Special Commission of Inquiry into Healthcare Funding

Statement of Professor Michael Hensley

Name:	Michael Hensley
Professional address:	Level 11, King George V Building, Missenden Road, Camperdown NSW 2050
Occupation:	Director Medical Services, Royal Prince Alfred Hospital (RPA), Sydney Local Health District

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 Director of Medical Services, RPA of the Sydney Local Health District (**SLHD**). I have held that role since 1 August 2020.

3. As the Director Medical Services, RPA, I am responsible for all RPA medical staff and for the Department of Pharmacy. There are 1,129 medical staff of whom 385 are Visiting Medical Officers (VMOs), 485 are Junior Medical Officers (**JMOs**) and 259 are salaried senior medical staff, the majority staff specialists. There are approximately 70 staff in the Pharmacy.

4. I am an academic physician. My specialty is respiratory and sleep medicine. I obtained my medical degree and Doctor of Philosophy (PhD) at Sydney University and attended Harvard University for my post-doctoral fellowship. From 1979, I was a member of the academic team that set up the new Newcastle Medical School. I finished at the University of Newcastle in 2010 following 9 years as Dean of Medicine. I was the Foundation Director of Respiratory & Sleep Medicine at John Hunter Hospital (**JHH**) from 1991 until 2014 initially as a Clinical Academic and as a full-time staff specialist from 2010. I was the first Director of Medical Services at JHH from 2014 until commencing my role at RPA in August 2020.

Process for Addressing Clinical Complaints and Concerns

5. At RPA, we follow the relevant guidelines for managing incidents and complaints, including but not limited to the following policies:

   a. Complaints management: PD2020_013 (MOH.9999.0837.0001) which provides a framework for management of complaints across NSW Health to support timely, efficient and fair management of complaints.

   b. Managing Complaints and Concerns about Clinicians: PD2018_032 (MOH.9999.0933.0001) which relates to 'the management of serious complaints or concerns about clinicians working in NSW Health.

   c. Incident Management: PD2020_047 (MOH.9999.0803.0001) which relates to consistency in managing and effectively responding to clinical and corporate incidents.

6. I find the current framework for handling complaints and concerns satisfactory. When required, I work closely with the RPA workforce team when addressing complaints or concerns about the behaviour of senior and junior medical staff. For matters of Clinical Governance, I work closely with the Clinical Governance Units of both RPA and the Sydney LHD Executive.

7. With respect to incidents, we encourage all medical staff to report incidents through the Incident Management System (**IMS+**). It has been observed that medical staff are less likely to submit reports of incidents compared to nursing staff.

8. With respect to concerns about the complaints process, there may be delays in completing the processes or a lack of follow up. As RPA is a large organisation with a large number of matters, the rate of progress can vary depending on priority and the volume of work. The current process involves receiving documentation, conducting an initial assessment followed, if required, by a risk assessment followed, if accepted, by an investigation and an outcome report with recommendations that must be considered and approved by the Chief Executive.

9. As a member of the RPA Executive, I receive clinical issues from a range of sources including IMS+, the Patient Safety & Quality Unit, individual clinicians, facility committees formal meetings of departments and services, the RPA Clinical Council and the RPA/Balmain Medical Staff Council.

10. If there is a complaint or concern about a practitioner, I look at the nature of the complaint as to whether it is serious or low level based on an initial inquiry. We strive to deal with complaints as expeditiously as possible. I am comfortable in working with the Head of Department or other supervisor to confirm the nature of the matter, including contacting the complainant directly and following up with the staff member. For serious incidents, I work with RPA and Sydney LHD Workforce.

11. For incidents, the severity is assessed by the harm score allocated. The incidents that are notified in the IMS+ are distributed to the RPA Executive each morning by the Director of Clinical Governance and Risk. In keeping with the Policy Directive, for a Clinical Harm Score 1, a Preliminary Risk Assessment (**PRA**) meeting will be arranged by the SLHD Clinical Governance team. The PRA team will review the information, decide on a final harm score and, if recommended, set up an investigation team for a Serious Adverse Event Review (**SAER**). If it is determined that the incident involves a lesser degree of harm than first reported, there may be a structured incident review or referral to consideration at a departmental Quality & Safety/Morbidity and Mortality (M&M) meeting to review the incident and make recommendations to reduce the risk of recurrence.

12. The recommendations from a SAER report will list who is responsible to implement the recommendations. An important role for the Clinical Governance Unit and RPA Executive is monitoring of the implementation of recommendations. The monitoring can be by audits such as confirming that there is adherence to a recommendation such as maintaining correct 'time out' procedures. I have strengthened the Medical Services Directorate since I commenced my role as Director of Medical Services at RPA to enable us to better support the strong medical leadership and staff across RPA. There are 46 heads of department, two Chairs of Divisions, and a number of senior medical leaders. Professor Paul Torzillo is the RPA Executive Clinical Director and plays a pivotal role in the relationship between the medical staff and the hospital administration.

13. I meet each week with the Executive Director of Medical Services, Clinical Governance and Risk, Dr Andrew Hallahan, to go over mutually relevant matters. In general, I am able to keep track of all matters relevant to the RPA Medical Services Directorate. However, they do not all move as expeditiously as I would like. The reasons include adapting to changes in performance expectations. For instance, the change in National Standards Accreditation from 6 to 12 months' notice to 48 hours' notice means that we have to maintain a constant level of activity in Clinical Governance performance, which is the way it should be.

Frameworks for Dispute Resolution at a Local Level

14. I am aware that concerns have been expressed by Concord Hospital that the RPA is treated differently and receives more resources than Concord. I cannot comment on the relative resourcing of the two hospitals but can confirm that RPA deserves its position as one of the best, if not the best, tertiary/quaternary referral teaching hospitals in Australia. Its role in advanced surgery, medicine, intensive care and obstetrics is recognised across NSW by the number of statewide services to which RPA contributes while serving its SLHD community. Following Concord's recent redevelopment, RPA has started a major redevelopment focussed on improving the facilities for the Emergency Department and support, especially for RPA's advanced services. From my experience over the last 4 years, the communication structures and processes work well overall for medical staff with most communications going through the heads of department and clinical superintendents through monthly meetings as part of the clinical stream structure and of the hospital Divisional structure. In addition, through committees, clinical council and emails.

15. Prior to the Garling Report in 2008 prepared by Peter Garling SC, the RPA Medical Staff Council was called the RPA Medical Board. Prior to ~~2008~~ 2023, a small number of senior medical staff attended the monthly meetings which, in addition to receiving reports from the Executive, focussed more on the academic, professional and cultural commitments of the hospital, including highly successful events such as RPA Week.

16. Following the events at Concord Hospital in June 2023, Dr Hallahan and I, with input from senior medical staff, changed the RPA medical board into a formal Medical Staff Council (**MSC**) based on the Model By-Laws (SCI.0001.0002.0001). This included an annual election of the Chair and two other office-bearers. Since late 2023, the RPA/Balmain MSC has been active in its engagement with both the large number of medical staff and the RPA, Balmain and SLHD Executives. The General Manager and I meet regularly with the Executive of the MSC and attend its monthly meeting. In my opinion, the engagement with the MSC has complemented the already widespread involvement of clinicians in the operation of the hospital. This in in keeping with the Objectives of Part 6, Section 22 of the Model By-Laws to provide structures for clinician input to facilitate effective patient care and services and to provide a forum for information sharing. We are able to discuss successes and significant problems, such as our budget situation and steps to be taken to improve it. I have found communication lines are good. If issues cannot be resolved initially, we work through our differences of opinion to reach

a satisfactory outcome. I will give two examples where feedback from the MSC has been received and acted upon.

17. The first example is the development of a Policy Compliance Procedure (**PCP**) following a SAER and referral to the Coroner of a patient who died from a perforated bowel at RPA in 2022. The SAER, using the information available at the time, identified aspects of care that could be improved. However, a year later, the coroner's report indicated that the patient had an undiagnosed bowel perforation and peritonitis at the time of death. It was noted that the Admitting Medical Officer (**AMO**) had not seen the patient during the 7 day admission. The Coroner asked about a policy which did not exist. The AMO PCP that I subsequently wrote indicates that the AMO is to see a patient within 24 hours of admission and at least twice a week after that. The AMO PCP development followed the usual practice of consultation and presentation to committees including the RPA Clinical Council in August 2023. Following comprehensive feedback by one senior medical staff member, the PCP was revised, resubmitted, approved at the RPA Clinical Council in December 2023 and published in January 2024. The RPA Clinical Council has around 70 members of whom many are senior medical staff. Following publication, the RPA/Balmain MSC reported major concerns with parts of the PCP including liability of AMOs and limitation on registrar training. The MSC Executive spoke to ASMOF about their concerns. I attended the next MSC meeting and agreed to consider suggestions to change aspects of the PCP without losing the primary intention of defining the responsibilities of the AMO. This highlights the problems that can occur with the consultation process to produce policies and procedures even though there is extensive opportunity for senior medical staff to provide feedback. I consider that we responded well to the concerns raised and addressed them appropriately. The MSC working group provided suggested edits to the PCP which Dr Hallahan and I reviewed and supported. The PCP will be considered at the May 2024 meeting of the RPA Clinical Council.

Staff Consultation Frameworks for Evaluating Major Changes at RPA

18. The frameworks for consultation with medical staff at RPA are substantial and include multiple meetings, emails and one-on one sessions with medical leaders such as Heads of Departments. The timing varies from the daily meeting of the RPA Operational Huddle which was introduced during COVID-19 and has remained in place. It is at 10am, 7 days a week and lasts about 10 minutes. Advice about the current state of the hospital is received from Bed Management, the Executive and leaders of major divisions and departments. Emails from me to HODs and Junior Medical Officer (JMO) supervisors are

sent about weekly with important updates and requests for urgent action with respect to the operations of the hospital. My emails are intended to be distributed widely.

19. There are monthly meetings of groups of HoDs and NUMs as well as hospital committees, departments and Divisions. On an annual basis I have Performance and Development Reviews (**PDR**) for HoDs. In my role at JHH, I was able to meet more frequently with individual HoDs but that was difficult during COVID and has not been put in place yet at RPA. An RPA Deputy DMS has been appointed. He has an excellent background as DMS at another major hospital and brings experience and skills that will enhance engagement and communication with senior medical staff. For instance, I have not been able to attend as many department meetings compared to my practice at JHH but the Deputy DMS and I will share the role of strengthening communication with departments.

20. In my experience, the RPA medical staff have a strong relationship with RPA Executive and administration. This has been demonstrated during the planning and now implementation phase of the large RPA redevelopment underway at present. The consultation during that process was excellent. Potential areas of friction have been managed very well.

21. A second example of managing problems with communicating change has been the recent experience of needing to manage, ideally reduce, expenditure across the hospital. In my portfolio, this involves the three groups of medical staff: JMOs, VMOs and salaried senior medical staff. One area to be addressed was the management of claims by VMOs for payment of services provided to RPA. There had been three audits about the processes for managing VMO claims via VMoney: two internal and one state audit. The recommendations included improving the checking and approving process. RPA had a large number of checkers, around 50 to 60, and a similar number of approvers. Other hospitals in the Sydney LHD have only one or two checkers and a small number of approvers.

22. I sent an initial email to all HoDs setting out the situation in which the hospital finds itself with respect to its finances and the plan to respond to the recommendations of the audits. As usual, the HoDs discussed the email with all senior medical staff. I received feedback from individual HoDs as well as the MSC. A major concern was about allowing VMOs to claim for remote attendance at certain meetings, especially Multi-Disciplinary Team (MDT) and departmental Safety and Quality/Morbidity & Mortality meetings. I responded positively to the concerns about these meetings for which it is important that there is

appropriate expert clinician advice about patient care. Requests about other meetings are under consideration.

23. In summary, I believe that the communication and engagement of senior medical staff and RPA Executive and administration have been very good for many years. I have complemented that with my own approach and plan to improve further in partnership with the Medical Services team.

M J Hensley
Michael Hensley

Miss Rebecca
Witness:

7 June 2024
Date

7/6/24
Date