

HICKSONS
HEALTH LAW FORUM
15 MARCH 2017

**2008 SPECIAL COMMISSION OF INQUIRY INTO ACUTE CARE
SERVICES IN NSW PUBLIC HOSPITALS –**

SOME OBSERVATIONS AFTER ALMOST A DECADE¹

Introduction

- 1 I would like to begin my address by acknowledging the traditional owners of the land upon which we meet: the Gadigal people of the Eora nation. I pay my respects to their elders, past and present.
- 2 I would also like to express my gratitude to Cameron Leaver for the invitation to speak at this forum on a topic which consumed a significant swathe of my life in 2008, and which I regard as something which merits revisiting this afternoon.
- 3 I specifically wish to note that in making these remarks today, it is not my intention to engage in any criticism of, or comment upon, current government policy.
- 4 New South Wales provides a very extensive, historically located, public hospital system which provides health care, largely on

¹ I acknowledge the assistance of my tipstaff, Jessica van Lieven, in the preparation of this presentation and the accompanying PowerPoint slides

demand, and generally without charge to all who live in, or visit the state. It is the subject of constant public oversight – by those who are treated by it or admitted to its facilities, or those who have relatives and friends who are treated in public hospitals and who have visited them in the facilities and, as well, by the media.

- 5 The system occupies a central place in the health and wellbeing of our state. But that means that essential to its efficient functioning is that it retains the confidence of the public. If it does not, then politicians as their representatives will tend to think that they should embark on instant fixes and apparently attractive changes and modifications, which do not readily fall within an order improvement plan.
- 6 In 2007, particularly in the second half of the year, public opinion in New South Wales about the public hospital system was bleak, if not dire. This was because public trust and confidence in the system had been tarnished by a number of adverse occurrences, including two high profile and extremely tragic incidents.
- 7 The first incident occurred on 25 September 2007 at the Emergency Department of the Royal North Shore Hospital, where Jana Horska arrived, around 7pm, 14 weeks pregnant and experiencing symptoms that indicated that she was at a risk of miscarriage.
- 8 Ms Horska was assessed by the triage nurse as a patient with a potentially serious condition, which required her to be seen within one hour. However, the level of activity in the Emergency Department was relatively high that evening, although this was not

an uncommon occurrence. Nevertheless, as a result of this activity, Ms Horska did not receive treatment within one hour. After 2 hours of acute pain, Ms Horska miscarried in a hospital toilet in very distressing circumstances. Significant publicity ensued. Demands were made for the health minister to resign. Demands were made for senior staff at Royal North Shore to resign. The Parliament of NSW held an enquiry. There was general outrage.

- 9 The second incident was brought to public attention by the release of the NSW Deputy State Coroner's Report on 24 January 2008 into the death of a 16 year old girl, Vanessa Anderson, who had died in 2005 at Royal North Shore Hospital after being struck in the temple by a golf ball.
- 10 The Coroner's Report found that poor communication between doctors, staffing inadequacies, no or inadequate medical notes, poor clinical decisions, ignorance of protocols and incorrect decisions by nursing staff had adversely impacted upon Ms Anderson's treatment. The coroner lamented that, in Vanessa's case, almost every conceivable error or omission occurred and continued to build on top of one another, leading to Vanessa's death.
- 11 The Coroner concluded his report with the following remark:

"It may be timely that the Department of Health and/or the responsible Minister, consider a full and open inquiry into the delivery of health services in New South Wales."

- 12 In short, it was becoming increasingly clear that ongoing chronic problems in the New South Wales public health system, such as lack of funding, staffing and beds, low wages, long shifts, poor staff relations, dirty facilities and a disconnect between hospital staff and hospital administration, were symptoms of the fact that the system had arrived at crisis point.
- 13 These ongoing problems were also the subject of publicity, which in my estimation served to promote the lack of confidence in the public about obtaining access to adequate care in public hospitals. The headlines often featured complaints by doctors, nurses and clinical staff about the adequacy of the public hospital system.
- 14 At a purely political level, the Minister for Health was being required, almost daily, to defend the indefensible. Clinical reality and clinical challenges had become political liabilities.
- 15 As a result, on 29 January 2008, Her Excellency Professor Marie Bashir AC, CVO, Governor of NSW, issued Letters Patent appointing me under the *Special Commissions of Inquiry Act 1983* to inquire into and report on the delivery of acute care services in public hospitals in this state.

Scope of the Special Commission of Inquiry

- 16 I was tasked with two broad objectives in the discharge of my commission. Firstly, to enquire into systematic and institutional issues in the delivery of acute care services in New South Wales public hospitals, and to recommend changes to address those

issues. Secondly, to identify models of patient care in the delivery of acute care services, and:

- (1) Recommend changes to these models to improve the quality and safety of patient care;
- (2) Identify any systemic impediments to the implementation of these changes;
- (3) Recommend changes to overcome these impediments; and
- (4) Recommend changes to workforce policies and practices to support improved models of patient care.

17 The scope of the Inquiry was “acute care”. In everyday language, "acute care" refers to medical services such as surgery, intensive care, medical and nursing care, which are provided for the immediate assessment and treatment of patients.

18 The term "acute care" is also used in a broader and more technical sense by NSW Health as follows:

“Acute care is where the principal clinical intent is to do one or more of the following:

- manage labour (obstetrics);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of an illness or injury;
- protect against exacerbation and/or complications of an illness and/or injury which could threaten life or normal function; and
- perform diagnostic or therapeutic procedures.”

- 19 At the start of the Inquiry, I read a number of earlier reports into the public hospital system in NSW and throughout Australia. In doing so, I came across the report of the 1926 Commonwealth Royal Commission on Health. It noted with approval the motto of the NSW Department of Health. Throughout the inquiry, I endeavoured to give effect to that motto which derived from Cicero's work "On the Laws": "*salus populi suprema lex esto*", meaning that the health or welfare of the whole of the population is the supreme law, and thereby prevails over that of an individual.
- 20 Accordingly, I concluded that, within the realistic economic parameters, the end principle for a public hospital system must be that every person who comes to be cared for in a public hospital should be treated with respect by an appropriate skilled clinician, in a safe and cost effective way, to achieve the best possible outcome for the patient.

Context of the Inquiry

Public Hospitals in NSW

- 21 To provide some context, at that time there were 251 public hospitals in NSW ranging in size from major metropolitan hospitals to remote multi-purpose services in towns like Wilcannia and Bourke. The workforce of NSW Health consisted of over 90,000 fulltime equivalent staff.
- 22 I established that if NSW Health was a publically listed company, it would probably be the fifteenth largest public company in Australia. In 2008, it provided public hospitals and healthcare to a population in a geographic area which was larger than the areas of each of

Germany, France and Spain. Moreover, the population of NSW was not, and is not to this day evenly distributed. Its bulk lives between the coastline and the Great Dividing Range, with the remainder living in less dense populations in the rural parts of the state. The Great Dividing Range is one long sandstone curtain.

- 23 The 251 public hospitals in NSW provided about 19,170 hospital beds which represented approximately one third of the Australian public in-patient beds. Private hospitals in NSW had a further 6,208 beds, which comprised about 24% of the total hospital beds in the State. NSW had a slightly higher ratio of 2.8 public beds per 1,000 people than the national average of 2.6.

An Ageing Population

- 24 Overwhelmingly, a significant feature of the population of NSW, and of Australia, was and is its ageing population. On any one day in 2008, a half of all hospital beds in NSW were occupied by patients aged over 65, and people aged 65 and over consumed 42.9% of total acute bed days in public and private hospitals. At June 2015 in NSW, 16% of the population was 65 years of age or older, and between 2010 and 2015, the number of people aged 65 or over in NSW grew by 18%.
- 25 This feature of NSW's population is a serious issue, not only in terms of the type of care which public hospitals will be required to provide, but also in terms of the likely increase in hospital capacity that will be necessitated by an increasingly elderly population. As an example, hospital presentations by those aged 75+ are growing at the rate of 20% per annum, and while the all patient average

stay in a hospital is 4 days, for a person over the age of 75, the average stay is 9 days.

- 26 A newspaper article published on 3 April 2015 by the Sydney Morning Herald stated that, on any given day in NSW, more than 550 people in acute hospital beds are ready to be discharged but remain in that bed because they are waiting for placement in a nursing home.² That is, the number and location of aged care placements have a significant impact on the operations of NSW public hospitals.

Methods of Inquiry

- 27 The inquiry was conducted by employing several different methods of information gathering. I called for submissions by advertising in major metropolitan and regional newspapers, and my staff contacted 95 organisations who appeared to have an interest in the subject matter. In total, I received over 1,200 submissions from more than 900 organisations and individuals.
- 28 In addition, from 14 February 2008, my staff and I visited 61 public hospitals throughout New South Wales, from Dubbo and Dorrigo and from Concord to Camden.
- 29 Between 10 March and 26 May, I also conducted 39 public hearings at, or near, hospitals. People had the opportunity either to give evidence in public, or to give evidence in private if it related to a confidential matter or if there was any other relevant concern.

² Harriet Alexander, 'Hundreds of elderly patients occupy NSW hospital beds in queue for aged care', *Sydney Morning Herald* 3 April 2015.

This Inquiry heard from a total of 500 witnesses in the public hearings, and a further 128 witnesses gave evidence in private.

- 30 In addition, I attended 110 meetings, the purpose of which was to gather information and enable discussion of topics more suited to a “round table” setting, such as briefings from NSW Health and other government departments on their roles, meetings with stakeholder groups, and meetings with independent health policy and research institutes such as the Sax Institute.
- 31 Two expert panels were also convened. A two-day panel convened to consider broadly the issues I had raised in my report, and a one-day panel to discuss the issues considered in my report in respect of babies, children and young people. Two hearings were also conducted to investigate two specific matters.
- 32 Finally, two feedback forums were held on 16 and 17 October 2008 as I was in the course of finalising my recommendations.

Steps to Reform

- 33 The first important step in the inquiry was to identify ways in which it could lead to reform. I identified six such steps to achieve lasting reform in the public hospital system.
- 34 The first step was to identify the existing state of NSW Health, encompassing as many perspectives as possible and learning as quickly and as comprehensively as possible. I have just canvassed the process by which this was done.

- 35 The second step was to identify and articulate the blockages to reform. It became immediately obvious that, in an organisation such as NSW Health, the most immediate blockage was the fear of change itself. Another barrier was the complete disintegration of working relations between clinicians and hospital management. If reform was to take place, trust needed to be restored, as did communication, mutual understanding, clear role delineations and clear delegations.
- 36 The complexity of funding arrangements of public hospitals in NSW, and the “silo” mentality of public hospitals – whereby hospitals saw themselves as a single institution and not part of a state-wide system – were also identified as barriers to reform. The final blockage that I identified was the continued presence of historical demarcations between the roles and clinical functions of hospital staff, particularly in Emergency Departments. These demarcations exerted only a negative influence in times of cost and resource pressure, lack of fully trained staff, and a significant increase in the demand on the system.
- 37 The third step was to identify and articulate the principles to which reforms should adhere.
- 38 The fourth step was to identify and create enablers of reform. The inquiry itself fell into this category, as did the processes by which the information and evidence for its findings was obtained – through public discussion and submissions. Other enablers of reform led inexorably to the four critical recommendations of the inquiry.

- (1) First, the availability of information and data about the performance of public hospitals against other public hospitals, so as to improve patient choice and to encourage improvement in all services by virtue of this comparison;
- (2) Second, innovation and clinical improvement to enable services to be provided in a smarter and more cost-effective way;
- (3) Third, a heavy emphasis on safety and quality, and the reduction of error; and
- (4) Fourth, education, and its relationship with the workforce.

39 The fourth step was the release of the final report including all recommendations and mapping out of a proposed pathway to reform.

Major Findings and Recommendations

40 Generally speaking, I found that the NSW public health system was of a good standard, but was unable to deal with the increasing pressure placed upon it by increased demand, stagnant funding, increasing cost, and other such matters.

41 I made 139 recommendations in my report, ranging from relatively routine issues to small steps which I thought would make a real difference, such as a system for role identification in the disaster-zone-like conditions of Emergency Departments.

42 However, the success of these reforms necessitated the creation, or strengthening of, four bodies or “pillars” upon which the reforms would be centred: the Bureau of Health Information, the Clinical

Excellence Commission, the Institute of Clinical Education and Training, and the Bureau of Health Information.

The Bureau of Health Information

- 43 The first pillar was the establishment of the Bureau of Health Information, which linked in with the importance of the availability of accurate and timely information and data. I recommended that the Bureau be established to access, interpret and report on all data relating to the performance of every public hospital, including the safety and quality of patient care, and to facilitate its interpretation and communication to the public on a regular basis.
- 44 I recommended that the Bureau be independent from NSW Health, and that it collect information on how quickly and appropriately a patient had been treated, as opposed to information which may be process or politically-driven.
- 45 This recommendation was grounded in my firm belief that public reporting of information and data would improve all aspects of acute care in public hospitals in two ways. Firstly, it would change consumer behaviour, because better informed consumers would demand timely and good quality health care, and because poor performance would be disciplined by the market of public opinion. Secondly, it would assist poor performers in identifying areas in need of improvement, and thereby lead to an improvement in that area.
- 46 I also believed that such publically available information would be the single most important enabler for the creation of public

confidence in the health system, engagement of clinicians, and improvement and enhancement of clinical practice and cost efficiency.

47 Moreover, a system which enabled the delivery, collation and dissemination of data back to hospitals and to the public would inject real competition into a system where true competition was absent. Such competition, whereby a hospital or ward could compare its performance against like hospitals or wards, would be a clear driver of improvement, particularly in a simple unitary government-owned and provided health system from which competition is absent.

48 In my report, I recommended that data be available in the following categories:

- (1) Access to and provision of hospital services, including timeliness of the service;
- (2) Clinical performance, including patient outcome, appropriateness of the clinical treatment method, and so on;
- (3) Safety and quality of the clinical care and the hospital attendance or admission;
- (4) Cost of the clinical care including re-presentation or re-admission cost and error cost;
- (5) Patient experience and satisfaction;
- (6) Staff experience and satisfaction; and
- (7) System impact and sustainability.

- 49 The Bureau of Health Information was established in 2009 as a direct result of my inquiry. In 2011, the Bureau of Health Information was recognised as the "primary source of quality information to the community, healthcare professionals and policymakers" by the NSW Health report, *Future Governance Arrangements for NSW Health*.
- 50 The Bureau's website allows access to interactive data, divided into sections relating to Hospital Data, Patient Survey Data, and International Data. A quick perusal of this facility enabled me to learn that between September and December 2016, 684,740 people presented in Emergency Departments in hospitals around NSW. For the number among these people triaged as "emergency" cases, the median time that they had to wait was 8 minutes. The time period in the 95th percentile was 41 minutes. One half of the hospitals had improved the timeliness of treatment in Emergency Departments.
- 51 The Bureau's strategic plan for 2015 – 2019 includes goals to "use a diversity of formats to disseminate ... information", "provide opportunities for [their] audience to interact with the data", and to "increasingly use linked datasets and sophisticated analytical methods that provide the most meaningful information".

Clinical Excellence Commission

- 52 The second pillar of reform of the NSW public hospital system was the strengthening of the Clinical Excellence Commission, a body which already existed but which needed to have its role acknowledged and supported. Linked with this recommendation

was a recommendation which effectively called for the abolition of the Safety and Quality branch of NSW Health, because the existence of the two bodies caused confusion, delay and ultimately lack of effect.

53 The CEC is a body which is devoted to safety and quality of public hospital healthcare systems. The importance of the CEC accorded with my view that it is essential to keep safety and quality as the principal determinant of patient care. The in-hospital error cost is significant. Elimination or minimisation of error brings with it dramatic cost savings and a manifest increase in confidence in the public hospital system.

54 The CEC has continued its excellent work. In its strategic plan for 2015 to 2018, it has nominated four key focus areas for working strategically to improve system level safety and quality: building system excellence, enhancing leadership and frontline capability and capacity in quality and safety, knowledge-based system improvement, and organisational excellence, supported by the development of adaptable delivery systems and aligning key priorities with CEC's processes.

Agency for Clinical Innovation

55 The third pillar of reform was the establishment of a body which I called the Agency for Clinical Innovation. The main task of that Agency, which would be managed by clinicians and would rely upon clinical networks for its work, was to devise innovative and cost effective models of care which would provide for the delivery of equal care to all patients across NSW.

- 56 This recommendation was based upon what I saw as two growing features of public hospital care in Australia – first, that public hospitals were being required to provide more care to more patients within existing resources and at an increasing level of sophistication and complexity, and second, that the cost of doing so was increasing at a much higher rate than the ordinary CPI.
- 57 It was my opinion that the system had to take steps to manage the tension between these features, and that this could only be done by providing services in a clinically smarter and more cost-effective way.
- 58 Looking across the system, it was obvious that individual units or wards had devised and implemented innovative solutions to particular issues. However, this innovation was not being shared or implemented across the whole system. Hence, I found that it was essential for the improvement of the public hospital system that such innovation and knowledge be gathered, sorted, and communicated.
- 59 My solution to this absence of shared ideas was to recommend the establishment of clinical networks of health professionals who had particular areas of expertise and whose function would be to be champions for and messengers of new and innovative models of care.
- 60 As a direct result of this recommendation in the Inquiry, the NSW Agency for Clinical Innovation was established in January 2010.

- 61 The ACI is spearheaded by a Board and senior staff. It also has a Consumer Council and a Research Committee. But, most importantly, it has 39 Networks, Taskforces, Institutes and Units in areas such as Acute Care, Aged Health and Rural Health. Its core values include collaboration, innovation and openness, and its purpose is to work with clinicians, consumers and managers to design and promote better healthcare for NSW.
- 62 The ACI's strategic plan for the years 2015 to 2018 states that its aim is to optimise its resource use and to strengthen communication and involvement among its staff in order to achieve its primary goals. Its primary goals are to facilitate quality healthcare by optimising operational agility, and by enhancing the capability for public hospital system-wide redesign in such a way that better health outcomes are received for all by connecting people with ideas to make a difference. It has designed, and redesigned, many models of care by a process of engaging with knowledgeable clinicians who then educate the system widely and who are champions of innovation and improvement.
- 63 Initiatives to achieve such goals include developing and implementing programs to promote the exchange of knowledge and shared learning, and continuing to build local capability in re-design, innovation and sustained improvement.

Institute of Clinical Education and Training

- 64 The fourth and final pillar was my recommendation for the creation of an Institute of Clinical Education and Training, which was established on 1 July 2010.

- 65 I envisage that the Institute would be responsible for creating education programs in areas such as postgraduate clinical education, leadership and hospital training, and would also include performance evaluations among participating staff.
- 66 This recommendation arose from my belief that a significant enabler of reform was the continued education of the workforce. Such education, I believed, should be delivered by those members of the workforce best placed to deliver that training, and not necessarily those individuals who were the most highly qualified.
- 67 To take an example, imagine how many times a skilled laboratory technician will take blood from an individual. The number would be many hundreds more times than will a doctor. As a result, it appeared to me that the skilled trainer of laboratory technicians ought to be the person training doctors, nurses and others how to take blood quickly and efficiently.
- 68 Moreover, it was my belief that team work was of the essence in the provision of modern medicine and in the continued enrichment of its workforce. Encouraging a greater emphasis on clinical education in teams and not just by profession, and ensuring adequate education in the clinical setting, would enable young doctors, nurses and other health professionals to be adequately skilled, and to be taught these skills by the most appropriate person.
- 69 In other words, the reform of public hospitals required role and function flexibility and ongoing education.

- 70 The Health Education and Training Institute is the successor body to the Clinical Education and Training Institute. It came into existence on 2 April 2012 following a Ministerial Review of Future Governance for NSW Health. It is also a Chief Executive governed Statutory Health Corporation established under the *Health Services Act 1997*.
- 71 HETI works closely with Local Health Districts, Specialty Health Networks, other public health organisations and health education and training providers in order to achieve its goal of improving the health of NSW citizens and the working lives of NSW Health staff through education and training.
- 72 HETI nominates its main functions as follows:
- (1) To design, commission, conduct, coordinate and evaluate education and training for patient care, administrative and support services;
 - (2) To take the lead role in NSW Health for the design, commissioning, conduct, coordination and evaluation of leadership and management development which is designed for both clinical and non-clinical staff;
 - (3) To support reform to improve workforce capacity and the quality of clinical and non-clinical training; and
 - (4) To develop, coordinate, oversee and evaluate education and training networks, ensuring they support service delivery needs and meet operational requirements.
- 73 Its strategic plan, which ends in 2017, HETI nominates its aspirations as providing education and training for the Health workforce, providing a responsive, innovative and best practice

approach to this education, and creating a workforce that can assess and respond to this need.

- 74 Currently, HETI is in the process of becoming a higher education provider, a development which it believes will enable it to become proactive, as well as reactive, in relation to the emerging needs of the health workforce.

Current Issues in NSW Public Health

- 75 As a result of the observations that I have just made, it is evident that the four key recommendations of the Inquiry have been brought to life, and there is no doubt that their existence has encouraged significant improvement in the NSW public health system. However, it would be erroneous to assume that the taking of these steps constitutes the end of the matter.
- 76 The extent to which other recommendations were implemented is beyond the scope of this presentation, and may have been lost in the mists of time.
- 77 The public health system is constantly changing; just as the demands and characteristics of the NSW population is constantly in flux. Even accounting for a certain level of agility in the provision of public health services, and for a degree of foresight or proactive behaviour, there will always be challenges to which the system will be asked to rise.
- 78 Although current public opinion of the health system could not be said to be as problematic as it was in 2008, a perusal of news

headlines in the last year indicates some dissatisfied rumbling. Here are some examples.

Gas Mix-Up Leading to the Death of a Baby

- 79 On Friday 22 July 2016, one baby died when it was mistakenly given nitrous oxide instead of oxygen at Bankstown-Lidcombe Hospital. Another baby was left with suspected brain damage as a result of the incident. Both babies had been born in the Hospital in June and July 2016 and had required resuscitation after birth.
- 80 A report into the two incidents by the NSW chief health officer, Dr Kerry Chant, released on Saturday 27 August 2016, revealed that “a series of tragic errors” led to the mix-up of the two gases. Not only were there failings in the installation of the gas piping by BOC Limited, the company contracted to perform the work, but the report found that the commissioning and testing processes for the pipes was also flawed.
- 81 The report also found that South West Sydney Local Health District and BOC Limited failed to comply with Australian standards. It also revealed broader clinical and governance issues around risk management, communication and lines of accountability. As a result, the report recommended that the South Western Sydney Local Health District go on performance watch.

Confusion in Mortuaries

- 82 In similarly tragic circumstances, it was revealed in a budget estimate sitting in the NSW Parliament on 31 August 2016 that the bodies of a 20-week old foetus and a still-born baby had been

confused by staff at the Royal North Shore Hospital in 2015, resulting in one baby being accidentally cremated against the wishes of its parents, who had intended to bury it.

83 Deputy Secretary NSW Health Dr Susan Pearce told the estimates hearing that a label on a blanket draped over one of the babies led hospital staff to believe it was the other deceased baby.

84 It was later revealed that a similar situation had occurred earlier at the same hospital, in 2012.

85 In the same estimates hearing, it was also revealed that the daughter of a woman who had passed away in the Royal North Shore Hospital discovered that her mother's body had been mislabelled in the mortuary.

86 These events can be defined as "sentinel events", or adverse events which result in death or very serious harm to the patient. The Productivity Commission's most recent report on Health, released on 1 February 2017, indicates that 50 such events occurred in NSW in the year 2014–2015, compared with 32 events in 2010-2011, 45 events in 2011-2012, 38 events in 2012-2013, and 53 events in 2013-2014.

87 Out of these 50 events, 20 involved re-surgery being required to remove retained instruments in the body of a patient, and 3 involved the death of a patient due to medication error.

Equal Access to Health Care

- 88 Finally, the issue of equal access to health care for Aboriginal and Torres-Strait Islander Australians has also risen to prominence in the last year.
- 89 One case illustrates the complexities of this issue. In the early hours of 1 January 2016, young Indigenous woman Naomi Williams presented at Tumut hospital with a severe headache. She was six months pregnant, and was directed to take a paracetamol and to return home. When she woke up the next morning, Ms Williams alerted her partner that she was unable to breathe or walk properly.
- 90 An ambulance was called, however her condition rapidly deteriorated and she died on the way to the hospital in an Ambulance. Her cause of death was found to be cardiac arrest as a result of meningococcal and septicaemia.
- 91 Ms Williams' mother wrote a letter to NSW Health asking why her daughter was not kept in the hospital for testing and observation. She also alleged that Ms Williams had not received adequate treatment because of her Aboriginal heritage.
- 92 A spokesperson for the hospital stated that all procedures had been followed, but acknowledged that lessons had been learned from Ms Williams' tragic death. The hospital has implemented a critical care advisory service, which links the hospital to specialist clinical advice at Wagga Wagga rural referral hospital. Staff also received training in the early identification and treatment of deteriorating patients.

Comment

- 93 The reporting of these incidents on a wide scale is clearly derived from the significant impacts that these incidents had upon those people who were involved. It serves as a reminder that, at its base, the public health system is a service upon which hundreds of thousands of people rely for a high level of support, care and assistance. Even more so, these stories demonstrate that, when the machinery of the public health system fails, or its workforce makes errors, the consequences can be catastrophic.
- 94 In such real life and death situations, the public health system will be held to account in the sometimes gladiatorial arena of the 24/7 media cycle, and it will not always emerge the victor.
- 95 That is not to denigrate the fact that the media is almost single-handedly responsible for holding the NSW public health system to account; quite the opposite. Indeed, what I would suggest is that the media reporting on issues in the public health system is an extremely effective canary in the gold mine.
- 96 While the media can undoubtedly influence opinions of the NSW public health system, it is also capable of holding a mirror up to the health system and revealing to those involved the faults in their reflection.
- 97 My continuing regret is that the media have yet to assist the confidence in the public hospital system by acknowledging significant achievements: hand hygiene compliance is now at 85%, the best in Australia, and better than ever before in NSW. In NSW,

the present estimate of mortality directly caused by anaesthetic is less than two deaths per million population per annum. A very, very low figure.

- 98 In the September-December 2016 quarter, according to the BHI Report published this morning, the average waiting time across all triage categories in Emergency Departments was lower than any previously recorded year, but the newspaper headline said that “*Sydney Hospitals were struggling under a deluge of sicker patients*”. We now know that more seriously ill patients attend the Emergency Departments, and fewer non-urgent cases than the year before. At last, we can celebrate the fact that Emergency Departments are being used more appropriately by the public. We know that these improvements have occurred even though there has been a 19% increase in the numbers attending Emergency Departments since 2011.

Conclusion

- 99 The Special Commission of Inquiry will celebrate its ninth anniversary this year. While it is not in doubt that its findings have benefited the NSW public health system, it is also evident that a continued awareness of the changing needs of the citizens of NSW is crucial if the system is to remain responsive to change and capable of delivering the high standard of safety and quality of care that its citizens expect.
- 100 To adapt the words of Professor James Reason: “*If the price of national security is eternal vigilance, the price we pay for a safe and effective public hospital system is constant nervousness*”. We

must look back to learn the lessons from the past in order to understand the improvements in the future.

101 Thus, as we recognise the achievements of the workforce that staffs our hospitals, and of the countless individuals who endeavour to support and encourage that workforce and enable it to reach its full potential, we must also recognise that even the best systems are not immune from crises.

102 What defines success in this context, therefore, is not success in a vacuum, but success in its context. In other words, success derived from responsiveness to change, from investment in education and training, from familiarity with the system and its realities, and from innovation and foresight with respect to the challenges ahead.

103 In the words of Charles Darwin: “It is not the strongest of species which survive, nor the most intelligent, but the ones most responsive to change”.