Special Commission of Inquiry into Healthcare Funding

Statement of Dr Andrew Hallahan

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1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

My role

2. I am the Executive Director Medical Services Clinical Governance and Risk for the Sydney Local Health District (**SLHD**). I have held that role since July 2020.

3. In this role, I am responsible for providing executive medical leadership for SLHD, which includes overseeing the recruitment and appointments of systems and credentialing, quinquennial renewal, medical professional matters and providing leadership and mentoring. I am also responsible for providing assurance and improvement to deliver safe, effective, patient and family centred care, risk management and successful accreditation of all SLHD facilities.

4. This outline addresses:

    a. The current frameworks for addressing clinical incidents and complaints at SLHD;

    b. The adequacy of current frameworks for consulting with staff about evaluating major change; and

    c. SLHD's evidence-based approach to policy development.

Process for Addressing Clinical Complaints and Concerns

Incident management

5. SLHD is required to comply with NSW Health's Incident Management Policy Directive PD2020_047(MOH.9999.0803.0001). SLHD has operationalised the requirements set out in the Incident Management Policy Directive through the SLHD's Policy Compliance Procedure 'Serious Incident Management' SLHD_PCP2021_024 (MOH.0002.0062.0001).

6. Once an incident occurs, staff are required to record the incident on ims+. All staff at SLHD are trained on how to use ims+ during their onboarding. SLHD Executive provides direct instruction to staff that where a clinical concern is held, an incident is to be entered in ims+. This is achieved through mandatory training and regular communication to staff. For example, on 5 April 2024 a memo (MOH.0002.0055.0001) was issued to all staff reminding them of their responsibility to identify and respond to incidents immediately and also to report incidents in the ims+ system. The memo also reminded staff that ims+ training is mandatory and provided information on how the training can be completed.

7. The ims+ system primarily utilises drop down menus to record the incident and also allows the staff member to insert free text to describe the incident. Utilising the information inputted by the reporter, ims+ allocates a preliminary clinical harm score rating (**HS**) between 1-4, with 1 being the most serious (including incidents resulting in resulting in death or serious harm to a patient), and 4 being the least serious (incidents resulting in no harm or a near miss to a patient). There is daily initial review of all incidents recorded in ims+ by each facility's Patient Safety Manager and SLHD Clinical Governance Unit (**GCU**). After an incident is recorded in ims+, the incident report will then be picked up by the local Patient Safety Manager and reviewed by them to ensure the HS is accurate.

8. The process around managing an incident depends upon the nature of the incident and its allocated HS and is set out in the SLHD Serious Incident Management Policy Compliance Procedure PCP2021_024 (MOH.0002.0062.0001). The principle is that the incident is managed at the facility closest to where it happened if there is capacity to do so and that staff are supported to do this. I am not usually involved in the management of less serious incidents such as clinical HS 3s, 4s and many 2s which are managed at a facility level so that the response is proportionate to the seriousness of the harm or potential harm caused. For example, if a nurse forgets to give someone their medication, the incident would be noted and logged in ims+ by a Nurse Manager and the Nurse Manager would talk to the nurse about the incident.

9. Incidents which result in serious harm or concern for serious harm, being HS1s and some HS2s are flagged in the daily incident surveillance and escalated for further review and response by the SLHD CGU Patient Safety Manager working with the local facility Patient Safety Manager per the SLHD Serious Incident Management Policy.

10. For incidents that are HS1, potential sentinel events or HS2-4 that may indicate serious systemic problems, a Preliminary Risk Assessment (**PRA**) is conducted within 72 hours of the incident being recorded in ims+. A team of assessors of between 5 to 12 people from SLHD is constituted to conduct a PRA. The team includes expert clinicians and members of the facility's executive and clinical governance team as well as my team, usually including myself or Tamsin McVeigh, SLHD Director of Clinical Governance. The clinicians selected to participate in a PRA are determined based on clinical expertise. The clinicians must be independent and not involved in the care of the patient concerned. During the PRA, the assessors:

    a. Determine whether the initial classification HS of the incident is suitable and if not, the suitable HS to be recommended to the Chief Executive for approval;

    b. Determine what the immediate response to the incident will be;

    c. Determine whether a Serious Adverse Event Review (**SAER**) is required or should be recommended and if so, the correct mechanism for investigating the incident;

    d. Assign a Dedicated Family Contact to ensure care of the person and their family and carers;

    e. Determine and ensure a plan of support for the relevant staff involved; and

    f. Consider future open disclosure requirements and whether initial disclosure has already occurred.

11. A SAER is required for all HS 1 incidents and approval is required by the Chief Executive of SLHD to conduct a SAER for HS 2-4 incidents. This may occur when a PRA identifies that the incident may raise systematic issues. Where a SAER is to be conducted, my team will also prepare a Reportable Incident Brief (**RIB**) to the Ministry of Health (**MOH**) which I approve prior to transmission.

12. After approval is granted by the Chief Executive to commence a SAER, a team will be constituted in accordance with the requirements set out in NSW Health's Incident

Management Policy Directive. This team is endorsed by myself then approved by the Chief Executive. For almost all SAERs conducted by SLHD, I expect that 1 or 2 members of the SAER team would be external to the facility and typically also the LHD. A careful process is undertaken to ensure the SAER team are independent and have relevant expertise. The investigation is then undertaken using the chosen methodology recommended by the PRA team for investigating the incident. SAERs at SLHD most frequently utilise the Root Cause Analysis (**RCA**) review method. The SAER team will meet as often as required and will formulate a report and recommendations.

13. Once a report has been prepared with recommendations proposed, I will then review the report and recommendations and either approve the report or go back to the SAER team with questions and comments. After I have approved the report and recommendations, it will be sent to the General Manager of the relevant facility to ensure the recommendations can be practically implemented. Once the SAER report has been approved by myself and the General Manager, it will then be reviewed by the Chief Executive of SLHD. Once the report and recommendations have been approved by the Chief Executive it will be submitted to the Clinical Excellence Commission (**CEC**). The recommendations are also reported to SLHD's Clinical Quality Council (**CQC**) on a monthly basis.

Monitoring of incidents

14. My team has ongoing oversight over incidents which occur at all facilities in SLHD by reviewing ims+ reports on a daily basis. A daily report of these incidents is shared across relevant members of SLHD Executive. Each facility also performs daily screening of incidents with reporting to facility executive. My team also reviews the incidents for patterns and trends and conducts an analysis of the incidents on a monthly basis. We pay close attention to the frequency of the types of incidents and provide comprehensive reports to SLHD's CQC (MOH.0002.0059.0001). Incidents are monitored by MOH through the Critical Response Action Group (**CRAG**) and the Patient Safety First Unit (**PSFU**).

15. Where a concerning trend is emerging, my team will request further information from the relevant facility on the issue/s and whether any action is in place to resolve the emerging issues.

Complaints management

16. SLHD is required to comply with NSW Health's Complaints Management Policy Directive PD2020_013 (MOH.9999.0837.0001) and Complaint Management Guidelines GL2020_008 (MOH.9999.0838.0001).

17. All complaints received are expected to be recorded by staff in ims+. Complaints are managed in accordance with a tiered approach:

    a. Ward/clinic level;

    b. Facility level; and

    c. District level.

18. The general approach is that complaints should be managed locally where possible. Support is provided to local management in order to do so. Each facility has a clinical governance team with an identified position for complaints management which oversees feedback and complaints. Complaints can also be escalated to the district level for review and investigation.

19. My team manages complaints:

    a. which have been escalated by the facility;

    b. which involve more than one facility or service; and

    c. which have been received externally, for example from Members of Parliament, the Health Care Complaints Commission or the NSW Ombudsman.

Monitoring of complaints

20. Similar to incident reporting, complaints received and logged on ims+ are monitored by my team on a daily basis and are reported to relevant SLHD and facility level executives.

21. Complaints recorded on ims+ are monitored in accordance with Key Performance Indicators (**KPI**) reporting requirements to the SLHD Performance Unit and CQC together with a comprehensive monthly Patient Experience Report (MOH.0002.0061.0001) that details complaint themes, resolution of complaints and Patient Reported Experience measures.

Open disclosure

22. SLHD is required to comply with NSW Health's Open Disclosure Policy Directive PD2023_034 (MOH.9999.0927.0001).

23. Giving effect to the requirements set out in the Open Disclosure Policy Directive is generally managed at a local level as the facility has the knowledge to determine the most appropriate person to provide disclosure to the patient and/or family. This person is usually a clinician.

24. For more serious incidents which require a PRA, consideration is given to what disclosure has already been given including whether an apology has been made. In the circumstance where this has not occurred a plan is determined for this at the PRA. It is also determined who will provide a final open disclosure following completion of the SAER.

Areas for improvement

25. I consider that NSW Health provides a robust and reliable response to incident management. I also consider that SLHD has implemented a high-quality system for incident management which complies with legislative and policy requirements.

26. Rigorous incident management takes significant resourcing and there is an associated need for resources to be allocated to improving systems. I acknowledge there will always be a tension between these two areas. There is a need for ongoing review of the system utilised to manage incidents as well as improve clinical practices across NSW. The system needs to be allowed to continue to evolve over time and to develop in consultation with Directors of Clinical Governance and the CEC regarding recommendations about the NSW incident management policy and processes.

27. A challenge which the current model poses is that while the analysis of and recommendations arising from a single incident are valid, applying them systematically may not always work because we have complex systems. HS 1 incidents are relatively rare and a question arises whether the system should design itself around those serious incidents or respond to the more common problems that arise from lower harm score incidents and to build on the strengths of the NSW Health system and what it is doing right. Currently, the system is more driven by responding to the causes of serious incidents which may occur once in every 1000 cases, rather than the majority of cases from which no incidents arise.

Staff Consultation Frameworks for Evaluating Major Changes

28. I do not have oversight over consultation with staff for major changes, such as the re-development of the Concord Hospital. That responsibility generally falls to those responsible for the planning process. In my participation in these processes I have been impressed that they have been transparent, open and inclusive with opportunities for all stakeholders to provide input.

Concord Hospital

29. I can comment on the level of staff consultation regarding clinical changes. In my role, I am responsible for consulting with medical staff at each facility's Medical Staff Council (**MSC**) and SLHD's Executive Medical Staff Council (**EMSC**), consistent with the requirements set out in the Model By-Laws (**By-Laws**) (SCI.0001.0002.0001). The chair of each facility MSC also attends the EMSC which is chaired by the Chief Executive. At MSC meetings, I advise about significant changes from a district level which are of importance to medical staff and get their feedback on those changes. Concord Hospital has a longstanding, well-established MSC.

30. SLHD's relationship with Concord Hospital's MSC (**CHMSC**) has been challenging over the past 3 years and there are multiple reasons for that. I understand CHMSC's dissatisfaction relates to its view that staff morale is low due to perceived inadequate resourcing of Concord Hospital. This dissatisfaction was reflected in CHMSC's 2022 proposal for new Terms of Reference (**TOR**). SLHD executives, including me, considered the proposed TOR were inconsistent with the By-Laws and accordingly were not accepted. The proposed TOR in effect, would have given the CHMSC authority over matters in respect of which SLHD's Board and the facility's General Manager has responsibility. After I obtained legal advice, I proposed a revised TOR to CHMSC consistent with my understanding of the By-Laws. The TOR I proposed was not accepted by CHMSC.

31. The CHMSC subsequently conducted a vote of no confidence in the Chief Executive of SLHD. Since that time, I have continued to attend CHMSC meetings and advise them of matters relevant to medical staff in the district and obtain their feedback.

32. I consider the operation of the MSCs at each facility within the district is a useful and constructive system of consulting with the facility's medical staff about clinical and other issues relevant to the administration of the facility. I think it is important to have a healthy dialogue about these issues. However, problems with this system arise where there is a

breakdown in relationships and there is no longer an ability to work through problems together, creatively and constructively.

33. With respect to Concord Hospital and the CHMSC I understand that ProActive ReSolutions were engaged as an external organisation to assist with resolving the dispute. They appropriately took a locally based approach which I was largely not involved with and their involvement has resulted in a restorative action plan. My view is that their involvement was partially successful. However, having regard to the report lodged by the Chair of CHMSC (MOH.0002.0060.0001) at a recent meeting of the SLHD MSEC, which states that the Chair of the MCHSM continues to have a lack of confidence in the Chief Executive and the SLHD Board, there is a long way to go.

34. Overall, I consider that a huge amount of effort has been put in from SLHD in good faith to improve the relationship between SLHD and the medical staff at Concord Hospital. I understand there is an ongoing commitment to achieve resolution, in accordance with the Concord Action Plan.

SLHD's evidence based approach to policy development

35. SLHD has a rigorous, well defined evidence based process for policy development across facilities. SLHD has implemented a Policy Compliance Procedure, Governance and Development of Policies and Procedures and Guidelines SLHD_PCP2021_002 (MOH.0002.0058.0001) to meet the requirements set out in the NSW Health's Policy Directives and other Policy Documents PD2022_047 (MOH.0001.0364.0001). The Procedure requires consultation with multidisciplinary stakeholders for each Policy proposed across SLHD prior to executive endorsement. This is overseen by the SLHD Policy Committee that I co-chair.

36. Policies which are intended to apply across SLHD require review and authorisation by SLHD's Clinical Quality Council, which means that they are reviewed and authorised at the highest level by experienced clinicians. Where a policy is particular to a facility this is ratified by their Clinical Council per their Clinical Governance Framework. Policies have training and implementation plans, are published on the SLHD Intranet and are accessible to all staff.

Dr Andrew Hallahan

Witness:

6.6.2024
Date

6/6/24.
Date