter of urgency current "administrative access arrangements" be reviewed to ensure that these facilitate the release of all relevant information of a personal nature via these arrangements (rather than having to resort to FOI processes) wherever possible. Further to this, that a central agency develop standardised guidelines for agencies promoting disclosure of information of a personal nature via administrative access arrangements.**

Recommendation 4: **That public sector information management processes and policies be reviewed to ensure that they facilitate (rather than hinder) the release of information via FOI of administrative access arrangements.**

Recommendation 5: **That as a sign of commitment to the principles underpinning FOI legislation that government "lead by example" and amend the provisions of the current act to ensure that the exemption provisions relating to Cabinet matters are not abused.**

B. Whether the FOI Act should be amended, and in particular:

(i) whether the object clauses should be amended;

As discussed elsewhere in this submission the QNU believes that the principle of access to information is critical to effective and democratic government. This review is occurring at a time however when the boundaries of government are becoming less easy to define as a consequence of , for example, contracting out of government services, the corporatisation of some governmental functions and authorities, joint ventures between government and the private sector and privatisation.

It is vital that these developments do not result in a restriction of access to information, yet increasingly this appears to be the case.

In order to retain participation in government, let alone extend it, access should be available to information on the functioning and functions of government irrespective of how or where they are carried out.

Therefore the object clauses of the Act need to reflect these developments and ensure access to information at the broadest possible level.

Recommendation 6: **That the object clauses of the Act reflect the right of access of the community to information on all the functions and processes of government irrespective of whether they are carried out by a government body.**

(ii) whether , and to what extent, the exemption provisions in Part 3 Division 2 should be amended

It is the view of the QNU that the current exemption provisions are too broad. In an environment where there remain cultural and attitudinal barriers to the release of information (see discussion above) the broad scope of the current Part 3 Division 2 matters gives excessive licence to restrict access to requested information. Specifically we make comments in relation to the following provision:

<u>Section 36</u>

See discussion above.

The QNU believes that the scope of this exemption should be restricted to the following:

(a) it has been submitted to Cabinet at the time the FOI application is made
(b) it is in the possession of a Minister for the purposes of Submission to Cabinet at the time the FOI application is made

(NB: Definitions to be amended accordingly)

This would have the effect of preserving Cabinet confidentiality while preventing reactive actions seeking to prevent access to information.

<u>Section 37</u>

See discussion above.

The QNU believes that the scope of this exemption should be restricted to the following:

(a) it has been submitted to Executive Council at the time the FOI application is made
(b) it is in the possession of a Minister for the purposes of Submission to Executive Council at the time the FOI application is made

(NB: Definitions to be amended accordingly)

This would have the effect of preserving confidentiality while preventing reactive actions seeking to prevent access to information.

<u>Section 38</u>

The operation of the section is dependent upon the understanding of the public interest. The presumption should be that it is in the public interest to release the information.

Section 40

(d) *delete*

The operation of the section is dependent upon the understanding of the public interest. The presumption should be that it is in the public interest to release the information.

Section 41

The operation of the section is dependent upon the understanding of the public interest. The presumption should be that it is in the public interest to release the information.

Section 45

The QNU believes this section should be broken up into its component parts, ie trade secrets, research and business affairs. In addition further distinction needs to be made between individual and corporate or agency interests. In addition definitions should be provided for the terms used. It has been our experience that increasingly terms such as 'commercial in confidence' have become a handy generic excuse to prevent access to information.. It is vital that this trend be stopped.

As elsewhere the operation of the section is dependent upon the understanding of the public interest. The presumption should be that it is in the public interest to release the information.

Recommendation 7: **That as a matter of urgency guidelines for a standardised public interest test be developed for use across agencies. Such guidelines for a public interest test should be developed following public consultations and should be made known to the public.**

(iii) *whether the ambit of the application of the Act, both generally and by operation of section 11 and section 11A, should be narrowed or extended;*

As mentioned above the QNU supports a narrowing of the existing exemptions. It follows therefore that we believe the ambit of the application of the Act should be extended. In particular we have concerns over access to information pertaining to privatisation and contracting out.

We draw the Committee's attention to the Administrative Review Council's recommendations to the Federal Attorney General contained in their report on the contracting out of government services. (A copy of these recommendations can be found as an attachment to this submission).

The Committee's attention should also be drawn to the definition of "Public Authority" contained in the Act which states in part that a public authority is:

> *"(c) another body (whether or not incorporated) – (i) that is (A) supported directly or indirectly by government funds or other assistance or over which government is in the position to exercise control".*

There are two possible options to address our concerns regarding access to information held by private sector operators providing government services. Firstly, the definition of a "public authority" could be extended to ensure that it covers private sector organisations in some form of contractual arrangement with government. Secondly, that all information generated and relating to an arrangement with a private sector organisation is deemed to be in the possession of the government, (and therefore accessible under FOI) other than that created by the private sector organisation.

We do not support any expansion of either section 11 or 11A of the Act either by legislation or regulation.

Recommendation 8: **That the ambit of the Act be expanded so that it applies to private sector organisations in a contractual arrangement with the government to provide some form of service.**

(iv) whether the FOI Act allows appropriate access to information in electronic and non-paper formats;

The QNU believes there should be no distinction between paper, non-paper and electronic information.

Recommendation 9: **That there should be no distinction between paper, non-paper and electronic information.**

(v) whether the mechanisms set out in the Act for internal and external review are effective, and in particular, whether the method of review and decision by the Information Commissioner is excessively legalistic and time consuming;

It is difficult to make a general assessment of whether the internal and external review mechanisms are effective given the limited information made available via the FOI reporting processes in Queensland. The information only allows us to make an extremely broad assessment of the appropriateness of these processes. This assessment can also only be made on 1996-97 data given that the 1997-98 Freedom of Information Report provided by the Department of Justice is not yet publicly available. It is also difficult to make a valid assessment of those matters dealt with via internal and external review for the 1996-97 year given the significant backlog of cases within the office of the Information Commissioner. Our comments on this particular term of reference will, therefore, be brief and broad.

The QNU believes it is necessary to maintain the current arrangements for internal and external review of FOI decisions. It is essential to maintain the office of an independent Information Commissioner. Based on the recent experiences of delays in the processing of FOI applications, as well as delays in the internal and external review processes, the QNU believes that it is essential there be a review of the adequacy of resources currently provided for the operation of the FOI Act. It appears some agencies are currently experiencing extreme difficulties in meeting statutory obligations because of excessive workload demands. We are advised, for example, that the Queensland Health Administrative Law Unit has been under considerable pressure over the last six months given that they have been inundated with complex requests for information. Given the peaks and troughs of demand it may be appropriate for a centrally established "pool" of experienced FOI practitioners to be established for agencies to access at times of extreme demand.

The QNU has experienced delays in the processing of reviews via the Office of the Information Commissioner. Given the complexity of some of these cases delays are to be expected to some extent. However, undue delays in dealing with matters have caused unnecessary stress to QNU members. The QNU believes the current delays are unacceptable and action must be taken to address this issue. We believe that delays experienced in the external review process could possibly be addressed by the provision of a further small increase in review staff. The considerable increase in output from the Office of Information Commissioner that has occurred in the 1997-98 reporting period should be acknowledged. This has made inroads into the backlog of cases and was achieved with a modest increase in staff via additional temporary funding. The Information Commissioner should be consulted about whether the resourcing requirements of this office are currently being met.

The QNU believes a statutory time frame should be established for external review with a decision required between 30 and 60 days after an appeal is made.

In order to assist the Information Commissioner the provision of investigative powers should be considered where the Commissioner is of the opinion they are being obstructed in their function and/or the exercise of such powers would assist the speedy resolution of the matter.

The QNU does not find the method of review or decisions made by the Information Commissioner unduly legalistic. Support for our view is best evidenced by the significant number of cases referred to the Information Commissioner that are resolved following mediation.

Recommendation 10: **That the current internal and external FOI review arrangements be maintained but that time limits be established for external review as suggested above.**

Recommendation 11: **That there be a review of the adequacy of FOI resources currently provided by agencies.**

Recommendation 12: **That consideration be given to the establishment of a central "pool" of experienced FOI practitioners be established so that agencies can access the additional FOI services in times of extreme demand.**

Recommendation 13: **That as a matter of urgency, the Information Commissioner be consulted regarding the adequacy of resources and investigative powers provided to that office and that additional resources be provided where necessary/appropriate to deal with the current backlog of cases.**

(vi) the appropriateness of, and need for, the existing regime of fees and charges in respect of both access to documents and internal and external review;

The QNU takes the Committee to the 1991 Report of the Parliamentary Committee for Electoral and Administrative Review *Freedom of Information for Queensland,* which states:

> *"The Committee acknowledges that the fee charges proposed by EARC will not make the administration of freedom of information self funding. It should be frankly conceded that freedom of information costs money and that the competing demands on government resources, for example, for schools, hospitals and police are considerable. The Committee considers, however, that a well-resourced, system of freedom of information is essential for enabling citizens to gain access to government information, which is in turn an essential prerequisite for a health democracy."*[6]

The QNU believes that the cost of administration and access to FOI should never be an impediment to the principles behind the provision of information and government should commit adequate resources to this end.

Recommendation 14: **That there be no increases to charges for access to information and that Government commit adequate resources to ensure the appropriate operation of FOI legislation in this State.**

(vii) whether amendments should be made to minimise the resource implications for agencies subject to the FOI Act in order to protect the public interests in proper and efficient government administration, and, in particular:

- *whether section 28 provides an appropriate balance between the interests of applicants and agencies;*
- *whether data collection and reporting requirements, which inform the parliamentary and public understanding of how well the FOI Act is operating in Queensland, exceed what is necessary to achieve their legislative purpose;*
- *whether time limits are appropriate.*

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[6] *Freedom of Information for Queensland* a Report of the Parliamentary Committee for Electoral and Administrative Review, Brisbane, 1991, Page 32.

It is difficult to make a definitive statement on the resource implications for agencies given that current reporting on the operation of FOI in Queensland fails to provide sufficient detail on the issues raised. According to the *Freedom of Information Annual Report 1996-97* only a handful of cases that went to internal review were denied access to information under Section 28 of the Act. There is no other readily available data to back up an assertion that the processing of FOI applications is placing an unreasonable demand on the resources of agencies. Indeed this report is not detailed enough to make a definitive statement on the matters raised above. This report should be compared to its federal counterpart, the *Freedom of Information Act 1982 Annual Report.*

The report on the operation of the federal act is much more "user friendly" and provides more detailed information than the Queensland annual report. In the Federal report, for example, the estimated costs attributable to the administration of the federal legislation, for the 1997-98 year was $12,191,478. Reports were also provided on an agency-by-agency basis. These costs are based on estimates provided by agencies and although they are not exact they provide a valuable insight that is not available in the Queensland jurisdiction. The report does express some concern about the inadequacy of the data collected and states that the Attorney General's Department is currently implementing strategies to improve the quality of statistical information. For example, they are planning to implement an Internet-hosted data base system for the electronic lodgement of statistics.

Given that the report on FOI data collected in Queensland is less comprehensive than its federal counterpart, the QNU believes that it would be difficult to sustain an argument that these data collection and reporting requirements "exceed what is necessary to achieve their legislative purpose". It may be the case that the current FOI reporting systems in Queensland are not efficient or effective, and if this is the case it would be appropriate to investigate strategies to improve processes and the quality of statistical data available, (for example, the potential use of Internet-hosted data base systems).

With respect to whether time limits are appropriate, it is again the case that we can only rely on data provided in the Annual FOI Report and our own experience to make a judgement. According to the *Freedom of Information Report1996-97:*

> *"The number of applications processed within 45 days after receipt by an agency fell slightly from 62.8% in 1995/96 to 66.4% in 1996/97. Applications processed within 60 days after receipt by an agency also fell from 11.8% in 1995/96 to 10.6% in 1996/97. Applications processed within 75 days after receipt by an agency increased slightly from 5.5% in 1995/96 to 5.8% in 1996/97 while applications which took longer than 75days to process increased from 14.5% in 1995/96 to 17.2% in the current reporting period."*[7]

The report also states that when the responses from two major agencies (Queensland Police Service and Department of Families, Youth and Community Care) are removed then the response times of all other state government agencies improve markedly.

Based on the information available to us and the experience of the QNU, we believe that the timeframes as they currently stand in the FOI legislation are appropriate.

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[7] *Freedom of Information Annual Report 1996-1997,* Department of Justice, Brisbane 1997, page 12.

Recommendation 15:	**That efforts be made to improve the current FOI Reporting arrangements in Queensland, and in particular that the adoption of innovative and time saving reporting arrangements (eg Internet-hosted data base systems) be actively considered.**
Recommendation 16:	**That mechanisms be developed to ensure that timely assistance is provided to agencies identified as being unable to meet statutory FOI timeframes.**
Recommendation 17:	**That there be no change to the timeframes for the processing of FOI applications as they currently stand in the legislation.**

(viii) ***whether amendments should be made to either section 42(1) or section 44(1) of the Act to exempt from disclosure information concerning the identity or other personal details of a person (other than the applicant) unless its disclosure would be in the public interest having regard to the use(s) likely to be made of the information;***

The QNU does not wish to make any submissions relating to amendments to section 42(1) of the FOI Act. We do however wish to make a brief statement about the necessity to amend section 44(1) in light of a recent high profile Victorian case involving the disclosure of information identifying nurses to a convicted murderer.

This particular case, made public early this year, involved the disclosure of the names of 51 nurses on duty at a Melbourne hospital on the night a triple homicide was committed. The convicted murderer claimed he could not have committed the crime as he was visiting his partner who was an inpatient at the Frankston Hospital at the time of the murders. He sought access to the names of nurses on duty at the hospital on that shift in the hope that someone could confirm he was at the hospital at the time the crimes were committed.

This case is of particular concern on a number of levels. Most importantly, it is feared that this case will be used as the impetus for the Kennett government to review FOI legislation in that state and significantly restrict information available under FOI. It is also of concern because of the hospital's failure to mount a satisfactory case against disclosure on behalf of its employees or indeed to ever consult these employees regarding the release of this information. The hospital and the health department also failed to lodge an appeal against the original decision of the Victorian Civil and Administrative Tribunal (VCAT).

This case also highlights the tension that exists between FOI and privacy considerations. It is the view of the QNU that these tensions could be largely resolved if the state FOI legislation were to be amended to reflect the relevant provisions of the federal FOI ACT rather than refer to "matter relating to person affairs"[S44(1) Qld Act]. At Section 41(1) of the *Freedom of Information Act 1982 Clth,* refers to disclosure of personal matter in the following way:

> *"A document is exempt if its disclosure under this Act would involve the unreasonable disclosure of personal information about any person (including a deceased person)."*

The Interpretation section of this Act defines personal information as:

> "*information or an opinion (including information forming part of a data base), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent or can reasonably be ascertained, from the information or opinion.*"

This Act has obviously taken into account the provisions of the federal *Privacy Act* and attempts to balance competing rights to privacy and access to information

The QNU believes that, in light of this extraordinary Victorian case and the privacy concerns (amongst others) that it highlights, it is necessary to amend the Queensland FOI legislation to take account of these concerns.

Recommendation 18: **That section 44(1) of the FOI Act be appropriately amended so as to better reflect an intent to ensure an appropriate balance between individual privacy considerations and the right to access of information.**

(ix) whether amendments should be made to the Act to allow disclosure of material on conditions in the public interest (for example, to a legal representative who is prohibited from disclosing it to the applicant);

In light of the recent Victorian case highlighted above, it may be appropriate to consider amendments to the FOI Act that would allow qualified disclosure of material when it is determined to be in the public interest. (For example, it might be appropriate for information to be released to a legal representative in specific limited circumstances). The QNU believes that it would be appropriate to review the current legislation to see whether it would be appropriate to amend relevant sections of the legislation to allow for qualified release of information in certain defined circumstances.

Recommendation 19: **That careful consideration be given to whether relevant sections of the FOI legislation be amended to allow for qualified release of information that is in the public interest.**

C. Any related matter.

At this stage the QNU does not wish to make any further submissions in relation to any other matter.

> *"Information is the lynch-pin of the political process. Knowledge is, quite literally power. If the public is not informed, it can not take part in the political process with any real effect." Fitzgerald Report* [8]

> *"Without information, there can be no accountability. It follows that in an atmosphere of secrecy or inadequate information, corruption flourishes. Wherever secrecy exists, there will be people who are prepared to manipulate it." Fitzgerald Report* [9].

[8] Report of *Commission of Inquiry Into Possible Illegal Activities and Associated Police Misconduct,* AG (Tony) Fitzgerald (Chair), 1989, Brisbane, page 126.
[9] Report of *Commission of Inquiry Into Possible Illegal Activities and Associated Police Misconduct,* AG (Tony) Fitzgerald (Chair), 1989, Brisbane, page 124.

RECOMMENDATIONS

Recommendation 1:	That a whole of government approach be adopted to develop strategies aimed at promoting an open and accountable culture within government agencies. This should include improved training for departmental officials at all levels on the philosophy underpinning FOI legislation and the importance of such legislation as an accountability mechanism.
Recommendation 2:	That performance criteria for Director Generals/CEOs and agencies be reviewed to ensure that these include a commitment to the principles of openness and accountability.
Recommendation 3:	That as a matter of urgency current "administrative access arrangements" be reviewed to ensure that these facilitate the release of all relevant information of a personal nature via these arrangements (rather than having to resort to FOI processes) wherever possible. Further to this, that a central agency develop standardised guidelines for agencies promoting disclosure of information of a personal nature via administrative access arrangements.
Recommendation 4:	That public sector information management processes and policies be reviewed to ensure that they facilitate (rather than hinder) the release of information via FOI of administrative access arrangements.
Recommendation 5:	That as a sign of commitment to the principles underpinning FOI legislation that government "lead by example" and amend the provisions of the current act to ensure that the exemption provisions relating to Cabinet matters are not abused.
Recommendation 6:	That the object clauses of the Act reflect the right of access of the community to information on all the functions and processes of government irrespective of whether they are carried out by a government body.
Recommendation 7:	That as a matter of urgency guidelines for a standardised public interest test be developed for use across agencies. Such guidelines for a public interest test should be developed following public consultations and should be made known to the public.
Recommendation 8:	That the ambit of the Act be expanded so that it applies to private sector organisations in a contractual arrangement with the government to provide some form of service.

Recommendation 9: That there should be no distinction between paper, non-paper and electronic information.

Recommendation 10: That the current internal and external FOI review arrangements be maintained but that time limits be established for external review as suggested above.

Recommendation 11: That there be a review of the adequacy of FOI resources currently provided by agencies.

Recommendation 12: That consideration be given to the establishment of a central "pool" of experienced FOI practitioners be established so that agencies can access the additional FOI services in times of extreme demand.

Recommendation 13: That as a matter of urgency, the Information Commissioner be consulted regarding the adequacy of resources and investigative powers provided to that office and that additional resources be provided where necessary/appropriate to deal with the current backlog of cases.

Recommendation 14: That there be no increases to charges for access to information and that Government commit adequate resources to ensure the appropriate operation of FOI legislation in this State.

Recommendation 15: That efforts be made to improve the current FOI Reporting arrangements in Queensland, and in particular that the adoption of innovative and time saving reporting arrangements (eg Internet-hosted data base systems) be actively considered.

Recommendation 16: That mechanisms be developed to ensure that timely assistance is provided to agencies identified as being unable to meet statutory FOI timeframes.

Recommendation 17: That there be no change to the timeframes for the processing of FOI applications as they currently stand in the legislation.

Recommendation 18: That section 44(1) of the FOI Act be appropriately amended so as to better reflect an intent to ensure an appropriate balance between individual privacy considerations and the right to access of information.

Recommendation 19: That careful consideration be given to whether relevant sections of the FOI legislation be amended to allow for qualified release of information that is in the public interest.

Attachment

Recommendations from the Report to the Attorney General From the Administrative Review Council titled

The Contracting Out of Government Services

Recommendations

Recommendation 1

Agencies should be required to keep relevant information relating to the management and monitoring of contracts such as will enable the evaluation of the effectiveness of the delivery of particular services. Such information should include details about the performance standards required of contractors, the actual performance of contractors and the number and types of complaints received by the agency and the contractor. The information kept by agencies should be publicly available. Agencies should include provisions in their contracts to ensure that they are able to comply with this recommendation.

Recommendation 2

Agencies should include provisions in their contracts that require contractors to keep and provide sufficient information to allow for proper Parliamentary scrutiny of the contract and its management. The information required to meet this need will vary from contract to contract according to a number of factors including the value of the contract, the nature of the service to be delivered under the contract and the characteristics of the service's recipients.

Recommendation 3

Agencies should include provisions in contracts which require contractors to provide sufficient information to the agency, to enable the Auditor-General to fulfil his or her role as the external auditor of all government agencies.

Recommendation 4

Agencies should consider when letting a contract whether it would be appropriate to require the contractor to agree to the Auditor-General carrying out a performance audit of their performance under the contract.

Recommendation 5

When preparing contracts, agencies need to be satisfied that contractors will be able to deal with complaints properly. Contractors' complaint-handling procedures should normally satisfy the standards identified by Standards Australia including the recording of complaints and their outcomes. Where the contractor is a small business, simpler complaint-handling procedures may be appropriate. Agencies should also consider what information they should require from contractors about complaints to ensure that contractors' performance can be properly monitored.

Recommendation 6

Where an industry-based complaint mechanism is in place, people with a complaint about a contracted service should have the option of using that mechanism rather than complaining to the relevant agency or to the Commonwealth Ombudsman. Where appropriate, the Commonwealth Ombudsman should be able to refer a complaint about a contractor to the industry body in the first instance.

Recommendation 7

Industry groups, contractors, service recipients, peak organisations and government agencies should work together to develop industry-based complaint-handling systems that comply with benchmarks identified in *Benchmarks for Industry-Based Customer Dispute Resolution Schemes*.

Recommendation 8

Agencies should be responsible for ensuring that service recipients are made aware of all of their avenues of complaint, either by providing this information directly to service recipients or by requiring contractors to do so.

Recommendation 9

Members of the public who have a complaint about a government contractor should be able to make the complaint to the Commonwealth Ombudsman.

Recommendation 10

The jurisdiction of the Commonwealth Ombudsman should extend to the investigation of actions by a contractor under a government contract. The Ombudsman should also be able to deal with contractors informally to resolve complaints under the *Ombudsman Act 1976*. Any statutory extension or clarification of the Ombudsman's jurisdiction should recognise that government agencies retain responsibility for proper management of their contracts.

Recommendation 11

In dealing with complaints against contractors the Ombudsman should have the same powers to obtain information and documents from government contractors as he or she currently has in respect of agencies under investigation.

Recommendation 12

Where the Ombudsman is unable to resolve a complaint about a contractor informally, the Ombudsman should be able to make a formal report to the agency, the Prime Minister and the Parliament about the complaint.

Recommendation 13

It would be appropriate and desirable for agencies to draft contracts in such a way that contractors would be contractually obliged to act on the recommendations of the Ombudsman.

Recommendation 14

The option of complaining to the Ombudsman should be in addition to avenues of complaint which should be provided by the contractor and any complaint-handling mechanisms provided by government agencies or industry arrangements. The Ombudsman should have a discretion to redirect complainants to contractors, industry-based complaint-handling schemes or the agencies where appropriate.

Recommendation 15

The *Freedom of Information Act 1982* should be amended to provide that all documents in the possession of the contractor that relate directly to the performance of the contractor's obligations under the contract would be deemed to be in the possession of the government agency.

Recommendation 16

The *Freedom of Information Act 1982* should be further amended to require contractors to provide these documents to the government agency when an FOI request is made.

Recommendation 17

All agencies involved in contracting out should regularly provide training to staff on the meaning and operation of the FOI Act and in particular the meaning and application of the exemption provisions.

Recommendation 18

The Council reiterates the recommendation in the FOI Report for the establishment of an FOI Commissioner who would be able to assist agencies in dealing with FOI requests relating to contracted out services. In the absence of an FOI Commissioner; the Attorney-General's Department should issue guidelines to government agencies on how the exemptions in section 43 and 45 should be interpreted and applied by government agencies.

Recommendation 19

Guidelines should be developed and tabled by the Attorney-General setting out the circumstances in which Commonwealth agencies will treat information provided by contractors as confidential.

Recommendation 20

Where a contractor exercises statutory decision-making powers that would be subject to merits review if the decision were made by an agency officer, the decisions of the contractor should also be subject to merits review.

Recommendation 21

Where a contractor is to exercise statutory decision-making powers, agencies should ensure that the contractor is required under the terms of the contract to give effect to any decision of a merits review tribunal reviewing the contractor's decision.

Recommendation 22

The *Administrative Decisions (Judicial Review) Act 1977* should extend to include a decision of an administrative character made, or proposed to be made, by an officer under a non-statutory scheme or program, the funds for which are authorised by an appropriation made by the Parliament.

Recommendation 23

Where there is a change in a service from a statutory scheme to a non-statutory scheme, access to effective merits review of decisions relating to that service should not be lost or diminished.

Recommendation 24

Where services are delivered under a new non-statutory scheme, the agency should ensure that effective merits review of decisions under that scheme is available where appropriate.

Recommendation 25

Agencies should consider when contracting out a service, whether legislation should, in appropriate circumstances, provide third parties with the ability to enforce particular terms of the contract. Any contractual remedies so provided should not detract from other remedies such as complaint-handling mechanisms and should not relieve the agency from responsibility of enforcing the contract itself.

Recommendation 26

Agency heads should be empowered under the existing arrangements for the Chief Executive's Instructions to be able to make payments to people who have suffered loss or damage as a result of the actions of a contractor where as a matter of common sense either the contractor or the agency is liable for the damage.

Recommendation 27

The Ombudsman should monitor claims and payments under the scheme.

Recommendation 28

As a general rule, where an agency's contract involves the provision of services, the agency should develop effective mechanisms for obtaining information from service recipients, either directly or through community groups or peak organisations, which can be used in defining the service.

Recommendation 29

Agencies should require contractors to keep and make available records to enable the agencies' accountability for management of the contract to be maintained.

Recommendation 30

As a general rule, where an agency's contract involves the provision of services, the agency should develop effective mechanisms for obtaining information from service recipients, either directly or through community groups or peak organisations, which can be used to monitor and evaluate the performance of particular contractors.

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS ON BEHALF OF THE QUEENSLAND NURSES' UNION

Contribution of the QNU to Investigations in relation to the Bundaberg Base Hospital

1. The Queensland Nurses' Union ("the QNU") supported nursing staff in raising concerns with the Director of Nursing, Ms Linda Mulligan, in October 2004[1] and February 2005[2]. The QNU encouraged Ms Toni Hoffman to put her concerns in writing to the District Manager and discussed other possible avenues of complaint to the Medical Board and Health Rights Commission. QNU officials met with Mr David Kerslake, Health Rights Commissioner, on 4 February 2005[3], the Chief Medical Officer, Dr FitzGerald, on 11 February 2005[4] and Mr James O'Dempsey, Executive Officer of the Medical Board, on 15 February 2005[5] in relation to concerns held by nursing staff at the Bundaberg Base Hospital ("BBH").

2. Subsequent to the then Minister for Health, Mr Nuttal, and the then Director-General of Queensland Health, Dr Buckland, advising staff on 7 April 2005 that the results of Dr FitzGerald's investigation would not be released, the QNU complained to the Crime and Misconduct Commission ("CMC") in relation to the failure of members of the executive management at the BBH to act upon complaints regarding Dr Patel.

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[1] Statement of Linda Mulligan, exhibit 180 paras 164 - 166

[2] Statement of Linda Mulligan, exhibit 180 paras 210

[3] Statement of David Kerslake, exhibit 354, paragraphs 46 – 47, T5661 - 5663

[4] Statement of Dr FitzGerald, exhibit 225, para 62, T4205

[5] Statement of James O'Dempsey, exhibit 28, paras 30 – 31, T638-639, T641 - 642

3. Subsequent to the announcement of the Bundaberg Hospital Commission of Inquiry, the QNU and its legal representatives provided assistance to the Commission of Inquiry and the CMC by facilitating interviews by CMC investigators of its members, and the provision of statements of its members to the Commission of Inquiry.[6] The QNU, through its legal representatives, have provided 33 statements of its members to the Commissions of Inquiry. 19[7] of those statements have been admitted into evidence before the Commission of Inquiry and 11[8] of those members have been called to give evidence before the Commissions of Inquiry. The QNU also provided additional information to assist the Commission of Inquiry in its investigations,[9] and devised a patient key system which was adopted by the Commission.

4. The QNU filed a preliminary submission to the Bundaberg Hospital Commission of Inquiry, a copy of which is attached as Appendix 1. The QNU made a submission to the Forster Inquiry into Queensland Health, a copy of which is attached as Appendix 2.

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[6] By letter dated 3 May 2005, Commissioner Morris QC requested the QNU to "provide full cooperation with the Inquiry", and specifically, "to identify those persons ... who are likely to be able to provide useful evidence to the Inquiry, ... [and] to prepare, and provide to the Inquiry, statements of the evidence which such witnesses are able to provide."

[7] It is presently proposed by Counsel Assisting that a further 3 statements prepared by the QNU (Karen Jenner, Margaret Mears and Gail Doherty) will be tendered to the Inquiry on 27 October 2005.

[8] Counsel Assisting has advised that a further 3 QNU members will be called to give oral evidence on 27 October 2005: Karen Jenner, Margaret Mears, and Gail Doherty.

[9] The further information provided included suggesting lists of potential witnesses and documents to obtain on 16 May 2005. Many of the suggested witnesses were interviewed by Inquiry staff and ultimately gave evidence, and many documents the QNU suggested should be obtained were ultimately tendered in evidence.

Scope of these Submissions

5. These submissions are directed towards the terms of reference in paragraphs 2(b) to (e) of the Commissions of Inquiry Order (No 2) 2005 insofar as those terms of reference apply to evidence before the Commission concerning the Bundaberg Base Hospital ("the BBH").

6. The QNU is confident that the Commission, consistent with the thoroughness of its examination of issues during the public hearings, will conduct a thorough analysis of all the relevant evidence touching upon such matters. These submissions do not seek to duplicate such a process and are not intended to be an exhaustive or definitive analysis of all the evidence relevant to the BBH.

7. These submissions will attempt to highlight some of the most striking examples of failure on the part of the executive management at the BBH to address concerns raised by nursing staff during the course of Dr Patel's tenure as Director of Surgery and the findings and recommendations it is submitted should follow.

8. Consequent recommendations as to processes for clinical governance will be addressed mainly by reference to the QNU's submission to the Forster Inquiry and the Final Report of Mr Forster. Further submissions will be made as to some systemic issues which have been highlighted in evidence before the Commission.

9. It is not proposed in these submissions to address the questions of whether or not Dr Patel or any other practising doctors should face criminal or disciplinary action as a result of findings of failure in the care of patients. The QNU is confident that the Commission, assisted by submissions by the Bundaberg Hospital Patient Support Group and the Medical Board of Queensland, will address such matters without the assistance of submissions from the QNU. The

QNU does not see its role as including passing judgment on the clinical competence of medical practitioners mentioned in evidence before the Commission. The QNU's approach has been to ensure as far as possible that the legitimate concerns of its members as to patient safety were appropriately investigated by this Commission and other investigative bodies, and that the appropriate bodies pass such judgment. This is consistent with the approach taken by its members at the BBH during 2003 and 2004 when raising concerns regarding Dr Patel. Those members did not purport to be in a position to form conclusive judgments as to Dr Patel's clinical competence, but sought an appropriate assessment of such. As stated by Ms Toni Hoffman to Mr Leck on 20 October 2004[10], Ms Hoffman would have been quite happy to be proven wrong in her fears but wanted independent assurance from outside of the BBH that her fears were unfounded.

Summary of submissions re failure of clinical governance at BBH

10. The failure on the part of the Medical Board to properly investigate Dr Patel's United States registration history meant that an opportunity was lost to refuse registration of Dr Patel as a medical practitioner in Queensland or place appropriate restrictions upon his scope of practice.

11. The failure on the part of Dr Kees Nydam and, thereafter, Dr Keating and Mr Leck, to ensure that Dr Patel was appropriately credentialled and privileged prior to, or soon after, his appointment as Director of Surgery permitted the following consequences:

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[10] Exhibit 8

(i) Dr Patel was permitted to perform surgery outside the scope of practice of the BBH;

(ii) Dr Patel was permitted to perform surgery outside his own scope of practice; and

(iii) Patients underwent procedures, in particular oesophogectomies, performed by Dr Patel that should never have been undertaken and died or otherwise suffered harm as a result.

12. Mr Leck and Dr Keating failed to take appropriate steps to ensure that Dr Patel was credentialled and privileged or to restrict his scope of practice despite knowledge of adverse outcomes of the patients, concerns voiced by medical and nursing staff and their knowledge as to the lack of credentialling and privileging of Dr Patel.

13. The failure of the Director of Nursing, Ms Linda Mulligan, to provide effective nursing leadership contributed to the dysfunctional gulf between executive management and clinical nursing staff.

14. Mr Leck and Dr Keating should have, at the very latest in October or November 2004, at least restricted the scope of practice of Dr Patel. They failed to do so. This was most likely because of the prioritisation of budgetary considerations. Meeting elective surgery targets outweighed concerns for patient safety.

15. Mr Leck and Dr Keating failed to diligently investigate concerns raised by nursing staff as to Dr Patel's practice, apparently motivated by a desire to maintain his services as a surgeon.

16. Dr Keating was prepared to express dishonest opinions as to Dr Patel's level of clinical competence to Dr FitzGerald and the Medical Board so as to retain his

services and Mr Leck was prepared to write a dishonest and unbalanced letter of support for Dr Patel to the local newspaper to the same end.

17. Mr Leck and Dr Keating betrayed the public trust incumbent in their positions as District Manager and Director of Medical Services in a way that requires consideration of charges of official misconduct.

18. The audit process of investigating concerns raised in relation to Dr Patel's practice, conducted by Dr FitzGerald, was not conducive to eliciting the full truth but rather fashioned to manage any adverse consequences to Queensland Health.

19. Such circumstances presented a compelling reason for Ms Toni Hoffman to ventilate her concerns outside Queensland Health to a local member of Parliament.

20. The response of Mr Leck, and subsequently the Director General and the Minister, to the public airing of legitimate concerns was to criticize and denigrate such disloyal behaviour.

21. The failure of the Queensland Health executive management at the BBH, and of Queensland Health generally, to appropriately address concerns raised regarding Dr Patel is indicative of a problematic management culture in Queensland Health that requires fundamental reform.

The Three Monkeys

22. The triumvirate of executive management at the Bundaberg Base Hospital exemplified the "three monkeys" management ethos of Queensland Health when addressing concerns as to clinical services and patient safety. Whilst each of the District Manager, Director of Medical Services and Director of Nursing

demonstrated characteristics of each of the three monkeys, emphasis can be placed upon the relevant characteristics of each:

- Mr Leck would "see no evil" in the detailed written documentation of concerns from patients and nursing staff regarding Dr Patel;
- Linda Mulligan would "hear no evil", stifling verbal communication of concerns by nursing staff and taking the view that anything that could not be seen in writing need not be heard[11];
- Dr Darren Keating was the true exemplar of all three monkeys in closing his eyes and his ears to the mounting body of evidence casting serious doubts upon Dr Patel's competence and finding himself unable to utter words critical of Dr Patel to his District Manager, Dr FitzGerald or the Medical Board.

Scope of Practice of the Bundaberg Base Hospital

23. Dr Patel was permitted to perform surgery beyond the scope of practice of the BBH. Complex surgical procedures such as oesophagectomies and Whipples procedures were beyond the proper scope of practice of the BBH, in particular because of the nature of the available intensive care facilities.

24. The Intensive Care Unit (the "ICU") at the BBH is a Level 1 Combined Intensive Care/Coronary Care Unit. It did not have the services of a Specialist Intensivist but was medically managed by Dr Carter, an Anaesthetist. The limited number of available appropriately qualified and experienced nursing staff placed practical

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[11] Evidence of Mr Leck T7219 Lines 30 - 40

restrictions on the number of acutely ill patients who could have their needs met in the unit at any one time. It was well recognised at all relevant times that Level 1 Intensive Care Units of the nature of that at the BBH, should generally only keep patients who require ventilation for between 24 and 48 hours before transferring them to a hospital with a higher level of intensive care[12]. The BBH ICU could only realistically deal with a maximum of two patients on ventilators at any one time because of nursing staffing levels.

25. The level of post operative care required for patients undergoing complex procedures such as oesophagectomies exceeded the capabilities of the BBH ICU. Such was recognised not only by Toni Hoffman but also by doctors who had practised at BBH prior to and during the relevant period under investigation[13]. Dr FitzGerald's evidence was that one would reasonably expect a reasonably competent Director of Medical Services to realise that such procedures were outside the scope of practice of such a hospital[14].

Scope of Practice of Dr Jayant Patel

26. It is now of course abundantly clear that surgery of such complexity was also outside the individual scope of practice of the surgeon, Dr Patel. He had in fact been restricted from performing procedures including oesophagectomies and Whipples procedures in the United States. Two of the four patients upon whom

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[12] Statement of Toni Hoffman, Exhibit 4, paras 3 – 6 and statement of Dr Carter, Exhibit 265, paras 29 – 35

[13] Dr Jayasekera at T.5973; Dr Baker at T.6358; Dr Joiner at T.5012, l.45 to 5013, l.5; Dr Risson at T.2813, ll.40-45 and 2811, ll.10-30; Dr Kariyawasam at T.3074, l.30 to 3075, l.5. (cf. Dr Anderson T.2764-2765). Such opinion was shared by other witnesses including Dr FitzGerald at T.3146, ll.1-15 and Dr De Lacy at T.3603 – 3604, 3612, ll.20-30, 4422, l.5 to 4423, l.10

[14] T. 3152, ll.15-50

Dr Patel performed oesophagectomies died shortly thereafter. The other two suffered significant post operative complications. Dr de Lacy gave graphic evidence as to the poor outcome of the second of such survivors, Mr Philip Deakin, and the impact upon his quality of life[15]. The other survivor, Mr Grave, underwent three returns to theatre for post-operative complications, an extended stay in the ICU at Bundaberg and his post-transfer treatment is described in the evidence, including that of Dr Peter Cook.

27. There are real questions as to whether any of these four patients should have undergone oesophagectomies at all. Certainly, none of them should have undergone oesophagectomies at the BBH carried out by Dr Patel. The fact that Dr Patel was not restricted from undertaking surgical procedures of such complexity until after the death of the fourth oesophagectomy patient, Mr Kemps, is tragic and disgraceful. That Dr Patel could be permitted to continue to undertake surgery of this nature for a period over 18 months after specific concerns were raised with regards to it by Toni Hoffman and Dr Joiner in May and June 2003 exemplifies the failure of clinical governance on the part of the executive management of the BBH.

28. The failure on the part of the Medical Board of Queensland to make further enquiries into Dr Patel's United States registration history meant that an opportunity to not register or to restrict Dr Patel's scope of practice upon registration was lost. Such unfortunate failure would not have had the tragic consequences it did but for the failures of those who held management positions at the BBH.

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[15] T.3064, l.30 to 3065, l.10

Lack of Credentialing and Privileging of Dr Patel

29. The Commission has heard a great deal of evidence confirming the importance of an appropriate process of credentialing and privileging medical practitioners. The importance of such is spelt out in the terms of the relevant Queensland Health policy governing credentialing and privileging[16]. The then Acting Director of Medical Services, Dr Nydam, gave no consideration to any process of credentialing and privileging of Dr Patel before or upon employing him as a Senior Medical Officer, and soon after appointing him to the unsupervised position of Director of Surgery. Dr Keating became well aware of the lack of any process of credentialing and privileging of surgeons upon commencing in the position of Director of Medical Services soon after. The requirement for appropriate credentialing and privileging of a surgeon in such circumstances is manifest. The need that Dr Patel be appropriately credentialed and privileged with regard to the service capabilities of the BBH and its ICU, should have been seen as even more acute by any diligent Director of Medical Services upon concerns being raised by Toni Hoffman and Dr Joiner in May and June 2003 in relation to the two patients who underwent oesophagectomies during that period, followed by the voicing of concerns by Dr Peter Cook in relation to the second of those patients.

30. The inability on the part of Dr Keating to secure a nominated representative of the relevant college to sit on a credentialing and privileging committee does not excuse such failure in the circumstances. The need for such a process being

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[16] Exhibit 279

manifest in relation to any surgeon, combined with the mounting chorus of alarm regarding Dr Patel's practice and in particular his willingness to practice outside the scope of practice of the BBH, required an appropriate response on the part of Dr Keating and Mr Leck, not a slavish adherence to the terms of a written policy. Evidence has been given by appropriately qualified persons that a practical and available option was to seek the participation of an appropriately qualified surgeon, either from the local or from a hospital in Brisbane. Such an approach would have been infinitely preferable to doing nothing.

Mr James Phillips (P34)

31. On 19 May 2003, Mr Phillips underwent an elective oesophagectomy performed Dr Patel. An anaesthetist reported to ICU staff that the patient had no obtainable blood pressure during the last 45 minutes of surgery. The patient was obviously critically ill when admitted to the ICU and ultimately died on 21 May 2003. During the course of the patient's time in the ICU, Dr Patel informed medical and nursing staff that the patient was stable.

32. In late May or early June 2003[17] Toni Hoffman, accompanied by the then Director of Nursing, Ms Goodman, met with Dr Keating to voice concerns arising from the above events. Toni Hoffman expressed her concerns about surgery such as oesophagectomies being undertaken at the BBH given the lack of appropriate ICU facilities for post operative care for such patients. She expressed her concern that Dr Patel would describe a patient as stable when they were

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[17] Statement of Toni Hoffman, exhibit 4, para 10; Dr Keating states on or about 30 May 2003 at para 48 of his statement exhibit 448.

obviously critically ill. She voiced further concerns as to Dr Patel's behaviour and the apparent lack of modern clinical knowledge. The Commission would accept the evidence of Ms Hoffman that at this meeting she raised the issue of Dr Patel undertaking oesophagectomies outside the scope of practice of the BBH[18].

33. Dr Keating's response to such concerns raised by Ms Hoffman at that time was completely inappropriate and inadequate. Ms Hoffman states that she was told by Dr Keating that Dr Patel was a very experienced surgeon and that she was required to cooperate with him and work together, that there was an expectation that the BBH would continue to provide surgery to the people of Bundaberg and that Dr Patel was experienced and used to performing those types of surgery[19]. Dr Keating states that he suggested to Toni Hoffman that she make an appointment with Dr Patel to discuss the issues raised by her, explain unit capability and capacity and the need to work together as a team[20]. Given the nature of the issues raised and the confronting personality of Dr Patel, it is of no surprise that any attempt at rational discussion of such issues and cooperation with Ms Hoffman was flatly rebuffed by Dr Patel. It was inappropriate in the circumstances to expect Ms Hoffman to be able to successfully resolve such a situation with Dr Patel. It was an inexcusable abdication of responsibility on Dr Keating's part to proceed in such a fashion. The matters raised with him at that time should have led him to facilitate an appropriate process of credentialing and

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[18] Although Dr Keating claims a lack of recollection of this issue being raised (Para 48 of Exhibit 448), at no time prior to the commencement of the Commission hearings did he voice dissent with the contents of Ms Hoffman's correspondence to Mr Leck in October 2004 referring to such an issue having been raised (Exhibit TH10 andTH37)

[19] Exhibit 4, para 11.

[20] Para 48 of exhibit 448.

privileging of Dr Patel and to properly define the scope of practice of Dr Patel and the BBH with regards to complex procedures such as oesophagectomies.

34. Ms Hoffman recalls a further meeting soon after with Dr Keating in the company of Dr Joiner during which she once again raised concerns about oesophagectomies being carried out at the BBH in light of her understanding that Dr Patel was to undertake another oesophagectomy. Dr Joiner's recollection was unclear as to having accompanied Toni Hoffman to any meeting with Dr Keating and as to exactly when in relation to the dates of procedures regarding Mr Phillips and Mr Grave that he had two meetings with Dr Keating to discuss associated issues. The Commission would accept Ms Hoffman's recollection as to having met with Dr Keating and Dr Joiner, despite Dr Keating's denial of such, given Dr Keating's lack of dissent to Ms Hoffman having clearly stated that such a meeting occurred in her correspondence with Mr Leck[21].

Mr James Grave (P18)

35. Mr James Grave underwent an elective oesophagectomy performed by Dr Patel on 6 June 2003 and was admitted to the ICU later that day. He returned to the operating theatre on 12 June 2003 and 16 June 2003 for abdominal wound dehiscence and on 18 June 2003 for leakage from the jejunostomy site. Prior to the third return to theatre, steps had been taken to find a bed in a Brisbane

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[21] Exhibit 4, TH10 and TH37 which was available to Dr Keating at the very latest on or about 22 October 2004. Notwithstanding some variations in the accounts of Ms Hoffman, Dr Joiner and Dr Keating as to the exact chronology of conversations with Dr Keating on such topic, it is most certain that Ms Hoffman and Dr Joiner raised concerns with Dr Keating on at least 3 occasions as to the capability of the BBH to appropriately care for patients undergoing oesophagectomies.

Hospital for the patient. Dr Patel did not cooperate in the process required for transfer.

36. Toni Hoffman communicated her concerns as to Mr Grave, in the context of her continuing concerns of Dr Patel operating outside the BBH scope of practice, by e-mails to the then Director of Nursing[22] and to the Director of Medical Services, Dr Keating[23].

37. It was in the context of his concerns as to the circumstances of Mr Grave, that Dr Joiner again raised concerns with Dr Keating as regards to the capacity of the BBH to properly care for oesophagectomy patients[24]. His evidence[25] is enlightening when depicting the nature of Dr Keating's dealings with Dr Patel. Dr Joiner attended a meeting with Dr Keating and Dr Patel regarding Mr Grave. Dr Joiner states that he and the intensive care staff had formed the view that the patient required ongoing intensive care support and should be transferred to an intensive care unit at the Royal Brisbane Hospital. At the time that decision was made, it was ascertained that a bed was available in the RBH ICU so that the patient could be transferred. Dr Patel confronted Dr Joiner and threatened to resign if the patient was transferred to the RBH. At the meeting with Dr Keating and Dr Patel, Dr Keating was informed that an ICU bed in Brisbane had been arranged but that Dr Patel was not agreeable to the patient being transferred to

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22 Exhibit 4, TH2.

23 Exhibit 4, TH3.

24 T5013 - 5014.

25 T5015 - 5016.

Brisbane. Presented with the sound clinically-based arguments for transfer of the patient on the one hand and the unreasoned but adamant refusal on the part of Dr Patel to the patient being transferred, a compromise was reached at the meeting that the patient would remain for another couple of days and his clinical condition be reviewed. The fact that Dr Keating would permit a compromise of care of the patient to mollify the recalcitrant Dr Patel is an inexcusable abdication of responsibility on his part. It exemplifies the approach of Dr Keating throughout the controversy regarding Dr Patel in that he was prepared to make decisions compromising the clinical care of patients in light of a fear that to do otherwise would result in the loss of the services of Dr Patel to the Hospital.

38. Mr Grave was eventually transferred to the Royal Brisbane Hospital on 20 June 2003. In late June or early July 2003, Dr Peter Cook, Intensivist, and communicated his concerns regarding surgery of such complexity and being undertaken at the BBH, including verbally to Dr Keating. Dr Keating states that such conversation occurred on 1 July 2003, and that Dr Cook expressed concern about this type of operation being performed at Bundaberg in that it required robust intensive care backup[26]. Dr Keating says that he told Dr Cook he would discuss such concerns with the Directors of Surgery and Anaesthetics and with the Credentials and Privileging Committee at the Hospital. No such functioning committee in so far as surgery was concerned was then in existence. Dr Keating claims to have relied upon the opinions of Dr Patel and Dr Carter to conclude that oesophagectomies could be safely performed at Bundaberg Hospital[27]. The

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[26] Exhibit 448, para 52.

[27] Exhibit 448, para 55.

failure on the part of Dr Keating, in light of the manifestly unfavourable outcomes for Mr Phillips and Mr Grave and the concerns raised by a specialist intensivist, to take appropriate steps to credential and privilege Dr Patel and define an appropriate scope of practice for the BBH is inexcusable.

Other Warnings Ignored

39. During 2003, every one of six patients at the BBH who had a peritoneal dialysis catheter placed by Dr Patel suffered complications, including acute and chronic infections and migration of catheters requiring further surgery, mostly related to the incorrect external positioning of the catheters. On 17 December 2003, Mr Eric Nagle (P30) underwent surgical intervention to address the migration of his peritoneal catheter. This additional surgery was required because of the incompetence of Dr Patel in inserting the catheter, yet was performed by Dr Patel. The patient died as a result of haemopericardium due to perforated thoracic veins during the insertion of a permacath by Dr Patel. The patient would not have required this additional procedure had his peritoneal catheter been in position correctly in the first place. Renal Unit Nurses, Ms Robyn Pollock and Ms Lindsay Druce, reported their concerns on 10 February 2004 to the then acting Director of Nursing, Mr Patrick Martin[28]. Mr Martin spoke to Dr Keating on the same day to relay such concerns[29]. Mr Martin relayed to nurses Druce and Pollock that Dr Keating required further statistics regarding procedures

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[28] Statement of Lindsay Druce, exhibit 67, para 17. Statement of Robyn Pollock exhibit 70, para 30.

[29] Statement of Patrick Martin, exhibit 139, paras 26 - 27.

undertaken by Dr Patel highlighting all renal related cases uneventful compared with the number of adverse events which had recurred as a result of an intervention[30]. Dr Keating took no immediate steps to clarify the significance of the information that had been presented to him which would have informed him of the alarming fact of a 100% failure rate on the part of a surgeon undertaking such a procedure.

40. Dr Miach has given evidence that he supplied Dr Keating in about April 2003 with the results of the Renal Unit Nurses' investigations demonstrating 100% complication rate in relation to the insertion of peritoneal dialysis catheters. It is not completely clear on the evidence whether such document would have been that which now forms exhibit 18 or exhibit 69. Dr Miach's evidence is that when he again raised such issue with Dr Keating on 21 October 2004, Dr Keating denied having earlier spoken to Dr Miach regarding the matter or seeing any such document. The Commission would prefer the evidence of Dr Miach in this regard. In any event, even according to the account given by Dr Keating, at the time he was following up on the most recent concerns raised by Toni Hoffman on 20 October 2004 with Mr Leck, he failed to question Dr Miach as to the significance of such information and claims that even at that stage not to have realised that the information indicated 100% failure rate in such a procedure. Dr Keating claims to have failed to advert to the possibility that such information would be evidence indicative of a general lack of clinical competence on the part of Dr Patel.

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30 Exhibit 139, PM3.

41. Dr Keating showed a repeated inability or unwillingness to address concerns raised by nursing staff in relation to the clinical practice of Dr Patel. When concerns were raised by Gail Aylmer, the Infection Control Clinical Nurse Consultant, as to rates of wound dehiscence in mid 2003, she was placed in the invidious position as a nurse of having to question an apparently experienced surgeon as to the possible courses of wound dehiscence noted in relation to his patients. Ms Aylmer should never have been placed in such a position and Dr Keating should have taken the obvious and appropriate steps of having such an issue examined in an appropriate mortality and morbidity committee by appropriate clinicians or at least reviewed by an appropriately qualified surgeon[31]. This was yet another example of Dr Keating seemingly not wanting to become involved in examining concerns regarding Dr Patel's clinical confidence and not taking appropriate steps for proper review of such concerns.

42. Similarly, after receiving a report sourced from three nurses who witnessed serious breaches of aseptic technique on the part of Dr Patel, Dr Keating was prepared to dismiss the matter on the basis that Dr Patel denied such behaviour. Dr Keating demanded statistical data to support the assertion that there was a problem with Dr Patel's aseptic technique[32] despite the available eye witnesses who could verify a very serious breach of aseptic technique.[33]

[31] Statement of Gail Aylmer, exhibit 62, para 3.

[32] Statement of Gail Aylmer, exhibit 59, para 19.

[33] See statements of Waters, Yeoman and Turner (Exhibits 195 – 197)

Toni Hoffman raises concerns with Mr Leck in March 2004

43. The Commission would accept the evidence of Mr Leck that he discussed the matters raised with him (and confirmed in writing) by Ms Hoffman in March 2004 with both Dr Keating and Ms Mulligan. Not only is it likely that such matters would be discussed by the District Manager with the Director of Medical Services and the Director of Nursing, but Mr Leck's account of such conversations was detailed and plausible. In particular, his detailed recollection of the nature of the response from Ms Mulligan had the ring of truth[34]. It exemplified the management style of Ms Mulligan that if a concern was not raised officially and adopted in writing, then it could be disregarded.

44. The nature of the concerns communicated directly to Mr Leck at such time, notwithstanding Toni Hoffman's communication that she did not wish the matter to be treated as an official complaint, would have caused any reasonable District Manager in Mr Leck's position to question the advice he was receiving from Dr Keating that the matter was a mere personality conflict and to consider some type of appropriate peer review of Dr Patel's surgical competence. At the very least, it would have caused a reasonably diligent District Manager to ensure that the long overdue process of credentialing and privileging of Dr Patel proceed as a matter of haste and that the scope of practice of the BBH be urgently reviewed in light of the matters raised.

[34] "I went to talk to Linda about it and I said I had received this correspondence from Toni but that Toni didn't want me to do anything with it, and Linda said that her usual response in that situation would be to hand the letter back and ask the staff member to give it to them when they were prepared to lodge a complaint.", T7219 Lines 30 – 40.

Lack of Nursing Leadership

45. From the time of her commencement in the position of District Director of Nursing, Ms Linda Mulligan had the responsibility for providing leadership to the nursing staff of the BBH, being accessible to staff who wished to voice concerns or seek her assistance and to advocate for the nursing staff with executive management. As a nursing professional Ms Mulligan had professional responsibilities in addition to managerial responsibilities. It is clear that she failed to fulfil these responsibilities of her position. She adopted the role of a manager rather than a nursing leader[35]. She made herself inaccessible to nursing staff, placing restrictions on the ways in which she could be contacted and essentially remaining invisible to most of the nursing staff[36]. She did not do rounds of the wards and if staff wanted to see her they had to make appointments. Toni Hoffman in her statement says "We had to make appointments with her secretary and had to give a reason for why we wanted the appointment. The appointments were often cancelled after they were made."[37] She discouraged open discussion of concerns ventilated by nursing staff at meetings[38].

46. In a hospital the size of the BBH, there was no practical reason why the Director of Nursing could not play a visibly supportive role and provide leadership to the nursing staff. Her cessation of regular nursing rounds upon taking up her

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[35] Statement of Gail Aylmer, exhibit 59, para 43

[36] Statement of Toni Hoffman, Exhibit 4, paras 78-81; statement of Jennifer White, Exhibit 71, paras 31-32

[37] Exhibit 4 at [78] to [80]

[38] Statement of Gail Aylmer, Exhibit 59, para 43; statement of Toni Hoffman, Exhibit 4, para 77

position removed the opportunity for nursing staff to ventilate concerns with her in an informal way. She did not choose to take a proactive role in visiting nursing staff in e.g. the ICU after becoming aware of events that must have been traumatic for nursing staff e.g. following the death of Mr Kemps.

47. Ms Mulligan regularly received reports from the after hours nurse manager and monthly cost centre reports for the ICU which should have led her to take a more proactive approach in investigating those stresses being placed upon the ICU and nursing staff by Dr Patel operating outside of the scope of practice of the ICU.

48. The extent of Ms Mulligan's failures to provide nursing leadership left nurses feeling unsupported by management and Ms Hoffman in the position that she felt that she had to look to officials of the QNU for such nursing leadership.

October 2004 Complaint

49. In a meeting with Mr Leck and Ms Mulligan on 20 October 2004 and in subsequent correspondence, Ms Hoffman raised detailed concerns in relation to Dr Patel's behaviour and clinical competence including reference to particular patients. The failure of the executive management to act swiftly and decisively at such time was inexcusable and had tragic consequences, eg for Mr Gerard Kemps. The concerns of executive management should have been heightened by the subsequent interviews of Drs Berens, Risson and Strahan[39]. The failure to discuss the matters raised with Dr Miach is inexplicable. Dr Keating's advice to Mr Leck that there were no substantial matters of concern requiring any immediate action was either dishonest or grossly incompetent.

[39] Exhibit 448 DWK 62-64

50. It is clear that the approach of management in response to the matters raised by Ms Hoffman was to attempt to arrange a review by a hand picked doctor suitable to management who would report only to the executive management of the BBH. It was not until mid December that there was any official contact with the office of the Chief Medical Officer and not until January 2005 that there was official advice of the complaint to zonal management.

51. The executive management's inertia in response to the matters raised by Ms Hoffman contributed directly to the unfortunate result for Mr Gerard Kemps.

52. At the very latest following upon the interviews of medical practitioners in early November 2004, Mr Leck and Dr Keating should have taken action, if not to suspend Dr Patel from practice entirely, than to at least limit his scope of practice by way of prohibiting him from undertaking complex surgery such as oesophagectomies. Their failure to do so constituted a gross breach of the trust invested in them by way of their positions.

53. Mr Leck and Dr Keating as District Manager and Director of Medical Services respectively, both held an appointment in a unit of public administration within the meaning of s.21 of the *Crime and Misconduct Act* 2001. It is submitted that their failures as particularised above involved breaches of the trust placed in them as holders of the respective appointment within the meaning of s.14 of the Act. It is submitted that such conduct could amount to a disciplinary breach providing reasonable grounds for termination of the services of such a holder of an appointment and thus can amount to official misconduct within the meaning of s.15 of the Act. It is submitted that the evidence before the Commission is sufficient for referral of both Mr Leck and Dr Keating to the CMC for investigation of charges of official misconduct.

54. In a telephone conversation with an officer of the Queensland Health Audit and Operational Review Branch on 17 December 2004[40], Mr Leck stated that the district would need to handle Ms Hoffman's complaint carefully as Dr Patel was of great benefit to the district and they would hate to lose his services as a result of the complaint. It is an irresistible inference from all the evidence that the manner in which the executive management responded to Ms Hoffman's complaint was coloured by the executive management not wishing to lose the services of Dr Patel as a surgeon. Any surgeon was better than no surgeon at all in the context of budget imperatives driven by the need to meet elective surgery targets for the financial year. Dr Patel's value to the BBH in maximising the throughput of elective surgery procedures was well known to both Mr Leck and Dr Keating and such was expressed to Dr FitzGerald in his subsequent investigation. The e-mail from Dr Keating to the Nurse Unit Manager of the Operating Theatres[41] of 8 February 2005, lends support to the view that the executive management were desirous of retaining the services of Dr Patel at least until 30 June 2005, notwithstanding the seriousness of any concerns being raised as to his clinical competence. Such an attitude provided the context in which Ms Hoffman eventually saw no alternative but to raise her concerns outside the Queensland Health system with a Member of Parliament.

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[40] Exhibit 225 GF10

[41] Exhibit 72 AKA Exhibit 501

Mr Gerard Kemps (P21)

55. Mr Kemps underwent an oesophagectomy carried out by Dr Patel on 20 December 2004. The Commission received evidence from nursing staff, including Mr Damien Gaddes, Ms Jenelle Law and Mr Martin Brennan, and doctors, including Dr Berens, Dr Kariyawasam and Dr Carter, as to the circumstances of Mr Kemps' operative and post-operative treatment. For the reasons explored elsewhere in the submission, Mr Kemps should never have undergone such a procedure at the Bundaberg Base Hospital, and certainly not at the hands of Dr Patel.

56. Mr Kemps death was a "reportable death" within the terms of s.8(3)(d) of the *Coroners Act* 2003. Drs Berens and Carter sought the advice of Dr Keating as to whether such death should be reported to the Coroner. Dr Keating abdicated his responsibility as Director of Medical Services to advise Dr Berens and Dr Carter that such death should be reported and failed to take any steps to report the death himself.

57. In circumstances where Dr Berens and Dr Carter acted conscientiously in seeking the guidance of the Director of Medical Services as to whether the death should be reported and were motivated partly by concerns that reporting such death might cause further distress to Mr Kemps' family in light of his impending funeral, it is not submitted that the Commission should make recommendations adverse to those doctors.

58. Dr Keating's failure in such regard is more serious because of his position of responsibility in responding to Drs Berens' and Carter's request for advice. It is submitted that there is sufficient evidence to justify referral of this matter to the CMC for consideration as to whether or not a charge of official misconduct

should be laid against Dr Keating for failing to advise Dr Berens and Dr Carter that the death should be reported and failing to take any steps to report the death himself. Alternatively, it is submitted that there is sufficient evidence for consideration as to whether the matter should be referred to the Commissioner of the Police Service for prosecution of Dr Keating for an offence pursuant to s.7(2) of the *Coroners Act* 2003.

Executive Management's attempts to retain the services of Dr Patel

59. The conduct of Mr Leck and Dr Keating throughout the whole period of time that concerns were raised in relation to Dr Patel was indicative of a desire to retain his services as a general surgeon so as to meet budget imperatives, regardless of any legitimate concerns as to patient safety. The extent to which they were prepared to disregard patient safety and the length they were prepared to go to to retain Dr Patel's services are starkly demonstrated by their conduct in early 2005.

60. Dr Keating expressed dishonest opinions as to Dr Patel's clinical competence and judgment in conversations with Dr FitzGerald and in written communications to the Medical Board considering Dr Patel's re-registration. Mr Leck authored a dishonestly unbalanced letter of support for Dr Patel to the local newspaper for the express purpose of attempting to retain Dr Patel's services as a surgeon.

61. After Mr Messenger's statements in Parliament had been publicly reported, the Acting Director of Nursing, Deanne Walls, called a meeting of ICU staff on the 23 March 2005. This meeting was attended by the District Manager, Mr Leck. Mr Leck expressed anger about nurses breaching the confidentiality provisions of

Queensland Health's Code of Conduct.[42] Mr Leck referred to a departmental Industrial Relations document to the effect that staff breaching confidentiality could be imprisoned for two years and lose their jobs[43]. He stated that he was appalled that such a senior surgeon of the hospital could be treated in such a way that denied him natural justice[44]. Mr Leck left without giving any of the nurses an opportunity to respond to his comments or to discuss their concerns about Dr Patel[45].

62. Mr Leck later that day had a meeting with Level 3 Nursing staff. He reiterated that the leak was a breach of the Code of Conduct. "He was visibly angry and upset. He was saying that he knew that it was a nurse that was responsible for the leak"[46]. He went on to say that "a nurse had gone behind our backs and released this information before the report was released and they would be reprimanded"[47]. Nursing staff felt extremely "intimidated"[48] and "powerless"[49] as a result of the comments made by Mr Leck. Robyn Pollock wanted to respond to Mr Leck "...but I didn't because I felt intimidated ... I felt chastised after he left, and I hadn't done anything wrong. I was very concerned for whoever had sent

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[42] Exhibit 70 at [48]

[43] Exhibit 4 at [167]

[44] Exhibit 4 at [168]

[45] Exhibit 4 at [169]

[46] Exhibit 70 at [48]

[47] Exhibit 70 at [48]

[48] Exhibit 70 at [49]

[49] Exhibit 59 at [46]

the letter to Mr Messenger. I felt that if it was known who leaked the letter, that person would lose their job."[50]

63. Mr Leck's letter to the Bundaberg News Mail, 28 March 2005 while clearly supporting Dr Patel[51] expressed Mr Leck's view that the fact that allegations had been made public was "reprehensible"[52].

64. An email from Mr Peter Leck to Mr Dan Bergin, dated 7 April 2005, indicates that Mr Leck was prepared to threaten staff with reprisals for raising issues in a public forum. He refers to the staff member as "the culprit who leaked this information" and refers to them being "on very dangerous ground". He is prepared to use the Code of Conduct to "deliver some firm and scary messages"[53].

65. At the Staff Forum attended by Mr Leck, Dr Steve Buckland and the Honourable Gordon Nuttall MP on the 7 April 2005 Mr Nuttall and Dr Buckland told nursing staff that, because of the release of material in Parliament by Mr Messenger and the departure of Dr Patel from Australia, results of the Queensland Health investigation that had been underway would not be released[54]. Nursing staff felt that they were being criticised as being disloyal and believed that the Department would not be further investigating matters regarding Dr Patel. Dr Buckland

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[50] Exhibit 70 at [48] – [49]

[51] "Dr Patel is an industrious surgeon who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go."

[52] Exhibit 473

[53] Exhibit 477

[54] Statement of Gail Alymer (Exhibit 59) at paragraph 47

acknowledged in his evidence that, with the benefit of hindsight, he and the Minister had not handled the meeting well[55].

Dr FitzGerald's investigation

66. Dr FitzGerald's conduct in relation to the clinical review instigated as a response to Ms Hoffman's complaint was indicative of a preparedness on his part to "manage" the situation in a manner that would not reflect adversely upon the hospital management or Dr Patel and facilitate the desire of the executive management to retain Dr Patel's services. The report initially authored by Dr FitzGerald failed to include the serious findings as to Dr Patel operating outside the scope of practice of the BBH and the failure of the executive management to address concerns raised about Dr Patel over a lengthy period of time. The admitted approach of Dr FitzGerald to only include positive comments in relation to Dr Patel and deliberately not include negative ones necessarily presented a skewed report of the true situation.

67. It seems clear that subsequent steps on the part of Dr FitzGerald and Queensland Health were driven only as a result of the growing public exposure of the true situation and recognition on the part of Dr FitzGerald and his superiors that their response needed to be heightened in light of the growing public controversy. In the absence of public disclosure by Mr Messenger of matters in Parliament, it is a reasonable inference that the process of response to Ms Hoffman's complaint may well have finished with the preparation of the confidential audit report of Dr FitzGerald, with the real adverse findings by Dr FitzGerald never finding their way

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[55] Statements of Dr Buckland Exhibit 335 para 34 and Exhibit 337 paras 10 -13

into print. The addition of the memo to the Director-General containing those adverse findings would appear to have been responsive to the matters being raised in Parliament and advice being sought by the Director-General as to the process of his review.

68. It is a reasonable inference that, but for the depth of negative feeling ascertained by the Director-General and the Minister for Health on their visit to Bundaberg on 7 April 2005 and the knowledge obtained by the Director-General through an internet search regarding Dr Patel's registration on the same date, the matter would have concluded as was flagged to staff on that date, ie Dr FitzGerald's report would never have been released, the investigation would have ceased and the whole matter been buried. The announcement of a further review on 9 April 2005 was clearly a response to the realisation on the part of the Director-General and the then Minister that adverse publicity would necessarily result when the information regarding Dr Patel's registration became public knowledge.

Additional Submissions on Systemic Issues

69. The QNU submissions to the Queensland Health Systems Review (the Forster Inquiry) is included as Appendix 2. We urge upon the Commission consideration of the whole of such submission and the recommendations submitted therein. We refer in particular to the following aspects of that submission which have been highlighted and exemplified by evidence given before the Commission.

Chronic Underfunding of Queensland Health Services

70. The Commission has received evidence which puts beyond doubt those propositions submitted in Appendix 1 and Appendix 2 by the QNU that the Queensland public health system has been chronically underfunded for many years, with consistently lower expenditure per capita than in other States and Territories[56]. Queensland Health has placed an undue emphasis upon achieving greater and greater efficiency outcomes with insufficient emphasis placed upon the quality of care provided and whether health outcomes are satisfactory. By producing a situation where Queensland has the lowest number of medical practitioners and nursing practitioners per head of population than any other State[57], emphasis on efficiency gains has had a negative impact on quality of care as doctors and nurses are placed in situations where they are unable to deliver an optimal standard of nursing care. Frustration at being unable to provide appropriate standards of care has led to medical practitioners and nurses leaving the Public Health system or decreasing their hours of work because they can no longer cope with unrealistic work demands and the consequences such have upon their ethical obligations as health professionals[58]. Doctors and nurses within the Queensland Health system are working harder and being paid less than their interstate counterparts, becoming increasingly frustrated by the level of care that they can provide their patients and leaving the Public Health system in many cases after being burnt out by the system. The inescapable conclusion is

[56] See eg Exhibits 336 Statement of Dr Buckland, paras 64, 77 & 78; Exhibit 310 Extracts from the Productivity Commission's report on Government Services 2005

[57] Exhibit 209, Statement of Dr Young

[58] See eg the evidence of Dr McNeill at T.4748, 24749

that there can be no real solution to the crisis existing in the Queensland public health system without a greater allocation of public monies to that public health system.

Queensland Health's Culture of Secrecy

71. The Commission has a body of evidence before it which confirms and exemplifies submissions previously made by the QNU as to the culture of secrecy in Queensland Health and the need for improved openness, transparency and accountability in Queensland Health. The obsession with secrecy in Queensland Health has largely been derived from a combined imperative to "put a lid" on controversy and dissent and at the same time manage the budget imperatives of continuing to do more with less. Greater openness and transparency is necessary for there to be a genuine community debate in relation to priorities for our Queensland Health system. The evidence before the Commission in relation to the Queensland Health management of information concerning waiting lists and the measured quality program are only examples of the past approach which must be changed.

72. The evidence before the Commission has also provided examples of abuse of the cabinet exemption provisions of the *Freedom of Information Act* 1992. Attached as Appendix 3 to these submissions is a submission of the QNU on the review of the *Freedom of Information Act* 1992 to the Legal, Constitutional and Administrative Review Committee dated 14 May 1999. Submissions with regards to s.36 of the Act appear at page 7 of that document.

The Code of Conduct

73. The evidence shows instances of the Queensland Health Code of Conduct being used to intimidate nurses in an attempt to stifle discussion about concerns nurses had in Bundaberg.

74. As well as the specific events referred to above, there has been a general concern amongst Queensland Health staff as to reprisals from management in response to them raising issues. In his evidence to the Commission, Dr Nankivell stated: "The people in Queensland Health are terrified of the code of conduct, particularly the nurses, because the nurses are much more vulnerable. Doctors, if they get sacked, can always go to the private sector. Nurses are - because they're a more vulnerable group, are terrified"[59].

75. Toni Hoffman was concerned that on making the complaint in October 2004 her career was over[60]. Enrolled nurse Jenelle Law, in referring to the death of Mr Kemps, stated: "I was so distressed with what had happened that I wrote a statement early in January 2005 ... It took me quite a while to work up the courage to hand it in after I had written it as I feared for my job." She concludes "I have been concerned that I will lose my job. A few weeks ago, around the end of April start of May 2005, the tension over the Inquiry and the media attention

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[59] T2958

[60] T171: "I was very well aware that by making this complaint, even just to Peter Leck and Linda Mulligan at that particular time, that I would never get a chance to progress my career in Queensland Health...My belief was that I would never get an opportunity to act up into a higher position, I would never be given the opportunity to go to conferences or any of the things that enable you to progress in your profession. I knew that my making this complaint, that that would be the end of my career and it may even be the end of my career at that hospital.

just became too much. I broke down because I was so upset. Counsellors have since been brought in to speak to us"[61].

76. Nursing staff were concerned about reprisals which operated as a disincentive to make complaints and raise issues. Ms Robyn Pollock stated her feelings towards speaking out after an incident where Mr Peter Leck and others from the executive team accused staff of the Renal Unit of leaking information to the head of the renal patients support group: "I became so guarded in what I said to Richard and to others after this experience. That treatment was a huge disincentive to speaking out to management"[62]. As to the meeting where Mr Peter Leck accused nurses of leaking information to Mr Messenger in March 2005, Ms Gail Aylmer stated: "I was concerned that if nurses were made the scapegoat for this situation, then nurses in the future would be very reluctant to advocate for the patient."[63]

77. The lack of leadership support by Queensland Health management at BBH and management inaction in responding to concerns raised by nursing staff caused the nurses great anxiety and distress, especially as further incidents occurred. Registered Nurse Karen Fox pinpoints the cause of the major depressive disorder she is currently suffering as resulting from "the events I witnessed on 27 July 2004 [the death of Mr Bramich], and exacerbated by subsequent events at the BBH concerning Dr Patel. My condition deteriorated during the time Dr Patel

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[61] Exhibit 160 at [18] – [25]; Jenelle Law clarifies in cross examination that until she spoke to her solicitors she thought she would lose her job (transcript page 2214 at line 55)

[62] Exhibit 70 at [47]

[63] Statement of Gail Alymer at [46]

continued to work at the hospital and I ultimately needed to cease work for a period of time earlier this year"[64].

78. It is the right of all Queensland Health staff and citizens to raise concerns in the public domain about the conduct of public institutions including hospitals and other health facilities. It is the department's role to deal with these concerns in a timely and appropriate manner or to refute them. Misuse of the Code of Conduct and legislation must cease if we are to create a positive, problem solving and open culture in Queensland Health it must not be used to silence criticism and debate.

79. Recommendations:

(i) It is essential that the Code of Conduct be reviewed and amended to allow for discussion without fear of disciplinary action.

(ii) It is recommended that a penalty to be imposed for the inappropriate use of this document by Queensland Health management.

(iii) Amendments must be made to the *Health Services Act* 1991 and the *Whistleblowers Protection Act* 1994 to remove doubts held by QNU members as to whether they can approach the QNU, and other appropriate bodies, to raise and discuss matters of concern without the fear of disciplinary action or criminal prosecution.

Amendments to the *Whistleblowers Protection Act* 1994

80. The QNU agrees with the recommendations put forward by the Forster review as to changes to the *Whistleblowers Protection Act* 1994:

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[64] Exhibit 485 at para [9]

(i) Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act;

(ii) The media should not be approved as one of the bodies to whom Whistleblowers can lodge Public Interest Disclosures and have protection under the Act; and

(iii) Any person not just a public officer should be afforded protection for disclosing danger to public health and safety.

(iv) In addition it is submitted that whistleblowers should be able to lodge Public Interest Disclosures with their relevant professional and / or industrial organisation, eg the AMAQ and QNU.

Amendments to the *Health Service Act* 1991

81. The QNU submits that in addition to changes recommended by Mr Forster to the *Whistleblowers Protection Act* 1994, it is necessary to amend the provisions relating to confidentiality contained in the *Health Services Act* 1991. Section 62A of the *Health Services Act* 1991 presently makes it a summary offence for employees to disclose to another person any information "if a person who is receiving or has received a public sector health service could be identified from the confidential information". The exceptions in which such information can be disclosed are numerous, but unlikely to be of assistance to a clinician who is confronted with having to "blow the whistle" in the interests of advocating patient safety.

82. In particular, it seems quite absurd that section 62I requires the written authorisation of the Director-General of Queensland Health before a disclosure to prevent "serious risk to life, health or safety" can legally be made. Similarly,

disclosures in the "public interest" pursuant to section 62F must first be authorised, in writing, by the Director-General.

83. Section 62A may even operate to prevent a clinician from obtaining professional, industrial or legal advice concerning occurrences in Queensland Health.[65]

84. It is submitted that the current provisions are plainly unbalanced and serve as a disincentive to clinicians who feel ethically bound to act in a particular way in the interests of their patients. While it is not disputed that there should be proper protections for the confidentiality of patient information, this should not operate in any way which may fetter patient safety. At the very least, there should be amendments that allow clinicians to disclosure confidential information to:

(i) prevent risks to life, health or safety; and

(ii) obtain professional, industrial and legal advice.

85. Furthermore, it is submitted that the threat of criminal sanction is inappropriate in respect of clinicians who hold appropriate professional registration. Section 62A should not apply to registered clinicians on the basis that they are subject to professional disciplinary proceedings if they make unethical disclosures of patient information.

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[65] A written authority pursuant to section 62F was finally given by the then Director General Dr Buckland on 16 May 2005 to enable Queensland Health employees to communicate freely with the QNU and its legal representatives in respect of any official inquiries into the Bundaberg Base Hospital after an exchange of correspondence in which it was implied by Queensland Health that the union's members could not communicate any information to the union or the lawyers engaged to represent them which could identify patients.

Complaints Management & Resolution Reform

86. Effective management and resolution of complaints is of great concern to members. The QNU's ultimate submission in this regard is that there is a need for complaint management and resolution reform. The experience of the nursing staff at the BBH is that complaints and concerns raised by nursing staff regarding clinical outcomes were not adequately addressed by Queensland Health Executives. The internal complaints process was not promoted and not well known by staff. As an illustration, Michelle Hunter, indicated that while she knew that the BBH had access to the Queensland Health intranet, she did not know of web pages that gave guidance as to how to go about making a complaint[65].

87. On the whole the QNU supports the risk management and clinical governance recommendations in Chapter 9 of the Forster Review, the Final Report of findings of the Queensland Health Systems Review, tabled in Parliament on Friday 30 September 2005.

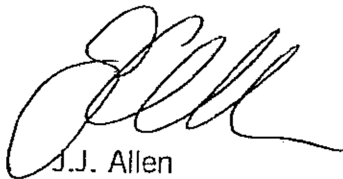
88. As detailed in the Forster review, the QNU supports and advocates for the adoption of a complaints model that provides for local complaint resolution with an escalation process to an independent complaints body. However, the QNU submits there should be a reduction in time frames regarding the escalation of complaints in the recommended Complaints Management & Resolution Model. The nominated total period of 30 days for escalation of the complaint to an independent complaints body is too long in the current environment where patient and staff safety are compromised by staff shortages. Furthermore, the

[66] Transcript at page 2046 line 7

QNU recommends that such reform be implemented across both the public and private sectors.

89. The QNU recommends that an adequately funded patient advocacy group be established to support patients in making complaints through this process.

90. Any new legislative framework should explicitly provide that complaints may be made as of right by medical and nursing staff as well as patients (cf s 59 *Health Rights Commission Act* 1991).



J.J. Allen

L.D.Coman

Counsel for the QNU

26 October 2005

David Groth

From: Gavin Rebetzke

Sent: Friday, 28 October 2005 12:59 PM

To: David Groth

Cc:

Subject: Revised submissions of QNU

The Secretary
Queensland Public Hospitals Commission of Inquiry

I attach revised QNU submissions to replace the submissions previously filed.

Apart from some cosmetic changes to the formatting of footnotes, the only changes are, in accordance with the Commissioner's direction yesterday, to supplement the submission by reference to the additional evidence given yesterday. Those supplementary submissions are:

a. para 3 - updating details re number of witnesses and statements
b. para 54 - reference to evidence of Gail Doherty
c. paras 62-64 - reference to evidence of Jenner and Mears
d. paras 67-68 - reference to evidence of Jenner and Mears
e. para 70 - reference to evidence of Jenner.

Gavin Rebetzke
Roberts & Kane Solicitors

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QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS ON BEHALF OF THE QUEENSLAND NURSES' UNION

Contribution of the QNU to Investigations in relation to the Bundaberg Base Hospital

1. The Queensland Nurses' Union ("the QNU") supported nursing staff in raising concerns with the Director of Nursing, Ms Linda Mulligan, in October 2004[1] and February 2005[2]. The QNU encouraged Ms Toni Hoffman to put her concerns in writing to the District Manager and discussed other possible avenues of complaint to the Medical Board and Health Rights Commission. QNU officials met with Mr David Kerslake, Health Rights Commissioner, on 4 February 2005[3], the Chief Medical Officer, Dr FitzGerald, on 11 February 2005[4] and Mr James O'Dempsey, Executive Officer of the Medical Board, on 15 February 2005[5] in relation to concerns held by nursing staff at the Bundaberg Base Hospital ("BBH").

2. Subsequent to the then Minister for Health, Mr Nuttal, and the then Director-General of Queensland Health, Dr Buckland, advising staff on 7 April 2005 that the results of Dr FitzGerald's investigation would not be released, the QNU complained to the Crime and Misconduct Commission ("CMC") in relation to the failure of members of the executive management at the BBH to act upon complaints regarding Dr Patel.

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[1] Statement of Linda Mulligan, exhibit 180 paras 164 – 166

[2] Statement of Linda Mulligan, exhibit 180 paras 210

[3] Statement of David Kerslake, exhibit 354, paras 46 – 47, T.5661 – 5663

[4] Statement of Dr FitzGerald, exhibit 225, para 62, T.4205

[5] Statement of James O'Dempsey, exhibit 28, paras 30 – 31, T.638-639, T.641 – 642

3. Subsequent to the announcement of the Bundaberg Hospital Commission of Inquiry, the QNU and its legal representatives provided assistance to the Commission of Inquiry and the CMC by facilitating interviews by CMC investigators of its members, and the provision of statements of its members to the Commission of Inquiry.[6] The QNU, through its legal representatives, have provided 33 statements of its members to the Commissions of Inquiry. 22 of those statements have been admitted into evidence before the Commission of Inquiry and 14 of those members have been called to give evidence before the Commissions of Inquiry. The QNU also provided additional information to assist the Commission of Inquiry in its investigations,[7] and devised a patient key system which was adopted by the Commission.

4. The QNU filed a preliminary submission to the Bundaberg Hospital Commission of Inquiry, a copy of which is attached as Appendix 1. The QNU made a submission to the Forster Inquiry into Queensland Health, a copy of which is attached as Appendix 2.

Scope of these Submissions

5. These submissions are directed towards the terms of reference in paragraphs 2(b) to (e) of the Commissions of Inquiry Order (No 2) 2005 insofar as those

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[6] By letter dated 3 May 2005, Commissioner Morris QC requested the QNU to "provide full cooperation with the Inquiry", and specifically, "to identify those persons ... who are likely to be able to provide useful evidence to the Inquiry, ... [and] to prepare, and provide to the Inquiry, statements of the evidence which such witnesses are able to provide."

[7] The further information provided included suggesting lists of potential witnesses and documents to obtain on 16 May 2005. Many of the suggested witnesses were interviewed by Inquiry staff and ultimately gave evidence, and many documents the QNU suggested should be obtained were ultimately tendered in evidence.

terms of reference apply to evidence before the Commission concerning the Bundaberg Base Hospital ("the BBH").

6. The QNU is confident that the Commission, consistent with the thoroughness of its examination of issues during the public hearings, will conduct a thorough analysis of all the relevant evidence touching upon such matters. These submissions do not seek to duplicate such a process and are not intended to be an exhaustive or definitive analysis of all the evidence relevant to the BBH.

7. These submissions will attempt to highlight some of the most striking examples of failure on the part of the executive management at the BBH to address concerns raised by nursing staff during the course of Dr Patel's tenure as Director of Surgery and the findings and recommendations it is submitted should follow.

8. Consequent recommendations as to processes for clinical governance will be addressed mainly by reference to the QNU's submission to the Forster Inquiry and the Final Report of Mr Forster. Further submissions will be made as to some systemic issues which have been highlighted in evidence before the Commission.

9. It is not proposed in these submissions to address the questions of whether or not Dr Patel or any other practising doctors should face criminal or disciplinary action as a result of findings of failure in the care of patients. The QNU is confident that the Commission, assisted by submissions by the Bundaberg Hospital Patient Support Group and the Medical Board of Queensland, will address such matters without the assistance of submissions from the QNU. The QNU does not see its role as including passing judgment on the clinical competence of medical practitioners mentioned in evidence before the Commission. The QNU's approach has been to ensure as far as possible that the legitimate concerns of its members as to patient safety were appropriately

investigated by this Commission and other investigative bodies, and that the appropriate bodies pass such judgment. This is consistent with the approach taken by its members at the BBH during 2003 and 2004 when raising concerns regarding Dr Patel. Those members did not purport to be in a position to form conclusive judgments as to Dr Patel's clinical competence, but sought an appropriate assessment of such. As stated by Ms Toni Hoffman to Mr Leck on 20 October 2004[8], Ms Hoffman would have been quite happy to be proven wrong in her fears but wanted independent assurance from outside of the BBH that her fears were unfounded.

Summary of submissions re failure of clinical governance at BBH

10. The failure on the part of the Medical Board to properly investigate Dr Patel's United States registration history meant that an opportunity was lost to refuse registration of Dr Patel as a medical practitioner in Queensland or place appropriate restrictions upon his scope of practice.

11. The failure on the part of Dr Kees Nydam and, thereafter, Dr Keating and Mr Leck, to ensure that Dr Patel was appropriately credentialled and privileged prior to, or soon after, his appointment as Director of Surgery permitted the following consequences:

    (i) Dr Patel was permitted to perform surgery outside the scope of practice of the BBH;

    (ii) Dr Patel was permitted to perform surgery outside his own scope of practice; and

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[8] Exhibit 8

(iii) Patients underwent procedures, in particular oesophogectomies, performed by Dr Patel that should never have been undertaken and died or otherwise suffered harm as a result.

12. Mr Leck and Dr Keating failed to take appropriate steps to ensure that Dr Patel was credentialled and privileged or to restrict his scope of practice despite knowledge of adverse outcomes of the patients, concerns voiced by medical and nursing staff and their knowledge as to the lack of credentialling and privileging of Dr Patel.

13. The failure of the Director of Nursing, Ms Linda Mulligan, to provide effective nursing leadership contributed to the dysfunctional gulf between executive management and clinical nursing staff.

14. Mr Leck and Dr Keating should have, at the very latest in October or November 2004, at least restricted the scope of practice of Dr Patel. They failed to do so. This was most likely because of the prioritisation of budgetary considerations. Meeting elective surgery targets outweighed concerns for patient safety.

15. Mr Leck and Dr Keating failed to diligently investigate concerns raised by nursing staff as to Dr Patel's practice, apparently motivated by a desire to maintain his services as a surgeon.

16. Dr Keating was prepared to express dishonest opinions as to Dr Patel's level of clinical competence to Dr FitzGerald and the Medical Board so as to retain his services and Mr Leck was prepared to write a dishonest and unbalanced letter of support for Dr Patel to the local newspaper to the same end.

17. Mr Leck and Dr Keating betrayed the public trust incumbent in their positions as District Manager and Director of Medical Services in a way that requires consideration of charges of official misconduct.

18. The audit process of investigating concerns raised in relation to Dr Patel's practice, conducted by Dr FitzGerald, was not conducive to eliciting the full truth but rather fashioned to manage any adverse consequences to Queensland Health.

19. Such circumstances presented a compelling reason for Ms Toni Hoffman to ventilate her concerns outside Queensland Health to a local member of Parliament.

20. The response of Mr Leck, and subsequently the Director General and the Minister, to the public airing of legitimate concerns was to criticize and denigrate such disloyal behaviour.

21. The failure of the Queensland Health executive management at the BBH, and of Queensland Health generally, to appropriately address concerns raised regarding Dr Patel is indicative of a problematic management culture in Queensland Health that requires fundamental reform.

The Three Monkeys

22. The triumvirate of executive management at the Bundaberg Base Hospital exemplified the "three monkeys" management ethos of Queensland Health when addressing concerns as to clinical services and patient safety. Whilst each of the District Manager, Director of Medical Services and Director of Nursing demonstrated characteristics of each of the three monkeys, emphasis can be placed upon the relevant characteristics of each:

- Mr Leck would "see no evil" in the detailed written documentation of concerns from patients and nursing staff regarding Dr Patel;
- Linda Mulligan would "hear no evil", stifling verbal communication of concerns by nursing staff and taking the view that anything that could not be seen in writing need not be heard[9];
- Dr Darren Keating was the true exemplar of all three monkeys in closing his eyes and his ears to the mounting body of evidence casting serious doubts upon Dr Patel's competence and finding himself unable to utter words critical of Dr Patel to his District Manager, Dr FitzGerald or the Medical Board.

Scope of Practice of the Bundaberg Base Hospital

23. Dr Patel was permitted to perform surgery beyond the scope of practice of the BBH. Complex surgical procedures such as oesophagectomies and Whipples procedures were beyond the proper scope of practice of the BBH, in particular because of the nature of the available intensive care facilities.

24. The Intensive Care Unit (the "ICU") at the BBH is a Level 1 Combined Intensive Care/Coronary Care Unit. It did not have the services of a Specialist Intensivist but was medically managed by Dr Carter, an Anaesthetist. The limited number of available appropriately qualified and experienced nursing staff placed practical restrictions on the number of acutely ill patients who could have their needs met in the unit at any one time. It was well recognised at all relevant times that Level 1 Intensive Care Units of the nature of that at the BBH, should generally

[9] Evidence of Mr Leck T.7219, ll.30 – 40

only keep patients who require ventilation for between 24 and 48 hours before transferring them to a hospital with a higher level of intensive care[10]. The BBH ICU could only realistically deal with a maximum of two patients on ventilators at any one time because of nursing staffing levels.

25. The level of post operative care required for patients undergoing complex procedures such as oesophagectomies exceeded the capabilities of the BBH ICU. Such was recognised not only by Toni Hoffman but also by doctors who had practised at BBH prior to and during the relevant period under investigation[11]. Dr FitzGerald's evidence was that one would reasonably expect a reasonably competent Director of Medical Services to realise that such procedures were outside the scope of practice of such a hospital[12].

Scope of Practice of Dr Jayant Patel

26. It is now of course abundantly clear that surgery of such complexity was also outside the individual scope of practice of the surgeon, Dr Patel. He had in fact been restricted from performing procedures including oesophagectomies and Whipples procedures in the United States. Two of the four patients upon whom Dr Patel performed oesophagectomies died shortly thereafter. The other two suffered significant post operative complications. Dr de Lacy gave graphic evidence as to the poor outcome of the second of such survivors, Mr Philip

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[10] Statement of Toni Hoffman, exhibit 4, paras 3 – 6 and statement of Dr Carter, exhibit 265, paras 29 – 35

[11] Dr Jayasekera at T.5973; Dr Baker at T.6358; Dr Joiner at T.5012, l.45 to 5013, l.5; Dr Risson at T.2813, ll.40-45 and T.2811, ll.10-30; Dr Kariyawasam at T.3074, l.30 to T.3075, l.5. (cf. Dr Anderson T.2764-2765). Such opinion was shared by other witnesses including Dr FitzGerald at T.3146, ll.1-15 and Dr De Lacy at T.3603 – T.3604, T.3612, ll.20-30, T.4422, l.5 to T.4423, l.10

[12] T. 3152, ll.15-50

Deakin, and the impact upon his quality of life[13]. The other survivor, Mr Grave, underwent three returns to theatre for post-operative complications, an extended stay in the ICU at Bundaberg and his post-transfer treatment is described in the evidence, including that of Dr Peter Cook.

27. There are real questions as to whether any of these four patients should have undergone oesophagectomies at all. Certainly, none of them should have undergone oesophagectomies at the BBH carried out by Dr Patel. The fact that Dr Patel was not restricted from undertaking surgical procedures of such complexity until after the death of the fourth oesophagectomy patient, Mr Kemps, is tragic and disgraceful. That Dr Patel could be permitted to continue to undertake surgery of this nature for a period over 18 months after specific concerns were raised with regards to it by Toni Hoffman and Dr Joiner in May and June 2003 exemplifies the failure of clinical governance on the part of the executive management of the BBH.

28. The failure on the part of the Medical Board of Queensland to make further enquiries into Dr Patel's United States registration history meant that an opportunity to not register or to restrict Dr Patel's scope of practice upon registration was lost. Such unfortunate failure would not have had the tragic consequences it did but for the failures of those who held management positions at the BBH.

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[13] T.3064, l.30 to T.3065, l.10

Lack of Credentialing and Privileging of Dr Patel

29. The Commission has heard a great deal of evidence confirming the importance of an appropriate process of credentialing and privileging medical practitioners. The importance of such is spelt out in the terms of the relevant Queensland Health policy governing credentialing and privileging[14]. The then Acting Director of Medical Services, Dr Nydam, gave no consideration to any process of credentialing and privileging of Dr Patel before or upon employing him as a Senior Medical Officer, and soon after appointing him to the unsupervised position of Director of Surgery. Dr Keating became well aware of the lack of any process of credentialing and privileging of surgeons upon commencing in the position of Director of Medical Services soon after. The requirement for appropriate credentialing and privileging of a surgeon in such circumstances is manifest. The need that Dr Patel be appropriately credentialed and privileged with regard to the service capabilities of the BBH and its ICU, should have been seen as even more acute by any diligent Director of Medical Services upon concerns being raised by Toni Hoffman and Dr Joiner in May and June 2003 in relation to the two patients who underwent oesophagectomies during that period, followed by the voicing of concerns by Dr Peter Cook in relation to the second of those patients.

30. The inability on the part of Dr Keating to secure a nominated representative of the relevant college to sit on a credentialing and privileging committee does not excuse such failure in the circumstances. The need for such a process being manifest in relation to any surgeon, combined with the mounting chorus of alarm

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[14] Exhibit 279

regarding Dr Patel's practice and in particular his willingness to practice outside the scope of practice of the BBH, required an appropriate response on the part of Dr Keating and Mr Leck, not a slavish adherence to the terms of a written policy. Evidence has been given by appropriately qualified persons that a practical and available option was to seek the participation of an appropriately qualified surgeon, either from the local or from a hospital in Brisbane. Such an approach would have been infinitely preferable to doing nothing.

Mr James Phillips (P34)

31. On 19 May 2003, Mr Phillips underwent an elective oesophagectomy performed Dr Patel. An anaesthetist reported to ICU staff that the patient had no obtainable blood pressure during the last 45 minutes of surgery. The patient was obviously critically ill when admitted to the ICU and ultimately died on 21 May 2003. During the course of the patient's time in the ICU, Dr Patel informed medical and nursing staff that the patient was stable.

32. In late May or early June 2003[15] Toni Hoffman, accompanied by the then Director of Nursing, Ms Goodman, met with Dr Keating to voice concerns arising from the above events. Toni Hoffman expressed her concerns about surgery such as oesophagectomies being undertaken at the BBH given the lack of appropriate ICU facilities for post operative care for such patients. She expressed her concern that Dr Patel would describe a patient as stable when they were obviously critically ill. She voiced further concerns as to Dr Patel's behaviour and the apparent lack of modern clinical knowledge. The Commission would accept

[15] Statement of Toni Hoffman, exhibit 4, para 10; Dr Keating states on or about 30 May 2003 at para 48 of his statement exhibit 448.

the evidence of Ms Hoffman that at this meeting she raised the issue of Dr Patel undertaking oesophagectomies outside the scope of practice of the BBH[16].

33. Dr Keating's response to such concerns raised by Ms Hoffman at that time was completely inappropriate and inadequate. Ms Hoffman states that she was told by Dr Keating that Dr Patel was a very experienced surgeon and that she was required to cooperate with him and work together, that there was an expectation that the BBH would continue to provide surgery to the people of Bundaberg and that Dr Patel was experienced and used to performing those types of surgery[17]. Dr Keating states that he suggested to Toni Hoffman that she make an appointment with Dr Patel to discuss the issues raised by her, explain unit capability and capacity and the need to work together as a team[18]. Given the nature of the issues raised and the confronting personality of Dr Patel, it is of no surprise that any attempt at rational discussion of such issues and cooperation with Ms Hoffman was flatly rebuffed by Dr Patel. It was inappropriate in the circumstances to expect Ms Hoffman to be able to successfully resolve such a situation with Dr Patel. It was an inexcusable abdication of responsibility on Dr Keating's part to proceed in such a fashion. The matters raised with him at that time should have led him to facilitate an appropriate process of credentialing and privileging of Dr Patel and to properly define the scope of practice of Dr Patel and the BBH with regards to complex procedures such as oesophagectomies.

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[16] Although Dr Keating claims a lack of recollection of this issue being raised (para 48, Exhibit 448), at no time prior to the commencement of the Commission hearings did he voice dissent with the contents of Ms Hoffman's correspondence to Mr Leck in October 2004 referring to such an issue having been raised (Exhibit TH10 and TH37)

[17] Exhibit 4, para 11.

[18] Para 48 of exhibit 448.

34. Ms Hoffman recalls a further meeting soon after with Dr Keating in the company of Dr Joiner during which she once again raised concerns about oesophagectomies being carried out at the BBH in light of her understanding that Dr Patel was to undertake another oesophagectomy. Dr Joiner's recollection was unclear as to having accompanied Toni Hoffman to any meeting with Dr Keating and as to exactly when in relation to the dates of procedures regarding Mr Phillips and Mr Grave that he had two meetings with Dr Keating to discuss associated issues. The Commission would accept Ms Hoffman's recollection as to having met with Dr Keating and Dr Joiner, despite Dr Keating's denial of such, given Dr Keating's lack of dissent to Ms Hoffman having clearly stated that such a meeting occurred in her correspondence with Mr Leck[19].

Mr James Grave (P18)

35. Mr James Grave underwent an elective oesophagectomy performed by Dr Patel on 6 June 2003 and was admitted to the ICU later that day. He returned to the operating theatre on 12 June 2003 and 16 June 2003 for abdominal wound dehiscence and on 18 June 2003 for leakage from the jejunostomy site. Prior to the third return to theatre, steps had been taken to find a bed in a Brisbane Hospital for the patient. Dr Patel did not cooperate in the process required for transfer.

[19] Statement of Toni Hoffman, exhibit 4, TH10 and TH37 which was available to Dr Keating at the very latest on or about 22 October 2004. Notwithstanding some variations in the accounts of Ms Hoffman, Dr Joiner and Dr Keating as to the exact chronology of conversations with Dr Keating on such topic, it is most certain that Ms Hoffman and Dr Joiner raised concerns with Dr Keating on at least 3 occasions as to the capability of the BBH to appropriately care for patients undergoing oesophagectomies.

36. Toni Hoffman communicated her concerns as to Mr Grave, in the context of her continuing concerns of Dr Patel operating outside the BBH scope of practice, by e-mails to the then Director of Nursing[20] and to the Director of Medical Services, Dr Keating[21].

37. It was in the context of his concerns as to the circumstances of Mr Grave, that Dr Joiner again raised concerns with Dr Keating as regards to the capacity of the BBH to properly care for oesophagectomy patients[22]. His evidence[23] is enlightening when depicting the nature of Dr Keating's dealings with Dr Patel. Dr Joiner attended a meeting with Dr Keating and Dr Patel regarding Mr Grave. Dr Joiner states that he and the intensive care staff had formed the view that the patient required ongoing intensive care support and should be transferred to an intensive care unit at the Royal Brisbane Hospital. At the time that decision was made, it was ascertained that a bed was available in the RBH ICU so that the patient could be transferred. Dr Patel confronted Dr Joiner and threatened to resign if the patient was transferred to the RBH. At the meeting with Dr Keating and Dr Patel, Dr Keating was informed that an ICU bed in Brisbane had been arranged but that Dr Patel was not agreeable to the patient being transferred to Brisbane. Presented with the sound clinically-based arguments for transfer of the patient on the one hand and the unreasoned but adamant refusal on the part of Dr Patel to the patient being transferred, a compromise was reached at the meeting that the patient would remain for another couple of days and his clinical

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[20] Statement of Toni Hoffman, exhibit 4, TH2.

[21] Statement of Toni Hoffman, exhibit 4, TH3.

[22] T.5013 – T.5014.

[23] T.5015 – T.5016.

condition be reviewed. The fact that Dr Keating would permit a compromise of care of the patient to mollify the recalcitrant Dr Patel is an inexcusable abdication of responsibility on his part. It exemplifies the approach of Dr Keating throughout the controversy regarding Dr Patel in that he was prepared to make decisions compromising the clinical care of patients in light of a fear that to do otherwise would result in the loss of the services of Dr Patel to the Hospital.

38. Mr Grave was eventually transferred to the Royal Brisbane Hospital on 20 June 2003. In late June or early July 2003, Dr Peter Cook, Intensivist, and communicated his concerns regarding surgery of such complexity and being undertaken at the BBH, including verbally to Dr Keating. Dr Keating states that such conversation occurred on 1 July 2003, and that Dr Cook expressed concern about this type of operation being performed at Bundaberg in that it required robust intensive care backup[24]. Dr Keating says that he told Dr Cook he would discuss such concerns with the Directors of Surgery and Anaesthetics and with the Credentials and Privileging Committee at the Hospital. No such functioning committee in so far as surgery was concerned was then in existence. Dr Keating claims to have relied upon the opinions of Dr Patel and Dr Carter to conclude that oesophagectomies could be safely performed at Bundaberg Hospital[25]. The failure on the part of Dr Keating, in light of the manifestly unfavourable outcomes for Mr Phillips and Mr Grave and the concerns raised by a specialist intensivist, to take appropriate steps to credential and privilege Dr Patel and define an appropriate scope of practice for the BBH is inexcusable.

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[24] Exhibit 448, para 52.

[25] Exhibit 448, para 55.

Other Warnings Ignored

39. During 2003, every one of six patients at the BBH who had a peritoneal dialysis catheter placed by Dr Patel suffered complications, including acute and chronic infections and migration of catheters requiring further surgery, mostly related to the incorrect external positioning of the catheters. On 17 December 2003, Mr Eric Nagle (P30) underwent surgical intervention to address the migration of his peritoneal catheter. This additional surgery was required because of the incompetence of Dr Patel in inserting the catheter, yet was performed by Dr Patel. The patient died as a result of haemopericardium due to perforated thoracic veins during the insertion of a permacath by Dr Patel. The patient would not have required this additional procedure had his peritoneal catheter been in position correctly in the first place. Renal Unit Nurses, Ms Robyn Pollock and Ms Lindsay Druce, reported their concerns on 10 February 2004 to the then acting Director of Nursing, Mr Patrick Martin[26]. Mr Martin spoke to Dr Keating on the same day to relay such concerns[27]. Mr Martin relayed to nurses Druce and Pollock that Dr Keating required further statistics regarding procedures undertaken by Dr Patel highlighting all renal related cases uneventful compared with the number of adverse events which had recurred as a result of an intervention[28]. Dr Keating took no immediate steps to clarify the significance of the information that had been presented to him which would have informed him

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[26] Statement of Lindsay Druce, exhibit 67, para 17. Statement of Robyn Pollock exhibit 70, para 30.

[27] Statement of Patrick Martin, exhibit 139, paras 26 - 27.

[28] Statement of Patrick Martin, exhibit 139, PM3.

of the alarming fact of a 100% failure rate on the part of a surgeon undertaking such a procedure.

40. Dr Miach has given evidence that he supplied Dr Keating in about April 2003 with the results of the Renal Unit Nurses' investigations demonstrating 100% complication rate in relation to the insertion of peritoneal dialysis catheters. It is not completely clear on the evidence whether such document would have been that which now forms exhibit 18 or exhibit 69. Dr Miach's evidence is that when he again raised such issue with Dr Keating on 21 October 2004, Dr Keating denied having earlier spoken to Dr Miach regarding the matter or seeing any such document. The Commission would prefer the evidence of Dr Miach in this regard. In any event, even according to the account given by Dr Keating, at the time he was following up on the most recent concerns raised by Toni Hoffman on 20 October 2004 with Mr Leck, he failed to question Dr Miach as to the significance of such information and claims that even at that stage not to have realised that the information indicated 100% failure rate in such a procedure. Dr Keating claims to have failed to advert to the possibility that such information would be evidence indicative of a general lack of clinical competence on the part of Dr Patel.

41. Dr Keating showed a repeated inability or unwillingness to address concerns raised by nursing staff in relation to the clinical practice of Dr Patel. When concerns were raised by Gail Aylmer, the Infection Control Clinical Nurse Consultant, as to rates of wound dehiscence in mid 2003, she was placed in the invidious position as a nurse of having to question an apparently experienced surgeon as to the possible courses of wound dehiscence noted in relation to his patients. Ms Aylmer should never have been placed in such a position and Dr

Keating should have taken the obvious and appropriate steps of having such an issue examined in an appropriate mortality and morbidity committee by appropriate clinicians or at least reviewed by an appropriately qualified surgeon[29]. This was yet another example of Dr Keating seemingly not wanting to become involved in examining concerns regarding Dr Patel's clinical confidence and not taking appropriate steps for proper review of such concerns.

42. Similarly, after receiving a report sourced from three nurses who witnessed serious breaches of aseptic technique on the part of Dr Patel, Dr Keating was prepared to dismiss the matter on the basis that Dr Patel denied such behaviour. Dr Keating demanded statistical data to support the assertion that there was a problem with Dr Patel's aseptic technique[30] despite the available eye witnesses who could verify a very serious breach of aseptic technique.[31]

[29] Statement of Gail Aylmer, exhibit 62, para 3.

[30] Statement of Gail Aylmer, exhibit 59, para 19.

[31] See statements of Waters, Yeoman and Turner (exhibits 195 – 197)

Toni Hoffman raises concerns with Mr Leck in March 2004

43. The Commission would accept the evidence of Mr Leck that he discussed the matters raised with him (and confirmed in writing) by Ms Hoffman in March 2004 with both Dr Keating and Ms Mulligan. Not only is it likely that such matters would be discussed by the District Manager with the Director of Medical Services and the Director of Nursing, but Mr Leck's account of such conversations was detailed and plausible. In particular, his detailed recollection of the nature of the response from Ms Mulligan had the ring of truth[32]. It exemplified the management style of Ms Mulligan that if a concern was not raised officially and adopted in writing, then it could be disregarded.

44. The nature of the concerns communicated directly to Mr Leck at such time, notwithstanding Toni Hoffman's communication that she did not wish the matter to be treated as an official complaint, would have caused any reasonable District Manager in Mr Leck's position to question the advice he was receiving from Dr Keating that the matter was a mere personality conflict and to consider some type of appropriate peer review of Dr Patel's surgical competence. At the very least, it would have caused a reasonably diligent District Manager to ensure that the long overdue process of credentialing and privileging of Dr Patel proceed as a matter of haste and that the scope of practice of the BBH be urgently reviewed in light of the matters raised.

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[32] "I went to talk to Linda about it and I said I had received this correspondence from Toni but that Toni didn't want me to do anything with it, and Linda said that her usual response in that situation would be to hand the letter back and ask the staff member to give it to them when they were prepared to lodge a complaint.", T.7219, ll.30 – 40.

Lack of Nursing Leadership

45. From the time of her commencement in the position of District Director of Nursing, Ms Linda Mulligan had the responsibility for providing leadership to the nursing staff of the BBH, being accessible to staff who wished to voice concerns or seek her assistance and to advocate for the nursing staff with executive management. As a nursing professional Ms Mulligan had professional responsibilities in addition to managerial responsibilities. It is clear that she failed to fulfil these responsibilities of her position. She adopted the role of a manager rather than a nursing leader[33]. She made herself inaccessible to nursing staff, placing restrictions on the ways in which she could be contacted and essentially remaining invisible to most of the nursing staff[34]. She did not do rounds of the wards and if staff wanted to see her they had to make appointments. Toni Hoffman in her statement says "We had to make appointments with her secretary and had to give a reason for why we wanted the appointment. The appointments were often cancelled after they were made."[35] She discouraged open discussion of concerns ventilated by nursing staff at meetings[36].

46. In a hospital the size of the BBH, there was no practical reason why the Director of Nursing could not play a visibly supportive role and provide leadership to the nursing staff. Her cessation of regular nursing rounds upon taking up her position removed the opportunity for nursing staff to ventilate concerns with her

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[33] Statement of Gail Aylmer, exhibit 59, para 43

[34] Statement of Toni Hoffman, exhibit 4, paras 78-81; statement of Jennifer White, exhibit 71, paras 31-32

[35] Statement of Toni Hoffman, exhibit 4, paras 78 – 80

[36] Statement of Gail Aylmer, exhibit 59, para 43; statement of Toni Hoffman, exhibit 4, para 77

in an informal way. She did not choose to take a proactive role in visiting nursing staff in e.g. the ICU after becoming aware of events that must have been traumatic for nursing staff e.g. following the death of Mr Kemps.

47. Ms Mulligan regularly received reports from the after hours nurse manager and monthly cost centre reports for the ICU which should have led her to take a more proactive approach in investigating those stresses being placed upon the ICU and nursing staff by Dr Patel operating outside of the scope of practice of the ICU.

48. The extent of Ms Mulligan's failures to provide nursing leadership left nurses feeling unsupported by management and Ms Hoffman in the position that she felt that she had to look to officials of the QNU for such nursing leadership.

October 2004 Complaint

49. In a meeting with Mr Leck and Ms Mulligan on 20 October 2004 and in subsequent correspondence, Ms Hoffman raised detailed concerns in relation to Dr Patel's behaviour and clinical competence including reference to particular patients. The failure of the executive management to act swiftly and decisively at such time was inexcusable and had tragic consequences, eg for Mr Gerard Kemps. The concerns of executive management should have been heightened by the subsequent interviews of Drs Berens, Risson and Strahan[37]. The failure to discuss the matters raised with Dr Miach is inexplicable. Dr Keating's advice to Mr Leck that there were no substantial matters of concern requiring any immediate action was either dishonest or grossly incompetent.

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[37] Exhibit 448, DWK 62-64

50. It is clear that the approach of management in response to the matters raised by Ms Hoffman was to attempt to arrange a review by a hand picked doctor suitable to management who would report only to the executive management of the BBH. It was not until mid December that there was any official contact with the office of the Chief Medical Officer and not until January 2005 that there was official advice of the complaint to zonal management.

51. The executive management's inertia in response to the matters raised by Ms Hoffman contributed directly to the unfortunate result for Mr Gerard Kemps.

52. At the very latest following upon the interviews of medical practitioners in early November 2004, Mr Leck and Dr Keating should have taken action, if not to suspend Dr Patel from practice entirely, than to at least limit his scope of practice by way of prohibiting him from undertaking complex surgery such as oesophagectomies. Their failure to do so constituted a gross breach of the trust invested in them by way of their positions.

53. Mr Leck and Dr Keating as District Manager and Director of Medical Services respectively, both held an appointment in a unit of public administration within the meaning of s.21 of the *Crime and Misconduct Act* 2001. It is submitted that their failures as particularised above involved breaches of the trust placed in them as holders of the respective appointment within the meaning of s.14 of the Act. It is submitted that such conduct could amount to a disciplinary breach providing reasonable grounds for termination of the services of such a holder of an appointment and thus can amount to official misconduct within the meaning of s.15 of the Act. It is submitted that the evidence before the Commission is sufficient for referral of both Mr Leck and Dr Keating to the CMC for investigation of charges of official misconduct.

54. In a telephone conversation with an officer of the Queensland Health Audit and Operational Review Branch on 17 December 2004[38], Mr Leck stated that the district would need to handle Ms Hoffman's complaint carefully as Dr Patel was of great benefit to the district and they would hate to lose his services as a result of the complaint. It is an irresistible inference from all the evidence that the manner in which the executive management responded to Ms Hoffman's complaint was coloured by the executive management not wishing to lose the services of Dr Patel as a surgeon. Any surgeon was better than no surgeon at all in the context of budget imperatives driven by the need to meet elective surgery targets for the financial year. Dr Patel's value to the BBH in maximising the throughput of elective surgery procedures was well known to both Mr Leck and Dr Keating and such was expressed to Dr FitzGerald in his subsequent investigation. The e-mail from Dr Keating to the Nurse Unit Manager of the Operating Theatres, Ms Gail Doherty, of 8 February 2005[39], lends support to the view that the executive management were desirous of retaining the services of Dr Patel at least until 30 June 2005, notwithstanding the seriousness of any concerns being raised as to his clinical competence. Ms Doherty said in evidence that the only response she received when she raised the issue of excessive overtime and staff fatigue was this email from Dr Keating[40]. She gave evidence that, if Dr Patel had been suspended from practicing as a surgeon in late 2004

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[38] Exhibit 225 GF10

[39] Exhibit 72 (also admitted as exhibit 501) and see the Statement of Gail Doherty, exhibit 509, paras 24 - 26

[40] T.7403 ll.10-15

or early 2005, that "we certainly would not have met targets if he had been suspended"[41].

55. It was in this context that Ms Hoffman eventually saw no alternative but to raise her concerns outside the Queensland Health system with a Member of Parliament.

Mr Gerard Kemps (P21)

56. Mr Kemps underwent an oesophagectomy carried out by Dr Patel on 20 December 2004. The Commission received evidence from nursing staff, including Mr Damien Gaddes, Ms Jenelle Law and Mr Martin Brennan, and doctors, including Dr Berens, Dr Kariyawasam and Dr Carter, as to the circumstances of Mr Kemps' operative and post-operative treatment. For the reasons explored elsewhere in the submission, Mr Kemps should never have undergone such a procedure at the Bundaberg Base Hospital, and certainly not at the hands of Dr Patel.

57. Mr Kemps death was a "reportable death" within the terms of s.8(3)(d) of the *Coroners Act* 2003. Drs Berens and Carter sought the advice of Dr Keating as to whether such death should be reported to the Coroner. Dr Keating abdicated his responsibility as Director of Medical Services to advise Dr Berens and Dr Carter that such death should be reported and failed to take any steps to report the death himself.

58. In circumstances where Dr Berens and Dr Carter acted conscientiously in seeking the guidance of the Director of Medical Services as to whether the death should

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[41] T. 7400 -7401

be reported and were motivated partly by concerns that reporting such death might cause further distress to Mr Kemps' family in light of his impending funeral, it is not submitted that the Commission should make recommendations adverse to those doctors.

59. Dr Keating's failure in such regard is more serious because of his position of responsibility in responding to Drs Berens' and Carter's request for advice. It is submitted that there is sufficient evidence to justify referral of this matter to the CMC for consideration as to whether or not a charge of official misconduct should be laid against Dr Keating for failing to advise Dr Berens and Dr Carter that the death should be reported and failing to take any steps to report the death himself. Alternatively, it is submitted that there is sufficient evidence for consideration as to whether the matter should be referred to the Commissioner of the Police Service for prosecution of Dr Keating for an offence pursuant to s.7(2) of the *Coroners Act* 2003.

Executive Management's attempts to retain the services of Dr Patel

60. The conduct of Mr Leck and Dr Keating throughout the whole period of time that concerns were raised in relation to Dr Patel was indicative of a desire to retain his services as a general surgeon so as to meet budget imperatives, regardless of any legitimate concerns as to patient safety. The extent to which they were prepared to disregard patient safety and the length they were prepared to go to to retain Dr Patel's services are starkly demonstrated by their conduct in early 2005.

61. Dr Keating expressed dishonest opinions as to Dr Patel's clinical competence and judgment in conversations with Dr FitzGerald and in written communications to the Medical Board considering Dr Patel's re-registration. Mr Leck authored a dishonestly unbalanced letter of support for Dr Patel to the local newspaper for the express purpose of attempting to retain Dr Patel's services as a surgeon.

62. After Mr Messenger's statements in Parliament had been publicly reported, the Acting Director of Nursing, Deanne Walls, called a meeting of ICU staff on the 23 March 2005. This meeting was attended by the District Manager, Mr Leck. Mr Leck expressed anger about nurses breaching the confidentiality provisions of Queensland Health's Code of Conduct. Mr Leck referred to a departmental Industrial Relations document to the effect that staff breaching confidentiality could be imprisoned for two years and lose their jobs[42]. He stated that he was appalled that such a senior surgeon of the hospital could be treated in such a way that denied him natural justice[43]. Mr Leck berated the nurses and said that he had it on good sources that the letter was leaked by an intensive care nurse[44]. Ms Karen Jenner gave evidence that "I was intimidated[45]. He was quite angry"[46] and "I think his whole manner was threatening"[47]. "He told us that we had caused a rift between medical and nursing staff, that the general public would

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[42] Statement of Toni Hoffman, exhibit 4, para 167

[43] Statement of Toni Hoffman, exhibit 4, para 168

[44] Statement of Karen Jenner, exhibit 508, para 15

[45] When pressed during cross examination at T.7394 ll.28-50 as to what was intimidating about Mr Leck's behaviour, she responded "The fact that he came unannounced to the ICU. We had no idea he was coming. That we got this lecture and that he left. I'd never met Mr Leck previous to that despite working at the hospital for two years, and to go to a meeting thinking it's going to be something that's completely different, to sit there, cop this huge, big lecture about all the stuff that he mentioned and then for him just to leave is quite intimidating when that's not what you're expecting the meeting to be about".

[46] T.7394 ll.49-50

[47] T.7395 ll.1-10

never look at ICU staff the same way again ... and that the person who leaked the letter couldn't be trusted"[48]. Mr Leck left without giving any of the nurses an opportunity to respond to his comments or to discuss their concerns about Dr Patel[49].

63. Mr Leck later that day had a meeting with Level 3 Nursing staff. He reiterated that the leak was a breach of the Code of Conduct. "He was visibly angry and upset. He was saying that he knew that it was a nurse that was responsible for the leak"[50]. He went on to say that "a nurse had gone behind our backs and released this information before the report was released and they would be reprimanded"[51]. There would be serious repercussions[52]. Nursing staff felt extremely "intimidated"[53] and "powerless"[54] as a result of the comments made by Mr Leck. Ms Robyn Pollock wanted to respond to Mr Leck "... but I didn't because I felt intimidated ... I felt chastised after he left, and I hadn't done anything wrong. I was very concerned for whoever had sent the letter to Mr Messenger. I felt that if it was known who leaked the letter, that person would lose their job."[55]

64. It is significant that these meetings occurred in circumstances where there was an apparent expectation on the part of Mr Leck that the media might make

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[48] T7393 ll.30-40

[49] Statement of Toni Hoffman, exhibit 4, para 169; T.7393 ll.40-48

[50] Statement of Robyn Pollock, exhibit 70, para 48

[51] Statement of Robyn Pollock, exhibit 70, para 48

[52] Statement of Margaret Mears, exhibit 507, para 11

[53] Statement of Robyn Pollock, exhibit 70, para 49

[54] Statement of Gail Alymer, exhibit 59, para 46

[55] Statement of Robyn Pollock, exhibit 70, paras 48 - 49

contact with members of the nursing staff to inquire as to those matters referred to in the letter of Ms Toni Hoffman[56] that had been tabled in Parliament the previous day[57]. Attendees at the meetings included Ms Hoffman and other nurses named in the letter[58]. It is reasonable to infer that Mr Leck intended to discourage, by threats and intimidation, those present at the meetings from discussing matters concerning Dr Patel with anyone outside Queensland Health.

65. Mr Leck's letter to the Bundaberg News Mail, 28 March 2005 while clearly supporting Dr Patel[59] expressed Mr Leck's view that the fact that allegations had been made public was "reprehensible"[60].

66. An email from Mr Peter Leck to Mr Dan Bergin, dated 7 April 2005, indicates that Mr Leck was prepared to threaten staff with reprisals for raising issues in a public forum. He refers to the staff member as "the culprit who leaked this information" and refers to them being "on very dangerous ground". He is prepared to use the Code of Conduct to "deliver some firm and scary messages"[61].

67. At the Staff Forum attended by Mr Leck, Dr Steve Buckland and the Honourable Gordon Nuttall MP on the 7 April 2005 Mr Nuttall and Dr Buckland told nursing staff that, because of the release of material in Parliament by Mr Messenger and the departure of Dr Patel from Australia, results of the Queensland Health

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[56] Exhibit 4 TH37

[57] Statement of Karen Jenner, exhibit 508, para 15; T.7387 ll.9-16

[58] Karen Stumer, Karen Fox, Karen Jenner, Vivienne Tapiolais: Statement of Karen Jenner, exhibit 508, para 15

[59] "Dr Patel is an industrious surgeon, who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go."

[60] Exhibit 473

[61] Exhibit 477

investigation that had been underway would not be released[62]. Ms Margaret Mears states "It was very clear - made very clear to us that the information from Dr Gerry Fitzgerald inquiry would not be released"[63]. Nursing staff felt that they were being criticised as being disloyal[64]. Ms Margaret Mears states: "During the meeting, Mr Nuttall said that the only way that we could stop the rubbish that was going on at Bundaberg Base and in Bundaberg was if we were to vote Mr Messenger out"[65].

68. Ms Karen Jenner, in response to Dr Buckland saying that he supported his staff one hundred percent and would not tolerate his staff being tried by the media and being denied natural justice, asked Dr Buckland if he "supports his staff one hundred percent then where is the support for the nurses who made the multiple formal complaints about Dr Patel..."[66]. Ms Jenner stated: "His response was words to the effect - he sort of said to me, "Well, what part of 'there's going to be no inquiry don't you understand?'", that - once again, that Dr Patel wasn't in the country and he couldn't - he didn't have a right of reply, and he hadn't been given natural justice, so that was it. There was nothing more that they could really do regarding Dr Patel"[67].

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[62] Statement of Gail Alymer, exhibit 59, para 47

[63] T.7376 ll.9-20; Statement of Margaret Mears, exhibit 507, paras 12 - 15

[64] Statement of Karen Jenner, exhibit 508, para 18

[65] T.7375 L.34

[66] Statement of Karen Jenner, exhibit 508, para 18

[67] T.7384 l.40- T.7385 l.5

69. Dr Buckland acknowledged in his evidence that, with the benefit of hindsight, he and the Minister had not handled the meeting well[68].

Dr FitzGerald's investigation

70. Dr FitzGerald's conduct in relation to the clinical review instigated as a response to Ms Hoffman's complaint was indicative of a preparedness on his part to "manage" the situation in a manner that would not reflect adversely upon the hospital management or Dr Patel and facilitate the desire of the executive management to retain Dr Patel's services. In February 2005 interviews of nurses were conducted. Ms Karen Jenner states: "They told us that they were gathering information to see whether or not an investigation would be necessary ... We were told quite clearly that it wasn't an investigation at that stage"[69]. The report initially authored by Dr FitzGerald failed to include the serious findings as to Dr Patel operating outside the scope of practice of the BBH and the failure of the executive management to address concerns raised about Dr Patel over a lengthy period of time. The admitted approach of Dr FitzGerald to only include positive comments in relation to Dr Patel and deliberately not include negative ones necessarily presented a skewed report of the true situation.

71. It seems clear that subsequent steps on the part of Dr FitzGerald and Queensland Health were driven only as a result of the growing public exposure of the true situation and recognition on the part of Dr FitzGerald and his superiors that their response needed to be heightened in light of the growing public controversy. In

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[68] Statements of Dr Buckland, exhibit 335 para 34 and exhibit 337 paras 10 -13

[69] T.7390 ll.20-50; Statement of Karen Jenner, exhibit 508 paras 13 - 14

the absence of public disclosure by Mr Messenger of matters in Parliament, it is a reasonable inference that the process of response to Ms Hoffman's complaint may well have finished with the preparation of the confidential audit report of Dr FitzGerald, with the real adverse findings by Dr FitzGerald never finding their way into print. The addition of the memo to the Director-General containing those adverse findings would appear to have been responsive to the matters being raised in Parliament and advice being sought by the Director-General as to the process of his review.

72. It is a reasonable inference that, but for the depth of negative feeling ascertained by the Director-General and the Minister for Health on their visit to Bundaberg on 7 April 2005 and the knowledge obtained by the Director-General through an internet search regarding Dr Patel's registration on the same date, the matter would have concluded as was flagged to staff on that date, ie Dr FitzGerald's report would never have been released, the investigation would have ceased and the whole matter been buried. The announcement of a further review on 9 April 2005 was clearly a response to the realisation on the part of the Director-General and the then Minister that adverse publicity would necessarily result when the information regarding Dr Patel's registration became public knowledge.

Additional Submissions on Systemic Issues

73. The QNU submissions to the Queensland Health Systems Review (the Forster Inquiry) is included as Appendix 2. We urge upon the Commission consideration of the whole of such submission and the recommendations submitted therein. We refer in particular to the following aspects of that submission which have been highlighted and exemplified by evidence given before the Commission.

Chronic Underfunding of Queensland Health Services

74. The Commission has received evidence which puts beyond doubt those propositions submitted in Appendix 1 and Appendix 2 by the QNU that the Queensland public health system has been chronically underfunded for many years, with consistently lower expenditure per capita than in other States and Territories[70]. Queensland Health has placed an undue emphasis upon achieving greater and greater efficiency outcomes with insufficient emphasis placed upon the quality of care provided and whether health outcomes are satisfactory. By producing a situation where Queensland has the lowest number of medical practitioners and nursing practitioners per head of population than any other State[71], emphasis on efficiency gains has had a negative impact on quality of care as doctors and nurses are placed in situations where they are unable to deliver an optimal standard of nursing care. Frustration at being unable to provide appropriate standards of care has led to medical practitioners and nurses leaving the Public Health system or decreasing their hours of work because they can no longer cope with unrealistic work demands and the consequences such have upon their ethical obligations as health professionals[72]. Doctors and nurses within the Queensland Health system are working harder and being paid less than their interstate counterparts, becoming increasingly frustrated by the level of care that they can provide their patients and leaving the Public Health system in many cases after being burnt out by the system. The inescapable conclusion is

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[70] See eg Statement of Dr Buckland, exhibit 336 paras 64, 77 & 78; Exhibit 310 Extracts from the Productivity Commission's report on Government Services 2005

[71] Statement of Dr Young, exhibit 209

[72] See eg the evidence of Dr McNeill at T.4748-4749

that there can be no real solution to the crisis existing in the Queensland public health system without a greater allocation of public monies to that public health system.

Queensland Health's Culture of Secrecy

75. The Commission has a body of evidence before it which confirms and exemplifies submissions previously made by the QNU as to the culture of secrecy in Queensland Health and the need for improved openness, transparency and accountability in Queensland Health. The obsession with secrecy in Queensland Health has largely been derived from a combined imperative to "put a lid" on controversy and dissent and at the same time manage the budget imperatives of continuing to do more with less. Greater openness and transparency is necessary for there to be a genuine community debate in relation to priorities for our Queensland Health system. The evidence before the Commission in relation to the Queensland Health management of information concerning waiting lists and the measured quality program are only examples of the past approach which must be changed.

76. The evidence before the Commission has also provided examples of abuse of the cabinet exemption provisions of the *Freedom of Information Act* 1992. Attached as Appendix 3 to these submissions is a submission of the QNU on the review of the *Freedom of Information Act* 1992 to the Legal, Constitutional and Administrative Review Committee dated 14 May 1999. Submissions with regards to s.36 of the Act appear at page 7 of that document.

The Code of Conduct

77. The evidence shows instances of the Queensland Health Code of Conduct being used to intimidate nurses in an attempt to stifle discussion about concerns nurses had in Bundaberg.

78. As well as the specific events referred to above, there has been a general concern amongst Queensland Health staff as to reprisals from management in response to them raising issues. In his evidence to the Commission, Dr Nankivell stated: "The people in Queensland Health are terrified of the code of conduct, particularly the nurses, because the nurses are much more vulnerable. Doctors, if they get sacked, can always go to the private sector. Nurses are - because they're a more vulnerable group, are terrified"[73].

79. Toni Hoffman was concerned that on making the complaint in October 2004 her career was over[74]. Enrolled nurse Jenelle Law, in referring to the death of Mr Kemps, stated: "I was so distressed with what had happened that I wrote a statement early in January 2005 ... It took me quite a while to work up the courage to hand it in after I had written it as I feared for my job." She concludes "I have been concerned that I will lose my job. A few weeks ago, around the end of April start of May 2005, the tension over the Inquiry and the media attention

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[73] T.2958

[74] T.171: "I was very well aware that by making this complaint, even just to Peter Leck and Linda Mulligan at that particular time, that I would never get a chance to progress my career in Queensland Health...My belief was that I would never get an opportunity to act up into a higher position, I would never be given the opportunity to go to conferences or any of the things that enable you to progress in your profession. I knew that my making this complaint, that that would be the end of my career and it may even be the end of my career at that hospital.

just became too much. I broke down because I was so upset. Counsellors have since been brought in to speak to us"[75].

80. Nursing staff were concerned about reprisals which operated as a disincentive to make complaints and raise issues. Ms Robyn Pollock stated her feelings towards speaking out after an incident where Mr Peter Leck and others from the executive team accused staff of the Renal Unit of leaking information to the head of the renal patients support group: "I became so guarded in what I said to Richard and to others after this experience. That treatment was a huge disincentive to speaking out to management"[76]. As to the meeting where Mr Peter Leck accused nurses of leaking information to Mr Messenger in March 2005, Ms Gail Aylmer stated: "I was concerned that if nurses were made the scapegoat for this situation, then nurses in the future would be very reluctant to advocate for the patient."[77]

81. The lack of leadership support by Queensland Health management at BBH and management inaction in responding to concerns raised by nursing staff caused the nurses great anxiety and distress, especially as further incidents occurred. Registered Nurse Karen Fox pinpoints the cause of the major depressive disorder she is currently suffering as resulting from "the events I witnessed on 27 July 2004 [the death of Mr Bramich], and exacerbated by subsequent events at the BBH concerning Dr Patel. My condition deteriorated during the time Dr Patel

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[75] Exhibit 160, paras 18 - 25; Jenelle Law clarifies in cross examination that until she spoke to her solicitors she thought she would lose her job (T. 2214, l.55)

[76] Exhibit 70, para 47

[77] Statement of Gail Alymer, exhibit 59, para 46

continued to work at the hospital and I ultimately needed to cease work for a period of time earlier this year"[78].

82. It is the right of all Queensland Health staff and citizens to raise concerns in the public domain about the conduct of public institutions including hospitals and other health facilities. It is the department's role to deal with these concerns in a timely and appropriate manner or to refute them. Misuse of the Code of Conduct and legislation must cease if we are to create a positive, problem solving and open culture in Queensland Health it must not be used to silence criticism and debate.

83. Recommendations:

(i) It is essential that the Code of Conduct be reviewed and amended to allow for discussion without fear of disciplinary action.

(ii) It is recommended that a penalty to be imposed for the inappropriate use of this document by Queensland Health management.

(iii) Amendments must be made to the *Health Services Act* 1991 and the *Whistleblowers Protection Act* 1994 to remove doubts held by QNU members as to whether they can approach the QNU, and other appropriate bodies, to raise and discuss matters of concern without the fear of disciplinary action or criminal prosecution.

[78] Exhibit 485, para 9

Amendments to the *Whistleblowers Protection Act* 1994

84. The QNU agrees with the recommendations put forward by the Forster review as to changes to the *Whistleblowers Protection Act* 1994:

(i) Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act;

(ii) The media should not be approved as one of the bodies to whom Whistleblowers can lodge Public Interest Disclosures and have protection under the Act; and

(iii) Any person not just a public officer should be afforded protection for disclosing danger to public health and safety.

(iv) In addition it is submitted that whistleblowers should be able to lodge Public Interest Disclosures with their relevant professional and / or industrial organisation, eg the AMAQ and QNU.

Amendments to the *Health Service Act* 1991

85. The QNU submits that in addition to changes recommended by Mr Forster to the *Whistleblowers Protection Act* 1994, it is necessary to amend the provisions relating to confidentiality contained in the *Health Services Act* 1991. Section 62A of the *Health Services Act* 1991 presently makes it a summary offence for employees to disclose to another person any information "if a person who is receiving or has received a public sector health service could be identified from the confidential information". The exceptions in which such information can be disclosed are numerous, but unlikely to be of assistance to a clinician who is confronted with having to "blow the whistle" in the interests of advocating patient safety.

86. In particular, it seems quite absurd that section 62I requires the written authorisation of the Director-General of Queensland Health before a disclosure to prevent "serious risk to life, health or safety" can legally be made. Similarly, disclosures in the "public interest" pursuant to section 62F must first be authorised, in writing, by the Director-General.

87. Section 62A may even operate to prevent a clinician from obtaining professional, industrial or legal advice concerning occurrences in Queensland Health.[79]

88. It is submitted that the current provisions are plainly unbalanced and serve as a disincentive to clinicians who feel ethically bound to act in a particular way in the interests of their patients. While it is not disputed that there should be proper protections for the confidentiality of patient information, this should not operate in any way which may fetter patient safety. At the very least, there should be amendments that allow clinicians to disclosure confidential information to:

(i) prevent risks to life, health or safety; and

(ii) obtain professional, industrial and legal advice.

89. Furthermore, it is submitted that the threat of criminal sanction is inappropriate in respect of clinicians who hold appropriate professional registration. Section 62A should not apply to registered clinicians on the basis that they are subject to professional disciplinary proceedings if they make unethical disclosures of patient information.

---

[79] A written authority pursuant to section 62F was finally given by the then Director General Dr Buckland on 16 May 2005 to enable Queensland Health employees to communicate freely with the QNU and its legal representatives in respect of any official inquiries into the Bundaberg Base Hospital after an exchange of correspondence in which it was implied by Queensland Health that the union's members could not communicate any information to the union or the lawyers engaged to represent them which could identify patients.

Complaints Management & Resolution Reform

90. Effective management and resolution of complaints is of great concern to members. The QNU's ultimate submission in this regard is that there is a need for complaint management and resolution reform. The experience of the nursing staff at the BBH is that complaints and concerns raised by nursing staff regarding clinical outcomes were not adequately addressed by Queensland Health Executives. The internal complaints process was not promoted and not well known by staff. As an illustration, Michelle Hunter, indicated that while she knew that the BBH had access to the Queensland Health intranet, she did not know of web pages that gave guidance as to how to go about making a complaint[80].

91. On the whole the QNU supports the risk management and clinical governance recommendations in Chapter 9 of the Forster Review, the Final Report of findings of the Queensland Health Systems Review, tabled in Parliament on Friday 30 September 2005.

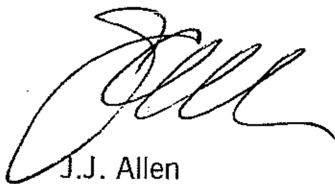
92. As detailed in the Forster review, the QNU supports and advocates for the adoption of a complaints model that provides for local complaint resolution with an escalation process to an independent complaints body. However, the QNU submits there should be a reduction in time frames regarding the escalation of complaints in the recommended Complaints Management & Resolution Model. The nominated total period of 30 days for escalation of the complaint to an independent complaints body is too long in the current environment where patient and staff safety are compromised by staff shortages. Furthermore, the

[80] T.2046, l.7

QNU recommends that such reform be implemented across both the public and private sectors.

93. The QNU recommends that an adequately funded patient advocacy group be established to support patients in making complaints through this process.

94. Any new legislative framework should explicitly provide that complaints may be made as of right by medical and nursing staff as well as patients (cf s 59 *Health Rights Commission Act* 1991).



J.J. Allen

L.D.Coman

Counsel for the QNU

28 October 2005

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS IN REPLY ON BEHALF OF THE QUEENSLAND NURSES' UNION

A. SUBMISSIONS BY THE MEDICAL BOARD OF QUEENSLAND

Submissions re Mr Desmond Bramich (P11) at Part C, pp.2-11

1. (a) Pages 3-4 "Sr Hoffman gave evidence of very significant concerns relating to Dr Patel's conduct in relation to this patient in her statement and in her oral evidence. The concerns emerged from her chronology as follows:

> "...
> 10. That Dr Patel performed a pericardiocentesis to extract fluid from around the heart. This was contra-indicated from the ultrasound. He did so with a needle and stabbed around the patients heart 50 times (T.141)"

(b) Page 10:

> "No other witness supported Hoffman's account that Dr Patel stabbed the witness (sic) 50 times. This could only be hearsay. Whilst it is clear that Dr Patel applied 10 or more stabbing motions, no eye witness saw 50 motions, as stated (as hearsay) by Hoffman (no other witness corroborates Hoffman's hearsay version)."

(c) These submissions appear to carry with them an implicit criticism of Ms Hoffman's veracity as regards her testimony concerning Mr Bramich. Ms Hoffman never purported to give anything other than hearsay evidence in relation to the ill advised and incompetently executed perocardiocentesis. The only reference in Ms Hoffman's evidence to "around 50 times" is in her oral testimony during the course of a very lengthy and emotional account as to her concerns regarding Mr Bramich, during which she makes it quite clear that she is merely repeating what she has been told by a nursing colleague

who was extremely concerned as to the matter[1]. Any implicit criticism contained in these submissions is unwarranted.

2. (a) Pages 3-4: "Sr Hoffman gave evidence of very significant concerns relating to Dr Patel's conduct in relation to this patient in her statement and in her oral evidence. The concerns emerged from her chronology as follows:

> "...
> 12. That her sentinel event form raising concerns about the patient had been downgraded by Dr Keating (this was incorrect - see evidence of Raven)."

(b) The evidence of Ms Raven on this issue is demonstrably incorrect. Ms Raven[2] claimed that the Sentinel Event form had not been downgraded but there had been an administrative error whereby the separate Sentinel Event form and Adverse Event form were stapled together in error and entered as an Adverse Event in the Register[3]. Such understanding on the part of Ms Raven was based upon what she had been told by others and was proven subsequently to be incorrect.

(c) The evidence of Mr Leck[4] was that he was aware of the receipt of both forms, i.e. a Sentinel Event form and an Adverse Event report and after discussion with the Quality Co-Ordinator (most likely Dr Jane Truscott acting in that position) and Dr Keating, Mr Leck made a

---

[1] T.141, ll.30-35

[2] Ms Raven was a most unimpressive witness. If the Commission feels it necessary to make any findings as to the credibility of Ms Raven's evidence, it is submitted that it would be instructive to view the video testimony of her evidence during the afternoon of Day 21 of proceedings, although a perusal of the evidence at T.2247 - 2316 may well suffice in this regard.

[3] Statement of Ms Raven, Exhibit 162, para 39, T.2295 - 2298

[4] Statement of Mr Leck, Exhibit 463, paras 32-36, T.7225

determination that the events described in the Sentinel Event form did not constitute a sentinel event. Whilst such a conclusion was demonstrably incorrect in the circumstances, such evidence is completely consistent with the understanding formed on the part of Ms Hoffman that the Sentinel Event form had been downgraded by Dr Keating, i.e. that it had been deemed not to be a sentinel event, as was reported to her by Dr Truscott[5]. The criticism of the evidence of Ms Hoffman in this regard is unwarranted.

3. (a) Page 11:

> "The issue which is of greater significance is the blocked and/or inadequate drainage. It is submitted that Dr Woodruff's evidence is important on this issue. Given that the time period prior to this discovery is unclear, there is insufficient evidence that the drainage failure can be sheeted home to Dr Patel over other staff. No referral for disciplinary investigation of any individual is justified. It was a team failure."

(b) The opinion expressed by Dr Woodruff that a team failure on the part of medical and nursing staff to note that an underwater seal drain was not working contributed to Mr Bramich's death was, it is submitted, in error and based upon a misunderstanding as to whether the contents of an Adverse Incident Report[6] were of any real significance in relation to Mr Bramich's outcome. In relation to such a contention, the following should be noted:

(i) Dr Woodruff contends that medical or nursing staff should have realized that Mr Bramich had an internal bleed and inadequate

---

[5] Statement of Ms Hoffman, Exhibit 4, paras 86 - 89

[6] Exhibit LTR 9 to the statement of Ms Raven; Exhibit 162

drainage but cannot point to anything in the patient's medical record prior to 1300 that should have raised such concern;

(ii) Observations of the underwater seal drainage as late as 1120 record that the ICC is swinging and draining and that consideration has been given to mobilizing the patient;

(iii) There would appear to be a sudden decompensation of Mr Bramich at 1300 consistent with internal haemorrhaging that is not being adequately drained but nothing to alert medical or nursing staff prior to that of those facts;

(iv) The drainage tube is readjusted at that time and it is most unlikely that an absence of water in the drain could have gone unnoticed at that time;

(v) Indeed the fact that the readjustment of the drain produced some outflow indicates positively to the contrary;

(vi) The absence of water in a drain is noted at some undetermined time after Mr Bramich has been transferred to the ICU at 1420;

(vii) There is nothing to indicate that the absence of water in a drain at some undetermined time subsequent to Mr Bramich's decompensation at 1300 and subsequent transfer to the ICU at 1420 in any way contributed to his ultimate demise;

(viii) The Pathologist, Dr Ashby, did not agree that the drainage was not adequate[7].

In the circumstances, there is no evidence to justify a finding of a "team failure" as contended.

---

[7] T.2719, ll.30-45

B. SUBMISSIONS ON BEHALF OF LINDA MULLIGAN

1. The content of paragraph 16 of the outline appears to carry with it an implicit criticism of Ms Hoffman for failing to explicitly state verbally or in writing to Mr Leck in late February 2004 that she had formed the view that Dr Patel was "clinically unsound". Such a criticism is not warranted:

   (a) Although Ms Hoffman did not explicitly state an opinion that Dr Patel was "clinically unsound", she did raise with Mr Leck matters of clinical concern relating to Dr Patel at such time (as is clear from the contents of the relevant part of TH10[8]);

   (b) Although Ms Hoffman had formed such a belief, it was not one she was able to hold with certainty (still hoping as late as October 2004 to be proven wrong in her concerns) and in the absence of support from Dr Carter, she did not feel that she had sufficient evidence to ground an official complaint or allegation of clinical incompetence[9].

2. Paragraph 86 of the outline contained an allegation that "a small minority" (unnamed) of an unidentified group (but presumably allegedly nursing staff of the BBH) "chose for reasons best known to themselves, not to voice their concerns to" Ms Mulligan. This regrettable allegation should not receive acceptance by the Commission:

   (a) The suggestion that members of nursing staff, for some unknown reason, chose to hide concerns regarding Dr Patel is flatly contradicted by the weight of evidence:

---

[8] Statement of Ms Hoffman, exhibit 4.

[9] T.1378 l.15 - 1380 l.58.

(i) Ms Hoffman raised concerns with the then Director of Nursing, Ms Goodman, and Dr Keating regarding Dr Patel operating outside the scope of practice of the BBH in May and June 2003, in person and by way of e-mails[10];

(ii) Ms Pollock and Ms Druce reported their concerns regarding patients suffering complications following peritoneal dialysis catheter placements by Dr Patel with the then acting Director of Nursing, Mr Martin on 10 February 2004[11];

(iii) Ms Aylmer raised concerns as to rates of wound dehiscence with Dr Keating in mid 2003[12];

(iv) Ms Aylmer and Ms Pollock reported concerns as to Dr Patel's aseptic technique to Dr Keating on 27 November 2003[13];

(v) Ms Hoffman raised specific concerns as to the behaviour of Dr Patel, including clinical matters, in March 2004;

(b) The management style adopted by Ms Mulligan was not one that facilitated a frank and confident communication to her of concerns held by nursing staff[14];

(c) The only member of the nursing staff to whom such an allegation was put by Counsel for Ms Mulligan i.e. Ms Hoffman, strenuously rejected the allegation[15].

---

[10] See paras 32 and 36 of the Submissions on behalf of the Queensland Nurses' Union.

[11] See para 39 of the Submissions on behalf of the Queensland Nurses' Union.

[12] See para 41 of the Submissions on behalf of the Queensland Nurses' Union.

[13] See para 42 of the Submissions on behalf of the Queensland Nurses' Union.

[14] See paras 45 and 46 of the Submissions on behalf of the Queensland Nurses' Union.

[15] T.1382 l.28 - 1383 l.4.

C. SUBMISSIONS ON BEHALF OF PETER LECK

1. Paragraphs 112 to 147 deal with "Mr Leck's meetings with the nurses on 23 March 2005". Paragraph 140 reads:

> "The following people were at the first (ICU) meeting. Mr Leck, Ms Walls, Ms Hoffman, Ms Jenner, Ms Marks, Ms Stumer, Ms Fox and Ms Tapiolas. Of those eight people only three, namely Mr Leck, Ms Hoffman and Ms Jenner gave evidence on this topic. Ms Fox gave a 'supplementary' statement but it does not address this issue. Ms Walls, Ms Marks, Ms Stumer and Ms Tapiolas did not give evidence at all. **It can be assumed that the Commission did not call evidence from Ms Walls, Ms Marks, Ms Stumer, Ms Fox and Ms Tapiolas because their evidence would not assist.**" (emphasis added)

2. Such a submission is quite disengenuous and lacking in any weight:

   (a) There is nothing to suggest that either Ms Walls or Ms Marks were ever approached by the Commission to provide their recollection of the meeting;

   (b) The Commission and Mr Leck's legal representatives[16] are aware that, notwithstanding the Commission not admitting the following statements into evidence:

      (i) Vivian Ann Tapiolas at paras 34 - 39 of her statement dated 18 May 2005 provides a consistent account of Mr Leck's behaviour at the meeting with ICU nurses, describing Mr Leck as being "incredibly angry", and describing the event as intimidating and creating a very hostile and threatening environment;

      (ii) Karen Lynne Fox at paras 24 and 25 of her statement dated 18 May 2005 provides a consistent account of the meeting and

[16] A CD containing the statements referred to was provided by the Commission to all interested parties during the Bundaberg sittings of the Bundaberg Hospital Commission of Inquiry

refers to it as being one of the factors that exacerbated her symptoms of anxiety and depression;

(c) Mr Leck's legal representatives did not request that any of Ms Walls, Ms Marks, Ms Stumer or Ms Tapiolas be called to give evidence on the topic;

(d) The submission fails to recognize the nature of, and practical constraints upon a Commission of Inquiry of this type;

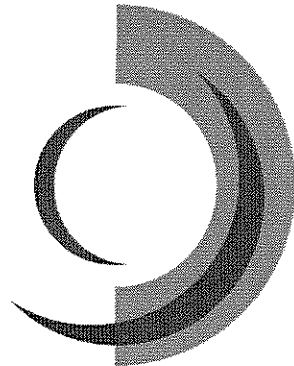
(e) No such Jones v Dunkel reasoning is appropriate in these circumstances.

JJ Allen
Counsel for the QNU
1 November 2005

26.

Submissions

Queensland Ombudsman



QUEENSLAND
ombudsman

Submission to the Bundaberg Hospital Commission of Inquiry

August 2005

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Abbreviations and Dictionary

ACSQHC	Australian Council for Safety and Quality in Health Care
ADR	Alternative dispute resolution
AORU	Audit and Operational Review Unit within Queensland Health
BHCI	Bundaberg Hospital Commission of Inquiry
CH	Caloundra Hospital
CJC	Criminal Justice Commission
CMC	Crime and Misconduct Commission
CC	Complaints Coordinator
D-G	Director-General
EARC	Electoral and Administrative Review Commission
ED	Emergency Department
EFT	Equivalent full time positions
Executive Director	Executive Director of Medical Services, Sunshine Coast Health Service District
HCCA	Health Care Complaints Act 1993 (NSW)
HCCC	Health Care Complaints Commission (NSW)
HDC	Health and Disability Commissioner
HPPSA	Health Professionals (Professional Standards) Act 1999
HRC	Health Rights Commission
HRCA	Health Rights Commission Act 1991
HAS	Health Services Act
HSP	Health service provider
IHSC	Independent Health Services Commission
MBQ	Medical Board of Queensland
NHS	National Health Service
NPSA	National Patient Safety Agency
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
OCHO	Office of the Chief Health Officer
OHPRB	Office of the Health Practitioner Registration Boards
OPSME	Office of Public Service, Merit and Equity
PCJC	Parliamentary Criminal Justice Committee
PD	Position Description
PID	Public Interest Disclosure
PSC	Professional Standards Committee of the QNC
QH	Queensland Health
QNC	Queensland Nursing Council
RCA	Root Cause Analysis
RCH	Royal Children's Hospital
RN	Registered Nurse
SCHSD	Sunshine Coast Health Service District
Tas	Tasmania
the Code	Code of Health of Health Rights and Responsibilities
The Commissioner	Commissioner of the Health Rights Commission
The Minister	Minister for Health
the policy	QH's Complaints Management Policy
Tribunal	Health Practitioners Tribunal
UK	United Kingdom
Vic	Victoria
WA	Western Australia
WPA	Whistleblowers Protection Act 1994

Foreword

By letter dated 3 May 2005, Commissioner AJH Morris QC invited me to lodge a written submission regarding:

- appropriate systems of accountability to ensure the proper processing, investigation and resolution of complaints about clinical practice and procedures at Queensland Health hospitals;
- the role of the Queensland Ombudsman in respect of such complaints; and
- the desirability or otherwise of establishing a specific 'Health Ombudsman' for Queensland.

Since then, the Bundaberg Hospital Commission of Inquiry (BHCI) has published several Discussion Papers, inviting submissions on specified issues.

Part 1 of this submission addresses issues relevant to Discussion Paper No 2, "Whistleblowers in the Queensland Public Health Sector".

Part 2 of this submission addresses issues relevant to Discussion Paper No 3, "Complaints Handling Systems in the Queensland Public Health Sector".

The key proposals made in respect of the three major subject areas covered in this submission appear as follows:

(a) the protection of whistleblowers - at section 5 of Part 1;
(b) QH's internal health complaint systems - at section 3.1.3 of Part 2; and
(c) a new external health complaints system - at sections 5.4 to 5.9 of Part 2.

David Bevan
Queensland Ombudsman

PART 1: Issues relating to protection of whistleblowers

1. Introduction

During the course of the inquiry, there has been considerable criticism of the response by Queensland Health (QH) to disclosures made by QH staff about clinical issues. The purpose of this part of the submission is to review the current process in QH for managing public interest disclosures (PIDs) and recommend improvements to that process to ensure that such disclosures are appropriately dealt with and those who make them are not subject to reprisal.

The broader issue of how to encourage staff to bring to attention issues of clinical concern or maladministration is beyond the scope of this submission. It involves fostering a culture in QH that strives for high standards of service and promotes openness and accountability. The emphasis needs to be on continual improvement and learning.

Such a change of culture must be driven from the top and must be supported by appropriate policies and procedures that evidence the organisation's commitment to these principles.

There are innumerable authorities advocating the value of both public and private sector agencies having in place systems that encourage whistleblowing. These are some examples:

> *"Whistleblowers have a vital role to play in the development of an open and effective public sector."*
> New South Wales Legislative Council
> Complaints handling within New South Wales Health
> Report 17, June 2004 page 62

> *"The genuine whistleblower should be seen as providing management with an opportunity for improvement and not as some 'rat under the house' requiring extermination."*
> New South Wales Ombudsman
> Protected Disclosure Guidelines
> 5th edition, May 2004 page iii

> *"Internal reporting of suspected misconduct and maladministration is vital to the integrity of the Queensland public sector. Employees who are prepared to speak up about wrongdoing or dubious practices are now well recognised as one of the most important and accurate sources of information about management problems and their possible solutions."*
> Crime and Misconduct Commission Chairperson
> Speaking up: Creating reporting climates in the Queensland public sector
> December 2004

2. The Queensland framework

The *Whistleblowers Protection Act 1994* (WPA), *Public Sector Ethics Act 1994*, *Public Service Act 1996*, and *Crime and Misconduct Act 2001* aim to create a work

environment in which proper standards of ethical conduct are widely understood and adopted. Under these Acts, public officials are required to report knowledge of serious wrongdoings using appropriate internal or external channels. Private citizens are encouraged to do the same.

2.1 Whistleblowers Protection Act 1994 Qld: An Overview

The WPA is administered by the Office of Public Service Merit and Equity (OPSME). The OPSME is responsible for providing advice and guidance to public sector agencies and officers and to private citizens, about their rights and obligations under the Act.

The Act gives protection to people who make a PID.

A PID by a public officer may be about conduct that is:

- official misconduct[1]
- maladministration that adversely affects anybody's interests in a substantial and specific way[2]
- negligent or improper management involving a substantial waste of public funds[3]
- a substantial and specific danger to public health or safety or to the environment[4].

Anybody may make a PID about:

- a substantial and specific danger to the health or safety of a person with a disability[5]
- an offence under certain legislation that is or would be a substantial and specific danger to the environment[6]
- a reprisal taken against anybody for making a PID[7].

The Act provides that disclosures must be made to an "appropriate entity"[8].

Any public sector entity is an appropriate entity to receive a PID about its own conduct (or that of its officers); about anything it has power to investigate or remedy; or if referred by another public sector entity[9]. The Crime and Misconduct Commission (CMC) is an appropriate entity to receive PIDs about official misconduct. The Queensland Ombudsman is an appropriate entity to receive PIDs about maladministration involving an entity within its jurisdiction.

[1] s.15
[2] s.16
[3] s.17
[4] s.18
[5] s.19(1)(a)
[6] s.19(1)(b) and (c)
[7] s.20
[8] s.25
[9] s.26

Maladministration is defined to cover *"illegal, arbitrary, oppressive or improper public sector 'administrative action'"*;[10] and *"administrative action that is unlawful, arbitrary, unjust, oppressive, improperly discriminatory or taken for an improper purpose"*[11].

For a disclosure by a public officer about maladministration to be a PID, it must involve conduct that *"adversely affects anybody's interests in a substantial and specific way"*[12].

2.2 Queensland Health

QH has developed a document entitled *Policy and Procedures for the Management of Public Interest Disclosures* (September 2000) made in accordance with the Act. The purpose of the policy document is to ensure all employees, supervisors and managers of QH are aware of their responsibilities to report serious misconduct and other important matters affecting the public interest, and to establish procedures for persons wishing to make a PID.

The document includes procedures for QH employees, and persons external to QH, to make a PID in accordance with the Act. The document outlines the scope of a PID, sets out who a PID can be made to, and details the procedures to be followed once a PID is made.

These procedures require that a PID be brought to the attention of the Director-General, or nominated delegate, who then assesses the PID to determine its appropriate management and investigation. The Director-General, or nominated delegate, is also to assess whether any risk of reprisal exists and take all steps within the authority of QH to ensure that any employee who makes a PID is not disadvantaged as a result of making the disclosure.

Where requested by the person making the PID, QH must provide reasonable information to the whistleblower within a reasonable time about the action taken by QH on the PID and its outcome.

Within QH, the Audit and Operational Review Branch is responsible for recording disclosures, including the action taken and whether the PID was verified or substantially verified.

2.3 Review of the *Whistleblowers Protection Act 1994* Qld

The Parliamentary Crime and Misconduct Committee's *Three Year Review of the Crime and Misconduct Commission* (Report No 64 tabled in Parliament on 10 September 2004) made the following observations about the WPA:

> *"...the* Whistleblowers Protection Act 1994 *does not establish a centralised system by which one agency or authority is responsible for protecting whistleblowers in Queensland. Essentially each public sector entity has responsibility for receiving public interest disclosures about the conduct of their officers, managing the disclosure process and taking steps to protect its officers from reprisals."* (page 96)

[10] s.8(3)
[11] schedule 6
[12] s.16

The Committee also referred to the observations made on this issue in the previous *Three Year Review of the CMC*:

> *"The 4th PCJC concluded that there was a gap in the oversight and coordination of whistleblower support across the public sector. In particular, no single body was charged with responsibility for supervising whistleblower support programs in public sector agencies. The 4th PCJC, while noting that the OPSME was in the process of addressing these apparent deficiencies, recommended that the Government give consideration to a full review of whistleblower protection in Queensland and the* Whistleblowers Protection Act 1994 *including a review of:*
> - *the roles of the CJC [now CMC] and the OPSME;*
> - *the need for an oversight body and inter-agency committee;*
> - *training and support of public sector managers and other public sector employees;*
> - *research needs in the area of whistleblower protection; and*
> - *reporting to Parliament on whistleblower protection."*
>
> (pages 99, 100; and 4th PCJC Three Year Review, Report No 55, pages 141, 142, 150, 151)

The Committee noted that while the Government had said it would give consideration to the above matters raised in the 4th PCJC report, the extent and nature of a review was to be given further consideration. The Committee recommended:

> *"That the Government give consideration to a full review of whistleblower protection in Queensland and the* Whistleblowers Protection Act 1994 *in accordance with the recommendations of the 4th PCJC in Report No 55."*
> (page 100)

Pursuant to this recommendation, the OPSME is preparing a report to the Premier of a review of the WPA. Some of the main ideas being considered are to:

- form an interagency committee of OPSME, CMC, Office of the Ombudsman, Queensland Audit Office, and the Department of the Premier and Cabinet for informal oversight of the administration of the Act;

- develop a whistleblower policy template to improve consistency of application across the large number of entities under the Act;

- build a network of whistleblower contact officers from entities for knowledge management; and

- add further education initiatives to the whistleblower website.

Although I support these ideas, I do not think they go far enough. In particular, they do not address the deficiencies in the current arrangements under the Act relating to the coordination, supervision or review of disclosures that do not involve official misconduct.

In my view, just as agencies must refer disclosures of official misconduct to the CMC for investigation and/or referral back (ss.38, 48 *Crime and Misconduct Act 2001*), so too should agencies have an obligation to refer disclosures involving serious

maladministration to the agency that has the statutory role of investigating maladministration, namely the Queensland Ombudsman.

The Ombudsman should be empowered to investigate these disclosures or to supervise or review the investigation of such disclosures by the relevant agency in the same way that the CMC can supervise or review agencies' investigations of official misconduct.

In the case of PIDs of maladministration received from QH staff that related to clinical/patient care issues, the Ombudsman would have the option of referring (under s.15 of the Ombudsman Act) the investigation to another complaints entity with appropriate expertise (for example, a remodelled Health Rights Commission (HRC) as recommended in Part 2 of this submission), and monitoring, and reviewing the outcome of, the investigation.

3. Interstate models: An Overview

The New South Wales, South Australian and Queensland Acts dealing with PIDs were passed in 1993 and 1994.

However, Victoria and Tasmania have passed much more recent (and almost identical) legislation in 2001 and 2002 respectively. Their legislation goes beyond the mere "nuts and bolts" of receiving, recording and reporting disclosures and protecting whistleblowers. It is more consistent with the recommendations of the Parliamentary Crime and Misconduct Committee and my proposal that my Office receive PIDs concerning serious maladministration.

Under the model operating in Victoria and Tasmania, if an agency proposes to:

- accept a disclosure as a PID, it must refer the disclosure to the Ombudsman who may investigate it or refer it back to the agency for investigation
- decline a disclosure on the basis that it is not a PID, or having investigated a matter as a disclosure decline to take any action in respect of it, the agency must notify the person who made the disclosure of his or her right to have the matter referred to the Ombudsman for review.

In this way, consistency is achieved in both the identification and investigation of disclosures.

The other recent Act (the Western Australian *Public Interest Disclosures Act 2003*) is similar to the Victorian and Tasmanian legislation in principle in that it seeks to produce consistency in the handling of PIDs. In particular it provides that the Commissioner for Public Sector Standards must:

- establish a code setting out minimum standards of conduct and integrity to be complied with by a person to whom a disclosure of public interest information may be made; and
- prepare guidelines on internal procedures for agencies to observe, with an Annual Report to Parliament on non-compliance.

As such it can be seen that the modern trend in this area is to go beyond an individual agency approach and to provide some degree of centralisation, to ensure that:

- agencies are appropriately administering their responsibilities under the Act so that the purposes of the Act are not defeated by misinterpretations, inconsistent approaches, inadequate investigations or lack of commitment; and
- this can be verified with much more confidence than is currently possible, without significant expense or delay and without creating another accountability agency.

3.1 New South Wales

The New South Wales model is similar to that in Queensland. The objective of the *Protected Disclosures Act 1994* NSW is to encourage and facilitate the disclosure, in the public interest, of corrupt conduct, maladministration and serious and substantial waste in the public sector by:

- enhancing procedures for making disclosures;
- providing for disclosures to be properly investigated and dealt with; and
- protecting persons from reprisals for making disclosures[13].

To be protected by this Act, a disclosure must be made by a public official to:

- an investigating authority;
- the principal officer of a public authority;
- another officer of the public authority to which the public official belongs or an officer of the public authority to which the disclosure relates, provided that it is in accordance with the authority's procedure established for this purpose; or
- in certain circumstances[14] to a member of Parliament or a journalist[15].

An investigating authority includes the Ombudsman[16].

Conduct is of a kind that amounts to maladministration if it involves action or inaction of a serious nature that is:

- contrary to law, or
- unreasonable, unjust, oppressive or improperly discriminatory, or
- based wholly or partly on improper motives[17].

Where a public official chooses to make a disclosure to the Ombudsman about conduct amounting to maladministration, to be protected by the Act, a disclosure to the Ombudsman is to be made in accordance with the *Ombudsman Act 1974* NSW, and the conduct is to be of a kind that amounts to maladministration[18].

The New South Wales Ombudsman has produced *Protected Disclosures Guidelines* (5th Edition May 2004) to give practical guidance to public officials who are charged with the responsibility for implementing the Act to assist them to meet management obligations.

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[13] s.3(1)
[14] s.19
[15] s.8
[16] s.4
[17] s.11(1)
[18] s.11(1)

The Ombudsman's primary roles in relation to protected disclosures involve dealing with disclosures about maladministration by public authorities or officials; and the implementation of the *Protected Disclosures Act 1994*.

An example of an agency that has put in place relevant procedures to assist in the implementation of this Act is New South Wales Health, which has developed a *Protected Disclosures Policy*.

The purpose of this policy is to set out procedures that will encourage and facilitate the disclosure, in the public interest, of possible corrupt conduct, maladministration, and serious and substantial waste in the public sector. The procedures are provided to staff to publicise and enhance the reporting processes to ensure that any disclosures are managed appropriately in accordance with the provisions of the Act. The policy also sets out the responsibilities of principal officers, managers and staff. For example, principal officers are responsible and accountable for, amongst other things:

> *"Leading by example to create an organisational culture that gives a clear message that making disclosures is encouraged and valued and corruption, maladministration and serious and substantial waste is not acceptable."*
> (page 15)

The policy describes how to lodge a complaint/protected disclosure to an officer within New South Wales Health or, if the public official wishes, to an external investigating authority – which for issues relating to maladministration is the Ombudsman (page 13).

The New South Wales Legislative Council Report 17 *Complaints handling within NSW Health* (June 2004) arose out of serious allegations about inadequate patient care at Campbelltown and Camden Hospitals, and followed an investigation by the Health Care Complaints Commission (9 December 2003). There were also several other related investigations including the Special Commission of Inquiry into Campbelltown and Camden Hospitals (30 July 2004).

In the context of analysing systemic issues relevant to complaint handling in the health system, the New South Wales Legislative Council Report found that the events which followed the making of complaints by staff *"resulted in enormous collateral damage to staff"* (page 46). Yet, the Report found that *"one of the most important 'cultural' issues raised by this inquiry is the need to encourage health professionals to report adverse events"* (page 46).

For these reasons the New South Wales Legislative Council Report said that *"finding ways to ensure health professionals are able to use formal channels for incident reporting, and therefore do not have to resort to whistleblowing, is an important challenge for this inquiry"* (page 46).

Nevertheless these findings give weight to arguments for the strengthening of the existing system for PIDs.

3.2 Victoria/Tasmania

Another model has been put in place by more recent similar legislation in Victoria (*Whistleblowers Protection Act 2001*) and Tasmania (*Public Interest Disclosures Act 2002*).

Under this model the Ombudsman's functions include:

- determining whether disclosures are PIDs;
- investigation of matters disclosed in PIDs;
- publishing guidelines to be followed by public bodies; and
- monitoring investigations by public bodies.
  (Vic s.38; Tas s.38)

The purpose of these Acts is to encourage and facilitate disclosures of improper conduct by public officers and public bodies, to protect persons making those disclosures and others from reprisals, and to provide for matters disclosed to be properly investigated and dealt with.

A person (public officer in Victoria) who believes on reasonable grounds that a public officer or public body has engaged in *improper conduct*, may disclose that improper conduct to the Ombudsman or the relevant public body. (Vic ss.5,6; Tas ss.6,7)

Improper conduct is defined as:

(a) corrupt conduct; or
(b) a substantial mismanagement of public resources; or
(c) conduct involving substantial risk to public health or safety; or
(d) conduct involving substantial risk to the environment –
that would, if proved, constitute –
(e) a criminal offence; or
(f) reasonable grounds for dismissing or dispensing with, or otherwise terminating, the services of a public officer who was, or is, engaged in that conduct. (Vic s.3; Tas s.3)

Disclosures under the Acts may also be made about detrimental action against a person in reprisal for a protected disclosure. (Vic ss.5,18; Tas ss.6,19)

In these jurisdictions, if a person makes a disclosure to a public body, the public body must conclude/determine whether the disclosure is a PID. (Vic s.28; Tas s.33)

In Victoria, if the public body concludes that a disclosure is a PID, the public body must notify the person who made the disclosure, and refer the disclosure to the Ombudsman for a determination as to whether it is a PID. (Vic s.29)

In Tasmania, if the public body determines that a disclosure is a PID, the public body must notify the person who made the disclosure, and notify the Ombudsman. (Tas s.34)

If the public body concludes/determines that a disclosure is not a PID, the public body must advise the person who made the disclosure that he or she may request the

public body to refer the disclosure to the Ombudsman for a determination as to whether it is a PID. (Vic s.30; Tas s.35)

Guidelines to assist agencies to comply with the legislation have been prepared by the Ombudsman in Victoria (*Whistleblowers Protection Act 2001, Ombudsman's Guidelines,* November 2001) and Tasmania (*Public Interest Disclosures Act 2002, Ombudsman's Guidelines,* November 2003).

The Ombudsman has a central role in handling disclosures of improper conduct made under these Acts. The role of the Ombudsman, as set out in the guidelines, involves:

- preparing and publishing guidelines to assist public bodies in interpreting and complying with the Act
- reviewing written procedures established by public bodies and making recommendations in relation to those procedures
- determining whether a disclosure warrants investigation
- investigating disclosures
- monitoring investigations where they have been referred to public bodies
- monitoring the action taken by public bodies where the findings of an investigation reveal that improper conduct has occurred
- reporting to Parliament where public bodies fail to implement recommendations made by the Ombudsman at the conclusion of an investigation
- collating and publishing statistics about disclosures handled by the Ombudsman
- educating and training public bodies.

(Vic p.5; Tas p.5)

It is recognised that the jurisdictional environment in which this model operates in Victoria and Tasmania is dissimilar to Queensland in a number of respects. In particular those States do not have a body equivalent to the CMC; and the definition of whistleblowing, or PID, is confined to what would be regarded essentially as official misconduct in Queensland (that is, conduct which if established would amount to a criminal offence or grounds for dismissal).

4. Research Project: "Whistling While They Work" Project – Griffith University

Whistling While They Work: Enhancing the theory and practice of internal witness management in public sector organisations is a three year (2005-2007) collaborative national research project being led by Griffith University and jointly funded by the Australian Research Council, five participating universities, and 12 industry partners. In Queensland the industry partners are the CMC, the Queensland Ombudsman and the OPSME.

The project will use the experience and perceptions of internal witnesses and first and second level managers to identify and promote current best practice in workplace responses to public interest whistleblowing, including strategies for preventing, reducing and addressing reprisals and other whistleblowing-related conflicts.

5. Proposed Model

Despite the jurisdictional differences that operate in Victoria and Tasmania, it is submitted that the essential features of the Victorian and Tasmanian model should be adopted in Queensland for the purpose of giving the Queensland Ombudsman supervisory jurisdiction over disclosures of serious maladministration to complement the CMC's supervisory jurisdiction over disclosures that may involve official misconduct.

Under the proposed model, agencies would have an obligation to refer to the Ombudsman all PIDs that involve serious maladministration but do not amount to official misconduct. The Ombudsman would:

- investigate the disclosure; or
- refer the disclosure back to the relevant agency (or another complaints entity with appropriate expertise) and supervise, monitor or review its investigation (as the CMC does in relation to official misconduct allegations); or
- refer a disclosure not amounting to maladministration back to the relevant agency or appropriate investigative body.

This would mean that two agencies, the CMC and the Ombudsman, would have responsibility for ensuring consistency across the full range of possible serious disclosures, working in a coordinated way through an interagency committee.

This would assist significantly in achieving consistency in application of the WPA and the conduct of investigations across the public sector.

In addition to the Ombudsman's Office conducting investigations itself, and supervising and reviewing individual agency investigations, the Ombudsman could periodically audit investigations by agencies of PIDs to identify any systemic deficiencies in the way such matters are being handled.

The Ombudsman's Office and the CMC could also advise and assist:

- agencies regarding the protection of whistleblowers; and
- existing and potential whistleblowers in relation to their rights, obligations and protections.

The roles for the Ombudsman and CMC referred to above are consistent with their existing statutory responsibilities. However, a better system is needed for assisting whistleblowers, and coordinating and monitoring the responses of agencies to PIDs, as recommended by the Parliamentary Crime and Misconduct Committee.

As mentioned earlier, disclosures of serious maladministration relating to clinical/patient care issues could be referred for investigation by another complaints entity with appropriate expertise (for example, a remodelled HRC, as recommended in Part 2 of this submission) with the Ombudsman monitoring, or reviewing the outcome of, the investigations.

Some additional resources would be necessary for the Ombudsman's Office to take on this role.

If these proposals work as intended, complaints of the kind made by staff of Bundaberg Hospital to their managers about Dr Patel, should be identified as complaints of serious maladministration, and referred to the Ombudsman. The Ombudsman would then decide whether to investigate the complaint, or refer it back to the agency or another complaints entity for investigation, while monitoring the timeliness and adequacy of the investigation, and reviewing its outcomes.

These proposals strike an appropriate balance between ensuring that agency managers accept responsibility for taking the necessary steps to identify and rectify maladministration in their agencies, and providing for independent external oversight of the system. The ability of the Ombudsman to monitor investigations in the health sector would also enable independent identification and analysis of any significant trends.

This additional safeguard should make it unnecessary to tamper extensively with the delicate balances that have been struck in the WPA to reconcile competing interests such as:

(a) the interest of the public in the exposure, investigation and correction of illegal or improper conduct, and dangers to public health and safety;
(b) the interest of the whistleblower in being protected from retaliation by the persons or organisation whose illegal or improper conduct has been reported, <u>and</u> in seeing that proper action is taken on the PID;
(c) the interests of persons against whom allegations are made which turn out to be inaccurate, or (worse still) against whom false or misleading allegations are made. Such persons are liable to suffer not only damage to their personal and/or professional reputations, but also the stress (and perhaps, expense) of being subject to investigation;
(d) the interests of an organisation affected by a PID in not having its operations unduly disrupted, causing unwarranted interference with its pursuit of its business or administrative goals. (The word "unwarranted" is a key qualification here. The interests of an employer in preventing destabilising and disruptive behaviour in an organisation cannot be regarded as an absolute value – especially where there is substance to allegations of corruption or serious maladministration); and
(e) the need to ensure that a system of whistleblower protection has safeguards against abuse by persons whose purported whistleblowing seeks only to further their own interests (for example, speculative allegations in order to claim protection from adverse personnel action that may have been justified on other grounds) rather than any genuine public interest.

Most whistleblower protection statutes provide, in effect, that the interests of the public in learning about allegations of illegal or improper conduct, or of dangers to public health and safety, must defer to the rights of a person or organisation accused of illegal or improper conduct to have their reputations protected from adverse publicity, until such time as the allegations are substantiated after investigation by a proper authority.

However, there is arguably scope for expansion of the categories of protected disclosure under the WPA, to more closely accord with the recommendations made by

the Electoral and Administrative Review Commission (EARC) in its "Report on Protection of Whistleblowers" (No 91/R4, October 1991) at paragraphs 5.67 to 5.82.

The Bundaberg Hospital experience indicates that it may be preferable that:

(a) any person (not just a public officer) should be entitled to obtain protection for disclosing to a proper authority a substantial and specific danger to public health and safety (thus protecting patients or their family members from reprisals such as defamation proceedings, or withdrawal of access to health services, for a disclosure made to QH, a Minister, the HRC, the Medical Board of Queensland (MBQ), etc); and
(b) any person should be entitled to obtain protection for a disclosure made (with an honest belief, based on reasonable grounds, in the accuracy of the information) to any person (including a journalist/media organisation) of information showing a serious, specific and immediate danger to the health or safety of the public (*cf.* clause 13 of EARC's recommended Whistleblowers Protection Bill).

Had such protections been available at the time concerns were emerging at Bundaberg Hospital about Dr Patel's surgical outcomes, more individuals may have come forward thereby increasing the pressure for remedial action.

PART 2: Issues relating to health complaints systems

1. Introduction

1.1 Purpose

The purpose of this submission is to:

- provide an overview of the current health complaints system in Queensland;
- identify deficiencies in the system and, by way of example, provide a case study of a complaint about the inefficiencies of the current system;
- review health complaint systems in other jurisdictions; and
- make recommendations for an enhanced system in Queensland.

There are two main aspects to the current health complaints system, namely, internal complaints management and external complaints management. This submission addresses both aspects.

Currently, there are three external bodies (other than the practitioner registration boards) that investigate health complaints in Queensland. They are:

- The HRC
- The Queensland Ombudsman
- The CMC.

1.2 Role of the Health Rights Commission

The HRC was established by the *Health Rights Commission Act 1991* (HRCA) in early 1992 as a specialist agency to provide the Queensland public with an independent and impartial means of reviewing, resolving and/or investigating health service complaints.

According to its mission statement, the HRC aims to provide *"an independent, impartial and collaborative health complaints system designed to improve health care services and promote health rights and responsibilities in Queensland."*

The principal responsibilities of the HRC are the receipt and assessment of complaints about a health service provider (HSP) and the resolution of disputes through conciliation. The HRC encourages the local resolution of all complaints consistent with the requirement in the HRCA that the complainant has taken all reasonable steps to resolve the complaint with the provider[19].

Complaints to the HRC are dealt with in one or more of the following stages:

- Intake;
- Assessment;
- Conciliation;
- Investigation.

All services provided by the HRC are free.

[19] s.71(2)

In addition to providing an independent and impartial avenue for resolving complaints, the HRC is able to recommend improvements to health practices and procedures based on information obtained from complaints and work collaboratively with HSPs to assist them to improve their own complaint resolution strategies.

According to its Annual Report for 2003-2004, the HRC received 4,281 complaints. I have been informed by staff of the HRC that approximately 64% of all complaints received by the HRC relate to private sector HSPs. In its second submission to the BHCI (at p.3, footnote 3), the HRC stated that complaints against public hospitals account for only 19% of complaints made to the HRC, with those against QH as a whole in the vicinity of 27%. Other public sector providers (for example, ambulance services, aboriginal health services, corrections health services) account for approximately 9%.

1.3 Role of the Queensland Ombudsman

The Ombudsman is an officer of the Parliament[20] empowered to deal with complaints about the administrative actions of Queensland government departments and public authorities, and local governments.

Under the Ombudsman Act, I have authority to:

- investigate maladministration by public sector agencies, in response to complaints, although I can also investigate on my own initiative;
- make recommendations to an agency being investigated about ways of rectifying the effects of its maladministration and improving its practices and procedures;
- consider the administrative practices of agencies generally and make recommendations, or provide information or other assistance, to improve practices and procedures.

If I consider that an agency's actions involve maladministration, I may provide a formal report to the principal officer of the agency. In my report, I may make recommendations to rectify the specific maladministration or to improve the agency's policies, practices or procedures with a view to minimising the prospect of problems recurring. In almost every case, the recommendations are implemented, making the Ombudsman's Office an effective mechanism to improve the standards of administrative practice for the ongoing benefit of the Queensland community.

I may cause a report to be tabled in Parliament:

- if the issues investigated are of significant public interest; or
- if my recommendations to the agency's principal officer are not implemented.

The Ombudsman can investigate administrative actions of an agency[21], including Queensland agencies that provide health services, deal with complaints about the provision of health services, and regulate the health service professions.

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[20] s.11(2) of the *Ombudsman Act 2001*

[21] as defined in ss.8 and 9 of the *Ombudsman Act 2001*

However, the Ombudsman is expected to liaise with other complaints entities to avoid inappropriate duplication of investigative activity[22] and would not ordinarily accept an initial complaint about the provision of a health service if the complaint more appropriately fell within the jurisdiction of the HRC, the MBQ (or another registration board), or the Queensland Nursing Council (the QNC).

Furthermore, in most cases, we will not accept a complaint unless the complainant has tried to resolve it with the agency which is the subject of the complaint.

In the 2004/2005 financial year, my Office received 339 health related complaints. Of those:

- 256 related to QH;
- 50 related to the HRC;
- 33 related to a registration board or the QNC.

In accordance with our normal practice in relation to QH complaints, many of the 256 complaints received (126) were referred to QH for internal review, while an additional 37 complaints were referred to the HRC or to the relevant registration board.

The Ombudsman received no complaints about medical services at Bundaberg Hospital, or about maladministration by health agencies in dealing with complaints about medical services at Bundaberg Hospital.

Complaints Management Project

Since March 2003, my Office has been helping public sector agencies (including QH) to improve their systems for managing customer complaints through our Complaints Management Project. The aim of the project has been to assist agencies by evaluating the strengths and weaknesses of their existing complaints management arrangements and identifying potential improvements. As part of this project my Office has also developed and published useful information to help agencies in developing effective complaints management policy and procedures.[23]

One of the principles underpinning the project is the importance of "frontline complaints handling" – that is, the timely resolution of complaints at the local level. Any good complaints management model should focus on resolving the bulk of complaints at the frontline, while also providing for further internal and external review. This principle has also guided the design of the new health complaints model we propose in this submission.

1.4 Role of the CMC

The CMC was established in January 2002 with the merger of the Criminal Justice Commission and the Queensland Crime Commission. The CMC's responsibilities include improving integrity in the Queensland public sector.

Under the *Crime and Misconduct Act 2001*, the CMC also has a responsibility to build the capacity of units of public administration to prevent and deal with cases of

[22] see s.15 of the *Ombudsman Act 2001*
[23] Queensland Ombudsman "Developing Effective Complaints Management Policy and Procedures", March 2004 and supporting Fact Sheets (can be accessed from www.ombudsman.qld.gov.au)

misconduct. The Act stipulates that action to prevent and deal with misconduct in a unit of public administration should generally happen in the unit.

Therefore most complaints are referred back to the agency concerned for investigation. As a result, senior management throughout the public sector are required to take responsibility for nurturing an integrity culture within their organisations.

The CMC continues to conduct or manage misconduct investigations where complaints involve complex, sensitive or serious allegations, or may require the use of CMC powers. It can also monitor, issue directions about, review and audit investigations conducted by a public official.

In the last financial year, the CMC received 231 complaints relating to QH. Of these matters, 13 were retained by the CMC for investigation, 172 matters were returned to QH to deal with and no further action was taken on 46 complaints.

2. A case study of a major investigation by the Ombudsman concerning a health related complaint – the Neville complaint

To demonstrate the deficiencies and inefficiency of the current health complaint system in Queensland and the consequential frustration for complainants, we present as a case study details of our investigation of a complaint made to us by Dr Gerard Neville and Mrs Lorraine Neville.

2.1 Background to the complaint

The Nevilles' complaint relates to events that occurred on 7 January 2002 after their daughter, Elise, aged 10, fell from the top of a bunk bed in a holiday unit at Caloundra, suffering a blow to the head.

After Elise's fall, at approximately 3.25am, the complainants rushed her to the Emergency Department at the Caloundra Hospital (CH). Elise was assessed by a registered nurse and the medical officer on duty at the time and sent back to the unit with her parents.

Elise's condition deteriorated and, at approximately 7.25am, she was transported in an unconscious state back to CH by ambulance. Elise was prepared for evacuation, and at approximately 9.40am she was transferred by helicopter to the Royal Children's Hospital (RCH) in Brisbane where she underwent emergency surgery.

On 9 January 2002, Elise died without regaining consciousness.

2.2 Summary of complaints

Shortly following Elise's death, the Nevilles lodged formal complaints with QH, HRC, MBQ and the QNC concerning the standard of care provided to Elise by nursing staff and the medical officer on duty, at the time of Elise's first and second presentations at CH. Their allegations included:

- unprofessional conduct;
- delay in providing appropriate treatment at the second presentation; and
- delay in transferring Elise to the RCH.

The Nevilles also raised concerns about a "Preliminary Investigation Report" into the circumstances of Elise's death prepared by the then Executive Director of Medical Services (Executive Director), Sunshine Coast Health Service District (SCHSD), as detailed below.

2.3 Responses by QH, HRC, MBQ & QNC to complaints

2.3.1 Response by QH

After the then Director-General of QH, Dr Robert Stable, was informed of Elise's death on 9 January 2002, he contacted the Executive Director, and asked that he "find out what happened in this matter and send a brief preliminary report to him (Dr Stable) as

soon as possible." The Executive Director furnished a report to Dr Stable on 11 January 2002, expressing his opinion that Elise's early management had been "reasonable".

Following receipt of the Nevilles' original letter of complaint dated 7 February 2002, Dr Stable provided them with a copy of the Executive Director's report together with copies of medical and departmental documents relevant to Elise's presentations to CH.

The Nevilles considered that these documents did not address their concerns but rather reinforced their legitimacy. In addition, they believed the Executive Director's report was "inept" and contained "deliberately false and misleading information" (allegations which, if proven, could amount to official misconduct).

The Nevilles outlined all their concerns in a 21 page letter to Dr Stable and sought a full investigation. Dr Stable's response was to advise the Nevilles that, given the HRC, MBQ, QNC and the State Coroner were likely to conduct their own investigations into the Nevilles' complaints, he did not propose to undertake any investigation until the outcomes of those independent inquiries were known.

In December 2003, the Nevilles brought their still unresolved concerns to the attention of Dr Steve Buckland, the then Acting Director-General of QH. Dr Buckland agreed to commission Professor Bryant Stokes (an experienced neurologist from Western Australia) to conduct an independent review of QH's response to the Nevilles' complaint, including the Executive Director's report.

The "Terms of Reference" provided to Professor Stokes were:

1. To review the management of children who present with head injuries at CH, including the adequacy of the systems and processes used by the hospital upon such presentation.
2. To examine the appropriateness of the Executive Director's report (including clinical and non-clinical components) and concerns raised by Dr Gerard Neville and Mrs Lorraine Neville.
3. To examine the appropriateness of Queensland Health's response to concerns raised by Dr Gerard and Mrs Lorraine Neville in respect of the management of their daughter Elise at CH when presenting with head injuries on 7 January 2002.
4. To make recommendations in relation to the above, including, if appropriate, improvements to the system and processes at CH.
5. Final report to be completed by 19 May 2004.

Professor Stokes presented his ten page report to Dr Buckland in early June 2004. His findings and recommendations can be found in Appendix 2. A copy of his report was provided to the Nevilles for comment.

While the Nevilles noted that Professor Stokes had made a number of significant adverse findings and recommendations, they did not consider that he had adequately addressed terms of reference 2 and 3; in particular, that he failed to consider the accuracy of the Executive Director's report.

The Nevilles raised these concerns at a meeting with Dr Buckland on 22 June 2004. The Nevilles have stated that, although Dr Buckland had shared some of their

concerns, he did not consider that there was anything further he could do, other than to forward to Professor Stokes a copy of the Nevilles' letter outlining their concerns with his report.

No further advice has been provided to the Nevilles by QH. In particular, they have not been informed of what actions, if any, QH has taken in respect of the findings and recommendations made by Professor Stokes (or indeed the findings and recommendations made by the HRC, referred to below).

2.3.2 Response by the HRC

On 28 March 2002, the Nevilles lodged a formal complaint with the HRC raising a number of concerns about systemic and individual clinical care issues in relation to the care their daughter received at CH on 7 January 2002, and about the Executive Director's report.

HRC's assessment

On 10 May 2002, the HRC informed the Nevilles that their complaints had been accepted for assessment and summarised the key issues as follows:

1. Care provided to Elise by CH;
2. Care provided by the attending medical officer at CH (referred to in this submission as the Doctor);
3. Care provided by the two registered nurses on duty at the time of Elise's first presentation to CH (referred to in this submission as RN 1 and RN 2);
4. The investigation report by the Executive Director.

HRC's investigation

The HRC completed its assessment of these issues on 8 August 2002 and retained for investigation issues 1 and 4 on the basis that they were "health service complaints" within the scope of s.57 of the HRCA. Because issues 2 and 3 were about a registered medical officer and two registered nurses, the HRC had a statutory obligation to consult with the MBQ and the QNC respectively, to determine whether each body would accept for further action the complaints about its registrants.

The MBQ agreed to accept for investigation the complaint about the medical officer. The QNC agreed to accept for investigation the complaint about one of the registered nurses but not the other.

The HRC directed its inquiries in relation to issues 1 and 4 to the District Manager of the SCHSD. While the SCHSD initially responded to the HRC's inquiries, it subsequently challenged the HRC's jurisdiction to investigate the Nevilles' allegations concerning the Executive Director's report. After seeking its own legal advice from Crown Law, the HRC informed the Nevilles on 16 July 2003 (approximately 15 months after first receiving the complaint), that it did not have jurisdiction to proceed with its investigation concerning the Executive Director's report because the allegations did not relate to an administrative service directly related to a health service.

Approximately six months later, after being informed that the MBQ had also refused to investigate the Nevilles' complaint against the Executive Director, the HRC

approached the Minister for Health (the Minister) to seek approval for it to investigate that complaint[24]. The HRC was informed that Dr Neville had recently met with the Director-General of QH, Dr Steve Buckland, and QH had undertaken to commission an independent review (by Dr Stokes) of its overall response to the Nevilles' complaints, including in respect of the Executive Director's report. In these circumstances, the Minister did not give approval for the HRC to investigate the Nevilles' complaint about the Executive Director's report[25].

HRC investigation report

The HRC provided its investigation report (a three page letter) to the Nevilles on 4 September 2003 (that is, approximately 18 months after having first received their complaint). The report did not include any adverse findings or recommendations. The HRC did note, however, that some changes had been made by the District following Elise's incident which impacted upon the CH. These include:

- Rostering medical staff on a 24 hour basis, rather than an "on call" schedule. The roster was said to ensure a medical officer has not been working continuous long hours should the officer be called during the night;
- Upgrading CH's services to the community as a result of some additional funding being made available to the District.

The HRC provided a copy of its investigation report to the District Manager of CH under a separate letter, which also included some additional comments that were not provided to the Nevilles. These comments related to the lack of medical notes taken on Elise's presentations and the adequacy of information contained on Head Injury Advice forms given to patients.

Complaint about HRC investigation

The Nevilles met with the Health Rights Commissioner (the Commissioner) on 12 September 2003 to inform him of their dissatisfaction with the outcome of the HRC's investigation. In particular, they queried the absence of any adverse findings or recommendations. The Commissioner provided the Nevilles with a copy of the HRC's letter to the District Manager which contained the additional comments. The Nevilles could not understand why these additional comments had not been included in the HRC's report. The Nevilles were not satisfied with the Commissioner's explanation that the comments dealt with minor issues and wrote to him in these terms:

> *"Your letter to* [the District Manager of Caloundra Hospital] *is hardly a "covering letter". It is actually further findings of your investigation and it contains details that are highly critical of Caloundra Hospital. It should have been given to us as a matter of course as we are the complainants in this matter. We are appalled by this double standard...*

[24] Section 3(3) of the HRCA provides that "*The Commissioner may with the written approval of the Minister, decide to treat a decision or action of an officer or employee of the department as if it were a health service.*"

[25] This has been identified as one of the problems with the current jurisdiction of the HRC which is discussed in more detail in section 3.4.3.

We are totally dismayed by what you have done. In fact we are no longer confident that the HRC is an unbiased and independent health complaints agency."

HRC review

Because of the Nevilles' numerous concerns about the adequacy of the HRC's investigation and report, the Commissioner agreed to conduct a review. On 28 June 2004, some nine months later, the Commissioner completed his review and issued a subsequent report. This 20 page report bore little resemblance to the HRC's earlier report. The Commissioner emphasised in his revised report that some of the issues raised by the Nevilles were intrinsically very difficult, and the HRC's re-examination of those issues had led to different conclusions. The Commissioner concluded that :

"Elise's tragic death has highlighted significant systemic issues at Caloundra Hospital".

Upon reconsideration of the "admission issue", the Commissioner concluded that, while there was not a formal policy of "Non- Admission of Children" in existence at the time of Elise's presentation, the word "policy" can be taken to denote not only a formally documented guideline or requirement, but also a common practice or a "culture" of behaviour. On that basis he held a serious concern that there appeared to be an informal understanding among at least some of the staff at CH, reinforced by common practice, that children were not to be admitted but were to be referred to the larger and better equipped Nambour Hospital if requiring additional treatment or admission. This concern was further supported by a memorandum from the then General Manager (Health Services), QH, to the District Manager of CH in which the General Manager specifically stated that he could not accept the continuation of the "*existing practice*" regarding the admission of children.

The Commissioner made a number of recommendations including:

1. QH investigate the introduction of an accredited course that would assist staff in smaller hospitals to be proficient in the current practices of emergency care of children as well as a process of specialist clinical oversight and review.
2. QH undertake periodic auditing to monitor the effectiveness of the changes already introduced at CH to ensure the changes are both effective and sustainable.
3. As a matter of urgency, the District Manager review the comments made by the Commissioner about the culture at CH and initiate appropriate action to bring about sustainable changes, so that there is no doubt in anyone's mind as to the level of care that can and should be afforded to children at CH. Senior management of QH should monitor the review.

2.3.3 Response by the MBQ

On 10 April 2002, the MBQ received a written complaint from the Nevilles about the actions of:

- the Doctor; and
- the Executive Director.

The MBQ considered the complaint at its next meeting with the HRC on 17 April 2002 and it was agreed that the complaint would be retained by the HRC for assessment. Upon finalisation of the assessment by the HRC, the MBQ met again with the HRC on 7 August 2002, and agreed to accept for investigation the complaint about the Doctor. At that stage, the HRC had retained for investigation the complaint about the Executive Director.

Investigation by MBQ

On 27 August 2002, the MBQ appointed an investigator from the Office of the Health Practitioner Registration Boards (OHPRB) to carry out the investigation. The OHPRB is responsible for carrying out investigations on behalf of the individual health practitioner registration boards. The Nevilles have advised that they were informed by the OHPRB that its investigation would take approximately six months.

The Nevilles initially approached the MBQ seeking interim action against the Doctor pending the outcome of the investigation into his conduct. However, the MBQ considered there was insufficient evidence to warrant suspending the Doctor or imposing any conditions on his registration pending the outcome of its investigation.

The Nevilles, relying on medical evidence that their daughter had died from a fully treatable injury, were disappointed by the MBQ's decision and sought a review. In support of their request for a review, they submitted an independent medical opinion prepared at their request by a Neurosurgeon that was very critical of the Doctor's management and concluded:

> *"In a responsible medical system, such as we enjoy, with such access to hospitals of ascending levels of sophistication, it is tragic and unacceptable that an event such as this should occur."*

Six months later, the MBQ advised the Nevilles that it had decided to reaffirm its earlier decision not to take any interim action against the Doctor.

After repeated complaints by the Nevilles as to the delay in the OHPRB completing its investigation, on 24 June 2003 the OHPRB appointed an external investigator to conduct the investigation. The Nevilles state that, at this point, it became evident to them that very little active investigation had taken place up to that time. The external investigator completed the investigation within six months and provided a draft investigation report to the MBQ for its consideration.

On 20 January 2004, approximately 17 months after receiving the complaint for investigation, the Board provided the Nevilles with a copy of the final investigation report. The finding of the MBQ was that:

> *"there is sufficient evidence to conclude that [the Doctor's] management of Elise Neville at her first presentation to Caloundra Hospital on 7 January 2002, constitutes unsatisfactory professional conduct."*

The MBQ referred the matter to the Health Practitioners Tribunal (the Tribunal) for hearing. On 8 November 2004, the Tribunal accepted a guilty plea by the Doctor and imposed a number of conditions/sanctions on his registration.

2.3.4 Response by the QNC

The QNC received a copy of the Nevilles' complaint on 11 April 2002.

In August 2002, following assessment by the HRC, the complaint about the two registered nurses (RNs) was referred to the QNC for action. The QNC accepted for investigation the complaint about RN 1 but declined the complaint about RN 2. The complaint about RN 1 alleged that she:

- displayed an uncaring attitude and unprofessional manner;
- failed to complete an appropriate triage assessment; and
- fabricated observations and recorded incorrect and misleading information on triage documentation.

An investigator was appointed by the QNC on 6 September 2002 to carry out an investigation. On 27 November 2003, the investigator completed the investigation and issued her report. In summary, the investigator found sufficient evidence to warrant a finding that there were concerns regarding the nurse's competence. The report also raised concerns about the conduct of RN 2.

The QNC sought legal advice, and the advice of a specialist in emergency medicine, in relation to the investigator's findings. After considering this further advice, the QNC resolved on 5 March 2004 to:

- await any inquiry/inquest by the Coroner before making a determination as to what action, if any, should be taken against RN 1; and
- initiate an investigation in relation to RN 2.

In a statement to this Office dated 21 June 2005 the Executive Officer of the QNC explained that the first recommendation was consistent with its previous practice in order to ensure that procedural fairness is accorded to nurses facing disciplinary action.

The QNC asserted that:

- if disciplinary action were to be instigated by the QNC prior to a coronial inquiry, a nurse's right to refuse to answer questions at a coronial inquest on the grounds of self-incrimination could be prejudiced; and
- if the QNC were to prefer a charge prior to a coronial inquest, a nurse would be at liberty to seek a stay of those proceedings from the Nursing Tribunal pending the outcome of that inquest.

On 19 March 2004, the QNC initiated an investigation into the conduct of RN 2. The investigator completed her report in July 2004 reaching the following opinion:

> *"The nurse, with her level of experience and knowledge, should have enquired further regarding the doctor's question and provided the doctor with additional options."*

While the investigator found the allegation was substantiated, she did not consider that RN 2's conduct amounted to discreditable conduct.

Action following investigation

Following finalisation of the investigation of the conduct of RN 2, the QNC sought the advice of senior counsel as to whether there was sufficient evidence to prefer a charge of gross negligence, malpractice or conduct discreditable to a registered nurse against RN 1 or RN 2.

After considering senior counsel's advice, and subsequent recommendations by the Professional Standards Committee (an advisory committee of the QNC), the QNC decided that it held concerns regarding RN 1's knowledge of triage assessment and functioning as a member of a multidisciplinary team. The QNC decided that, before preferring a charge against RN 1, it would convene a pre-charge "without prejudice" meeting to attempt to resolve the concerns raised by the Nevilles. This course of action was in accordance with QNC policy. As no formal disciplinary action was to be taken, the QNC believed it could proceed prior to the coronial inquest without potentially prejudicing the nurse's rights.

With regard to RN 2, the QNC did not consider there was sufficient evidence to warrant taking any disciplinary action. However, in a letter informing her of its decision, the QNC took the opportunity to remind RN 2 of her obligations as a nurse operating in a multidisciplinary team, as well as the importance of practising as a nurse in a manner that could not lead a reasonable person to form the view that she lacked empathy or was uninterested.

The Nevilles provided the QNC with a detailed submission dated 23 September 2004 outlining their concerns about the failure to take disciplinary action against RNs 1 and 2. The Nevilles reminded the QNC that the investigation reports supported their belief that the actions of the nurses had contributed to Elise's death. The matter was re-considered by the QNC at its October 2004 monthly meeting, where it reaffirmed its earlier decision not to take any disciplinary action against RN 2. It refrained from making any decision about RN 1 until it had sought further legal advice concerning some of the issues raised by the Nevilles' latest submission.

After a meeting with the Nevilles on 5 October 2004 to further discuss their concerns, the QNC wrote to RN 1 seeking a statutory declaration from her (by 17 November 2004) addressing a number of issues, in particular her triage assessment of Elise and a description of the steps she undertook to make the various assessments which she relied on in determining the Glasgow Coma Scale (GCS)[26]. The Nevilles believed this information should have been obtained during the investigation and was relevant to determining what disciplinary action was justified.

RN 1's statutory declaration was not received by the QNC until May 2005 (some seven months after being requested). At the time of writing this submission, the matter is yet to be resolved by the QNC. Accordingly, 18 months after the investigation was completed, the Nevilles still do not know what disciplinary action is to be taken against RN 1.

[26] A standard test for head trauma patients.

2.4 The Nevilles' complaint to the Ombudsman

Following a meeting with an Assistant Ombudsman to discuss their complaint, on 24 December 2003 the Nevilles provided my Office with a brief covering letter and four A4 folders of documents in relation to their complaint. A detailed analysis of that material revealed a number of serious concerns raised by the complaint. Therefore, in accordance with s.22 of the Ombudsman Act, I commenced a preliminary inquiry into the Nevilles' complaint to determine whether my Office should investigate.

The complaint raised numerous concerns about the actions and decisions of various government agencies responsible for investigating the health services provided to Elise (namely, QH, HRC, MBQ and QNC).

2.4.1 Principal allegations about QH, HRC, MBQ and QNC

- The current health complaints system in Queensland is inadequate and inaccessible to the majority of complainants.
- Lengthy delays in the investigation and resolution of the Nevilles' complaints about the Doctor and RNs 1 & 2.

2.4.2 Principal allegations about QH

- Unreasonable refusal by the former Director-General (Dr Rob Stable) to carry out a full internal investigation into the circumstances surrounding Elise's death;
- Failure by QH to take action to suspend the Doctor and RNs 1 & 2 from duty, or limit their duties, pending the outcome of external investigations by their registrant boards.
- The Executive Director's report into the incident was false and misleading.
- The external investigation conducted by Professor Stokes (commissioned by the then Director-General of QH, Dr Steve Buckland, in early 2004) failed to adequately address its limited terms of reference.
- The medical retrieval process is inadequate.

2.4.3 Principal allegations about the HRC

- There was a 15 month delay in the HRC determining that it did not have jurisdiction to investigate the Nevilles' complaint about the Executive Director.
- There was a lengthy delay in the investigation process by the HRC.
- The HRC's initial investigation and report (dated 4 September 2003) into the Nevilles' complaint against CH was grossly inadequate in that:
    - it failed to cover all issues raised in the complaint;
    - many of the investigation findings were not supported by the facts;
    - no recommendations were made in the report for future improvements;
    - the HRC provided to the Nevilles a different version of the report findings from those sent to QH ;
    - the HRC failed to allow the Nevilles an opportunity to comment on the initial report prior to its release.

2.4.4 Principal allegations about the MBQ

- Delay in advancing and completing its investigation.
- Refusal to take any interim action to suspend, or impose interim restrictions on, the Doctor's registration pending the outcome of its investigation into his conduct.
- The MBQ's refusal to investigate the Nevilles' complaint against the Executive Director was unreasonable.

2.4.5 Principal allegations about the QNC

- Lengthy delays in the investigation of the complaints against RNs 1 & 2 and in the QNC making a decision as to what, if any, disciplinary action was to be taken against either or both RNs.
- Lengthy delay in finalising a review of its decision as to the disciplinary action to be taken against RN 1.
- Failure by the QNC to take appropriate disciplinary action against either RN.
- Failure to adequately investigate the Nevilles' allegation that RN 1 "fabricated observations and recorded incorrect and misleading information on triage documentation".

2.5 Ombudsman's investigation of the Neville complaint

The focus of our inquiry has been to review the administrative actions taken by each of the agencies in response to the complaints by the Nevilles. As a result of our preliminary inquiry we resolved to investigate the following:

- the adequacy of QH's response to the Nevilles' complaint;
- the adequacy of the current health complaint mechanisms in Queensland, and what changes should be made to provide a more efficient health complaints system;
- the health complaint mechanisms in other jurisdictions, to determine if there is a best practice model.

Our investigation is nearing completion and has identified a number of systemic issues of significant public interest. These include:

- unsafe working hours for doctors;
- a junior doctor being left in charge of an Emergency Department without adequate supervision and without appropriate clinical protocols;
- inadequate response by QH to an adverse event (for example, no internal investigation undertaken or "Open Disclosure" provided to the Nevilles);
- inadequate safety regulations in respect of bunk beds.

However, the focus of this submission will be on the research undertaken with a view to recommending a more efficient health complaints system for Queensland.

2.6 Issues raised relating to the health complaints system

2.6.1 Adequacy of response by QH, as the health service provider, to a complaint about an adverse event

The Nevilles raised their concerns about the treatment provided to Elise in a letter to the then Director-General of QH, Dr Rob Stable, on 7 February 2002 (approximately one month after Elise's incident). In particular, the Nevilles sought that the Director-General *"carefully investigate the culture of that (Caloundra) hospital.."* and *"investigate the events fully and independently of Caloundra Hospital and the Health Service District, and...take appropriate action".*

In Dr Stable's response (on 11 April 2002) to the Nevilles, he stated:

> *"I understand that you intend to make formal complaints to the relevant registration bodies and the Health Rights Commission in relation to the health providers involved in the treatment of Elise on 7 January this year. Given that these bodies are likely to conduct investigations and that the matter is also in the hands of the Coroner, I do not propose to undertake any further investigations until the outcome of these independent inquiries become known."*

In considering the appropriateness of Dr Stable's decision not to investigate the Nevilles' complaints, the following factors should be considered:

- the complaints related to a significant adverse event[27]; and
- they raised a number of systemic issues, including an allegation that a culture of "non-care of children" existed at CH. In particular, this referred to an alleged "policy" that children could not be admitted to CH;
- they raised a number of concerns about the adequacy of the provision of health services by CH.

QH has since advised that, at the time of Elise's incident, it did not have an endorsed State-wide approach to adverse events or incident management. As mentioned previously, it was not until June 2004 that QH introduced its Incident Management Policy. Even so, having regard to the gravity of the concerns raised by the Nevilles about a culture of "non care of children" existing at CH, QH's decision not to conduct its own investigation is open to question.

In a letter to me dated 20 June 2005, the former Director-General of QH, Dr Steve Buckland, advised that:

> *"Queensland Health's consistently stated response to the incident has been to participate and assist, to the fullest extent reasonable, the various independent inquiries. The outcome of those independent inquiries has, from an early time, always been intended to guide where necessary an appropriate departmental response."*

[27] An "adverse event" is defined by the Australian Council for Safety and Quality in Healthcare as "An incident in which harm resulted to a person receiving health care."

However, Dr Buckland added that *"... The response of Queensland Health to the incident ... should not be taken as indicating that I consider that the Department's response/s to the incident was optimal"*.

This view was shared by Professor Stokes (the independent external investigator appointed by Dr Buckland in April 2004 to investigate certain aspects of the Nevilles' complaint), who made these findings in his report of June 2004:

- *"Sadly QH has never conducted a formal investigation into events leading to the death of Elise, nor has it conducted a "root cause" analysis. In this manner Dr and Mrs Neville have been badly served.*
- *QH has not responded in an appropriate manner to Elise's parents in so much that no attempt would appear to have been made to discuss with the parents issues of systems which may have failed or been inadequate;*
- *'Open Disclosure' was difficult because of the legal framework set up to protect QH from liability and because no formal investigation was ever conducted."*

QH's existing Complaints Coordinators Handbook (which as previously stated was not in existence at the time of the incident) provides for a root cause analysis[28] to be undertaken as part of the process of investigating complaints. It recognises that root cause analysis supports a learning, informed organisational culture that focuses on improving systems rather than on punitive measures. The benefit of undertaking a root cause analysis is that it identifies factors that contribute to incidents, and also involves planning preventative measures (that is, measures to prevent recurrence) and developing control measures, including remedies, modifications or the development of systems to enable service recovery.

QH has advised that its recently established Patient Safety Centre has developed a two day Root Cause Analysis training program which is to be rolled out across Health Service Districts shortly.

I have made inquiries of QH to ascertain the complaint management policy and procedure in place at the time of Elise's death. QH advised that, at the time:

- there was no written procedure for complaints management within the District;
- although not clearly documented, there was a mechanism for managing complaints received via the HRC, and complaints directed to the District Manager;
- QH was establishing a policy and procedure on how to respond to a critical incident/adverse event; however, no policy or procedure had been introduced into all healthcare facilities;
- QH's current Health Complaints Management Policy was not introduced until after Elise's incident (effective date 31 August 2002);
- a formalised complaints management procedure was being developed at the time of the response, by the recently formed Clinical Governance Unit.

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[28] Root Cause Analysis (RCA) is a retrospective approach to investigating incidents or near misses. It is already widely used to look at major industrial accidents. Systematically applying RCA can help discover the errors that contribute to system failures underlying adverse events or near misses and may uncover "root causes" that link a group of problems that don't seem to be related (for example, a variety of serious adverse events occurring during changes of shift). (Obtained from the Australian Council for Safety and Quality in Health Care, Spring 2003 Newsletter.)

It appears that QH's inadequate response to the Nevilles' complaint stemmed from an "ad hoc" approach to dealing with patient complaints.

2.6.2 Fragmented health complaints system

The most concerning aspect of the Nevilles' complaint was the inability of the current health complaints system to provide for one investigation that could cover all aspects of the complaint. The Nevilles saw their complaint as being essentially about one incident. However, the current health complaints scheme dictated that their complaint had to be split, and different aspects of it referred to different agencies for action.

In the last three years, there have been six separate inquiries (not including my inquiry) into aspects of the adverse incident involving Elise Neville (that is, by the State Coroner, HRC, MBQ, QNC and QH and by the CMC concerning the allegation of official misconduct against the Executive Director). Putting aside the involvement of the State Coroner and the CMC, the fact that this complaint necessitated investigations by the HRC, the MBQ and the QNC (as well as the investigation commissioned by QH as the HSP), is indicative of an inefficient, dysfunctional and compartmentalised health complaints system.

As a result, there were:

- four separate investigations by four different health related agencies, all acting under different legislation and with different internal policies and procedures;
- four different investigation reports delivered at different times and with different outcomes;
- considerable delays brought about by the numerous consultation processes during the assessment and investigation processes.

From the complainants' perspective, this is far from an optimal complaint process.

The Commissioner in the HRC's Annual Report for 2003-2004 commented on the obvious frustration for all parties involved with the Neville complaint in having to deal with a number of inquiries into the one incident with separate findings delivered at different stages. In his opinion an optimal complaint handling process would involve:

- a single report covering all of the issues which in turn would have provided a more complete picture of events; and .
- centralised complaint handling and information gathering processes, at least in the initial stages of dealing with a complaint.

A complaint handling process based on these principles will not only provide for a more timely and cost effective process, but also reduce the possibility of duplication of investigations, and uncertainty about who has jurisdiction to investigate what.

2.6.3 Lengthy process

Given the serious nature of the allegations raised by the Nevilles' complaint and the possibility of an ongoing risk to public safety, they expected, not unreasonably, that their complaints would be dealt with in a timely manner.

The following table summarises the health complaints process applicable to the Nevilles' complaint:

Process	Legislative basis	HRC	MBQ	QNC
Receipt of complaint by agencies	s.67 HRCA	28/3/02	10/4/02	11/4/02
1st consultation with HRC			17/04/02	1/5/02
HRC receives more specific complaints about the two nurses and Caloundra Hospital		2/5/02		
HRC accepts for assessment all complaints & seeks submissions from providers	s.69 HRCA	10/05/02		
HRC forwards copy of complaints about registrants	s.69 HRCA		10/5/02	10/0502
HRC consults with MBQ & QNC before making decision about what further action is to be taken	s.71 HRCA		7/8/02	7/8/02
Assessment by HRC completed and complaints referred to MBQ & QNC for further action	s.71 HRCA	7/8/02	7/8/02	7/8/02
Assessment period by HRC	s.76 HRCA	10/05/02 to 7/08/02 (89 days)		
QNC accepts for investigation complaint against RN 1				21/8/02
QNC appoints an investigator to commence investigation of RN 1				6/9/02
HRC commences its investigation in relation to CH, SCHSD, the Executive Director and other systemic issues	s.95 HRCA	24/9/02		
MBQ appoints an officer of the OHPRB as investigator to investigate complaint about the Doctor	s.73 HPPSA		27/8/02	
MBQ appoints an external consultant to take over investigation of the Doctor	S.73 HPPSA		24/6/03	
HRC completes its investigation of CH & SCHSD and issues first report (complaint about the Executive Director dropped due to lack of jurisdiction)	s.125 HRCA	4/9/03 (investigation takes approx 11 months)		
QNC completes investigation of RN 1 and produces its report				27/11/03 (investigation takes 14 months)
External consultant completes investigation on behalf of MBQ and report issued			2/1/04 (investigation takes approx 17 mths)	
QNC appoints an investigator to commence investigation of the Nevilles' complaint against RN 2				19/3/04
HRC conducts a review of its investigation and issues a 2nd report		28/6/2004 (review takes 9 months)		
QNC completes its investigation of RN 2 and issues a report				16/7/2004 (4mths)

The HRC, MBQ and QNC have provided responses to my Office's invitation to provide an explanation for the time taken to complete the different investigations into the Nevilles' complaint. A brief summary of their responses follows:

HRC

The Commissioner of the HRC advised that:

- A timeframe of 11 months to complete its investigation was not inordinate given the complexity of the investigation.

- A lot of information was gathered from a wide variety of sources.
- A review of the first report was conducted on the basis that after receipt of the first report, the Nevilles were able to better define the full extent of their concerns. As a result, the review warranted an actual re-investigation of aspects of their complaint.

MBQ

The MBQ advised that:

- The MBQ did not have any record of telephone conversations with the Nevilles on 25 October 2002 and 18 December 2002 in which they alleged they were told the investigation into their complaint about the Doctor would take approximately six months. Accordingly, it was unable to confirm or deny their assertions.
- The factors which resulted in a delay in commencing and finalising the investigation of the Doctor included the referral of the complaint to the HRC, untimely resignation of the investigator appointed on 27 August 2002, and the backlog of complaints faced by the Complaints Unit at that time.
- The delay in commencing an investigation into the Nevilles' complaint against the Doctor is explained by the fact that under s.51 of the *Health Practitioners (Professional Standards) Act 1999* Qld (the HPPSA), the MBQ is required to refer such a complaint to the HRC. Once referred, consultation takes place between the MBQ and the HRC to determine whether or not the MBQ will investigate the matter. At a meeting between the MBQ and the HRC on 17 April 2002, a decision was made to refer the Nevilles' complaint to the HRC for assessment. Once a complaint is referred to the HRC for assessment, the MBQ does not take any further action unless and until the complaint is referred back to it for further action. Pursuant to s.74 of the HRCA, the complaint was referred back to the MBQ for action on 8 August 2002. The MBQ then noted at its meeting on 27 August 2002 that an investigator was to be appointed.
- The appointed investigator resigned from his position on or about 6 June 2003, following unexpected leave in the three weeks prior to his resignation. This prompted the appointment of an external investigator on 24 June 2003.
- In August 2002, the MBQ had 295 investigations, with each investigator responsible for approximately 50 investigations. The Nevilles were advised by letter of 6 May 2003 that there was a backlog of complaints. Additional resources were allocated to the Complaints Unit from April 2003 to clear the backlog. This facilitated their complaint being referred to an external investigator on 24 June 2003.

QNC

The QNC provided detailed statements by its Executive Officer, and by the inspector who conducted the investigations of both nurses, which set out the actions taken by the QNC and the inspector in respect of the Nevilles' complaints. In summary, they advised:

- In accordance with its statutory duty, upon receipt of the Nevilles' complaint about the two nurses, the QNC consulted with the HRC as to what action should be taken. The HRC retained the complaint for assessment and then on 7 August 2002, referred the complaint back to the QNC for action. The QNC was precluded by the provisions of the *Nursing Act 1992* from taking any action on the complaint until the HRC had referred the complaint back to it for action.

- After seeking legal advice, the QNC agreed to investigate the complaint against RN 1 but not RN 2. An inspector was appointed by the QNC on 6 September 2002.

- In preparing the particulars of the complaint, the QNC sought advice from the HRC and its legal advisers, and consulted extensively with the Nevilles and a paediatric nursing expert and other experts.

- Particulars of the complaint were provided to RN 1 and she was given the opportunity to provide a submission in response.

- Upon receipt of her response, the inspector sought expert opinions from a paediatric nurse and a medical practitioner.

- QNC sought other relevant expert medical opinion and access to evidence which the State Coroner had obtained relating to Elise Neville's death.

- The investigation report was referred to QNC's solicitors for advice.

- Following receipt of this legal advice, further discussions were undertaken with one of the medical experts who provided expert advice to clarify the standard of nursing care he expected of an Emergency Department nurse in this matter. This further advice was referred back to the QNC's solicitors.

- Subsequent legal advice and the investigation report were referred to the QNC's Professional Standards Committee (PSC) for recommendations as to what action, if any, should be taken following the outcome of the investigation.

- A copy of the investigation report was then sent to RN 1, care of her lawyers, inviting her to make a further submission. This was done to satisfy the obligation imposed on the inspector pursuant to s.103(5)(b) of the Nursing Act.

- In accordance with a further statutory duty, the QNC also forwarded a copy of the investigation report to the Health Rights Commissioner for his comments. The Commissioner concurred with the conclusions reached in the investigation report, but expressed concern over the QNC's decision to await the outcome of the coronial inquest before making a determination in relation to the findings of the investigation report.

- An investigation was initiated in relation to the actions of RN 2[29] and an inspector was appointed on 19 March 2004. This was as a result of a recommendation by the PSC after considering the findings contained in the investigation report relating to RN 1. Once again, the QNC consulted with the HRC, and with its own solicitors, concerning the particulars of complaint in relation to RN 2.

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[29] some 2 years after Elise's incident

- RN 2 was advised of the QNC's decision to initiate an investigation into her conduct and asked to provide a submission in response.

- The inspector completed her investigation in relation to RN 2 on 18 July 2004, and the report was referred to the QNC's solicitor for advice, and to the HRC for comments.

- The QNC's solicitors provided a brief to Senior Counsel to advise whether any action should be taken against RN 1 and/or RN 2.

- Upon receipt of Senior Counsel's advice, the matter was referred to the PSC for recommendations and then to the QNC for a direction as to whether disciplinary action should be taken against either of the two nurses.

A lengthy process was inevitable for a number of reasons, including:

- Certain statutory requirements caused delays, in particular the inability of the QNC to commence an investigation until the complaint had been referred back to it by the HRC for action.

- Extensive consultation undertaken (with nursing experts, legal advisers, the complainant and the HRC) to settle on the particulars of the complaint.

- Inviting submissions from the nurses in response to the particulars of the complaint, in accordance with natural justice considerations.

- Internal QNC processes including referral of matters to the PSC for advice and recommendations prior to consideration by QNC (noting that both only meet once a month).

- In this instance, the initial decision by QNC was to await the outcome of the coronial inquiry before making any determination as to what action, if any, should to be taken against the nurses. It was the usual practice of the QNC to await the outcome of any criminal action before finally deciding on whether to take disciplinary action. This practice reportedly developed because of a belief that any disciplinary action against a nurse was likely to be stayed pending the outcome of a coronial inquiry or relevant criminal charge. The QNC considered a stay was likely to be granted because, under the *Coroners Act 1958* (which applies to deaths occurring before December 2003) a person could refuse to answer questions before the coroner that might tend to incriminate him or her, and also decline to give evidence at a hearing of criminal charges against him or her.

In a letter to the Minister for Health dated 19 July 2004, the Executive Officer of the QNC informed the Minister that the average timeframe from the initiation of an investigation to the presentation of an investigation report to Council, is approximately six months. The letter stated that the investigation of RN 1 took longer than this average because of the complexity of some of the issues involved which required legal advice to be obtained on more than one occasion, as well as the commissioning of expert reports.

2.6.4 Delays in QH's implementation of recommendations, and in the MBQ and QNC finalising disciplinary processes

It must be remembered that the Nevilles' complaint raised serious allegations concerning the conduct and competence of medical and nursing staff employed in an Emergency Department of a regional public hospital, and systemic issues impacting on the quality of service provided by the hospital. Accordingly, it is necessary to consider whether the interests of the public were adequately protected during the time that investigations by the HRC, MBQ and the QNC were continuing.

It has already been noted that QH declined to conduct an investigation of the Nevilles' complaint, or a root cause analysis, on the basis that investigations were being undertaken by the independent health complaint agencies.

As a consequence of inquiries made of the SCHSD by the HRC in its initial investigation, the SCHSD implemented some changes that related to some of the systemic issues raised by the Nevilles' complaint. These included:

- As of 14 January 2002 (that is, one week after Elise's presentation), the rostering system was changed so that medical staff were rostered on a 24 hour basis (rather than "on call" between the hours of 10pm and 8am). It was claimed that this ensured that medical staff who had been working continuously long hours would not be called during the night.

- On 15 January 2002, a direction by the General Manager (Health Services) QH to the District Manager confirmed that he could not accept the continuation of the existing practice at CH regarding the admission of children. In other words, it was made clear to the SCHSD that children could be admitted to CH, and that nothing other than clinical considerations should determine the treatment to be provided.

- Certain actions taken by the SCHSD to increase staff awareness of documentation standards (for example, inclusion of documentation standards as part of continuing medical education sessions).

I recently asked QH to report on what steps, if any, it had taken in response to the recommendations included in the investigations reports prepared by the HRC and by Professor Stokes. In a letter dated 24 May 2005, the then Director-General of QH responded as follows.

<u>Professor Stokes report of May 2004</u>

In relation to Professor Stokes' report, QH stated that:

- there were two recommendations included in the body of Professor Stokes' report, and a further 12 recommendations listed in its conclusion;
- the two recommendations included in the body of the report were actioned by the Director-General during his meeting with the Nevilles on 22 June 2004;
- while not strictly in response to the other 12 recommendations, a number of initiatives had been implemented at District level which satisfied the substantive recommendations.

While the listed initiatives arguably go some way towards rectifying some of the issues raised by the recommendations, recommendations made by Professor Stokes which have a direct impact on the standard of care provided to the public (for example, that the Emergency Department should be staffed by experienced third or fourth year postgraduate doctors who have received training in Emergency Departments before going to Caloundra) appeared not to have been actioned, as of the date of QH's response to me.

HRC's report of June 2004

On 24 May 2005, QH wrote to the HRC outlining the actions taken by QH up to that date to implement the Commissioner's recommendations contained in his report of June 2004.

On 6 June 2005, the Commissioner wrote to the Director-General of QH seeking more detailed information concerning QH's specific responses to the first three of his substantive recommendations.

In summary, it appears from QH's responses that it has not taken action to ensure that the specific recommendations made by Professor Stokes and the Commissioner have been implemented. Rather QH has relied on other distinct processes (for example, other independent reviews already underway prior to the Commissioner's report, funding allocations and QH initiatives) to support an argument that some action has been taken. There is no clear indication that the recommendations have either been satisfactorily actioned, or appropriately considered (with stated reasons) as unsuitable for action.

Doctors working hours

QH also responded to my concern about the numbers of hours the doctor who treated Elise Neville had been working (approximately 19 hours) when Elise first presented for emergency care.

The then Director-General advised that he considered the issue of safe working hours for doctors to be a professional standards issue as opposed to an industrial relations issue. Therefore, he had approached the MBQ to accept the role of developing, implementing and monitoring standards that relate to safe hours of work for doctors. The MBQ agreed that the issue was consistent with both its legislative functions and strategic direction and that it was appropriate for it, as an independent statutory authority, to establish a standard, rather than a standard being developed by any one employer, professional association or college. I am advised that the MBQ has sought additional funding from QH to cover this project which has been estimated to take approximately two years.

Disciplinary action by the MBQ & QNC

Another issue raised by the Neville investigation was the time taken before disciplinary proceedings were undertaken. It took in excess of two and a half years before any disciplinary action was taken against the doctor who treated Elise. This is of particular concern given that the Health Practitioners Tribunal ultimately decided that specific conditions should be imposed on the doctor's registration.

The QNC took the same amount of time to reach a determination that some form of disciplinary action was warranted against one of the nurses investigated (RN 1) but, to date, no disciplinary action has been taken. This is partly due to the following factors:

- The Nevilles sought a review of the QNC's decision of 3 September 2004, as to what disciplinary action was to be taken.
- In response to a meeting with the Nevilles on 5 October 2004, the QNC sought a further statement from RN 1 which was requested to be provided by 17 November 2004.
- The nurse's statement was not received by the QNC until 17 May 2005 (six months later). Reasons for the delay include RN 1 changing her legal advisers and then making an FOI application to QNC on 10 February 2005.
- The Nevilles were asked to provide comment on the contents of RN 1's further statement which they did on 10 June 2005.

In a letter dated 2 June 2005, the Acting Executive Officer of the QNC informed me that, upon receipt of the Nevilles' response, it was intended that the matter would be referred back to its solicitors for further legal advice. I am informed that the matter has subsequently been referred to Senior Counsel for advice. Upon receipt of Senior Counsel's opinion, the QNC will be required to make a further determination whether the matter warrants referral to the Nursing Tribunal. On that basis, it may be some time before the matter is finalised.

Some of the delays in finalising disciplinary action against the doctor and nurses in this instance were arguably unavoidable. However, in my view, structural flaws in the health complaints system have contributed to the lengthy timeframe between the incident and finalisation of the disciplinary proceedings (2 ½ - 3 years).

3. The current health complaints system in Queensland

It should be noted that, while the HRC is considered to be the primary agency for dealing with health related complaints, it is only one element in a broad complaints system which includes formal complaint mechanisms in private and public hospitals (and other elements of the public health system), and the professional registration boards. Under the current health complaints system in Queensland, complaints can be directed to:

1. the relevant HSP;
2. the HRC and/or the relevant health practitioner registration board/QNC; or
3. the Ombudsman (if the complaint relates to a government agency within the Ombudsman's jurisdiction).

3.1. The relevant health service provider

The current system requires complainants to attempt to resolve their health service complaint at the initial point of service. This is reflected in the HRCA which provides[30]:

> *"Before deciding to accept a health service complaint for action, the commissioner is to be satisfied-*
>
> *(a) that all reasonable steps have been taken by the complainant to resolve the complaint with the provider:.."*

While there is currently no reciprocal legislative duty on an HSP to resolve a complaint with a complainant, it logically follows that for the system to work effectively, HSPs need to have adequate systems in place in order to receive complaints and respond to them in a timely manner. One of the statutory functions of the HRC is to assist providers to develop their own effective complaints handling procedures[31].

A useful guide to complaint handling is Australian Standard *AS4269-1995: Complaints Handling*, which sets out the essential elements for the management of complaints from inception to resolution or final determination (as the case may be), irrespective of the nature of the complaint or the size of the organisation receiving the complaint. The Standard, which is currently advisory only, provides information that can be used to design a process for handling complaints in both the public and private health sectors. The Standard specifies several essential elements for effective complaint handling, including:

- appropriate systems for recording complaints and their outcomes;
- appropriate reporting on the operation of the complaint-handling process against documented performance standards;
- regular reviews of the process to ensure that it is efficiently delivering effective outcomes.

Australian Standard *AS4269* is currently being reviewed and it is expected that it will be amended to substantially reflect the current international standard *ISO 10002-*

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[30] refer s.71(2) HRCA
[31] refer s.10 HRCA

Quality Management - Customer Satisfaction - Guidelines for complaints handling in organisations which was introduced in July 2004. The ISO covers elements such as:

- visibility
- accessibility
- objectivity and impartiality
- confidentiality
- separating complaints-handling procedures from disciplinary procedures
- monitoring
- continual improvement.

My Office has also produced a number of publications designed to help public sector agencies make good decisions and manage complaints effectively. These publications are available on our website www.ombudsman.qld.gov.au and include:

- Developing Effective Complaints Management Policy and Procedures;
- Effective Complaints Management fact sheets; and
- Complaints Management Audit and Assessment checklist.

While these publications have been designed specifically for public sector agencies, any HSP could easily adapt them.

It is also important for an HSP to develop strategies for internal and external communication of its complaints management policy and procedures to ensure customers and staff know how complaints are handled by that organisation.

3.1.1 QH's complaints management framework

QH currently has a complaints management process based on the QH Complaints Management Policy (No. 15184 approved on 23 July 2002) which outlines how complaints are to be received and then handled. In developing the complaints management process, regard was had to *AS 4269-1995: Complaints Handling*.

The policy covers complaints received by any QH staff member about any aspect of a health service before, during or after the provision of a service. Complaints can be made verbally or in writing to QH by a user, their advocate, carer or family member, groups of consumers or consumer organisations, or general members of the public.

QH's Complaints Management Policy (the policy) is supported by a comprehensive "Complaints Management Handbook" (the handbook) as well as a "Guidance Document to the Queensland Health Complaints Management Policy". The handbook provides that the complaints process is an organised way of responding to, recording, reporting and using complaints to improve the service. It acknowledges that consumers want:

- it to be easy to make a complaint;
- to be listened to, understood and taken seriously;
- to be treated politely and with respect;
- staff to focus on solving the problem and not be defensive or give consumers the "run around";
- a timely response;

- the complaint to be investigated fairly with no cover-ups;
- to be told what is happening and what has happened and not be "left in the dark."

Once received, complaints are required to be assessed immediately and categorised as negligible, minor, moderate, major or extreme. Delegated staff at the point of service are required to attempt to resolve all "negligible and minor complaints". Complaints classified as moderate, major or extreme, plus any unresolved minor complaints, are to be referred to the complaints coordinator within each Health Service District. Where possible, such complaints are to be investigated and assessed and, where appropriate, referred to the District Executive.

Under the policy, the complaints coordinator for each Health Service District has several important duties including:

- Coordinating the complaints management process;
- Ensuring that complaint information is considered as part of District quality improvement and risk management processes;
- Managing and reviewing outcomes and investigations;
- Coordinating staff training on complaint management.

The handbook contains some common examples of the types of complaints relating to health service delivery such as:

- dissatisfaction with the type or level of treatment provided to a user (for example, at a public hospital) such as unsuitable care, misdiagnosis, communication issues, non-consent to procedures;
- general dissatisfaction with the health care or services received such as waiting lists or inappropriate diet;
- concerns that relate to unsatisfactory conduct of HSPs;
- limited or no access to personal records, disrespectful behaviour, lack of privacy, and/or confidentiality breaches.

The handbook also links risk management with complaints management. In other words, all complaints are also to be assessed to determine whether the level of risk for a specific complaint is acceptable or not. It provides a matrix for use in trying to determine the level of risk. QH's Integrated Risk Management Policy provides that each District, Branch or other accountable area is required to maintain a register of all risks to the organisation.

In June 2004, QH also introduced an *Incident Management Policy* (23360) which directs that Managers are required to report and manage sentinel events[32] and events with very high and extreme risk ratings. The policy was introduced to enable QH to learn from underlying causes of incidents and near misses and to improve systems to reduce the likelihood of recurrence.

The handbook outlines the timeframes for handling complaints. Basically, complaints should be acknowledged, or referred to external agencies for handling, within 3 working days of being received, or the need being identified. Relevant staff should

[32] Sentinel events are rare events that lead to catastrophic patient outcomes. The ACSQHC has endorsed a national list of sentinel events that includes, for example, retained instruments or other material after surgery requiring re-operation or further surgical procedure.

endeavour to resolve complaints within a 28 day timeframe, otherwise complainants are to be advised of progress of the complaint every 28 days until the complaint is resolved.

A health service may decide to undertake an investigation of any matter. Those complaints that cannot be resolved at the point of service, or those that are of a more serious nature (namely, those categorised as moderate, major or extreme), will usually be investigated.

Depending on the degree of seriousness of the matter being investigated, investigations may be conducted internally by a number of nominated QH employees including the line manager, the complaints coordinator, a senior member of the health care team or an investigator appointed by the Queensland Audit and Operational Review Branch. Complaints may also be referred to and investigated by an external agency like the HRC, MBQ or QNC.

The Director-General of QH may appoint a person as an auditor or investigator pursuant to s.52 of the *Health Services Act* (HSA). The functions of an investigator are to investigate and report to the Director-General on any matters relating to the management, administration or delivery of "public sector health services" (that is, a health service provided by the State), for example, matters relating to clinical practices and standards of health care in the delivery of public sector health services[33].

There is no requirement for QH to consult with the HRC or any of the registration boards at any time during the complaints process. However, QH may refer a complainant to an external entity at the end of the internal complaint process. For example, a complaint about a registered health practitioner may be referred to the relevant health professional registration body if it raises competence concerns because of a series of errors, or a pattern of behaviour demonstrating a lack of knowledge, skill or ability, and/or poor judgment based on problems with assessment, analysis or decision-making. The District Manager (or delegate) is responsible for such a referral.

QH recognises that many “minor” complaints can be resolved through the provision of information, or an explanation of why things happened the way they did, together with an apology and recognition of the effect the situation had on the complainant.

With more complex complaints, resolution may be achieved with the assistance of a trained mediator or conciliator, or by a process of facilitation. Facilitation is utilised when a group or parties with divergent views want to reach a goal or complete a task to their mutual satisfaction. A facilitator assists in defining issues, and in assisting and taking steps to encourage the parties to reach consensus.

3.1.2 Assessment of QH’s Complaints Management Policy and Procedures

In March 2003, my Office initiated a project called the Complaints Management Project (CMP), which involved my staff giving assistance to 11 State and local government agencies to implement complaint handling systems that meet recognised national and international standards. For the purposes of the project, my Office produced several publications, including fact sheets explaining the essential components of a best practice complaints management system, and a template to

[33] s.55 HSA

follow when drafting complaints management policies and procedures. These documents are available on our website[34].

At the time our project commenced, QH, which was one of the agencies participating in the project, had recently finalised a new policy and procedures for managing complaints received from members of the public.

Each of the agencies involved in the project, including QH, carried out a self-assessment of their current complaints management systems using an audit and assessment checklist which my Office designed for that purpose.

The QH complaints management system is based on QH's Complaints Management Policy (No 15184 approved on 23 July 2002). The Policy relates to complaints made "by or on behalf of a consumer or a group of consumers regarding the provision of a health service". A complaint can be made orally or in writing.

The Policy does not apply to complaints made by QH employees that involve PIDs or that relate to staff grievances or other staff concerns. Nor does it apply to complaints made to QH about public health issues (for example, complaints about food outlets).

QH's policy on Whistleblowers is IRM 3.1-4, *Policy and Procedures for the Management of Public Interest Disclosures – In Accordance with the Whistleblowers Protection Act 1994.* Its policy for handling staff complaints is Policy IRM3.5, *Grievance Resolution* and EB5 *Grievance Settling; and Industrial Disputes.* We did not review those documents as part of our CMP because the focus of the CMP is on complaints from members of the public.

My officers reviewed a copy of the completed audit and assessment checklist provided by QH. Based on their review of the checklist and other information relating to QH's complaint management process, my officers prepared a report of their assessment, which I provided to the Director-General of QH on 8 March 2004.

Particulars of the QH complaints management process have been explained earlier[35]:

Our report concluded that the QH system (assuming QH complied with its complaint policies and procedures) "compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management."

However, we considered that the system could be improved. In particular, we recommended that QH:

- Develop and establish a central or common complaint database to enable complaints data across all Districts to be collated and analysed.

- Improve awareness of the QH complaints management system on the part of QH staff across all Districts.

Our first recommendation was based on the fact that QH did not have a centralised database for recording complaints data across all Health Service Districts. In our view,

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[34] www.ombudsman.qld.gov.au
[35] at 3.1.1

this is an essential component of an effective complaint system. The existing systems within the Districts had limited compatibility which meant there was little capacity to:

- identify significant complaint issues, complaint trends or improvement strategies, or
- ensure an appropriate level of consistency in the management of complaints across all districts.

The second recommendation resulted from our assessment that there was no program in place to ensure consistent staff awareness across Health Service Districts concerning the complaints management system. For the system to operate effectively, we considered it essential that QH staff, especially those who deal directly with the public, be aware of the system.

Although the Policy specified that "all staff receive training on complaints handling within six months of commencement and at least every 3 years thereafter", information that we received indicated that training was conducted on an *ad hoc* basis within and across Districts and hence there was no guarantee that consumer complaints were being dealt with in accordance with the process. We suggested that QH should conduct surveys of staff awareness of the system.

In relation to training for QH officers who deal with complaints, we made no recommendation because of advice from QH that it had a comprehensive training regime for complaints staff, as outlined in its complaints management handbook. QH also advised that complaints coordinators are selected and trained in accordance with the principles outlined in QH's policy and handbook and all undergo a two day training session.

We have not conducted any audit to determine whether QH is providing such training as this is not part of the current phase of our CMP.

In the course of the project, we made several other suggestions to improve QH's complaints management system one of which resulted in the QH website being amended to include a dedicated section on consumer complaints.

Following receipt of our report, QH commenced work to develop a State-wide consumer feedback information system/database for the management and tracking of consumer complaints as well as for receiving information concerning critical incidents and for risk management purposes.

QH also advised that, in accordance with our recommendation, it planned to provide further training to staff to raise awareness of its complaints management process and that this training would be provided in conjunction with training associated with the implementation of the new database.

I am informed that the database has been developed and is currently undergoing testing in a Health Service District.

I am also informed that the database is not intended to capture information concerning PIDs under the WPA. Under current QH procedures, details of PIDs are provided to the Audit and Operational Review Branch of QH which is responsible for:

- ensuring that proper recording processes are in place for filing and receiving PIDs, and
- maintaining confidential files on disclosures.

It needs to be understood that the purpose of the CMP is to assist agencies, including QH, to implement complaints management procedures and systems that meet recognised standards. The project does not involve auditing whether agencies are complying with those procedures. For example, QH's complaints system imposes various responsibilities on the complaints coordinator in each District. However, it is noted that QH's Initial Submission to the Inquiry dated 16 May 2005 (p.38) stated that the Bundaberg Health Service District "has had no dedicated Complaint Coordinator".

Based on the evidence presented to the BHCI, I believe further action needs to be taken by QH to improve its current complaints management. In formulating these proposals, we have also had regard to QH's publication "Issues Paper for Bundaberg Hospital Commission of Inquiry – Complaints Management, July 2005".

3.1.3 Proposals for further improving QH's complaints management system

I propose that:

- QH develop a central Complaints Management Unit that will be responsible for:
  - overall internal complaints management including devising, implementing, reviewing and improving complaints systems;
  - providing advice and training to all complaints staff about both patient and staff complaints;
  - monitoring and reviewing local complaints handling to ensure that all complaints are actioned in a timely and appropriate manner;
  - investigating, or monitoring the investigation (at the local level) of, all complaints categorised as moderate, major or extreme;
  - liaising with the external complaint agency, where an unresolved complaint is escalated by the complainant to external review;
  - the collection and analysis of consumer feedback on QH health services;
  - benchmarking, conduct of complaint trend analysis, and auditing of complaints processes in the districts;
  - providing regular analysis reports about internal complaints management back to health districts and to senior management; and
  - liaison with the Patient Safety Centre to provide inputs, from analysis of patient complaints data, into strategies for quality improvement initiatives/activities.
- All Health Service Districts should have a dedicated complaints coordinator (CC) appointed at the level of A05 – A07 (depending on the size of the relevant

District/Branch), to ensure that CCs have an appropriate skill level, and sufficient seniority in the organisation, to credibly manage complex patient complaints. CCs should be accredited in complaints handling. There should be one State-wide position description (PD) as opposed to each District having its own PD for the role. It is acknowledged that some of the smaller health districts that do not receive many complaints may only require a part-time CC. The CC should report directly to the District/Branch Manager (or in large Districts, to an appropriate manager at senior executive level). The CC needs to have the standing and influence to ensure that serious attempts are made to resolve complaints at the local level wherever possible, and that issues warranting closer examination by management are escalated appropriately.

- All staff responsible for the receipt, referral and actioning of complaints should be adequately trained in respect of QH's Complaints Management Policy and Handbook.

Coordination of health data management systems

One of the important issues exposed during the hearings of the BHCI was the need for health services to maintain well integrated data management systems. In the case of Bundaberg (and potentially elsewhere), it is understood that the local patient complaints register and the adverse events and sentinel events records were not reconciled or integrated in any way, which significantly impeded capacity to identify systemic issues relevant to patient safety and delayed effective intervention.

Furthermore, a scan of the QH data management practices revealed a number of instances where data relevant to patient safety and quality improvement activities is collected via more than one source, eg. as part of preparations for accreditation surveys and for measured quality improvement activities. This duplication of effort in data collection and reporting requirements wastes resources and is understandably a source of frustration for staff.

It is also significant to note that several witnesses at hearings of the BHCI gave evidence that they seldom, if ever, received any feedback on the outcome of data collection and reporting activity.

The following proposals are made to address these deficiencies:

i) QH should finalise the implementation of its web-based complaints database as a matter of priority.

ii) Consideration should be given to amending the Health Act to establish a new statutory data collection of adverse events and complaints relevant to patient safety for public and private health care facilities. This database would be maintained by the QH Information Centre.

iii) Steps should be taken to improve and streamline coordination of data collection practices within QH to minimise duplication of effort.

iv) Feedback should be given at appropriate intervals (quarterly or biannually) to all services providing data for quality improvement or accreditation purposes.

Enhancing research on patient complaints and patient safety matters

At present, there is considerable scope for QH to enhance the scope and transparency of its patient complaints and patient safety data management practices. Without reliable quantitative data, performance management and quality improvement activity are hampered.

In view of the recent events at QH, the public will soon be seeking reassurance that the circumstances leading to these events have been addressed and that the situation has significantly improved. Developing the capacity to undertake research of reliable data will assist QH to demonstrate that the problems in the existing system are being addressed.

If, as proposed, QH implements improved data management practices as a priority then it would be possible to commence a range of research activity aimed at identifying the factors that could lead to improvements in patient safety and reduce the incidence of complaints. Good data would enable health care facilities to identify the most significant factors influencing public confidence in the health care system. Funding for such research could be provided to monitor the public health care system only (for example, through enhanced funding to the Patient Safety Centre in QH) or alternatively to capture data on the entire health sector in Queensland (through enhanced funding to a remodelled HRC to undertake research specifically on consumer complaints and patient safety issues within both the public and private sectors).

3.2 Complaints management by the HRC

If a complainant is unable to resolve a complaint with the service provider or is dissatisfied with the outcome or response provided, the complainant can seek the assistance of the HRC in resolving the complaint. If a complaint or serious allegation is about a registered health practitioner or registered nurse/midwife, the complainant may also take the complaint direct to the relevant health practitioner registration board or the QNC.

Part 5 of the HRCA outlines the types of complaints which can be made to the HRC, the assessment process, and what action can be taken if the HRC accepts a complaint.

Complaints may be made about any aspect of care or treatment provided anywhere in Queensland by any health service or health care practitioner, whether operating in the public or private sector. However, complaints must be raised with the HRC within 12 months of knowledge of the cause for complaint.

Only a person prescribed by s.59 of the HRCA may make a complaint to the HRC, that is:

- the user of the health service or his/her representative;
- someone with sufficient interest to act on behalf of the user if the user cannot choose a representative;
- if the user has impaired capacity, an appropriate attorney or the Adult Guardian or other guardian;
- the Minister for Health;

- anyone else the Commissioner considers should be permitted to make the complaint in the public interest.

If a complainant is not a prescribed person under s.59, the HRC does not have jurisdiction to assess or investigate the complaint. In these cases, the HRC may refer the complainant to the relevant registrant's board or other body.

3.2.1. Assessment process

Upon receipt of a complaint, the HRC undertakes a formal assessment and acts as an impartial link between the complainant and the HSP to resolve the complaint. The HRC may elect to facilitate resolution of a complaint even before formal assessment of the complaint has been undertaken.

Where the complaint is retained by the HRC for assessment, the Commissioner may invite submissions from the complainant and/or the provider and must invite a submission from the registration board.

Before deciding to accept a complaint for action, the HRC must be satisfied that, if at all practicable, the complainant has taken all reasonable steps to resolve the complaint with the provider[36].

The HRC endeavours wherever possible to take an informal and conciliatory approach to resolution of health complaints as the HRCA specifically refers to proceedings being conducted with "*as little formality and technicality, and with as much expedition, as practicable*[37]*.*"

From commencement of an assessment, the Commissioner has a statutory time limit of sixty (60) days in which to assess the complaint. This period, however, may be extended by a further thirty (30) days in certain circumstances, for instance, if the complaint is too complex to assess in 60 days or the Commissioner considers the complaint can be satisfactorily resolved[38].

Upon assessing a complaint, the Commissioner must decide whether to take any action[39]. If the complaint is about a registered provider, the Commissioner must consult with the Board prior to taking action[40].

If the HRC decides to accept for action a complaint about a provider (other than a registered provider), the HRC may[41]:

- conciliate the complaint (under Part 6 HRCA);
- investigate the complaint (under Part 7 HRCA); or
- refer the complaint to another entity (s.73 HRCA).

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[36] s.71 HRCA
[37] s.30(1)(a) HRCA
[38] s.76 HRCA
[39] s.71(1) HRCA
[40] s.71(3) HRCA
[41] s.73(2) HRCA

3.2.2 Complaint about registered provider

Generally, the Commissioner must immediately assess a health service complaint[42]. However, where the complaint is about a registered provider, the Commissioner must refer it to the registered provider's registration board without assessment and not take any further action in relation to the complaint if:

- the Commissioner considers it is in the public interest for the complaint to be immediately referred to the registered provider's registration board; and
- after consulting with the registration board about the complaint, the board agrees it is in the public interest for the board to immediately deal with the complaint[43].

In addition, if the Commissioner believes:

- the registered provider poses an imminent threat to the life, physical or psychological health, safety or welfare of users of the provider's services, or another person or class of person, or the registered provider; and
- immediate action to suspend, or impose conditions on, the registered provider's registration appears necessary to protect the person or persons,

the Commissioner must immediately refer the complaint to the registration board[44].

The HRC meets regularly with representatives from the health registration boards for the purpose of discussing complaints received and determining how best those complaints should be handled.

The Commissioner must not take any action about the complaint until the first of the following happens:

- the Commissioner receives the registration board's comments (usually to be provided within 14 days of the Commissioner consulting with the board)[45]; or
- the registration board advises the Commissioner that the board does not intend to give any comments; or
- the time for providing comments ends[46].

The Commissioner must have regard to any comments made by the registration board in making the decision[47]. If the registration board has advised the Commissioner it considers the complaint warrants investigation or other action by the board, the Commissioner must not decline to take action on the complaint, but must refer the complaint to the board[48].

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[42] s.67 HRCA
[43] s.68 HRCA
[44] s.77 HRCA
[45] s.71(5)(a) HRCA
[46] s.71(6)(a) HRCA
[47] s.71(6)(b) HRCA
[48] s.71(7) HRCA

3.2.3 Conciliation

Conciliation under the HRCA is a relatively formal process, that is accorded a number of statutory protections, in contrast to informal methods of dispute resolution that may be undertaken at the Intake or Assessment stage.

On accepting a complaint about an HSP, the Commissioner has a primary obligation to try to resolve the complaint by conciliation if the Commissioner considers it can be resolved in that way[49]. A decision to conciliate a complaint must take into account the public interest[50].

Conciliation is a flexible process which focuses on helping people to resolve their complaint about an HSP, through discussion and negotiation. Both the complainant and the HSP must agree to a matter proceeding to conciliation. The Conciliator acts impartially in the process and tries to encourage settlement of the complaint in a way that is acceptable to both parties. Some examples of the possible outcomes of conciliation include:

- an explanation of what happened;
- an apology;
- financial settlement;
- quality assurance changes;
- change in health care provision.

If no satisfactory outcome has been reached, the complainant still retains the right to commence civil action[51]. The Commissioner may also decide to commence an investigation into the complaint. However, any information gathered for the purposes of conciliation or anything said or admitted during conciliation cannot be used by the Commissioner as a ground for investigation or inquiry[52] and is not admissible as evidence in a proceeding before a court, tribunal or disciplinary body.

3.2.4 Investigation process

Investigation is a formal process whereby the Commissioner gathers and analyses information concerning a complaint, and then forms a view as to the reasonableness or otherwise of the action being investigated. The Commissioner has substantial powers to obtain information and records, and to interview relevant parties. A report may be issued at the end of an investigation with recommendations to appropriate persons/organisations.

However, the Commissioner has no power to investigate a registered provider.

Where the complaint is about a registered provider and the Commissioner and the registration board have agreed that the complaint requires investigation or other action

[49] s.73 (3) & s. 74 (4) HRCA
[50] s.73(4) & s. 74(5) HRCA
[51] Any civil action must be commenced within a period of three years from the incident that led to the complaint.
[52] s.91 HRCA

by the board, the Commissioner must immediately refer the complaint to the board[53]. If the Commissioner and the board cannot agree, the Minister will decide[54].

3.3 Complaints management by the registration boards

The Health Practitioner Registration Boards (the boards) have a legislative duty to protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way. The boards must also aim to uphold the standards of practice within the health care professions and to maintain public confidence in their profession.

Each board is responsible for the determination of professional standards, assessment of applications for registration and investigation of complaints. If a board reasonably believes at any time, whether on the basis of a complaint or otherwise, that a registrant poses an imminent risk to the health or safety of others, the board has authority to suspend, or impose conditions on, the registrant's registration[55].

The boards may institute disciplinary action against their registrants for "unsatisfactory professional conduct", a term defined in the Schedule Dictionary to the HPPSA.

3.3.1 Complaint handling by the boards

If users of health services are unable to resolve their complaint directly with the registered provider, they may lodge a complaint with the HRC or the appropriate registration board. As mentioned earlier, the HRC and the boards consult regularly about complaints.

A complaint about a registrant may be made to the registrant's board about any aspect of the registrant's conduct or practice, or another matter relating to the registrant, that appears to provide a ground for disciplinary action against the registrant[56]. Also, a complaint may be made to a board about a matter for which a complaint may be made under the HRCA[57].

While most complaints are dealt with by the HRC in the first instance, the boards will deal with certain types of complaint, for example:

- complaints about compromised standards of practice;
- sexual misconduct;
- complaints made by one practitioner about another practitioner; and
- complaints about medico-legal reports.

A registration board must investigate the registrant:

(a) if directed by the Minister ;
(b) where the registration board and the Commissioner have agreed the board is to investigate the complaint; or

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[53] s.74 HRCA
[54] s.74(7) HRCA
[55] s.59 HPPSA
[56] s.48(1) HPPSA
[57] s.48 HPPSA

(c) where the board has suspended or imposed conditions on the registrant's registration.

In addition, a board may investigate a registrant of its own motion (that is, without a complaint being received) if it reasonably believes that an aspect of the registrant's conduct or practice, or another matter relating to the registrant, may provide a ground for disciplinary action against the registrant[58].

An investigation is commenced by the appointment of an investigator or investigative committee. The HPPSA provides for who may be appointed as an investigator, including a member of a board, the Executive Officer of a board, a member of the board's staff (with the consent of the Executive Officer) or other person considered by the board to have the necessary expertise or experience to be an investigator[59].

The registration boards have similar investigative powers to the HRC (Part 5 Division 5 of the HPPSA). However, unlike the HRC, the boards have power to compel a registrant to respond to a complaint and provide stated information within a reasonable time. A penalty can be imposed for failure to provide the requested information[60].

Upon finalisation of an investigation, a preliminary report and/or a final report is prepared by the board, including the findings and proposed action to be taken by the board[61]. A copy of the report is provided to the Commissioner who may provide comments about the report within 14 days after receiving the report or such longer period as agreed to by the board[62].

After providing the Commissioner with a copy of the report, the board must not take any action on the complaint until one of the following happens:

a) the board receives the Commissioner's comments about the report and considers the comments;
b) the board receives advice that the Commissioner does not intend to give any comments;
c) the period for the Commissioner to give comments about the report ends. [63]

Section 118 of the HPPSA outlines the types of action the board may take upon finalisation of the investigation. For example, the board may decide to refer a disciplinary matter for hearing by a panel or by the Health Practitioners Tribunal (the Tribunal) or start proceedings to prosecute the registrant for an offence. Where appropriate, the board may also decide to enter into an undertaking with the registrant, with the registrant's agreement, about the registrant's professional conduct or practice. This will be recorded in the board's register for the term of the undertaking.

As soon as practicable after deciding what action to take under s.118, the board must give written notice about its decision to the registrant, the complainant, and the Commissioner[64] and then proceed with the relevant action.

[58] s.63 HPPSA
[59] s.73 HPPSA
[60] ss.78 & 79 HPPSA
[61] ss.114 & 115 HPPSA
[62] s.116 HPPSA
[63] s.116 HPSA
[64] s.120(1) HPPSA

The HPPSA provides that the purposes of disciplinary proceedings and disciplinary action against registrants are:

(a) to protect the public;
(b) to uphold standards of practice within the health professions; and
(c) to maintain public confidence in the health profession[65].

There are a number of grounds outlined in the HPPSA[66] that the registration boards can rely on when commencing disciplinary action against a registrant, including:

- the registrant has behaved in a way that constitutes unsatisfactory professional conduct;
- the registrant has failed to comply with a condition on practice imposed under that Act or the Health Practitioner Registration Act under which the registrant is registered, or an undertaking entered into under the HPPSA.

The term "unsatisfactory professional conduct" is defined in the Schedule to the HPPSA. It includes professional conduct that is of a lesser standard than that which might reasonably be expected of the registrant by the public or the registrant's professional peers. It also includes professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgment or care, in the practice of the registrant's profession. This definition gives a wider scope to "unsatisfactory professional conduct" than "conduct discreditable to the profession" or "professional misconduct" as previously understood and applied, because the concept embraces public and peer group perceptions of what is acceptable conduct.

A registrant's board may start disciplinary proceedings against a registrant if it reasonably believes a disciplinary matter exists in relation to the registrant. This may be in response to a single complaint received about the registrant or a number of complaints which may suggest a pattern of conduct or practice.

Part 6 of the HPPSA provides a three level disciplinary framework to which the MBQ may refer disciplinary matters. The three levels are:

- Disciplinary proceedings conducted by the MBQ (in the form of a hearing or by correspondence);
- Professional Conduct Review Panel;
- Health Practitioners Tribunal (the Tribunal).

The three levels differ in the constitution of the disciplinary body, and in the severity of the sanction which may be imposed if allegations against the registrant are proven.

The QNC is governed by the provisions of the Nursing Act, and has similar functions and disciplinary powers and procedures as the boards, but in respect of registered nurses and midwifes. It also meets regularly with the HRC for the purpose of discussing the management of complaints about registered nurses/midwives received by either itself or the HRC.

[65] s.123 HPPSA
[66] s.124

3.4 Development of Queensland's current health complaint mechanisms

Queensland experienced a significant health reform process in the 1990s. The establishment of the HRC in 1992 followed the inquiry into Ward 10B of the Townsville General Hospital during the 1980s.

3.4.1 The previous scheme

When it was established in 1992, the HRC had jurisdiction to investigate complaints against registered health providers. If it was decided that a complaint warranted action, the HRC had the power to retain the complaint for conciliation or investigation, or it could refer the complaint to whichever of the registration boards it determined had the most appropriate functions and powers to deal with the case[67].

The ability of a board to investigate complaints about its own registrants was somewhat hampered, for a number of reasons:

- a board was required to refer any complaint it received to the HRC (even though there was no reciprocal requirement for the HRC to refer a complaint to the board);
- there was no legislative provision to enable boards to require the HRC to refer to a board complaints on which the board wished to take action;
- except for the MBQ, the boards lacked investigative powers.

Under this scheme, the HRC was the primary agency for investigating and resolving health service complaints, with the boards mostly responsible for addressing disciplinary issues arising from health care complaints. However, under this scheme, the HRC did experience some operational problems. The disciplinary provisions of the health practitioner registration Acts did not dovetail with the HRCA, and this created the potential for delay and an increased risk that professional standards issues could be overlooked.

During the consultation stage of the reform process, a number of concerns about the old scheme were raised, including:

- the absence of parallel jurisdiction to the HRC to accept and investigate complaints;
- doubts about the admissibility of the HRC's investigation reports in disciplinary proceedings before the boards;
- inadequate powers of the boards to investigate disciplinary matters;
- deficiencies in the statutory consultation requirements (for example, the Commissioner was not required to consult a board before making an assessment decision and a board was not required to advise the Commissioner when disciplinary proceedings were being commenced);
- inability of the Commissioner to refer complaints to a board without going through the assessment process, which was causing delays in disciplinary matters being addressed.

[67] refer s.121 of the *Health Rights Commission Act,* as then in force

3.4.2 The current scheme

In the late 1990s, 13 Acts relating to health care were passed which substantially addressed these concerns and reformed the existing health complaints system. The most notable of these was the HPPSA which had been under discussion and consultation for six years before it became law in 1999.

The operations of the HRC were affected by the passing of the HPPSA, because it removed the HRC's powers to investigate complaints against registered providers and placed them instead in the hands of Queensland's health practitioner registration boards. This shift in power to the boards represented a judgment that complaints against individual registered practitioners should be primarily assessed and actioned on the basis of peer review.

The then Commissioner expressed strong concerns about this change during the proposal stage of the Act. In the HRC's Annual Report 1999-2000 at p.4, he said: *"If the investigation of complaints is to be seen to be undertaken in an open and accountable manner this can best be achieved by an independent and impartial agency."* Many did not see the registration boards as meeting these criteria. As a consequence of their protests, the proposed legislation was amended to give the HRC a role in monitoring complaints referred to a board for investigation, with the board being required to provide its investigation reports to the HRC for comment.

Under the new legislative scheme, the HRC was left with its existing jurisdiction to investigate complaints against:

- non-registered practitioners; and
- institutions/organisations providing a health service, including both public and private hospitals.

The intention of the reforms was to better protect the public by:

- enabling the boards to investigate complaints about their own registrants and initiate disciplinary proceedings for unsatisfactory professional conduct; and
- freeing up the HRC to more readily carry out its statutory function of overseeing, reviewing and improving the health system.

It was anticipated that this model would allow the HRC to continue to oversee the handling of complaints about health services, through monitoring complaint handling by the boards thereby promoting consistent approaches by the different boards.

Provisions were introduced into the respective Acts to require the boards and the QNC to keep the HRC informed of all matters relating to an investigation, and to forward to the Commissioner a copy of the reports on an investigation prior to taking action on the matter.

In considering the reports, the boards and the QNC are required to have regard to the comments of the Commissioner. There is no statutory requirement for boards and the QNC to comply with comments made by the Commissioner. However, the Commissioner in his 2003-2004 Annual Report, stated that, where he had commented

on or raised issues requiring further attention by a board, the board had taken those comments into account before making a final decision.

If the Commissioner considers a board has not taken appropriate action in response to his comments, he may give a report to the Minister.[68]

3.4.3 Weaknesses in the current jurisdiction and powers of the HRC

A comparative study of the HRCA and corresponding legislation in other states and territories in Australia and New Zealand indicates that the HRC's jurisdiction and powers in respect of health service complaints are limited in comparison to its counterparts, in particular, with respect to:

(i) the limited category of persons who may complain to the HRC;
(ii) the HRC's lack of power to compel a registered provider to respond to a complaint;
(iii) the HRC's lack of jurisdiction to formally investigate complaints about registered providers, or to initiate "own motion" investigations on matters that may be in the public interest;
(iv) the HRC's lack of power to impose any formal sanction on HSPs (particularly unregistered providers who are not subject to any prosecutorial or disciplinary action by another body), and limited involvement (that is, commenting on action proposed by a registration board) in decisions about disciplinary action against registered HSPs.

<u>Who may complain to the HRC</u>

Section 59 of the HRCA provides that a complaint may be made to the HRC by:

- the user of the health service or his/her representative;
- someone with sufficient interest to act on behalf of the user if the user cannot choose a representative;
- the Legal Friend or Adult Guardian;
- the Minister for Health; and
- anyone else the Commissioner may accept a complaint from in the public interest.

Section 59 effectively excludes complaints from non-users of a health service (for example, another HSP, clinical or administrative staff of an organisation providing health services, or whistleblowers) unless accepted by the Commissioner as a complaint concerning a health service which should be accepted in the public interest.

The New South Wales Health Care Complaints Act (HCCA) provides that "any person" may make a complaint[69]. This is considered preferable in that it enables independent external review of complaints from both users of a health service, and other potential complainants of the kinds indicated above.

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[68] s.126 HCRA
[69] s.8 of the *Health Care Complaints Act 1993* (NSW)

The HRC's lack of power to compel a registered provider to respond to a complaint

When the HRC receives a complaint about a registered provider, the Commissioner is to assess the complaint to determine whether or not to accept it for action. However, while the HRC has power to require a non-registered provider, or an organisation, to respond to a complaint and to provide information, it has no power to make the same requirement of a registered provider. Rather, the HRC can only invite a response from a registered provider[70]. A refusal by a registered provider to co-operate with the HRC's enquiries can lead to unnecessary delay in the complaint being progressed.

This often leads to the HRC having no other option but to refer the matter to the relevant board, which does have the power to compel a registered provider's co-operation with a board's investigation of a complaint (although the board will only investigate complaints that raise issues sufficiently serious as to potentially involve "unsatisfactory professional conduct" as defined in the Schedule to the HPPSA).

The Commissioner in his 2003-2004 annual report (p.9) noted that one way around the above problem would be for the HRC to be given the power to obtain relevant information and to require providers to respond to a complaint. This would bring the HRC into line with interstate Commissions that currently have this power.[71]

The HRC's lack of jurisdiction to formally investigate complaints about registered providers or to initiate "own motion" investigations

The HRC is the only Commission in Australia that does not have jurisdiction to investigate a complaint about a registered provider. All other interstate Commissions have a discretionary power to investigate such complaints.

In Victoria, if a complaint relating to a registered provider is received by the Commission, it must refer the complaint to the appropriate registration board if, after consultation with the provider's registration board, the Commissioner considers that the board has the power to resolve or deal with the matter and the matter is not suitable for conciliation[72].

In other jurisdictions, the Commissioner's view prevails in respect of more serious complaints, for example, complaints involving issues of a systemic nature or complaints relating to professional conduct, or complaints raising concerns about public health or safety or the public interest[73]. In other words, in these jurisdictions the Commission may exercise a discretion to investigate in the interests of public health or safety, or if the complaint raises significant issues as to the provider's practice.

One of the flaws in the HCRA is that, although the HRC must refer all complaints about registered providers to the relevant registration board, the boards are not compelled to accept a complaint for action, and will only do so if they consider the

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[70] s.70 HRCA. The only obligation on a registered provider is to advise the HRC whether or not he/she intends to make a submission.
[71] s.28 of the *Health and Community Services Complaints Act 2003* (NT); s.30 of the *Health and Community Services Complaints Act 2004* (SA)
[72] s.19(6) *Health Services (Conciliation and Review) Act 1987* Vic.
[73] *s.48 Health and Community Services Complaints Act 1998* (NT); *s.40 Community and Health Services Complaints Act 1993* (ACT); *s.26 Health Care Complaints Act 1993* (NSW); *s.43 Health and Community Services Complaints Act 2004* (SA); *s.46 Health Services (Conciliation and Review) Act 1995)* WA.

complaint is sufficiently serious to warrant their intervention because it may involve unsatisfactory professional conduct (as defined in the Schedule to the HPPSA) by a registered provider.

This creates a hiatus for complaints against a registered provider which have substance, but which the board considers are not sufficiently serious for it to take action (because they would not reach the standard for disciplinary action, that is, "unsatisfactory professional conduct", as defined). The HRC has no power to investigate such complaints against a registered provider (unless specific permission is obtained from the Minister on 'case by case basis'). In these circumstances, the complainant may well have no avenue for independent review.

The Neville complaint provides an example of the difficulties that can arise when a board declines to accept a complaint for further action (on the basis that the conduct complained of does not appear to provide a ground for disciplinary action). After the MBQ declined to accept the Nevilles' complaint about the Executive Director, the Commissioner sought the Minister's approval for the HRC to investigate the matter. The Minister refused on the basis that QH had appointed an external investigator to investigate this aspect of the Nevilles' complaint. In my view, the external investigator did not adequately address this issue, with the result that this aspect of the Nevilles' complaint has never been adequately investigated. This situation could have been avoided if the HRC had the power to investigate aspects of a complaint that relate to the conduct of a registered HSP.

The HRCA does not empower the HRC to conduct "own motion" investigations. The Health and Disability Commission in New Zealand and a number of interstate Commissions have the power to initiate investigations[74] on their own motion, as does the newly formed Legal Services Commission in regulating the legal profession in Queensland, and my Office.

The HRC's lack of power to impose any formal sanction on HSPs (particularly unregistered providers who are not subject to any prosecutorial or disciplinary action by another body), and limited involvement in decisions about disciplinary action against registered HSPs

The HRC is able to accept for investigation complaints about non-registered providers (primarily, organisations such as hospitals, hostels or nursing homes and a number of alternative therapists not subject to professional registration requirements). However, in instances of unsatisfactory service (no matter how egregious) it is unable to impose any formal sanction or initiate any disciplinary action against that provider, and there is no other disciplinary body able to take on this role.

The boards and the QNC are empowered to take disciplinary action against registered providers before established disciplinary bodies. While the Commissioner is unable to initiate, or direct a board or the QNC to initiate, disciplinary action, the Commissioner does have some limited input into the process. Where the Commissioner has requested a board or the QNC to provide him with reasonable reports during an investigation, the board /QNC must give the Commissioner a report about the findings of the investigation and the action taken or proposed to be taken (including any

[74] e.g. s.59 HCCA; s. 40 *Community and Health Services Complaints Act 1993*(ACT); s. 43 *Health and Community Services Complaints Act 2004* (SA); s.48 *Health and Community Services Complaints Act 2003*(NT)

proposed disciplinary action to be taken against the registrant the subject of the investigation). The Commissioner may then make comment or recommendations to the board/QNC about any proposed disciplinary action to be taken. The HRCA also makes provision for the Commissioner to intervene in a proceeding against a registered provider before a disciplinary body at any time during the proceedings[75].

The only jurisdictions in which the Commissions are empowered to prosecute cases against individual registrants before disciplinary bodies are New South Wales and New Zealand. In both jurisdictions, the decision whether to take any disciplinary action is made by a Director of Proceedings, who is a senior lawyer employed by the Commission (see Appendix 4 for more detail).

Some commentators believe that a Commission having a prosecutorial role is inimical to obtaining co-operation by registered HSPs for the resolution of complaints through negotiation and formal conciliation, which should be the primary emphasis of a health complaints body[76]. The contrary view is that decisions on possible disciplinary action should not be left in the hands of registration boards comprised mostly of members of the relevant health care profession.

In Queensland, we have a precedent for the prosecutorial model in the recently established Legal Services Commission, which may indicate a legislative preference for removing control of professional regulation and discipline from bodies comprising members of the relevant profession.

The Legal Services Commission currently initiates disciplinary proceedings against legal practitioners if, after investigation, there is a "reasonable likelihood of a finding by a disciplinary body of unsatisfactory professional conduct or professional misconduct" and "it is in the public interest to do so". When the evidence warrants it, the Legal Services Commissioner prosecutes legal practitioners before the Legal Practice Committee or, for more serious matters, the Legal Practice Tribunal. Accordingly, there is an established precedent in Queensland for an independent complaints agency that investigates, or monitors the investigation of, complaints about the provision of professional services, and makes decisions about whether or not to initiate disciplinary proceedings.

[75] s.130 HRCA.

[76] D.Thomas (ed.). *Medicine called to Account: Health Complaints Mechanisms in Australia, UNSW Press, 2002 p.8*

4. Health complaints models interstate and overseas

4.1 Australia and New Zealand

The various bodies established in Australian States and Territories and in New Zealand for receiving and investigating health care complaints (called "Commissions" here for the sake of brevity) differ in their jurisdiction and powers. In general though, they all have jurisdiction to:

- receive health care complaints;
- attempt to resolve complaints, primarily through a process of mediation or conciliation between the service provider and the complainant; and
- oversee, review and improve the overall health system.

The Commissions are also, to varying degrees, empowered to investigate "systemic" issues. The New Zealand Health and Disability Commissioner is among those offices which have a wider brief, with the ability to investigate and prosecute private and public providers, orthodox and alternative therapists and, importantly, to initiate "own motion" investigations.

The complaints mechanisms set up in all Australian States and Territories, other than in New South Wales, are based on a conciliation approach. The New South Wales Health Care Complaints Commission is the only Australian Commission that, like the New Zealand Health and Disability Commissioner, is empowered to prosecute health practitioners before registration boards, tribunals and professional standards committees. However, conciliation has been introduced in New South Wales as an alternative to the Commission's predominantly prosecutorial approach.

The proponents of the conciliation approach argue that, when medical errors or misadventures occur, the best way to deal with them is through non-legal conflict resolution measures. Furthermore, the conciliation approach enables those who have suffered medical misadventure to obtain financial compensation. They also argue that an adversarial, legalistic approach is not the best way to promote efficiency and effectiveness in the health care area, or to deal with situations in which human error rather than intentional misconduct has resulted in adverse events.

Until March 2005, the New South Wales Health Care Complaints Commission provided an advocacy role for complainants. On that date, it lost that role and took on a role as an impartial body for alternative complaints resolution. This provides a less formal option to the conciliation approach and is completely independent of the investigative processes of the Commission. The New Zealand Commission is now the only jurisdiction that has an advocacy role for complainants.

While there are some subtle differences, the individual processes of the Commissions are very similar.

The following table summarises the key processes of the Commissions in each State/Territory and New Zealand.

	QLD	NSW	VIC	NT	WA	ACT	TAS	SA	NZ
Health Commission	x	x	x	x	x	x	x	#	x
Formal Investigative role	x	x	x	x	x	x	x		x
Formal Conciliation role	x	*	x	x	x	x	x		x
Advocacy role									x
Legislation includes services for aged				x		x			
Legislation includes services for disabled				x		x			x
Consult with Boards	x	x	x	x	x	x	x		x
Prosecutorial function		x							x
Assessment timeframe	x	x	x	x	x		x		
Extension of Assessment option	x	x	x						
Code of Health Rights & Responsibilities				x			x		x
Act recently reviewed/under review		x		x	x	x	x	x	

*In New South Wales the conciliation function is carried out by the Health Conciliation Registry. This was previously a separate body within the New South Wales Department of Health. However, on 1 March 2005, the Registry was integrated with the New South Wales Health Care Complaints Commission (HCCC) so that the existing conciliation service could be better utilised and all alternative dispute resolution functions could be performed efficiently under the auspices of the HCCC. It has retained its independence, in that it is not subject to the direction or control of the Commissioner when carrying out its conciliation function.

Since 1 March, the HCCC also has a complaints resolution role (refer to Division 9 of the *Health Care Complaints Act 1993* as amended).

#Currently, the SA Ombudsman considers health complaints, but only those relating to public providers. The SA Parliament has passed legislation to establish a Health and Community Services Complaints Commissioner. The Act is expected to operate from mid to late 2005.

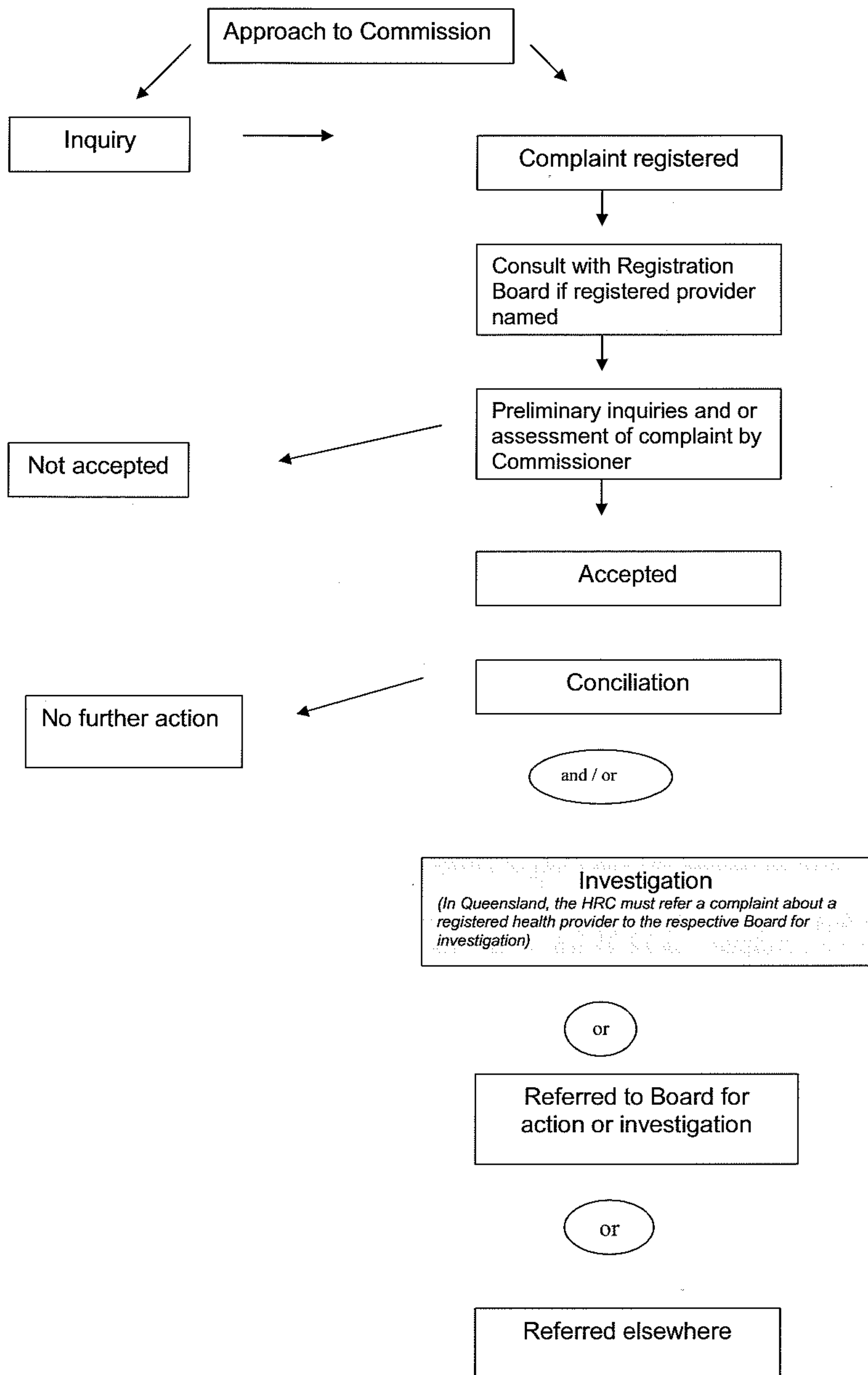
4.1.1 Relationships between the Commissions and the registration authorities

In Australia, the respective Commissions and registration boards generally have a statutory obligation to report complaints about registered providers to each other, and consult on the best way to manage the complaint. A complaint may be referred to the board if the Commission considers the board has power to deal with it, or if the complaint is not suitable for conciliation. There is a requirement for written protocols to ensure consultation occurs and, where the legislation is silent, on how disagreements regarding management of a complaint are to be resolved.

Except in Western Australia, there is no requirement for a Commission to obtain the complainant's consent before referring a complaint received about a registered provider to a registration board for action. In Western Australia, the Office of Health Review has a statutory obligation to obtain the written consent of the complainant before referring the complaint to the registration board for action[77].

The following flowchart represents the standard processing of complaints by the Commissions (with the exception of New South Wales):

[77] *s.31 Health Services (Conciliation and Review) Act 1995* WA.


Approach to Commission
Inquiry
Complaint registered
Consult with Registration Board if registered provider named
Preliminary inquiries and or assessment of complaint by Commissioner
Not accepted
Accepted
Conciliation
No further action
and / or
Investigation
(In Queensland, the HRC must refer a complaint about a registered health provider to the respective Board for investigation)
or
Referred to Board for action or investigation
or
Referred elsewhere

4.2 New Zealand

In New Zealand, the complaint mechanism established by the *Health and Disability Commissioner Act 1994* NZ is the primary method for dealing with complaints about the quality of health care and disability services.

The New Zealand model employs a code, entitled the *Code of Health and Disability Services Consumer's Rights* (the Code), that has a binding effect on all providers of health and disability services. The Code sets out ten rights, including the right to be treated with respect, to be free from discrimination or exploitation, to dignity and independence, to services of an appropriate standard, to give informed consent, and to complain.

The role of the Commissioner is to protect the rights of consumers of health and disability services, and facilitate the fair, simple, speedy and efficient resolution of complaints. There is a national network of independent advocates (free service) under the Director of Advocacy. There is also an officer called the Director of Proceedings who is an employee of the Commissioner's office but who acts independently of the Commission in exercising the powers and performing the duties and functions of the position[78]. The objectives of the Act are achieved through the Code, the establishment of a complaints process to ensure enforcement of the rights in the Code, and the ongoing education of providers and consumers.

The Commissioner is also able to undertake investigations on his/her own initiative. This enables the Commissioner to fulfil the role of "consumer watchdog" and to ensure public safety.

All complaints made to the registration boards must be referred to the Commissioner. Once this occurs, no disciplinary action can be taken by the registration board until the Commissioner, or the Director of Proceedings, has dealt with the matter and decided to take no further action. Only at that point can the registration board take up the matter.

However, referral of a complaint to the Commissioner does not preclude a registration board from considering a member's fitness to practice for reasons other than discipline, namely health or disability or competence to practice.

The Commissioner's options in respect of complaints are to take no further action, to investigate, or to refer the complaint to formal mediation or to advocacy. Advocates can assist a consumer in resolving a complaint with a provider. The advocate, after hearing the complaint, can provide free advice about the rights of the complainant and provide support in deciding what course of action to take.

If the Commissioner decides to investigate a complaint, an investigator is appointed. Once all relevant information has been gathered, the Commissioner may ask an expert in the area to review the information and advise whether the services provided met the appropriate professional standards. Taking into account the expert advice and other relevant evidence, the Commissioner determines whether the rights in the Code have been breached.

[78] s.15 *Health and Disability Commissioner Act 1994* (NZ)

If the Commissioner forms an opinion that a provider has breached the Code, the respective parties are notified and the provider will be given an opportunity to make a written submission. In reporting the final decision, the Commissioner may refer the matter to the Director of Proceedings, who may bring disciplinary and/or other proceedings. On referral to the Director of Proceedings, the principal avenues of redress are a claim before the Human Rights Review Tribunal, or disciplinary proceedings before a health professional disciplinary body. The Director may decide to take action in both forums. If the Director of Proceedings decides to take no action, an individual is able to take his or her own case to the Human Rights Review Tribunal.

The Commissioner does not have any power to award compensation. Examples of recommendations that may be made where a provider has not met the obligations under the Code include:

- an apology;
- a refund of some or all of the money a consumer has paid for services that are found to be below expected standards;
- a change in the way the provider does things, or changes to organisational policies.

The Commissioner can also ask the Minister for Health to take steps to improve a service if an investigation reveals a problem, or if new rules are needed to protect consumers.

4.3. United Kingdom (UK)- National Health Service

In 1999, a national evaluation of the National Health System (NHS) complaints procedure revealed that the public considered the procedure was not sufficiently independent. A further report released in 2003 found the complaints system was perceived as inconsistent, and that complaints took too long to be processed.

As a result, the UK Department of Health decided that a new complaints system should be set up, incorporating a second level of review by an independent organisation, the Healthcare Commission (HCC). The HCC is an independent inspection body for both the NHS and private and voluntary healthcare. The aim of the HCC is to increase patient confidence in the NHS complaints procedure, and to improve services in the NHS by pinpointing where things are going wrong in an independent, fair, consistent and timely manner. The HCC has the power to charge the NHS Trusts[79] for reviewing complaints made against them.

[79] Trusts are public bodies that provide health services.

An outline of the changes to the complaints process is summarised below:

	Old Process (est. 1996)	New Process (July 2004)
Stage 1 - Local Resolution	Patient, or someone acting on their behalf, complains to the organisation or practitioner concerned.	(Unchanged)
Stage 2 - Independent review	If the patient was unhappy with the response obtained at stage 1, they could apply for an independent review overseen by an NHS convener - usually a non-executive Director of the Trust to which the complaint was made. If the individual was unhappy with the convener's initial response, a panel consisting of the convener, a chair nominated by the strategic health authority, and one other, would be established to hear the complaint.	If the patient is unhappy with the response obtained at stage 1, they can apply to the HCC for an independent review. Trusts can also refer complaints to the HCC with the patient's consent. If the individual is still unhappy after the initial review and investigation by the case manager, they have the option of having their case heard by an independent panel. There are set timescales and phases the HCC works to in handling these requests.
Stage 3 - Health Service Ombudsman	If a patient was unhappy, the complaint could be referred to the Health Service Ombudsman.	If a patient is still unhappy, complaint can still be referred to the Health Service Ombudsman and, in some circumstances, the HCC will refer complainants directly to the Ombudsman.

The success of the new NHS complaints procedure depends on good complaints handling locally, by the service provider. The HCC works with the Department of Health to identify best practice complaints handling and to promote good clinical practice.

Under the new system, an individual needs to bring a complaint to the HCC within two months (60 days) of receiving a formal written response from the trust or health practice concerned. The only exception to this is if the complaint has been with the trust or practitioner for more than six months without a formal response, in which case the HCC can be asked to investigate.

All requests for an independent review by the HCC are acknowledged within two days. A member of the complaints team then conducts an initial review of the case, with the help of expert advice if necessary, to determine whether further investigation is needed. To ensure consistency, a team leader reviews any recommended course of action by the case manager. Both the complainant and organisation/practitioner complained about are advised of the decision and any recommendations within 20 days. The following table summarises the complaints process and the timeframes involved.

ACTION	TIME
Acknowledge complaint	Within two days of receipt
Obtain consent forms (obtain medical records)	Up to 5 days
Call for papers, including views of organisation complained against on the complaint	Up to 20 days
Expert advice identified and received	Up to 30 days
Decision on what will happen to the case	Up to 10 days
Communication to all parties	Immediately following decision on what is to happen to the case
If investigation agreed, terms of reference drafted	Two days
Comments from parties	Up to 10 days
Identify and secure experts	Up to 20 days
Arrange interviews, call for further papers, write report, quality assurance	Must be completed within 90 days of decision to investigate unless there is good reason
Request from complainant or organisation complained against for hearing by a panel	Within 40 days of report
Panel established	Within 48 days of the receipt of the request
Draft report for checking by parties for factual accuracy	Within 10 days of panel hearing
Receipt of comments and checks for quality	Within 10 days of deadline for comments
Issue report	

N.B. Some of the timeframes may be concurrent.

The HCC investigates allegations of, or information suggesting, serious failings that have a negative impact on the safety of patients, clinical effectiveness or responsiveness to patients such as:

- a higher than anticipated number of unexplained deaths;
- serious injury or permanent harm, whether physical, psychological or emotional;
- events that put at risk public confidence in the healthcare provided, or public confidence in the NHS generally;
- a pattern of adverse events or other evidence of high risk activity;
- a pattern of failures in services or teams, or concerns about these;
- allegations of abuse, neglect or discrimination against patients.

Other failings with less serious effects on patient safety may be subject to review by the HCC.

If the decision is made to carry out further investigation, the investigation's terms of reference are agreed upon with both the complainant and the organisation/practitioner. Even if a complaint has been made to a statutory professional regulatory body, an investigation by the HCC and full report of the investigation findings are provided to both parties at the end of the investigation.

If individuals are unhappy with the outcome of the investigation, they have a right to request an independent panel be established to hear their concerns. The panel consists of three members of the public, who are not connected to the NHS but who have been specially trained to deal with NHS complaints. The panel will hear both sides of the complaint. They will also make recommendations for resolution and/or for improving services where appropriate. In the majority of cases, the whole process should take no longer than six months.

The panel is not adversarial, but must uphold the principles of fairness and consistency. The standard of proof is the civil standard of "balance of probabilities". The majority view prevails.

Accurate records approved by the panel members are kept of conclusions and recommendations, and the reasons for reaching the conclusions. The panel makes two sets of recommendations: one concerned with redress for the individual and the other regarding improvement of the services (where appropriate). A full report is available to the parties and an anonymised report is published and available on the HCC website. At every stage of the procedure, anonymised information is fed into the HCC's baseline information systems on the organisations complained against, to facilitate analysis of patterns or trends.

The boards of the relevant NHS trusts are responsible for putting into operation the recommendations (if any) in the investigation and panel reports. The HCC expects NHS bodies to be able to demonstrate how they have improved systems as a result of information from complaints. This involves the NHS service providers producing action plans based on recommendations from the HCC investigations, panel hearings and reports.

One of the problems faced by review panels under the old system was that they often had incomplete information on which to make a judgment. Under the new system the panel will have a full investigation report and so will not need to reinvestigate issues that have been established.

An individual can expect that the HCC will pursue an explanation and acknowledgement of what went wrong, and action to put the matter right. Where warranted, the HCC seeks an apology for the patient and can also recommend the healthcare provider change the way it works so that similar things don't happen again and that lessons are learnt from what went wrong. The HCC is unable to seek compensation for the complainant/patient.

Where complaints involve different aspects of care, such as a GP service and a hospital for acute care, the HCC can look at the whole of the patient's experience. The HCC works with other agencies to ensure that the complaint investigation covers the whole of the patient's experience, rather than separate investigations for different elements of a complaint. In this way it helps to avoid duplication of investigation for healthcare organisations and makes it easier for the relevant bodies to learn from complaints.

By carrying out its responsibilities for inspection and audit of healthcare, the HCC is in a position to ensure that information from complaints is used by local organisations to improve services.

Clear cases of negligence are referred to the General Medical Council.

The HCC also shares information obtained from complaints with the National Patient Safety Agency (NPSA). The NPSA is a special health authority created in July 2001 to establish a national system for identifying adverse events and near misses in healthcare by:

- gathering information on causes; and
- acting to reduce risk and prevent similar events occurring in the future.

The NPSA was established to help address the estimated 900,000 incidents (at that time) either harming or nearly harming NHS hospital inpatients in the UK each year.

As well as making sure errors are reported in the first place, the NPSA promotes an open and fair culture in the NHS and encourages the reporting of incidents and "near misses" without undue fear of personal reprimand in the knowledge that, by sharing their mistakes, others will be able to learn lessons and improve patient safety. It proactively works to develop national solutions to prevent incidents that affect patient safety and aims to discover why things go wrong, rectify incorrect actions and make it harder to do the wrong thing.

The NPSA's areas of work originate from a number of sources including individual patients, patient groups, clinical experts, healthcare professionals and coroners. Issues are also identified by a National reporting and learning system and data from other organisations in the UK and abroad.

When the NPSA identifies an issue, it builds up a complete picture using information from a number of sources. Solutions are designed in partnership with clinical experts and patients, and then piloted in NHS organisations to assess their impact. The NPSA undertakes risk assessments at every stage, evaluates the effectiveness of solutions and learns from the results. The following summarises the different stages of the NPSA process:

- understand the patient safety issue
- identify areas for solution development
- explore possible solutions
- test and refine solutions and
- monitor solutions and track progress.

5. Proposals for a new health complaints system

5.1 Shortcomings of the existing health complaints system in Queensland

The Neville investigation demonstrates a number of significant shortcomings and problems with the current health complaints system in Queensland. The system is difficult for many complainants to access and navigate. This is illustrated by the difficulties Dr Neville experienced in trying to obtain timely and appropriate outcomes from the system. Dr Neville is a medical practitioner (although his field is medical research), with highly developed research skills, and as a senior QH official, had a good understanding of the relevant systems. His travails highlight the difficulties liable to be experienced by others who attempt to use the current system without the advantages Dr Neville possessed.

The shortcomings of the current system can be summarised as follows:

- A fragmented health complaints system, involving several health complaint agencies, each with limited jurisdiction, but whose jurisdictions can overlap to varying degrees and are not well integrated. This results in:
    - inability of one agency to investigate all aspects of a complaint (for example, if the HRC investigates a complaint against a hospital it has to stop at the point where clinical competence of a registered provider becomes an issue);
    - complainants having to decide on the most appropriate agency to which to direct their complaint, or whether separate aspects of the one complaint may need to be referred to another agency or agencies for assessment, investigation and/or other action;
    - potential for duplication where a complaint has been split and a number of agencies are investigating different issues arising from the same incident;
    - annoyance for the complainant and witnesses when different agencies seek different kinds of information (relevant to the issues they have jurisdiction to investigate) at different times;
    - inability to produce one coordinated response following investigation of a complaint which has been split because different agencies have sole jurisdiction to deal with particular issues.

- A system that is not consumer-focused or user-friendly, principally because of the fragmentation referred to above, but also through:
    - lack of information by HSPs about their complaint processes;
    - a "culture" that does not welcome complaints thereby discouraging complainants for fear of reprisal;
    - "open disclosure" principles[80] not being broadly implemented;
    - lack of readily available support and advice for complainants who may require assistance in presenting and resolving their complaints with HSPs (for example, complaints coordinators in each QH Health Service District or an independent patient advocacy service).

[80] See section 5.9.2 below

- The system itself tends to foster delay through requirements for cross-referral and consultation between agencies with overlapping jurisdiction (or gaps in their jurisdiction), and because of the HRC's inability to compel a registered provider to respond to a complaint during the assessment phase. With regard to the latter, the HRC may frequently have no option but to refer a complaint to the relevant registration board (which does have coercive powers), but the registration board will only take action if it believes the matter may involve unsatisfactory professional conduct. This has a relatively high threshold test which would not be met in many instances of unsatisfactory service by HSPs.

- There is a perceived or potential lack of impartiality in registration boards, comprised of members of the relevant profession, conducting an investigation, and undertaking disciplinary action, against 'one of their own' (*cf.* recent moves to have an independent Legal Services Commissioner, rather than the Queensland Law Society Inc, take responsibility for supervision of complaints and disciplinary matters involving the legal profession).

- There is currently no provision for the centralised collection of complaints data, that could be analysed to reveal recurring problems and trends, as a basis for quality improvement measures.

5.2 Key features of a better health complaints system

A quality complaints system should be:

- accessible and user friendly to everyone, including those with special needs;
- fair and impartial in its processes;
- timely and efficient in dealing with complaints;
- committed to achieving fair remedies and promoting systemic improvements;
- accountable and transparent in its operations;
- committed to best practice and continuous improvement;
- cost effective;
- subject to periodic review.

A comprehensive coordinated system is needed for handling health complaints in Queensland. The primary means of dealing with such complaints should be the internal complaint management processes of the HSPs themselves. Each HSP should be required to implement a complaint handling procedure that complies with the Australian Standard.

In the case of QH, its internal complaint process should be enhanced as proposed at section 3.1.3 in Part 2 of this submission. That process also needs to be supplemented by appropriate procedures for encouraging and acting on PIDs and providing safeguards for those who make them, as recommended in Part 1 of this submission.

An independent body is also needed with overriding responsibility for all complaints (referred to here as "external complaints") that cannot be resolved by the relevant HSP or that are not appropriate to be resolved by the HSP. That body would deal with external complaints itself or ensure they are appropriately dealt with by another body.

In summary, this body should:

- receive and assess all external complaints about health service provision in both the public and private sectors, including complaints about registered providers, as well as non-registered providers;
- wherever possible, attempt early informal resolution of complaints, and where that is not successful, provide access to mediation and conciliation;
- investigate all aspects of the more serious complaints, including complaints about registered providers;
- refer cases warranting disciplinary action to a new disciplinary body (that would deal with disciplinary issues currently dealt with by the boards/QNC) or, in more serious cases of unsatisfactory professional conduct, to the Health Practitioners Tribunal (as is currently the position);
- be empowered to order minor remedial action for breaches by HSPs of a Code of Health Rights and Responsibilities;
- centralise the recording, collation and analysis of complaint data, so that complaint trends can be identified enabling complaint reduction measures and service delivery improvements; and
- be funded independently of QH, and report to Parliament and not to a Minister.

The focus of both internal and external complaint management should, wherever practicable, be more consumer focussed by providing complainants with ready access to informal complaint resolution processes and explanations for the causes of complaints. Furthermore, the system should focus not only on redressing the effect of poor decisions and service, but also on identifying and addressing the cause of recurring complaints and systemic failure.

Specific details of the recommended new health complaints system are set out in section 5.4, followed by reference to some other issues which should be considered in order to improve current arrangements.

5.3 Response to the BHCI proposals for a "One Stop Shop"

The BHCI has suggested that the best approach to dealing with the deficiencies in the existing public sector health complaints environment is to establish a "one stop shop" such as a Health Sector Ombudsman.

It is considered that a "one stop shop" is an appropriate model for external complaints resolution. However, the primary emphasis should be on local complaints resolution, with independent investigation, oversight and review where the matter cannot be satisfactorily resolved directly with the relevant HSP.

There should also be strong emphasis on non-adversarial complaints resolution processes, and on learning from patient complaints information to improve patient safety outcomes.

Within QH, a State-wide network of adequately resourced complaints coordinators would assist other measures referred to above for improving systems for, and outcomes from, local complaint resolution.

Local complaint resolution should be complemented by a remodelled HRC to provide a comprehensive health complaints system. Legislative amendment will be required to

empower the HRC to take a more effective and central role in resolution of complaints that cannot be resolved locally with the HSP, in improving standards of health service provision, and in professional disciplinary matters. The HRC will need additional funding if it is to perform these responsibilities effectively.

The BHCI Discussion Paper made the recommendations numbered 1-5 below in relation to the role of the Health Sector Ombudsman, and I have made comments below about those proposed functions.

1. Receive complaints from any interested party, including patients, clinical staff, administrative staff, and the general public

Adopting the approach proposed in the BHCI Discussion Paper potentially adds a further layer or step in the complaints resolution process by requiring all complaints to go first through a central bureaucracy (which would have to be substantial given the number of complaints that are currently made each year) rather than encouraging direct local resolution wherever possible in the first instance.

It is considered preferable that, as the initial response, the local complaints coordinator work with the complainant to resolve the complaint with the HSP at the local level. Part of the receipt and referral function would involve facilitating access to alternative dispute resolution mechanisms where appropriate. The matter would be escalated to the appropriate entity where necessary.

Broadening the scope of persons eligible to complain would be better dealt with by an administrative policy within public sector health services and an amendment to the HRCA that entitles health practitioners to complain.

2. Refer complaints to the appropriate authority, whether it be the hospital administration, QH, the HRC, or the MBQ

Having a Health Sector Ombudsman screen and refer complaints would require substantial resources that could be better directed to enhancing the capacity of service providers to deal effectively with complaints at the local service delivery level and for better resourcing a remodelled HRC to undertake expanded functions and to achieve better performance in terms of timeliness.

3. Monitor the investigation and handling of complaints, to ensure that they are addressed and dealt with, both fully and expeditiously

The vast majority of complaints do not require monitoring because they should be resolved quickly and easily at the local level. For those matters which cannot be resolved, a remodelled HRC should take responsibility for timely complaint resolution, and providing more resources to that body would be more a effective allocation of resources.

Public sector health complaints could be centrally monitored directly via the web based complaints management system that is currently being trialled by QH. A similar and linked system could be established by the HRC to capture complaints from the public and private health sectors that are escalated for independent investigation.

To ensure that complaints related to patient safety are appropriately monitored and investigated, another option would be to establish a statutory data collection integrating all complaints related to patient safety, as well as serious adverse and sentinel events reports. *The Health Act 1937* could be amended to create a duty for such matters to be reported by public and private health care providers and complaints management entities to the QH Information Centre. This data would then be available for research and intervention focussed on quality improvement and patient safety.

4. **Where necessary, ensure the investigation of the complaint is escalated to the appropriate level if it cannot be resolved at a lower level; and**

5. **Ensure that the complainant receives feedback regarding the outcome of the complaint**

The model proposed in this submission should satisfy recommendations 4 and 5 through reform or enhancement of existing entities, without establishing a further agency or duplicating existing systems.

These requirements could become part of an operational protocol or administrative instruction to staff employed in complaints management at the local level. In the case of both public and private sector health service organisations, the escalation of unresolved complaints could be facilitated by ensuring that complaints coordinators report directly to the Senior Manager at the health facility. In the public sector this could be monitored by the complaints management unit in QH via the web-based complaints system.

It is reasonable to expect a complainant, who is dissatisfied with the relevant HSP's attempts at local resolution, to directly refer the complaint to a remodelled HRC for independent external review. The referral process should be straightforward because the HRC would be, in effect, a 'one stop shop' at the external review stage.

In keeping with adopting a non-adversarial approach to complaints management, it is proposed that following the HRC's assessment of a matter, an attempt should be made to conciliate the complaint provided it is considered suitable for conciliation. The most recent HRC Annual Report suggests that there is already a heavy demand on these services and an associated backlog of cases, so it may not be possible to extend the availability of formal conciliation without additional resources.

Furthermore, the HRC's current practice of trying to informally resolve complaints prior to finalising its formal assessment should be continued as it is less resource intensive than conciliation under the HRCA.

5.4 Outline of the proposed health complaints system

The following outline is provided of the key features of the proposed new health complaints system.

5.4.1 In relation to QH and public sector HSPs, the system will involve a three stage complaints process, as is presently the case:

- Stage 1 - Delegated staff will resolve minor complaints at the point of service wherever possible.
- Stage 2 - More serious complaints and any unresolved minor complaints will be referred to the complaints coordinator within each Health Service District for resolution, but with monitoring and review by a central Complaints Management Unit[81].
- Stage 3 – Independent external review by a remodelled HRC, which for the purposes of this submission, is referred to as the Independent Health Services Commission (IHSC).

In addition, the Queensland Ombudsman will retain jurisdiction to review administrative action of public sector health agencies, including the IHSC, and investigate systemic issues.

5.4.2 Private sector HSPs should adopt a similar complaint management system with any necessary modifications and be subject to review by the IHSC.

5.4.3 The complaint resolution process of each HSP should be based on the current Australian Standard for Complaints Handling 4269:1995 (or as revised). This could be made a condition of their registration/licensing.

5.4.4 A "Code of Health Rights and Responsibilities" (the Code) should be developed similar to codes presently in existence in the Northern Territory, Tasmania, and New Zealand (copies provided at Appendix 3). The main function of the Code is to establish standards to assess the conduct of HSPs. The Code will provide for the consumer's right to complain about breaches of the Code.

5.4.5 To emphasis its independence, the IHSC should be accountable directly to Parliament rather than to the Health Minister and should be independent of QH in its operations and funding.

5.4.6 The jurisdiction of the IHSC should be broader than that of the HRC, particularly in the areas of assessment and investigation. The IHSC should have coercive powers to compel registered and non-registered providers to provide information and documents, at the assessment and investigation stages.

5.4.7 The IHSC should provide complainants with a "one stop shop" in that it should have jurisdiction to deal with all aspects of complaints in relation to both registered and non-registered providers, and in both the public and private sectors.

5.4.8 The IHSC should be able to accept complaints from any person, that is, not only recipients or users of health services (or their representatives), but other registered providers, including employee health practitioners complaining about health service provision by an organisation that employs them. The current measures in the HRCA[82] aimed at protecting complainants from reprisals, should be retained for the expanded class of prospective complainants.

[81] See section 3.1.3 of Part 2
[82] For example, s.64, s.142

5.4.9 Following the initial intake of a complaint, the IHSC should, in all appropriate cases, attempt early informal resolution of the complaint (that is, without detailed assessment or investigation), before a matter is assessed as to whether it is suitable for conciliation or should be referred for investigation.

5.4.10 The IHSC should have a discretion to decline to accept a complaint, or decline to take further action on a complaint, if legal proceedings have been commenced. However, the IHSC may retain the complaint if it is in the public interest to do so, for example, if the complaint raises systemic issues or the possibility of unsatisfactory professional conduct by the HSP.

5.4.11 The initial objective of the IHSC in most cases will be to attempt to resolve complaints primarily through a process of informal resolution or conciliation.

5.4.12 Where informal resolution or conciliation is not successful, the IHSC will be empowered to investigate the complaint, or to refer the investigation of less serious matters to the relevant HSP (such as a hospital with a substantial investigative capacity) or to the relevant registration board/QNC. The HSP or the board would be obliged to investigate the referral, and report to the IHSC on the investigation.

5.4.13 The IHSC should be able to undertake investigations on its own initiative.

5.4.14 Where the Commissioner, after investigation, is satisfied that a breach of the Code has occurred, the Commissioner should be able to order that simple remedies be provided, for example:

- that an explanation or apology be given;
- that the HSP take remedial action to improve systems or procedures;
- that the consumer be provided with a refund for an unsatisfactory service;
- that restitution be made for additional expenses.

5.4.15 When assessing or investigating a complaint, the IHSC should have access to relevant professional advice from a panel of clinical experts, or to legal advice.

5.4.16 The grounds for taking disciplinary action should be the same as at present, namely, conduct by a registered HSP that is "unsatisfactory professional conduct", according to the current definition in the HPPSA.

5.4.17 The Commissioner should be able to initiate disciplinary proceedings for less serious instances of unsatisfactory professional conduct before a Health Practitioners Disciplinary Committee which would be able to impose a range of sanctions on registered HSPs, including conditions or undertakings, reprimands and fines.

5.4.18 For more serious instances of unsatisfactory professional conduct, the Commissioner should be able to initiate proceedings before the Health Practitioners Tribunal which would be able to impose the same range of sanctions as the proposed Health Practitioners Disciplinary Committee with the additional power to suspend or cancel an HSP's registration, and make orders as to costs of the proceedings.

Code

The proposed model calls for a Code of Health Rights and Responsibilities to be developed, published, and given practical effect and enforceability through empowering the IHSC to investigate breaches of the Code, and, in appropriate cases, award minor remedies where a breach of the Code is established. The provisions of the Code should also provide a reference point for complaint resolution at the local level.

It is notable that ss.37-39 of the HRCA already provide for the Health Rights Commissioner to develop a Code for consideration by the Minister, although the Act is silent on what the Minister is to do after considering the proposed Code.

My inquiries have disclosed that a draft Code was developed and submitted to the then Minister for Health in 1994, but I am not aware of any further action being taken in respect of it (although I note that QH currently has a Public Patient Charter which sets out a number of specific rights and responsibilities for the benefit of public patients).

5.5 Complaint resolution by HSPs (local complaints resolution process)

It has already been noted that, under the existing scheme, a complainant must have taken all reasonable steps to resolve a complaint with the relevant HSP before the HRC will decide to take any further action. This should also be a feature of the proposed model.

Experience indicates that it is generally good practice to resolve complaints locally at the "point of service" [83]. This approach helps HSPs to maintain good relationships with their customers and encourages HSPs to take responsibility for dealing with sub-optimal service and to take an open and improvement-focused approach to customer feedback. It also recognises that many people do not want to formally complain to an external body but simply want some action taken so that "the same thing does not happen to someone else".

Local resolution involves the service provider attempting to resolve a complaint as directly and as quickly as possible, with the primary aim of addressing the complainant's concerns. Data from the UK reveals that the local resolution stage in the NHS complaints process is effective in dealing with the vast majority of health related complaints. In fact, between 96 and 98% of written complaints do not proceed beyond the local stage.[84]

Current information from QH indicates that a lesser rate of approximately 85% of complaints are resolved by frontline complaint handling. Implementation of the proposals in this submission is likely to substantially increase the incidence of local resolution of complaints.

[83] Ombudsmen commonly define complaints as "any expression of dissatisfaction". Others draw a distinction between complaints and concerns or complaints and service delivery issues.
[84] "Achieving local resolution" ICAS Resources for the Complaints Journey www.icasresources.com

Management and resolution of complaints at the point of service delivery are important elements of quality management and require an HSP to have an effective complaint handling system in place. A benefit of such a system is the identification of areas for improvement to raise the quality of service provided to the community.

An effective complaint handling system should also provide for the receipt of complaints from staff. Staff are in the best position to identify potential risks or existing problems with the quality of health services being provided. Therefore they should be able to raise these with their employer in the knowledge that they will be appropriately acted upon. This is a key aspect of quality management (see section 5 of Part 1 of this submission for proposals on enhancing protections for whistleblowers).

If a complainant is dissatisfied with the outcome provided at the local level or "point of service", then the HSP's complaints system should provide for internal review (this may not be practicable with small health practices). If an HSP does not have the capacity, or any process, for internal review, the complainant should have the right to take the complaint to the IHSC. Furthermore, an HSP should have an obligation to advise the complainant of their right to seek external review, and how to do so, where the complainant expresses dissatisfaction with:

- the outcome of local resolution and the HSP has no internal review process; or
- the outcome of internal review.

5.6 Details of proposed IHSC's process

5.6.1 Intake/Early Resolution

Where a complaint is received by the IHSC, as part of the intake process, the complainant should generally be required to demonstrate that they have attempted to resolve the matter with the HSP. There should be exceptions to this, for example, where there is an immediate risk to the health or safety of a user or consumers, or where a complaint is made by a staff member of the relevant HSP who is fearful of reprisal.

Wherever appropriate, staff of the IHSC should encourage complainants to employ alternative dispute resolution mechanisms, or directly facilitate resolution of the complaint at the local level to promote early resolution of the complaint.

The IHSC should be able to receive complaints from any person, including employees of QH or a HSP.

This jurisdiction is significantly wider than that of the HRC. It is submitted that creating an independent body capable of considering health service complaints from both consumers and persons "in the system" will enhance public confidence in the health system.

5.6.2 Assessment

The IHSC should undertake an assessment of all external complaints. This is a departure from the current process which also enables the boards to assess complaints received about their registrants.

The IHSC should give written notice of the making of a complaint, the nature of the complaint and the identity of the complainant, to the person against whom the complaint is made. However, the IHSC should have a discretion to withhold provision of the notice, or some details that would normally go in a notice, if disclosure would be likely to:

- prejudice the investigation of the complaint; or
- place the health or safety of a person at risk; or
- place the complainant or another person at risk of reprisal.

The IHSC may also seek a response/submission from the person complained about.

In certain circumstances it will also be appropriate for the IHSC to provide details of the complaint to the relevant board/QNC and invite a submission.

If, at any time, the Commissioner suspects that a complaint involves or may involve official misconduct, the Commissioner will be obliged to refer the matter to the CMC.

The Commissioner should also refer to the Ombudsman matters involving maladministration of a kind more appropriate for the Ombudsman to deal with, in accordance with protocols to be developed with the Ombudsman.

The Commissioner should have power to recommend interim action against an HSP during or immediately following assessment. For example, if the IHSC has concerns that a registrant poses a risk to patients or the public, it may recommend that the relevant registration board consider suspending, or imposing conditions on, the registrant's registration. If the board refuses to impose the recommended restrictions, the Commissioner should be empowered to apply to the Health Practitioners Disciplinary Committee for an order imposing interim conditions or suspension.

Under the existing system, the HRC has no power to recommend to a board that it take interim action against a registrant.

5.6.3 Conciliation

With the consent of both parties, matters may be referred for conciliation if considered appropriate after initial assessment by the IHSC. The HRC currently has the same power.

However, in a recent meeting with my officers, the current Commissioner adverted to a flaw in the current conciliation process in that he has no power to take action against an HSP if, during the conciliation process, it becomes evident that the HSP has been guilty of conduct that would normally attract some form of disciplinary action. This problem may be difficult to address in that, while there is a public interest in disciplinary action being taken in appropriate cases, there is also a public interest in having a conciliation process that encourages open disclosure in a confidential setting with a view to reaching a mutually acceptable outcome.

5.6.4 Investigation

The IHSC should undertake, monitor or review, the investigation of all external complaints whether the complaint relates to a registered or non-registered provider, in

a public or private health service. This will provide complainants with one centralised independent complaints body.

The registration boards would no longer conduct investigations of complaints about their own registrants, except by arrangement with the Commissioner, and subject to monitoring and review by the Commissioner. This should remove any potential or perceived "conflict of interest". This is a significant change from the existing system.

Examples of matters that would be investigated by the IHSC include:

- complaints where conciliation is not agreed to by both parties or has been unsuccessful;
- complaints raising matters of public interest or concerns about policies/practices that have broader implications for public health care;
- complaints that are not of an isolated nature but may reflect systemic problems;
- complaints that may involve cause for taking disciplinary action.

The IHSC should be able to conduct investigations informally or by exercising coercive investigative powers.

Investigators should have a mix of skills. Some should have a clinical background. Furthermore, the IHSC should engage (on sessional rates of pay) a variety of clinicians to form a panel of experts from which the IHSC may seek advice on clinical or technical issues during the assessment or investigation process.

If a report of the IHSC includes any recommendations for specific action by the HSP, the HSP should be obliged to submit advice to the IHSC outlining a plan for the implementation of the recommendations and an associated timeframe.

The IHSC should be given power to make recommendations about, or to impose some minor remedies for, breaches of the Code, for example, an apology; order to improve systems or procedures, order for restitution or a refund; an explanation to the complainant as to what went wrong and what has been done by the HSP to ensure it doesn't happen again. It may be appropriate to also provide that:

- where an investigation has resulted in disciplinary action against an HSP, the IHSC's proposed jurisdiction to award a compensatory remedy should not be exercised until after disciplinary proceedings have been finalised; and
- where a complainant commences a civil action for damages against an HSP, there should be, in any award of damages made by a court, a set-off for any compensatory award made by the IHSC.

The IHSC should be able to provide a report to a registrant's board if the Commissioner has concerns about an aspect of a registrant's conduct, although that conduct may not amount to "unsatisfactory professional conduct" (for example, unsatisfactory service attributable to impairment).

If, as a result of an investigation, the IHSC considers that disciplinary action should be taken for unsatisfactory professional conduct, such action would be taken in accordance with the disciplinary process discussed below.

The Commissioner may also wish to consult with a member of the panel of experts (or obtain other specialist advice) or seek legal advice, before making a final decision as to whether a matter should be referred for disciplinary action.

As an alternative to initiating disciplinary action before the Health Practitioners Disciplinary Committee in less serious instances of unsatisfactory professional conduct, the Commissioner should have a discretion, in appropriate cases, to accept an undertaking from an HSP (for example, to undertake additional skills training, or to perform certain health services only under qualified supervision) if the Commissioner considers that that course of action will afford satisfactory protection to consumers of health services. The Commissioner would make arrangements with the relevant registration board to supervise compliance with the undertaking(s). Breach of an undertaking should itself be a sufficient ground for disciplinary action.

5.6.5 Disciplinary action

Under the proposed scheme, the Commissioner would take over the existing role of the boards/QNC of determining whether disciplinary action should be initiated against a registered HSP.

Another model operates in New South Wales and New Zealand where the decision about whether disciplinary action should be instituted is made by a senior lawyer called the Director of Proceedings, employed by the relevant complaints commission. A summary of the role of that officer in New South Wales and New Zealand is provided in Appendix 4. It is an option that could be considered for Queensland, if it is considered that there are advantages in having the Commissioner recommend disciplinary action to a semi-independent legal expert, who would assess the available evidence, decide whether it warranted the laying of disciplinary charges, and prosecute the proceedings.

It is proposed that disciplinary proceedings be heard by:

(1) the Health Practitioners Disciplinary Committee, chaired by a legal practitioner of 10 years standing, assisted by a member of the relevant registration board, and a community representative appointed from a panel; or
(2) the Health Practitioners Tribunal chaired (as now) by a District Court judge, assisted by the Chair of the relevant registration board, and a community representative appointed from a panel.

The Health Practitioners Disciplinary Committee would hear less serious cases of unsatisfactory professional conduct. It would have power to:

- order the imposition of conditions (including limited registration or enrolment);
- obtain an undertaking from the registrant;
- impose fines (to a monetary limit or penalty units); or
- reprimand.

This Committee would also be able to impose interim suspension, or interim conditions, on a registrant pending the outcome of an investigation.

The Health Practitioners Tribunal would hear more serious matters of unsatisfactory professional conduct and have power to impose all of the above sanctions, as well as the power to:

- suspend or cancel a registrant's registration;
- make orders as to costs.

The proposed scheme does not contemplate a continued role for the Nursing Tribunal, which in 2003-2004 dealt with only eight cases (according to the QNC's Annual Report for that financial year). Its functions can be performed by the Health Practitioners Tribunal.

5.6.6 Role of the registration boards

Unless the Commissioner considers a matter is more appropriately investigated by a board, the board would not investigate a complaint against one of its registrants.

Furthermore, the board would no longer have the responsibility for making decisions about disciplinary action to be taken against their registrants. However, it is proposed that the boards would continue to undertake the balance of their existing functions, for example:

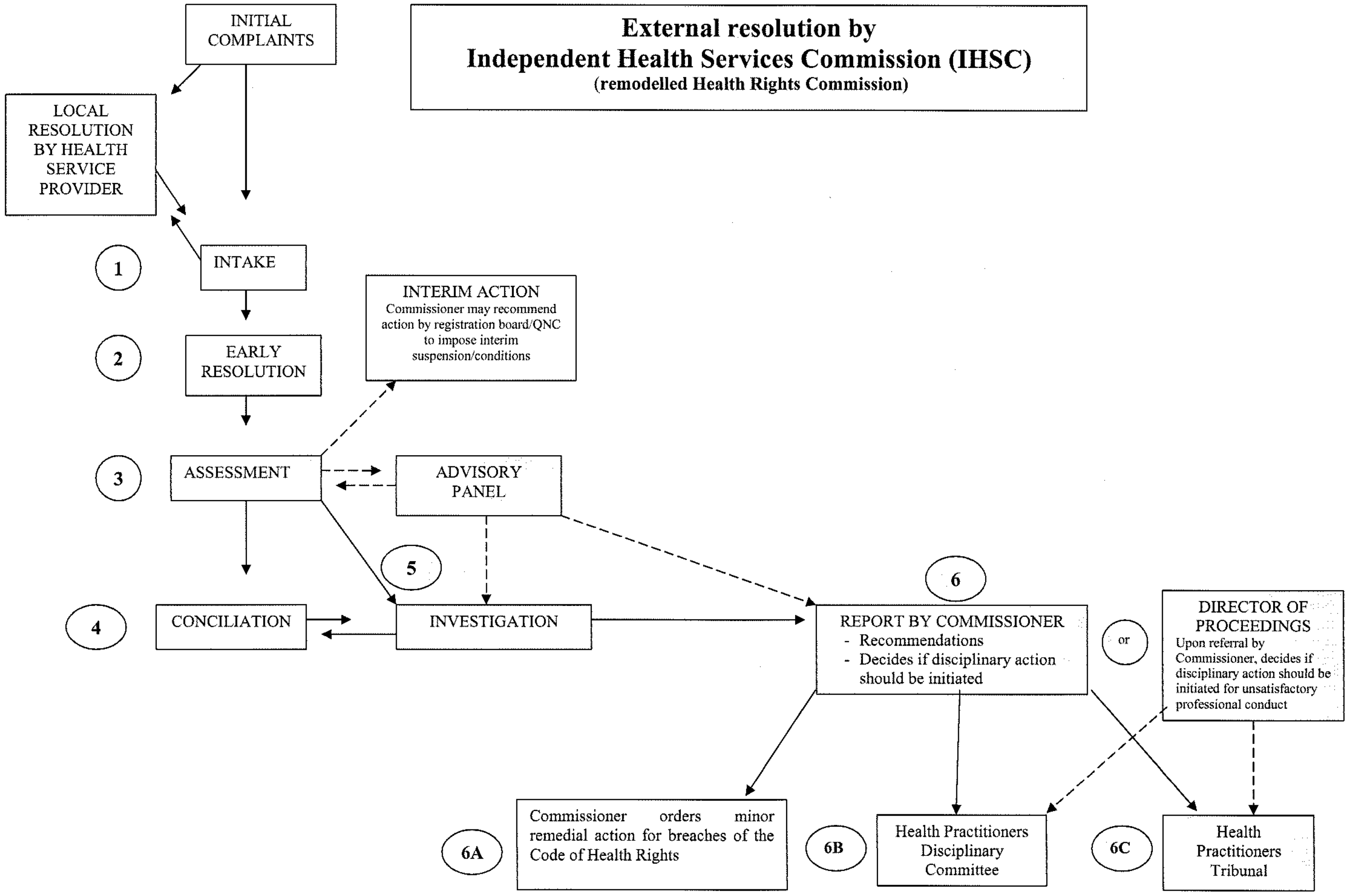
- registration and maintaining a roll of registrants;
- promoting continuing education;
- competitive regulation;
- managing impaired and self reported practitioners with health concerns;
- supervising/overseeing compliance with conditions/undertakings or other disciplinary sanctions ordered by the Health Practitioners Disciplinary Committee and Health Practitioners Tribunal, or undertakings by an HSP that are accepted by the IHSC as a suitable alternative to initiating disciplinary action before the Health Practitioners Disciplinary Committee.

5.7 Independent Patient Advocacy Services

Appendix 5 contains information about the independent patient advocacy services that operate in the UK and New Zealand. Those services assists complainants through all stages of the complaints process, and provide information about consumer rights to consumers and HSPs. It is recommended that consideration be given to whether the likely benefits of establishing an independent patient advocacy service (including whether it will facilitate high levels of complaint resolution at the local level) will outweigh the costs of establishing and maintaining such a service. In the context of the recommendations made in this submission for an improved health complaints system, a patient advocacy service should be viewed as an optional extra rather than as an essential component of the system.

5.8 Flow chart

The steps of the complaint process under the proposed new system are shown in the flow chart on the following page.


External resolution by
Independent Health Services Commission (IHSC)
(remodelled Health Rights Commission)
INITIAL COMPLAINTS
LOCAL RESOLUTION BY HEALTH SERVICE PROVIDER
1
INTAKE
2
EARLY RESOLUTION
INTERIM ACTION
Commissioner may recommend action by registration board/QNC to impose interim suspension/conditions
3
ASSESSMENT
ADVISORY PANEL
5
4
CONCILIATION
INVESTIGATION
6
REPORT BY COMMISSIONER
- Recommendations
- Decides if disciplinary action should be initiated
or
DIRECTOR OF PROCEEDINGS
Upon referral by Commissioner, decides if disciplinary action should be initiated for unsatisfactory professional conduct
6A
Commissioner orders minor remedial action for breaches of the Code of Health Rights
6B
Health Practitioners Disciplinary Committee
6C
Health Practitioners Tribunal

5.9 Other issues

5.9.1 Lack of a uniform health complaints system

There is presently no uniform system of patient complaints management across the private and public health sectors within Queensland. The *Private Health Facilities Act 1999* enables the Chief Health Officer to make standards on a wide range of matters for the protection of the health and wellbeing of patients receiving health services at private health facilities. However, the Chief Health Officer does not have authority to require private health facilities to establish patient complaints processes.

If all health consumers in Queensland are to be guaranteed access to patient complaints systems which focus on processes for local resolution, this issue will need to be addressed by legislative amendments.

Consideration should be given to amending s.12(2) of the *Private Health Facilities Act 1999* to empower the Chief Health Officer to make standards with respect to patient complaints management systems within the private health sector in order to guarantee all patients access to complaints processes that meet recognised standards.

5.9.2 Open disclosure and protection from civil liability

In July 2003, the Australian Council for Safety and Quality in Health Care (ACSQHC) introduced a National "Open Disclosure" Standard, which was endorsed by all Australian Health Ministers at the time. The Standard promotes a clear and consistent approach by Australian hospitals to open communication with patients and their nominated support person following an adverse event. "Open Disclosure" refers to open communication when things go wrong in health care. The elements include:

- an expression of regret;
- a factual explanation of what happened;
- consequences of the event; and
- steps being taken to manage the event and prevent a recurrence.

QH's *Incident Management Policy* (introduced in June 2004) states that the ACSQHC Standard on Open Disclosure is to be followed as part of the incident management of adverse events.

QH has advised that a structured piloting plan of the Open Disclosure Standard within QH is currently under development by the Safety Improvement Unit, Patient Safety Centre. In January 2005, the Australian Health Ministers reaffirmed their commitment to piloting this Standard with pilot reviews to be assessed at the Australian Health Ministers Conference in December 2006 prior to full implementation.

Queensland Health currently has five Health Service Districts that are pilot sites participating in the national pilot (Townsville, Rockhampton, Princess Alexandra, QE11, and The Royal Brisbane and Women's Hospital), with two more under negotiation.

One of the impediments to open disclosure by HSPs and individual registrants is concern about civil liability. However, in many cases, people who raise concerns about provision of health services simply want an explanation and an apology.

To encourage HSPs to provide explanations and apologies in the interests of resolving health service complaints, it is proposed that the legislation for an IHSC should include provisions making it clear that an apology provided by an HSP to a person who has (including through an agent) made a complaint directly to the HSP, or to the IHSC, does not constitute an express or implied admission of fault or liability by the HSP, and is not relevant to the determination of fault or liability in any civil proceeding brought against the HSP. Evidence of an apology should not be admissible in any civil proceedings as evidence of fault or liability of the HSP who provided the apology. The *Civil Liability Act 2002* NSW affords an appropriate model in that regard: see s.67(1), s.68(definition of apology), s.69.

It is considered that ss.69-72 of the *Civil Liability Act 2003* Qld are too restricted, compared to the New South Wales provisions. The Queensland provisions protect from admissibility in a civil proceeding only an expression of regret "to the extent that it does not contain an admission of liability on the part of the individual or someone else".

It may be preferable to amend the general provisions in ss.69-72 of the *Civil Liability Act 2003* Qld, to correspond with the aforementioned New South Wales provisions. There is no reason for limiting these recommended changes to health service complaints, as the desirability of encouraging apologies in appropriate cases is just as relevant in many other areas. However, if that does not occur, specific provisions relating to HSPs are considered necessary for the proposed new health complaints system to work efficiently and effectively.

Appendix 1: Statutory objectives of the HRC

Purpose

The purpose of the *Health Rights Commission Act 1991* is to provide independent review and conciliation with respect to services provided by health service providers to health service users and for improvements to those services.

Objectives (section 4)

The principal objectives of this Act are –

(a) to provide for oversight, review and improvement of health services by establishing an accessible, independent facility that will –
  (i) preserve and promote health rights; and
  (ii) receive and resolve health service complaints; and
  (iii) enable users and providers to contribute to the review and improvement of health services; and
  (iv) provide education and advice in relation to health rights and responsibilities and the resolution of complaints about health services, whether or not made under this Act; and
  (v) assist users and providers to resolve health service complaints; and

(b) to provide for the development of a Code of Health Rights and Responsibilities; and
(c) to provide for the appointment, functions and powers of a Health Rights Commissioner; and
(d) to provide for the establishment, functions and operation of a Health Rights Advisory Council.

Commissioner's Functions (section 10)

The functions of the commissioner are –

(a) to identify and review issues arising out of health service complaints; and
(b) to suggest ways of improving health services and of preserving and increasing health rights; and
(c) to provide information, education and advice in relation to –
  (i) health rights and responsibilities; and
  (ii) procedures for resolving health service complaints; and
(d) to receive, assess and resolve health service complaints; and
(e) to encourage and assist users to resolve health service complaints directly with providers; and
(f) to assist providers to develop procedures to effectively resolve health service complaints; and
(g) to conciliate or investigate health service complaints; and
(h) to inquire into any matter relating to health services at the Minister's request; and
(i) to advise and report to the Minister on any matter relating to health services or the administration of this Act; and
(j) to provide advice to the Council; and
(k) to provide information, advice and reports to registration boards; and
(l) to perform functions and exercise powers conferred on the commissioner under any Act.

Appendix 2: Findings and recommendations by Professor Stokes

Findings

- In January 2002 there were no protocols in place at the hospital giving guidelines on the management of paediatric head injury and neither was there in April 2004 when the Investigator visited the ED.

- It was inappropriate for a junior doctor to be working unsupervised and without proper protocols in the ED.

- The hours of work were also inappropriate for the doctor in the ED.

- The confusion by the staff over the admission or otherwise of children for observation was a major factor in the outcome of this case and the issue needs a very complete investigation by QH.

- The [Executive Director's] report was not an investigative report as no investigation was carried out nor was he asked to. Rather it was simply an "incident report".

- Sadly QH have never conducted a formal investigation into the events leading to the death of Elise nor has it conducted a "root cause" analysis. In this manner Dr and Mrs Neville have been badly served.

- QH have not responded in an appropriate manner to Elise's parents in so much that no attempt would appear to have been made to discuss with the parents issues of systems which may have failed or been inadequate.

- "Open disclosure" was difficult because of the legal framework set up to protect QH from liability and because no formal investigation was ever conducted.

- Some system improvements have been made including:
    - the appointment of a senior medical officer to the ED at Caloundra who is working on developing protocols for the management of clinical states and the training of junior staff;
    - Director of Nursing is developing training programmes for nurses in triage and has increased nursing numbers.

Recommendations

- Attempts be made to clarify with Dr and Mrs Neville the type of report the [Executive Director] wrote.

- Dr and Mrs Neville be interviewed again by the Director-General of QH for the purpose of discussing the process issues that would appear to have contributed to Elise's death and to outline the steps taken to rectify these issues in the hope of minimising risk of such a future event.

- There be an urgent review of the district ED arrangements including management and supervision of clinical care.

- QH should urgently develop and promulgate guidelines on the assessment and treatment of head injury (specifically paediatric) and ensure that education programmes are put in place for these across the health districts.

- Clinical staffing in the ED at Caloundra Hospital to be consistent, drawing resources from Nambour hospital on a rotational basis.

- The ED should be staffed by experienced 3rd or 4th year post graduate doctors who have received training in the ED before going to Caloundra.

- The district should develop clinical policies for Caloundra Hospital and medical education activities, especially for the ED staff.

- ED staff should be competent in intubation and resuscitation, especially when left without senior supervision after hours.

- A firm and stable communicative link for doctors be established between Caloundra and Nambour hospitals on a 24hr basis seven days a week. A telemedicine network would also assist with this.

- Nursing training and competency programmes should continue.

- When staffing issues become critical it may be wise to close down the ED and refer patients to Nambour Hospital.

- Consideration be given to the possibility of one of the two privately owned CT scanners in the Caloundra area to be relocated to the Caloundra Hospital.

- Current work being done to define the emergency medical systems should be expedited.

- The current retrieval systems should be enhanced by overall regional coordination.

Appendix 3: Northern Territory, New Zealand and Tasmanian Code of Health Rights

1. Northern Territory

CODE OF HEALTH RIGHTS AND RESPONSIBILITIES

INTRODUCTION TO THE CODE

The Code confers a number of rights and responsibilities on all users and providers of health and community services in the Northern Territory.

The rights and responsibilities set out in the Code are not absolute. The obligation imposed on users and providers is to take reasonable action in all circumstances to give effect to the Code.

When a complaint is made, the Commission will consider the reasonableness of the action taken by the provider, in light of the circumstances. The circumstances in a particular case may include the user's state of health or well-being and any resource constraints operating at the time.

The Code does not override duties which are set out in Territory or Commonwealth legislation.

Principle 1: Standards of Service

1. Users have a right to:
    a. timely access to care and treatment which is provided with reasonable skill and care ;
    b. care and treatment which maintains their personal privacy and dignity;
    c. care and treatment free from intimidation, coercion, harassment, exploitation, abuse or assault;
    d. care and treatment that takes into account their cultural or ethnic background;
    e. providers who seek assistance and information on matters outside their area of expertise or qualification;
    f. services provided in accordance with ethical and professional standards, and relevant legislation;
    g. services which are physically accessible and appropriate to the needs arising from an impairment or disability; and
    h. services provided without discrimination, as set out in relevant Territory and Commonwealth legislation.

Principle 2: Communication and the Provision of Information

1. Providers have a responsibility to:
    a. provide accurate and up to date information responsive to the user's needs and concerns, which promotes health and well-being;
    b. explain the user's care, treatment and condition in a culturally sensitive manner, and in a language and format they can understand. This includes the responsibility to make all reasonable efforts to access a trained interpreter;
    c. answer questions honestly and accurately;
    d. provide information about other services, and as appropriate, how to access

   these services;
   e. provide prompt and appropriate referrals to other services, including referral for the purpose of seeking a second opinion; and
   f. provide the user with a written version or summary of information, if requested.

3. Users have a responsibility, to the best of their ability, to:

   a. provide accurate and timely information, about their past care and treatment and issues affecting their condition; and
   b. inform the provider of issues that might interfere with participation in care or treatment recommended by the provider.

Principle 3: Decision Making

1. Subject to any legal duties imposed on providers, users have a right to:
   a. make informed choices and give informed consent to care and treatment;
   b. seek a second opinion;
   c. refuse care and treatment, against the advice of the provider;
   d. withdraw their consent to care and treatment, which includes the right to discontinue treatment at any time, against the advice of a provider;
   e. make an informed decision about body parts or substances removed or obtained during a health procedure. This includes the right to consent or refuse consent to the storage, preservation or use of these body parts or substances; and
2. In non-emergency situations, providers have a responsibility to seek informed consent from users before providing care and treatment by:
   a. seeking consent specific to the care and treatment proposed, rather than a generalised consent;
   b. discussing the material risks, complications or outcomes associated with each care or treatment option;
   c. ensuring the user understands the material risks, complications or outcomes of choosing or refusing a care or treatment option;
   d. where relevant, explaining the legal duties imposed on providers which prevent users from refusing a type of care or treatment, such as those imposed by the Mental Health and Related Services Act and the Notifiable Diseases Act;
   e. providing users with appropriate opportunities to consider their options before making a decision;
   f. informing users they can change their decision if they wish;
   g. accepting the user's decision; and
   h. documenting the user's consent, including the issues discussed and the information provided to the user in reaching this decision.
3. Providers have a right to treat without the user's consent where:
   a. treatment is provided in a life threatening emergency or to remove the threat of permanent disability and it is impossible to obtain the consent of the user or the user's personal representative; or
   b. treatment is authorised or required under Territory or Commonwealth legislation.
4. Where a provider reasonably considers that a user has diminished capacity to consent, the user still has a right to give informed consent to a level appropriate to their capacity.
5. Where a provider considers a user lacks the capacity to give informed consent, a provider must, except under specific legal circumstances, seek consent from a person who has obtained that legal capacity under the Adult Guardianship Act or other relevant legislation.

Principle 4: Personal Information

1. Users have a right to information about their health, care and treatment. However, they do not have an automatic right of access to their care or treatment records.
2. Providers may prevent users from accessing their records where:
   a. legislative provisions restrict the right to access information; or
   b. the provider has reasonable grounds to consider access to the information would be prejudicial to the user's physical or mental health.
3. Providers have a responsibility to protect the confidentiality and privacy of users by:
   a. ensuring that the user's information held by them is not made available to a third party unless:
      - the user gives written authorisation for the release;
      - subject to subpoena or pursuant to legislation; or
      - it is essential to the provision of good care and treatment and the provider obtains the user's consent. This may take the form of consent to share information between a treating team.
   b. providing appropriate surroundings to enable confidential consultations and discussions to take place;
   c. having policies and procedures in place, including policies relating to the storage of information, and ensuring all staff are aware of these;
   d. communicating with the user and other providers involved in their care and treatment in an appropriate manner and environment.

Principle 5: The Relationship between User and Provider

1. Both users and providers have a responsibility to treat each other with respect and consideration.
2. Providers have a responsibility to:
   a. make clear the standards of behaviour and language acceptable in the relationship between user and provider;
   b. make clear the circumstances under which they will restrict or withdraw the services they provide;
   c. advise users if and why they are unable to provide a service the user has requested; and
   d. subject to those responsibilities regarding emergency treatment, remove, or seek the removal of any person whose behaviour is considered dangerous to the provider or service users.
3. Users have a responsibility to ensure they do not endanger or deliberately put the safety of the provider or other service users at risk.
   This responsibility is extended to the user's family members, friends, carers and advocates in their interactions with the provider.
4. Providers have a right to be able to provide care and treatment free from intimidation, coercion, harassment, exploitation, abuse and assault.

Principle 6: Involvement of Family, Friends, Carers and Advocates

1. Users have a right to:
   a. involve their family, friends, carer or advocate in their care and treatment;
   b. withhold information from family members, friends and carers on their care and treatment, or request the provider do so;
   c. seek help from an advocate if required.
2. Providers have a responsibility to:
   a. respect the role family members, friends, carers and advocates may have in the user's care and treatment, and the user's right to withhold information from them; and
   b. recognise the carer's knowledge of the user and of the impact care and

treatment options may have on the user's health and well-being.

Principle 7: Research, Experiments and Teaching Exercises

1. Providers have a responsibility to:
    a. inform users if the care or treatment offered to them is experimental or part of a teaching or research exercise, of its functions and aims, and of their avenues for complaint;
    b. inform users they can withdraw from the research, experiment or teaching exercise at any stage; and
    c. accept the user's refusal to take part in research, experiments and teaching exercises.

Principle 8: Complaints and Feedback

1. Providers have a responsibility to:
    a. provide a mechanism for users to give feedback or make complaints about their care and treatment;
    b. inform users of the complaint process and of how to make a complaint;
    c. ensure that complaints are dealt with in an open, fair, effective and prompt manner, and without reprisal or penalty; and
    d. provide users with information about external complaint resolution mechanisms and advocates.
2. Users and providers have a responsibility to be fair, truthful and accurate when making or responding to a complaint.

2. New Zealand

The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996

1. Consumers have rights and providers have duties

1) Every consumer has the rights in this Code.
2) Every provider is subject to the duties in this Code.
3) Every provider must take action to -
   a) Inform consumers of their rights; and
   b) Enable consumers to exercise their rights.

2. Rights of consumers and duties of providers

The rights of consumers and the duties of providers under this Code are as follows:

RIGHT 1
Right to be Treated with Respect

1) Every consumer has the right to be treated with respect.
2) Every consumer has the right to have his or her privacy respected.
3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 3
Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5

Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

RIGHT 6

Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
   c) Advice of the estimated time within which the services will be provided; and
   d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
   e) Any other information required by legal, professional, ethical, and other relevant standards; and
   f) The results of tests; and
   g) The results of procedures.
2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.
3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about -
   a) The identity and qualifications of the provider; and
   b) The recommendation of the provider; and
   c) How to obtain an opinion from another provider; and
   d) The results of research.
4) Every consumer has the right to receive, on request, a written summary of information provided.

RIGHT 7

Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.
2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.
3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.
4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -
   a) It is in the best interests of the consumer; and
   b) Reasonable steps have been taken to ascertain the views of the consumer; and
   c) Either, -
      i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the

services is consistent with the informed choice the consumer would make if he or she were competent; or
    ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

5) Every consumer may use an advance directive in accordance with the common law.
6) Where informed consent to a health care procedure is required, it must be in writing if -
   a) The consumer is to participate in any research; or
   b) The procedure is experimental; or
   c) The consumer will be under general anaesthetic; or
   d) There is a significant risk of adverse effects on the consumer.
7) Every consumer has the right to refuse services and to withdraw consent to services.
8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.
9) Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.
10) No body part or bodily substance removed or obtained in the course of a health care procedure may be stored, preserved, or used otherwise than
   (a) with the informed consent of the consumer; or
   (b) for the purposes of research that has received the approval of an ethics committee; or
   (c) for the purposes of 1 or more of the following activities, being activities that are each undertaken to assure or improve the quality of services:
      (i) a professionally recognised quality assurance programme:
      (ii) an external audit of services:
      (iii) an external evaluation of services.

RIGHT 8

Right to Support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.

RIGHT 9

Rights in Respect of Teaching or Research

The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

RIGHT 10

Right to Complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.
2) Every consumer may make a complaint to -
   a) The individual or individuals who provided the services complained of; and
   b) Any person authorised to receive complaints about that provider; and
   c) Any other appropriate person, including -
      i. An independent advocate provided under the Health and Disability Commissioner Act 1994; and
      ii. The Health and Disability Commissioner.
3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.
4) Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.

5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.
6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -
   a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and
   b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of -
      i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and
      ii. The Health and Disability Commissioner; and
   c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and
   d) The consumer receives all information held by the provider that is or may be relevant to the complaint.
7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, -
   a) Decide whether the provider -
      i. Accepts that the complaint is justified; or
      ii. Does not accept that the complaint is justified; or
   b) If it decides that more time is needed to investigate the complaint, -
      i. Determine how much additional time is needed; and
      ii. If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.
8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of -
   a) The reasons for the decision; and
   b) Any actions the provider proposes to take; and
   c) Any appeal procedure the provider has in place.

3. Provider Compliance

A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

The onus is on the provider to prove it took reasonable actions.

For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

4. Definitions

In this Code, **"Advance directive"** means a written or oral directive:

(a) By which a consumer makes a choice about a possible future health care procedure; and
(b) That is intended to be effective only when he or she is not competent.

"Choice" means a decision:

(a) To receive services.
(b) To refuse services.
(c) To withdraw consent to services.

"Consumer" means a health consumer or a disability services consumer; and, for the purposes of rights 5, 6, 7(1), 7(7) to 7(10), and 10, includes a person entitled to give consent on behalf of that consumer.

"**Discrimination**" means discrimination that is unlawful by virtue of Part II of the *Human Rights Act 1993.*

"**Duties**" includes duties and obligations corresponding to the rights in this Code.

"**Ethics committee**" means an ethics committee :

(a) established by, or appointed under, an enactment; or
(b) approved by the Director-General of Health.

"**Exploitation**" includes any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence.

"**Optimise the quality of life**" means to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances.

"**Privacy**" means all matters of privacy in respect of the consumer, other than matters of privacy that may be the subject of a complaint under Part VII or Part VIII of the Privacy Act 1993 or matters to which Part X of that Act relates.

"**Provider**" means a health care provider or disability services provider.

"**Research**" means health research or disability research.

"**Rights**" includes rights corresponding to the duties in this Code.

"**Services**" means health services, or disability services, or both; and includes health care procedures.

"**Teaching**" includes training of providers.

5. Other Enactments

Nothing in this Code shall require a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment.

6. Other Rights

An existing right is not overridden or restricted simply because the right is not included in this Code or is included only in part.

2. The Tasmanian Charter of the Rights & Responsibilities of Health Service Users and Providers (currently under review)

Charter of the Rights and Responsibilities of Health Service Users and Providers

The Charter of Health Rights and Responsibilities has been developed following consultation with health service users, referred to as consumers in this Charter, and health service providers.

When viewed as a partnership, the relationship between the health service consumer and the health service provider is more likely to benefit the health outcomes of the service consumer. While the health service provider has a responsibility to meet certain rights of the health service consumer, the consumer in turn, should also assume some responsibility for their own health care.

This Charter is intended to be used as a guideline to maintain the balance of rights and responsibilities, and strengthen the relationship between, health service users and health service providers.

Who is covered by the Charter?

The Charter is in place for any person who gives or receives a health service including those who are under age or whose capacity to be self determining is limited. Under the Health Complaints Act 1995, someone who is not yet 14 years of age is considered to be under age.

The parent or guardian of a child who has not attained the age of 14 years, claims the rights and responsibilities listed in this Charter on behalf of that child. Similarly, if the carer of a person with limited capacity has guardianship in the area of health care, they too can claim the rights and responsibilities listed in this Charter on behalf of that person.

Do the rights described in the Charter always apply?

Sometimes health service providers may not be able to meet all of the rights of the health service consumer. Similarly, consumers may not always be in a position to meet all of the rights of the provider. However, both providers and consumers should always do what they reasonably can under the circumstances.

What services are covered by the Charter?

The *Health Complaints Act 1995* sets out the requirement for a Charter of Health Rights. Under Schedule 1, Part 1 the Act also describes services that are recognised as health services for the purpose of the Act. These services are covered by the Charter.

1. A service provided at a hospital, health institution or nursing home.

2. A medical, dental, pharmaceutical, mental health, community health, environmental health or specialised health service or a service related to such a service.

3. A service provided in association with the use of premises for the care, treatment or accommodation of persons who are aged or have a physical disability or mental dysfunction.

4. A laboratory service provided in support of a health service.

5. A laundry, dry cleaning, catering or other support service provided to a hospital, health institution, nursing home or premises referred to in item 3, if the service affects the care or treatment of a patient or resident.

6. A social work, welfare, recreational or leisure service, if provided as part of a health service.

7. An ambulance service.

8. Any other service provided by a provider, for or purportedly for, the care or treatment of another person.

9. A service provided by any of the following:

   - audiologist;
   - audiometrist;
   - optical dispenser;
   - dietitian;
   - prosthetist;
   - physiotherapist;
   - dental prosthetist;
   - psychotherapist;
   - radiographer;
   - podiatrist;
   - therapeutic counsellor; or

   any other service of a professional or technical nature provided for, or purportedly for, the care or treatment of another person or in support of a health service.

10. A service provided by a practitioner of massage, naturopathy or acupuncture or in another natural or alternative health care or diagnostic field.

11. The provision of information relating to the promotion or provision of health care or to health education.

12. Any other service provided by a person registered by a registration board.

RIGHT 1: ACTIVE PARTICIPATION IN HEALTH CARE

The Rights of the Health Service Consumer

The health service consumer has the right to take an active role in his/her own health care. This role includes making decisions about his/her own health care and being responsible for those decisions.

- The health service consumer has the right to choose a health service provider subject to several conditions including the treatment required and whether the consumer is a public or private patient.

- The right to be provided with information enables the consumer to make informed decisions about his/her own health care. This information might include:

  ◊ diagnosis, the possible nature of the illness or disease;
  ◊ test results and their implications;
  ◊ the approach to proposed treatment or further investigation as well as,
    a) what that entails;
    b) the expected benefits;
    c) any likely side effects that may occur;
    d) any recognised risks associated with that investigation and/or treatment;
  ◊ other options for investigation and/or treatment;
  ◊ the likely consequences of any treatment option available;
  ◊ the likely consequences of not having any particular treatment or procedure;
  ◊ an estimate of the costs of any particular treatment or procedure or other health service fees; and
  ◊ advice regarding additional services, facilities and support groups.

  This information should be presented in a way to best ensure the consumer's understanding. The information should be simple and straightforward. If necessary diagrams, models or other visual aids should be used.

  Those with physical or intellectual limitations such as visual, auditory or verbal difficulties and those who have other difficulties with language or communication have the right to be offered alternative means of information dissemination. These alternatives may include, among others, interpreters and/or translation services, large print or audio tapes. In theses cases and where a health service consumer has limited capacity, information can be provided to a guardian or person authorised by the consumer.

- The right to feel comfortable and at ease and be encouraged to take an active role in his/her own health care in being consulted about options and by participating in decisions.

- The right to take notes, ask questions and expect honest, comprehensive and direct answers in order to clarify information provided by health service providers.

- The right to take sufficient time to absorb and consider information, seek advice and additional information from other sources, and discuss issues with family, friends and supporters.

  It may not always be possible to fully exercise this right particularly in emergency situations where there is often little time to consult and consider.

- The right to not only be informed by the provider about his/her condition and options, but to offer suggestions and feedback and discuss these with the provider.

- The right to choose any treatment option available and have the provider respect that decision, even if they prefer a different option.

  It is important to note that the provider is not required to provide any treatment with which he/she does not agree and has the right to withdraw from the provision of treatment.

- The right to grant, withhold or withdraw consent for treatment or performance of a procedure at any time.

The Rights of the Health Service Provider

- The provider has the right to inquire about all aspects of the health of the consumer so that he/she is able to provide the highest level of quality health care possible. The information about which the provider might inquire includes:

  ◊ condition, symptoms and health history;
  ◊ outside factors that may impact on health care provision such as work, sport, family, home life and life style choices;
  ◊ changes to circumstances;
  ◊ expectations of the provider;
  ◊ outcomes for health and well-being; and
  ◊ the level of involvement the consumer wants in making decisions about his/her own health care.

  The provider has the right to have this information presented openly, with honesty and in a straightforward manner.

- The right to be told if the consumer does not understand the information provided or if he/she would like more information.

- The right to be informed if the consumer is consulting, or receiving treatment from, another health care provider.

- The right to be informed if the consumer is unable or unwilling to proceed with any care or treatment.

- The right to express any concerns if he/she does not agree with a decision made by the consumer about his/her health care, and have those concerns acknowledged.

- The right to withdraw from the provision of care if the consumer elects to proceed with an option for health care about which the provider expresses concerns.

- The right to be given notice if the consumer is unable to attend an appointment.

RIGHT 2: INDIVIDUALISED SERVICE THAT IS FREE FROM DISCRIMINATION

Discrimination generally refers to unfair or less favourable treatment of a person based on a range of personal attributes or criteria that might include gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation, political belief or activity, cultural belief or activity, situation, circumstance, economic or social status.

The Rights of the Health Service Consumer

- The health service consumer has the right to receive health services regardless of gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation,

political belief or activity, cultural belief or activity, situation, circumstance, economic or social status.

- The right to receive health services where the values and beliefs and associated judgements, attitudes, opinions and behaviours of the provider in relation to the areas listed above, do not impact on the provision of care.

- The right to receive health services free from any harassment, exploitation, abuse, deception, assault or fraud.

- The right to receive health services free from physical intimacy unrelated to the health service or medical treatment and free from unwarranted attention of a sexual nature.

- The right to be treated with dignity, courtesy and respect.

- The right to receive health services where the needs, wishes and background of the consumer are known, and considered in the provision of his/her health care.

- The right to withdraw from service provision if the provider behaves in an unacceptable way or places the consumer under duress.

The Rights of the Health Service Provider

- The provider has the right to request information about the consumer's background, needs and wishes so that he/she can consider the impact of these on the provision of health care, for example:

    ◊ if the consumer feels that his/her gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation, political belief or activity, cultural belief or activity, situation, circumstance, economic or social status will have an impact on his/her health or provision of care, the consumer should inform the provider.

- The right to be informed if the needs or wishes of the consumer are not being met or if the provider has been intrusive, insensitive or inconsiderate of the background of the consumer.

- The right to be informed if the consumer wishes to seek a second opinion.

- The right to expect reasonable courtesy and respect from the consumer.

- The right to provide health services free from any harassment, exploitation, abuse, deception, assault or fraud.

- The right to refuse to provide a health service if he/she has a conscientious or other objection.

  In these circumstances the provider should refer the consumer to another provider who may be able to provide the service or to a support group or organisation who can assist the consumer in seeking appropriate service provision.

- The right to refuse service if the consumer behaves in a threatening or unacceptable way or places the provider or those working with the provider under duress.

RIGHT 3: CONFIDENTIALITY, PRIVACY AND SECURITY

The Rights of the Health Service Consumer

- The health service consumer has the right to have his/her personal health information and any matters of a sensitive nature kept confidential.

  No identifying information about the consumer, his/her condition or treatment may be disclosed without his/her consent unless the disclosure is required or authorised by law.

  In some cases, the provider is legally required to disclose health issues under mandatory reporting requirements or in the public interest.

- The right to be informed if the provider is required to disclose information about his/her health due to mandatory reporting requirements or in the public interest.

- The right to know who may have access to his/her personal health record, within the bounds of confidentiality.

- The right to know what sort of information is kept on his/her health record.

- The right to nominate another person who may receive information about the consumer's health status and care. This person does not necessarily have to be a next of kin.

- The right to have information about his/her health status and care passed on to another provider, at his/her request.

- The right to expect that staff of health service facilities are bound by confidentiality agreements, and will be disciplined if these agreements are breached.

- The right to health service facilities which ensure his/her privacy when receiving health care.

- The right to be treated with sensitivity as regards his/her confidentiality and privacy.

- The right to expect that information about his/her health is kept securely and cannot be easily accessed by unauthorised persons.

  Any record that contains personal information about the consumer's health should not be left in reception areas or treatment rooms. When the provider or another authorised person does not have a file, it should be stored securely. The same applies to computer or electronic records.

  Similarly, health service providers should not talk about consumer's health or care where other unauthorised persons can overhear them.

The Rights of the Health Service Provider

- The provider has the right to discuss the health care and treatment of a consumer with other providers for advice and support, in the best interest of the consumer's health and well-being.

RIGHT 4: ACCESS TO COMPLAINTS MECHANISMS

The Rights of the Health Service Consumer

- The health service consumer has the right to complain about health services and health service providers if he/she has reason to be dissatisfied with the service that he/she has received.

- The right to be informed about complaints procedures.

  Complaints procedures might be internal to the health service that the consumer has been using or external like the Registration Boards or The Health Complaints Commissioner.

- The right to access complaints procedures that are easy to use.

- The right to have his/her complaint dealt with promptly, fairly and without any adverse effect or discrimination arising as a consequence of having made a complaint.

The Rights of the Health Service Provider

- The provider has the right to be made aware of complaints about him/her or the service provided.

- The right to have a complaint against him/her, lodged with the appropriate authority in accordance with established complaints procedures with supporting documentation as required.

  An appropriate complaints procedure might be internal to the health service or a Registration Board, or the Office of the Health Complaints Commissioner.

- The right to be made aware of the outcomes the consumer would like to achieve in making his/her complaint.

RIGHT 5: CARERS

The Rights of Carers

The relationship between the health service consumer and the provider is the primary relationship. While those who provide care for health service consumers have rights and responsibilities as part of their role as carer, their rights are secondary to the rights of the health service user in the consumer/provider relationship. However, carers have the right to be treated with respect.

The parent/s of a child under 14 years of age is not considered to be a carer. However, the carer of a person with limited capacity for self determination does possess the rights listed in this section.

- Carers have the right to have their particular knowledge about the person in care considered and included in the health service provision for the person in care.

- Carers have the right to be involved in care planning and delivery, especially where it impacts on their role as carer.

- Carers have the right to information about the care of the health service user, support services and equipment, including support services and training for themselves as carers.

The Rights of the Health Service Provider

- The provider has the right to be informed when changes in the health status, circumstances, needs or treatment outcomes of the consumer impact on his/her health or treatment.

RIGHT 6: THE CONTRIBUTION OF THE HEALTH SERVICE PROVIDER

The Rights of the Health Service Provider

- The provider has the right to be acknowledged for their contribution to health care and their commitment to providing quality care.

- The right to recognition and respect for the level of training undertaken by providers and for the knowledge, skills and experience providers bring to the provision of consumer's health care.

- The right to expect that the advice provided and the treatment he/she dispenses will be considered and followed, and if this is not possible or does not occur, he/she will be informed.

- The right to feedback on the health services provided including positive and negative comment where appropriate or necessary.

  This might include participating in evaluation exercises or questionnaires about services.

- The right to reasonable expectations from consumers about the level of care and treatment that can be provided.

  Consumers should realise and acknowledge the limitations of health services and health service providers. For example, consumers may have to wait to receive service, attend a different provider or be referred.

- The right to expect consumers to pay accounts promptly or if there is any difficulty in doing so, to discuss the matter with the provider.

Appendix 4: Director of Proceedings

New South Wales Model

The function of determining whether a complaint should be prosecuted before a disciplinary body and by whom (that is, by the Commission or some other person or body for prosecution) is undertaken by the **Director of Proceedings** (s.90B HCCA). If the Director determines that a complaint should be prosecuted before a disciplinary body by the Commission, the Director will prosecute the complaint. The Director does not exercise any other function of the Commission other than this function and is not subject to the direction and control of the Commissioner in dealing with any particular complaint that has been referred by the Commissioner to the Director for consideration. Criteria for determinations of the Director include:

- the protection of the health and safety of the public;
- seriousness of the alleged conduct the subject of the complaint;
- the likelihood of proving the alleged conduct;
- any submissions by the HSP.

New Zealand Model

Director of Proceedings is an independent statutory officer appointed under the *Health and Disability Commissioner Act 1994* and is a lawyer. Although the Director may provide representation or assistance to complainants in any forum (for example, a court, tribunal, inquiry), the primary focus is on disciplinary proceedings or proceedings before the Human Rights Review Tribunal.

In certain circumstances where the Commissioner forms the opinion that a breach of a consumer's rights has occurred, the Commissioner may refer the case to the Director of Proceedings. The Director reviews the Commission's file and makes an independent decision whether or not to take any further action. The Director can lay a disciplinary charge before the Health Practitioners Disciplinary Tribunal, issue proceedings before the Human Rights Review Tribunal or both. A team of lawyers and assistants work with the Director in reviewing files and prosecuting cases.

Appendix 5: The Independent Patient Advocacy System in the UK and New Zealand

The Patient Advocacy System as it operates in other jurisdictions such as the UK and New Zealand, functions as an independent service funded via grants from the National Health Service (NHS) to existing community based organisations or, as in the case of New Zealand, via staff contracted by the Health and Disability Commissioner (HDC). In New Zealand, there is a total of 26 equivalent full-time staff working throughout the country, and in the UK, there is a total of 180 full time equivalent staff. In both instances, independent Patient Advocates operate in *tandem* with the network of Complaints Coordinators employed by health service providers.

The rationale for establishing these services was to intervene to resolve complaints as early as possible, address the perceived power imbalance which exists between health service providers and complainants and to ensure that the public have access to an independent support service to assist them through all stages of the complaints process.

Both the UK and the New Zealand systems are premised upon the assumption that local complaint resolution is always the preferred approach and should be achieved wherever possible. In the UK, data indicates that approximately 97% of health complaints do not proceed beyond the stage of local resolution.[85] In New Zealand, the HDC reported that in 2004 approximately 85% of complaints were resolved locally with advocacy assistance, or as a result of the consumer's own action after advocacy, and on average only 4% were escalated to formal complaints with the HDC.[86]

In both countries presently using this model, the Patient Advocate requires that in the first instance, complainants who are able to, must take up their complaint directly with the service provider in order to attempt to sort out their concern. Only if complaints are unable to be resolved locally with the HSP, do complaints proceed to external review. Patient Advocates help clients identify the options for taking forward their complaints. This may include coaching consumers to handle the issue themselves (where appropriate), an option that a number of consumers appreciate. Many say that once they have the options explained to them, they are able to "get on with it". Patient Advocates also make sure lessons from users' experiences arising from the complaint are fed back into the service and to those responsible for scrutinising the delivery of health care services.

UK Patient Advocates do not assist clients who want to commence, or who are already involved in, litigation against a HSP, nor do they directly investigate complaints.

Patient Advocates in the UK encourage local complaint resolution in order to provide prompt investigation and resolution of the complaint at local level, aiming to satisfy the complainant and be fair to staff. A verbal response or explanation from the HSP is often the best way of resolving concerns quickly. An advocate may assist a complainant by meeting with or writing to HSPs, accessing medical records or other information related to the health service, or formulating a formal complaint.

In the UK, the NHS complaints reforms aim to change attitudes to complaints so they are integral to clinical governance and service improvement. There, Patient Advocates attempt to differentiate at the outset between complaints which are relatively minor in nature and relate to purely "personal grievance" matters and those which have a relevance to "clinical governance", that is, those that might indicate that a health professional has placed a patient at risk or has delivered a poor standard of care.

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[85] ICAS Resources for the Complaints Journey http://www.icasresources.com/reviewoptions2.html
[86] NZ HDC 2004 Annual Report p.13. http://www.hdc.org.nz/files/pagepublications/report2004.pdf

Patient Advocates generally attempt to ensure "personal grievance" complaints are addressed by way of conciliation and mediation to restore, if possible, the relationship of trust between the health professional and the complainant. However Patient Advocates are likely to encourage more formal consideration of "clinical governance" complaints, so that the health service concerned can address the issues raised as part of its clinical governance responsibilities.

In the UK, when Patient Advocates consider that there is a serious risk to patient safety or there is clear evidence of malpractice, the advocate, with the advice of their line manager, will work with the complainant to identify how the complaint can be dealt with as promptly and thoroughly as possible, preferably via more formal processes.

Those who support the Patient Advocate concept argue that the Patient Advocate plays an important role in making the system more accessible, enhancing public confidence in the fairness of the process and improving trust in the complaints resolution system. Citing the results of its 2004 survey of complainants who used its investigation services, the New Zealand HDC observed that only 46% of complainants were satisfied overall with the fairness of the process (in contrast to 80% of providers), although interestingly in the HDC's 2003 evaluation of customer satisfaction the parties surveyed who had experienced advocacy, reported much higher levels of satisfaction (over 86% of complainants *and* providers).[87]

In its 2004 Annual Report, the New Zealand HDC observed that the number of new complaints remained fairly static (1,142 compared to 1,159 in the previous year), but the Office made considerable progress in clearing the backlog of open files. The HDC considered this progress could be attributed to the "greater use of advocacy and intervention by HDC's complaints assessors, improving the speedy low-level resolution of complaints." Therefore, despite concerns that patient advocacy systems entrench adversarial processes, are unpopular with HSPs and unnecessarily complicate health complaints resolution systems, the New Zealand experience suggests that this may not be correct.

Should a similar independent patient advocacy model to the New Zealand or UK systems be adopted in Queensland with a comparable level of service provision, it is estimated that 28 EFT (A06) Patient Advocates would be required State-wide plus a State-wide coordinator (A08) and administrative support officer (A03).

As mentioned earlier, until March 2005, the New South Wales Health Care Complaints Commission provided an advocacy role for complainants but lost that role when it took on its alternative complaints resolution role.

[87] NZ HDC 2004 Annual Report p.1 http://www.hdc.org.nz/files/pagepublications/report2004.pdf

Submissions

Ms Leonie RAVEN

Crown Law
Queensland Government

Department of
Justice and Attorney-General

Your ref:
Our ref: CS5/HEA027/5744/DZP
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3 November 2005

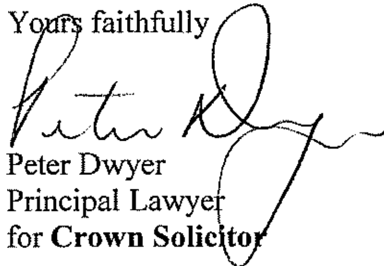
Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry
Level 9, Brisbane Magistrates Court
363 George Street
BRISBANE QLD 4000

Dear Mr Groth

Response on behalf of Leonie Raven

I **enclose** a response on behalf of Ms Leonie Raven, Queensland Health to the further submission of the Queensland Nurses' Union dated 1 November 2005. The response was drawn by Mr Farr of Counsel.

Yours faithfully



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RESPONSE ON BEHALF OF LEONIE RAVEN TO THE QUEENSLAND NURSES' UNION SUBMISSION OF 1st NOVEMBER 2005

1. Leave is sought to allow the acceptance of this further submission. It arises only as a result of a submission made on behalf of the Queensland Nurses Union (QNU) on 1st November 2005 which did not comply with the Commissioner's directions of 20th October 2005.

2. In "footnote 2" in the QNU's submission the general credibility of Ms Leonie Raven is attacked.

3. That attack did not comply with the Commissioner's directions in that it is not in any way responsive to an adverse submission from another party. This attack upon Ms Raven's credibility amounts to no more than gratuitous criticism which should be disregarded by the Commissioner due to:-

   (a) that non-compliance; and

   (b) its non specificity.

4. Furthermore, in paragraph 2(b) of that submission, the QNU argue that the evidence of Ms Raven is incorrect insofar as it relates to the non-downgrading of the Sentinel Event form regarding the death of Mr Bramich.

5. Such a submission is plainly wrong. The evidence of Ms Raven on this topic was:-

- she was not working at the time of this incident;

- her subsequent inquiries revealed that the Adverse Event form and the Sentinel Event form, both of which related to Mr Bramich, were stapled together inadvertently;

- the Sentinel Event form was nevertheless forwarded onto the District Manager and the Director of Medical Services as required, for their attention and action;

- whilst the records generated by her unit failed to record the Sentinel Event form due to the earlier administrative error, the form was still actioned appropriately.

6. Such evidence is entirely consistent with the subsequent evidence of Mr Leck[1] and Dr Keating.[2]

7. It is submitted that the evidence of Ms Raven on this topic should be accepted.

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[1] Statement of Leck, Exhibit 463, paragraph 31-41.
Evidence: T7167/50 - 7169/50; T7288/45 - 7289/36.

[2] Statement of Keating, Exhibit 448, paragraphs 132-160.
Evidence: T6998/10 - 7000/13.

Submissions

Dr John SCOTT

QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

FURTHER SUBMISSIONS ON BEHALF OF JOHN SCOTT

These submissions are made in response to the potential adverse findings notified to Dr Scott in a letter dated 18 October 2005 from the Queensland Public Hospitals Commission of Inquiry. They are supplementary to our previous submissions of 7 October 2005 (misdated September). The potential adverse findings are reproduced in bold below, with our submissions following immediately below each of them.

The introductory words to the list of potential adverse findings are: **With respect to your tenure as the General Manager of Health Services for Queensland Health that:**

Dr Scott was appointed to act as Senior Executive Director Health Services in November 2003; he was on long service leave from July to October 2004; appointed as SEDHS in November 2004, and his employment was terminated in July 2005. He acted as General Manager Health Services for some time after November 2003 - see the CV which is "JGS1" to his statement , ex 317, and paragraph 1.6 of that statement.

(a) **Following Dr Aroney writing to the Premier on 16 December 2003, in the company of Mr Dan Bergin and Dr Andrew Galbraith, you met with Dr Aroney on 8 January 2004 and commented to Dr Aroney that if he made further comments about Queensland Health in the media, then Queensland Health would respond in kind. The Commission may find that these comments were a threat of reprisals against Dr Aroney if he made any further disclosure or complaint about the provision of cardiac services at the Prince Charles Hospital.** (Underlining added)

1.1 It is wrong to say that the meeting of 8 January 2004 followed the sending of the letter of 16 December 2003 because it gives a false impression that the first thing caused the second. In a causal sense, the meeting followed Dr Aroney's decision to go to the media with his allegations about cutbacks and deaths. This is clear from Dr Aroney's statement ex 263 – paragraphs 17-23 (attachment A). Indeed, it was Dr Aroney's view that there was no response

at all to his letter to the Premier. That is why he decided to go to the media. The meeting was organised, according to Dr Aroney, as a result of his going to the media – see paragraph 23 of his statement.

1.2 Second, the comment with which the Commission is concerned is responsive to Dr Aroney's use of the media, not his writing to the Premier. So much is accepted in the potential finding notified – see the first underlined part of the passage above. For this reason we will not direct the Commission specifically to the evidence about this, unless we hear further from the Commission. However, we note that the assumption in the first underlined part of the passage above accords with the evidence of both Dr Aroney and Dr Scott, for instance see t 6261 l30: *"I was very taken aback when Dr Scott launched into me at the meeting to intimidate me and shut me up. Obviously angry about the public disclosures and seeking to keep me solely from then onwards."* [sic]

1.3 The comment made by Dr Scott was, as is assumed in the second underlined part of the passage above, about Dr Aroney's use of the media. Dr Scott says at paragraph 19.12 of his statement, ex 317, (attachment B), *"What I intended to convey was that if Dr Aroney continued to criticise QH in the media, that we would respond to any allegations he made."* This is the natural meaning of the words in the context which Dr Aroney has them in his notes of the meeting, see "CA6" (attachment C) where the comment follows directly upon Dr Aroney's saying that he will continue to report deaths, the very thing which has provoked the meeting. Again, unless we hear otherwise from the Commission, we will assume that, in accordance with the second underlined part of the passage above, the Commission takes this view of the meaning of the comment with which it is concerned.

1.4 It would therefore be wrong to find that a comment which is to the effect that, *"If you want to debate these matters in the media then we will too"* is a threat or a threat of reprisal. Dr Aroney says he was frustrated by a lack of response to his using more conventional channels to put his points of view. There are things that might be said about that, but accepting that view for the

purpose of these submissions, Dr Aroney has decided to *"up the ante"* and go to the media. He is told that if he wishes to debate matters that way, QH will too.

1.5 If the Commission is concerned that the exchange on 8 January 2004 is an illustration of difficulties in communication between clinicians and QH administrators, then, subject to what is said at 1.6 -1.11 below, so be it. However, it would be would be wrong to make any finding as regards that in terms of *"threat"* or *"reprisal"* because these words have specific legal meanings, particularly in the context of the *Whistleblower's Protection Act 1994*, and the factual circumstances here do not amount to conduct which falls within the terms of that Act – what Dr Aroney was doing in terms of his use of the media does not amount to conduct which is protected under that Act, indeed the Act concerns itself with ensuring that disclosure takes place in a balanced and responsible way and forum (ss 7(2) and 10 of that Act).

1.6 On 8 January 2004 two senior medical men lost their tempers with each other and had an argument – see Mr Bergin tt 6059-6060 (attachment D). Dr Aroney made a note after the meeting and it records the comment with which the Commission is concerned. Dr Aroney made angry comments too - t 6261 ll1-11. Dr Scott did not bother to record them. Personality factors no doubt intruded. Dr Aroney is prepared to make scandalous allegations on the basis of extremely flimsy evidence – see paragraph 8 of our previous submissions. He is also, as he illustrated both in his statement, and his evidence, prepared to make allegations that most people find very offensive – eg., that people – variously Mr Bergin, Ms Wallace and Dr Scott – didn't care about people dying on waiting lists –tt 6257 l 50; 6259. He was, and still is, of the view that senior administrators, like Dr Scott, didn't *"stand up"* and ensure the health system operated in a better way –t 6252. He is incapable of seeing these matters in anything but an extreme way – see the last transcript reference – if to stand up meant that you were sacked then that was just too bad, and compare his evidence that clinicians who did not have a private practice to fall back on could not afford to stand up in the hospitals – tt 3951-2.

1.7 The other side of this personality equation is that Dr Scott was undoubtedly a sincere man dedicated to the improvement of public health – see ex 436 (attachment E). In fact, he was *"standing up"* in a system which had many faults – see the evidence as to the use of the Measured Quality Reports – tt 5247-8, and see Mr Nuttall's evidence at tt 5365-5369 and exs 322-324 which show that Dr Scott was trying to have the government consider the cost of addressing the problems in QH. It is a small but illustrative point, that Dr Aroney volunteered that he was so impressed by the Courier Mail's championing of anti-smoking legislation that he wrote to congratulate the editor – t 6251. In fact, unknown to Dr Aroney, it was Dr Scott who had been the moving force behind this – see ex 436 p7. The point is that Dr Aroney simply had no understanding of who Dr Scott was; what he was doing, or the reality of funding within the health system – time and time again he said in his evidence that he did not care to concern himself with budgets.

1.8 Dr Scott says, *"Before the meeting Dr Aroney chose to go to the media, and to proclaim that Queensland Health administrators did not care if people died but was driven by budgets. He had not taken the time to meet with me to discuss his issues and concerns. I found the claim personally deeply offensive having worked in direct patient care and being at least as ethically and morally motivated as Dr Aroney."* At paragraph 1 of Dr Scott's statement he explains that his work as a GP in particular has been in rural and remote areas, and that as an administrator he took a strong interest in the better provision of services to these areas. He is obviously well aware of the problems rural Queenslanders face in accessing tertiary institutions like TPCH. The same part of his statement also explains that he was a Censor, not only of the Queensland faculty, but also a member of the Board of Censors of the Royal College of General Practitioners at a national level. A Censor is a keeper of standards; the position is elected, an indication that he had the respect of his peers.

1.9 Perhaps if Dr Scott had been the type of person who was not so sincere about his work there would have been no argument at the meeting because

he would not have been so offended by Dr Aroney's comments. Perhaps if Dr Aroney had been more temperate in his views expressed before the meeting, or had some understanding that the senior bureaucracy was not able to deliver everything they thought sensible and desirable, there would not have been an argument.

1.10 In the end, the Commission has evidence that two senior men who were both working in their different ways to improve health in Queensland had an argument. No doubt intemperate comments were made by both. One is recorded. It may not have been a constructive thing to say, but it does not amount to a threat or a threat of reprisal. Look at the substance of the matter –patient care: TPCH and the very cardiac centre where Dr Aroney worked was given funding well above its base line budget before and after the meeting of 8 January 2004 – see paragraph 4 of our earlier submissions. It was Dr Scott who gave out this extra funding, the second tranche of which was given even without a formal request – see the documents referenced at 4(g) of our previous submission, which are attached as attachment F.

1.11 No adverse finding should be made about the comment made at the meeting of 8 January, 2004. There is no evidence that Dr Scott was a bully or was part of what the media and others have labelled the bullying culture of QH. In fact the evidence about Dr Scott's work, demeanour and character is that he is sincere, dedicated and respected – see attachment E; see the evidence of Ms Edmond – t 4969-4971, and Mr Nuttal - t 5361-2 (together attachment G). It would be a grave and unjustifiable thing to make a finding attributing blame for one angry comment in the course of such a career in the Commission's public report in circumstances which are detailed above.

(b) On 15 October 2004 during an interview on the Australian Broadcasting Corporation's television show "Stateline" you made statements to the effect that:

(i) Queensland was not behind other States in terms of the number of cardiologists per head of population.

2.1 The formulation of the above sub-paragraph is inaccurate. The transcript of

the interview is "CA13" to ex 263 (attachment H). In response to a question about *"international standards"*, and the *"number of cardiologists* [QH] *should have"* Dr Scott said, *"We certainly would be prepared to accept that we have issues to address with staffing but really that's an issue for Australia generally. So we don't see that we are behind any other States in Australia."*

(ii) Queensland Health had sufficient cardiologists to meet clinical need.

2.2 Dr Scott did not say that Queensland Health had sufficient cardiologists to meet clinical need. To the contrary, he said that there were issues with staffing, that QH was behind internationally, and that Dr Aroney's view that QH had one-third of the cardiologists needed was not true <u>to the level he [Dr Aroney] was describing it</u>.

(iii) patients were not at risk whilst awaiting cardiac treatment by Queensland Health.

2.3 Again the formulation of the above sub-paragraph is inaccurate. Dr Scott said, *"I suppose we would say that we are behind but we really feel that the services that we are delivering at the moment are not putting any Queensland lives in jeopardy."*

(iv) there had not been a reduction in cardiology services provided by the Prince Charles Hospital.

2.4 Again the formulation of the above sub-paragraph is inaccurate. Dr Scott was asked: *"Have you reduced the number of services cardiology procedures at the Prince Charles Hospital from 80 to 57?"* He replied, *"No, What we've done is we've said let's go ahead and enhance services and that was happening in fact we've put something in the order of $ 5 million extra dollars into cardiac services in Queensland this year. And that $ 5 Million will be there each year from here on. But what has happened is there has been an increase budget will allow situation and we've asked the cardiologists to review the situation with a view to at least staying within the resources that are available to us but we have not in any way respects reduced services."* [sic].

2.5 This is in the context of the comment immediately above in the transcript: *"What we are doing is looking to increase services across Queensland and of course what that means is that services and resources are going to hospitals other than Prince Charles…"*.

(c) The statements above were false and misleading, and the inference that may be drawn by the Commission is that the statements were intended to:

i. create a positive media response to prior comments by Dr Con Aroney who had claimed that Queensland Health had cut cardiology services at the Prince Charles Hospital; or

ii. suggest that Dr Aroney's comments were alarmist or untrue; or

iii. both of the above;

3.1 A fair reading of the transcript of the Stateline broadcast as a whole makes it clear that Dr Scott was attempting to explain the situation in Queensland in relation to cardiology services. Dr Scott is not a lawyer and he was not making some formal written submission; he was responding orally to questions on a television interview. Of course it is a legitimate enquiry to see if the sense of what he was conveying was false or misleading, but this should not be done in an unreal context where individual sentences or words are parsed over minutely in isolation from the context of the interview overall.

3.2 As to (b)(i) above, Dr Scott is asked whether it is true that by international standards Queensland has only one third of the cardiologists it should have. The substance of his answer is to concede that Queensland needs more cardiologists by international standards, but not to the extent Dr Aroney thinks. He points out that Queensland is not the only state in Australia to have too few cardiologists by international standards. If the last sentence read to the effect - *"So the problem is Australia- wide"*, no-one would have any quarrel with any of the answer. Instead, Dr Scott used the words, *"So we don't see that we are behind any other States in Australia"*. Had he said, *"So we don't see that we are <u>substantially</u> behind any other States in Australia"*, no-one would have any quarrel with any of the answer. The one sentence

which is impugned is in a context where appropriate concessions have been made immediately before and after the statement that Queensland has issues to address with staffing, and that it is behind with respect to international standards. The response of Dr Scott when cross-examined about these matters is exactly to this effect – see tt 5266-5275(attachment I).

3.3 As to (b)(iii) above, the first thing is that the statement is an expression of opinion. The second thing is that it is not strictly responsive to the question asked but is responsive in terms of the allegations made by Dr Aroney in the public debate which led to the interview. And that second point is important to bear in mind in judging the statements made by Dr Scott generally, they are in a context of a wider debate where Dr Aroney has made allegations which are not all put to Dr Scott in the interview. The allegations Dr Aroney was making in the media prior to this interview have not proved to be correct. He made the allegations that 3 patients died waiting in the press in January 2004. He made those allegations without first hand knowledge of the circumstances of the deaths - "MIC9" to 301C - and without making that clear in the press. The investigation – "MIC14" to ex 301C - considered that 1 of the deaths (patient 3) was caused by a wait – there may have been fault involved in the deaths of patients 1 and 2 but their deaths were not caused by a wait.

3.4 By 4 March 2005, ex 301C paragraph 65, after this interview, an investigation had found 1 more death attributable to a wait. The deaths of patients A , B, D and E appear from ex 439 not to be caused by a wait. The others in that document cannot, on the information available to the Commission, be said to be due to a wait, rather than disease, or other fault. It is not even clear that anything could have been done for these patients to prevent their deaths. The Commission cannot conclude much from the notes in this document which are scant, unexplained and untested. Findings about serious matters should not be made when the evidence is minute compared to, say, what might be led even in a civil trial.

3.5 As to (b) (iv) above, the alleged reduction in cardiology procedures at the

Prince Charles Hospital from 80 to 57 is explained by Dr Scott as a return to baseline funding after extra one-off funding provided after the election of early 2004 had been spent – Ex.317, para.19.8 and 19.9 (attachment B) and in response to cross-examination as to this point – t 5273.

3.6 Out of any context at all, it is true that to bring back procedures from 80 to 57 is a reduction. The point is, that what happened did not happen out of any context, it happened in a context where procedures were only at 80 because of a temporary increase in funding. This is not just semantic. A is paid at $570 per week but is asked to act in higher duties for 3 months while B is on long service leave. For that time A is paid $800 per week. When B comes back from leave, A is no longer on higher duties and reverts to a pay rate of $570. A cannot complain that his pay has been reduced, a temporary increase has been taken away.

3.7 To say, as Dr Aroney did, that there had been a reduction is a half-truth, it is a statement which is literally true, but not in substance true, because it only tells part of the story. The truth is that there was funding for 57 procedures; a temporary increase, and then a reversion to base levels. This might be undesirable in terms of health policy and health funding, but Dr Scott was not telling untruths about what was happening. He was correcting a half-truth told by Dr Aroney. And it is not irrelevant to note, turning to the substance of the matter – patient care - that there was never a time when procedures reached 57 per week – that was because Dr Cleary complained to Dr Scott about it, and Dr Scott increased base line funding so that the baseline could be increased from 57 - see paragraphs 4 (f)-(g) of our previous submission and attachment F.

3.8 No finding should be made as proposed.

(d) In conducting yourself as a senior public service officer, namely the General Manager of Health Services, you chose to act as an advocate for the Minister and the Government <u>instead</u> of maintaining impartiality and integrity in informing, advising and assisting the Government. You therefore failed to comply with the principles of public service management contained in s.23 of

the *Public Service Act 1996.* (original emphasis)

4.1 First, see the introductory paragraph as to Dr Scott's employment at p1, above.

4.2 Second, Dr Scott's appointment as SEDHS was under s.24 of the *Health Services Act 1991*. (see attachment J) As such he was a *"health service employee"* as that term is defined in that Act. While acting as GMHS and SEDHS it would appear that Dr Scott was employed as a health service employee under s24(3)(c) of the *Health Services Act*. The position of SEDHS was a contract position under this Act and so, we believe, was the position of GMHS, this could be checked with QH. Section 25 of the *Health Services Act* provides that a health service employee is not a public service employee. Thus the *Public Service Act* does not apply to Dr Scott.

4.3 Third, even if Dr Scott were a public service employee, s23 of the *Public Service Act* sets out a number of principles introduced by the words, *"Public service management is to be directed towards:"*. It is meaningless in legal terms to say that Dr Scott failed to comply with that section. It is meaningless in factual terms to say that he failed to comply with the section in the abstract as the passage above does. There are no facts or allegations put as to this supposed non-compliance.

4.4 This proposed finding appears to be based on the response to a question by counsel for Dr Aroney:

> *"Do you identify any deficits in your own performance as a senior bureaucrat?-- I'm sure I did, I'm sure we all do.*
>
> *And what are they?-- I think probably if I look back in retrospect, I would say that I probably was more of an activist for the Government and the Minister than perhaps I should have been. I think that there are issues that need to be addressed which sometimes aren't attractive politically, but I think that in terms of how hard I've worked, how hard I've tried to support people, I don't have any deficits from that point of view that I can see." – t5287, l 41.*

4.5 This response did not relate to any specific incident. It was made in response to a very general question which required Dr Scott to critically analyse his performance throughout the entirety of his tenure as a senior bureaucrat. To say that if he had his time again he would act less as an activist for the minister and government does not imply that Dr Scott acted partially or without integrity in his time with QH, in general, or in relation to any specific matter. No doubt there is a range of legitimate conduct in relation to any particular matter; nothing said by or about Dr Scott would suggest that he acted outside this legitimate range. Indeed, there are instances like the Measured Quality reports and the cabinet submissions put up in June 2005, see paragraph 1.8 above, where, despite his reflection above, Dr Scott was clearly acting, within that legitimate range, as an activist for public health. Indeed, he has been recognised nationally for so doing – attachment E, look at the achievements listed:

4.5.1 Protect and Promote Public Health Within Australia

4.5.2 Increased Investment in Public Health

4.5.3 Promotion of Multi-disciplinary approaches to Designing Public Health Solutions and Solving Public Health Problems

4.5.4 Advance Community Awareness of Public Health Measures and Outcomes and the Real Cost of Inadequate Public Health responses

4.5.5 Advance the Ideals and Practice of Equity in the Provision of Health care,

These are the achievements of someone who worked with integrity and impartiality to better public health.

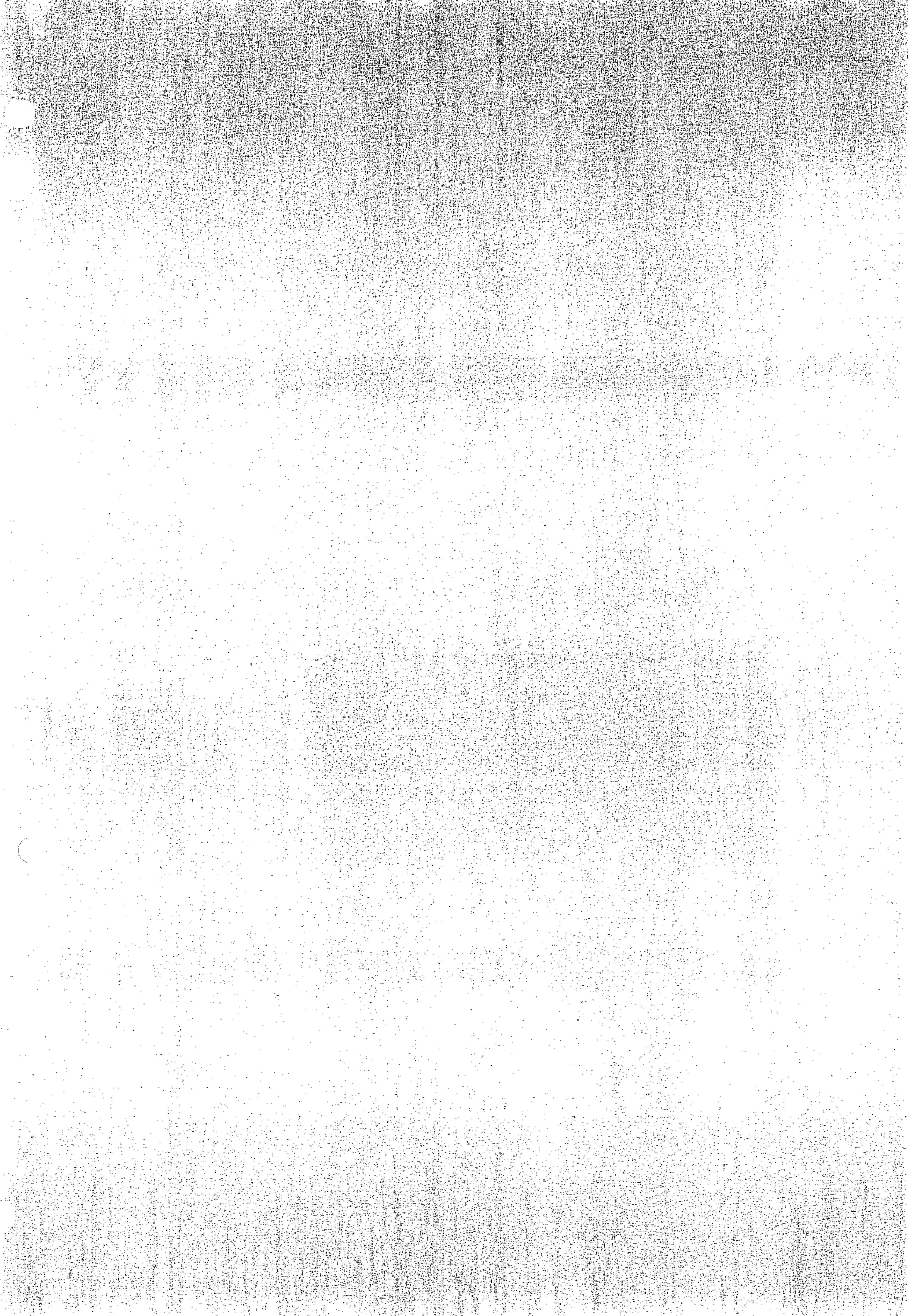
4.6 Note that if it did apply to him, there are several principles espoused by the *Public Service Act* which obviously must be balanced against each other, s25 (c) for instance, provides that a public service employee's work performance and personal conduct must be directed towards giving effect to Government policies and priorities.

4.7 There is simply no basis in fact or law for the finding mooted. It is quite contrary to all the evidence about Dr Scott's work.

Dated this 25th day of October 2005.

JH Dalton SC

C S Harding



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The cardiologists had argued strongly against this closure, as it was pure cost-cutting and would blow-out cath lab Category 1 and 2 patient waiting lists even further. Closure of the cardiac outpatients (already with 5-7 month waiting times) was also enforced at this time, which we had also argued against (the heart failure unit felt that patient care would be severely compromised and more lives would be placed at risk), and this closure also occurred.

First letter to the Premier and its aftermath

17 After we had received no withdrawal of these many "life-threatening" cutbacks in early December 2003, I wrote to the Premier and Health Minister on 16/12/03 (**CA5**).

18 I made the following points to the Premier:

- Cardiologists have been directed that they cannot proceed with immediate treatment of severe coronary lesions (stent angioplasty) except in emergencies, but must rebook patients for a second procedure, which may be three or months later.
- Cardiac booking staff have been directed not to schedule elective stent angioplasty cases from 1st January 2004, and Queensland patients have

been placed in a holding pattern for an indefinite period until funds become available.

- These changes are against best-practice, put patients at risk of death or heart attack, delay effective treatment, may require a second hospital admission and lead to increased costs! They are also in direct violation of the Queensland Health 20-20 document and the Health Outcomes Plan – Cardiovascular Health: Coronary Heart Disease 2000-2004.
- Plans are being made to reduce coronary angiography, stent-angioplasty and cardiac surgery numbers for Central Zone patients, despite increases in demand in all zones.

19 I also apprised him of three recent avoidable cardiac deaths (Pts 3-5).

20 After my letters to the Health Department and Premier did not lead to any withdrawal of the cutbacks, meetings of all the cardiologists at PCH from 3rd- 5th January 2004, discussed the prospects of the life-threatening cutbacks which were about to begin, and in desperation they asked that I, as the Chair of the Qld Branch of the CSANZ release details of the cutbacks and recent deaths to the media.

21 The Public Sector Ethics Act (1994) and Code of Conduct (Qld Health 2000) include:

- Employees should also ensure that any conflict between their personal interest and official duties is resolved in favour of the public interest
- Employees should disclose fraud, corruption and maladministration of which they are aware
- Employees should exercise diligence, care and attention and for high standards of administration and health care.

22 In my view, public disclosure of the unnecessary causation of deaths by ill-informed and intransigent budget control was in the circumstances fully justified and even required by the Act and the Code of Conduct. After repeated attempts to be heard through line management, through letters to the Premier, through direct face to face waylaying of the Minister, and senior QH bureaucrats, the need to stem this rising rate of unnecessary deaths was without doubt the higher public interest. As Chair of the Qld Branch of the CSANZ, I therefore issued a press release on January 5 2004 to the Courier Mail.

23 On January 8, 2004, I was contacted by Qld Health bureaucrat Dr John Scott by telephone who requested an urgent meeting to discuss the problems I had raised (in my press release), and I immediately accepted his request, anticipating that progress might at last be made. I met with Dr Scott and Mr. Dan Bergin from Qld Health on the evening of Jan 8, and I invited another cardiologist Dr Andrew Galbraith to also attend. The

meeting began with what would be best described as a vicious verbal assault which was I felt was clearly intended to reprimand and intimidate me from ever raising these issues again. Dr Scott even stated to me "You come after us with more shots, and we'll come after you". Dr Scott refused to comment on my statement that cutbacks would lead to increased deaths and rejected my suggestion of developing an expert cardiac committee to directly advise the department. Herewith are excerpts of minutes of the meeting (**CA6**) which were made after the meeting by myself and Dr Galbraith.

Excerpts of the Meeting 5.15pm Jan 8th 2004: Lvl 3, Holy Spirit Northside Medical Centre.

Dr Constantine Aroney (Cardiac Society)

Dr Andrew Galbraith (Invited by Cardiac Society, and Cardiac Society Member)

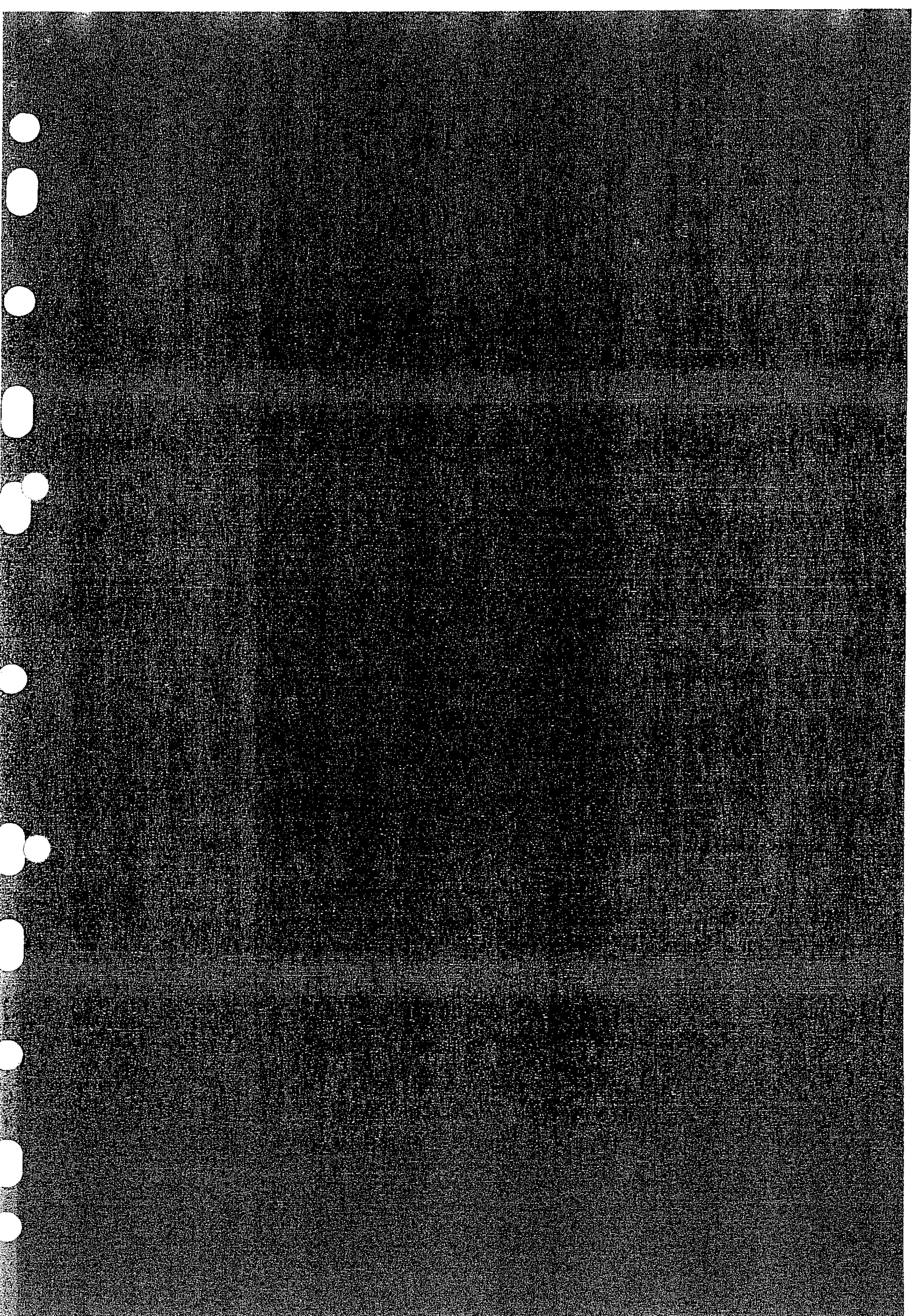
Dr John Scott (Queensland Health)

Mr. Dan Bergin (Queensland Health)

JS: "Your letter to the Premier was offensive to Queensland Health and personally offensive to me" "You made a lot of cheap shots"

CA "I don't consider unnecessary deaths as cheap shots – you might"

JS - "We're going to investigate the 3 deaths you mentioned"



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review, which I supported, recommended that in future patients are transferred as soon as they are stable. The clinical call as to whether this patient was stable after the first or second operation would be difficult, as the patient was very shocked, so I was not alert to issues about Dr Patel's initial post-surgical judgment needing further examination; the problems with the boy's health emerged after Dr Patel went on leave. As to subsequent care, I agreed with the recommendations that major vascular injuries should be transferred as soon as possible, so again I did not see a need to get Dr Patel's views on that.

18.4 I agree that the severity of the patient's condition as described in the 5 January briefing report is difficult to reconcile with the descriptions received by the Commission from e.g. Dr Rashford. At the time the issue I saw was that the initial surgery was appropriate, but the post-surgical care was not. Reports from the RBH may have given me a different, more damning picture of the post-surgical care at Bundaberg. This would not have led me to enquire about Dr Patel because, as explained he was on leave before the boy's condition worsened. Even had I received reports from RBH I doubt I would have investigated further as to their (too lengthy) retention of the patient with Bundaberg because that hospital had accepted that they should transfer such patients at the earliest stage possible – i.e., the hospital had put in place a policy to prevent repetition of like occurrences and the Zone Manager was working with RBH to ensure the policy worked, as that hospital would be the receiving hospital.

19. **Dr Aroney in his evidence (see the statement and the transcripts for 10 August and 24 August 2005) makes a number of comments about Dr Scott. Does Dr Scott dispute the accuracy of those comments?**

19.1 I dispute the accuracy of Dr Aroney's comments. Prior to my commencing the role of SEDHS, work had been started to develop separate cardiac services at TPCH, RBWH, and PAH, to establish services at Gold Coast and to enhance services at Townsville/Cairns. I believe this approach is appropriate given that Queensland is a decentralised state and treating patients close to where they live is the ideal both in terms of patient convenience (thereby ensuring that patients are likely to attend for treatment), and also to provide equity of access.

19.2 Dr Aroney makes reference to Queensland's coronary mortality rate. QH's approach was to address all facets of cardiac disease not just coronary artery disease. As well as coronary artery disease this requires an approach to heart failure management; rheumatic heart disease; and congenital conditions. To comprehensively address these matters it is also necessary to consider environmental, lifestyle and risk factors; access to primary treatment services; prevention approaches like diabetes and blood pressure management; access to secondary level diagnostic services to identify and treat conditions before serious outcomes develop, and access to tertiary level treatment. The responsibility of any health department is to ensure all of these factors are addressed. QH is required to allocate funding within its budget. The funds available to QH are not unlimited and must be used to address all aspects of public health management. To give a disproportionately high level of funding to tertiary treatment services using

percutaneous coronary interventions in one location is to condemn more people to developing what are often preventible conditions and probably to allow more preventable deaths than those to which Dr Aroney refers. Dr Aroney's view that QH's approach was simply to take services away from TPCH is deeply flawed.

19.3 I believe that the development of a properly organised cardiac service across the state was the appropriate direction to take in providing the best possible cardiac care in Queensland.

19.4 The first round of cuts to which Dr Aroney refers (Statement page 3), was not a cut in funding but a reallocation of funds from TPCH to the PAH after construction of cardiac catheter laboratory and other facilities at the PAH. After the construction of the cardiac catheter laboratory, the level of activity funded at TPCH and the PAH was determined based on population figures. Any perception that there was a cut in funding to TPCH was not real as patient treatment activity had moved, with funds, to PAH from TPCH i.e., patients who were historically treated at TPCH were now treated at PAH. QH was not reducing services across the state and TPCH was still receiving the same amount per patient treated. In fact QH put significant extra amounts of funding into cardiac services in the 2003/4 financial year - an extra $1.86 million into the RBWH; $4.5 million into TPCH; $1.44 million into PAH to build the extra catheter laboratory and other facilities and $1 million for ongoing work, $290,000 into Townsville, and $5.1 million into the Gold Coast. In addition approximately $1 million extra beyond the population-based estimate was put into TPCH budget based on work done by an independent external consultant Mr Jim Lowth (currently assisting Mr Peter Forster).

19.5 I was not involved in the issues Dr Aroney describes prior to November 2003 as I was not in the SEDHS position at that time. I was in fact State Manager of Public Health Services, working at the state and national levels to reduce smoking rates (a major cause of coronary artery disease); respond to some of the highest rates of childhood obesity in the world (a risk factor for heart disease); improve nutrition and physical activity (risk factors for heart disease) across the population, and to improve remote aboriginal community living conditions (risk factors for rheumatic heart disease). My budget to address these issues was about 1% of the total health budget, giving little chance of adequately responding to these major health determinants and making me very aware of the need for a balance in terms of how funds were allocated to respond to heart disease.

19.6 Dr Aroney refers to a cut in activity at TPCH in 2003 of "300 cardiac surgical cases, 500 angiograms, and 96 angioplasties/stents" (Statement page 3). This reduction in activity was part of the transfer of funds and activity to PAH referred to above which took effect on 1 July 2003. While the budgeted activity at TPCH reduced by these levels, the budgeted activity at PAH increased by 300 cardiac surgical cases, 560 angiograms, and 140 angioplasties/stents. As such there was no reduction across the two facilities, in fact there was an increase of 60 angiograms and 44 angioplasties/stents with cardiac surgical cases remaining static. Activity across the state in 2002/03 was 2720 cardiac surgical cases, 6238 angiograms, and 1427 angioplasties/stents whereas for 2003/04 it was 2706

cardiac surgical cases, 6394 angiograms, and 1724 angioplasties/stents. Again, there was no reduction. Rather there was an increase of 303 cases (and an increase from 2001/02 of 766 cases).

19.7 Dr Aroney suggests that there was a second cut in activity announced for 1 January 2004 (Statement page 4). There was in fact no cut in activity in January 2004. In November 2003 the district of which TPCH was a part, had provided figures indicating that they would be over budget for the financial year by approximately $2.2m. This was caused in a large part by the fact that cardiac interventions were being performed at a greater rate than was allowed for by the funding that had been provided to TPCH. Dr Aroney would have been aware of the level of activity that was funded and that he was exceeding this level of activity. TPCH was reminded by QH that they were obliged to limit themselves to the new level of activity which had been funded. It was not concerned that the procedures at TPCH were unnecessary, but to ensure equity across districts. These are obviously difficult matters. This is what Dr Aroney refers to as the second round of cuts. There was in fact no cut in activity at this time. In fact funding to TPCH in the 2003/04 financial year, for coronary related inventions, increased above the baseline budget by at least $1.45 million.

19.8 Dr Aroney talks of a third cutback in September 2004 (Statement page 6). I was not involved personally in this issue as I was on long service leave from July to October 2004. Again there was no cutback but a return to baseline activity after the one-off extra funding ($20 million to reduce elective surgery waiting lists) provided after the election of early 2004.

19.9 In fact, the available budget was sufficient to allow 57 procedures per week to be performed and that is the level to which activity was limited. When further funds were made available in January 2004 as part of the 2004/05 $20 million funding increases, further work was able to be undertaken. When this funding had been expended, activity level was reduced to the budget level of 57 procedures per week. There was no decrease in funding activity below the budgeted level.

19.10 Dr Aroney suggests that subsequently in January 2005 the hospital realised that they weren't doing enough to get funding, because funding is based on activity and these activity cuts were then withdrawn in January 2005 and the numbers were pushed up in order to obtain the appropriate funding for activity – t 3948. In fact in January 2005 extra funding became available. Some of this money went to TPCH, allowing activity to be increased from 57 to 65 procedures per week. Dr Aroney's suppositions about the reasons for the increase in activity in January 2005 are totally untrue.

19.11 The matter of what activity budget allows compared to what is needed due to clinical demand is a major problem across the world and creates hugely difficult decisions for politicians, administrators and clinicians. Available funds must be spread across services from the primary to the tertiary level, from prevention to treatment, from neurology to podiatry, from the north to the south of the state, from hospitals to the community. The administrator is uniquely placed to be aware of all of the impacts of non-availability of optimal resources, the deaths that occur, and the frustrations of not having enough

resources to respond comprehensively. The administrator is required to allocate the available budget appropriately, always knowing that not all people will get the services they need. This can often be a thankless task which results in criticism from people such as Dr Aroney, who only consider their particular area of interest.

19.12 Dr Aroney met with me, accompanied by Dr Andrew Galbraith and Mr Dan Bergin on 8 January 2004. He has made allegations of bullying against me at that meeting. I reject the allegations that I bullied Dr Aroney at that meeting or on any other occasion. Before the meeting Dr Aroney chose to go to the media, and to proclaim that Queensland Health administrators did not care if people died but was driven by budgets. He had not taken the time to meet with me to discuss his issues and concerns. I found the claim personally deeply offensive having worked in direct patient care and being at least as ethical and morally motivated as Dr Aroney. After fifteen years in direct patient care I had come to Public Health and to public sector management not to rest, but rather to do my best for patients and the people of Queensland at the statewide level. His claims were made without speaking to me and without making any attempt to ascertain my personal views and values. At that meeting I did say words to the effect that if Dr Aroney came after us we would come after him. This was never intended to convey that QH would take steps to go after Dr Aroney personally. What I intended to convey was that if Dr Aroney continued to criticise QH in the media, that we would respond directly to any allegations he made.

19.13 His recollection of the events of the meeting (as contained in his statement) is clearly intended to paint me as uncaring and insensitive. I am amazed that he chooses to suggest that I seriously tried to tell him how to treat acute coronary syndrome. For fifteen years as a GP I referred my patients to specialists in recognition of their expert knowledge in their particular field. I stated to Dr Aroney that I had difficulty getting a consensus view on management of cardiac issues from a range of expert clinicians in the area. I did not disagree with the views put to me by Drs Aroney and Galbraith regarding the management of acute coronary syndromes. What I said was that I had been provided with differing views regarding management. I do not accept that it follows that I do not have any idea about the central principles of modern management of such patients.

19.14 At the meeting I tried to talk through a range of issues with Dr Aroney. In particular I advised Dr Aroney of the variety of issues which were required to be managed by QH and in particular the breadth of the approach being taken. His responses appeared to indicate that he was only interested in TPCH and tertiary services. It became apparent to me in that meeting that Dr Aroney did not have the capacity to be objective in terms of what I said to him. My kindest interpretation is that he was passionate about the issues and this clouded his observations of my actions and views. I have spoken to Mr Bergin about this meeting. Dr Aroney's comment regarding Mr Bergin's memory of the conversation does not fit with Mr Bergin's recollection of the meeting. Mr Bergin's recollection, and my recollection, is that Mr Bergin did not speak to the media. Mr Bergin's recollection is that he did not state that he was in the bathroom during part of the meeting.

19.15 I later wrote twice to Dr Aroney saying I would appreciate the Cardiac Society's view on how they believed we should allocate funding in the south-east corner. He did not help us with this. He replied asking for staffing numbers, budgets, numbers of patients etc. At my initiative, Dr Buckland and I met with members of the Cardiac Society to address this and other issues.

19.16 Dr Buckland and I went to the meeting with the Cardiac Society on 15 February 2004 to hear what the Society had to say and to share information. From the first presentation we, and the QH position, were attacked. Steve Buckland said that we were happy to hear people's points of view but we weren't there to be personally attacked. I reject the allegation that we had an intention to intimidate speakers or to discourage open discussion of the problems being presented. Nor do I believe that there was such behaviour on our part. To the contrary, Dr Buckland and I remained after the formal meeting speaking with participants. I subsequently spoke further with one or two of the participants to follow-up themes presented.

19.17 The first speaker at that meeting, who is mentioned by Dr Aroney in his statement, Dr Darren Walters, has since been promoted to the position of Director of Cardiology at TPCH. Obviously this does not demonstrate malice, bullying or victimisation and I am happy to have on record my appreciation for Dr Walters' actions as Director.

19.18 Dr Aroney raises the issue of publication of waiting lists for coronary angiograms and cardiac defibrillators. These lists were not published because they did not form part of the national reporting requirements for elective surgery. This is however a decision for government and not QH. If the government decides that they wish to have additional waiting lists published, this will be done by QH. Data was collected and used within the department. Had the government wished to use it publicly it was available.

19.19 Dr Aroney refers to an inquiry into three deaths, completed in January/February 2004. He disparagingly refers to the two authors as QH bureaucrats although they were in fact the Deputy Medical Superintendent of the RBWH and the Deputy Director of the PAH Emergency Department. He says he feared that the internal enquiry would be a whitewash. In fact the report made three recommendations regarding inter-hospital referrals, bookings of procedures, and a review of the implantable defibrillator waiting lists at different facilities to ensure that there was consistency of categorisation and potential for referrals of patients between TPCH, RBWH and PAH depending on clinical urgency. It was not released publicly as it contained information on the deceased patients that was identifiable and the recommendations in the report were implemented.

19.20 Classification of patients as categories 1, 2 or 3 between PAH, RBWH and TPCH was problematic given that different criteria seemed to be used at each hospital. Dr Aroney in his evidence to the Commission labels this discrepancy as a devious excuse to transfer patients and cut services at TPCH yet the categorisation of patients at the PAH was done by clinicians and these same clinicians were prepared to accept patients transferred from TPCH. On 22 January 2004 the DG requested that further steps be taken to

ensure that patients referred for cardiac services could be efficiently managed across the three Brisbane facilities to ensure that patients were seen in whichever facility could ensure their treatment first. In particular the DG noted "Executive Management at PAH advise they have immediate capacity to address patients on the Prince Charles Hospital angiography waiting list".

19.21 At the same time work was being done to establish the Clinical Coordination Centre and to establish a contract (subsequently signed with Care Flight) to enhance our capacity to refer people, by air if required, to facilities for appropriate care and to ensure that the first available bed was used. Our response was to increase the numbers of interventions provided and the ability of people in peripheral areas to be transferred when they need it. This work around transfers was not just about cardiac care but also involved intensive care, general surgical and medical processes and other key emergencies.

19.22 As I have stated, an extra $11,250,000 was put into cardiac services across the state in 2004/05 and an extra $17,330,000 will be allocated in each year from 2005/06 onwards. Dr Aroney's statement that QH was either deliberately trying to precipitate a crisis by enforcing cutbacks or was guilty of culpable negligence as managers, is totally baseless and untrue. I absolutely reject Dr Aroney's comment that suggests cutbacks occurred as a punishment against the hospital for his stance on speaking out about deaths of people on waiting lists.

19.23 Dr Aroney accuses me of labelling him as dishonest on radio and television. I do not recall saying such things and do not expect that I would have done so. I did however disagree with the view he was putting forward in the media. Dr Aroney says that other clinicians were unwilling to go public. In fact I believe the clinical staff at TPCH were becoming tired of Dr Aroney's constant sniping. They told me in a meeting with them that they just wanted the issue to settle down. I believe that members of the clinical staff may have had a quiet word with Dr Aroney around this time to suggest that it was time for things to be allowed to settle.

19.24 Dr Aroney refers to my comments on the ABC Stateline programme and implies that I lied when asked if cardiac catheter laboratory work was planned to be reduced to 57 procedures per week. The baseline of activity in the laboratory was always 57 and I stand by my comments.

19.25 The Maher Report was released in late February 2005, though Dr Aroney says that the Report was not released until April 2005. In discussing the Mahar Report, Dr Aroney accuses QH management of media bullying and making a thinly veiled attack on the two dedicated cardiologists at TPCH (Denman and Walters) who perform these life-saving procedures, as well as a vindictive attack on the hospital itself. I have nothing but respect from these two doctors and have spoken to both of them and indicated my support for their work.

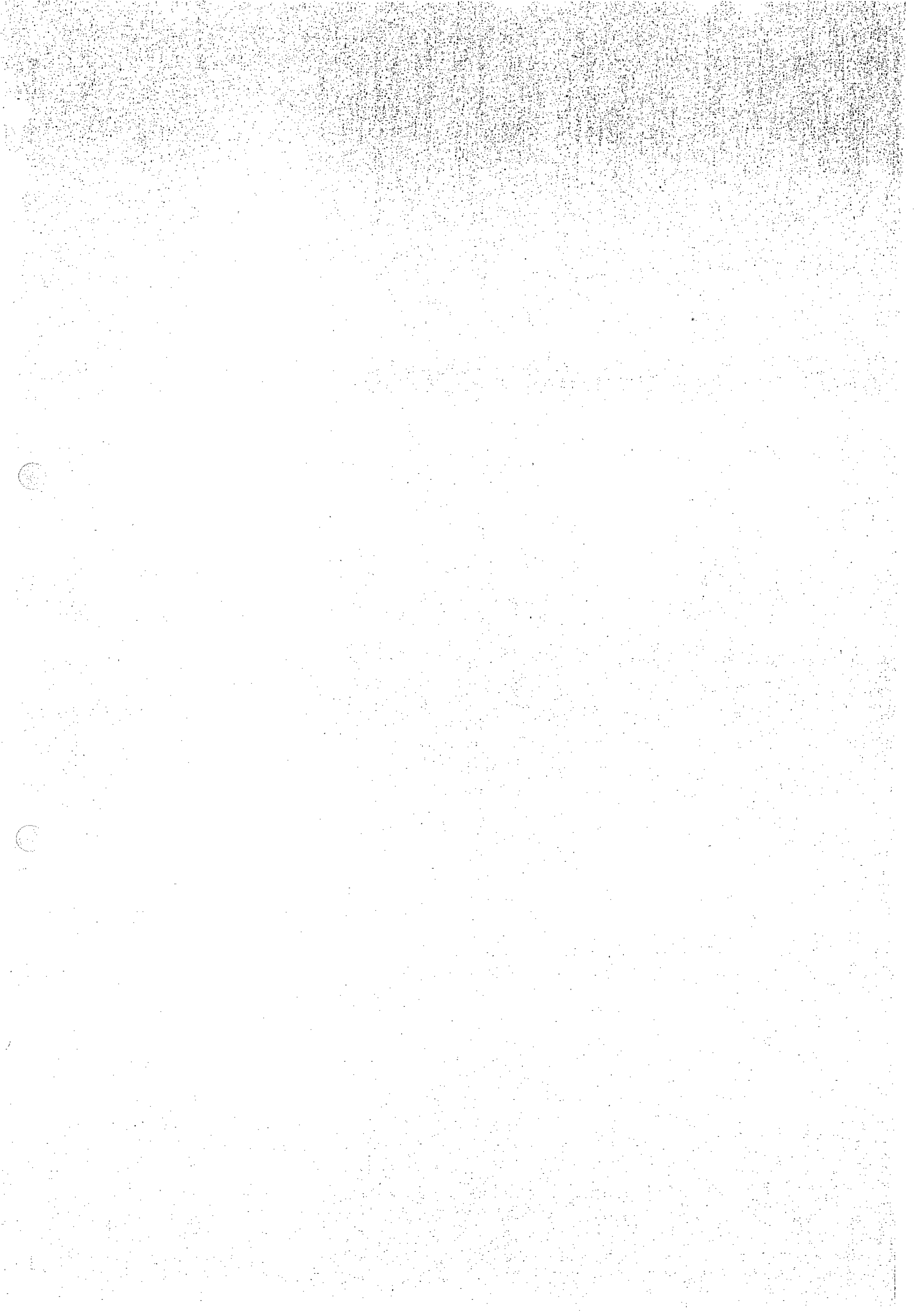
19.26 In discussing his resignation, Dr Aroney talks of QH's cavalier attitude to unnecessary deaths and says that QH's stated intention of establishing more

cardiac committees without increasing activity was totally inadequate. He also says that he felt QH's continued failure to consult the CSANZ on important issues and QH's dismissal of the advice provided in CSANZ's submission meant that progress appeared unlikely. Dr Aroney was however invited in April 2005 to participate in a meeting on 5 May 2005 to develop a strategic approach to cardiac services in Queensland. He also spoke in early 2004 of the need to have an expert cardiac committee for Queensland.

19.27 Dr Aroney says that I threatened to punish TPCH and made him fear for his job. These allegations are untrue. So is his allegation that TPCH "cuts" were as a punishment for his speaking out.

20 The Commission website contains a number of discussion papers. What comments, if any, does Dr Scott wish to make about those papers?

20.1 I have not had time to prepare a response to this question and I rely on the Morris Commission's letter of 30 August 2005 in this regard. I am happy to deal with any specific questions in my evidence.



C

CA 6

Meeting 5.15pm Jan 8th 2004: Lvl 3, Holy Spirit Northside Medical Centre.

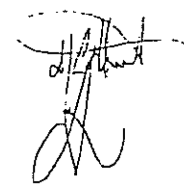
Dr Constantine Aroney (Cardiac Society)
Dr Andrew Galbraith (Invited by Cardiac Society, and Cardiac Society Member)
Dr John Scott (Queensland Health)
Mr Dan Bergin (Queensland Health)

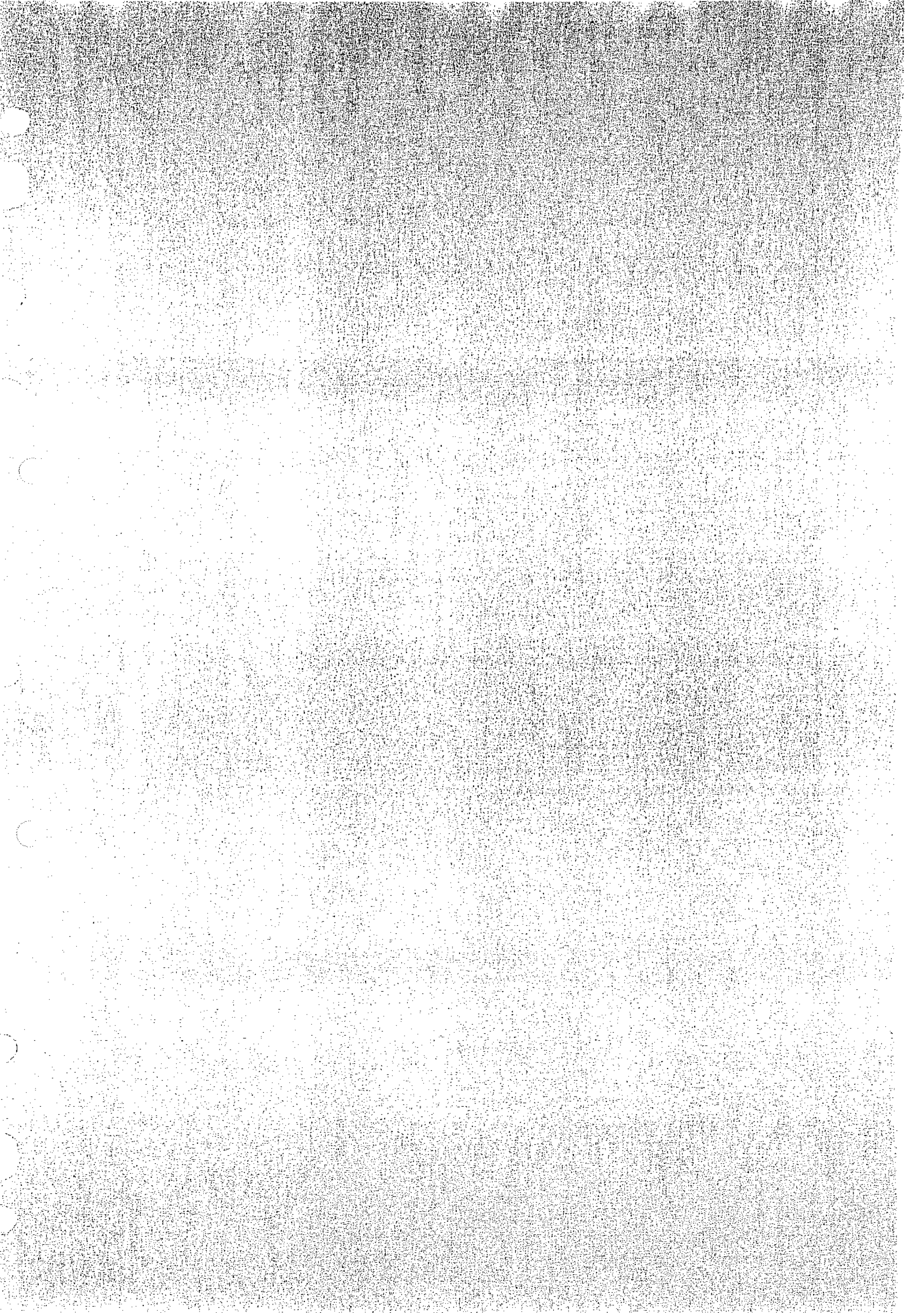
CA: "Thankyou for coming to hear our concerns"
JS: "Your letter to the Premier was offensive to Queensland Health and personally offensive to me" "You made a lot of cheap shots"
CA "I don't consider unnecessary deaths as cheap shots – you might"

JS - "We're going to investigate the 3 deaths you mentioned"
CA - "Investigate the deaths, but remember the Cardiac Society is an advocate for our patients, and we will continue to monitor all deaths and report them."

JS - "You come after us with more shots; and we'll come after you"

JS - Stated that there was increased funding in cardiac risk prevention strategies, planned cath lab at Gold Coast Hospital, increased surgery at PAH.
AG: Stated that the committee formed to facilitate an increase in referrals to PAH to increase the size of the cardiac surgical unit, had not taken into account a new cath lab at the Gold Coast Hospital. That forward planning was deficient.
JS: Agreed that forward that the addition of referrals from the Gold Coast Hospital had not been factored into the equation.
Would not put a moratorium on reducing angiography, angioplasty or surgery numbers at PCH.
Stated that a cardiac surgeon he spoke too, felt differently about managing high risk acute coronary syndromes, and that surgeons should manage these patients and treat them with surgery and not stents.
CA: Stated that he was totally incorrect. Pointed out the lack of communication between expert cardiologists and Qld Health, and recommended the formation of an expert advisory committee.
JS: Would not agree to formation of an expert committee to assist in cardiac services. Stated that previous committees had disagreed on too many issues.
AG: We have shown 30% reduction in readmissions with community nurses trained in managing heart failure patients. We need a statewide strategy for managing cardiac failure.
JS: We agree with increasing community nursing strategies in heart failure.
CA: "The planned reduction in cardiac services at PCH will lead to increased deaths in the Central Region." JS did not comment.





been restricted----- 1

COMMISSIONER: You did nothing?-- I felt that we should wait until the outcome of the clinical audit.

All right.

MR FREEBURN: So, you basically awaiting an independent investigation?-- Yes.

Thank you. 10

COMMISSIONER: Thank you.

MR BODDICE: I understand Ms Dalton-----

COMMISSIONER: That was a long 20 minutes.

MR BODDICE: I understand Ms Dalton has a couple of questions - she's indicated----- 20

MS DALTON: I promise I will be five minutes, Commissioner.

COMMISSIONER: I don't think you should promise. Go on.

CROSS-EXAMINATION:

30

MS DALTON: Mr Bergin, I am Joan Dalton. I act for John Scott. I would like to take you to one topic and that is the meeting that occurred on the 8th of January 2004 between yourself, Dr Constantine Aroney, John Scott and Andrew Galbraith. I think you were asked some questions about that earlier today?-- Yes.

Dr Aroney says that at that meeting John Scott bullied him; that is, bullied Dr Aroney. Can you comment on that for me, please?-- That wouldn't be my assessment of what occurred. I believe that there was a very robust discussion of equals standing toe to toe, so to speak, and having that robust discussion. 40

When you say "equals", you mean Dr Aroney and Dr Scott as equals-----?-- Yes.

-----having a robust discussion?-- Yes.

All right. Was there - to your observation was there any intimidation of Dr Aroney by Dr Scott at that meeting?-- Well, look, I'm not an expert. I can only give a layman's view, but my impression of Dr Aroney was that he was not intimidated in any way----- 50

And-----?-- -----by anything that Dr Scott said.

He gave as good as he got, didn't he?-- That would be my view, yes. 1

Now, Dr Aroney says that after that meeting there was a press conference. Are you aware he says that?-- I have - I understand he has made that statement, yes.

Did you go to that press conference?-- No.

Did you speak to the press at all after that conference?-- No. 10

Were you ever asked whether at that conference Dr Scott bullied Dr Aroney and did you ever give an answer, "I don't know, I must have been at the bathroom at that time."?-- Certainly not.

How would you describe that allegation?-- Bizarre.

Do you recall yourself being on the receiving end of allegations from Dr Aroney that you didn't care if people died on Queensland Health waiting lists?-- I understand that Dr Aroney made that in relation to the meeting that - where I addressed the doctors out at Prince Charles Hospital----- 20

Yes?-- -----the 60 doctors. I can't - I can't recall that particular set of comments or statements by Dr Aroney, I must admit.

You don't recall him making that allegation about you?-- At the time at that meeting? 30

Yes. Well, at any time?-- I can't recall that, no.

You'd agree with me, I think, that any sincere person working in Queensland Health would be angered by such an allegation?-- Well, it's very offensive. It's - people might have concerns about the way in which things are done, but to sort of impute those sort of motives is pretty offensive, in my view.

40

Thanks, Mr Bergin. Thank you, Commissioner.

COMMISSIONER: Thank you. Mr Boddice?

50

Ex 436

In Australia, the Public Health Association of Australia Inc (PHAA) provide for the exchange of ideas, knowledge and information on public health. Tł Association is also involved in advocacy for public health policy, developn research and training.

Membership is open to any person who is supportive of the objects of the These are:

- to encourage research and promote knowledge relating to the problem and development of public health;
- to promote and provide a forum for the regular exchange of views and
- to promote the development and education of public health workers;
- to promote, maintain and extend the interests of PHAA's Branches, Sp Interest Groups and any affiliated organisations;
- to promote excellence in public health practice; and
- to advocate the objects and policies of the Association.

As PHAA has a national and multidisciplinary perspective on public health able to make a major contribution to the public health debate in Australia t representation on government boards, committees and other decision-ma such as the National Health and Medical Research Council and the Austr Institute of Health and Welfare. PHAA members also sit on many state an committees contributing to a broad spectrum of public health issues.

PHAA members also contribute to the development and execution of publ policy in Australia, and in particular bring their experience and expertise to development of **policies for the Association**. These policies are conside annual general meeting of the membership, and if endorsed, become the public health action for the association.

PHAA has **Branches** in every state and territory. Membership of more tha individuals spans the health spectrum and over 40 public health related or are represented. PHAA has fourteen **Special Interest Groups** for membe with those who have similar interests and passions, to exchange informat

develop policy positions and papers.

PHAA has links with public health associations world-wide and is an activ the World Federation of Public Health Associations.

The Association produces a bi-monthly academic refereed journal, the ***Au and New Zealand Journal of Public Health***, which disseminates public l research and ideas throughout Australia and internationally.

The Association's newsletter, *In Touch*, published bi-monthly, is the focus health news and events in Australia.

PHAA undertakes project and conference work on issues such as immuni public health workforce and training and knowledge development in healtl and reports on these topics and many other are available from the nationa secretariat.

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Printable Version of About PHAA

Sydney Sax Public Health Medal Winners

The Public Health Association of Australia, in 2000, initiated the first Public Healt
This Medal was designed to be the Associations pre-eminent prize. The Medal is
every year. To be eligible a nominee must:

· Have a proven track record in the advancement of public health in Australia;
· Be an Australian citizen or resident; and,
· Have undertaken his/her activities in Australia.

The criteria for the Medal are that nominees will have actively engaged in work o
Australia designed to achieve one or more of the following:

· Protect and promote public health in Australia;
· Promote multi-disciplinary approaches to designing public health solutions and
public health problems;
· Advance community awareness of public health measures and outcomes and tl
of inadequate public health responses; and,
· Advance the ideals and practice of equity in provision of health care (equity defi
equal care for equal need).

In 2001 the Public Health Medal was re-named the Sidney Sax Medal in honour
Dr Sidney Sax. For further information about the Sidney Sax Medal click on XX.

Winners of the Medal are:

Dr Neal Blewitt - The inaugural Public Health Medal, later renamed the Sidney S
was awarded to Dr Neal Blewitt in 2000 for his record of advancement of public h
Australia.

Professor Mary Sheehan - Was awarded the Sidney Sax Medal 2001, in recogr
involvement in teaching, education, research and service in promotion of public h
the past twenty years.

Professor Judith Lumley - Was awarded the Sidney Sax Medal in 2002, for her
two decades of work dedicated to the promotion of public health and for her effor
improving maternal care in Australia.

Professor Annette Dobson - Was awarded the Sidney Sax Medal in 2003, for h
dedication to public health education and commitment to developing integrative a
disciplinary approaches to solving public health problems in Australia and overse

Associate Professor David Legge - Was awarded the Sidney Sax Medal in 20(
pioneer work in community participation in health services in Victoria and his con
a wide range of health policies including regionalisation of community health, anc
Health Council's Program.

Dr John Scott

Nominee for the Sidney Sax Public Health Medal

2005

Biography

Dr John Scott graduated from the University of Queensland with a MBBS in 1976, and completed a Bachelor of Economics at the University of New England in 1994. He holds a postgraduate Diploma of Obstetrics (1980) and a Master of Applied Epidemiology from the Australian National University (1994). He is a fellow of several professional colleges, the Royal Australian College of General Practitioners (1989), the Faculty of Public Health Medicine, Royal Australasian College of Physicians (1994) and the Australian College of Tropical Medicine (1995).

After completing his Resident Medical Officer training at the Royal Brisbane Hospital (1977-1978), Dr Scott finished his training as a General Practice Registrar at the Toowoomba General Hospital (1979-1980). He then spent over ten years in general practice at the Ingham Medical Centre in North Queensland (1981-1991). During this period, he acted as State Government Medical Officer for Hinchinbrook Shire, and Shire Medical Officer of Health and Designated Medical Officer for the Civil Aviation Authority. He also chaired the Ingham District Welfare Council and was a committee member for the Queensland Ambulance Transport Brigade and the North Queensland Sub-Faculty of the RACGP. In addition, he held various other honorary positions, including Medical Officer for the boxing and swimming clubs. Dr Scott also spent some time as a locum Medical Officer with the Royal Flying Doctor Service in Cairns (1991-1992).

Dr Scott then went on to undertake postgraduate studies in epidemiology and completed his training as an Epidemiology Registrar with Queensland Health (1992-1994). Over the last twelve years he has held a number of senior management positions responsible for various and then all aspects of public health throughout the organisation, namely:

- Acting Director of Communicable Diseases Branch (1994-August 1995)
- Co-ordinator, Public Health Unit (PHU) Network – responsible for establishing Queensland's first network of 5 public health units (February-May 1995)
- Assistant Regional Director, Community and Clinical, at the Brisbane North Regional Health Authority (August 1995-January 1996)
- Acting Director, Public Health in the Division of Public Health Services (January–October 1996)
- State Manager, Public Health Services, (October 1996-November 2003)
- Seconded to the position of Acting General Manager, Health Services (November 2003)
- Senior Executive Director, Health Services Directorate, following an organisational realignment (from July 2004)

Personal Attributes

Dr Scott is highly respected professionally and personally within the field of public health in Queensland and nationally, the Queensland health sector more broadly, and by key partners of Queensland Health.

His leadership skills, including key strategic, analytical, advocacy, problem solving, decision making and communication skills, have been instrumental in shaping public health practice statewide in Queensland over the past 10+ years. This has included raising the profile and importance of public health within the broader health system and with other government departments, securing significant additional investment in key and emerging public health programs, and ensuring that its place within a contemporary health system has become well understood and well respected.

This has been achieved, in large part, through a strong commitment to partnerships with a wide range of health and intersectoral partners throughout his career, and through the trust he has gained through two Directors-General and three Ministers, to be able to clearly define the problem and the solution, and with their agreement, to go away and deliver on that solution. This has been instrumental in the growing confidence in, and investment in the public health function in Queensland.

A great strength of Dr Scott's is his personal values and his management and leadership style, which clearly supports the development of strong, capable public health leaders, fosters managers and staff who are excited by the opportunities offered by strategic thinking and sound business cases for service improvement, and where he communicates his confidence and trust in the abilities of his unit and network Directors and their staff. In return, he has enjoyed the confidence and support of staff in his ability to lead and deliver on the shared vision for public health services within Queensland. In addition, Dr Scott has shown amazing capacity to maintain the energy required to address obstacles, and resilience and good humour in the face of a daunting workload, ever-present political pressure and diverse public health challenges on a regular basis, all in the context of broader health care system challenges and demands.

Key achievements and supporting testimonials

Since Dr Scott commenced his career in public health, his unwavering vision, leadership, ethical approach, professionalism and strong advocacy have inspired and motivated a broad cross section of people, as a true transformational leader in public health. He has been responsible for, or a key player in, a broad range of significant achievements within Queensland and across Australia, spanning a diverse range of public health challenges from communicable disease issues to nutrition, injury, environmental health and social determinants of health.

In his relatively short time in the role of Senior Executive Director, Health Services, a role in which he has been responsible for all aspects of health service delivery provided or funded by Queensland Health, he has also brought a clear public health perspective to the key challenges for clinical service delivery. In doing so, he has provided a strong population based focus on key reform areas, including action on avoidable hospital admissions, a strengthened primary health care capacity, action on Indigenous health, the interface between public health and clinical service delivery, and equity and accessibility in the provision of health care. A summary of the some of the key achievements in relation to the criteria is provided below.

1. Protect and promote public health within Australia

Dr Scott has demonstrated strong and consistent leadership at both state and national levels to enable the following key achievements:

Public health leadership

- Establishment of Public Health Services as a statewide service of public health functions, consisting of statewide units with policy/program coordination functions and regional-based public health unit networks. Dr Scott's leadership brought together a disparate group of

professions and business units into a strategically focused service, encompassing policy development, regulation, surveillance and service delivery - with a shared vision and clear priorities, with an appropriate balance in relation to delivering on major national and state priorities, strengthening consistency and quality practice across the state, while at the same time being responsive to local needs and acknowledging local capacity and opportunities.

This has been achieved through the implementation of a system for strategic planning, monitoring and reporting, based on key outcome areas providing three year, outcome focused plans which are directly linked to resource allocation processes through a Board of Management and implementation of a quality improvement agenda based on the Australian Business Excellence Framework, now part of Standards Australia. The statewide model for delivery of public health services has involved a level of integration not seen to the same extent in other jurisdictions and is now well respected by public health professionals and administrators within Australia.

- Provision of a strong public health focus to the development of Queensland Health's vision for the future, *Smart State: Health 2020,* the development of its implementation process *Integrating Strategy and Performance (ISAP)* and the reworking of the organisation's mission, vision and strategic intents. It was no accident that four of the seven key sections of Health 2020 clearly acknowledge the importance of disease prevention and health promotion, a whole of government approach addressing the underlying determinants of health and illness, and the role of the health system as a 'leader for health' as well as provider of health services.

Increased investment in public health

- Strong leadership in securing significant additional investment in public health services within Queensland has included:
  - growth in core public health capacity (ie. statewide units and public health unit networks) from approximately 400 positions when Public Health Services came together in 1996 to approximately 750 at the time of this nomination in 2005. During that time, the budget has also doubled.
  - Investment enhancements have extended across a broad range of areas including needle and syringe availability, drug courts, Indigenous public health and primary health care workforce, nutrition and physical activity, tobacco control including environmental health workforce enhancement to support tobacco legislation enforcement, food regulation reform, school based youth health nurses and enhanced communicable disease preparedness and response capacity
  - advocacy for the collaborative state/federal funding for the establishment of three new public health units in western Queensland (Mt Isa, Longreach, Roma and Charleville). Prior to this, there had been no offices beyond the eastern seaboard and Toowoomba.
  - most recently, as part of the 2005/06 budget, substantial additional resources in public health and related primary health care capacity in key public health issues have been secured in relation to:
    - chronic disease prevention (nutrition, physical activity, alcohol and other drugs) totalling $37.7M as part of a $151M chronic disease package over four years and culminating in an additional recurrent investment of $13.3M per annum from 2008/09
    - tobacco control (an additional $4.5M per annum recurrently); and
    - Indigenous health ($89M over four years) for the priority areas of chronic disease prevention and early intervention, cervical screening, sexual and reproductive health, alcohol and drug misuse, environmental health and children and young people's health, again culminating in an additional recurrent investment of over $26M per annum from 2008/09.

Public health legislation

- Leading the substantial reform of Queensland's public health legislation in the areas of pool fencing, safer housing (thermostatic mixing valves to reduce the risk of scalds from hot water to children aged 0 to 5 years, Child Safe Housing guidelines for public housing, building standards), public health, food safety and tobacco control.

A national leader

- Leading activity where Queensland has been a national leader in a number of fields, through the development of new areas like programs for nutrition, physical activity and school-based youth health nurses, development of statewide information systems including NOCS (notifiable conditions) and VIVAS (vaccination information and vaccine administration – ahead of the national ACIR), and in achieving significant performance improvements in areas like immunisation and breast cancer screening in a state with the geographic, Indigenous, GP access and other challenges.
- Longest serving member on the National Public Health Partnership – past Chair, Chair of SIGNAL (nutrition), Co-Chair of SIPP (injury) and a key advocate for collaborative national action on a broad range of public health issues, for example, food reform, the role of general practice in population health, public health surveillance, and food supply and access in rural and remote Indigenous communities.

2. Promote multi-disciplinary approaches to designing public health solutions and solving public health problems

From his broad-ranging training and experience in multiple aspects of public health, combined with his high level understanding of public health problems, Dr Scott brings a clear vision about innovative solutions required to solve public health problems and is a strong advocate for multidisciplinary approaches. This operates at multiple levels, both within the public health workforce itself, practitioners across the health continuum and intersectorally. His strong commitment to working in partnership both within the health sector and intersectorally, combined with his strong and sustained advocacy at multiple levels, has enabled significant progress towards achieving a shared vision. This is well demonstrated through:

- creation of the network of multidisciplinary public health units across Queensland in the early 1990s. This brought together small numbers of existing health promotion and environmental health staff and added public health medical officers, public health nurses and data managers, and over time public health nutritionists, immunisation nurses, epidemiologists, entomologists and vector control officers and additional staff in all existing disciplines.
- promoting the importance of drawing on the value of different perspectives in planning and priority setting through the establishment of a statewide mechanism for strategic and operational planning which brings together multidisciplinary teams from across relevant statewide and public health unit networks into outcome areas teams which are responsible for leading annual planning and review for each program area (eg. environmental health, injury).
- refocusing Queensland Health's vision for the future to clearly acknowledge the integral role of disease prevention and health promotion and whole of government role in addressing underlying determinants of health and illness, as outlined in *Smart State: Health 2020*
- establishment of the Queensland Public Health Forum, consisting of18 member organisations (including commonwealth, state and local government, key professional associations, other state government departments and non government organisations, the

university sector, Queensland Division of General Practice, Inc. and Indigenous health) with a commitment to improve public health outcomes through a partnering approach. The Forum has continued to grow in importance as an effective mechanism for joined up action across the diverse health and related sectors in Queensland.

- establishment of formal partnership agreements and work programs with local government and Education Queensland
- supporting, advocating and securing resources to develop a stronger role for health impact assessment in policy, major infrastructure projects, land-use planning and program development, which involves harnessing the skills of diverse disciplines including such as scientists, urban, town and social planners, social workers, etc.
- establishment of a statewide health surveillance network to more effectively work with and support multidisciplinary public health practitioners with a broad-based focus across the communicable disease, chronic disease and underlying risk and broader social determinants.

3. Advance community awareness of public health measures and outcomes and the real cost of inadequate public health responses

Dr Scott has made a significant contribution to increasing community awareness of public health issues, measures and outcomes by initiating the development and accessibility of improved information on health status and health determinants at zonal and district, local government, general practice and community organisation levels. *Health Indicators for Queensland* (2001) clearly brought together and identified for the first time the significant contribution to ill health by common risk factors, and the burden of ill-health experienced predominantly by the socially and economically disadvantaged. *Health Determinants Queensland* (2004) clearly pulled together for the first time the impact of these factors and the ways we could intervene to address the inequity. Dr Scott's commitment to progressing a system wide understanding of the social determinants of health and the role that the health system has to play in relation to these issues has been critical in moving this agenda forward. These reports have been instrumental in progressing a shared understanding of the social determinants of health as a platform for intersectoral action and have been widely used in planning, priority setting, and partnership development by these stakeholders.

He has been a strong and consistent advocate within Queensland Health, with General Practice through his long term active participation in GPAC, the General Practice Advisory Council, and across government more broadly in increasing broader awareness of the risks of failing to invest adequately in public health responses. This has been demonstrated by significant increases in investment across a broader range of program areas as mentioned above, as well as additional investments in other portfolios such as education, transport (active transport), local government and planning (Indigenous environmental health) and emergency services (safe communities).

4. Advance the ideals and practice of equity in the provision of health care (equity defined as equal care for equal need)

Over an extended time period, Dr Scott was responsible for raising awareness of the social determinants of health across the health sector and the need for ameliorating the effects of social disadvantage and exclusion in reducing health inequalities. His success in this area is demonstrated by ensuring that the strategic agenda for Queensland Health, as articulated in *Smart State Health 2020: Directions Statement*, clearly reflects the social determinants of health.

Dr Scott has also championed the need to improve Indigenous health. In the late 1990s, he established a core of dedicated Indigenous positions within public health unit networks to address environmental health, nutrition and communicable disease prevention and control. More recently, his ongoing advocacy in this area has been instrumental in achieving the significant new investment referred to above in both public health unit and primary health care settings. He has also strongly advocated for sharper focus on Indigenous health challenges via the National Public Health Partnership.

In planning and resource allocation processes, he has consistently challenged and asked the hard questions of PHS managers and staff and the broader department in terms of the focus and investment going beyond 'neat solutions for neat people' and fundamentally addressing the needs of those most in need. In taking a statewide and epidemiological perspective, he has driven a focus on better use of data to understand equity, service and access gaps, to develop different solutions to address these gaps and to evaluate their impact.

Supporting Testimonials

Dr Scott's contribution to the field of public health programs and intervention and his impact across the four inter-related criteria addressed above is best evidenced by the testimonials of colleagues and staff. While too many to include in this nomination, Appendix 1 includes a snapshot of Dr Scott's impact from a small selection of colleagues on his contribution to the field of public health nationally and within Queensland.

Appendix 1: Supporting Testimonials

Reform of Queensland tobacco legislation

In 2001, smoking bans were introduced in many public places and workplaces, and point-of-sale tobacco advertising prohibited. During 2004, Dr Scott successfully led and supported further legislative reforms which built on those introduced in 2001.

The new tobacco legislation represents the toughest and most comprehensive smoking bans in Australia which will make a significant contribution to reducing the public's exposure to environmental tobacco smoke. This has included banning smoking at outdoor areas (including patrolled beaches, children's playgrounds entrances to non-residential buildings and at major sporting stadiums) from 1 January 2005. In addition, the smoking ban for indoor areas of liquor licensed premises is being implemented progressively in three phases so that by 1 July 2006, smoking will be banned in all indoor areas of liquor licensed premises. From 1 July 2006, outdoor areas where food or drink is provided as part of a business will also be no smoking. The new legislation also contributes to a culture that supports smokers trying to quit and discourages young people from taking up the habit.

Research shows that since the commencement of the tobacco legislative amendments in January 2005, 58% of smokers report smoking less in public areas, 26% of smokers report an overall decrease in the number of cigarettes they smoke, and 19% of smokers have made a quit smoking attempt.

(Mark West, Program Manager, Alcohol, Tobacco and Other Drugs Unit, Public Health Services Branch (PHSB)).

National and state nutrition agenda and enhanced public health nutrition capacity in Queensland

Dr Scott has been a particularly active and effective champion for public health nutrition over the last 5 years. Nationally, he has been Chair of SIGNAL, the nutrition arm of the NPHP from 2002 to present. In this role he steered implementation of Eat Well Australia and the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP). With practical flair, he led effective action in three priority areas: Indigenous nutrition (particularly workforce and food supply initiatives); capacity building (especially around national nutrition monitoring and surveillance essential for acquiring reliable and timely data to inform national chronic disease and food standard policy setting); and fruit and vegetable promotion. To support the latter work, he took on the role of Chair of the Australian Fruit and Vegetable Coalition which was pivotal in instigating the recent national social marketing campaign based on the successful Go for 2 fruit and 5 veg developed in WA.

In Queensland Health, Dr Scott together with Director-General Dr Steve Buckland, presided over a huge corporate change agenda to reform public health care in Queensland, including reorientating and building service capacity towards primary prevention and health promotion. As a specific example, the significantly increased funding in nutrition and physical activity since 2002 would not have been possible without Dr Scott as a key driver of this agenda within Queensland. New initiatives announced in the 2005-06 state budget will result in an additional recurrent Queensland Government investment in nutrition and physical activity from 2002 to 2010 to over $16M per annum. These initiatives include enhanced nutrition promotion programs, many with a focus on equity issues particularly amongst Indigenous groups, and increased support for environmental change to help make healthy choices easier choices. All of these initiatives are guided by the evidence-based approaches outlined in *Eat Well Queensland*, the Queensland food and nutrition strategy developed by the inter-sectoral Queensland Public Health Forum, another of Dr Scott's legacies.

Dr Scott's vision, ethical approach, professionalism, knowledge and skills have inspired and motivated a broad cross section of people, as a true transformational leader in public health. In public health nutrition, an often under-appreciated field, Dr Scott has left an inspiring legacy that illustrates clearly the significant health gains which may be achieved by tackling this complex issue.

Dr Scott's track record is notable against all four of the criteria for the Sidney Sax Public Health Medal, and on behalf of the broader public health nutrition community in Queensland and Australia, we urge the selection committee to recognise his achievements by bestowing this honour on Dr Scott.

(Dr Amanda Lee, Principal Public Health Nutritionist, Health Promotion Unit and on behalf of the public health nutrition staff across the state, PHSB).

Increased focus and capacity of health promotion workforce

Dr Scott has shown an ongoing commitment to health promotion action through overseeing the building of a strong health promotion workforce and bringing about significant achievements in the areas of smoking, nutrition, physical activity, alcohol, injury, skin cancer and mental health promotion. His commitment to quality and his willingness to 'ask the hard questions' that build that quality, have been directly responsible for a strengthening of the health promotion capacity of Queensland Health. Under Dr Scott's leadership, increased resources have been committed to health promotion and led to improved outcomes in this area.

This commitment has also extended to increasing the health promotion capacity of the broader Queensland Health workforce. Dr Scott championed the expansion of the range of duties performed by dental therapists in Queensland Health to include prevention and health promotion duties.

(Michael Tilse, Director, Health Promotion Unit, PHSB).

Immunisation

The immunisation program in Queensland has made considerable gains under Dr Scott's leadership and continued strong advocacy for immunisation as a fundamental component of public health.

Dr Scott was responsible for the establishment and development of Queensland Health's vaccine register and state of the art vaccine distribution system, Vaccine Information and Vaccination Administration System (VIVAS). This system was established well ahead of the national system. He also advocated for the establishment of Public Health Nurse (Immunisation) positions in Public Health Units across Queensland. These positions are integral to delivery of the immunisation program across the state and provide critical support to vaccine service providers and the community.

In 1996, an Australian Bureau of Statistics (ABS) survey estimated national immunisation coverage at 53%, and a similar level of coverage in Queensland. Currently, vaccination coverage for children in Queensland at 12 months and 2 years of age is comparable to, or better than, the national average and is over 90%. This is a significant achievement given Queensland's dispersed population distribution, the significantly lower rates of bulk billing by GPs and GP access is rural areas. In recent years, Queensland has led the way in managing quality issues in immunisation, including vaccine management (or cold chain).

Dr Scott also advocated strongly for provision of the Japanese Encephalitis vaccine to the TPHUN in 1995, which enabled an effective response to the outbreak.

(Ms Karen Peterson, Immunisation Coordinator, Communicable Diseases Unit and Dr Ross Spark, Director, Tropical Public Health Unit Network, PHSB).

Indigenous environmental health

Over an extended time period, Dr Scott has advocated in a range of intersectoral forums for increased investment in Indigenous environmental health. This laid the foundations for the recent success in securing significant new recurrent state government investment in this area for the employment of Indigenous Environmental Health Workers by local councils in all Deed of Grant in Trust (DOGIT) communities and Cape York (34 councils in all), and the establishment of Animal Management Workers to focus on issues of domestic and feral animal management. This infrastructure represents a major development in effectively and sustainably addressing what continue to be significant public health issues in these communities. This investment will enable delivery on relatively short term, measurable improvements in the living conditions and selected health conditions of people in these communities.

(Sophie Dwyer, Director, Environmental Health Unit, PHSB)

Communicable Diseases

Through the development of the public health unit networks in the early/mid 1990s, Dr Scott oversaw a tremendous increase in the capacity to respond to communicable diseases of public health importance across the state. There are now eight public health medical officer positions and a significant public health nurse workforce across Queensland who are involved in communicable disease surveillance and control. Their inclusion within the public health unit networks reporting, through the Network Director, to the Executive Director, Public Health Services Branch, as does the Director, Communicable Diseases Unit, greatly enhances the ability to coordinate and standardise their activities throughout the state.

Queensland is now in the enviable position of being well-resourced and efficiently organised from a communicable disease control perspective. This has enabled us to undertake enhanced surveillance for a range of conditions, to be able to respond well to urgent matters such as outbreaks, and to work together, support each other and quickly marshall the necessary resources in urgent situations.

When he was State Manager, Public Health Services, Dr Scott supported the development of the Notifiable Conditions Information System (NOCS), which pioneered electronic disease notification in Australia. This system has greatly enhanced the timeliness and ability to respond to notifiable diseases across the state.

He was also instrumental in driving significant policy reform in relation to the role of nurses and other health practitioners in the areas of immunisation and sexual health service delivery and isolated practice more generally.

(Dr Linda Selvey, Director, Communicable Diseases Unit, PHSB)

Dr Scott secured critical resources to establish the Dengue Action and Response Team (DART) in the Tropical Public Health Unit Network, following an outbreak of dengue fever in 1998 with further enhancements in 2004. The DART has been highly successful, the key to the success being the early recognition and notification of a dengue case, followed up by thorough, effective mosquito control. This level of infrastructure has proved critical in managing the 2005 outbreak in the Torres Strait.

(Dr Ross Spark, Director, Tropical Public Health Unit Network, PHSB).

Dr Scott supported a whole of government approach to HIV/AIDS, Hepatitis C and Sexually Transmissible Infections through the development and Cabinet endorsement of the

Queensland *HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005 – 2011*. This whole of government endorsed strategy is a first for any state or territory government.

Dr Scott has also provided sponsorship of the Queensland Health and Papua New Guinea (PNG) HIV/AIDS and Sexual Health Collaboration Project to develop a joint work plan with PNG colleagues to address the unique public health challenges within the Torres Strait Treaty Zone.

He was also responsible for securing recurrent state funding for the zonal sexual health medical officer in the Tropical Public Health Unit network, which has had a direct and positive impact on the unique challenges related to sexual health service delivery to the large Indigenous population of North Queensland.

(Mr Mark Counter, A/Manager, HIV/AIDS, Hepatitis C and Sexual Health, Communicable Diseases Unit, and Dr Ross Spark, Director, Tropical Public Health Unit Network, PHSB).

Cancer Screening

Dr Scott recognised the importance of the population based cancer screening programs of BreastScreen Queensland and the Queensland Cervical Screening Program in the early stages of forming Public Health Services. He became a strong advocate and corporate supporter of these public health interventions and assisted greatly in their ongoing establishment and growth in Queensland. He also provided key advocacy at the national level by raising key issues, particularly about the level of resourcing to continue to grow these programs in line with population growth and aging and through his negotiations for the Public Health Outcomes Funding Agreements over the last eight years.

A key part of his leadership is evidenced by his support and advocacy for the development and implementation of the software application for the Registry databases that underpin these programs, in the face of many challenges in information management and technology.

The achievements of these programs in Queensland have been facilitated by Dr Scott's supportive and visionary leadership.

(Ms Jennifer Muller, Director, Cancer Screening Services Unit, PHSB).

Establishment of a health surveillance network with a broader focus on social determinants

When Public Health Services was formed in 1996, the health surveillance workforce was very limited and professionally aligned with communicable diseases only. Dr Scott recognised that in order to make significant gains in improving the health of Queenslanders, health surveillance across the range of health outcomes and broader social determinants was required, in order to provide information for decision making through monitoring and evaluation within public health as well as advocacy for public health across the health sector.

Public Health Services Branch now has a coordinated workforce of epidemiologists and other health surveillance staff who work collaboratively with public health managers, practitioners, policy officers to provide, collect, analyse and communicate information across the breadth of diseases and determinants amenable to public health intervention within PHSB, but more importantly beyond PHSB. The lighthouse was always clear, and Dr Scott was responsible for keeping it shining.

(Ms Catherine Harper, Coordinating Epidemiologist, Planning and Research Unit, Public Health Services Branch).

Reflections from a colleague and fellow advisory board member

Dr John Scott was one of the original members of the Advisory Board for the Centre for Public Health Law. His contribution was always thoughtful, practical and grounded in a sophisticated understanding of how the law might support solutions to public health problems. One example I recall was a conversation about the obesity issue and a problem where local councils were charging fees for use of playing grounds, affecting the ability of small, local sporting clubs to use the grounds. Comments were being made about the short sighted approach of the Council. Dr Scott said that he thought it was appropriate for councils to charge for use of the playing grounds. He said that, in deciding what to charge sporting clubs, consideration should be given to the contribution made to the community in fostering activity, community involvement, etc. The value of the community contribution made by sporting clubs would reduce the amount they should pay to a nominal amount. This was an elegant solution which saw council by laws pursuing cost recovery, but not at the expense of a public health approach.

In addition to his contribution to conceptual thinking, he was supportive on a personal level and agreed to be a mentor of one of the Centre's Legal Interns.

(Genevieve Howse, Director (Programs), Centre for Public Health Law)

Social determinants of health

Dr Scott has been instrumental in raising awareness of the social determinants of health across the health sector and in embedding action to address these determinants of health within the work practices of Public Health Services in Queensland. Work in this area was in its infancy in Australia when Public Health Services, under the leadership of Dr Scott, undertook the challenge to determine Public Health Services' role in addressing social determinants. Dr Scott has demonstrated the importance of ameliorating the effects of social disadvantage and exclusion in reducing health inequalities. As a consequence the organisation now has a clear charter to address equity issues.

Dr Scott's leadership in addressing the social determinants of health has significantly influenced the policy and practices of Queensland Health. Examples include:

- Increased organisational capacity to redress health inequalities, through promoting integration of public health practices, further research to increase our understanding of the causal pathways and intervention points and investing in community engagement functions.
- Strengthening community action, including sponsoring multiyear projects such as the Community Public Health Planning in Rural and Remote Areas Project, a community development project undertaken in remote disadvantaged communities. This approach has now been embedded as a core aspect of the practice of the Western public health units.
- Building supportive physical and social environments and healthy public policy through greater investment in public health planning and health impact assessment functions
- And ensuring the social determinants of health are embedded in the policies of the broader department including the *Smart State Health 2020: Directions Statement*

Whilst Dr Scott's leadership in addressing the social determinants of health has significantly influenced Queensland Health's policy and practices, he has also personally undertaken the role of champion for these issues across the health sector and with other government departments. Whether he was among colleagues, addressing public forums or conferences or meeting with the CEOs of other government departments, Dr Scott was able to raise awareness of the social determinants of health and mobilise action accordingly.

(Paul Harris, Natalie Baig & Garth Henniker, Senior Project Officers, Health Promotion Unit, Public Health Services Branch)

Contribution to the National Public Health Partnership

Dr Scott has been the Queensland member of the NPHP since February 1999. From October 2001 to September 2002, he served as Chair of the NPHP. As Chair, Dr Scott presented the future priority agenda of the NPHP which was endorsed by CEOs of Health (Australian Health Ministers Advisory Council - AHMAC) and oversighted work across a range of key public health issues including environmental health, health information development, public health genetics, communicable disease control, child and youth health, legislative reform, General Practice and population health, and mental health prevention and promotion.

Dr Scott was instrumental in the establishment of the Aboriginal and Torres Strait Islander Working Group of the NPHP and was a key player in the development of the Smoking, Nutrition and Physical Activity (SNAP) framework which has been developed as a resource for general practice.

Since 2002, Dr Scott has chaired the Strategic Inter-governmental Nutrition Alliance (SIGNAL), with responsibility for oversight of *Eat Well Australia*. He led work to progress implementation of the *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010*; to facilitate nationally consistent health promotion messages on the consumption of fruit and vegetables; and engagement of the food industry through the establishment of the Australian Fruit and Vegetable Coalition. He also represented SIGNAL on the National Obesity Task Force (NOTF) addressing healthy weight issues for children, adults and older Australians.

Since 2002, Dr Scott has co-chaired the Strategic Injury Prevention Partnership (SIPP). During this time he assisted in oversight of implementation of the *National Injury Prevention Plan* and development of a suite of new national strategies for injury prevention and safety promotion, consisting of the *National Injury Prevention and Safety Promotion Plan 2004-2014* and the *National Aboriginal and Torres Strait Islander Safety Promotion Strategy.*

On behalf of the NPHP, Dr Scott led the work on development of a Public Health Action Plan for an Ageing Australia to contribute to the *National Strategy on Healthy Ageing.* The Plan was endorsed by Health and Community Services Ministers. Implementation commenced under the auspice of the NPHP in 2005 and with the support of the Positive Ageing Taskforce of the Community Services Ministers Advisory Council.

On behalf of NPHP, Dr Scott has raised issues for AHMAC related to refugee health, and has championed state and territory and Australian Government contribution to a project for improving access to healthy foods in remote Indigenous communities in Australia.

(Ms Karen Roger, Secretariat, NPHP).

Reflections on local and national public health capacity-building from a former Public Health Unit Network and NPHP colleague

John Scott followed on from the vision of Diana Lange and Gerry Murphy to become the driving force in implementation and coordination of a newly established public health unit network across Queensland - a network that grew remarkably rapidly to provide a consistent and coherent public health protection and promotion service that remained responsive to local needs.

The National Public Health Partnership has benefited not only from Dr Scott's chairing, but also from his drive and leadership in a number of its output areas – particularly in areas such as SIGNAL and SIPP. Systems changes in such areas require time, and the benefits of this work will continue to be realised for some time to come.

There have been several keys to Dr Scott's success in public health. One is his commitment to multi-disciplinary approaches to solve public health problems, as exemplified by the management and professional leadership structures put in place in Queensland's Public Health Services. Many of the excellent achievements described above obviously were not the result of a single person's effort: what is important to note is that Dr Scott provided an enabling and supportive environment for work colleagues to collectively and effectively progress mutual goals. Another success factor has been an ability to extrapolate from the local to the national, to bring about systemic responses to address public health issues such as Indigenous nutrition. He had the ability to provide, in appropriate circumstances when support was required from key decision-makers, a brief narrative based on local knowledge and experience to illustrate the need for and benefits of a public health intervention. This helped bring about a sense of the practical importance of public health and build strategic alliances. These attributes, combined with a pointed sense of humour and irony, have made John Scott a highly effective public health practitioner well-deserving and worthy of the honour of the Sidney Sax award.

(Dr Roscoe Taylor, public health physician in Central Queensland Public Health Unit 1994 – 2002; Director of Public Health and Director of Population Health, Tasmania and NPHP member since 2002).

Reflections from a NPHP colleague

I would like to contribute to the nomination of Dr John Scott for the Sidney Sax Public Health Medal 2005. I am sure there are many public health professionals who would welcome the opportunity to advocate for Dr Scott as an outstanding public health professional for this nomination and I am but one of those.

I have known Dr Scott for approximately ten years. My association with John has been through national committees concerned with public health in Australia, particularly the National Public Health Partnership (NPHP), SIGNAL and SIGPAH.

Dr Scott is an eminent public health professional in Australia, particularly in view of his experience, his good character, his broad knowledge and ability to translate that knowledge articulately, his sound counsel in balancing the political dimension, industrial and community issues we deal with and his ability to take a leadership role.

Dr Scott has employed all of these attributes within his role in the NPHP and other national committees and has promoted public health at the highest level within the national context.

His aims have always been the protection of public health and safety of the community and he has always acted impeccably.

Of particular significance has been his leadership in the nutrition area in chairing the SIGNAL group and in so doing bringing nutritional issues to the highest level of government. This has been demonstrated through the NPHP and the Australia New Zealand Food Standards Ministerial Council.

Dr Scott has recently promoted the 2 Fruit & 5 Veg Campaign in the national arena by enlisting the support of the food industry, particularly the horticultural industry, supermarket chains and marketing companies in the promotion of fruit and vegetables. This together with his work in the promotion of other lifestyle issues such as physical activity are key determinants in many of the chronic diseases affecting the Australia and New Zealand public which have a profound impact on the health costs of the Australian health system.

I believe that Dr Scott more than satisfies the criteria for this medal in that he has protected and promoted public health within Australia in particular, but has throughout his career addressed all of the criteria for this medal.

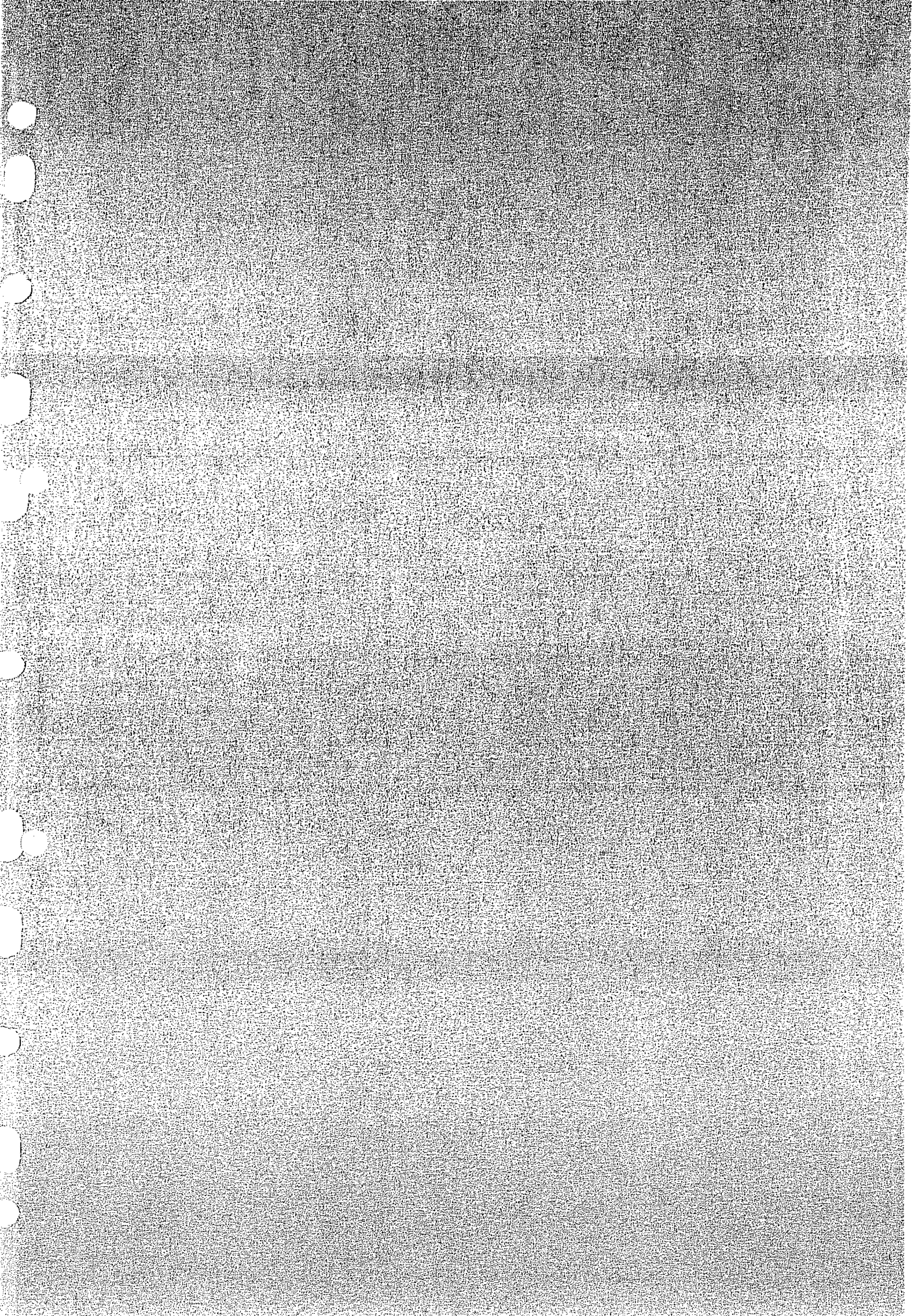
It is without hesitation that I highly recommend Dr Scott as an eminent public health professional and one who is eminently appropriate for the award of the Sidney Sax Public Health Medal 2005

(Michael P Jackson, Executive Director, Population Health, Western Australia Department of Health)

A former peer's and academic perspective

Over a period of more than 10 years, Dr Scott has bought a practical reality to the public health agenda in Australia, bringing his disciplinary backgrounds in economics and general practice to a commitment to population health. Perhaps more than any of the other government based leaders of public health in Australia, he has been able to articulate a vision of population health as the public health-clinical interface in a way that resonated to Director-Generals of Health. Through his leadership, Queensland government has adopted this as can be clearly seen in the *Health 2020 Strategic Directions Statement*.

(Professor Andrew Wilson, University of Queensland)



ATTACHMENT "F"

1.	Exhibit 301C, paragraphs 28 – 33, 109 – 110	1 – 2
2.	Attachment MIC-7 to exhibit 301C	3 – 8
3.	Exhibit 263, attachment CA4	9 – 15
4.	Transcript 6269 – 6270	16 – 17
5.	Exhibit 301C, MIC - 21	18 - 27

February 2003. The Director General, subsequently requested the issue be progressed.

22 Discussions took place between the Director General, General Manager Health Services and Zonal Managers, who provided 'in principle' support to the transfer of activity and resources.

23. Following these discussions, Queensland Health made a decision in early 2003, to expand cardiac services at PAH through the transfer of services from TPCH.

24 The Cardiac Surgery Services Working Party was commissioned and a project officer appointed to provide a detailed assessment of the recurrent and capital requirements of the service expansion.

25. A copy of the Cardiac Surgery Services Working Party Terms of Reference are attached and marked **MIC-3**.

26. In April and May 2003, both TPCH and PAH prepared Impact Analysis Reports based upon the transfer of 300 cardiac surgical procedures, 700 coronary angiograms and 233 coronary angioplasty procedures. Copies of those impact reports are attached and marked **MIC-4**.

27. Due to some disparities in the two reports, it was agreed at the May 2003 Cardiac Surgery Services Working Party meeting, that an external consultant would be appointed to review both business cases to determine the reasonableness of the assumptions and projections Mr Jim Lowth, was appointed to undertake this process. Copies of the minutes of that meeting are attached and marked **MIC-5.**

28 On 30 July 2003, a meeting was held between myself, Mr Lowth, Graeme Kerridge, Manager Central Zone Management Unit and Dr Paul Garrahy, Director of Cardiology, PAH to finalise the cardiac services activity transfer.

29. It was agreed at that meeting that the final transfer numbers would be 300 cardiac surgical procedures, 500 coronary angiograms and 96 coronary angioplasty/stent procedures.

30 The transfer in cardiology activity was to commence in April 2004. The transfer in cardiac surgical activity was to commence in July 2004. Attached as a bundle and marked **MIC-6** is copies of memorandums from me to department heads regarding this transfer.

31. Despite the transfer of activity from TPCH to PAH, demand for cardiology and cardiac surgery continued to increase.

32. Submissions were made for additional funding for cardiac surgery by TPCH to Dr John Scott, Acting General Manager Health Services on 24 May 2004. Attached and marked **MIC-7** is a copy of that submission.

33. Additional funding in the sum of $2.4M was provided in the 2004-2005 financial year to undertake additional cardiac surgery at TPCH.

109. On 12 October 2004, I prepared a briefing to Dr Scott, Acting Senior Executive Director Health Services in relation to these issues. A copy of that briefing is attached and marked **MIC-21**.

110. In response to this briefing, Queensland Health provided additional funding as follows:
- October 2004 $1.07M (used for additional angiography and ICD activity);
- December 2004 $1.4M (allocated to ICD, ASD closures and angiography);
- April 2005 $3M (used to support ICU, transplants - heart and lung, and oncology).

111. The cumulative effect of the additional funding allocations referred to above has been that, since February 2005 (the date from which reliable data on this topic is available to me):
- The angiography waiting list reduced from 192 to 99 cases;
- The angioplasty waiting list reduced from 52 to 48 cases;
- Currently only 7% of Category 1 angioplasty cases are waiting longer than their recommended 30 days compared to January 2005 when 30% of such cases waited longer than 30 days;
- The waiting list for defibrillators has reduced from 68 (February 2005) to 55 (current). Of these current cases, over 70% are facing a wait longer than their recommended 30 days. However, only last week I submitted a funding request for an additional $2.1M to address their wait. I am optimistic of a favourable outcome to my funding request;
- Currently the cardiac waiting list for new patients is 575 cases compared to 745 such cases in October 2004.

112. Attached and marked **MIC-21A** are true copies of the statistical data on average waiting times for cardiology services (other than out-patients)

Resignation of Aroney and credentialing/privileging issues

113. By letter dated 9 March 2005 addressed to Ms Wallace, Dr Aroney gave written notice of his resignation from TPCH. In that correspondence, Dr Aroney requested ongoing privileges at TPCH. By letter dated 21 March 2005, I advised Dr Aroney that *'if the need arises, the process for considering and awarding privileges will be awarded through Medical Administration'* A copy of that correspondence is attached and marked **MIC-22**.

114. I note in paragraph 58 of his statement, Dr Aroney states that his offer to provide services was *'effectively refused'* and that it was treated *'as a request for privileges rather than an offer of voluntary service'*.

115. I refer to my previous statement to the Commission of Inquiry, regarding the role of the EDMS signed 23 August 2005. In paragraph 6 (e) and (f) I have provided information regarding the way in which clinical privileges are awarded. For any person who is not a member of staff at TPCH, privileges are granted on a case-by-case basis for each procedure undertaken. This is a very simple process and is approved by the EDMS or the EDMS on-call.

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-7

EMAILED
McZ 4/6/04

02-03.3.

Queensland Government
Queensland Health

SUBMISSION TO THE A/GENERAL MANAGER HEALTH SERVICES

DATE:	24 May 2004		
PREPARED BY:	Paul Winton – Program Business Manager, Cardio-Thoracic Surgery, Orthopaedic Surgery & Critical Care, TPCHHSD	**Contact No:**	(07) 3350 8802
	Dr Greg Stafford – Program Medical Director, Cardio-Thoracic Surgery, TPCHHSD	**Contact No:**	(07) 3350 8696
	Mary Wheeldon – Nursing Director, Cardio-Thoracic Surgery, Orthopaedic Surgery & Critical Care, TPCHHSD	**Contact No:**	(07) 3350 8215
	Jon Roberts – Executive Director of Finance & Information Services, TPCHHSD	**Contact No:**	(07) 3350 8418
	Dr Michael Cleary – Executive Director Medical Services, TPCHHSD	**Contact No:**	(07) 3350 8226
CLEARED BY:	Gloria Wallace - District Manager, TPCHHSD (signed G Wallace 3/6/04)	**Contact No:**	(07) 3350 8224
SUBMITTED THROUGH:	Mr Dan Bergin – Zonal Manager, Central Zone Management Unit	**Contact No:**	(07) 3234 0825
DEADLINE:	District Initiated	**File Ref:**	02.03.3

SUBJECT: Funding Submission – Extra Activity Cardio-Thoracic Surgery

11

APPROVED/ NOT APPROVED

COMMENTS

Dr John Scott
A/General Manager Health Services

PURPOSE:

To seek additional funding to allow The Prince Charles Hospital to increase elective Cardiac Surgery throughput.

BACKGROUND:

The potential exists for The Prince Charles Hospital (TPCH) to increase elective Cardio-Thoracic surgery for the 2004/2005 financial year.

TPCH supports the largest Cardio-Thoracic Surgical Service in Australia.

TPCH redevelopment included 2 x 30 bed Cardio-Thoracic Surgical wards and an expanded operating theatre complex. The planned capacity in the redevelopment allowed for significant workload increases in cardiac and thoracic services.

Currently the Cardio-Thoracic service utilises 44 of the 60 beds allocated to Cardio-Thoracic Surgery. An average of 38 half day operating sessions per week are currently used to achieve funded activity levels.

As a result of the transfer of 300 cardiac surgery cases to the Princess Alexandra Hospital (PAH), there will be vacant theatre sessions available to facilitate additional Cardio-Thoracic Surgical activity.

ISSUES:

Queensland Health is in the process of expanding the cardiac service infrastructure at the PAH through the allocation of growth funds to PAH and the transfer of funding from TPCH to PAH. Planned activity transfer included transfer of both surgical and interventional cardiology.

To a large degree interventional cardiology activity from the Southern Zone has shifted to the PAH during the past 18 months.

- As at 1 April 2004, TPCH had 380 patients on the Cardio-Thoracic Surgical Waiting List, in the following categories:
  - Category 1 – 65
  - Category 2 – 243
  - Category 3 – 72

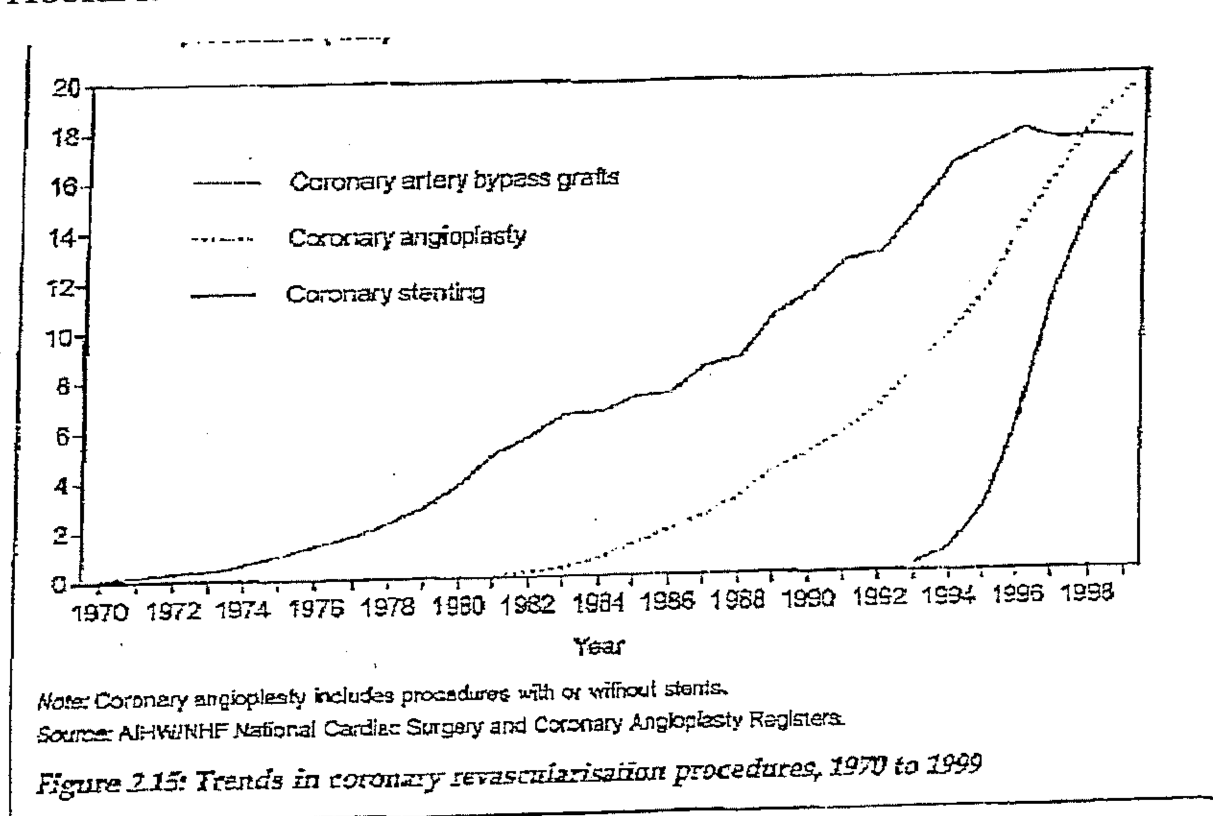
- As at 1 April 2004, TPCH had 79 new patients waiting to be seen in Cardio-Thoracic Surgical Outpatients.
- The average waiting time for a new patient appointment for a Cardio-Thoracic Surgical Outpatient Clinic is 5 weeks.
- New surgical referrals from the Cardiology Department to the Cardiac Surgical Department have increased over the previous 12 months from approximately 15 cases per week to over 20 cases per week.
- Ten to fifteen percent of cardiac surgical activity undertaken at TPCH relates to patients from the Southern Zone who require specialist services eg. Congenital Heart Surgery for children, transplantation, etc.
- Given the success of donor rates, transplantation procedures are likely to increase.

- Additional funding to support interventional cardiology totalling $2.0M has been approved for the 2004/05 financial year. This will result in an increase in the number of angiograms being performed within Queensland. Given that 30% of patients having angiograms are referred for surgery, this increase in cardiological activity will result in additional patients being referred for surgery.
- In Australia revascularisation (coronary angiogram and stenting procedures) rates vary across all states. Queensland rates are significantly lower than the national rates (see table 1 and figure 1).
- Clinical practice changes related to the treatment of acute coronary have resulted in, and will continue to result in, an increase in patients requiring acute cardiac surgery.
- As the population ages there will be an increasing need for cardiac valve surgery.
- Adults who as children had cardiac surgery to treat congenital heart conditions are increasingly requiring further corrective surgery. This is an emerging area of cardiac surgery demand.

TABLE 1:Percutaneous coronary intervention rates per million of population by region, 2000

	National Rate	Queensland Rate	Variance	Victorian Rate	West Australian Rate	SA & NT Rate	Tasmanian Rate
PCI	1125	944	-181	1370	1065	1155	1203

FIGURE 1:



Note: Coronary angioplasty includes procedures with or without stents.
Source: AIHW/NHF National Cardiac Surgery and Coronary Angioplasty Registers.

Figure 2.15: Trends in coronary revascularisation procedures, 1970 to 1999

BENEFITS AND COSTS:

Increasing the level of cardiac surgical activity at TPCH will provide the following benefits:

- Assist with the reduction of Category 2 long wait patients at TPCH.
- Improved community access to elective cardiac surgery.
- Increase the utilisation of the spare physical capacity at TPCH.
- Maintain service at TPCH in line with the Hospital Redevelopment Business Case.
- Reduce the average cost per weighted separation at TPCH.
- TPCH current activity target is 42,000 weighted separations under Phase 8 Cost Weights.
- The provision of an additional $2,432,500 in funding would allow an increase in net activity of 973 weighted separations under the Phase 8 Cost Weights.

CONSULTATION:

N/A

ATTACHMENTS:

N/A

RECOMMENDATION(S):

The Acting General Manager Health Services approve the allocation of an additional $2,432,500 in funding for elective cardiac surgery in the 2004/2005 financial year.

CA 4

Queensland Government
Queensland Health

SUBMISSION TO THE
A/GENERAL MANAGER HEALTH SERVICES

DATE:	24 November, 2003		
PREPARED BY:	Dr Andrew Galbraith, Program Medical Director, Cardiology, TPCHHSD	Contact No:	3350 5566
	Tony Shields, Acting Program Nursing Director, Cardiology, TPCHHSD		3350 5884
	Hayley Middleton, Program Business Manager, Cardiology, TPCHHSD		3350 8913
CLEARED BY:	Jon Roberts, Executive Director Finance and Information, TPCHHSD	Contact No:	3350 8418
	Cheryl Burns, Executive Director Nursing Services and Sponsor for Cardiology		3350 8214
	Dr Michael Cleary, Acting District Manager, TPCHHSD		3350 8224
SUBMITTED THROUGH:	Dan Bergin, Central Zone Manager	Contact No:	3234 0825
DEADLINE:	URGENT	File Ref:	CPMT03-001
SUBJECT:	Emergency and Unplanned Activity Demand for patients presenting with Acute Coronary Syndrome and existing resource availability for treatment		

APPROVED/ NOT APPROVED

COMMENTS

Dr John Scott
A/General Manager Health Services
/ /

PURPOSE:

To inform Queensland Health and confirm Zonal support of demand management strategies being put into place to provide treatment to adult patients presenting with Acute Coronary Syndrome to Queensland Public Hospitals and subsequent referral options to The Prince Charles Hospital Catheter Laboratory.

To seek additional funding within Central Zone to address the increasing ratio of emergency/ unplanned activity that is compromising capacity to undertake elective revascularisational procedures at The Prince Charles Hospital.

BACKGROUND:

Despite a decline in Cardiovascular deaths, mortality reduction has not been achieved equally amongst the population. Gains continue to be linked to higher socioeconomic groups who are more likely to be managed in the private HealthCare system. Thus the major burden in terms of funding and demand remain on the public health system.

Queensland's tyranny of distance results in mortality increasing with distance from large population centres. Queensland Health Information Centre confirms that mortality rates are statistically higher in remote areas (25%) and socioeconomically disadvantaged areas (10%).

The challenge facing Catheter Laboratories is managing the increasing demand, both metropolitan and rural/remote. Increased demand for access by regional public hospitals to transfer at-risk patients to tertiary centres has occurred as clinical management shifts to adopt and reflect Acute Coronary Syndrome Guidelines. These guidelines are aligned to both European and American clinical management.

Unplanned Demand

The Inter-hospital transfer rates for non-surgical cardiac DRGs has exponentially grown over the last 2 years. Inter-hospital transfers now accounts for over 50% of the PCI activity at TPCH. The current budget is set for an average of 13 PCI's per week. Over the preceding 12 months there has been a significant increase in the number of Inter-hospital transfers requiring interventional activity from 33% of PCI activity in 2002 to 50.5% in 2003. In terms of absolute numbers, this has grown from 46 patients in the September 2002 Quarter to 93 in the September 2003 Quarter. The full year growth in PCI activity from Inter-hospital transfers is projected at an additional 188 patients.

Elective Demand

Categorisation used for Elective patients is similar to that used for elective surgery.

Current Elective Waiting List

[illegible]	Waiting Time [illegible]	[illegible]	[illegible]	[illegible]
Angio Cat 1 (30 days)	155	34	67	15
Angio Cat 2 (90 days)	[illegible]	[illegible]	[illegible]	[illegible]
Angio Cat 3 (365 days)	5	1		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PCI	12	12	8	8
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

This data is not reported with the elective surgery data.

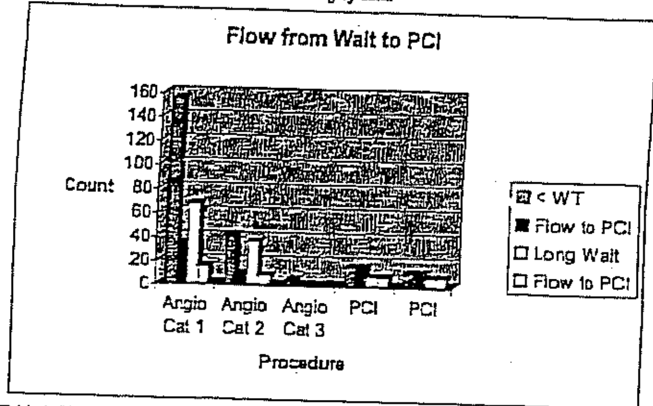


Table 1: Elective Waiting list and flows to PCI (Stents)

Improving Treatment Options

Patients presenting to Emergency Departments throughout Queensland with the following indications constitute the demand for access to the TPCH Catheter laboratory:

- Myocardial infarct
- Unstable angina
- At risk patient groups:
  - Pain or ischaemia refractory to medical therapy
  - ECG changes (depression or inversion)
  - Positive serum markers, eg Troponin levels
  - Associated heart failure or haemodynamic instability
  - High risk on stress testing
  - Recent MI or revascularisation

All patients are risk stratified through the TIMI score to prioritise patients in terms of clinical need to determine appropriate timeframes for transfers.

High Risk Patients

Early invasive revascularisation is recommended for high-risk patients with an ACS to reduce the six-month relative risk of death, infarct or re-hospitalisation for ACS. These patients are the most at risk of having a subsequent coronary event and therefore have the most to gain from early treatment.

Whilst the current average ratio of patient:stent is resourced at 1:1.38 – there is significant risk in this ratio increasing over time as the complexity of patients grows and scope of the procedures expand. Given the significant financial implications of changes within this ratio, it will require monitoring and planning in terms of numbers of stents and numbers of patients resourced.

Timing of Therapy is shifting – evidenced- based medicine and medicine-based evidence

The Cardiac Catheterisation Laboratory has experienced increased demand over the preceding years and the change in ratio between elective and emergency / unplanned transfers is now placing significant pressures on the service to continue to function within current resource allocations. Demand management strategies have revolved around capacity within the elective waiting lists to absorb the increased demand from inter-hospital activity. However, the elective lists now include a number of patients outside the best-practice waiting time to access service. There is also increased waiting times for inter-hospital transfers and these are being managed based on clinical priority.

The CHI Cardiac Collaborative activities focus has had an emphasis on the secondary prevention activities to deliver improved outcomes. There is anecdotal evidence that needs to be further reviewed, that would suggest a significant decrease in the practise of lysing in regional public health facilities. This would reflect improved awareness of the ACS guidelines and a desire to improve patients' outcome, reduce disability of patients by fast-tracking access to revascularisation.

Technology impacts – the issue around substitution

The scope of revascularisation within the Catheter Laboratory environment does have some impact on the number of procedures undertaken surgically. This change in scope of procedures within a laboratory environment will continue to escalate as new technology (viz drug eluting stents) becomes available. The impact of substitution needs to be assessed in conjunction with revascularisation demand projections based on the ageing population and underlying burden of disease in Australia.

Unplanned Admissions

The ratio of unplanned admissions impacts on service delivery planning and has an impact on the efficient utilisation of resources. Elective patients are often not scheduled given the risks of outlier patient bed management from inter-hospital transfers waiting in regional hospitals. There are inherent difficulties in planning for what is in its very nature – an unplanned event.

To address this, the Catheter Laboratory is building a model to predict the daily number of admissions in the short to medium term. An important aspect of this model will be to quantify daily risk that the actual number of admissions will be within this prediction. Development of this model has identified a likely further impact on capacity for local elective activities.

ISSUES:

- The cardiac catheterisation intervention rate has been regulated at TPCH in an attempt to contain activity within available funding for the District.
- The level of intervention for a public patient in Queensland verses the rest of Australia is 351.5/million (Qld) population compared to 565.3/ million (Aust.) population (data from the 2001/2002 National Hospital Cost Data Collection). This confirms that public intervention rates in Queensland are significantly below the Australian average. (Refer to Table 2)

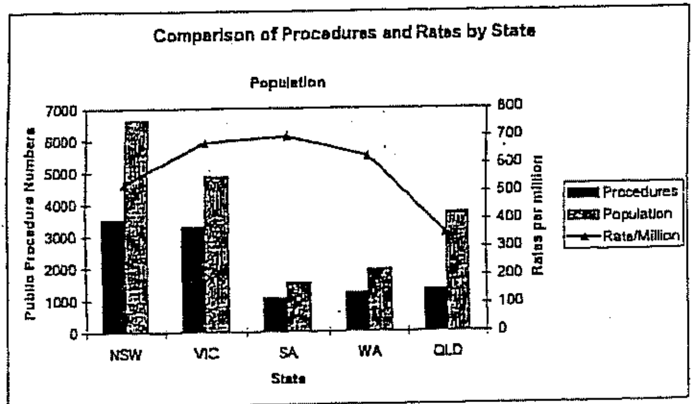


Table 2: Queensland has the lowest rate per million for major states.

- There has been a significant increase in the number of Urgent Inter-hospital Transfer's to TPCH. (Refer to Table 3)

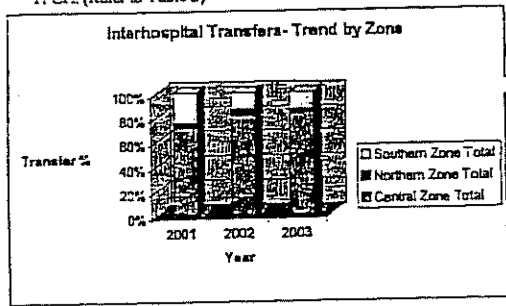


Table 3: Inter-hospital Transfers

- Intervention rates at RBWH appear to be static and therefore have not contributed to the increased demand at TPCH.
- Patients from the Southern Zone are actively redirected to the PAH. There are currently no Southern Zone patients on the Inter-hospital transfer list at TPCH. This is supported by an analysis of all cardiac related DRG's for the last 3 years
- Patients from the Northern Zone are actively redirected to Townsville. Reduction in actual numbers at TPCH has been offset by the commencement of TPCH Cardiologists travelling to Townsville monthly to undertake procedures at that centre. There is an agreement in place to recover marginal costs associated with PCI activity for the Northern Zone.

- The potential for diagnostic procedures to progress to percutaneous revascularisation is approximately 22 - 25%. Meeting these elective requirements is difficult to accommodate within the current resources.

- The District is progressing integration between RB&WHHSD and TPCHHSD Cardiac Services. There is preliminary commitment to developing a single coordination for both Catheter Laboratories. The first phase of this includes exploring how single point coordination and logistics can be operationalised in terms of emergency and requests for inter-hospital and urgent unplanned admissions. This model is in alignment with strategies being employed in Metropolitan Sydney and Melbourne with coordination across Cardiac services to address emergency and unplanned urgent cases. The Working group across TPCH and RB&WHHSD will be reviewing and exploring this model as progress is made toward integration.

BENEFITS AND COSTS:

Management of Acute Coronary Syndrome is hospital based and resource intensive. The centralisation within Metropolitan areas of public cardiac catheter laboratories supports improved outcomes through volume, but also adds to demand in trying to respond to planned and unplanned activity from many referring sources and populations with varying community and social determinants and risk factors.

The *Health 2020* documents identify the need for more locally accessible and community based services in terms of access to health services. It also identifies that Acute Hospitals will become more specialised with higher volumes of complex care. There is significant work already underway in terms of health promotion and secondary prevention for managing cardiovascular disease. There remains a need for decision and appropriate investment regarding the model of care for management of acute coronary syndrome within public hospitals.

Strategies identified in the Queensland Health Outcomes Plan - Cardiovascular Health: Coronary Heart Disease 2000-2004 for Clinical management identify the following key areas relative to Acute tertiary services targeted to improve service response to Queenslanders.

- The adoption of evidence based practice for the clinical management of acute myocardial infarction (AMI), unstable angina and post cardiac surgery patients by service providers.
- A coordinated response by emergency services to acute coronary events.
- Early identification and resuscitation of people who suffer from AMI.

Costs of care are shifting and will now be front-loaded within initial acute presentation for Acute Coronary Syndrome. The District request a Health Technology Assessment be undertaken regarding the health outcomes and economics of investing in initial acute presentation and treatment for Acute Coronary Syndrome and identification of the flow on savings that would support the significant growth required for Queenslanders to access this therapy.

Based on the current demand for urgent care directly resulting from Inter-hospital Transfers, the District estimates the need to perform an additional 188 procedures per annum to address the current demand for Urgent Inter-hospital Transfer's and a further 38 procedures per annum to address the long wait elective cases.

There is limited capacity to further reduce elective activity without further impact on the waiting list and waiting times for the population to access further treatment.

patients should not be exposed to multiple procedures when in most cases this can be achieved in the primary episode of care.

The marginal cost implications of this level of activity are estimated to be approximately $600,000 – $700,000.

The capacity of the District to manage within current resources for Cardiology has previously been flagged as a budget risk. This concern has now been confirmed.

CONSULTATION:

TPCH
Jon Roberts, Executive Director Finance and Information Services
Dr Sue Phillips, Acting Executive Director Medical Services
Cardiology Program Management
Dr Darren Walters, Clinical Director Catheter Laboratory Services
Margaret Dahl, Clinical Nurse Manager, Catheter Laboratory Services

ATTACHMENTS:

1. National Acute Coronary Syndrome Guidelines
2. District Manager Memo regarding Catheter Laboratory Activity
3. Cardiology Protocol for Inter-hospital Transfers of Cardiology patients
4. Proposed tools for Registrars to assist in understanding Zonal patient flows for Catheter activity
5. Presentation from Dr Walters "Changing Management of Acute Coronary Syndrome"
6. Health Outcome Plan (Note Page 8: ACS clinical management strategies)

RECOMMENDATION(S):

1. That Queensland Health Zonal Management review the issues relating to the resourcing difficulties being experienced in managing demand resulting from increasing Inter-hospital Transfers for acute coronary syndrome patients presenting at Queensland Public Hospitals.
2. That Central Zone review the resourcing applied to the demand for emergency and unplanned revascularisational activity within Central Zone and increase resource allocation by $650,000 to address the projected demand for unplanned and urgent transfers during 2003/2004 and assist to reduce the resulting long wait patients for elective procedures.
3. Central Zone support planning and resourcing relating to the development and implementation of a coordinated emergency revascularisational cardiology service across Brisbane North Catheter laboratories (TPCH and RB&WHHSD) in line with the strategy :- Queensland Health Outcomes Plan - Cardiovascular Health: Coronary Heart Disease 2000-2004.
4. That Northern Zone continue to reimburse TPCH for Northern Zone activity based on agreed patient acceptance and transfer protocols and marginal cost recovery mechanisms.
5. A statewide plan based on a Health Technology Assessment for acute revascularisation (including cardiac surgery) as recommended in the Queensland Health Outcomes Plan - Cardiovascular Health: Coronary Heart Disease 2000-2004 is developed and funded to support the cardiovascular burden of disease for Queenslanders.
6. That Southern Zone Management unit supports these demand management strategies and Southern Zone Catheter Laboratories provide access to emergency and unplanned revascularisational cardiology for Southern Zone patients.

MS DALTON: I want to discuss these - the cutbacks with the witness. 1

COMMISSIONER: I thought you had, but all right.

MS DALTON: No, I want to discuss them individually. Look, I don't know. I might be another 30 minutes.

COMMISSIONER: All right.

10

MS DALTON: Dr Aroney, you know that as part of that extra $20 million elective surgery funding, you got extra money to be doing work in the cath lab at Prince Charles, don't you?-- Yes, we did.

And the extra money meant you increased the number of procedures you did?-- Yes. As I said, this happened during an election campaign - or after the election, after our public disclosures of the second cutbacks. These were then announced, promised by the government, and went ahead after the election. I don't think that none of this would have gone ahead if we hadn't made our public disclosures. 20

And that meant that the cath lab procedures increased to 80 a week?-- Yes, back to where they should have been, where they have been for the past four or five or more years.

Well, they'd never been that high, have they?-- Yes, they have. I tendered that information this morning.

30

Well, you didn't tender it. You gave some oral information. Where did you get those figures from?-- I've had access to the activity at the cath lab continually, as my work in the cath lab and as Director of the Coronary Care Unit.

Do you just remember them off the top of your head?-- I keep the information, and I've got it here.

In what form is that information?-- I write it down and I have - I have the exact numbers, and you can get them from Queensland Health directly. 40

So it's your personal, handwritten records, is it?-- Yes.

And the cutback to 57 per week, Dr Aroney, was when that funding money was lost in about June - that extra $20 million funding money was lost in June 2004?-- As I stated, the activity for the past four years has been between 77 and 80 per week. So cutting this back suddenly to 57 per week in November 2004 can't be due to a loss of extra funding. 50 It's a direct cutback. There's no other explanation, and someone should be held accountable for this, and for the reasons for it. The tendered explanation is incorrect. What you're just saying now is incorrect.

Well, you say that, and you say that the reason it was cut back to 57 per week is in September 2004-----?-- The decision was made then. The cutback didn't apply until November.

1

Okay. The decision was made in 2004 - September 2004, was it?-- Mmm.

And that was John Scott punishing you?-- My view is it was either John Scott or Steve Buckland punishing the hospital and the people of Queensland for our public disclosures. That is my view.

Dr Aroney, you have no basis to suggest that at all, do you?-- I do have. I do have basis for that. 10

In fact even in your statement you say that the action was either due to "punishment" for bringing these deficiencies to light or to negligent mismanagement. You don't know what it was about?-- I believe it was punishment. There's - certainly Scott and Buckland aren't going to come directly out and tell me, "You are being punished and the hospital is being punished", but Ms Wallace told us at the meeting - and it is minuted at that meeting - when I asked her, "Why is the hospital being bullied about this 57 cutback", and her answer, and I quote, is that the cardiologists were not "politically savvy". Now, there's no other explanation for her to say that. 20

That's what Ms Wallace told you?-- That's what he told us, and she also told us she was the meat in a sandwich. It wasn't her decision, the decision-----

Where are these meetings?-- In the minutes of the July meeting. It's been tendered here as evidence previously. 30

The July meeting? The decision was made in September?-- September meeting.

MR FITZPATRICK: I think it's MIC19 to Mr Cleary's statement.

COMMISSIONER: Thank you, Mr Fitzpatrick.

MS DALTON: See, it's just - John Scott was on long service leave from July until October 2004?-- Yes. 40

It's a scandalous thing to say that-----?-- In his evidence - in his evidence that he's tendered he says that he was well aware of this 57 cutback, and in full knowledge that it occurred, in full knowledge. He says that in his documentary evidence.

I'm sure he knew it occurred, but it is a scandalous thing to say that it was done as a punishment to you. 50

COMMISSIONER: He didn't say a punishment to him. He said as a punishment to the hospital and the people of Queensland for the statements - public statements he had made.

MS DALTON: That's a scandalous thing to say about an individual when you don't even know that they're at work or not?-- I didn't see - wasn't sure it was Scott or Buckland or

F

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-21

01-01-A

13

Queensland Government
Queensland Health

EXECUTIVE SERVICES STAFF
MIN / DG / GMHS / DDGP&O / FILE
EMAIL: MIN SDLO DLO EXDG
EMMC MCM

A BRIEFING TO THE A/SENIOR EXECUTIVE DIRECTOR HEALTH SERVICES DIRECTORATE

BRIEFING NOTE NO: District Initiated

REQUESTED BY: District Initiated

DATE: 12 October 2004

PREPARED BY: Michael Cleary, Executive Director Medical Services, The Prince Charles Hospital Health Service District (TPCHHSD), contact 3350 8220

CONSULTATION WITH: N/A

CLEARED BY: Gloria Wallace, District Manager, TPCHHSD, contact 3350 8223

DEADLINE: N/A

SUBMITTED THROUGH: Dan Bergin, Zonal Manager, Central Zone, contact 3234 0825

SUBJECT: **Cardiology Program – The Prince Charles Hospital**

COMMENTS A/SED HEALTH SERVICES:

FILE
BRIEFING FILE
7/4/05

DR JOHN SCOTT
A/Senior Executive Director
Health Services Directorate

/ /

PURPOSE:

To brief the A/Senior Executive Director Health Services on issues currently impacting on the Cardiology Program at The Prince Charles Hospital.

BACKGROUND:

The Cardiology Program at The Prince Charles Hospital provides comprehensive care to cardiac patients in Queensland. This includes a number of statewide services including:

- Heart Failure and Heart Transplantation
- Paediatric Cardiology
- Specialists support for electrophysiology services (shared with the Princess Alexandra Hospital)

The District is currently actively managing a number of issues in relation to the Program. These include:

Higher than usual demand for clinical services

- The District is currently experiencing an increase in demand for inpatient services. This has in part, been driven by increased referrals to the hospital.

Emergency Department referrals

- The Emergency Department has increased as outlined in Figure 1. The increase in admissions principally relates to Cardiology activity.

Figure 1 – Emergency Admission

	Admissions per week
2002/03	83
2003/04	85
2003/04	95
4 weeks to 28/09/04	112-120

The admission rate overall in the emergency Department has increased from 39% of attendances in 2003/04 to 46% in 2004/05. This increase has been related to Category 3 attendances.

CARDIAC INVESTIGATION UNIT

An area of contention within the Cardiology area is the level of planned activity that will be performed in the 2004/2005 financial year with the Cardiac Investigations Unit. The Unit performs Angiograms, Percutaneous Cardiac Interventions (PCI) such as acute coronary stents a well as the implantation of pacemakers and defibrillators.

The activity levels in the area are being redefined, based on the impact of activity transfer to the Princess Alexandra Hospital that occurred in July 2004 as well as growth funds received in the 2004/05 financial year and "one all" funding in 2003/04. The past two years activity and the funded activity for the current financial year, taking into account these factors, is outlined in figure 2 and figure 3.

Figure 2 – Cardiac Investigation Unit activity

	2002/03 Actual	2003/04 Actual	*2004/05 Estimated	Changed from 2003/04 to 2004/05
Angiogram	2526	2491	2117	-374
PCI	550	700 (includes 23 patients funded by Townsville Hospital)	538	-162
ICD Implants	120	179	143	-36
ASD Closures	15	57	15	-42

*2004/05 activity is after adjusting for the PAH transfers and including the indicative funding allocation for 2004/05 Election Commitments.

Figure 3 – Analysis of activity and funding

	Funding changes	Change in level of activity
Service transfer to PAH	- $1.2m	Activity Production at TPCH includes and transferred to PAH includes: - 500 Angiograms - 95 PCI's
Growth funds as part of 2004/05 election commitments Note: This has yet to be confirmed by Central Zone	+ $0.845m(interventional cardiology) + $0.25m (ICD activity)	Activity increase at TPCH includes: - 90 Angiograms - 78 PCI's - 10 ICD's
Funding of drug eluting stent	+ $0.7m	No change in activity, but provides ability to use drug eluting stents in patients having PCI'S

*This table identifies changes to base funding and activity.

In addition to the recurrent funding changes identified above, it should be noted that additional activity was undertaken in 2003/04 as part of the Government's election commitments to elective surgery. This activity is identified in Figure 4.

Figure 4 -Additional activity funded in 2003/04 (non recurrent) as part of election commitments.

Funding	Activity
$0.24m	100 PCI's
$0.7m	28 ICD's
$0.51m	42 ASD Closures

Recent meetings have been held with cardiologists in an attempt to contain interventional activity within existing funding limits. This is particularly important as the District's budget position for the first quarter of the financial year shows an operating deficit of $2.2M with a major contributor to this being in interventional cardiology.

Current funding allows a weekly schedule of 57 funded acute and elective catheter laboratory procedures (excluding ASDs and valvuloplasty) to be performed, however weekly activity for the first quarter has in some weeks exceeded 80 procedures.

Cardiologists have been asked to revise the activity schedule to the 57 weekly procedures and to schedule cardiac investigations unit hours of operation, around the revised activity schedule. They have also been asked to revise rosters to cater to the revised schedule (see attachment 1, agreed activities to be undertaken by the program to correct current activity/expenditure).

PROGRAM MANAGEMENT

The leadership within the Cardiology Program has been limited by the willingness of some clinical staff to engage in discussions and negotiations in relation to service models and activity planning.

Dr Galbraith, Program Medical Director for the Cardiology Program resigned his Directorship on 16 September 2004, the day before he was due to go on annual leave for three weeks, following a meeting with the Cardiac Investigations Unit (CIU) staff to discuss required changes. Dr Galbraith advised that he found the role too stressful.

The District Manager elected not to appoint Dr Darren Walters as the Acting Program Medical Director because of his high clinical workload, his need to finalise the activity plan for the CIU and because of a lack of confidence that Dr Walters would cooperate to lead the Program in a manner commensurate with District requirements.

Because the District was unable to identify a senior member of the medical staff to provide the appropriate leadership, and in consultation with Dr Keith McNeil (Chair, Medical Advisory Committee), the District elected to nominate Dr Michael Cleary (Executive Director Medical Services) and Dr McNeil to support the Program's management team during the period that Dr Galbraith was on leave. Program staff members were advised that the Program Nursing Director would undertake the business administration of the Program.

On 17 September, the District Manager received a petition from a number of cardiologists, demanding that Dr Darren Walters be appointed interim Director of Cardiology. The District Manager advised the petitioners that this was not possible due to Dr Walters' workload and advised Dr Walters of her reservations in relation to his suitability for the leadership role.

The District Manager, Executive Director Medical Services, Executive Director Nursing Services and Executive Director Corporate Services met with the Cardiology Program medical staff on Friday 24 September 2004 to discuss issues within the Cardiology Program. Cardiologists invited a range of other persons to the meeting, including Dr Con Aroney and numerous cardiac surgeons.

Discussions at the meeting included:

- the state-wide cardiac services planning proposal
- the status of the heart failure community support project
- budget and activity planning (including the need to revise activity to meet budget)
- staffing within the Cardiology Program, with specific reference to leave relief, succession planning and paediatric cardiology staffing issues
- leadership and management within the Cardiology Program, including advertising for a Director of Cardiology.

Dr Aroney attempted to put a formal motion that Queensland Health be advised that patients over 75 years of age would not be treated through interventional cardiology procedures at TPCH, until such time as funding issues were addressed. Other medical staff did not support this motion, which was lost.

Program staff were asked to consider the issues raised with them and to provide feedback on their views, including that of a suitable interim Director of Cardiology, to carry through to the appointment of a new Director At the request of cardiologists, a follow up meeting was scheduled for Thursday 30 September 2004 to gain feedback on their considerations of the issues discussed.

In the absence of the District Manager on leave, Dr Michael Cleary as Acting District Manager was asked to conduct this meeting, however only two cardiologists attended (ie. those in the heart failure sub program). The District was later advised that there had been agreement among the cardiologists to boycott the meeting. The interim directorship issue remains unresolved.

Cardiology Inter-hospital transfer waiting list

There have been recent pressures on the cardiology inter-hospital transfer waiting list. For example:

- The number of patients waiting for transfer to TPCH as at 27 September 2004 was 17. Five of these cases were noted to be of a high priority.

- Three of the high priority patients were transferred to TPCH for further care.

- Following discussions with the Executive Director of Medical Services at the Royal Brisbane and Women's Hospital (RBWH)the remaining two high priority patients were accepted by RBWH for care.

- The Princess Alexandra Hospital Executive Director of Medical Services advised that they had five patients on the inter-hospital transfer waiting list and could not accept additional patients at this time.

Deaths on the Waiting List

Two patient deaths occurred in recent months that have been the subject of a previous brief. As a result of the issues raised in relation to these deaths by medical staff, Dr Leo Mahar from the Royal Adelaide Hospital and Dr Andrew Johnson from Townsville General Hospital were appointed to investigate both the deaths, and the allegations made by some cardiology staff in relation to waiting lists. The investigations are occurring this week, but preliminary verbal reporting from the investigating team is that the nominated patients had both received an appropriate standard of care.

Surgical Activity

The number of patients who are currently waiting in hospital for urgent cardiac surgery has fluctuated over recent weeks. This has been the result of increased referrals for surgery including some urgent cases eg:

- two patients on ventricular assist devices (VAD'S) who have had multiple returns to theatre
- increased paediatric cardiac surgical activity prolonged ICU stays for post transplant patients The net effect of this increase in urgent referrals for surgery has been a reduction in elective surgical activity, some of which relates to increased occupancy in the cardiology wards.

Cardiologist Leave

It is extremely difficult to plan suitable leave relief and to ensure adequate cover, with the lack of medical team cohesiveness in the Cardiology Program. Dr Con Aroney is currently on extended leave to 31 December, and has today requested to extend that leave further. Dr Darren Walters wished to take leave at the same time as the approved leave of Dr Nick Bett. This would have left TPCH with no interventionist cover other than 1 VMO session, so leave approvals have been given only where there is adequate cover.

Dr Walters has also requested a reduction of hours to half time, but has been advised that the District is unable to accommodate this while Dr Aroney is still on leave.

KEY ISSUES:

- It is proposed to contain cardiac diagnostic and intervention procedures within the 57 funded procedures limit as described above. This will take one month to implement, to manage the public perceptions, ie. to ensure that currently booked patients are not cancelled;
- This is creating political and media pressure, however for the TPCH Cardiology Program to achieve budget integrity, this is necessary;
- The preferred option for the distribution of PCI and diagnostic procedures has been established in consultation with cardiologists;

- Given the demand pressures, once this schedule is implemented, there will be waiting list growth;

- There are differing criteria for cardiac interventional procedures being applied across the metropolitan hospitals and there needs to be agreement on consistent standards, particularly for the categorising on wait lists.

- While TPCH functions at the more "liberal" end of the interventional scale in relation to AICD implantations, there is increasing collegial pressure for service expansion in the treatment of heart failure. It is proposed that this should be referred to MSAC to allow national intervention criteria for AICD utilisation in heart failure, to be agreed.

- While TPCH is moving to fill its Director of Cardiology position by national and international advertising, there appears to be no local solution to interim medical leadership, other than to place a non cardiologist in the role. It is proposed to either:

  - Appoint a non cardiologist from TPCH to the medical leadership role for the interim period; or

  - Seek Corporate assistance in the appointment of an interim Medical Director of Cardiology from another facility, to work through the issues of criteria standardisation, cross hospital workload and workforce distribution and management of medical issues within the program/s, and the appropriate distribution of any further funding investment.

RELATED ISSUES:

N/A

BENEFITS AND COSTS:

If actions are not taken within the next month, the forecast budget overrun full year effect in cardiology at TPCH will be $2.4M.

ACTIONS TAKEN/ REQUIRED:

Corporate endorsement is sought of:

- Limiting activity as described above, at TPCH and

- a proposed strategy in accordance with this brief.

ATTACHMENTS:

Attachment 1 – Activity Profile

ATTACHMENT 1

Based on weekly target of 4 paediatric cases/week however allowing for up to
6 scheduled spaces per week to accommodate operator availability and peak demands

Weekly acute target - 25 per week on a 35%/65% PCI/Cors split.

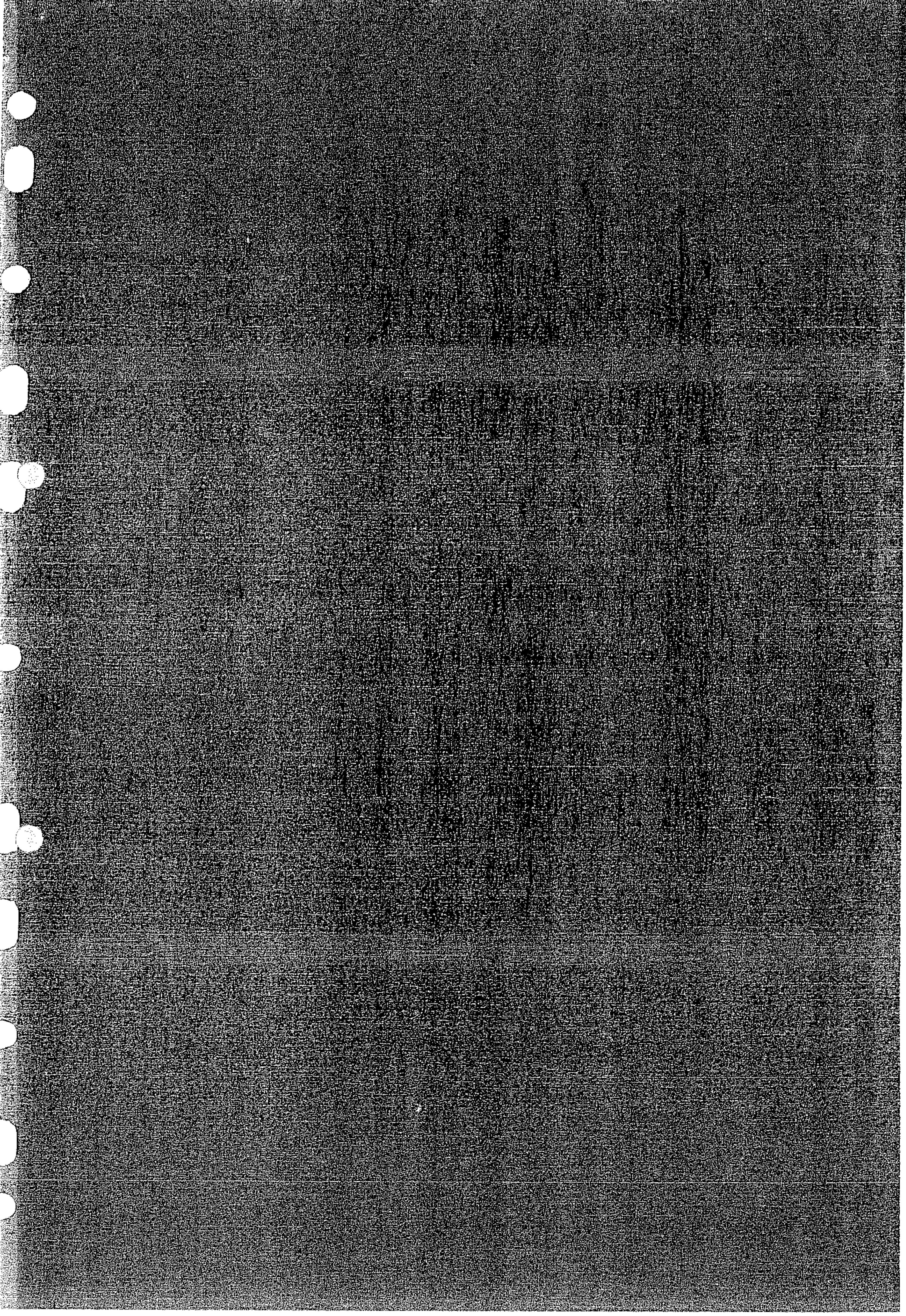
				Weekly target	Yearly spread	Annual Target
Acute	PCI	35%	9	25	52	1300
	DIAG	65%	16			
Elective	PCI	11%	3	28	48	1344
	DIAG	89%	25			
Paediatrics				4	48	192
% DISTRIBUTION	PCI	23%				
	DIAG	77%				
TOTAL				57		2836

Activity Profile (Acute and elective)

57 PCI and Angiograms per week
Excludes Valvuloplasty at 10/year
Embolisation at 32/year
ASD Closures at 15/year
(note that 8 have already been performed and the remaining 7 booked to be performed by December 2004)

Year Profile (Acute and Elective)

PCI	612
CORS	2032
Paeds	192



long time because doctors in the bush came in, I think was the first in Australia of that proposal, it was about 2000. 1

Or even earlier than that perhaps?-- It might have. I mean, the discussions et cetera started not long after I became Minister and the work-up for the proposal, and but I think it was in 2000, January 2000 we signed up the first ones. I'm sorry, please don't hold me to that date.

No, no, that's all right. But you don't recall him anyway from that context apparently. Do you recall that he had quite an interest in rural health work?-- He certainly had a wide interest in rural health and certainly particularly in getting programs such as breast screening to rural, you know, the small rural communities, all of that, those programs, make the public health programs - he was particularly committed to making sure they were available to people in no matter how remote a community. 10

And you were aware, no doubt, that he'd spent long years working in hospitals or as a GP in rural hospitals himself?-- Yes, I was. 20

One of the things somebody's passed comment in giving their evidence here that he was more a bureaucrat, I think the words were "He wasn't a real doctor"?-- I have to say it was considered rather amusing when I met Administerial Health Councils that I used to have more doctors on my side of the table than the rest of the Council put together because so many of the senior bureaucrats in Queensland did have long and extensive experience as clinicians. 30

Mmm, and in Dr Scott's case, as a rural clinician for many years?-- Yes.

Now, you explain in your statement the process I think when you - and you've given evidence here about how you would go to Cabinet and that Cabinet Budget Review Committee to fight your hardest for your department?-- Mmm-hmm.

40

And you didn't always get what you wanted?-- I think that's a fair comment.

The process, I suppose, preceding that is that the districts would each year, each budget cycle put in what they called their bids for the money that they wanted each year?-- Yes.

So-----?-- It goes up the chain. I think everybody has a say. I think the units, the various units in a hospital and in the community et cetera would put their bids into the District Manager who would collate those and put - and do any extra work that needed to be done with them and prioritise them and put those bids into the - into the zonal manager. 50

Yep?-- And yes, it did work up the chain but it also meant that people right down at the grass roots in many cases had input into that process in identifying what the needs were.

Yes. And that input would be people acting in their own interests so if you're a cardiologist at Prince Charles?-- Yes. 1

You're going to be bidding your level best for cardiology at Prince Charles and that will feed into the system which ends up does it not with the department coming to you prior to you going to the Cabinet Budget Review Committee?-- Mmm.

So that all of the bids and submissions from Queensland Health end up with the senior bureaucrats in health-----?-- Yes. 10

-----coming to you and saying this is what the department wants?-- Yes.

And I suppose when you come back from Budget Review Committee, they don't get what they want either?-- Yes, and there's an important - but there's an important second part of that, I'm Minister for Health in Queensland right across Queensland.

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Yes?-- And the health department has a responsibility as do - did I at the time to ensure that services were provided as far as possible equitably across the State.

Yes?-- It's not about looking after - while the submissions may be, I guess being pushed, you know, various people obviously pushed their barrow they see that as most important.

Yes?-- But you have to balance the needs right across the State, you can't sort of say we're only going to look after North Brisbane or we're only going to look after Cape York, it has to be across the board and doing the best you can with the budget you've got in the fairest possible way to meet the needs of people in Queensland and to meet the greatest needs first. 30

And when town or Charlotte Street goes back to the districts after the budget process and says, "Well, you asked for X but you've got X minus Y"?-- Mmm.

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"Sorry about that"?-- Yes,.

It's not because the bureaucrats in town don't recognise that the bids were legitimate and don't recognise that the clinicians who have put them in sincerely want or need what they've asked for, it's because of that process, there's a limited pie to cut up, isn't there?-- There's a limited pie at State level and there's a limited pie at the department at level.

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Mmm?-- Yes.

Were you able to observe Dr Scott interacting with other staff while you were Minister in either of the two roles he held? Were you-----?-- Oh quite, I did a lot of work with Dr Scott in both of his roles.

Mmm. See, there's some evidence before the Commission that

his manner is bullying, attacking, overbearing and intransigent; can you comment on that so far as you've seen him?-- Am I allowed to say that the staff in my office fell about laughing when they read that in the paper because he is such a gentle person, that he is one of the people that staff in my office, if they had a health issue, often went to for advice, but-----

You mean a personal health issue?-- Yes, I'm just sort of saying he was one of the persons who as he very approachable.

Mmm?-- The idea of him bullying actually was something that caused something of amusement to people in my office.

1

I think one of the people he is supposed to have bullied, or a person in a group he is supposed to have bullied is a fellow called Darren Walters, who is the Director of Cardiology at Prince Charles. Have you come across him in your travels?-- I am not sure I know - is that Dr Walters?

Dr Walters, yes?-- I don't think I know Dr Walters.

That's all right. I will ask you also, in your dealings with him while you were Minister, was there ever an occasion when you were seeking information from him and it wasn't provided to you promptly and fully that you are aware of?-- I think the only occasion we had some issues about the tobacco action plan when I think - but that was when he was in the position of Director of Public Health - about - I guess there was a difference of opinion from some of the people in his - in that area and myself, and the briefs I kept getting kept saying the same thing, and I kept saying, "No, that is not where we're going. That is not what the government wishes to do." And there was some difficulties, but that's the only time I can actually recall that. 10 20

That was-----?-- That wasn't Dr Scott, that was more people in a particular unit within the public health area.

And by the sounds of it, it wasn't a request from you to provide factual information, such as some discussion this morning as to waiting list numbers, or that sort of thing, it was a difference of opinion as to where the policy should go, by the sounds of it?-- Yes, about how something should be done, yes. 30

I was concerned to ask you that because it was suggested to you this morning that senior bureaucrats within the Charlotte Street office might have tried to impede your access as minister to information about, well, in particular, waiting lists and the numbers of people on waiting lists?-- I don't think I had a reputation for being easily bowled over or swamped. If I didn't get the information I wanted, I would perhaps more rigorously ask for it. 40

And I suppose specifically, so far as Dr Scott was concerned, did you have any difficulties getting information from him when you requested it?-- No.

And I think the other suggestion that was put to you this morning was that there might have been some advice coming to you from senior bureaucrats in Charlotte Street that you ought not to be talking about waiting lists, and, again, asking you about Dr Scott. Was there that sort of comment coming to you from him?-- No, there was a lot of advice that I couldn't be talking about waiting lists, that was a daft idea, et cetera, when I first put the proposal up. 50

That's back in 19-----?-- In opposition. That was back when I was in opposition.

senior bureaucrats, doctors Buckland and Scott, during the course of your ministry of health was to ensure that you were never placed in possession of unpalatable news?-- No, I disagree with that. That's incorrect. 1

All right. You're aware, are you, that Dr Scott has attached to his statement - have you read his statement incidentally?-- No.

Are you aware then that yesterday Dr Scott was taken to JG3, which is an attachment to his statement, in which it was indicated that the no surprises rule in relation to advice to you meant no surprises except pleasant ones?-- No, I disagree with that. 10

Were you unaware that within the documentation, which Dr Scott put in yesterday, reference was made to there being a no surprises rule, which meant no surprises except pleasant ones?-- No, I wasn't.

You weren't aware of that?-- No. And on numerous occasions my department - my department's job is to give me information whether it's good or bad, and they did that. 20

Well, should they adopt a policy of only giving you pleasant news-----?-- No, not at all.

Let me finish the question. Should they adopt the policy of giving you only pleasant news. That would be a breach of your expectation?-- That's right. 30

And that would be a breach of their duty to fully and frankly keep you informed?-- I - I expect - I believe the department did keep me fully informed of all - of events whether they be good or bad.

See, I suggest to you that - well, are you aware of the classic, the famous approach by Peter Reith to irrefutable evidence; that is, if the video shows that, we should not see the video. Are you familiar with the incident to which I refer?-- No. Yes. 40

The children overboard incident?-- Yes.

Are you referring that you didn't have such a policy in your office?-- That's right.

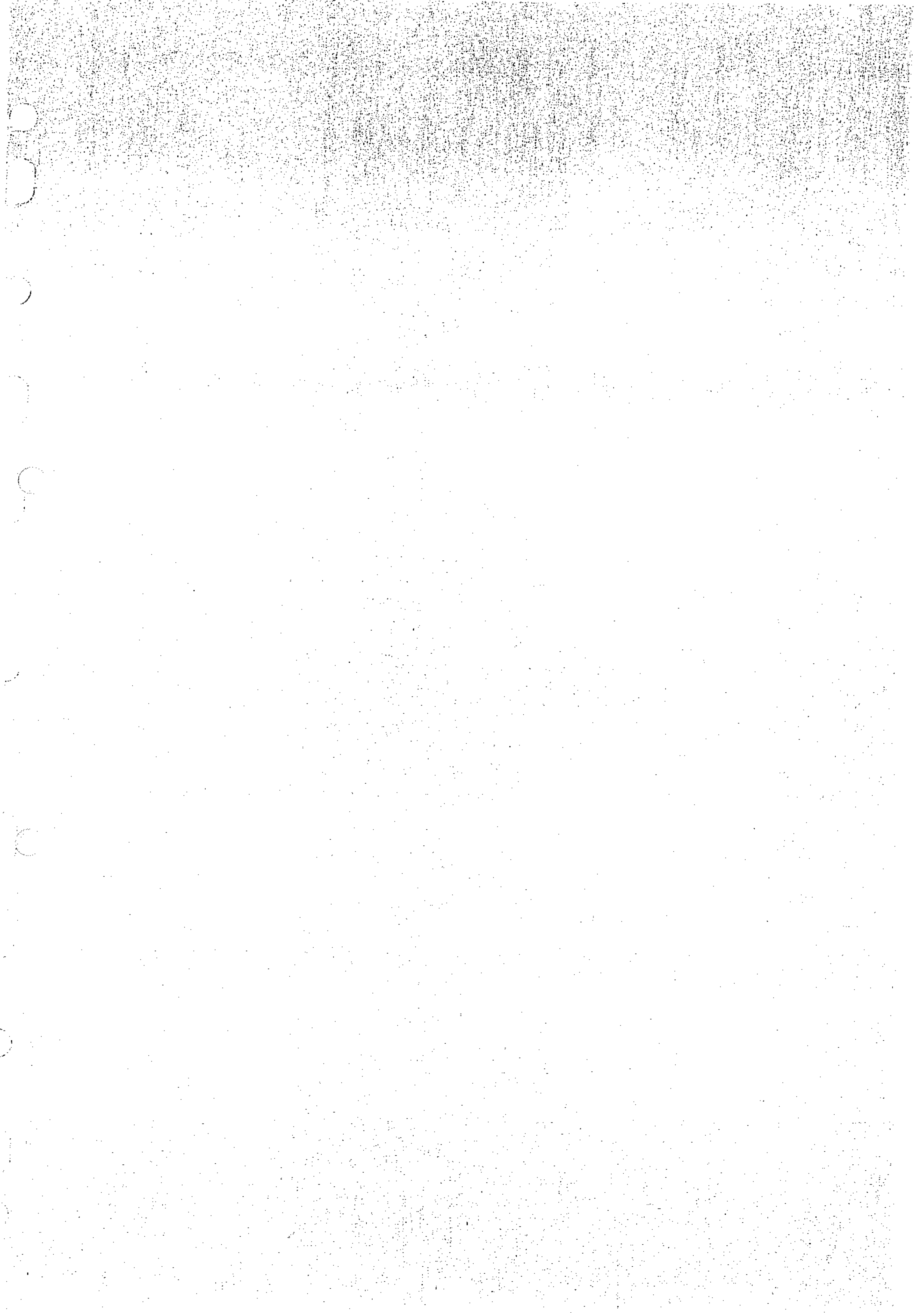
"If the news was bad, make sure I don't see it"?-- No.

"Or, if necessary, bury those who are exposing it"?-- No, I couldn't disagree with you more on that. 50

You see, I suggest to you, Mr Nuttall, that you had a particular reason to be very concerned to ensure that bullying didn't take place on your watch?-- I don't support the concept of bullying full stop. And as IR Minister, that was quite clear because I was the Minister responsible for working on that policy for the government.

So were you to come across evidence of such bullying, you would be deeply concerned and asked for your officers to implement a process whereby it could be stamped out; is that right?-- That's - that's correct, yes.

All right. Are you satisfied that occurred?-- I'm satisfied that we did the best we possibly could to try and eliminate bullying in the workplace.



Heart Response

Broadcast: 15/10/2004

DR JOHN SCOTT, QLD HEALTH: Thanks.

KIRRIN MCKECHNIE: Dr Con Aroney is predicting a crisis in cardiac care. He says by international standards Queensland has only one third of the number of cardiologist that it should have, is that true?

DR JOHN SCOTT: We don't believe that it's true to the level that he's describing it. We certainly would be prepared to accept that we have issues to address with staffing but really that's and issue for Australia generally. So we don't see that we are behind any other states in Australia.

KIRRIN MCKECHNIE: How behind are you though in international standards?

DR JOHN SCOTT: I suppose we would say that we are behind but we really feel that the services that we are delivering at the moment are not putting any Queensland lives in jeopardy.

KIRRIN MCKECHNIE: Well the cardiac society says there are only the equivalent of 25 full time public cardiologists in Queensland and there should actually be 75. Is Queensland health actually reducing the number of cardiology procedures then at Prince Charles Hospital?

DR JOHN SCOTT: No, I think that, and this is the disappointing aspect of this debate is that we seem to be accused of cost cutting of reducing services and I can't see why we would want to do that. In fact what we're doing is looking to increase services across Queensland and of course what that means is that services and resources are going to hospitals other than Prince Charles and perhaps that's part of the reason why we're having this debate.

KIRRIN MCKECHNIE: Have you reduced the number of services cardiology procedures at the Prince Charles Hospital from 80 to 57?

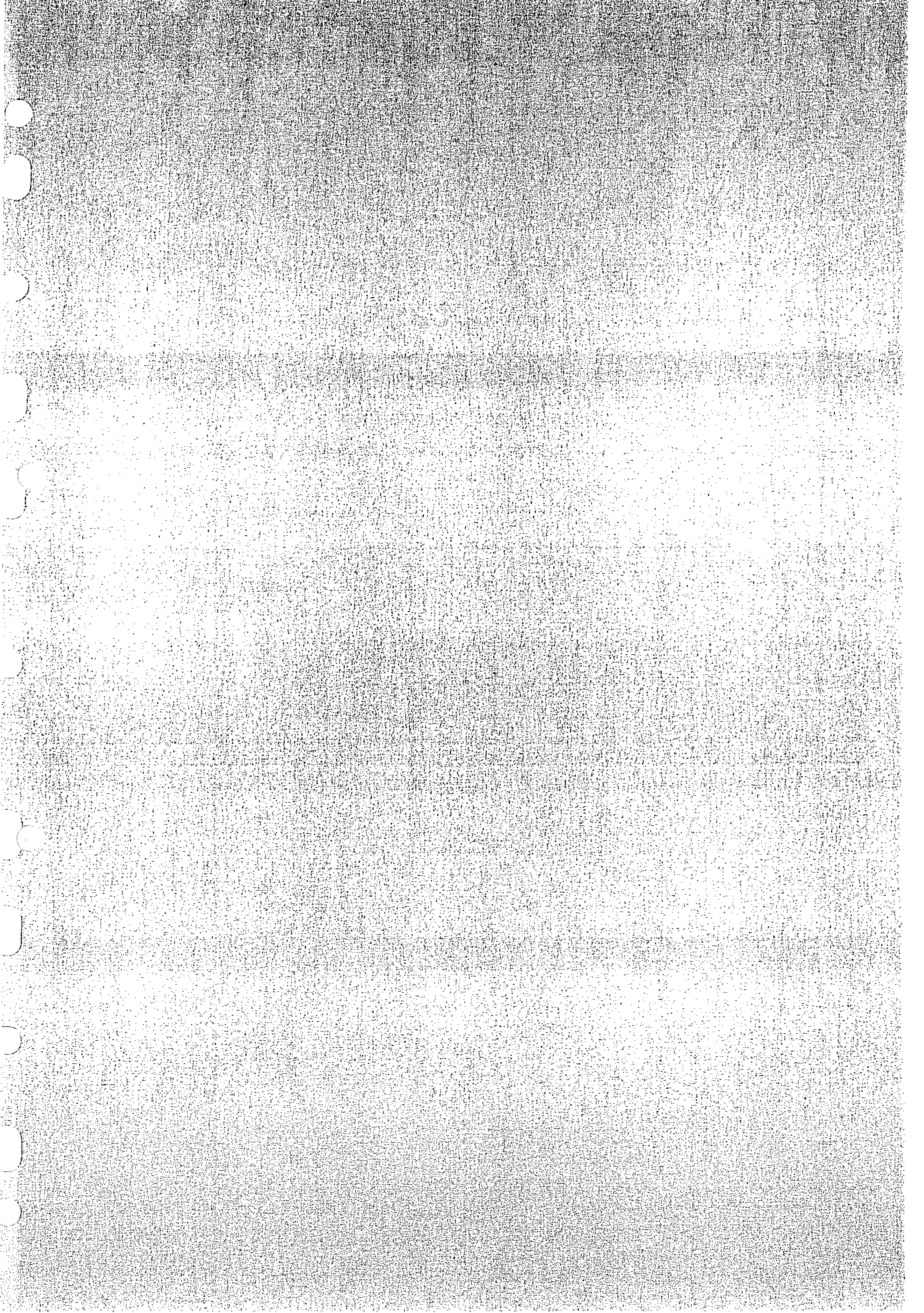
DR JOHN SCOTT: No, what we've done is we've said lets go ahead and enhance services and that was happening in fact we've put something in the order of $5 million extra dollars into cardiac services in Queensland this year. And that $5 million will be there each year from here on. But what has happened is there has been an increase in services above what that increase budget will allow situation and we've asked the cardiologists to review the situation with a view to at least staying within the resources that are available to us but we have not in anyway respects reduced services.

KIRRIN MCKECHNIE: Dr Aroney says, well he's given us some examples of patients having heart attacks in regional areas and instead of waiting the recommended 48 hours to get help in a big city hospital that there are many other cases waiting over a week. Is that right?

DR JOHN SCOTT: We don't believe it is and of course as I've said before we're looking to services to enhance services for north Queenslanders so they've got better facilities to be transferred to. We've recently done work and are continuing to do work on clinical co-ordination and on aero-medical retrievals. So we're looking to provide people with the ability to transfer from their small service that they might have to attend if they have problems to larger services and we're ensuring that those larger services are more appropriately placed to take those transfers.

KIRRIN MCKECHNIE: Well it seems that you have a stand off then between our leading cardiologists in this state and Queensland health. How do you hope to fix this problem?

DR JOHN SCOTT: I'd say we have a stand off between certainly me and our leading cardiologists if you wish to call Dr Aroney that. In time I hope that we can show the cardiac society and Dr Aroney that we are here for the long term.



an issue could arise which the Minister may need to know about or, in fact, any of the members of the senior executive, then it was preferential to advise people of those issues rather than to not advise them. So, essentially issues that people thought might become problematic or which they felt were worthy of attention would be escalated up the chain and would go to certainly to myself and to the Director-General and usually on the basis that it was better to tell the Minister or the Minister's media advisor. They would be advised as well.

All right. Now, was it part of that no surprises rule that the rider was attached that the surprises, if any, be pleasant ones?-- Oh, I think that wasn't other than in a document that we were developing around indicators for the health services directorate and that was thrown in almost as a throw-away line, that if we are going to get surprises let's make them pleasant ones rather than unpleasant ones.

JG3 I think might be the document to which you refer. Have you got your statement in front of you?-- Yes.

Turn to JG3?-- Yes, that's right, yes.

Some perhaps 10 pages in?-- Yes.

"No surprises, except pleasant ones." Is that the one to which you refer?-- Yes. Tthat was very much a throw-away line.

So the throw-away line then, in effect, meant that the Minister didn't wish to be acquainted with any information introduced to him by the media or the public of which he wasn't already aware unless it was pleasant news?-- No.

Is that right?-- No. No, the throw-away line came at the level of myself and my executive and it was purely if we're going to get surprises, let's make them pleasant ones.

What were you to do with unpleasant surprises?-- Make sure that no-one got any unpleasant surprises.

What were you to do with unpleasant news?-- Make sure that the Minister was advised so that he wasn't surprised by the unpleasant news.

Was it part of your task as a senior - I don't like to use the pejorative term, what's become a pejorative term, bureaurocrat, but if you can accept I'm using-----

COMMISSIONER: It's not a pejorative term in the Inquiry.

MS KELLY: Thank you, Commissioner. That's what I wish to have made clear. As a senior bureaurocrat in Queensland Health, was it part of your task to manage those issues which might, quote, "blow-up", unquote, so that there was no need to acquaint the Minister with any such news?-- No. No, it was my job to acquaint the Minister and then to

manage them and if the Minister directed they should be managed in a certain way, then that was the way that we managed them. 1

Did you then acquaint the Minister with the public - the potential for public disquiet at disclosures being made by Dr Aroney in the course of November 2003 to the cessation of your tenure at Queensland Health?-- Yes, yes, as appropriate.

You did. On what occasions did you brief the Minister on Dr Aroney's disclosures?-- Oh, on numerous occasions and I briefed two ministers when Dr Aroney first raised the issues in, I think, November of 2003 or December. I was briefing the previous - the - at that time - sorry, Minister Edmond. 10

Yes?-- And then subsequent to that I was briefing Minister Nuttall.

Yes. And did you advise the Minister that essentially Dr Aroney's allegations being publicly made were in essence false?-- I think what we briefed the Minister was that there were issues around what Dr Aroney was claiming, that there were some elements of what he was claiming which were related to shifts in resourcing from Prince Charles to PA, which were part of established policy and had been part of established policy since probably 2002. So there were no cuts going on there. At the same time we also acquainted the Minister with other aspects of what Dr Aroney was saying around people on waiting lists, but at that point in time and subsequently as we have discussed this morning there are waiting lists which will always exist until we get sufficient funding to take them away. So, it's not a matter of these are terrible things that we can address now, but there will be waiting lists that will exist into the future until we have got sufficient funding. 20 30

So Dr Scott, were there any matters which you briefed the Minister - any matters raised by Dr Aroney which you briefed the Minister which were in essence false?-- Yes.

What were they specifically?-- I think Dr Aroney spoke about cuts in funding, which I think he referred to in the 2002/2003 financial year, and then he spoke about another two rounds of cuts to funding which were not cuts to funding. 40

Now, were these briefings committed to writing?-- I am sure that they would have been.

And do you have possession of those writings?-- No, I don't.

Do they remain in the possession of Queensland Health?-- I would expect that they are, yes. They would be on the formal system. 50

Thank you. Now, you have said that you advised the Minister that the allegation of funding cuts were wrong?-- Yes.

The essence of Dr Aroney's public disclosures, I suggest to you, was to the effect that people were dying and would die if

these limitations in procedures, if I can use that neutral term, were not addressed. Did you advise the Minister that that was true or false?-- We advised the Minister that particularly there were two elements to this. There was one element which was a list of specific cases that Dr Aroney raised, and we subsequently had those investigated and advised the Minister in relation to the substance of those claims, and then there was a broader claim in relation to waiting lists and people dying on waiting lists which we also advised him about. We found in the investigation of the first group that out of the, I think, probably eight or nine cases that were investigated we could only find one or two where perhaps we could have improved the management of those people. But on the broader issue of waiting times for people and people dying on waiting lists, I think that the advice would have been that while there were waiting lists there would be inevitably deaths, particularly in the area of implantable defibrillators, and this is taken up in the Maher Johnson report that was done, where until we - I think the funding estimate was about $60 million to address all of the people who could potentially be waiting and there was a potential for people to die on those waiting lists.

So, is the latter part of that answer you advised the Minister that the allegations of people dying on waiting lists was true?-- There are people who will die on waiting lists simply because - being something which is of a cardiac nature there is no way that you can avoid people waiting unless you put those defibrillators in, for instance, as soon as they come to the attention of the clinicians.

And the response of the Minister, if any? Was there any response of the Minister to acquire the defibrillators and put them in?-- Well, I think this comes back to my - I mean, the answer is yes but in a limited way compared to the $60 million worth of funding that was estimated to be required. But the question really comes back to the discussion that we had this morning around waiting lists, which is - and this is also the essence of the issue we took with Dr Aroney's concerns.

Sorry, Dr Scott, if can I just stop you.

COMMISSIONER: Now, let him finish. Let him finish his answer. Keep going, doctor?-- The difficulty is there will never be enough resources, so if we put resources of the amount of maybe $60 million into implantable defibrillators, I have already said that we probably need about $80 million a year to put in elective surgery waiting lists, and of course there's - Mr Douglas has shown us this morning there are a lot of people who are on waiting lists for oncology services. I have also spoken about some of the early interventions like colonoscopies that will prevent avoidable deaths. We just did not have the resources available, and it comes down to a decision as to where those resources are going to be put. That was the Minister's decision and I think the Minister took advice from the department as well as making his own calls on where those resources would be allocated. So, I'm sorry, but the short answer is some money was put towards addressing

people waiting for defibrillators and other cardiac interventions, but certainly not anywhere near the level that you would need to commit to stop avoidable deaths. 1

MS KELLY: Yes. Dr Scott, all I was asking you about is what was the Minister's response, not the defence or otherwise of that response?-- I was trying to explain how he'd come to that decision.

Okay. Thank you. So, Dr Scott, was it any part of your duty to make defence of the restrictive budget of Queensland Health and its impact on the provision of clinical services in the media?-- Put that way, no, it wouldn't be. 10

You appeared in the media on a number of occasions and I will take you to one in particular. On the 15th of October 2004 you made an appearance on Stateline, the ABC program?-- Mmm.

Do you recall that?-- Yes.

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It's CA13 to Dr Aroney's statement, the transcript of that interview. Now, did you tell the truth in that interview, Dr Scott?-- I believe I did.

All right. Can I just explain to you the context? I understand you had recently returned from long service leave on the 3rd of October; is that right?-- Thereabouts, yes.

You had previously in January of 2004 met with Dr Aroney and there had been some acrimony over Dr Aroney's disclosures. That's right, isn't it?-- Yes. 30

You and Dr Buckland attended a Cardiology Society - Cardiac Society-----?-- Cardiac Society.

-----meeting on the 15th of February 2004 where there was more acrimony. That's right, isn't it?-- I think at the start of the meeting. I felt by the end of the meeting that there wasn't a lot of acrimony at all.

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All right. And the Cardiac Society then prepared for and presented to you in the middle of 2004 a comprehensive submission, which is CA2 to Dr Aroney's statement, on the planning for and provision of clinical services for cardiology in Queensland. That's right, isn't it?-- I think it might have been to the Minister because I think the Minister responded to Dr Aroney. But-----

You were aware of that submission?-- Yes, definitely-----

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It was a comprehensive submission?-- Yes.

Of which Dr Aroney was the principal authority; that's right?-- I certainly recall that but it was - it went to the Minister.

Following that, at the Prince Charles Hospital there was what Dr Aroney has called a third round budget cuts?-- Mmm.

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Reducing the number of procedures from some 90 angiographies or some 90, 80 or 90, to 57?-- Mmm.

Over a fixed period?-- Mmm-hmm.

Do you recall that?-- Yes.

And in protest Dr Aroney made public comment about the impact of those cuts or that reduction on the cardiac patients serviced-----?-- Yes. 10

-----by his zone?-- Yes.

You went on ABC television and said that you don't see that you were - "We are behind" - we, being Queensland - "being behind any other States in Australia in terms of the number of cardiologists per head of population." Is-----?-- Did I say this?

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All right. Let me be fair to you. The interviewer said to you, "Dr Con Aroney is predicting a crisis in cardiac care. He says by international standards Queensland has only one third of the number of cardiologists that it should have. Is that true?" Your response was, "We don't believe that it's true to the level that he's describing it." You go on to compare to Australia generally and say, "So we don't see that we are behind any other States in Australia." Now, was that true? Is that - does that truly represent your opinion?-- Yes. I think Dr Aroney - and I'm sorry but I can't recollect - but I think he said that we needed something like an extra 70 cardiologists in Queensland. Maybe I have got that wrong, but it was certainly of a quantum that we had no capacity at all to recruit to Queensland and we would never be in a position - even with very competitive wages we wouldn't be able to recruit the numbers that we were talking about to Queensland. 30

Dr Scott, if I can just ask you, is it true that Queensland is not behind any other States in Australia in terms of cardiologists per head of population?-- No, I think I was saying not the level that Dr Aroney was talking about. 40

COMMISSIONER: That's not the way it was read out, Dr Scott.

MS KELLY: Perhaps if I can put it up - ask for it possibly to be put up on the screen.

COMMISSIONER: Yes?-- Sure.

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MS KELLY: I have the only copy to hand.

COMMISSIONER: All right.

MS KELLY: And it's marked. The blue highlighted - the first blue highlight, Dr Scott, is what I've read out to you. I have read out all of it to that point?-- Yeah. Well, I think that's certainly what I said.

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It's not true, is it?-- Well, I think when - we see that we would certainly be prepared to accept that we have issues to address with staffing, but really that's an issue for Australia generally, and so the question really is are we behind other States. We probably are in terms of numbers per head of population, but I think when we look at the other factors that we confront in terms of decentralised States, I think my point is we would be prepared to accept that we have issues to address with staffing. I think I go on to say, "I suppose we would say that we are behind but we're not putting lives at risk." I mean, essentially what I'm saying there is we are going ahead with further funding and I think if you look at the record we have done that. 10

COMMISSIONER: You are saying you not behind in the statement, Dr Scott?-- Well, what I'm saying is I said, "We're not behind any other States in Australia." That sentence there - but the sentence prior to that I have said, "We would certainly be prepared to accept that we have issues to address with staffing." 20

No, I know, but you still say and you seem to want to qualify that now that, "We are not behind other States of Australia." That's what you say?-- Well, in terms of that sentence, I guess, yes, that's a sentence that I would say is not correct.

So you accept that now that that's not true?-- That sentence is not correct. I guess I'm saying I would put it into the context of the two paragraphs that are there around it. 30

Well, I can't see how the meaning of that sentence changes by reference to what's around it?-- No, well, I will have to accept that. I will have to accept that, Commissioner.

Yes.

MS KELLY: In relation to the second highlighted excerpt, "We really feel that the services we are delivering at the moment are not putting any Queensland lives in jeopardy.", now, that isn't what you really felt because you have told us following evidence you gave this morning that, "The services we", Quendland Health, "are delivering at the moment were, in fact, putting Queensland lives at jeopardy." That's right, isn't it, because people were dying on waiting lists?-- Yes, but again----- 40

Thank you?-- I would probably stand by what I said about all other States in Australia as well.

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COMMISSIONER: No, no, but the point is whether, in fact, the services that Queensland is delivering at the time you made those statements are putting any Queensland lives in jeopardy and you just said here that they were?-- Yep. Okay. Well, look, I will accept again that as a basic sentence taken as it's written it's not correct.

Taken in context it's not correct, in the context of anything

else you have said there is not correct?-- Well, again, I guess I will have to take your view of that, Commissioner. 1

All right. Well, you don't have to. You can explain to me why I'm wrong?-- Well, as I have said before, I have tried to qualify in terms of the staffing issues and I think without getting into a great level of detail, as I have said, we also have to put this into the context of resources being scarce, allocation of those resources across a whole range of issues.

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You don't say that. You just make a royal statement there the services are not putting Queensland lives at risk and that's not correct?-- No, and I accept in the context of the print that's in in front of me that it is not correct, but I'm just saying to you in the context of what I knew I believe that there is a different picture which needs to be presented in the context of scarce resources in the context of decisions around implantable defibrillators that are not being made by any State in Australia as well. So if we are putting lives in jeopardy, then every other State in Australia was putting the lives of all of their populations in jeopardy as well. 20

MS KELLY: Well, you see, I want to suggest to you, Dr Scott, there was a concerted spin being placed on the lack of procedures or the cut in procedures available to Queenslanders and that was to suggest constantly that this was an Australia-wide problem and if you looked in any other State you will find exactly this same circumstance there, and this is the line that you have produced on Stateline-----?-- Well----- 30

-----to suggest that Queensland is the same as all the other States?-- Well, again, I would have to say I have said that we have got issues to address with staffing. I have also pointed out that there are other States in Australia where they don't have policies for implantable defibrillators and I have also spoken about resource allocation and scarce resources and they are issues for the other States in Australia as well.

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Well-----?-- Perhaps-----

Sorry, I want to suggest to you that they are not issues for the other States to the degree they are in Queensland. Is that true or not?-- They probably aren't, but again I'd have to say we have the most - probably the most decentralised State in Australia. We have a significant proportion of indigenous people in our State who are living in remote communities. We have got some of the highest rates of smoking and obesity in the country and we have been endeavouring to address those. So it's a multi-factorial issue and part of the argument that we were putting was the solution to this is not purely more angiograms and stents. 50

In fact-----?-- It-----

In fact, the Cardiac Society had told you as early as the 15th of February that Queensland had the worst coronary heart

disease outcomes of all the major States?-- Yes. 1

And that was attributable in large part to a lack of cardiologists?-- I absolutely disagree with that. I mean, I haev just said to you that it is not attributable in large part - it is attributable in large part, and I go back to the evidence of Dr Keith McNeill, that if-----

Sorry, we may be at cross-purpose?-- -----we were dealing with smoking we would not need to have the Prince Charles Hospital there. I absolutely reject that. 10

We may be at cross-purposes, Dr Scott. I'm not asking you whether you agree with me what the Cardiac Society told you. I'm asking you that is what they told you in February 2004?-- Again, I'd have to see what they have said because that's such a difficult proposition to put because as I said, Keith McNeill was recognised that the solution is not cardiologists.

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All right. Just before we leave, we will come to what you were told in February 2004. Just before we leave this, I want you to look at the last paragraph on the screen - sorry, where it says, "We seem to be accused of cost cutting." Do you see that blue highlight?-- Yes.

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Now, what you were asked by the interviewer was, "There are a reduction in the number of cardiology procedures at Prince Charles Hospital"?-- Yes. 1

And you said, "No"?-- And I still stand by that.

All right. All right, we'll come back to that. You said, "No", and then answered a question about cost cutting?-- Yes.

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All right. Which isn't the same as procedure cutting. It's not the same thing, is it?-- No.

And you answered the point by saying, "We're transferring to other hospitals", in effect, and then ended up by saying, "And perhaps that's part of the reason why we're having this debate." Now, I suggest to you that that was clearly to implicate Dr Aroney as being Prince Charles-centric, if I can use that phrase, in protecting his own turf. Is that what you were intending to do when you answered that question?-- No, I think what I was endeavouring to do was to respond to an attack from Dr Aroney. 20

Yes?-- On me. So I didn't initiate an attack on Dr Aroney. I think what happened was Dr Aroney went out to the media first and took the issues to the media and I was responding to allegations like I was prepared to sit in Corporate Office and didn't care if people were dying. So what I'm saying here is we are not cost cutting. In fact, we have increased the investment that we've made in cardiac services significantly and we are not about cutting costs or cutting funding to Prince Charles; we're about expanding cardiac services across the state. Then when we come down to the issue of reducing cardiac procedures at the Prince Charles Hospital, I'm being accused of cost cutting because I've reduced the procedures, and what I was saying was, "No, the base budget has always been predicated upon 57 procedures." We increased the funding for procedures in 2004 as part of the increases in funding that came for elective procedures but the baseline always remained at 57. I hadn't cut the baseline funding. I hadn't cut the funding to Prince Charles, and in fact across the state, and I've highlighted this in my statement, we had increased services for cardiac care. 30 40

Dr Scott, I'm suggesting to you that you were indeed responding to what you perceived to be an attack by Dr Aroney on you?-- Mmm.

And you did that by identifying his concerns as being turf protection type concerns in protecting Prince Charles and at the expense of other districts; is that true?-- I was making the point that I didn't hear Dr Aroney talking about the increases in funding that were going to cardiac services at the PA, at the Gold Coast and Townsville or the increased number of procedures that we were doing across the state. All I heard about was what was happening at Prince Charles. 50

Dr Scott, nowhere in the interview is it indicated that

Dr Aroney had attacked you. So what is the basis on which you say you were responding to an attack by Dr Aroney on you?-- Well, again, I'm making the point that Dr Aroney has gone to the media and said, "Queensland Health administrators did not care if people died", that we're about protecting budgets, and I think----- 1

Did you identify that as an attack upon you personally?-- Well, as the person who was responsible for health care services in the health services directorate at that stage, as the person who Dr Aroney earlier in the year had accused of bullying, I thought it was----- 10

Sorry, can I get you to answer my question. Did you identify that as an attack upon you personally?-- Yes.

All right. Now, if I can come to the interviewer's next question it was a reduction, it was true, was it not, that Prince Charles had put in place a reduction in services from 80 to 57 per week or per fortnight?-- No. No, as I said before, the baseline activity was 57. The baseline activity had always been 57. For a period of time the activity increased with the funding that came in the elective surgery allocation and then - as with the previous round of costs, as Dr Aroney referred to them, people were being asked to come back to their baseline level of funded activity, which was 57 procedures per week. 20

COMMISSIONER: This is just playing with words, Dr Scott. They were reduced from 80 to 57. You have explained the reasons why they have been reduced from 80 to 57, but they were in fact reduced?-- Well, I guess that's----- 30

Isn't that right?-- Commissioner, I have got to accept your view of the words-----

No, no, don't accept my interpretation; just answer my question?-- They weren't - they weren't reduced. They had increased and they were coming back. Now, I'm sorry, if I sound like I'm playing with words. I apologise sincerely. 40

At one point in time there were 80 cardiac procedures performed at Prince Charles Hospital. At a later point of time there were 57?-- Yeah, I mean, without wanting to play with words, I would rather say-----

A lot of them transferred and brought back to baseline, you have said all that?-- For a period of time we increased the procedures that were being done.

50

Yes, yes, but in the long term, they were reduced from 80 to 57?-- No, in the short-term they were increased from 57 to 80. I apologise.

All right. They were 80 at one point?-- Yes.

All right. They were reduced from that to 57?-- I can't argue with that interpretation but I guess the-----

1

All right?-- -----interpretation-----

But you say they had already been increased from 80 to 57 and they were brought back to baseline?-- Yes, and the interpretation I was trying to get across to Kieran McKechnie on Stateline was we are not about funding and cutting. We have for a period of time increased-----

But you didn't say that. You didn't say that?-- No, well, I'm sorry, I'm demonstrating today how on the media as well, sometimes I can't say exactly what I would like to say but the intent was very much we have not cut services. 10

All right.

MS KELLY: Well, I suggest to you, Dr Scott, that your intent was to identify Dr Aroney as the source of false information and the source of unfair criticism. What do you say?-- Well, I don't accept that. 20

Could the other document be put up, please? It's the document going on to the screen now, is CA8. That is the attachment CA8 to Dr Aroney's statement. Now, these were what passes for minutes of the meeting of the Cardiac Society on the 15th of February 2004 at which you attended with Dr Buckland. Do you recall the meeting?-- Yes.

Do you recall there was - you said initially there was some controversy but by the end it seemed to be rather less controversial; is that right?-- Yes. 30

I suggest to you that's not right but we'll come back to that. You were advised in the course of a meeting by numerous speakers that Queensland had the worst coronary heart disease outcomes of all the major states?-- Yes, yes.

Yes. And you were advised of inordinately high rates of death in northern and central Queensland centres?-- Yes.

40

Which have no staff cardiologists?-- Yes.

All right. And so, when you said earlier that you had not been so advised, you were wrong?-- I had not-----

I asked you earlier was it not the case that the Cardiac Society had advised you as early as February that not only did Queensland have the worst outcomes in Australia but that this was attributable to a lack of staff cardiologists?-- No, I - I absolutely reject the interpretation that what that says is that those deaths, inordinately high in northern and central Queensland centres have no staff cardiologists - that the cause of inordinately high deaths in those centres was no staff cardiologists. 50

COMMISSIONER: I agree with Dr Scott about that. I can't see that you can draw that inference at all.

MS KELLY: Thank you. Thank you, Commissioner. I take you to a further document. I'm going to take the witness to CA2, which is an attachment to Dr Aroney's statement. 1

COMMISSIONER: Can you put that up on the screen.

MS KELLY: Which is too large to put on the monitor.

COMMISSIONER: Right.

MS KELLY: But, Dr Scott, just let me ask you: do you recall having seen the cardiac submission which, as you mentioned earlier, was addressed to the Minister; it claims to also be addressed to you and to Dr Buckland and to the Premier?-- What was the date again? 10

29 July 2004?-- Well, as I say, I was on long service leave at that stage.

Oh, okay. So does that mean that as at the 15th of October 2004, when you were on Stateline responding to Dr Aroney's assertions, you hadn't read the Cardiac Society's submission?-- I can't recall. I mean, I don't know whether - I certainly wouldn't have received it when it was delivered because I wasn't there. Whether I read it after that, I don't know. I mean, I was aware of these sorts of interpretations before being told on the 15th of February 2004 but I don't know what that document says. 20

Have you read it now?-- If you could - oh, I have but not recently. If you would like to tell me what specifically you're referring to. 30

Well, there is no point me putting to you what it contained and what inference - what knowledge you had arising from it in October if, indeed, you hadn't read it?-- As I say, I may have read it.

MS DALTON: Commissioner, just in fairness, could the witness see that? It is a big document. It is Exhibit 2 to the affidavit which is Exhibit 263 in these proceedings. 40

MS KELLY: Sure.

COMMISSIONER: Yes. Exhibit what was it?

MS KELLY: CA2.

COMMISSIONER: CA2. What did you want him to see, Ms Dalton, the statement? 50

MS DALTON: CA2.

COMMISSIONER: Is a statement?

MS DALTON: It's Exhibit 2 to Dr Aroney's statement. Dr Aroney's statement is 263 in these proceedings.

Queensland
Government

CONTRACT

OF

EMPLOYMENT

FOR

CONTRACTED HEALTH SERVICE EMPLOYEE

IN THE DISTRICT EXECUTIVE SERVICE

DR JOHN GRANT SCOTT

Health Services Act 1991

Crown Solicitor

State Law Building

50 Ann Street

BRISBANE QLD 4000

Office of the Public Service Commissioner

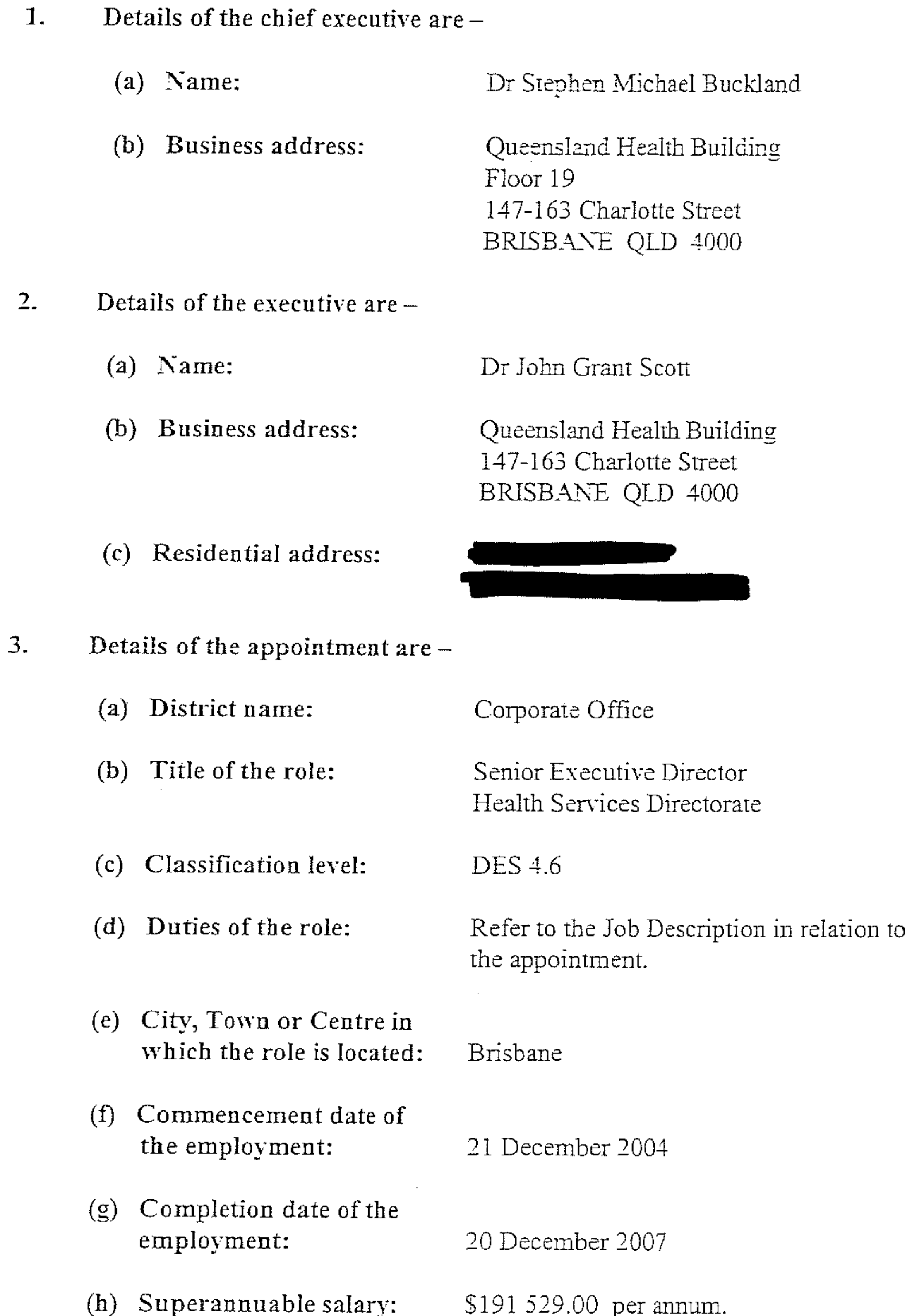
Level 3

61 Mary Street

BRISBANE QLD 4000

This contract of employment is made between the chief executive and the person appointed as a district executive ("the executive") under s.24(1) of the *Health Services Act 1991.*

PARTICULARS



1. Details of the chief executive are –

   (a) Name: Dr Stephen Michael Buckland

   (b) Business address: Queensland Health Building
   Floor 19
   147-163 Charlotte Street
   BRISBANE QLD 4000

2. Details of the executive are –

   (a) Name: Dr John Grant Scott

   (b) Business address: Queensland Health Building
   147-163 Charlotte Street
   BRISBANE QLD 4000

   (c) Residential address:

3. Details of the appointment are –

   (a) District name: Corporate Office

   (b) Title of the role: Senior Executive Director
   Health Services Directorate

   (c) Classification level: DES 4.6

   (d) Duties of the role: Refer to the Job Description in relation to the appointment.

   (e) City, Town or Centre in which the role is located: Brisbane

   (f) Commencement date of the employment: 21 December 2004

   (g) Completion date of the employment: 20 December 2007

   (h) Superannuable salary: $191 529.00 per annum.

PROVISIONS

1. Basis of Employment

The executive accepts appointment as a district executive on this contract from the commencement date until the termination date.

2. Location

(1) The executive will be located in the place specified in item 3(e) of the particulars.

(2) The executive acknowledges that travel throughout Australia and overseas may be required in the performance of the duties under this contract.

3. Responsibilities etc

The executive must –

(a) perform the duties specified in item 3(d) of the particulars or, where the duties are varied under clause 13(2), the varied duties;

(b) comply with the executive's annual performance agreement, and meet performance standards (if any) set by the chief executive;

(c) conform to such hours of work and other work arrangements as may from time to time be required of the executive by the chief executive;

(d) devote substantially the whole of the executive's time and attention during the hours determined in accordance with paragraph (c) to performing the duties under this contract; and

(e) be subject to those conditions of employment contained in section 28 of the Act.

4. Remuneration and Benefits

(1) The executive is entitled to –

(a) the actual salary payable fortnightly in arrears;

(b) remuneration benefits; and

(c) any other entitlements in accordance with a ruling.

(2) The superannuable salary amount may be increased by such amount as may be determined by the chief executive from time to time.

(3) Except where the chief executive considers that special circumstances exist, where, for any reason, actual salary is not payable for a period, the executive is not entitled to receive any remuneration benefit during that period.

(4) The executive is not entitled to the payment of any overtime and allowances for working more hours than referred to in clause 3(d).

(5) The remuneration benefits under subclause (1)(b) must be –

(a) nominated by the executive;
(b) varied; and
(c) costed,

in accordance with a ruling.

5. Superannuation

(1) Where the executive is, at the commencement date -

(a) a member of a category of the QSuper Scheme, the executive must continue to comply with the requirements of the QSuper Act in respect of the executive's membership of the Scheme; or

(b) on leave from other employment and continues as a member of an approved fund operated for the other employment, the Crown -

(i) shall contribute the standard employer contribution required under that fund, provided that the maximum period of time, whether under this contract or any other contract, for which the Crown will pay such payments, is three (3) years; and

(ii) thereafter, must contribute an amount that, if the executive was a member of the comprehensive accumulation category, would be required under the QSuper Act; or

(c) (i) not a member of a category of the QSuper Scheme; and

(ii) not on leave from other employment

then the executive is a member of the comprehensive accumulation category with the option to elect to become a member of the standard defined benefit category instead of the comprehensive accumulation category.

If the executive elects to receive 'the election amount' into an approved fund, the member will become a member of the basic accumulation category.

(2) The superannuation contribution will be automatically adjusted in accordance with the rules of the applicable superannuation plan.

6. Extension of Employment

(1) Subject to subclause (6), the executive may be offered an extension of employment under this contract of up to an additional term of two (2) years from the completion date.

(2) The executive will be considered for continued employment as a district executive if the executive gives a notice to the chief executive, indicating a wish to continue employment, not less four (4) months before the completion date.

(3) If the chief executive receives a notice under subclause (2), the chief executive must give a notice to the executive, not less than two (2) months before the completion date:

(a) advising the executive that the executive will not be continued in employment as a district executive; or

(b) offering the executive continued employment as a district executive for up to an additional two (2) years after the completion date, to be given effect by variation of the term of this contract.

(4) The executive acknowledges that if the executive does not give a notice under subclause (2), the executive has elected not to continue employment as a district executive after the completion date.

(5) The term of this contract, including any extensions of the term, will not exceed five (5) years.

(6) If the executive's term of employment has been extended under subclause (1) and further extension of the term is prohibited by subclause (5), the executive will be considered for reappointment as a district executive if the executive gives a notice to the chief executive, indicating a wish to be reappointed, not less than four (4) months before the completion date.

(7) If the chief executive receives a notice under subclause (6), the chief executive must give a notice to the executive, not less than two (2) months before the completion date, advising whether the executive will or will not be reappointed as a district executive after the completion date.

(8) The executive acknowledges that if the executive does not give a notice under subclause (6), the executive has elected not to be reappointed as a district executive after the completion date.

(9) A failure by the chief executive to give a notice under subclause (3) or subclause (7) is not a breach of this contract.

7. **Termination**

(1) If the executive –

(a) receives a notice under clause 6(3) or clause 6(7) (as relevant to the circumstances) which advises that the executive will not be continued in employment or will not be reappointed as a district executive after the completion date; or

(b) does not receive a notice under clause 6(3) or clause 6(7),

the employment of the executive will terminate on the completion date, without requiring further notice from the chief executive.

(2) (a) The employment of the executive may be terminated by the chief executive prior to the completion date by a notice given to the executive not less than one (1) month before the termination date.

(b) A notice under paragraph (a) need not give any reason for the termination of the executive's employment.

(c) The chief executive may revoke a notice under paragraph (a) before it takes effect.

(3) (a) The executive may resign by a notice given to the chief executive not less than one (1) month before the termination date.

(b) A notice under paragraph (a) takes effect in accordance with its terms and without needing the chief executive's acceptance.

(4) This clause does not limit the chief executive's capacity to terminate or suspend the executive's employment pursuant to a disciplinary process under the determination referred to in the Act or any other relevant legislation.

8. **Service and Separation Payments**

(1) This clause does not apply to the executive if –

(a) the executive is on leave from a public entity of another jurisdiction and the executive resumes duty with the public entity following the termination of the contract on the termination date; or

(b) prior to settlement of the termination of the contract on the termination date, the executive is appointed to, or otherwise employed by, a government entity, such that the executive has continuity of employment; or

(c) the executive has not given a notice under clause 6(2) and the employment of the executive is terminated on the completion date; or

(d) termination of employment occurs as a result of –

(i) disciplinary action against the executive under the Act; or

(ii) retirement of the executive, by reason of mental or physical illness or disability under the Act; or

(iii) voluntary retirement by the executive under the Act; or

(iv) resignation by the executive; or

(v) death of the executive.

(2) If the executive's employment as a district executive and this contract expire on the completion date under clause 7(1), the executive must be paid on the completion date, in addition to other payments and benefits to which the executive is entitled, a payment equal to twelve (12) weeks' superannuable salary, calculated at the rate of the superannuable salary at the termination date.

(3) If the employment of the executive is terminated prior to the completion date under clause 7(2), the executive must be paid on the termination date, in addition to other payments and benefits to which the executive is entitled, a service payment and a separation payment.

9. Payments to be Final

(1) Where the employment of the executive is terminated in accordance with this contract –

(a) the provisions herein as to the payments to be made to the executive constitute the whole of the entitlements of the executive under this contract;

(b) the executive must not, except where the executive has an express statutory right to do so, institute any proceedings for compensation for loss of office, injunctive relief, reinstatement or appeals;

(c) payments paid under clause 8 are deemed to be liquidated damages which each party acknowledges are a realistic assessment of any detriment which the executive may suffer following a termination of this contract; and

(d) payments due by way of statutory entitlement are to be calculated, where relevant, by reference to the superannuable salary at the termination date.

(2) Should a termination of this contract be determined by a court or a tribunal to be unlawful, any entitlement the executive may have is limited to the amount of payments paid under clause 8 as liquidated damages, as if the termination had been lawful.

(3) Nothing in this clause shall be deemed or construed as a release in respect of any action, personal injury or death of the executive, that the executive or anyone claiming by, through or under the executive, may have.

10. Repayment

(1) Where the executive –

(a) receives a service payment or a separation payment under clause 8; but

(b) before the completion date recommences public sector employment,

the executive must, within twenty-eight (28) days after recommencing such employment, or within such period as otherwise directed by the chief executive, repay to the Crown the total of the amounts calculated in accordance with the following formulas –

(i) Service Payment

$$A = B - (W \times S)$$

AND

(ii) Separation Payment

$$A = Z - \frac{(W \times S)}{5}$$

Where –

A in respect of each formula, is the amount to be repaid. For service payment, where the formula produces a negative result, then A equals zero.

B is the service payment which the executive has received under clause 8.

W is the number of weeks between the termination date and the date on which the executive recommenced public sector employment.

S is the weekly superannuable salary of the executive as at the termination date.

Z is the separation payment which the executive has received under clause 8.

(2) The executive is not entitled to a refund of a service payment or a separation payment repaid to the Crown under subclause (1) if the executive subsequently ceases public sector employment.

11. Other Agreements Superseded

This contract supersedes and replaces all other contracts, understandings or arrangements prior to its execution.

12. Notice

Any notice required to be given under this contract is effectively given if made in writing and signed by the party giving such notice, and –

(a) in the case of the chief executive, sent to the address specified in item 1(b) of the particulars; or

(b) in the case of the executive, sent to the business or residential address specified in item 2 of the particulars; or

(c) sent to such other address as may be notified to the other party giving such notice.

13. Variation

(1) A variation to this contract, other than a variation under subclause (2), must be approved by the Chief Executive and accepted in writing by the parties before taking effect.

(2) A variation to the duties specified in item 3(d) of the particulars must be accepted in writing by the parties before taking effect.

(3) To remove any doubt, where this contract provides for a determination to be made by a person, a fresh determination made by that person is not a variation to this contract.

14. Governing Law

This contract is governed by, construed and interpreted in accordance with the laws of Queensland and the parties submit to the jurisdiction of the courts of that State.

15. Interpretation

(1) The dictionary in the schedule defines the terms used in this contract.

(2) Unless otherwise defined in this contract, terms used have the same meaning as in the Act.

(3) Clause headings are not to be used as an interpretation aid.

(4) A reference to a clause, the schedule or the particulars is a reference to a clause, the schedule or the particulars of this contract.

(5) A reference to a subclause, paragraph or subparagraph is a reference to a subclause, paragraph or subparagraph of the clause of this contract in which the reference is made.

(6) A reference to the Act or any other Act, includes that Act as amended from time to time or any Act which replaces that Act, and any statutory instrument made under that Act.

(7) A reference to a number of days is a reference to that number of calendar days.

(8) Words in the singular include the plural and words in the plural include the singular.

SCHEDULE

DICTIONARY

Act	means the *Health Services Act 1991*;
actual salary	means the remuneration package amount *less* the total cost of providing the remuneration benefits;
annual performance agreement	means a performance agreement negotiated and developed by the executive with the chief executive, or the chief executive's delegate, in each year the contract is in force;
approved fund	means a superannuation fund approved by the Executive Officer under the QSuper Act;
basic accumulation category	means the category under Chapter 3 of the QSuper Deed;
commencement date	means the date specified in item 3(f) of the particulars;
completion date	means the date specified in item 3(g) of the particulars;
comprehensive accumulation category	means the category under Chapter 3 of the QSuper Deed;
confidential information	means information referred to in section 63 of the Act;

continuous service as a public sector employee - (1) means –

(a) the period of employment from the commencement date until the termination date, *less* any period of leave without salary which cannot be credited for service under a ruling;

(b) a period of service by the executive (unbroken by resignation, termination, retirement or redundancy) as a public sector employee on contract or on tenure, which continues up to immediately before the commencement date, *less* any period of leave without salary which cannot be credited for service under a ruling;

(c) any period of employment of the executive before the commencement date –

(i) which is capable of being recognised for the purpose of calculating an entitlement to long service leave under a ruling; or

(ii) which would, other than for the fact that the executive has taken long service leave or had an entitlement to long service leave paid as a cash equivalent, be capable of being recognised for the purpose of calculating an entitlement to long service leave under a ruling;

(2) does not include a period of employment which has already been used as the basis for calculating a payment received by the executive for an entitlement of the same or similar nature to a service payment;

Crown means the Crown in right of the State of Queensland;

department means the Department of Health established under the Public Service Act 1996, or any department which replaces that department;

district means the district specified in item 3(a) of the particulars;

election amount means an amount that, if the executive was a member of the comprehensive accumulation category, the Treasurer would require to be paid under the QSuper Act (including the contribution required to be made by or on behalf of the member) *less* any amount which is actually paid to the basic accumulation category.

party means a party to this contract;

public sector employment means employment for a cumulative period of more than twenty (20) working days in a government entity and includes –

(a) casual, part-time or full-time employment; and

(b) engagement as a contractor where the contract is wholly or principally for the labour of the executive, except where the executive does not have any financial interest in the company, partnership or similar entity engaged to provide the service;

QSuper Act means the *Superannuation (State Public Sector) Act 1990*;

QSuper Deed means the Deed of the State Public Sector Superannuation Scheme under the QSuper Act;

QSuper Scheme means the State Public Sector Superannuation Scheme under the QSuper Act;

remuneration benefit means a remuneration benefit referred to under clauses 4(1) and 4(3) and provided for under a ruling;

separation payment means a payment equal to twenty percent (20%) of the superannuable salary that would have been paid to the executive from the termination date to the completion date, had the employment of the executive not been terminated, calculated at the rate of the superannuable salary at the termination date;

service payment means a payment equal to two (2) weeks superannuable salary for each year of continuous service as a public sector employee, with a minimum of four (4) weeks superannuable salary and a maximum of fifty-two (52) weeks superannuable salary, calculated at the rate of the superannuable salary at the termination date;

standard defined benefit category means the category under Chapter 2 of the QSuper Deed;

statutory instrument has the same meaning as in the *Statutory Instruments Act 1992*;

superannuable salary means the amount specified in item 3(h) of the particulars or, where that amount is varied under clause 4(2), the varied amount;

termination date means the completion date or the date on and from which the employment of the executive under this contract is terminated.

The parties have executed this contract of employment as follows:

Signed by the chief executive or delegate

(signature of ~~chief executive or~~ delegate)

on the 27 day of January 2005

in the presence of

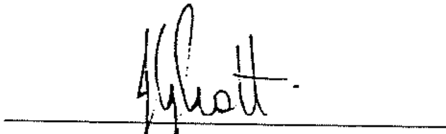
(signature of witness)

HAZEL ELIZABETH KABLE

(full name of witness - print)

AND

Signed by the executive



(signature of executive)

on the 19th day of January 2005

in the presence of

(signature of witness)

CHERYL BRENNAN

(full name of witness - print)

QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS IN RESPONSE TO DR ARONEY ON BEHALF OF JOHN SCOTT

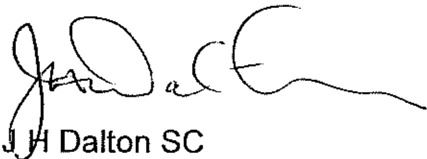
1. There is reference at paragraph 10 and paragraph 29 of Dr Aroney's submissions to Dr Scott linking cuts to TPCH to Dr Aroney's public statements. The only mention of this is that cited at those paragraphs - ex 263 paragraph 44. It is not proper or safe evidence and should not be acted upon. Particularly having regard to how quick Dr Aroney is to attribute blame and serious misdemeanour on the basis of what turns out to be hearsay, impression, rumour, etc. - see our previous submissions, and indeed paragraph 3 below.

2. The transcript reference at paragraph 17 of Dr Aroney's submissions - t 5209-1 (attachment K to these submissions) supports the point which we make at paragraph 1.2 of our submissions dated 25 October 2005.

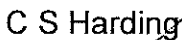
3. As to the last dot point at paragraph 34 of Dr Aroney's submissions:
   (a) the substance of the evidence of Drs Galbraith and McNeil and Mr Bergen was put to Dr Aroney as is quite proper. It would have been quite improper to have put questions such as: *"Dr X says ..."*;
   (b) the statements of Drs Galbraith and McNeil were distributed by Commission staff. They were provided to Commission staff well before Dr Aorney was cross-examined. This is not to attribute blame to those staff, or adopt Dr Aroney's criticisms, to the contrary, it is quite improper for Dr Aroney to submit that he ought to have known the evidence of others about contentious matters before he gave his own evidence;
   (c) we made the decision not to tender the statements of Drs McNeil and Galbraith. Ironically enough, it seems to be Dr Aroney who wishes to discuss the statements - see paragraphs 8, 34 and 45 of Dr Aroney's submissions. No doubt if the Commission wishes to have regard to the statements to understand these submissions it will do so, bearing in mind (of course) that the evidence was not tested.

4. Finally, as to paragraph 44 of the submissions, the discussion between counsel for Dr Scott and Mr Morris referred to is attached (attachment L). Dr Aroney conceded at the end of his cross-examination - tt 6274-5 (attachment M) that the amount of money needed to address the concerns he was putting to the Premier in 2003 was not possible within the current funding framework - see particularly at t 6275 ll 20-30. This is what was taken up with Mr Morris at t 4827. There is nothing odd about Dr Scott claiming credit for providing funds to Prince Charles Hospital. He responded to Dr Cleary's requests for large amounts of money promptly and by giving the amounts of money sought and the documents show this. They show that it was Dr Scott's decision to provide the money. They are attached as attachment F to our submissions of 25 October.

Dated this 28th day of October, 2005.



J H Dalton SC



C S Harding

people; Ross Cartmill, who's Chair of the Visiting Medical Officers Group has been prepared to say that; and Keith McNeil has been prepared to say that. 1

So did that - you didn't bully Dr Aroney?-- No, that I'm not a bully.

Right?-- I'm sorry, as I say-----

All right. Dr Scott, I'm almost finished. Did you discuss with either Dr Cleary or Ms Wallace the budget cuts instituted in late 2004 at Prince Charles Hospital prior to them being implemented?-- Well, there weren't any budget cuts. 10

All right, the reduction in numbers of procedures?-- Yes, I'm sure that I did.

All right. And who was present at those discussions?-- I'm just not sure, I don't know. I mean, I might have talked to them on the phone, if I'd talked to them together, then I would believe that it would have been one or both. 20

And it was part of your role as their superiors, Wallace and Cleary, to ensure that those reductions went ahead; that's right, isn't it?-- That they maintain budget, yes.

All right. And other areas, other areas such as the transplant area were not similarly cut in terms of the procedures, the numbers of procedures available at the same time, were they?-- Well, again, I know we're playing with words, but I'm not aware that the transplant team were overbudget, and if they were, then I would have taken the same approach, that we expect people to work within their budget and if we know that there are pressures on the budget and we believe they're legitimate pressures, then we would seek to put extra funding into supporting increases and, as I said, we've done that across the State in terms of the money that we've put in $11 plus million last year, $17 plus million for this year and into the future, some of that's gone to the transplant team, some of it's gone to management of cardiac failure, some of it's gone to increases in implant and defibrillators and some of it's gone into increases in angiograms and stents. 30 40

You see, you said in answer to a question this morning that you several times or many times made application to your superiors, in effect, I suspect, the Director-General and the Minister, if not the Budget Review Committee, for further funding?-- Mmm. 50

That's right?-- Yes.

Now, why did you not then regard Dr Aroney's disclosures of the severe shortage in funding as helpful to your cause?-- Well, I think we did see them as helpful to the cause through the channels of submissions to me and to the Director-General. I don't believe that going to the media and talking about death rates in the media is helpful because the only way it

can be helpful is if every other clinician who believes that they have needs in their area is allowed to go to the media as well. So in other words, I'm fine with people putting their requests forward, so long as we get a balance in terms of what's put forward and then we make appropriate investments in terms of the areas that we know are priorities. 1

And does that principle which you've just articulated apply also to Dr Aroney having written to the Premier which he did before he made any public disclosures?-- Well, again, I think everyone's welcome to write to the Premier, the Premier then manages those letters according to his want and that's up to them. 10

And it would be absurd to take offence at such a letter to the Premier, wouldn't it?-- Not if the implication is that I as an administrator are happy to let people die just to maintain my budget, it's not absurd.

But finally, Dr Scott, I suggest to you that you bullied Dr Aroney out of his job and out of service to the public patients of Queensland?-- Is that a suggestion or is it a question? 20

Yes, I suggest that to you, I'm sure you're going to say that's not the case?-- Yes, it's not the case.

And I suggest to you that you were concerned to make an example of Dr Aroney by ensuring that the services with which he was concerned were cut, or reduced if you'd prefer that term, so that other persons would be dissuaded from making public disclosures?-- You're obviously welcome to your point of view. If cutting the servicing means increasing the number of procedures done between PA and Prince Charles, if it means increasing the budget to Prince Charles for cardiac services in that year and subsequent years, then I guess I must be guilty, but I don't see that as cutting. The budget for that year increased, it didn't go down. 30

Thank you Commissioner. 40

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COMMISSIONER: Well, I guess Royal Commissioners are allowed to have regard to what appears in the newspaper, and my understanding is that Mr Nuttall subsequently conceded that he had received briefings. So I am not sure that there is an issue at all, but I am just making the point that if that's the sort of thing Mr Nuttall's concerned about, I would not expect we will be going down that path anyway.

MS DALTON: No, but the other issues I suppose I am concerned about in relation to the ex-Ministers are the things Dr Aroney raised in his evidence-in-chief that rather implied it was in my client's gift to be handing out money for this and money for that, so there were no constraints upon him, which, of course, is complete contrary----- 10

COMMISSIONER: Yes.

MS DALTON: He is concerned because they are substantial allegations as to his conflict. 20

COMMISSIONER: I understand his concern, and I guess the best test is that if those things had been said about me, I would feel very upset and I would wish to get the situation sorted out, but I think Dr Scott and, for that matter, Dr Buckland should understand that merely because something is said in the witness-box, doesn't mean that we accept the criticism involved in it. Indeed, whilst you were absent this morning during Professor Aroney's evidence, I made the point to him that he says he wants lots of money to have the world's best cardiac service but no doubt there are nephrologists who wants----- 30

MS DALTON: Everybody would like some money.

COMMISSIONER: Yes, and the real problem is there is not enough money to go around, and Professor Aroney very properly conceded that is the case. He is passionate about cardiac care and it is great to see a specialist who is passionate about his field, but that doesn't justify any adverse finding or any criticism of those who are given by the Parliament a limited budget and need to make the most of that. So I think that's as far as we can take it. You have leave to come and go as you feel----- 40

MS DALTON: Thank you, Commissioner. The other thing, as I understand, looking at the transcript from yesterday afternoon, my client won't be required before Friday, is that-----

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redirected back at PA. As I say, a lot of these patients couldn't get access to PA, and that's why they were coming to Prince Charles. As you know, PA, apparently, had no Category 1 and 2 patients. They were all lumped into this ridiculous Category 3, which was a total misclassification, and has only recently been redressed. 1

So that while Prince Charles lost funds in cutback number one and they were reallocated to PA, it also lost the patients it would have treated with those funds, and they were moved to PA too?-- Some - it did lose some patients. That's correct, yes. 10

Did you read the evidence that 11 million extra dollars are given to cardiology in the 2004/5 financial year, and $17 million in each year after that?-- Yes.

And you'd say that that's completely inadequate still?-- As I say, I cannot make comments about the overall budget, and questions like that I cannot answer. All I can answer is what was happening at the coalface at the hospitals that I was working at - at the hospital I was working at. 20

Well, you know one of the things you say is 25 - this is back in July 2004 - 25 cardiologists employed by Queensland Health - and really, per population you say there should have been 75?-- Yes, that's in our Cardiac Society submission, and that's based on the UK taskforce numbers. Queensland has one-third of the number of cardiologists looking after public patients that it should have. 30

All right. That's your submission, that it should be 75?-- That's a Cardiac Society submission.

Now, each of those cardiologists is going to cost about 300,000 a year to employ. Is that right?-- If they're employed as a full-time cardiologist, yes.

I presume that that's what you're talking about, full-time cardiologists?-- Yes, some of them are employed as VMOs, as part-time cardiologists, for instance. So there's an option to go both ways. 40

Apart from the cost of employing the cardiologists, would you know - would you have any idea - it's about $800,000 a year to fund the work that the cardiologists will do when you look at the operating theatres and the anaesthetists and the machines and the consumables and the outpatient appointments and inpatient stays?-- No, that would depend on what the cardiologist is doing. For example, a non-invasive cardiologist in Rockhampton, who doesn't do any angiograms or operating, there wouldn't be any of those extraneous costs that you mentioned at all, but for a cardiologist like myself who is doing a lot of interventions, that might be the cost. 50

But you're talking 10s of millions of dollars a year to increase the number of cardiologists to the level you say or the Cardiac Society says it should be; correct?-- That's correct. I mean, there is no cardiologists in the public system between Nambour and Townsville for instance. There is one private cardiologist there. So if you're anywhere along that central coast area, you won't come in contact with a specialist cardiologist when you have your heart attack. The same was true in Cairns for at least a year where the cardiologists there all resigned from the public system, and those hospitals coincidentally have the highest rate of death in hospital from a heart attack. 1 10

All right. So just to put the cardiologists in place is tens of millions of dollars every year and the other things you outline in your long letter to the Premier would be of an equal magnitude, wouldn't they, in terms of cost?-- I think it is consistent with what Dr Stable said about being underfunded by about a billion dollars a year and I think cardiology would fit into that argument as you've suggested. 20

Well, do you accept then that the things that you're asking for in that letter just can't realistically be provided in the current framework where our society doesn't give that extra billion dollars a year to health?-- That's right. It can't be provided with the current funding, that's correct, and that was why the submission was put in, in an effort to improve cardiac care and to improve funding. Thanks, Dr Aroney. Thank you, Commissioner. 30

COMMISSIONER: Thank you. Mr Fitzpatrick.

CROSS-EXAMINATION:

MR FITZPATRICK: Thank you, Commissioner. Doctor, I'm Chris Fitzpatrick and I act for Queensland Health. Can I ask you before I forget some questions about Exhibit 401 which was a HER HONOUR: letter produced from the Medical Staff Association to Debra
Podbury, the then District Manager at the Prince Charles. Doctor, the-----?-- It's a petition. 40

Thank you. Its covering page presents as a letter which bears the words "faxed 25 August 2005". To whom was the document faxed on that date, do you know?-- Oh, that's - that's my faxing to my barrister here. 50

That's your faxing to your barrister?-- That's correct.

Because you would be aware of Ms Podbury's evidence in the sense that she has told Dr Cleary in specific response to his question about whether she ever remembers receiving this letter?-- Mmm.

Submissions

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28 October 2005

Mr J Cowley-Grimmond
Principal Lawyer
Queensland Public Hospitals
Commission of Inquiry
By fax 3109 9151

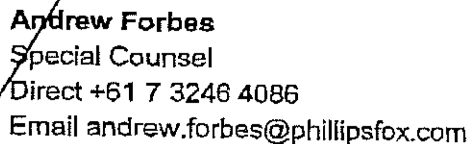
Dear Mr Cowley-Grimmond

Wavelength Consulting Pty Ltd

I refer to our telephone discussions yesterday in relation to the submissions delivered by other parties.

Copies of submissions on behalf of the Medical Board, the Queensland Nurses Union and various Queensland Health employees were received yesterday evening. In accordance with the directions made by the Commissioner, Mr Davies, we will deliver submissions on behalf of our client responding to these submissions on Wednesday, 2 November 2005.

Yours sincerely



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28 October 2005

Mr J Cowley-Grimmond
Principal Lawyer
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Commission of Inquiry
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By fax and hand: 3109 9151

Dear Mr Cowley-Grimmond

Wavelength Consulting Pty Ltd

I refer to the Notice of Potential Adverse Finding and **enclose** submissions on behalf of Wavelength Consulting Pty Ltd.

Yours sincerely

Kerry Hogan-Ross
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Encl

Queensland Public Hospitals *Commission of Inquiry*

Submissions on behalf of Wavelength Consulting Pty Ltd

Dr John Bethell gave evidence on behalf of Wavelength Consulting Pty Ltd (**Wavelength**) at the Commission of Inquiry on 1 and 2 June 2005 when it was constituted by Mr A Morris QC.

Wavelength makes submissions in response to the Notice of Potential Adverse Finding dated 19 October 2005 (**the Notice**).

1 In response to paragraph (a) of the Notice, Wavelength did not fail to insist on references that were less than twelve months old.

1.1 The contention that Wavelength failed to insist on references that were less than twelve months old overlooks that Dr Bethell obtained current oral references from two of the referees who had provided written references for Dr Patel.

1.2 Dr Bethell spoke to Dr Feldman and Dr Singh (T680 at 37 – 38;T696 at 21 – 22) and the references provided were glowing (T680 at 55 – 56). The effect of the references was that Dr Patel was a very high quality candidate and nothing adverse was revealed (T681 at 6 – 8).

1.3 The referees spoken to by Dr Bethell were selected by him because they were a surgeon and an anaesthetist respectively who had worked with Dr Patel. Dr Singh was the chief anaesthesiologist at Kaiser Permanente (T761 at 50 – T762 at 5).

1.4 The written references were respectively dated 4 May 2001, 18 May 2001, 23 May 2001, 30 May 2001 and two dated 4 June 2001. The written references were therefore current to when Dr Patel represented he had retired from practise and at the time of his application for employment in Australia were only approximately eighteen (18) months old.

1.5 Moreover, Dr Patel had been widely published in several internationally recognised and peer reviewed journals (T694 at 39 – 41; T695 at 7 – 10; T695 at 14 – 15; T695 at 20 – 21).

2 In response to paragraph (b)(i) of the Notice, Wavelength did not obtain an explanation from Kaiser Permanente for Dr Patel's departure from that hospital; however, no adverse finding should be made in this regard for the reasons that:

2.1 Dr Bethell specifically asked Dr Patel the reason for his ceasing employment with Kaiser Permanente and Dr Patel responded that he was in the process of retiring. The explanation given was a plausible and acceptable explanation (T695 at 35 – 39).

2.2 It is not unusual for practitioners in the United States to retire in their 50's as they make significant income during their careers. The retirement of Dr Patel is consistent with other candidates spoken to by Dr Bethell since placing Dr Patel (T679 at 25 – 31).

2.3 Dr Bethell received a written reference from the Director of Surgery who, it could reasonably be assumed, was Dr Patel's immediate supervisor. That

reference gave no basis upon which Wavelength should make further enquiries as to Dr Patel's reason for departing Kaiser Permanente.

2.4 On the basis of the six (6) written and two (2) verbal references obtained, there was no reasonable basis that should cause Wavelength to make further enquiry.

3 In response to paragraph (b)(ii) of the Notice, Wavelength did not contact Dr Patel's direct supervisor at Kaiser Permanente to obtain an explanation from Kaiser Permanente for Dr Patel's departure from that hospital; however, no adverse finding should be made in this regard for the reasons that:

3.1 Dr Bethell obtained oral references from the Chief of Anaesthesiology of Kaiser Permanente and the Staff Surgeon at that institution, both of whom would be expected to and did have a close association with Dr Patel in his daily practise, both having worked with him for in excess of 10 years.

3.2 The written reference obtained from the Chief of Surgery of Kaiser Permanente indicated nothing adverse concerning Dr Patel which would have called for further investigation.

4 In response to paragraph (b)(iii) of the Notice, Wavelength did not contact the Oregon State Board of Medical Examiners to ascertain whether there were any grounds for concern about Dr Patel's fitness to practise as a doctor; however, no adverse finding should be made in this regard for the reasons addressed at paragraphs 6.1 to 6.4 below in the response to paragraph (d) of the Notice.

5 In response to paragraph (c) of the Notice, Wavelength did not make enquiries into the inconsistencies between the CV's provided by Dr Patel, however, it is submitted that an adverse finding should not be made in this regard.

5.1 The discrepancy between the CV received in December 2002 (**the first CV**)(EX 41) and the CV received in January 2003 (**the second CV**)(Ex 46) was observed by Dr Bethell in or about May 2005 in the course of reviewing Wavelength's file in preparation for the Commission of Inquiry hearing (T689 at 2 – 20).

5.2 The second CV was provided by Dr Patel in January 2003 to support his application to the Medical Board of Queensland, which required more detail than was contained in the first CV. The second CV was dealt with administratively within Wavelength; simply being passed on to the Medical Board of Queensland.

5.3 By January 2003, the decision had already been taken by the Bundaberg Hospital to engage Dr Patel (T677 at 14 – 17; T688 at 17 – 22). In the circumstances, there was no reason for Dr Bethell to have undertaken a detailed examination of the second CV. Wavelength simply acted as a conduit in the transmission of the second CV to the Medical Board of Queensland.

5.4 The change to the second CV occurred as a result of a deception on the part of Dr Patel.

6 In response to paragraph (d) of the Notice, Wavelength did not make enquiries in relation to the Verification of Licensure issued by the Oregon State Board of Medical Examiners; however, it is submitted that an adverse finding should not be made in this regard.

6.1 Dr Bethell accepted in his evidence that he did not notice there was an attachment missing from Dr Patel's verification of licensure obtained from the Oregon State Board of Medical Examiners (T682 at 34).

6.2 The non-inclusion of the attachment to the verification of licensure in Dr Patel's application documents occurred as a result of a deception on the part on Dr Patel.

6.3 The fact that Dr Bethell did not make further enquiry with respect to the verification of licensure should be considered against the background of his experience and understanding of the practice of licensing authorities in Australia, New Zealand and the United Kingdom. In those jurisdictions, the relevant medical licensing authority does not issue a certificate of good standing (or its equivalent) if there is any impediment on the practitioners' fitness to practise (T697 at 56 – 58; T698 at 1).

6.4 On its face, the verification of licensure issued by the Oregon State Board of Medical Examiners gave no indication that there was any impediment to Dr Patel's fitness to practise. On the contrary, the verification of licensure expressly stated that there were no limitations (T698 at 12 – 18).

7 In response to paragraph (e) of the Notice, Wavelength did conduct enquiries into Dr Patel's background.

7.1 Reference is made to the oral references obtained by Dr Bethell.

7.2 There is no basis in the evidence to conclude that the references provided in writing by Dr Patel and obtained orally by Dr Bethell were not genuine. Nor is there any basis to infer that the referees contacted by Dr Bethell gave false, misleading or biased responses to Dr Bethell's enquiries.

7.3 During the course of interviewing the two referees, despite enquiry, those referees did not identify any concerns that they had with Dr Patel (T680 at 50 – 54). None were raised which caused or should have caused Dr Bethell any concern (T680 at 55 – 56 and T696 at 39 –40).

7.4 The assertion contained in (e) of the Notice, that Wavelength had no reason to believe that either Queensland Health or the Medical Board of Queensland would conduct relevant enquiries, is rejected.

7.5 It is a function of the Medical Board of Queensland, pursuant to section 11 of the *Medical Practitioners Registration Act* 2001, to assess applications for registration.

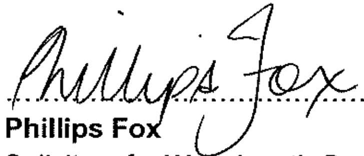
7.6 Further, Wavelength's terms and conditions expressly provided that the potential employer was required to make and rely upon its own enquiries with regard to the engagement of a candidate for employment (Ex42 clause 6; T676 at 10 – 17).

8 Wavelength did not ascertain the nature of the orders made by Oregon State Board of Medical Examiners and the Board of Professional Medical Conduct in the State of New York; however, it is submitted that an adverse finding should not be made in this regard.

8.1 Wavelength relies upon paragraphs 1 – 7 above in its responses to paragraphs (a) – (e) of the Notice above.

In the circumstances, no adverse finding should be made by the commission in relation to Wavelength.

Dated: 28 October 2005



Phillips Fox
Solicitors for Wavelength Consulting Pty Ltd