Why there must be change at Concord Hospital

This letter is strictly confidential and is not to be distributed to any other people.

It is only to be used for the purpose of considering how you will vote in the upcoming 2022 Concord Repatriation General Hospital Medical Staff Council election.

Dear Colleagues,

I am not here to lead the Medical Staff Council.
The MSC is bigger than one person. It always has been, and always will be.
All of you are the leaders.
All of you lead the MSC.

I am merely the catalyst for change.
We must change.
Because all is not OK at Concord.

For 17 years I have worked as a Staff Specialist at this great hospital. I have had the privilege to work with you all. You are an amazing group of people. I am immensely proud to call myself a Concordian.

The staff at Concord are the foundation upon which this hospital sits. Dedicated, diligent and hard working. You strive every day to do your best to improve the lives of our patients and serve the Concord community. I am proud to call you my Concord family.

We do our best to protect family. Which is the reason why I have written this letter.
Because all is not right at Concord.

I have never seen morale so low. This was happening before COVID befell us. COVID merely exacerbated the situation. I have never seen staff so despondent and feeling so helpless.

We need change, and change for the better.

We must reform the way we advocate.
We must change the way we determine our priorities.
We must reverse years of underinvestment.
We must grow and improve our clinical services.
We must improve our quality processes.
We must improve the way we educate.
We must reform the way we manage research.
We must prepare better for disasters.
We must resolve our industrial issues.
We must allow our patients to have a greater say in the future of this hospital.
We must reduce bureaucracy.

Above all, we must change our culture.

We must expect and demand transparency and accountability.
We must stop turning a blind eye.
We must no longer stay silent.

The Lessons

Public Service

Times are tough for public service.

But when I think about what defines us as public servants, and what we as public servants stand for, I look no further than the events that unfolded in USA in 2020. These events were defining moments for public service.

Protests had erupted across the country following the killing of a man by police officers. There was an election followed by an attack on the Capitol.

It was the actions of the public servants which prevented the country from being torn apart.
It was the public servants who kept the community safe.
It was the public servants who stood up to the abuse of authority.

A prominent public servant noted that the protests were defined by "tens of thousands of people of conscience who are insisting that we live up to our values – our values as people and our values as a nation." He went on to contrast the American ethos with another ideology pervasive during a previous World War. 'The slogan for destroying us was "Divide and Conquer". Our answer is "In Union there is Strength."

The former defence secretaries wrote a letter. They stated, "Each of us swore an oath to support and defend the Constitution... We did not swear it to an individual or to a party."

The events in USA hold important lessons for us in Australia.
We too are public servants.
We serve the people and we serve the community.

We must always act in the best interests of the people.

We have leaders, but they too are public servants. They too serve the people and the community.

Our leaders are accountable to the people for their actions and inactions. They too must always act in the best interests of the people.

Staff Wellbeing

In 2020 the "MDOK" wellbeing program was established at Concord. The slogan for the program was "Healthy minds. Healthy medicine."

The purpose of the MDOK program was described in an expression of interest for the MDOK Director of Wellbeing position:

> The primary purpose of the MDOK role is to lead the development, oversight, implementation, promotion and evaluation of medical officer wellbeing initiatives at CRGH. The MDOK Director of Wellbeing will ensure a high standard of professional performance and encouragement of an academic environment which supports education, research and professional development. MDOK is a multifaceted wellbeing program within SLHD that offers a variety of wellbeing initiatives across all levels of medical staff. These initiatives target the psychological, physical and social wellbeing of SLHD doctors and the overarching culture and systems improvement. The position holder will provide leadership role in wellbeing initiatives directed at increasing CRGH medical officer professional fulfilment, job satisfaction and wellbeing, working with the Hospital leadership and the SLHD WellMD senior leadership team.

Given the apparent noble objectives of the MDOK program, it was therefore surprising that in November 2021 Concord featured in the Sydney Morning Herald article titled, "Junior doctors report increased bullying in NSW hospitals, stress leading to mistakes."

The Australian Medical Association had run a "Hospital Health Check" survey of junior doctors. The SMH reported that Concord was the "only hospital to receive an overall D grade, with the lowest scores in rostering, overtime, behaviours, sick leave and facilities."

What the MDOK job description didn't mention was that MDOK had been actively "discouraged" to tackle the industrial issues that had beset the junior medical staff.

Concord could not have addressed staff wellbeing without addressing the fundamental needs of the employees.
In this situation, the problems were industrial ones.
To improve the wellbeing of the junior medical staff the industrial issues had to be acknowledged, and they had to be resolved.

This did not occur.

Action finally only happened because the problem ended up in a newspaper.

The problems of the junior doctors at Concord remind me of three organisations whose problems in recent times are disquietingly similar to those that we have at Concord. All three organisations had massive system failures.

We must not ignore the lessons learnt from these three organisations.

Crown Casino

In 2021, findings from a Royal Commission into the Crown Casino in Melbourne were handed down. Crown's shortcomings are well documented.

There were problems with money laundering and organised crime. 16 staff were imprisoned overseas. Crown underpaid tax. It concealed problems from regulators.

The Commission wrote Crown showed "indifference to acceptable conduct" and described the casino's conduct as "disgraceful".

Organisations such as Crown have legal and regulatory obligations. But what was clear from the Commission findings was that organisations also have ethical and moral obligations.

Organisations must make it their business to find out what problems beset them. They must make it their business to find out what they are not doing right, and they must make it their business to rectify these problems.

Crown did not do this.
As a result, a new board and new group of senior executives were appointed.

The Royal Commission findings into Crown did not exonerate the employees, but the criticism of Crown's employees was far less scathing than that of the management.

The employees also had obligations. One of the issues was problem gambling. The cost to the community was enormous. It was not only the gambler who suffered, but also many others. Crown's employees knew this was happening, but they failed in their obligations to prevent it.

Dreamworld

In 2020, the Coroner's Court handed down the findings of 2016 Thunder River Rapids Ride tragedy at Dreamworld. The problems which led to the deaths of several patrons has also been well documented.

Those in charge of safety at Dreamworld had large amounts of responsibilities. This made it difficult to complete reactive work, let alone conduct any proactive safety management. There was a general ignorance of proper safety, and the need for adequate safety assessments.

There was evidence of a lack of proper training and there were lack of processes in place to ensure training provided was suitable. The organisation utilised electronic reporting systems. They were described as reactive management. The systems were not user friendly, therefore not well utilised.

The managers claimed that risks and hazards had never been reported to them. They were unaware and therefore unable to take action. But no steps were ever taken to properly identify risks, therefore it was not surprising that the safety issues were not raised with management.

There had been a total failure by everyone at Dreamworld, from management to employees, to identify the safety issues.

Several innocent people lost their lives.

Commonwealth Parliamentary Workplaces

In 2021, the Australian Human Rights Commission conducted an independent review into Commonwealth Parliamentary workplaces. It was asked to make recommendations to ensure that parliamentary workplaces were safe and respectful, and represented the best practice in the prevention and handling of bullying, sexual harassment and sexual assault.

The Commission demonstrated that there were many barriers to parliamentary staff reporting issues. There was lack of clarity about processes. There were concerns about confidentiality. There was a sense that nothing would come of a report or complaint, or worse still, the report or complaint would be detrimental to the person making the report. There was a perception of the lack of consequences for misconduct. There was perception in some instances that misconduct was rewarded.

Commissioner Kate Jenkins summarised the problem by stating,

> "There was also a worrying low level of reporting indicating that it is not safe to speak."

One cannot help but wonder what may have been had staff at each of these three organisations spoken out about the problems within their organisation earlier.

The Problems

Underreporting

The approach to quality at Concord is problematic.

The simple fact is we do not know how many patients are inadvertently harmed at Concord every day.

Adverse events in our patients are expected because of the nature of their illnesses. But harm caused by the healthcare system can be hidden in these adverse events. This harm may be attributed to the consequences of disease. Because of this, harm caused by problems in the system can go undetected, unrecognised and unmanaged.

We see the problems at Concord every day. There are clinical problems, process problems, equipment problems, infrastructure problems, administrative problems, governance problems, problems with training and education, industrial problems, research problems, problems with staff health and wellbeing, and many more.

All problems can eventually result in harm, but we don't report them.

Many staff at Concord report either no incidents, or only 1 to 2 incidents per year. The actual reporting rate for incidents at Concord may be less than 1%.

There can be many reasons for underreporting. Staff may not have time to report. Staff may not believe that some problems need to be reported. Staff may fear other staff will be blamed. Staff may not feel supported.

At Concord, our detection systems are inadequate.

The failure to encourage and facilitate the identification of problems is the single biggest system failure at Concord Hospital.

Concord must learn the lessons from Crown, Dreamworld, Federal Parliament and the junior doctors in the Sydney Morning Herald. Failure to report can have disastrous consequences.

Concord must improve the reporting of all problems, no matter how big or small, and these problems must be addressed.

We must not remain silent.

The public expect us to protect them. And they also expect us to protect the health and wellbeing of staff.

For public servants who are afraid and wish to speak out, there are protections in place that can help. One of those protections is the NSW Public Interest Disclosure Act 1994.

NSW Public Interest Disclosure Act 1994

The NSW Public Interest Disclosure Act 1994 was created with three objectives. The first was to encourage and facilitate the disclosure, in the public interest, of corruption, maladministration, waste, government misinformation and conflicts of interest. The second was to protect people from reprisals that might otherwise have been inflicted on them because of those disclosures. The third was to provide for the disclosure to be properly investigated and dealt with.

The Act illustrates that public service employees who disclose are not necessarily without protection.

If a person takes detrimental action against another person that is substantially in reprisal for the other person making a disclosure under the auspices of the Act that person is guilty of an offence.

That offence carries a maximum penalty of 2 years imprisonment.

Quality Improvement Systems

At Concord we use reporting systems, but these systems have two pivotal failings. The first is we do not report. The second is

We do not appreciate that the reports do not matter as much as the objective and transparent investigative work, the understanding of the problem, and the collaborative work required to resolve a reported problem.

The rapid detection and resolution of safety issues requires a deeply embedded infrastructure of detection, investigation and improvement. It requires significant investment in resources.

We don't have this at Concord, because we have underinvested in quality improvement.

Being unable to adequately address problems in an overburdened system means that genuinely important problems may be overlooked, lost or may take too long to resolve. These problems "slip through the cracks."

Concord's quality improvement system is also based on wrong assumptions. Because our quality system is primarily reactive, usually to serious adverse events, they are based heavily on the assumption of guilt or wrong doing. They can be traumatic for those who are the subject of a report, and for those who make a report. There may be fear of blame. Claims may be unsubstantiated. There may be little evidence to support an assertion. The assumptions may be wrong.

Concord also has a significant problem with training. Members of investigative teams may not have enough training to recognise bias, lack of objectivity, or problems with process. How many staff at Concord have participated and contributed to findings and recommendations in Root Cause Analyses without proper training?

At Concord, reporting may be used for purposes other than quality improvement. Reports can be used for reprisal. They can be used to "cover up". They can be used to intimidate, bully and harass. There may be bias in favour of a predetermined outcome. There may not be enough objectivity to correctly ascertain the facts, or come to the correct conclusion.

Concord has a problem with the way it interprets quality improvement data and "trends". Our systems only detect a small proportion of incidents. Interpreting trends without looking at all the other factors which determine the results can be misleading.

Repeated reports of the same problems may suggest a poor culture of learning. Reduced reports of a problem may indicate that staff have become accustomed to a problem, they have stopped noticing the problem, or they have grown tired of reporting.

This results in organisational "blind spots".
The quality improvement systems at Concord are inadequate. They must be improved.

Focus on minimum standards

Ask any patient whether they want to be treated in a hospital that meets minimum standard, or treated in a hospital that is ranked in the top 10%, and I think you know what the answer will be.

Some organisations have a High Performance Unit.

High Performance Units aim to achieve excellence. They integrate teams of people and encourage innovation, collaboration and evidence-based approach to decision making. These teams have strong leadership, open communication, a strong sense of trust amongst members, and ensure accountability. Staff which perform at a high level need little management oversight because they are empowered and responsible for their work and accountable for their performance.

High Performance Units facilitate people to perform at the best that they can, to achieve the best that they can. And staff have more fun at work because they actually enjoy their work.

At Concord we don't have a High Performance Unit. Instead we have a unit which helps the hospital meet minimum standards.

Problems with training

Only when training is aimed at high performance do we achieve excellence.

Nothing can be starker in its contrast than two education programs that are run at Concord Hospital: Basic Physician Training and Mandatory Training.

Concord Basic Physician Training is a program which aims to achieve excellence. It was set up to help Physician trainees navigate the early years of their training. The Physician trainees at Concord consistently outperform trainees from other hospitals in the FRACP exams. The training program is independently managed by the Physicians, who feel empowered to innovate and improve. There is strong leadership, trust and accountability.

Contrast this with Mandatory Training at Concord. This was established to address minimum standards. But there was no high performance intention to achieve excellence. If there were, there would have been attempts to identify the deficiencies in the management of conditions that required mandatory training in the first place. There would have been the development of comprehensive education programs. There would have been greater engagement from staff. There would have been attempts to evaluate, innovate and improve.

Instead, mandatory training at Concord was set up with the wrong intentions. It was set up as a tick box exercise to satisfy accreditation committees.

Another opportunity to significantly improve healthcare for our community lost.

Perhaps the most damning indictment of how contentment with minimum standards and the failure to aim for excellence has compromised patient care was highlighted in the COVID pandemic.

There were staff who had not learnt the essential skills required to manage simple patients with COVID or pneumonia, or they had become deskilled. There were staff who did not know how to apply or titrate oxygen therapy, and staff who did not know how to give intravenous medications.

We must do better.
We must strive for excellence.

Underinvestment

Over the years I have seen the departure of many talented individuals from Concord. They left from all disciplines – nursing, allied health and medical. Amazing staff who should never have been allowed to leave. Organisations simply cannot afford to lose staff of this high calibre.

Their talents should have been nurtured. Their expertise retained. Their knowledge disseminated. Their drive should have been tapped. Their enthusiasm propagated. Their ideas acknowledged. Their wisdom recognised.

Instead Concord has allowed underinvestment in excellence to be the norm.

Underinvestment in staff. Underinvestment in processes, quality, education, and research. Underinvestment in the very foundations on which we base the care of our patients. This folly must end.

Concord must invest in excellence, and we should be aiming to be in the top 10% of everything that we do.

Intimidation, Bullying and Harassment

Over the years many staff have approached me and told me of their distressing stories of intimidation, bullying and harassment at Concord Hospital. All have requested that I keep their revelations confidential because they fear reprisals.

Their stories are similar, but their problems are not new. Their suffering is not new, and the inability to eradicate this scourge is not new.

The 2021 People Matter Survey showed again that a significant number of staff at Concord had experienced bullying, witnessed bullying, or were aware of misconduct, in the previous 12 months. Some staff had experienced sexual harassment, witnessed sexual harassment, had experienced threats or physical harm, discrimination and racism.

The 2021 Sydney Morning Herald article into junior doctors highlighted the same issues. A large proportion of doctors from Concord in the survey did not believe that the hospital addressed unacceptable workplace behaviour.

Support programs were established to improve mental health, but they are useless without addressing the fundamental issues that allow bullying to foster.

I would like to remind everyone of several landmark events that have happened in NSW over the last few years. We must not forget these events.

These events must spur us to action.

WorkCover NSW Inquiry

In June 2014, the NSW Legislative Council General Purpose Standing Committee gave their findings into Allegations of Bullying in WorkCover NSW. WorkCover was the State Regulator of occupational health and safety. Therefore the inquiry examining the culture of WorkCover was of significant importance because bullying is an occupational health and safety issue.

The Committee noted the "profound personal impact that bullying has on people" and that there was an imperative for "all NSW public sector workplaces to become as safe, effective and productive as possible."

For the inquiry, the Committee noted "the substantial volume of personal accounts received by the committee was very concerning, as was the fact that so many submissions sought confidentiality, largely due to fear of reprisals. More so, the content of submissions was very disturbing, highlighting the profound impact that workplace bullying has on people's mental health, self-worth and job performance."

The Committee was "deeply concerned by evidence that alleged widespread use of punitive processes, poor management practices, authoritarianism amongst senior managers, and denial by senior management that a significant problem of bullying exists within the organisation. The lack of trust between management and staff was very apparent to the committee."

It wrote "We highlight the need for the organisation to abandon its culture of denial and cover up, and to embrace transparency and accountability in order to build trust."

The Commission made many recommendations. A key recommendation was that "the Parliament of NSW enact laws which protect all workers in the state, including injured workers, from workplace bullying."

Public Service Commission Action Plan

Following on from the WorkCover inquiry, in 2016, the Public Service Commission published an Action Plan to support the government sector to act early and strategically on bullying. The NSW Public Service Commissioner gave a commitment to working with the sector and other stakeholders to "fundamentally reshape the way we think about, prevent and manage bullying in the workplace."

The strategies in the action plan included setting standards, addressing prevention and response, providing support, training, conducting monitoring and reporting, promoting transparency, setting expectations, and enforcing WHS requirements.

However, as revealed in events over the next few years, much work remained to be done.

Emergency Services Agencies Inquiry

In July 2018, the NSW Legislative Council Portfolio Committee for Legal Affairs published a report on Emergency Services Agencies in NSW.

The committee examined bullying, harassment and discrimination, as well the as the effectiveness of the protocols and procedures in place to manage and resolve complaints within five emergency services agencies. The agencies were: NSW Rural Fire Service, Fire and Rescue NSW, NSW Police Force, Ambulance Service of NSW, and NSW State Emergency Service.

The key purpose of the inquiry was to give workers a voice. The inquiry received 194 submissions.

The committee was "shocked by the many cases presented to us and by the seriousness of the allegations..." It was "even more disappointing to see that the actions, (or) inactions, of the agencies in investigating and responding to bullying allegations, have in some cases done nothing but cause further angst and trauma."

It was very clear to the committee that many emergency services workers had little confidence in the policies and procedures to manage such complaints.

It was observed that there was a "high level of underreporting" of complaints. It noted that SafeWork NSW had received only 113 requests for service for alleged bullying and harassment across the emergency services agencies in the previous 5 years, which "clearly shows underreporting of complaints to the regulator."

The Committee made many recommendations, but the key recommendation was the establishment an independent, external complaints management oversight body for workplace bullying and harassment and discrimination across all five emergency service agencies.

There are clear problems of bullying and harassment at Concord Hospital. It is clear that the current strategies to mitigate bullying and harassment are not working.

We must change our approach to this problem.

COVID-19

Before I provide you with my agenda for change, I finish this section with a reflection on what I have witnessed over the last 2 years.

In the last two years we have been at war. At war with an invisible enemy. A virus that has laid siege to our healthcare system and our way of life. The fight has been exhausting. Every day the magnificent staff at Concord soldiered on.

But the war took a toll. It took a toll on patients, a toll on families, and a toll on staff.

The nurses were scared. Many were inexperienced, and seconded from other departments. Many had spent little time in an ICU. Many had not nursed a complex ICU patient before. However, all were willing to do their best and work their hardest.

But they were scared that their best would not be good enough. They were scared that any mistake caused by their inexperience could harm the very patients that they had been tasked to protect.

The experienced nurses were just as scared. Their numbers dwindled through redeployments to other parts of the system. Those who remained in the ICU often had an impossible task of dividing their time between managing patients and supervising the inexperienced. Running around putting out spot fires.

They were scared too that their deficiencies in supervising would also lead to patient harm.

The reply from above was that everything was fine. They counted the numbers. There were enough staff.

There appeared to be a lack of understanding of how specialised ICU nursing was. Like building a house without the right tradespeople. The plumber doing the bricklaying. The electrician doing the tiling. The house gets built, but at what cost to quality?

However, what the staff endured was little compared to that endured by the patients. Run over by the COVID bus, now caught in a COVID hell. Isolated from family, suffering alone, and for many, dying alone.

"It was too risky to allow visitors." we were told.
"It was too hard." "We have to obey the ministry."

The problems were exacerbated by poor planning and the failure to look further than the immediate future. The wait and see approach. The staff could see the train wreck coming, but were powerless to stop it and powerless to soften the impact.

During one of the worst weeks, every day that week I witnessed a nurse crying. Sobbing quietly in a corner, or being consoled by a colleague. Traumatised by what they were going through. Uncertain when it would end.

And the truth hidden from the public.
The single greatest failure in healthcare policy of our generation.

The consequences of chronic underinvestment in healthcare laid bare for all who came to the ICU to see. But not the public. The public could not see.

The staff prevented from speaking publically. Prevented from sharing their stories. Prevented from sharing their concerns. Prevented from sharing their pain.

They cannot be silenced anymore.
The sacrifice and suffering of the magnificent staff at Concord during this pandemic must be acknowledged. Their stories must be told and their lessons must be heeded.

The Change

Living with COVID

For months now the public has demanded an end to the harsh public health measures that were implemented because of COVID. They now expect this to happen, and there is an expectation that we will learn to "live with COVID."

There is an expectation that we will "open up" and allow the freedoms that were removed over the last 2 years to be reinstated. And our political leaders have agreed with this populist view.

Whether the health system likes this or not, this is what our community wants, and this what our political leaders have decreed. There is an economic and social imperative for this to happen.

The community expects elective surgery to be back to normal levels, and the backlog fully cleared. They expect our outpatient departments to reopen. They expect patients with ailments other than COVID, who have been neglected over the last two years, to be treated.

They expect all our services to return to fully operational levels. The community expects Concord to return to providing the high level of healthcare that the public have become accustomed to, and significantly improving on this.

These expectations have not diminished.
But for us it also means the concomitant management of patients who continue to be afflicted by COVID-19. These patients did not exist at Concord two years ago.

From a healthcare perspective at Concord, "living with COVID" cannot be achieved with the current levels of resourcing.

"Living with COVID" requires additional resources. It is a folly to expect Concord to deliver on the community's expectations without this.

Our political leaders have not told us that they will be cutting back on healthcare spending. To the contrary, they have spent billions supporting the country during the pandemic.

At Concord, we will soon be operationalising a new hospital building. There was no agreement with the community or staff to spend hundreds of millions of tax-payer dollars on a new hospital, but not maintain hospital operations, and not improve on them.

The staff and departments at Concord must be provided with the additional healthcare resourcing required for the community to "live with COVID".

Our community expects it.
Our staff expect it.
It must happen.

Medical Staff Council Reform

One of the first things we must do is reform the MSC.

The MSC must be independent. The MSC must be incorruptible. The MSC must be free from external influence.

We must be staunch advocates for the public. Our local community has no significant voice in local healthcare decision-making. We must be their voice.

The MSC must stand up for our staff. The staff are the backbone of this hospital. We must protect them.

The MSC must develop a charter to espouse the values that we believe in as a collective. The charter should include the following statements:

- "Act in the best interests of the public."
- "Act to protect the health and wellbeing of staff (and students)."
- "Act to ensure transparency and accountability in governance and decision-making."
- "Act to ensure the community and the staff set the priorities."
- "Encourage and facilitate excellence and innovation."

Priorities

The staff at Concord must set the priorities for Concord.

The needs of the community determines the priorities and the staff act on behalf of the community. We know what healthcare services the community requires. We know best how to deliver these services. We act in the best interests of the public.

We are in the best position to decide the priorities.

The people who manage the hospital finances do not look after patients. We cannot expect them to know what the community expects or requires. Their role is to facilitate the resourcing of the community's healthcare priorities, not to determine them.

We must not allow the state of the finances to set the priorities.

We all have specific priorities for our patients and our services. We all want the best for our individual departments. We all want the best for our patients. We may have priorities that are unique. The MSC must not diminish the individual right to advocate for one's own requirements. This right must remain.

However, the MSC must advocate for those who have a lesser voice. It must advocate for all. We must not play staff and services off against one another. There must not be a battle of "the haves" versus "the have nots".

We must all succeed together.
We must leave no one behind.

The MSC must identify all the priorities, not just a chosen few, and present them to the Concord management to resolve.

It matters not that the priorities are easy or hard, big or small.
They are all still priorities.
There may be hundreds of priorities.
They all must be addressed.

Culture of Denial and Silence

We must rid ourselves of the denial culture at Concord. We must acknowledge that problems exist at Concord, determine the extent of those problems, and take steps to rectify them.

Why? Because these problems can compromise patient care, and these problems can affect the health and wellbeing of staff.

We must no longer stay silent. And silence must not be rewarded.
We cannot shirk our responsibilities.
We must never turn a blind eye to the problems and injustice that beset our patients and staff.

The MSC must lead the way.

Intimidation, Bullying and Harassment

The MSC must help the staff at Concord who have been intimidated, bullied and harassed.

Staff must know how to access good representation and good independent legal advice.

Staff must know how to access specialist industrial lawyers. Experts in managing these problems.

There must be a Parliamentary Inquiry into Bullying and Harassment in NSW Health.

This is long overdue.
The MSC must ensure that this occurs.

NSW Health has not learnt the lessons from the inquiries into six other public organisations: WorkCover NSW, NSW Rural Fire Service, Fire and Rescue NSW, NSW Police Force, Ambulance Service of NSW, and NSW State Emergency Service.

Those in the health service who have been intimidated, bullied or harassed must have a voice.
Those in the health service who have been intimidated, bullied or harassed must be able to tell their stories.

There must be the establishment of an independent, external body that oversees complaints of workplace bullying and harassment at NSW Health.

There must also be legislative changes to protect workers in NSW Health from workplace bullying.
The MSC must engage our political representatives to enact this change.

Anything less is an affront to those who have suffered.

Quality

Concord must act to improve quality.
Concord must engage a better system to rapidly detect and resolve problems.
We must significantly improve our reporting and Concord's reporting systems must be overhauled.
Concord must significantly improve the way we process and analyse the problems which are reported.

This requires significant resources.
There must be a significant injection of resources to improve quality at Concord.

We must no longer be satisfied with just meeting minimum standards. We must improve our standards, not just meet them. We should aim to be in the top 10% for everything that we do.

The underinvestment in excellence must stop. Concord must invest in excellence, for excellence is our future.

The community expects this.

Education

Concord must improve education and training. The underinvestment in human resources and the depletion in skills must end.

Concord's focus must shift from mandatory training to focusing on meaningful education programs that actually address the clinical problems.

Concord must not treat education as a tick box exercise to appease accreditors. The staff must be allowed to determine the education priorities. They must determine the gaps in their learning, and staff must be allowed to develop innovative and relevant education programs. Concord must allow staff to aim for excellence.

Staff must be given quarantined time to learn. We must then evaluate, modify and improve.

The pandemic issues which plagued Concord over the last two years must not occur again. It was a travesty to have insufficient staff numbers during the disaster. However, to have staff with insufficient training was avoidable. That must be remedied.

Given what we have just been through, to now not ensure staff are trained adequately is unacceptable. Concord must resource education properly, and not just make educators work harder. The community expects this.

Research

Research governance at Concord is a currently a quagmire of bureaucracy. This bureaucracy has become a genuine hurdle and disincentive to conducting research on the Concord campus. Research is important because it reinforces critical thinking.

Research governance must be improved. The staff in the research office do their best under trying circumstances. But they are under-resourced and constrained by bureaucracy.

The MSC must ensure all of the research community and research stakeholders are engaged to identify the problems and then develop solutions for these problems. Serious questions must be asked about the suitability of the current electronic research management system.

We must develop a better way to govern research.

Community Input

The MSC must ensure our community has greater engagement with Concord's plans for the future.

The community have had little voice to date to determine Concord's direction and to enact meaningful change.

There must be significantly more consumer engagement. It is their hospital. They must have a say.

Disaster Management

There were aspects of the COVID pandemic which were not managed well at Concord. We had four pandemic waves to get the management right.

There must be an independent transparent local inquiry into the management of this pandemic at Concord Hospital.

The MSC must ensure this happens.

The NSW Legislative Council Public Accountability Committee has overseen the Inquiry into NSW Government's management of the COVID-19 pandemic. There have been 18 hearings since March 2020.

At Concord we have had none.

The MSC must ensure accountability for the decisions made. The community expects this.

We need to find out what we did well and what we did badly. The staff need to debrief. They need to tell their stories. Their lessons need to be heeded so that the problems that occurred are never repeated.

We need to prepare for the next disaster.

Concord must address the staffing issues. Concord must examine all avenues to mitigate future staffing shortages. Staff must have a voice in addressing this problem.

Concord must train an army of "Reservists". The next disaster may not be a virus. It could be natural or it could be man-made.

I finish with a final observation.

History of Concord

Our suburb of Concord was named after the town of Concord, Massachusetts.

The Battle of Concord, in 1775, was one of the first military engagements of the American Revolutionary War.
It heralded the outbreak of armed conflict between the British Empire and its colonies in America.

The battle was in response to changes made to the colonial government by the British parliament. Changes which the Colonials disagreed with. The Colonials formed a Patriot provisional government and local militias prepared for possible hostilities. The British government declared the state to be in rebellion. It was they who attacked first.

The first shot fired by the Patriots was known as the "shot heard around the world." The ensuing battles led to the Declaration of Independence.

Our suburb of Concord was named after its American counterpart in the spirit of trying to encourage harmonious settlement between soldiers and settlers in Sydney.

The word "concorde" in French translates to "harmony, agreement, peace, amity" in English.

Our hospital exists in "concord" with our community.
We serve the community.
We serve the people.
We act in their best interest.

Our hospital should be in "concord" with our staff.
The community expects our healthcare workforce to be competent.
They expect it to be healthy.
They expect it to be happy.
They expect it to be sustainable.

Why?
Because the community expects us to look after them.

We have problems at Concord, the culmination of years of underinvestment and apathy, but they can be overcome.
We must stop saying "it is too hard." We must stop saying "it can't be done."

Our patients expect us to be their voice, and to act on their behalf. It is not too hard. It can be done. We can make it happen.

We must act. The softly, softly approach is merely an excuse for inaction. And the time for inaction has passed.

It is time to reform
our great hospital.
It is time to rebuild
our great hospital.
It is time to change.

And we all must be that change.

We must decide our destiny. We must not let others do this for us.

I have articulated my vision for Concord.
What happens next is up to you.

Yours Sincerely,

Winston Cheung

26 February 2022