EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE TRANSITION AND OPERATION OF SERVICES AT FIONA STANLEY HOSPITAL

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 19 AUGUST 2015

SESSION ONE

Members

Dr G.G. Jacobs (Chair)
Ms R. Saffioti (Deputy Chair)
Mr R.F. Johnson
Ms J.M. Freeman
Mr M.J. Cowper

Hearing commenced at 9.31 am

Dr IAN JENKINS
Chair, Inter-hospital Liaison Committee, Australian Medical Association (WA), examined:

Ms MARCIA KUHNE
Director, Industrial Relations/Legal, Australian Medical Association (WA), examined:

The CHAIR: We will make a start, ladies and gentlemen. On behalf of the Education and Health Standing Committee, I would like to thank you for your appearance before us today, Marcia and Ian. The purpose of this hearing is to assist the committee in its inquiries into the transition and operation of the services at Fiona Stanley Hospital. Graham Jacobs is my name and I am the Chair. On my left is Rob Johnson, on his left is Rita Saffioti, on her left is Janine Freeman, and on her left is Murray Cowper. The executive is Daniel Govus. This will be recorded by Hansard. We have some footage that will take place in camera, but after my opening statement they will leave and we will commence the inquiry. The hearing is a formal procedure of Parliament—but hopefully not too formal—and commands the same respect given to the proceedings of the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament.

Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you both completed the "Details of Witness" form?

The Witnesses: Yes, we have.

The CHAIR: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIR: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Do you have any questions in relation to being a witness before us today?

The Witnesses: No.

The CHAIR: We have your written submission here today. I will give you the opportunity, if you could, to give us a summary of this, because we have all had a bit of a read of your written submission, and then give us the opportunity to ask you some questions.

Dr Jenkins: Thank you, Chair. What was there really was intended to be the transcript of what I was going to say, but I will try to summarise it to give plenty of time for questions.

The CHAIR: Thank you.

Dr Jenkins: Thank you, Chair and committee, for allowing the opportunity to speak to this inquiry. As I said, I am Ian Jenkins, chair of the hospital liaison committee. I am also an intensive care specialist at Fiona Stanley Hospital and director of intensive care at Fremantle Hospital. I was involved a lot with the planning of Fiona Stanley right from the very beginning.

As a member of the AMA (WA) council, I am aware that AMA desires not to highlight problems with the reconfiguration but to work with government of the day to find solutions and improve

services and efficiency. Where I can, I have tried to make some comments with regard to positive areas where we could proceed with that. However, because of grave concerns of transitioning and operational matters, AMA (WA) conducted a survey of clinicians' opinions about commissioning the operation of Fiona Stanley. I have summarised some of the findings there, which you are able to read, but they do not make good reading. We got 668 respondents to the survey, which was within a matter of days of the survey going out, which I think demonstrates the depth of feeling that people had. It was a wide range, as you can see, of various levels of medical grade in the hospital from interns in their first year through to heads of department. Respondents were asked to comment on Fiona Stanley and how it was affecting their current workplace if they did not work at Fiona Stanley. As you can see there, nearly 60 per cent felt that the commissioning had been handled poorly or very poorly and 71 per cent of respondents felt that the resolution of operational issues had been handled poorly. Amongst the senior doctors, around two-thirds felt that commissioning was handled poorly, that operational issues were handled badly and that patient safety was being compromised. The exact figures are in the document as provided. I am happy for people to ask questions as we go, if you wish

The CHAIR: Thank you.

Dr Jenkins: Interestingly, the senior doctors felt that not enough weight, time and resources given to research and also to their ability to teach and train doctors in training, although, interestingly, the doctors in training felt that they had reasonable time for that, although they agreed that there was not adequate weight given to research. Similarly, the doctors in training had maybe a slightly lower percentage respondence in the poor and very poor categories, as outlined there in the top half of page 2.

Overall, more than half of the doctors felt that management at Fiona Stanley was not responsive to their concerns. Over two-thirds felt that the IT systems did not assist in providing efficient, high-quality care, and over a quarter felt that the outpatient department was not functioning to a desirable standard, and only eight per cent felt that CSSD—that is the central sterile supply department, which has had a lot of media coverage, of course—was safe and according to standard—one in 12, so 11 of 12 doctors —

Ms R. SAFFIOTI: Just confirming that, that is eight per cent that felt that sterilisation was safe.

Dr Jenkins: Was safe.

Mr R.F. JOHNSON: I would sooner them not operate on me.

Ms J.M. FREEMAN: Was that before the changes to CSSD?

Dr Jenkins: This was done back in August. It was after the official changes in terms of it not being run by Serco, but, obviously, there is a lag in people's psyche in terms of when —

Ms J.M. FREEMAN: So it was shortly after the changes or —

Ms Kuhne: It was around the time of the changes, because the survey was in May.

Dr Jenkins: It was not long after that. The survey is going to be repeated in several months' time. It will be interesting to see the change in perception on all of these things, which will be useful data.

The areas of concern I want to raise today—and, unfortunately, when I started writing this, they just kept on coming—I think number one was information technology services. We have heard this in the media, but there are a number of specific issues. The electronic patient record system, which is called BOSSnet, which apparently is going to be installed at the children's hospital, has caused a significant reduction in efficiency. It is untried in major Australian hospitals. It is supported by a relatively small company and it does not interface, as it is installed now, with the other applications, and it frequently crashes or freezes on users. Should the vendor not be able to support this product going forward for whatever reason, there is severe clinical risk as transfer of information from that system to a new one would be difficult, time consuming and expensive.

Support for IT applications through what I call the interwoven labyrinth of Serco, Health Information Network, WA Health and British Telecom, which run the infrastructure and background, the backbone, is often tedious to attain and slow to produce results. The same system, BOSSnet, is being installed at the children's hospital.

Going back to commissioning, there was inadequate training in the use of the new systems and inadequate support on site during commission, which caused a lot of frustration to our members and doctors and other clinical people. Outages are very frequent. Notifications of planned outages of IT are often emailed out, giving 15 minutes to eight hours warning, which is hardly planned. My view is that a review of the Department of Health's ability to provide modern, effective healthcare applications to new and redeveloped sites is desperately needed.

[9.40 am]

Ms J.M. FREEMAN: Have you worked anywhere where the IT system delivers to the health system?

Dr Jenkins: I work at Fremantle Hospital and whilst there are concerns, the level of problems is an order of magnitude greater at Fiona Stanley because they have introduced lots of new systems quickly. Clearly, there was a political imperative to open the building and in the end it was a real squeeze. We are seeing the same with the children's hospital.

Ms J.M. FREEMAN: At Fremantle Hospital there is just the Health Information Network that runs the systems there, so you do not have that inter —

Dr Jenkins: You do not have that problem of dealing with Serco and British Telecom and Health Information Network. You do not have all of the new applications which are not appropriately bedded down. Health IT is a poisoned chalice around the world, to be fair, but it has been particularly bad in Western Australia for a long time and Health Information Network has not had a formal professional in charge for goodness knows how long.

Mr R.F. JOHNSON: Why do you think that is?

Dr Jenkins: I think that right from the very top they need to employ someone very clever, experienced in healthcare applications, from wherever in the world. Health Information Network has had a succession of heads who have been not computer people, and certainly not successful computer people either in the private sector. The other issue is that when they go out for a succession of reports from the private sector, they do not get value for money. The private sector is there to gouge what it can.

Mr R.F. JOHNSON: They are there to make money.

Dr Jenkins: Yes, to make money.

Mr R.F. JOHNSON: Not just necessarily to deliver a service; I agree.

Dr Jenkins: Yes.

Ms J.M. FREEMAN: With the physical infrastructure for IT, I heard rumours that they could not find the cabling in the walls at one stage at Fiona Stanley Hospital. Are you aware of any of the physical infrastructure issues around IT?

Dr Jenkins: Yes, I was involved with some IT set-up within the intensive care unit and, yes, there was a legion of issues that were very difficult to overcome. Fortunately, we had embedded in the department an absolutely brilliant man from biomedical who spent days and days sorting that out— the wrong IP addresses at the wrong points; points not connected up.

Ms J.M. FREEMAN: So they had to pull walls out to connect points?

Dr Jenkins: No, they just had to re-route and —

Ms J.M. FREEMAN: Rewire?

Dr Jenkins: Yes, not actually much physical stuff but just flicking switches and that sort of thing.

Mr R.F. JOHNSON: You have just said that you believe there was a political imperative to open Fiona Stanley; I accept that and I think most people do. Do you accept that there was also a financial imperative; because of the state's finances, they had to try to get the place open and running as quickly as possible. It has been said by other people that a better situation would have been to have kept hospitals like Fremantle running their systems and running their patient care and all the things the doctors do there; rather than transition them in the course of a day or so from one hospital to another, they should have run them in tandem.

Dr Jenkins: That is a vexed question because it is very expensive and also very resource hungry on staff et cetera. Sometimes that is physically not possible. I will say one of my comments later on is that I have no knowledge whatsoever of the contract between Serco and the state, so I cannot comment on—one of the financial imperatives was probably what was costing the state to keep an empty hospital open, but that contract is totally opaque. When we ask for variations in various equipment issues, we have no idea what that is costing the taxpayer. Doctors are surprisingly parsimonious, in fact, with taxpayer money, because that is relevant to cost effectiveness: if you do not know the cost, you do not know how cost effective something is.

Mr R.F. JOHNSON: Many people are of the view that there should be a dedicated Minister for Health; that there should be a stand-alone ministry, basically, and to link it with Tourism is an absolute nonsense—it is diametrically opposed to health. I have been of the view, I will be honest, that if you are going to encompass other portfolios, you should have Mental Health, which in the past has always been part of the Health portfolio—I think it should be one portfolio. If you want to save money and add another one, perhaps Disability Services. They are all to some extent in the same direction. To have Health and Tourism is an absolute nonsense in my view. What is the view of the AMA? Do you believe that the Minister for Health has had a hands-on approach enough in relation to Fiona Stanley Hospital?

Dr Jenkins: I think the AMA's views are quite clearly known that the minister has not been involved enough and interested enough.

Ms Kuhne: Yes, I think the AMA has made it clear to the minister himself that it is the AMA's view that there should be one Minister for Health and that Minister for Health should also cover Mental Health.

Mr R.F. JOHNSON: What about Disability Services, because that is a similar one?

Ms Kuhne: In terms of Disability, we have not talked about Disability as being appropriately covered within Health. I think that is quite a different set of management issues. I would not know about Disability Services, but in terms of Health and Mental Health, yes, the AMA has been —

Mr R.F. JOHNSON: But Disability Services very often comes through mainstream hospitals, such as Charlie Gairdner's and Royal Perth. People involved in road accidents either go to Charlie Gairdner's or Royal Perth and they end up going to Shenton Park and Disability Services takes over there. There is a transition and I would have thought that AMA might have thought—people with disabilities with ongoing problems would need a doctor to oversee them.

Ms Kuhne: And they do. Of course, the quadriplegic centre is a public hospital; yes, we are aware of that. It is just that the issue of where Disability Services fits is not one that has been exercising the minds of the AMA recently.

The CHAIR: Sorry, can we get back onto Fiona Stanley and IT perhaps? We did an inquiry, as you know, called "More than Bricks and Mortar", in which we identified issues in and around IT, so it is not a surprise that you bring this almost as an area of concern as a priority number one. There were some concerns about the ability of the Health Information Network to do this job. Often what we get is, "Well, when we start a new hospital with twenty-first century IT, there will always be

teething problems." You would consider these more than teething problems and more about a systemic issue?

Dr Jenkins: Yes, in that the systemic issue goes right back to the meaningful engagement of clinicians, whether they be doctors or nurses, right back at the beginning. With a modern hospital, you start with planning your workflow and then you design your IT around that, and then you put the bricks and mortar around that to keep the cables and the servers dry; whereas we had it the other way around: we had the building designed, it needed to look good, and then IT put in some whiz-bang things, and a huge amount of time was wasted by planning workflow and so forth by people who were not necessarily experienced in it. Added to that, the perfect storm was created when they then—for whatever reason, depending on what side of politics you come from—"We're going to outsource all the so-called nonclinical work to the private sector in one go." Clearly, back at the beginning rather than running it business as usual, as a health department facility, and then, dare I say it, taking the unions on one by one to outsource things, which would have been an incremental approach to the privatisation of services—whatever your views are on that—by handing it over to one organisation, which has no experience in Australia running big hospitals and is demonstrated in the media to be financially and, maybe one would say, morally bankrupt —

[9.50 am]

Mr M.J. COWPER: A number of hospitals have been built in recent times—I am just leading on from what the doctor said—and admittedly Fiona Stanley is a big organisation, it is a big facility: how is that transition by comparison to, say, one of the other new hospitals?

Dr Jenkins: It is hard for me to comment because I do not work in them. Certainly with personal contact, people at Royal Adelaide Hospital are pulling out their hair, but it seems to be similar; it seems to be a systemic issue in state health departments, for whatever reason. And I have no explanation for that.

Mr M.J. COWPER: Is that complexity of the —

Dr Jenkins: I think it is the complexity of the build and not getting in really experienced people from even out of country to help guide it.

Ms J.M. FREEMAN: Your point 4 about temporal stability of leadership, is that part of the issue in terms of the transition? You talk about the stability of leadership.

Dr Jenkins: It certainly is now, yes. As I said, we now have a substantive director general after two and a half years. We have an acting chief executive of south metro; we have an acting executive director of Fiona Stanley; we have an acting director of clinical services on a six-month contract, brought from the UK.

Ms J.M. FREEMAN: But in your comments here you said that the South Metropolitan Health Service last had a substantive chief executive with Nicole Feely, and Nicole Feely left halfway through the Fiona Stanley Hospital build and transition into it, so has that been part of it?

Dr Jenkins: That is part of the problem in terms of leadership, absolutely.

The CHAIR: Could we just ask one question about this? Rita would like to move on to bed numbers. Has part of the problem with commissioning in and around IT been the interfacing of HIN, British Telecom and WA Health, and would it not be better perhaps for the government to go out and buy a total package of IT where it has been tried and tested and not try to do this integrated model which, from what I can see, led to some of the systemic issues in this space?

Dr Jenkins: I think what happened was that government decided, for whatever reasons, that it would be a good idea to have nonclinical—there is no such thing in a hospital really as anything that is truly nonclinical. We have seen that with cleaning, with sterilisation; they are very clinical, when you get a dirty scalpel cutting into you. A computer system that crashes at 3.00 am—or, for

example, the duress system in mental health, where a nurse or a doctor gets attacked by a patient, presses the thing around their neck, is forever breaking down.

Ms J.M. FREEMAN: At Fiona Stanley?

Dr Jenkins: At Fiona Stanley. The out-of-hours team is often resorting to walkie-talkies, two-way radios, because the mobile system does not work, the duress system does not work, the paging system is down for repatching, rebooting et cetera.

Ms J.M. FREEMAN: So at Fiona Stanley Hospital in the mental health area, the duress button, if a patient —

Dr Jenkins: We get frequent emails saying that it will be down from 2.00 am to 4.00 am for fixing.

Mr R.F. JOHNSON: Who is responsible for those?

Dr Jenkins: Serco is responsible for the British Telecom contract, and of course they use Siemens. All the little phones look like old Nokias because Siemens bought Nokia and they had 10 000 of them in a warehouse in Taiwan or somewhere.

Mr R.F. JOHNSON: Serco does not have a very good record in the UK, I have to tell you.

Dr Jenkins: Serco now have Winston Churchill's grandson as their chairman, which is —

Mr R.F. JOHNSON: Great if we go to war.

Dr Jenkins: It is interesting that there has been very little media coverage of this here, but there has been huge media. They nearly went bankrupt last year; they have gone to their shareholders for nearly a billion pounds. They have been ordered to pay back £80 billion that they obtained, essentially fraudulently, from the British government over the anklet, the home prisoner system. That is still being investigated by the serious fraud squad in the UK and it has had almost no media coverage here at all. And they are responsible for these so-called nonclinical services.

Ms R. SAFFIOTI: I have a follow-up question and then we can get on to bed numbers. I have been involved in the Public Accounts Committee that inquired into the IT system initially and then involved in this committee. Basically, that interface was a key failure and that was always something that we acknowledged very early on. Because of the complexity of the IT, trying to have two or three different bodies delivering that was always going to be a problem.

Dr Jenkins: Yes, and the essential problem is that Serco is subcontracting British Telecom to run the infrastructure backbone, but the pathology system comes from PathWest and all of the other systems—because you have to link with the other hospitals. For example, all of Health uses one video-teleconferencing system; British Telecom has decided to install another, so you cannot easily video-teleconference from Fremantle to Fiona Stanley. There are little issues like that all the time.

Ms J.M. FREEMAN: What about records transfer? So if you go to Fiona Stanley Hospital as a senior resident who gets put through emergency and then you have a stroke and then have to be transferred to Fremantle Hospital, is the records transfer done digitally, or does it all have to be done by hand because the digital process is not good enough?

Dr Jenkins: If you go to Fiona Stanley, the electronic record from Fiona Stanley can be read at Fremantle, or at least I can read it—most people have access to it. There is a discharge summary sent, which goes in the paper notes at Fremantle. More of a problem is with outpatients, especially if they go to the Fiona Stanley emergency department at 2.00 am and their records are in the basement at Fremantle; they are not accessible. There was a plan to scan paper records. That was meant to start two years prior to Fiona Stanley opening. The planning for that started about four years before and stopped about three years before, and it just simply fell off the radar, so that never occurred, which is a significant clinical risk.

Ms R. SAFFIOTI: We were told that—it is frightening.

Ms J.M. FREEMAN: Yes, we were told that. We had evidence about a patient, who died subsequent to going to Fiona Stanley Hospital, about his discharge summary; that the electronic record was not received by the GP. Is there something in here about that?

Dr Jenkins: I come to that under point 6 on the lack of engagement with primary care.

Ms R. SAFFIOTI: Can we go to bed numbers?

Dr Jenkins: Again, without wanting to sound too political, the original Reid report was that there was phase 1 of Fiona Stanley, which was the size it is now—that was to be built by 2010–11—and that by 2014–15 there were to be over 1 000 beds on that site, including state rehabilitation in phase 2. That phase 2 was completely put on the backburner when Royal Perth was left open. That was a decision made prior to an election. The minister has publicly said that he does not resile from the fact that that was a political decision to help win the election. We now already are short of beds, so there is extreme pressure on beds at Fiona Stanley. There was inadequate modelling of the population growth in the area.

Ms R. SAFFIOTI: Sorry, can I interrupt there because I was involved in the Reid reform. The population growth has increased dramatically since the Reid reform numbers were done too, so those bed numbers are totally out of date anyway in a sense because population growth over the past five or six years has been a lot more than Reid anticipated.

Dr Jenkins: The other thing is that people who were 65 back in 2010–11 are obviously now 70, and you are much more likely to go to hospital when you are 70 than when you are 65.

Ms R. SAFFIOTI: So it has been impacted two ways; the fact that the population growth is higher and the older population, basically.

Dr Jenkins: Emergency department presentations are much higher than was predicted, and that is not a tyre-kicking phenomenon; that still persists. In other words, when you open a facility, people are going to go there. There were huge numbers early on. The slight tail-off has now stopped and, in fact, numbers are back to being 10, 15, 20 per cent higher than predicted. The problem is that I think there was some rather fanciful modelling around how efficient we would be, in terms of not admitting people from the emergency department, so the percentage of admissions was predicted to be lower than it was at Royal Perth or Fremantle, for no particular reason, and they were meant to stay in hospital a whole day less, even though we already had made huge gains in efficiency over the last 10, 15 years. All of those things multiplied together mean that Fiona Stanley is already on what is called code black some days, so there are just no beds and extreme pressure to get people out. There obviously is no more money—we know that—and the ideal would be more beds on that site, but until that can occur, we need to relook at how we are using other beds in the system. Ten or 15 patients are transferred a day from Fiona Stanley down to Fremantle. If you live in Armadale or Bentley, that is a long way for relatives to go. So much for treatment closer to home; it is pretty sad.

[10.00 am]

Mr R.F. JOHNSON: It is the same with the northern suburbs. I know people who have been transferred from Joondalup hospital down to Fiona Stanley. I know people who have always attended the rehabilitation unit at Shenton Park who have been transferred to Fiona Stanley, and I have to tell you, they say, “Please, never send me there again”, because it is so disastrous and it is so dysfunctional.

Ms R. SAFFIOTI: One of your key points was appropriate care and appropriate setting behind the Reid reforms. Do you think that interaction between the teaching hospitals and the general hospitals, is right, or does there need to be more reconfiguration in respect of that?

Dr Jenkins: It is a really vexed issue. The idea of getting work further out in the periphery is laudable, but it is extremely difficult. I also work in Albany Hospital and it is delightful there because specialists either fly in or live there for lifestyle reasons, and they are five minutes from the

hospital. They see their patients every day, and it is straightforward. Getting the best specialists to work in Armadale and Rockingham is a difficult issue when there is a workforce shortage and a lot of work in the central metropolitan area. That is one issue. Also, once you have a certain level of care, you need to have the other things around it as support, like intensive care and 24-hour laboratory and so forth, and it gets expensive. I actually firmly believe that the idea that secondary patients treated in a tertiary hospital are expensive is not correct. If you added another 400 beds to Fiona Stanley now—as a mind thought—and you treated lesser acute conditions, you could do it quite efficiently; in fact, more efficiently than you would at Armadale and Rockingham.

Ms R. SAFFIOTI: Because you have the specialists?

Dr Jenkins: Yes, so they can be in one place and then go and do a list of minor surgeries, and then back. And you have all the back-up: blood bank, intensive care, a big anaesthetic department et cetera. But that is not something that was really promulgated in the Reid report.

The CHAIR: I want to ask about staffing. A lot we have heard so far is in and around sterilisation, cleaning of the hospital, neonatal ward and maternity. There seems to be an understaffing situation and it seems that that could be one of the major reasons for these difficulties that Fiona Stanley sees itself in. Would you like to comment on that?

Dr Jenkins: There are two issues: in some areas there is understaffing. I would not expect anyone to have perfectly modelled the staff required. The ability to be flexible and change for nonclinical staff is difficult, because that then means working through Serco, I presume, and a variation. Anyone who has done home renovations knows what variations are like. There is the issue of getting numbers right. Within the clinical side, there are certain departments that are continually under huge pressure. Oncology came out in the media earlier: there was much more demand for their services than was planned. Anaesthesia, I know, are unhappy. This results in people having their nose to the grindstone for 40, 45 or 50 hours a week, which does not help, either with professional development or actually becoming really engaged with the department or allowing time for teaching and/or research. The other issue is that Serco, without any significant experience in Australia in this, had to go out to the market and hire people who have no health experience whatsoever. You have porters—I do not like the way they are called “porters”; this is not England.

The CHAIR: What happened to the term “orderly”?

Dr Jenkins: Yes, exactly. Well, Serco runs hospitals in England. This is the NHS!

So they have hired people with no health experience previously. The head of the ICU was one day at a cardiac arrest and he asked for an ECG machine, I think it was, and the porter said, “What—an EPIRB?” Obviously the guy must have worked in the Navy previously! So some people there have no knowledge of health.

Ms R. SAFFIOTI: In relation to that we have heard two points: one is the understaffing of porters and, again, because we do not understand what the staffing levels are under the Serco contract, we cannot exactly ascertain if they are understaffed or adequately staffed according to the contract. The second point is that their role and responsibility under that contract are very different from the orderlies in other hospitals. Can you comment on those two?

Dr Jenkins: Yes. They do not understand the clinical requirements. An example is that early after opening in intensive care at Fiona Stanley we waited three hours for a unit of blood to be delivered from the blood bank to the ICU, because that is when we were really short of porters. The other issue is that at every level there is no autonomy within the departments. By that I mean that at Fremantle we had the same orderlies for 20 years. They cleaned the floors, they made the beds, they knew about the hygiene we needed in intensive care, they served the patients their meals and they helped with the turning. Of course, that is the other issue: Serco staff cannot touch patients, so now in intensive care there are people to roll patients but then there is someone else just to mop the floors.

Mr R.F. JOHNSON: What is your view on that? I find it absolutely extraordinary that porters-cum-orderlies are not allowed to touch patients, to be able to move them from a wheelchair into a bed, or a bed into a wheelchair, or even hold up their arm up or something like that. They are not allowed to touch them. Is that —

Dr Jenkins: That is correct. Essentially, they are not meant to touch them in the ordinary course. Obviously, if there was an emergency they would, like any other citizen, but that is correct. For example, in the operating theatre, it is one person to help the anaesthetist move the patient off the table onto the bed and then someone else to mop the floors.

Ms J.M. FREEMAN: The comments we have had put to us is that it is actually cost shifting. Because they cannot do the things that orderlies at Fremantle Hospital do, the hospital has to employ more nursing staff and additional staff—nursing assistants who—are directly employed by Health. So you are not actually saving anything because you are having to cost shift into directly employed staff by the health department. What is your view on that?

Dr Jenkins: Absolutely. As a brief anecdote, which I think will summarise what has happened, our orderlies at Fremantle Hospital, who have been there 20 years and have accrued lots of sick leave and long service leave, had said that no way would they go and work for Serco. So they sat put and, of course, they were told, "Well, sure, you work for Health, but it might be Armadale, it might be Rockingham or it might be Swan District." They went off and trained as assistants in nursing. They are now paid more by Health to effectively do less. They turn up to intensive care at Fiona Stanley and there they are, very happy in their "assistant in nursing" uniform, doing the turning and all the satisfying parts of their previous job, while someone else does all the cleaning and so forth. So they are now being paid more to do less, which is just absurd.

Ms R. SAFFIOTI: We understand that there is a greater number of nursing assistants in Fiona Stanley than in other hospitals because this job had to be created because porters cannot touch patients.

Dr Jenkins: Yes.

Mr M.J. COWPER: Can we just walk through, if you do not mind, the actual staffing numbers you may have available to you for clinical and nonclinical staff. Can you give me an idea of where that sits in comparison to, say, Fremantle?

Dr Jenkins: The other day I found a copy of a report that had been left with me. It was interesting. It was a PricewaterhouseCoopers report. Fremantle and Royal Perth had about 4.6 total staff per bed. It sounds a lot, but that is everyone in the whole hospital.

Ms R. SAFFIOTI: Is that Fremantle and Royal Perth?

Dr Jenkins: Yes, it was 4.62 and 4.61 at the two hospitals. There are two different managements and they came to an almost identical figure.

Mr M.J. COWPER: This is clinical staff?

Dr Jenkins: No, this is everyone—the gardeners, the builders, the engineers. The PricewaterhouseCoopers report had buried way, way in it that when you divided the numbers out it was 3.6 per bed. In other words, it was somehow one person less, which meant that, magically, over 780 beds it would be 780 less staff needed at Fiona Stanley than you would expect.

Mr M.J. COWPER: Let us just break that down a bit. You were saying before that the AINs are being brought in and are doing less work. Obviously then there is a big gap. If we are topping up this part here, there must be a big gap somewhere else that is lacking. Are you saying that it is in the —

[10.10 am]

Dr Jenkins: Sorry, I do not know the total numbers now but I suspect the reality would be that you need about four and a half people per bed.

Mr M.J. COWPER: There is one whole person being taken out of Fiona Stanley. Where is that coming from? Is it the top end, is it fewer doctors, fewer nurses or is it down the bottom?

Dr Jenkins: The original planning, I do not know, but currently the build will be about what it needs to be for a tertiary hospital. As you have seen, they have employed more. They are employing more doctors now, they are employing more orderlies and so forth. The trouble was that the planning figures were about what it was going to cost to run, which is why it is not running to budget.

Mr M.J. COWPER: The other issue that I wanted to talk to you about is this sense of lack of autonomy within the staff there—I am not at all diminishing the professionalism of the staff. How is that having an effect on morale and the capacity to attract the people that they need in the hospital to get the ship sailing?

Dr Jenkins: Enormously. At every turn there a is lack of some autonomy that we had at other sites. There has been a general shift towards what I call managerialism in health across Australia and WA in the last 10 to 20 years and some of it is useful. The old ways of, for example, a company that supplies equipment coming along—I am gilding the lily a bit here—taking a doctor out to dinner, he agrees to buy that sort of equipment and yes, that is the price, and it is signed off is inefficient and not probity by twenty-first century standards. However, swing the whole way around to saying, "Right; Serco, you buy everything for the hospital", firstly, it ended up being more expensive, I suspect, and, secondly, people have not got equipment that is fit for purpose. That was one thing on the equipment side of it. Now, in every department the autonomy is very poor. People are not accountable for budgets. They are not given the ability to hire and fire, or at least alter their staff numbers to clinical need. As I said, we are completely opaque with the arrangement with Serco, so we have no idea what that is actually costing for the services that we are providing.

The CHAIR: When it came to staffing, we heard that in CSSD, when sterilisation was taken from Serco, the department had to put in 12 more people to do the work in CSSD.

Dr Jenkins: Sorry; I do not have any further knowledge on that.

Ms J.M. FREEMAN: In terms of staffing, and given that you have a brand-new hospital—this is one of my issues—so infection control is paramount, you do not want an outbreak of VRE or any of those sort of aspects. Are there sufficient staff to ensure that that sort of infection control in terms of planning is at the level—you work in intensive care—that you think is needed, given what you know or what you have seen?

Dr Jenkins: There are a number of issues there. Obviously, Serco will only work to the minimum specification that is set, and I have already seen both in the media and also not in the media issues. For example, bed linen was changed on an as-needs basis, every five or six days—same sheets as long as you did not mess them. It is not the Hilton.

Ms R. SAFFIOTI: So that is the minimum standard that you understand to be set.

Dr Jenkins: No. They have now changed it to 24-hourly; all linen will be changed 24-hourly.

Mr R.F. JOHNSON: Whether or not two or three people have laid in that bed?

Dr Jenkins: Obviously, no—after someone is discharged, but it is certainly, at an absolute maximum, 24 hours. So, if you are in for three days, it gets changed. Staffing numbers are such that they were cleaning rooms late at night, which was obviously disturbing other patients. It was obviously very noisy and so forth. That then had to be addressed and they have agreed too. That came out in the independent clinical review—I hope you have a copy of the document—so they have now shifted to saying they are not going to be cleaning rooms after eight or nine o'clock

at night. There are those sorts of issues where they push down staff numbers and then try to get them to work over longer periods, and it ends up having other impacts.

Ms J.M. FREEMAN: Are you aware if they have the same sort of training? You were concerned about the porters not having the training and not having the knowledge, and going out and getting a pool of porters who did not have that sort of health background. Are you aware if there are any similar sort of issues around cleaning?

Dr Jenkins: I have not heard any data on how clean it is, but you would have to imagine that someone who has been working for 20 years in a hospital cleaning and so forth is going to be more experienced.

Ms J.M. FREEMAN: At the infection control?

Dr Jenkins: Yes. We need to look at other areas where Serco runs services, and how they sometimes come tragically adrift—prison services et cetera.

Mr M.J. COWPER: We have heard about understaffing, particularly in support services. Do you have a situation in which you have an excess of people in certain areas who have been wasted?

Dr Jenkins: If your terms of reference are around transitioning, yes. For example, the amount of activity happening at Fremantle Hospital is significantly less than planned. For example, the anaesthetic department at Fremantle is under-utilised. They really are not happy with that. When I work as the director of intensive care at Fremantle, that is under-utilised, because there is not enough surgery happening to keep the ICU full and ticking over.

Mr R.F. JOHNSON: To what degree? What percentage?

Dr Jenkins: The planning was for 10 beds in intensive care at Fremantle. We range between zero and three patients. The surgical activity at Fremantle is about 40 per cent of what was planned or what was being organised to be purchased.

Ms J.M. FREEMAN: You have one that is less and one that has got too much.

Dr Jenkins: Yes. The trouble is that it is difficult to shift services back because you have taken out a 24-hour laboratory and you have taken out radiology. You do not have any cardiologists on site, any neurologists et cetera. You do not have the support services that you need.

Mr R.F. JOHNSON: There might have been a financial saving in simply swapping from one hospital to another all those services overnight. There might have been an immediate financial saving, but in the long term it is going to cost more money because you are going to have to move some stuff back in there, otherwise you are not going to function properly at Fiona Stanley.

Dr Jenkins: Yes.

Mr R.F. JOHNSON: Ambulance ramping is alive and well. We read an article in today's *West* where it has been enormous this month. The point is that that was supposed to be fixed and it has not been. That must put enormous pressure on the emergency department in Fiona Stanley and your colleagues, and the nurses.

Dr Jenkins: Yes, and then the problem is that there is huge pressure to get patients to the wards and there are no beds. There is huge pressure on the wards to get those patients down to Fremantle Hospital who are meant to be there for subacute care, rehabilitation et cetera. There are many examples where those patients come really too early in terms of significantly acute problems. We get a number of patients into intensive care at Fremantle who have come down that path. In Fiona Stanley, problems are not sorted to a general medical or rehabilitation ward at Fremantle and then to intensive care. Their home may well be Bentley, Armadale or Roleystone.

Mr R.F. JOHNSON: Joondalup. It could be anywhere.

Dr Jenkins: Yes. There are dedicated patient transport vehicles. They are not using ambulances.

Ms J.M. FREEMAN: Do you want to take us to point 6, lack of engagement in primary care, and talk around that for us.

Dr Jenkins: Yes. When I was a cluster lead member with Nicole Feely, this was something I tried to push then. Being an anaesthetist and intensive care specialist, I also used to work in general practice, so it is an interesting blend. I really think that they have completely dropped the ball on working with primary care, with general practitioners, with out-of-hospital services to keep people out of hospital. First, it is much cheaper and, second, generally, it is federally funded. It seems like a no-brainer for a state government to virtually do it. There is absolutely no engagement with general practice at all. The new software at Fiona Stanley, the junior staff find incredibly inefficient, very time consuming, and the GPs find the reports, the summaries they get, really not particularly helpful at all. There is no system for checking that there is confirmation of reception or the receiving of those, although that is not something that exists in other hospitals. But because people are pretty busy and because there is not that sort of engagement, there is very little person-to-person contact as well. I do not have all the answers, but I think it is something that is vitally important.

The CHAIR: This was the issue with Jared Olsen when the discharge summary was not conveyed to the GP because it was not on the electronic database. It was not picked up, so essentially the GP did not get any of the information.

Dr Jenkins: It is awful when there is any tragedy, but when the tragedy is primarily due to lack of communication, that is doubly galling.

The other issue is Fiona Stanley has no fax machine. Fax is a little bit old-fashioned but a lot of GPs still use it for sending in referrals et cetera. No, no, they have a funny, complicated electronic thing. They were not going to have fax machines because it was going to be the paperless hospital. It is extremely difficult to communicate. Some of the communication issues have improved, both information going out but also coming in. The switchboard in the early days, they were not hospital trained at all. They simply had no idea who you were trying to get through to, which really made it difficult and sometimes quite dangerous.

[10.20 am]

Ms J.M. FREEMAN: Or put patients through what they did not need to go through, which would be the other thing, I should imagine, with the switchboard.

Dr Jenkins: I had a colleague who was good-humoured, but someone who wanted to be seen by a neurologist rang the Fiona Stanley switch and got put through to the on-call neurologist, who actually was not on-call; he was on holiday in Darwin. This person had never been seen by a neurologist, and then he said, “I’ll see you in my rooms.” The patient said, “Oh no, I don’t have insurance, I want to see you at Fiona Stanley.” The neurologist said “Actually, I’m on holiday in Darwin, and that’s not quite how it works.” It was quite bizarre.

Ms J.M. FREEMAN: Yes, I have a personal conflict, because my mother is a hospital receptionist, and I know how important their role is in terms of being able to field calls as well as properly allocate calls.

The CHAIR: Would you like to comment on webPAS, and the data of GPs referral for discharge summaries? Is that being attended to? Is there a systemic problem with that system?

Dr Jenkins: I do not know that it is being attended to. The personally controlled health record is a blighted issue as well. The links between the hospital and GPs is very poor, and it is just their discharge summary that is sent out. Even if it is electronic it is still like a paper document, rather than being directly linked into any database that GPs can access, which is a great shame.

The CHAIR: Even if there was just an email addressed to the doctor and then that obviously could be enough.

Dr Jenkins: That is meant to be happening, but we also want the system where you get a read receipt clearly for discharge summaries. I am a bit old-fashioned. I think in Jared Olsen's case and other cases where people are unwell, a phone call is the best way. Thus working in Albany, it is a delight to work down there, the GPs work in the hospital and you can ring them anytime. It would be nice to be able to bring that sort of culture of collaboration into a bigger environment. It does not always work.

Mr M.J. COWPER: I understand we are getting towards the end of our discussion, but in your view, what three things would you do to improve the situation at Fiona Stanley? What would be the key three points?

Dr Jenkins: One: leadership. We need someone who wants the job and wants to stay in the job as executive director and director of clinical services. For Fiona Stanley Hospital that would be the primary thing. Number two is a review of where to from here with IT services. I am not an IT expert, so I do not have the answers, but hopefully someone can sort it out. Some problems are so wicked that they are not solvable, but hopefully this one would be. From the leadership question, I think you would need engagement with senior and junior staff; that is lacking, and that is because of lack of leadership. The third item would be to remodel how we work between the different hospitals, so that there is less pressure on Fiona Stanley, including interaction with primary care, so that we can actually get on and get some elective surgery done at Fiona Stanley. This is a slight tangent, but we are seeing every month the waiting list blowing out and out and out, and that is going to continue. Unfortunately it is not going to get better; that problem is going to worsen.

Mr M.J. COWPER: So basically, you have got leadership, organisational behaviour and change management.

Dr Jenkins: Yes, but IT itself is a major issue in that.

Ms R. SAFFIOTI: With the Serco contract it appears that fundamentally there are many components of it that do not rest easy with a modern new hospital. You said basically every service is a clinical service really in a hospital, which is a good point, but given that we do not know what the contract actually contains in relation to some of those services, would it benefit, to try and actually move on and fix these problems, to create some transparency about this contract, about what the performance indicators are and what would be the cost in transitioning back into having public provision of some of those services?

Dr Jenkins: Absolutely. Personally I would welcome that, and so would senior clinicians, because they could see what things are actually costing and where to from here. The head of intensive care at Fiona Stanley has said from what he has heard filtering down that this contract is just going to gut the state. He is seriously concerned that this is going to be a major financial impost, not just on health, but on the state.

Ms R. SAFFIOTI: In the performance monitoring, what has confused me is that there are meant to be KPIs under which Serco has to deliver to a standard. Given that you represent a key part of the workforce in the hospital, who is determining whether they are delivering to a standard if even the doctors do not know what should be delivered?

Dr Jenkins: I do not know. None of that is fed back.

Ms R. SAFFIOTI: So we have got KPIs which the doctors are not aware of.

Dr Jenkins: Yes. There may be some KPIs around infection control that the infection control specialists are aware of, but I am not aware of what the KPIs are other than that. I do know that within intensive care at Fiona Stanley earlier this year, when you are doing pictures of the heart—what is called trans-oesophageal echo, so you put a probe down—the probe has ultrasound and lots of electronics. These are $50 000 each just for the probe. They need to be cleaned between patients. You keep the electronic end out of your solution. Serco said, "Don't worry, we know; we've spoken

to the manufacturer, and we know what we're doing." They put the whole thing in and ruined one, ruined two, ruined three, ruined four, ruined five.

Ms R. SAFFIOTI: So $250 000 worth of equipment was ruined?

Dr Jenkins: Yes.

Ms J.M. FREEMAN: Who pays for it?

Dr Jenkins: I do not know. Because of the contract, who knows? The head of ICU is fully trained in echocardiography and very experienced, and he kept trying to say to them, "No, you're not doing it right" and was told, "Don't worry, we know what we're doing." A lot of heads of departments are close to walking because of this day after day banging your head against a wall.

The CHAIR: Just to finish the IT, what do we do there? Do we just start again? How do we fix this?

Dr Jenkins: We cannot start again. The major thing people would like is at least for the applications to be talking to each other. We got the separate applications that you have to —

The CHAIR: That is the problem, is it not?

Dr Jenkins: That is one of the problems, so people who can write the code that will link these together. For example, when you go to do a discharge summary, or from the emergency department, where they are putting through 110 000 people a year, it pulls all the bits and pieces from the other applications and pops them in, and you do not have to put in much at all, rather than rewriting everything. Interlinking the IT products that we have got now is the first step. I think it is probably too late to turn the ship around at the new children's hospital because of the time imperatives, but it is not an electronic medical record, and I think linking with GPs in a meaningful way is another big step. Again, in my own experience in Albany, the software in the GPs rooms and in the hospital is the same. The junior staff can type like a typist, and they will type out a discharge summary that goes into the database that is available in the GPs rooms one second later, and we do not have that in Perth.

[10.30 am]

The CHAIR: What system do we envisage for the new children's hospital.

Dr Jenkins: The notes will be AusNet—the same digital record that we are using at Fiona Stanley.

Ms J.M. FREEMAN: I am going to Albany if I get sick.

Ms R. SAFFIOTI: Yes, I am moving to Albany.

Basically, as I see it, the only way the state can start getting out of this contract is to prove that they are not adhering to their indicators, so from a pure public policy, let-us-get-this-right type of view, that needs to be the key does it not, to actually say, "What are these indicators; is Serco failing to meet that?" And if they do, the state should have the ability to exit. Is that what your view would be?

Dr Jenkins: It would be. I think the chance of that happening in a meaningful way before February 2017 are extremely slim.

Mr R.F. JOHNSON: February or March?

Dr Jenkins: March. To admit that there has been a major problem in terms of the privatisation of a major aspect of public work is courageous.

Ms J.M. FREEMAN: They sort of did with the CSSD did they not? Well, they had to.

Ms R. SAFFIOTI: So you believe we will accept a substandard service, costing taxpayers millions, and possibly jeopardising services in the hospital for political reasons?

Dr Jenkins: I am just a doctor.

The CHAIR: We might finish with that if you do not mind. Ian and Marcia—sorry, we did not ask you many questions, Marcia, but we thank you for your support of Ian.

I will just make a closing statement. Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days of the date on the letter attached to the transcript. If the transcript is not returned within this period it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. For the written submission, you are happy for that to be open, as this inquiry?

Dr Jenkins: I am happy. There is one minor typo on the second last line of point 9. I think I have pointed that out.

Hearing concluded at 10.33 am