Special Commission of Inquiry into Healthcare Funding

Statement of Bethan Richards

Name:	Bethan Richards
Professional address:	Level 11, King George V Building, Missenden Road, Camperdown NSW 2050
Occupation:	Chief Medical Wellness Officer, Sydney Local Health District (**SLHD**), Senior Staff Specialist, Department of Rheumatology, Royal Prince Alfred Hospital (**RPA**), and Co-Director Institute for Musculoskeletal Health, SLHD

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.

2. I have been asked to respond to questions 10 and 11 (Concord Hospital) in the letter from Mr S Jacobs, Principal Solicitor, SCOI dated 19 April 2024 as follows:

   "10. The adequacy of current frameworks for addressing complaints and concerns (both clinical and non-clinical) and resolving disputes within local health districts, including the availability and suitability of external processes."

   "11. The adequacy of current processes for consulting with staff about and evaluating major changes, including the extent to which NSW Health does and should adopt 'evidence-based' approaches to policy and process implementation."

My role

3. I am the Chief Medical Wellness Officer (**CWO**) of Sydney Local Health District (**SLHD**), Senior Staff Specialist, Department of Rheumatology, at Royal Prince Alfred Hospital (**RPA**), and Co-Director, Institute Musculoskeletal Health (**IMH**) of SLHD. I have worked in SLHD since 2011 and held the role of CWO since 2019 at a 0.5 FTE. In that role, I report directly to the Chief Executive (**CE**) of SLHD.

4. Though I am currently based at RPA, I have worked at a number of hospitals throughout NSW, with varying systems and structures in place (MOH.0002.0013.0001).

5. The role of Chief Medical Wellness Officer is to optimise medical staff wellbeing. The CWO model has proven to be a success in the United States of America in addressing staff wellbeing, and when created in 2019, my position was the first of its kind in Australia. This role in SLHD was tasked with developing and operationalising a workplace wellbeing model for medical staff that could then be rolled out to all staff. This was achieved in 2023 when MyDistrictOK (**MDOK**) was launched. I have been allocated a budget, team and resources, and tasked with responsibility for determining how workplace wellbeing should be measured, monitored and addressed at an individual, cultural, organisational and system level.

6. I have been responsible for establishing the SLHD wellbeing framework, the MDOK Centre, and an MDOK Team. To ensure an evidence-based approach, I was also responsible for establishing the ethics approved SLHD Wellbeing database (needed to address gaps in the People Matters Survey) collecting granular, high-quality data each year regarding staff wellbeing, its impacts, the drivers of distress and possible solutions. In collaboration with our executive team, I have established the SLHD wellbeing governance structures that review the data collected to identify problem areas, strategically plan resource allocation, facilitate discussions around the piloting and evaluation of interventions, and oversee the roll out of successful initiatives at a facility and district level.

7. Since 2019, as the MDOK program has matured, the CWO role has continued to evolve. It remains an executive leadership role that helps to bridge the gap between front line staff and other operational leaders to drive organisational change. With foundational level programs (routine measurement of wellbeing, EAP, peer support, incident management system, personal resilience offerings, community and connectedness) and facility wellbeing teams in place, the role now has a greater focus on data driven strategy and complex system level interventions. It works closely with and connects many areas of the organisation that have portfolios which closely align with workplace wellbeing outcomes (eg Heads of Departments, Training directors, Employee Assistance Program, Work Health and Safety, Clinical governance, Staff Health, Diversity and Inclusion, Quality and Safety, Administration, and Sydney Education).

8. In this role I am focused on prevention and early detection of issues, rather than treatment. NSW Health and SLHD already have high quality services available (eg EAP, Lifeline, NSW Mental Health line) for people who need to access them. My goal as CWO is to foster workplace environments that prevent them becoming unwell in the first place. The focus of our workplace wellbeing strategy is to reduce occupational distress and

burnout (optimise engagement and professional fulfilment) by promoting positive workplace cultures, strengthening individual resilience and addressing inefficiencies in practice with system level change. We also have introduced programs of work to help identify those in distress early, address barriers to seeking help, and connect those in need with existing internal or external support services.

9. Examples of this include but are not limited to:

   a. Optimising nutrition and hydration of staff by addressing individual (tailored education, Tastebuds intervention), cultural (education leaders, social connection, fuelling performance campaign) and system level barriers (nutrition and hydration working group, protected lunch breaks, lack of kitchen facilities, access to water fountains, staff lounges);

   b. Minimising fatigue and its impacts with individual level (education, #Findyour fit), work unit level (energy pods, best rostering practices, Rest and Recharge spaces, on call rooms) and system change (flexible training positions, fatigue working group, backfill of staff to take ADOs and annual leave);

   c. Reduce stress of going through complaints and adverse events processes by ensuring access to mentorship and Peer Support program (Colleague Care Program, shared experience sessions);

   d. Programs such as #Itsoknottobeok and #GP4everydoctor to reduce stigma around mental health issues and encourage seeking help; and

   e. Leadership training (leadership shadow, executive coaching, GIMME 5 campaign, high performance leadership education series) and support (Leadership action sets, HOD Twilight series) to engage and support leaders at all levels and foster positive workplace culture and behaviours.

10. The CWO led staff wellbeing model has been a proven success for medical staff in SLHD. Since inception it has led to the delivery of over 200 initiatives, averages over 58,000 interactions per year and early data shows reduction in levels of burnout, distress, increase in levels of self-compassion, resilience, and self-care behaviours and improvements in quality and safety outcomes.

11. In regards to staff with grievances within the SLHD, as CWO I play a role in ensuring they are supported (directly and indirectly through system level interventions), know their

avenues for making a complaint, and are connected with the appropriate systems and/ or personnel to do so. When issues with grievance processes that affect staff wellbeing arise, I play a role in advocating for change at the executive level, bring stakeholders together and lead discussions about how to best address and implement solutions. As CWO, one of my aims is to reduce the need for grievance processes, by using a proactive and preventative approach. Having regard to the issue I have been asked to address, this outline focuses more on addressing and resolving grievances rather than proactive wellness measures that aim to reduce the chance of such grievances occurring in the first place.

12. When using the internationally accepted criteria for a CWO which include:

    a. practicing clinician with a minimum 0.5 FTE dedicated to CWO role; and

    b. reports directly to the CE / C-Suite and

    c. has a budget and resources to effect change.

13. The Stanford Chief Wellness Officer Course is currently considered the gold standard training for a CWO position, and I completed this is 2018. Since then, 14 Australians have completed this course. There are currently three other employees in Australia who hold the role of Chief Medical Wellness Officer in their respective regions.

Process for Addressing Complaints and Concerns

14. Issues can range from workplace grievances such as interpersonal conflicts and perceived unfairness, to employee pay and working conditions, to bullying or sexual harassment, to concerns about workplace performance and clinical care.

15. There are a number of relevant internal NSW Health Policy Directives and Guidelines, and external policies, specific to different workplace grievances. Depending on the nature of the issue, more than one policy or guideline may be relevant. When conducting the initial assessment of a grievance or concern once received, it is important to identify the nature of the issue so that the correct policy or policies are applied for its management.

16. Complaints may be lodged through a variety of formal channels both internally (eg via the Incident Management System (IMS++), a formal written complaint or via an employee's manager or supervisor) and externally (eg HCCC, ASMOF, AHPRA).

17. Self-resolution should be the first approach taken if a staff member feels safe enough to do so and has the necessary skills. Policy stipulates that all staff should receive appropriate training to develop skills in resolving complaints. However, in my experience, this training does not occur in any meaningful form. Mastering skills in conflict management is not currently part of prevocational or vocational medical training programs, rather something that is “leant on the job” or by an individual seeking out professional development training in their own time. Whilst online modules on how to manage complaints do exist, in my view this advanced-level skill set is not something you can teach with an online module.

18. While there are policies in place in the current framework that deal with workplace grievances in practice, there are often challenges with implementation which can render the policies ineffective.

19. Similarly, although appropriate frameworks and guidelines may be available, operationalising them at a local health district level can be difficult.

20. In my experience, I have directly witnessed and received feedback that these formal complaint channels are often not used for a variety of reasons. Some of the key obstacles that prevent the effective operationalisation of grievance policies in the workplace are the non-user friendly reporting systems’, their lack of confidentiality and effectiveness in addressing grievances in a timely manner, a lack of skill and training in conflict management in the workforce, a lack of awareness of local grievance processes available to staff, a lack of independence and therefore psychological safety in complaints processes (perceived and real), high levels of burnout, and existing professional and local workplace cultures. In such instances, grievances may be raised informally with a trusted colleague or not at all (“What’s the point…”). This can lead to “known” issues not being addressed, and results in a sense of frustration, low workplace morale, disengagement and a negative, cynical psychological climate at work.

21. There are some nuances specific to the medical profession that can make it feel unsafe for staff to speak up or use formal complaint processes. Some examples include the hierarchical and apprenticeship nature of medicine, the job insecurity created by short term contracts and competition for limited training positions, the small numbers of medical staff in departments, the short- term placements in unfamiliar environments, and the processes by how trainees are selected onto those programs. For example, if you are a junior doctor and wish to make a complaint about another doctor in your department, if you use the ims+ system the first thing the system will do is send your

complaint to the head of that department. That head of department may be involved in your future career selection and in the sign-off of any training you are currently undertaking. Depending on the circumstances, even if not reporting your personal details, it may also be difficult to maintain anonymity, so confidentiality is not assured. If the culture in that department is one that does not encourage reporting, the scenario is therefore created that in making a complaint, it may be counted against any future career progression.

22. Other barriers to addressing complaints may include staff with complaints against them may be in a position of power or have better representation, leadership may be unwilling to go against those considered 'high value assets' to the organisation, and confidentiality can have a negative impact where a lack of information flows to staff involved in the process.

23. It has been my experience that staff will be much more likely to report a serious adverse clinical event via the ims+, than a serious nonclinical workplace complaint. Medical staff are less likely to lodge a complaint through formal channels than nursing staff, and may use other professional processes available to them (eg morbidity and mortality meetings) to discuss grievances that arise.

24. While patient complaints are usually dealt with effectively and efficiently, the management of staff workplace complaints can be protracted and have significant negative impacts on all those involved. A symptom of the impact of the poor performing complaints system has been the need to introduce a peer support program to support staff involved in the complaint processes.

25. As a perceived independent and safe third party who understands the world of the clinician, my team and I will often receive requests from front line staff to debrief about distressing workplace issues. In this capacity, complaints of all levels of severity, that have often not been formally reported have been raised.

26. On many occasions, when I debrief with staff and a workplace grievance is identified, we discuss options available to them for formally lodging their complaint. It has been my experience in this setting that many staff are reticent to lodge a formal complaint. Reasons for this may include a fear of making their workplace situation worse, fear of repercussions if the complaint is against someone in administration or someone that has influence over their job role, a belief that lodging a complaint will impact their term assessment, job security or career progression, difficulty proving an allegation, not

wanting to be seen as “a trouble maker”, a belief that the process is too hard and/or will not remain confidential, and a conviction that either nothing will be done or nothing will change anyway.

27. Work unit staff will often view the workplace through the lens of their leaders and each work unit will usually have a micro-culture of its own. Work-unit leaders are usually the guardians of workplace culture and therefore if senior members of staff hold strong beliefs or model certain behaviours about the utility and effectiveness of complaints processes, these will often be adopted by those they lead. In my experience, with such hierarchical training structures, there has been and remains a strong culture in medicine to not speak up and to “not make waves” for fear of reprisal or being seen as “difficult” or “a troublemaker”. As an example, there is a perception held by trainees and fellows that future job selection may be affected if they are not seen to fit the mould. In senior staff, there is a perception that if they speak out against administration there may be repercussions for their service.

28. The lack of training for staff in advanced communication skills at all levels is a contributor to poor workplace culture and suboptimal operationalisation of grievance processes. Our data shows that one of the most common sources of distress for senior medical staff is delivering negative feedback to junior staff. Supervisors report that they fear giving negative feedback as it puts them at risk of being accused of bullying. They have usually not received training in how to do this and do not feel skilled in how to have these difficult conversations. The way they were taught and given feedback is no longer acceptable. Likewise, trainees do not receive any training in how to give or receive feedback. This is a key area that could be optimised to prevent grievances occurring in the first place, address them early before they escalate, and optimise management of them through the formal channels available.

29. There seems to be a significant difference in the level of communication, support, speed of the process and feedback between patient and staff complaints. Staff grievances submitted through ims+ or other formal channels should be treated in the same manner and with the same KPIs as patient complaints. Staff members involved in any complaints processes should always be made aware of where the process is up to and the final outcome. This does not always occur. To improve the implementation of current complaints policies several actions could be taken. Using the MDOK staff wellbeing framework improvements in the grievance process could occur at the individual, cultural and systems levels.

30. At the individual level:

    a. better advanced communication skills training could be offered to all staff (especially those in leadership roles and those managing complaints) > ideally this training would begin in prevocational / vocational training;

    b. an opt in peer support program (SLHD example is Colleague Care Program) should be integrated into the complaints (and response to adverse events) process; and

    c. guides on local avenues and internal and external escalation procedures for complaints (with worked examples, FAQs) could be made available.

31. At the cultural level:

    a. targeting leaders with education programs (including psychological safety, conflict resolution, delivering feedback, inclusion and diversity) so they will role model best complaints management behaviours;

    b. engaging a diverse group of leaders in co-design of any new complaints processes;

    c. transparency around flow of information and confidentiality better articulated; and

    d. initiatives to foster a stronger community and connection.

32. At the systems level:

    a. KPIs need to be established, monitored and reported back to front line staff in regard to best complaints management practice. This should also include timeframes, a measure of impact on staff wellbeing and seek feedback from those involved in the process;

    b. IT systems could be optimised for user experience and be more transparent about the flow of information. Parallel processes should communicate with one another to minimise any impact or delay on staff;

    c. Investigation of complaints should look at the system factors that contributed to the issue (not just focus on the individual); and

    d. Appointment of CWO positions that can work alongside administration in the design of grievance processes, ensure appropriate staff support programs are in

place, develop initiatives to improve workplace culture and reduce behaviours that can result from cynicism and burnout.

33. My team has introduced and instituted a successful peer support program to help and support staff during the complaints process, the Colleague Care Program, as we are aware the process can be nonoptimal for complainants. A copy of the brochure for this program is attached to this outline (MOH.0002.0074.0001). This program was created in partnership with the quality care, EAP, Sydney Education and clinical governance teams. We have been approached by multiple other Districts, national and international healthcare organisations who are interested in the model for the program.

Concord Hospital

34. Since 2011, I have observed a decline in the morale of staff at Concord Hospital. This was amplified during and following the Covid-19 pandemic. In conversations with Heads of Departments and colleagues there was a strong sense that the community spirit, that had previously been a strength of the hospital, had waned. People felt isolated from each other and from administration. Our medical officer wellbeing data shows very high levels of burnout with multiple drivers of distress. Common themes arising from our survey and focus group discussions were that workload and job demands had increased, administrative tasks had escalated without administrative support, staff did not feel valued, seen or heard, they had less autonomy and less access to administration to raise issues, when issues were raised they were not adequately addressed, there was a sense of unfairness in resource allocation compared to other hospitals, a lack of transparency about how decisions were made, a lack of consultancy and shared decision making, and pay and other disputes were not being adequately resolved.

35. NSW Health policy states that external parties can be brought in if issues cannot be resolved locally. This may be directed at an LHD or Ministry level. There are no specific policies or guidelines I am aware of in regard to what this looks like at an LHD level. Hence staff rely solely on the information provided in the NSW Health Policy. As mentioned above, local guidelines that clarify internal and external pathways (and who will have access to information) for grievances may be helpful. Further, an external safe process to raise complaints via a neutral third party may assist in situations where a staff member does not feel safe to use local grievance processes [22].

36. Where local processes have failed or are inappropriate to use, a neutral external party has been retained to attend and investigate in the past. An external party can assist where, despite local efforts to address them, grievance processes remain unresolved, or it is inappropriate to use local processes due to a conflict of interest. However, I have seen those external processes fail as well and when this happens, staff lose complete faith in the system. This in turn leads to further disengagement with the complaints process, and these beliefs and behaviours are then role modelled and passed on to current and junior generations.

37. The Concord Hospital situation highlights what can occur when staff feel they have exhausted local mechanisms but feel their complaints have not been heard or addressed. There was a growing discontent for years that was not adequately identified, escalated or managed early. The COVID-19 pandemic and increasing levels of burnout amplified this frustration and discontent. In this case, there was a belief that local structures and processes had failed, and the best course of action to be heard was a change of leadership and a vote of no confidence in the CE and LHD board. I am aware this course of action caused a lot of distress for all those involved. I was not a witness to these issues, though information concerning the situation at Concord was provided to me by staff involved in the process.

38. Hospitals work best when there is strong relationship between clinicians and administration. A Medical Staff Council with effective leadership can be a good barometer when it works well, meaning when the meetings bring a diverse range of medical staff and administration together to identify issues early, workshop and resolve those issues with true shared decision making. With this in place, people feel heard, there is transparency in the communication and many issues are able to be resolved before they escalate. This structure was in place at Concord, however was not working effectively.

39. One of the structural issues that I believe has contributed to the communication issues at Concord Hospital has been the clinical stream structure. The clinical stream structure provides a District level perspective, rather than a facility level perspective. This structure involves a District level Clinical Stream Director who may represent anywhere from 1 to 8 different and often unrelated specialities across up to three large hospitals. Those from the clinical stream are clinical leaders and attend meetings regularly with the Chief Executive. They are usually not the facility Heads of Departments who are responsible for day-to-day operations. This leaves Heads of Department feeling disempowered despite the great responsibility that they carry. The clinical stream structure operates in

parallel with Divisional Structures (eg Division of Medicine, Division of Surgery) which can lead to communication breakdowns and makes the escalation of staff's grievances more challenging. Despite representing a vast array of medical staff, Chairs of the Divisional structures are not positioned to have a voice in high level decision making.

40. Clinical Stream Directors are appointed by the executive and, with the right leaders in place, can work well at the Chief Executive level or in very small clinical streams (eg two departments). Placing one or two individuals in charge of a range of different services with very different cultures and needs can be very difficult to operationalise successfully though as it takes a unique person (and a lot of time) to be able to engage with all key stakeholders, understand their issues, present their concerns accurately, and feedback the results to them. It has been my experience that this has not tended to occur, and so the system fails. There is often a lack of Diversity in these positions and people occupy them for long periods of time.

Staff Consultation Frameworks for Evaluating Major Changes

41. Staff consultations do frequently occur, but they are not always successful in terms of ensuring true inclusion, diversity of opinion, early involvement, psychological safety and ensuring feedback of the process to staff. There are many barriers to the consultation process that can leave staff feeling like the process has not been a true consultative process, rather a 'tick a box' exercise. Examples may include relying on the same individuals for feedback, using unreasonable timeframes for feedback or scheduling meetings at times that prevent participation, challenges with reaching/communicating with front line staff, lack of psychological safety for people to raise issues or opposing viewpoints, lack of feedback following any consultation that communicates any changes that have been made, and a lack of including recommendations from the consultative process into final decisions.

42. Staff consultation is also very different from shared decision making. Best evidence shows that it is true shared decision making, not consultation that leads to better decision making, better performance of organisations and ultimately in our case, to better, more efficient, cost effective, patient care. In my experience, as discussed in the paragraph above, I have found a lack of meaningful staff consultation is one of the biggest drivers in exacerbating poor workplace culture. Not feeling seen, heard and valued are key drivers of distress and over time contribute to disengagement, cynicism, reduced efficiency, a negative psychological climate at work and burnout. A shift to building shared decision making into policies, practice and KPIs is another opportunity to bridge

the gap between administration and clinicians and strengthen the health system (and staff wellbeing) as a result.

Adoption of 'Evidence-Based' Approaches to Policy and Process Implementation

43. Evidence based approaches to policy and process are of utmost importance in fostering positive workplace environments to deliver best clinical care. Adopting a CWO model is an evidence-based approach to improve staff wellbeing in healthcare. There is an incredibly strong business case to support this model. There is a huge opportunity for NSW Health to address staff wellbeing at scale (and in doing so reduce costs, and improve staff wellbeing, efficiency, and patient care) by rolling out this model across the state.

44. In my role as CWO, adopting an evidence-based approach has been particularly important in addressing the complex, dynamic and often emotionally charged issue of healthcare staff wellbeing. As an Australian-first model, we initially had to rely on international best evidence policies and process. Following a successful pilot, with support from NSW Health and SLHD we now have high quality local data to inform best practice. This data is used to strategically plan and allocate finite resources, build the business case for future directions, educate key stakeholders regarding the importance, and impacts of the issue and evaluate success. It has taken the "fluffiness" out of wellbeing and our model is an example of how wellbeing can be operationalised, delivered at scale and aligned with a quality and safety and work health safety mindset.

45. The NSW Government People Matter Survey data is a valuable source of information in evaluating at a high level, how the sectors are going. For LHDs, and in my role as CWO it has several limitations. Response rates are low, there are few validated measures used, there are few questions regarding wellbeing, the data is not granular enough to act on and there are no KPIs to ensure that problem areas are addressed. With a dynamic workforce that changes year to year it is also hard to make valid direct comparisons to assess change over time. To address this gap and effect change, more granular LHD level surveys on wellbeing currently need to be undertaken to complement the People Matters Survey. There is therefore an opportunity for NSW Health to improve current policies and frameworks to reflect best practice and ensure high quality, actionable data is collected and actioned.

46. Given the prevalence of healthcare worker burnout and its significant impact on patient care, to support best practice, having NSW Health policies, processes and guidelines specifically in regards to staff wellbeing is another area of opportunity. NSW Health has great policies and processes in place to identify and address clinical variation in patient care outcomes (eg hospital acquired complications (HACs)). We need to view and address staff wellbeing outcomes in the same light.

47. With its clear relationship to patient care outcomes, staff wellbeing is not yet part of the National Safety and Quality Health Service Standards. I believe this is likely to change soon. There are currently no KPIs around staff wellbeing (or its measurement) in LHD performance agreements. Whilst NSW Health has placed staff wellbeing as a priority in its strategic plan, without clear KPIs to monitor this it is unlikely to become a focus in all health districts. This is another opportunity for improvement. Including evidence-based staff wellbeing KPIs in LHD performance agreements would help translate policy into practice and help drive individual level, cultural and system change. Looking forward an aim at an LHD level would be for all work units to have regular data on staff wellbeing outcomes provided to them with processes in place to review and act on that data. Organisational wellbeing support teams skilled in wellbeing interventions, change management, cultural change and efficiency of practice in place to help address issues. We are currently piloting a version of this in SLHD called the “Pebble in the Shoe Pilot”.

Bethan Richards	Witness:
07/06/2024	07/06/2024
Date	Date