Submission No 74

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Name: Name suppressed

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SUBMISSION

NSW Government Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

TERMS OF REFERENCE: (l) any other related matters.

Background

My personal background is many years in the Aviation Industry with experience in Aircraft Maintenance and Risk Management.

My wife was a senior specialist medical practitioner working in remote and regional hospital settings predominately in NSW but also interstate. For over twelve years, until recently, my wife worked as a medical specialist in a remote country NSW public hospital working one week per month on a locum basis.

I have therefore had the opportunity, over a number of years, to observe the functioning of the system of management of the NSW Department of Health from the perspective of a similarly life-critical industry, aviation.

As the sole doctor in her specialty providing cover for an area greater than the size of Germany, twenty four hours per day, seven days per week, it is not surprising that many professionally challenging and stressful incidents occurred on a regular basis.

On her return from each of her locum visits to this hospital my wife would debrief to me (in a general and de-identified manner), recounting tales of medical near misses due to resource and staff shortages.

The Incident Information Monitoring System (IIMS) in this hospital had become dysfunctional and was at times misused as a means of victimizing staff due to a breakdown in workplace culture. There were reports of many instances of deliberate staff non-compliance with NSW Health Department policies and procedures. In the aviation industry this behavior is termed “the normalization of deviance”. This situation is symptomatic of leadership failure and an unsafe workplace culture. The lack of Board and Executive leadership and accountability at this hospital was remarkable.

To illustrate this level of dysfunction, the hospital where my wife was on call twenty four hours per day, for seven days per week at times working fifteen hours straight, or ninety five hours per week lacked any Fatigue Management Plan for protection of medical clinicians. The hospital also lacked any Risk Management Plan and it is documented as actively resisting the establishment of such a plan.

A number of adverse events occurred at this hospital, reports of which were downgraded by administrative staff to avoid executive accountability. One of many such adverse outcomes was the avoidable death of a young man, who after four successive presentations at the hospital Emergency Department died from sepsis due

to an infected toenail. As a result of the efforts of my wife and small group of clinicians, this matter is now subject of a Coronial Inquiry.

There has been no accountability for this avoidable health disaster at a LHD Board, hospital Executive or Ministerial management level. With the exception of one Executive who left for family reasons, all Executive remain in place at this hospital.

My wife related stories of how she and her colleagues had attempted, over a protracted period, to establish an acceptable level of clinical governance to reduce the risks of adverse outcomes to patients and professional risks to clinicians.

These activities were ignored or resisted by the hospital administration executives.

Ultimately, as a result of these activities to improve clinical outcomes and reduce clinical risk, my wife and some colleagues were subjected to a campaign of bullying, defamation and intimidation. My wife was forced to leave this place of work. NSW Department of Health failed in their basic responsibility to provide a safe workplace.

Anecdotal reports support the perception that the situation described here is similar in other NSW regional public hospitals. These issues are systemic.

Current Context

The management of health in NSW is administered under a devolved system of fifteen Local Health Districts, each with a local Board and Chief Executive. This system has been in place for a number of years as a result of recommendations from the Garling Inquiry into Acute Care Services in Public Hospitals in 2008.

Over time this devolved system has become dysfunctional due to lack of effective oversight by NSW Ministry of Health and by the appointment of demonstrably unsuitable personnel to LHD Board and Executive positions.

It is clear that areas of regulation, accountability and risk management are now dysfunctional in the system of management of the NSW Department of Health.

Unlike the aviation industry in Australia, which is regulated at the Federal level by the Civil Aviation Safety Authority, (CASA), there is no independent Systems Regulator overseeing the administration of Health in NSW. The NSW Ministry of Health reports to the Minister and no other agency. A widely held impression is that the LHD Executive and Ministry “manage upward” and prioritize budget over health outcomes, particularly in the remote and regional health settings.

There appears to be no recognition at Ministry of Health level of the systemic risks arising from incompetent and budget driven decisions made at LHD Executive and Ministerial level.

The absence of a “Chain of Responsibility” system (as is in place in the transport and other industries) in the Health system ensures that the front line clinician and patient bears all risk of adverse outcomes. On the other hand, the system in place appears to

be designed to insulate LHD Executives and Ministry staff from the consequences of their decisions.

The effect of this situation places any consequences of ensuing systemic risks onto the front line clinicians and patients. It is known that an adverse clinical outcome can result in referral of the clinician to the Medical Board and their Regulator, Australian Health Practitioner Registration Authority, (AHPRA). For a number of medical practitioners, this has been a career-terminating situation.

As a result, it appears that clinicians have now effectively disengaged from the health management system. A recent NSW Auditor General report confirms this observation.

The data relating to adverse outcomes in regional and remote hospitals as compared to metropolitan hospitals is damning. In the last couple of decades, the average life expectancy in remote NSW has declined by 1.9 years, whereas in Sydney it has increased by 6.9 years.

Arguably their Regulator, ASIC, would close down any commercial corporation in Australia operating at the standard of the NSW Department of Health in rural and remote NSW.

Based on these observations, the system of management of health in NSW is a case study in management system failure. It is no longer fit for purpose.

Submission

This inquiry presents an opportunity to improve the system of management of NSW Health to align it with contemporary standards of governance such as those existing in Australian corporations and Federal government organizations.

My suggestions are as follows:

1 That the NSW Government engages reputable **external** consultants such as Price Waterhouse Coopers to conduct baseline system wide audits of all areas of activity of the NSW Department of Health against current best practice health management documentation and related legislation.
The consultants to recommend system redesign to ensure that the organization complies with and remain in continuing compliance with Australian Standard: AS/NZS 9001:2016 Quality Management Systems Requirements and with AS ISO 31000:2018 - Risk Management. These resulting audit reports and associated recommendations to be publicly available on delivery to the NSW Parliament.

2 The appointment of a person or body such as an **independent** Inspector General, NSW Health. This appointment would be made under an Act of the NSW Parliament. It is essential that this individual and staff be selected from outside the NSW Department of Health bureaucracy. The Inspector General NSW Health would have a strong background in business corporate governance and risk management. The Inspector would have powers under the

Act to monitor, audit and enforce compliance with all NSW Department of Health Policies, Procedures and other relevant legislation such as Safe Work. The Inspector would also have powers of sanction over **all** persons working in the system up to and including Secretary Department of Health NSW. The Inspector would have powers to modify or remove a hospitals accreditation to operate.

3 Ultimately, meaningful change in outcomes for patients at rural and regional hospitals is directly dependent on cultural change in the leadership of NSW Health. This is the real challenge for the Government of NSW. The mandated core values of NSW Health are Collaboration, Openness, Respect and Empowerment. When these values are expected but not reciprocated by the leadership of NSW Ministry of Health, the LHD Board or Executive, meaningful change is impossible.

4 I note that this inquiry is "Self Referred" by the NSW Government and it is also noted that the Inquiry Terms of Reference do not address the structural, cultural and institutional challenges facing an organization in disarray. However, in the view of those at the coalface of health service delivery, this inquiry is a test of the Government's commitment to meaningful change and improvement in service delivery of health services to the people of rural and regional NSW. The people of rural and regional NSW watch and await the Inquiry's recommendations with interest.

5 Pending these fundamental system and cultural changes and in the absence of a reliably functioning system of Health Quality Assurance for NSW Department of Health in regional and rural settings, I see a need to de-risk the experience for persons engaging with the NSW Department of Health in rural and remote areas, either as patients or as clinicians.
Prior to the establishment of an effective Systems Regulator for NSW Department of Health, as a short-term risk mitigation strategy, I believe that an **independent** Patient Advocate should accompany any person presenting to a remote or regional public hospital in NSW, either as an outpatient or for admission to the hospital.
This Patient Advocate would ideally be either a medical or an allied health professional or other person with a good working knowledge of NSW Department of Health documented processes, procedures and clinical governance requirements. This Patient Advocate would have authority to formally represent the patient in their interaction with the health system to ensure that NSW Department of Health requirements are observed and complied with.

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