Special Commission of Inquiry into Healthcare Funding

Statement of Dr Teresa Anderson AM

Name:	Dr Teresa Anderson AM
Occupation:	Chief Executive, Single Digital Patient Record Implementation Authority

1. This is a statement that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding (**the Inquiry**).

My role

2. I am the Chief Executive of the Single Digital Patient Record Implementation Authority. I was invited to take up this role by the Secretary because of my experience in the area. I commenced in this role on 27 May 2024. I was formerly the Chief Executive (**CE**) of Sydney Local Health District (**SLHD**) from 1 January 2011 until 26 May 2024.

3. I have previously provided the Inquiry with a statement dated 29 January 2024 (**MOH.0001.0258.0001**) in relation to Term of Reference E, including a copy of my CV (**MOH.0001.0438.0001**). This statement does not re-canvas my statement of 29 January 2024, unless necessary to explain the issues outlined below.

Scope

4. This statement addresses the matters raised in the Inquiry's letter dated 19 April 2024 insofar as it relates to Concord Hospital, including:

   a. Adequacy of current mechanisms for resolving complaints and concerns;

   b. Adequacy and suitability of external processes;

   c. Processes for consulting staff about major changes and evaluating the impact of major changes; and

   d. Evidence based approaches to policy and process implementation.

5. This statement also responds to matters raised in relation to Concord Hospital in the statements of Associate Professor Lloyd Ridley dated 14 July 2024, Duane Findley dated 15 July 2024 and Associate Clinical Professor Winston Cheung dated 16 July 2024. Where matters raised in the abovementioned statements are not directly addressed, this does not constitute my agreement with how they have been characterised.

A. CONCORD HOSPITAL'S ORGANISATIONAL STRUCTURE AND ADEQUACY OF MECHANISMS FOR RESOLVING COMPLAINTS AND CONCERNS

Organisational structure

6. Concord Repatriation General Hospital (**Concord Hospital**) is one of five hospitals that sits within SLHD. It is a 452-bed principal referral group A1 hospital employing over 2,800 staff (over 2,300 Full-time Equivalent (**FTE**)) and serving Canada Bay Local Government Area and surrounding areas for local services, and state or metropolitan catchments for its tertiary and quaternary services. Concord Hospital's clinical services are provided across more than 90 departments and wards and reflect its status as a principal referral hospital, with most services being delineated as level 5 or 6. Concord Hospital does not offer maternity or paediatric services.

7. Stage 1 of the Redevelopment of Concord Hospital was completed in January 2022 in partnership between Health Infrastructure NSW and SLHD at a cost of approximately $341 million. The Redevelopment was fast tracked to support the state's pandemic response and dedicated wards were opened in September 2021 to provide care for patients with COVID-19. Clinical services planning for the proposed Stage 2 Redevelopment of Concord Hospital commenced in 2019 and has continued to be updated annually in line with NSW Health requirements. Stage 2 is a priority on the SLHD's Capital Asset Strategic Plan.

8. Concord Hospital operates in accordance with the *Concord Hospital Strategic Plan 2019 – 2024* and the SLHD *Corporate Governance Plan 2023*, which incorporates the requirements of the *NSW Health Corporate Governance and Accountability Compendium 2020*.

9. The SLHD Board oversees the performance of SLHD and as the Chief Executive of SLHD I was accountable to the Board for the proper functioning of SLHD. The Board is governed by the *Health Services Act 1997* (**Act**) and structured into sub-committees, in accordance with SLHD Model By-laws (**MOH.0010.0025.0001**), which reflect the Model By-Laws which are made under the Act.

10. The SLHD Medical Staff Executive Council (**MSEC**) is established under the SLHD Model By-Laws. Membership includes the Chief Executive, the SLHD Director of Medical Services, Clinical Governance and Risk and the Chairs of each of the Facility Medical Staff Councils (**MSC**). The purpose of the Medical Staff Executive Council is to provide advice to the Chief Executive and Board on matters concerning medical staff with the Chairs of the MSCs being the conduit for information from broader membership of the MSCs. Two members of the Board attend The Medical Staff Executive Council as invitees to enable direct communication with the Board.

Complaint management and workforce

11. All staff play an important role in contributing to a positive workplace culture by working in a professional and productive manner.

12. When issues arise, policies and guidance are available to help staff through appropriate resolution.

13. NSW Health has a policy framework for managing complaints depending on the nature and circumstances of the matter. More than one policy may apply to a particular complaint and all complaints are required to be managed in accordance with the relevant legislation and Policy Directive.

14. As set out in the NSW Health Complaints Management Policy Directive (PD2020_013) (MOH.9999.0837.0001), effective complaint management is underpinned by the following principles:

    a. Respectful treatment;

    b. Information and accessibility;

    c. Good communication;

    d. Taking ownership;

    e. Timeliness;

    f. Transparency, and

    g. Respective confidentiality and privacy.

15. Managers have responsibility to create a positive culture within their teams and to identify, respond to and promptly address issues when they arise.

16. Staff have a range of avenues to raise complaints or concerns. They are able to do this both informally and formally.

17. Internally, staff are able to raise concerns or complaints through their team leaders and managers, through the local Workforce team, through the Facility or SLHD Executive, through the Clinical Stream Executive, through Internal Audit, through the Ministry of Health's Workforce Branch and through NSW Health.

18. Externally, staff are also able to raise concerns directly with the NSW Health Care Complaints Commission (**HCCC**) or the NSW Ombudsman.

19. Where staff raise concerns that are assessed as a Protected Interest Disclosure (**PID**) in accordance with the *Protected Interest Disclosures Act 2002*, the matter will be managed in accordance with the requirements of the Act.

20. Staff are able to raise concerns in relation to workplace or clinical issues through their Union representatives.

21. There is a regular meeting of the unions and facility executive – Facility Staff Consultative Committee (**SCC**) - and a regular meeting of the unions and SLHD Executive – the SLHD Joint Consultative Committee (**SLHD JCC**).

22. NSW Health has established a Junior Medical Officer (**JMO**) support line which was developed to provide specialised, confidential support to all JMOs. It was established in response to evidence of junior medical staff experiencing difficult and unacceptable behaviours and, in some instances, bullying and harassment during their training.

23. NSW Health has a portal which is available to all staff on Addressing Grievances and Concerns. The link to the website is front and centre on the SLHD Workforce Home page.

24. The Addressing Grievances and Concerns website (otherwise known as the Manager's and Staff Portals) has tools, information and advice to help staff and managers deal with grievances when they arise at work. It is not a website for lodging grievances.

25. The Manager's Portal is to support managers. It provides managers with resources such as processes, flowcharts and templates to help them deal with complaints and concerns as soon as they arise, including straightforward matters and those of a more complex and serious nature. By having the confidence to act early and by understanding what they can do, managers can prevent issues from escalating and causing unnecessary distress and disruption to their staff.

26. The Staff Portal aims to support Staff (complainants) with hands-on resources, tip sheets, processes, and tools to encourage them to resolve grievances themselves directly with other staff. It encourages them to act early to avoid issues escalating into serious matters. It also shows them how to participate in the process when an issue has been escalated to the manager for assistance. It tells them the benefits and importance of dealing with the matter as early as possible to prevent further impact and disruption in the workplace.

27. Staff can also seek advice through the NSW Health Antibullying Advice line which is hosted by HealthShare NSW and is at arms length to the Local Health Districts. The advice provided is of a general nature on how to raise concerns and the applicable policies and processes.

28. Staff are encouraged to raise any concerns with their manager where it is practical to do so or through key personnel within their organisation in the first instance.

29. Non-clinical workforce complaint management and other workforce issues are dealt with through the Workforce Structure at District and Facility level. Concord Hospital has 1 FTE Workforce Manager, 1 FTE Deputy Workforce Manager and 7 FTE workforce advisors who are embedded in the Facility and support Concord Hospital staff with a range of human resources functions, including grievance and complaint handing and dispute resolution. The Workforce team report to the SLHD's Deputy Director and Legal Counsel Workforce, who in turn reports to the SLHD Executive Director of Workforce and Corporate Operations. The Workforce team work closely with the General Manager of Concord Hospital.

30. Relevant to clinical complaints management, the *Concord Hospital Clinical Governance Framework 2021* (**MOH.0010.0024.0001**) sets out the clinical governance structure, clinical complaints processes and links to policy, the use of the NSW Health incident management system (IMS+), the expected culture of reporting, and the process of investigation and management of clinical incidents and complaints.

31. Often clinical complaints will involve a non-clinical workforce aspect or a workplace grievance may give rise to a clinical concern. Complaints crossing differing areas are jointly managed between Workforce staff and the facility level Clinical Governance and Risk Unit (**CGRU**) and, if escalation is required, by the SLHD level Workforce Team and SLHD level Clinical Governance and Risk Unit (**CGRU**).

32. Concord Hospital's Clinical Council (**CC**) and Governance, Leadership and Culture Committee (**GLCC**) are the two peak committees that provide oversight of all safety and quality planning processes across all services within Concord Hospital. They are intended to promote clinician engagement in local management and clinical decision making, including safety and quality planning processes. The CC is co-chaired by the General Manager and Executive Clinical Director of Concord Hospital with a large membership including clinical directors and managers, senior executives and clinicians. A consumer, as well as a representative from the Primary Health Network attend as invitees. It reports to the SLHD Clinical Quality Council. The GLCC is co-chaired by Concord Hospital's General Manager and Head of the Cardiology Department, with membership including clinicians and senior executives.

33. Each Hospital within SLHD has a clinical governance team with an identified position for clinical complaint management. Concord Hospital has a 1 FTE Patient and Experience Officer who oversees feedback and complaint management, reporting to the Director of Clinical Governance and Risk and through to the General Manager. There is a Clinical Governance Unit at the facility level, with the 4 – 6 weekly Concord Reporting and Accountability Meetings and the 4 weekly Heads of Department Circle important features of the management of clinical concerns. There is an escalation pathway from the Concord Hospital Clinical Governance Unit through to the SLHD level Clinical Governance and Risk Unit, led by the SLHD Director of Medical Services, Clinical Governance and Risk.

Overview of mechanisms for resolving complaints and concerns

34. SLHD's mechanisms for resolving complaints and concerns, which operate at Concord Hospital, are reflective of the mechanisms that exist across NSW Health. The use of a particular mechanism depends upon the nature of the complaint, whether clinical or non-clinical, the seriousness of the complaint and the context in which it arose.

35. The approach underpinning the complaints management and dispute resolution processes is to try to resolve disputes early, locally and quickly before they escalate; with the aim of provide clear mechanisms for escalation where required, ensuring procedural fairness and maintaining the confidentiality of all parties as per NSW Health Policy

Complaints received directly to the SLHD or local complaints

36. Where complaints are directly received at local or district level, SLHD is required to manage them in compliance with NSW Health *Complaints Management* Policy Directive PD2020_013 (**MOH.9999.0837.0001**) and NSW Health *Complaint Management Guidelines* GL2020_008 (**MOH.9999.0838.0001**). There are a suite of other policies which are related to particular types of grievances or conduct.

37. Clinical complaints are usually initially managed by the Concord Hospital Clinical Governance Unit, in accordance with the following policies:

    a. NSW Health PD2005_608 *Patient Safety and Clinical Quality Program* (**MOH.9999.0802.0001**) (replaced by PD2024_010 *Clinical Governance in NSW*) (**MOH.9999.0835.0001**));

    b. NSW Health PD2023_034 *Open Disclosure Policy* (**MOH.9999.0927.0001**);

    c. NSW Health PD2020_047 *Incident Management* (**MOH.9999.0803.0001**);

    d. NSW Health PD2013_009 *Safety Alert Broadcast System Policy Directive (replaced by PD2024_016 System-level patient safety risks: Response co-ordination and communication)*, and

    e. *NSW Health PD2018_032 Managing Complaints and Concerns about Clinicians* (**MOH.9999.0933.0001**).

38. All complaints received are expected to be recorded by staff in IMS+ which is a statewide incident management system.

39. Complaints are managed in accordance with a tiered approach: Ward/clinic level; Facility level; and District level.

40. The general approach is that complaints should be managed early and 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. Each site has a dedicated workforce resource to also provide support.

41. Complaints can also be escalated to the district level for review and investigation.

42. SLHD CGU manages clinical 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 HCCC or the NSW Ombudsman.

43. Compliance with the *Complaints Management* Policy Directive and process is monitored via Facility level and District level Clinical Governance and Risk Units and the SLHD Workforce and Corporate Operations Unit. This is achieved via monitoring and auditing of IMS+: Monthly complaint management through KPI reporting to the SLHD Performance Unit and to the SLHD Executive, Facility Clinical Councils, SLHD Clinical Quality Council (**CQC**) Monthly Patient Feedback Report, CQC Quarterly KPI and Patient Feedback Report to the SLHD Board and daily IMS+ surveillance reports to SLHD Executive management.

Complaints received from Members of Parliament or Ministerial complaints

44. SLHD has a centralised point of coordination for all Ministerial complaints - the Executive Support Unit (**ESU**). ESU receives all Ministerial complaints and establishes a corporate record of the complaint, allocates the complaint to the relevant SLHD Facility or Service based on the nature of the complaint, and circulates the complaint to the relevant SLHD Executives, Facility or Service General Manager, and both Facility and SLHD level Clinical Governance and Risk Units for review and assessment.

45. Documentation occurs in IMS+ and also in the corporate records via the drafting of the response. Ministerial responses are commonly in the form of Ministerial Briefs and an accompanying response letter or 'dot point advice' which is sent in an email. Both response formats require SLHD Executive approval. The facility General Manager approves the response and forwards it to ESU who oversees the review and approval of the response via the SLHD Executive.

Complaints received from the Health Care Complaints Commission (HCCC)

46. SLHD has a centralised point of coordination for all HCCC complaints, via the SLHD Clinical Governance and Risk Unit and this is overseen by the Director of Patient and Family Experience and the SLHD Patient and Family Experience Manager (**PFEM**).

47. The PFEM allocates the complaint to the relevant SLHD Facility or Service for investigation, management and drafting of the response based on the nature of the complaint and circulates the complaint to the relevant SLHD Executives, Facility or Service General Manager, Facility Clinical Governance and Risk Unit and the SLHD Clinical Governance and Risk Unit for oversight.

48. Investigation, management and drafting of the response sits with the Facility that the complaint was allocated to. The response incorporates an internal briefing note to the CE which documents the investigation conducted and findings, and a response letter to the HCCC. The Facility drafts the response which is reviewed by the SLHD PFEM and Director of Patient Family Experience, prior to Executive sign off.

49. The Facility General Manager approves the final response and forwards it to the SLHD PFEM who oversees the approval of the response via the SLHD Executive. Further monitoring and auditing of HCCC complaints is achieved by the SLHD Clinical Governance & Risk Units, daily IMS+ surveillance and monthly Patient Feedback Report to the CQC.

Complaints received via the NSW Ombudsman

50. On occasion, complaints will be received by the NSW Ombudsman. These are managed by the same process as a Ministerial complaint. As these matters are uncommon and often related to process and policy, the Director of Patient and Family Experience will support the Facility with the response and review the response prior to it proceeding to the General Manager and SLHD Executive for approval.

Adequacy of the current structure and mechanisms

51. In my view the structure for management of complaints or concerns is robust and appropriately balances a focus on early self-resolution to minimise the need for escalation against clear processes where escalation is required. It provides staff and patients with a range of mechanisms to raise a concern should they feel uncomfortable to raise their concerns through the normal management structures.

52. There is a consistent approach across NSW Health and a well-developed suite of policy and guidelines to assist staff and managers. At SLHD this is supported by embedded Workforce Managers at facility level to provide local assistance and escalation if required.

53. SLHD has a *Staff Accountability Framework* (**MOH.0010.0007.0001**) and a *Management Accountability Framework* (**MOH.0010.0008.0001**) which outlines responsibilities including management of complaints.

54. Orientation of all staff within SLHD includes Complaint Management Processes and the Union representatives attend and provide information.

55. There is also training available to staff on complaint management and resolution, through SLHD Sydney Education and the Health Education and Training Institute (**HETI**).

56. The following HETI Courses are available through MyHealthLearning for all NSW Health staff. *Promoting Acceptable Behaviour* is mandatory for all NSW Health Staff. Other courses available to staff include:

    a. Managing Grievance Early;

    b. Managing Grievance Early – Managers;

    c. Manage Grievance Early – all staff;

    d. Introduction to Managing Difficult Conversations;

    e. Managing Difficult Conversations: Part 2 De-escalation strategies and supporting through change, and

    f. Promoting Acceptable Behaviour in the Workplace (Mandatory for everyone).

B. EXTERNAL PROCESSES

57. Although the approach to complaints management is to attempt early and local resolution, this is not always possible and sometimes complaint processes have been exhausted and the complainant or the subject of the complaint, or both, remains dissatisfied. Where this occurs across multiple complaints within a department or where there appears to be a broad cultural problem, there can be benefit in involving an external facilitator.

58. An example relates to the Emergency Department at Concord Hospital (**ED**). In January 2018 the General Manager of Concord Hospital escalated concerns to me raised by clinicians within the ED in relation to the behaviour of staff toward each other and toward junior medical staff.

59. In April 2018, following discussion with me, the then General Manager of Concord Hospital commissioned an external review of the ED. The review was undertaken by a team from Alfred Health, a tertiary/quaternary hospital in Melbourne. The reviewers were the Acting Clinical Service Director Emergency and Acute Medicine and the Director of the Sandringham Emergency Department/Deputy Director Emergency Medicine Alfred Health.

60. The review was undertaken over a three day period in April 2018 and focused on reviewing the current model of care, workforce and management and governance.

61. The Concord Hospital Executive accepted 11 of the 14 recommendations with the remaining recommendations not considered suitable for implementation at Concord Hospital. Subsequent to the completion of the review, an implementation steering committee was formed to oversee the implementation of the recommendations.

62. One of recommendations of the review was to undertake a Workplace Culture Project once a permanent Head of Department was appointed. Mr Richard Jones, an independent External Consultant, was commissioned in December 2018 to work with the ED. Mr Jones worked with the staff within the ED through 2019.

63. There was ongoing disharmony within the ED and in July 2020, following communication with the Australian Salaried Medical Officers' Federation (**ASMOF**) and in consultation with NSW Health, ECI Partners (an external executive coaching and leadership organisation with extensive experience and proven track record of working with teams) was engaged to work with the senior medical staff within the ED. Mr David Gwynne and

Ms Prasuna Reddy worked with the senior medical staff to gain an understanding of the issues being experienced within the ED and to facilitate a process to lead to changes in behaviour that would positively impact on the desired culture and values to improve performance outcomes. A report was provided in April 2021 and the recommendations accepted and implemented.

64. Although this process of independent external consultant support to the ED provided some reassurance to staff that their concerns were being listened to and actioned; others remained concerned as they had not been involved in the selection of the external consultants and therefore were not happy with the outcomes.

65. The appointment of a new Head of Department has led to the development of a more positive workplace culture.

66. In about June 2023 there was a No Confidence vote in the Chief Executive by the Concord Hospital MSC which is discussed below. Following this vote, the Ministry of Health (**MOH**) appointed ProActive ReSolutions to undertake a similar "restorative" process and develop an action plan.

C. CONSULTATION

67. There are a number of different contexts in which staff would be consulted about change and invited to provide feedback of changes that would attract this type of consultation.

Industrial Consultative Arrangements

68. NSW Health's Policy Directive' PD20204_001 *Industrial Consultive Arrangements* applies to Concord Hospital and SLHD. The Policy Directive sets out procedures for consultation on a range of matters affecting employees throughout NSW Health. The Policy requires that meetings occur between the following committees:

    a. Peak Health Industrial Consultative Committee (**PHICC**) operates to facilitate communication between NSW Health and several unions on major state-wide issues and reforms. Meetings are held quarterly and may be increased when required.

    b. Joint Consultative Committee (**JCC**) operates to facilitate communication between the Health Service and health unions on issues including organisational changes, policy implementation and general issues that will impact employees. Meetings are held at least quarterly and may be increased when required. The SLHD JCC occurs

on a two monthly basis and is attended by the Chief Executive of SLHD and other members of the Executive.

c. Staff Consultative Committee (**SCC**) operates as a forum to facilitate consultation and discussion between management, unions and employees at health facilities. A SCC discusses organisational issues, issues that have an impact on employees at the health facility, policy implementation and issues including award/agreement conditions and issues. If a matter remains unresolved at a SCC, it may be referred to the JCC. At Concord Hospital meetings are held at least quarterly and may be increased when required.

d. Union Specific Consultative Committee (**USCC**) are union specific and are forums for consultation between management of a particular Health Service and the particular union. USCC's are convened where significant reforms will have a major impact on the employees covered by a specific union. Topics for discussion include organisational issues, issues that impact the employees of the health service and policy implementation. Meetings are held quarterly and may be increased when required.

69. An example is that the Health Services Union (**HSU**) recently raised concerns regarding the workload of Concord Hospital's cleaner/portering staff, specifically that staff were being asked to cover more than one area and there were staff shortages impacting the workload demand. Concord Hospital's Executive and Workforce Services representatives agreed to meet with the HSU representatives and Concord Hospital staff to hear their concerns. The HSU raised that staff were feeling pressure to undertake an unreasonable workload during periods of staff shortages by covering more than one area. The HSU also argued that there were 16 FTE of vacancies in the department that contributed to the workforce shortages experienced. The Concord Hospital Executive agreed to review the concerns raised by the staff. Further meetings were scheduled with the HSU and staff representatives to provide feedback on the review and work together to address the concerns raised.

70. The review identified that the number of FTE for cleaning staff had remained consistent over the last two years and that recruitment to vacant positions continued to occur. Further, it found that there are times that staff will be asked to cover more than one area during periods of staff shortage due to unplanned leave or while vacant positions are filled.

71. It was agreed to recruit eight FTE of cleaner/portering staff to meet workload demands and that during periods of staff shortages to provide clear communication with staff regarding the priorities for cleaning when covering more than one area to prevent staff taking on an unreasonable workload. It was also agreed that the Concord Hospital Executive, Workforce Services and the HSU would meet fortnightly to monitor the progress in the implementation of the agreed actions.

Clinical service and capital planning

72. There is extensive consultation undertaken in the preparation of clinical services plans and the development of capital plans. The Concord Hospital Stage 1 Redevelopment and the proposed Stage 2 Redevelopment have involved extensive consultation processes.

Additional Consultation Processes in SLHD and Concord Hospital

73. SLHD and each of its facilities has a wide range of structures and processes that facilitate consultation with staff in relation to but not limited clinical services provision, implementation of new policies or processes, procurement, capital works, implementation of new technologies, quality and safety matters and work place health and safety etc.

74. These include departmental meetings, facility and district committees which have representation of staff from many different parts of the organisation, focus groups, and working parties.

75. A recent example of the consultation processes utilised at Concord Hospital was that there was a need to review the service model of the Gynaecology Service due to challenges in recruiting and retaining the medical trainee workforce which also impacted on the senior gynaecologists. Concord Hospital is not an accredited training site for gynaecologists as it does not have an obstetric service and due to the number and complexity of gynaecology patients treated by the service.

76. Unaccredited trainees prefer to work at facilities that will provide them the best opportunity to develop the required experience to be accepted onto the gynaecology training program. Therefore, the poor retention and difficulty in recruiting unaccredited trainees created workforce challenges for the sustainability of the service.

77. A series of consultation meetings occurred in August 2023 with key stakeholders such as the Head of Department for Urology, SLHD Clinical Director Women's Health, Neonatology and Paediatrics, Head of Department Gynaecology, Chair of the Division of Surgery, Director of Surgery and the SLHD Clinical Director Cancer Services to review the current workforce challenges and identify service model options for a sustainable service. Consultation also occurred through the monthly Concord Hospital Division of Surgery meetings.

78. A model of care was developed that did not rely on having an unaccredited trainee workforce to support the service demand. Once the model was developed, further consultation occurred with the Division of Surgery prior to the implementation of the new model. Although it is recognised that this is not an ideal outcome, the safe care of patients has remained the priority.

D. EVIDENCE BASED APPROACHES TO POLICY AND IMPLEMENTATION PROCESS

79. Evidenced based policy making and implementation processes go through four basic stages:

    a. a diagnostic stage to determine what the problem is, its size and scale and the reason that it is happening;

    b. a planning stage to determine what is needed to address the problem or opportunity);

    c. an implementation stage where work is rolled out, and

    d. an outcome or evaluation stage where the impact of the policy and program is evaluated.

80. To do this effectively requires consultation with stake holders which include staff, patients, families and partner organisations depending on what the problem is that we are trying to address. The evidence comes from different forms and from a variety of sources. It can include, for example: activity data, quality and safety data including ims reports, clinical outcome data, and statistical data from surveys, censuses, administrative data eg activity data. An example of this is the implementation of the electronic medication management program which was initially trialled in SLHD at Concord Hospital and the Sydney Childrens Hospital at Westmead in partnership with a vendor. This has subsequently been rolled out across all hospitals in NSW Health.

Benefits realisation analysis has been undertaken and this work and that of the EMR connect program has put NSW Health in the position that it can now look to implement the single digital patient record across the whole of NSW Health.

81. I understand that Dr Pam Garrett, Director of Planning, will address in detail the process of evidence based clinical service and capital planning and the partnership with Health Infrastructure NSW. SLHD utilises a broad range of data provided by the Ministry of Health and the Agency for Clinical Innovation, and general population and demographics data to prepare detailed population health needs studies which underpin how we deliver services and plan services for the future.

E. CONCERNS EXPRESSED BY THE RADIOLOGY DEPARTMENT

Procurement of Imaging Equipment at Concord Hospital

82. NSW Health has developed supplier panels for the procurement of major medical equipment with state level clinical input to ensure LHDs meet NSW Health policy and to reduce the administrative burden on local clinicians.

83. On 18 November 2016, in response to a brief requesting procurement of a second MRI machine for Concord Hospital (**MOH.0010.0404.0001**), I approved the development of a business case to be prepared by the Radiology Department with the support of the facility executive for provision to MOH.

84. There was an extended delay in the Radiology Department providing the relevant information for the finalisation of the business case which was further impacted by Covid-19 and considerations of whether the MRI machine should wait until Stage 2 of the Concord Hospital redevelopment because of the space constraints within the Radiology Department. Ultimately, the Clinical Director of Medical Imaging Services stepped in to assist with the preparation of the business case.

85. The business case was completed in April 2023. The procurement of the machine was approved by MOH in late August 2023 and a purchase order was subsequently raised for the machine, following discussion between the Clinical Director for Imaging and the Acting Head of the Radiology Department. The machine selected was a Siemens machine from the panel because the Department already had a Siemens machine which meant that the Department would only have to deal with one vendor. I was not involved in the process and did not have any discussions with vendors.

86. My understanding is that the Radiology Department expressed displeasure with this decision to John McDonald, the Chief Executive Officer of ProActive ReSolutions, during the period when ProActive ReSolutions was undertaking its review at Concord Hospital. Mr McDonald advised me that there would be greater disharmony with the Radiology Department if the order of the second MRI machine was not cancelled. I discussed this with MOH and then cancelled the order. SLHD subsequently went through a procurement process led by HealthShare which involved clinicians from the Radiology Department. This resulted in the same equipment being selected by the tender review committee.

87. On 21 September 2023 as part of the ProActive ReSolutions process, I had a meeting with Mr McDonald and the Radiology Department to discuss the department's ongoing concerns, which included staffing, remuneration, the procurement of equipment and a recent Public Interest Disclosure (addressed further below).

88. A second ProActive ReSolutions meeting was held on 29 February 2024 to discuss progress that had been made in relation to the issues raised in the first meeting. At this meeting, the procurement of the second MRI machine was discussed. I explained the procurement process and the department expressed their support for proceeding with the second MRI machine with the exception of A/Prof Ridley who considered that there was insufficient consultation. I understand that A/Prof Ridley's discontent was reported back to the MSC in a way that created the impression that the entire department was unhappy.

89. A copy of the notes of this meeting is exhibited to this statement (**MOH.0010.0405.0001**). On 1 March 2024, Mr McDonald sent me an email (**MOH.0010.0406.0001**) following the meeting noting that it was positive and invited me to amend the notes. I did not do so because they had already been circulated and I did not feel it would assist.

90. Whilst processes were underway for the procurement of the second MRI machine, I received letters from the local member and parliamentary notes asking what was being done about the issue.

Recruitment challenges

91. It is recognised that nationally there are challenges in recruitment of radiologists to both public and private hospitals. SLHD has faced difficulty recruiting radiologists despite significant efforts. Members of the Radiology Department at Concord Hospital raised concerns that recruitment difficulties at Concord Hospital were due to the culture of the

hospital, issues of remuneration and workload, and the lack of imaging equipment. I was also advised that there was a concern about the potential impact of recruitment of additional staff specialist FTE on radiologists' income from Rights of Private Practice.

92. Due to a shortage of interventional radiologists, Concord Hospital decreased its onsite after-hours interventional radiology service. An arrangement was put in place for all urgent patients to be transferred to Royal Prince Alfred Hospital for interventional radiology. Relevant consultants from Concord Hospital were able to access and view images before receiving a formal report from a radiologist.

93. To address the radiology backlog, a large amount of diagnostic radiology was outsourced from late September 2023, following significant work to integrate the information systems of SLHD and the external provider. This outsourcing is consistent with the approach adopted by a number of other hospitals and LHDs.

Non-standard arrangement

94. Major challenges arising from the Covid-19 pandemic led to SLHD agreeing, on 3 August 2021, to top up the CRGH Radiology Department Rights of Private Practice No.01 Account Maximum Drawing Entitlement. This was a temporary non-standard arrangement with the radiologists at Concord Hospital to address the fact that their billings were impacted by the outsourcing of all elective surgery.

95. Following discussions with MOH about non-standard arrangements and the necessary approval processes after the Covid-19 pandemic, SLHD determined not to extend the non-standard arrangement for radiologists at Concord Hospital. These discussions were led at the local level by the Director of Medical Services and General Manager at Concord Hospital. The arrangement ceased on 30 June 2022.

Imaging backlog

96. The backlog of images at Concord Hospital during and after the Covid-19 pandemic decreased from 7362 unreported x-rays as of 2 July 2021 to 2472 unreported x-rays as of 8 July 2022. The backlog began to increase in the second half of 2022, rising to 22,404 unreported x-rays by 9 December 2022.

97. In his statement to the Inquiry dated 14 July 2024, A/Prof Ridley stated that in late 2022 he was doing twice the benchmark workload of radiologists at a lower rate than radiologists at other public hospitals. While I have no data that would permit me to comment on A/Prof Ridley's personal circumstances, the data provided by Concord Hospital indicated to me at the time that the Radiology Department was not working above its benchmark by reference to the average number of images reported per radiologist. I referred to this data in my correspondence, regarding ratio of images to radiologists with the College, on 30 January 2024 (**MOH.0014.0002.0001**).

98. On 21 October 2022, while I was on leave, a complaint was made and determined by the SLHD Internal Audit Team to be a Public Interest Disclosure (**PID**). On my return from leave on 13 November, the SLHD Internal Audit Team advised that they were investigating the PID, which alleged that radiology staff were not attending work or reporting on imaging. The Internal Audit Team ultimately concluded, in February 2023, that the complaint could not be substantiated but made a series of recommendations which included further capturing of data on activity.

99. On 11 April 2023, I attended a meeting with A/Prof Ridley to discuss his concerns in relation to the Radiology Department. I have reviewed [34] of A/Prof Ridley's statement of 14 July 2024 and do not concur with his characterisation of that discussion. I raised the need to improve culture in the Concord Hospital radiology department, but did so in the context of a discussion about a collaborative approach.

100. On 17 April 2023, I sent a letter to A/Prof Ridley in relation to the discussion on 11 April 2023 (**SCI.0012.0064.0001**).

ASMOF

101. On 2 September 2019, Dr Wallace and Dr Kash De Silva, Director of Medical Services at Concord Hospital, received correspondence from Dr Tom Karplus, Secretary of ASMOF on behalf of junior and senior medical radiologists employed at Concord Hospital regarding their concerns for their health, safety and wellbeing as a result of significantly increased workloads (**MOH.0010.0397.0001**).

Accreditation

102. A site accreditation assessment was conducted at Concord Hospital on 7 November 2019 by the Royal Australian & New Zealand College of Radiologists (**RANZCR)** (**'the College'**). Concord Hospital was subsequently downgraded to a Level C accreditation status. Recommendations to rectify inadequacies at the site included an additional 5 FTE, rostering safe working hours, improving feedback on reports, developing a risk management plan to address high clinical workload, consultant/trainee wellbeing and access to education. The site was upgraded to a Level B on the completion of the final progress report in 2020.

103. A new site accreditation assessment of Concord Hospital was conducted on 14 September 2023 as part of the 5 year review process.

104. On the same day, I attended a meeting with representatives from the College alongside Dr Andrew Hallahan and Joseph Jewitt. This meeting was unusually adversarial and of a nature which I have never experienced with a medical college. Comments were made at this meeting in relation to remuneration of clinicians which does not fall within the remit of a training college.

105. On 24 November 2022, I wrote to RANZCR advising of arrangements put in place at Concord Hospital to provide on-site support to radiology trainees (**MOH.0014.0006.0001**).

106. On 12 December 2023, based on the site visit on 14 September 2023, Concord Hospital was subsequently downgraded to a Level D accreditation status (**SCI.0012.0061.0001**). The Site Accreditation Assessment Final Report (**SCI.0012.0059.0001**) identified issues including Senior Medical Officer (**SMO**)/Clinical Supervisor workforce shortage, high clinical workloads and clinical staff wellbeing. It identified a significant root cause for SMO losses being dysfunctional communication between the hospital and LHD executive and the Radiology Department.

107. On 8 January 2024, I wrote to RANZCR requesting a meeting (**MOH.0014.0005.0001**). On 16 January 2024, I met with the College to discuss the LHD's concerns with the report. It was a positive meeting and we agreed that the LHD would work with the College to improve the training environment at Concord Hospital. Following that meeting, I sent a letter to the College on 30 January 2024 (**MOH.0014.0002.0001**) to confirm this discussion. The College responded on 21 February 2024 (**MOH.0005.0172.0001**). In this

letter, the College did not take issue with my description of what had been agreed at our meeting in January.

108. On 8 March 2024 (**MOH.0010.0408.0001**) the hospital produced a 3 month progress report which included all the progress made on the recommendations made by the hospital.

109. On 8 May 2024, having not received a response to the report, I sent a letter to the College suggesting a meeting with MOH to discuss any ongoing concerns (**MOH.0014.0021.0001**).

110. The College responded on 20 June 2024 (**SCI.0012.0173.0001**) stating that 10 out of 14 recommendations have been met and commending the site for its progress. The letter stated that consideration for a change in accreditation status will be made upon receipt of the site's next progress update.

111. I refer to paragraph 180 of Duane Findley's statement dated 15 July 2024, where it is stated that my letter of 8 May 2024 misrepresented RANZCR's offer made at the January meeting. I stand by my recollection of the meeting as documented in my letter of 30 January 2024.

F. CONCERNS EXPRESSED BY THE MEDICAL STAFF COUNCIL

Issues during A/Prof Cheung's tenure as Chair of the MSC

112. The MSC is an important governance mechanism at any hospital. However, it is only one of the mechanisms by which consultation can occur and be factored into decision-making. Management of a large and complex LHD with multiple demands, particularly during and following the COVID-19 pandemic, and the requirement to be consistent with NSW Health policy makes it difficult to adhere to all the demands of the workforce.

113. From about March 2022, when A/Prof Cheung ran for Chair of the MSC of Concord Hospital, I perceived an increasingly adversarial approach on the part of the MSC in its dealings with the facility and LHD executive. A/Prof Cheung was voted in as Chair on 10 March 2022. In particular, the following matters stand out as reflecting this change in approach:

    a. The document entitled 'Why there must be change at Concord Hospital' dated 27 February 2022, which was disseminated by A/Prof Cheung on 2 March 2022 in

the lead-up to his election as Chair of the MSC setting out his election platform. A copy of this document is exhibited to this statement (**MOH.0010.0393.0001**) (**Nomination Document**").

b. The draft MSC Terms of Reference (**TOR**) drafted by A/Prof Cheung, which envisaged an alternate governance structure under the auspices of the MSC.

c. The re-ventilation of resolved and confidential workforce complaint management matters in MSC meetings.

d. The use of the MSC to pass a vote of No Confidence against me as Chief Executive.

114. In the Nomination Document, A/Prof Cheung made a number of factually incorrect assertions or assertions unsupported by evidence, for example suggesting that:

a. The MDOK wellbeing program Director was actively discouraged from addressing industrial issues [p2];

b. Less than 1% of clinical incidents at Concord Hospital are reported [p4], and

c. Inexperienced nurses were placed in the ICU during COVID (without acknowledging the minimum advanced lifesaving training requirement set for staff assisting in the ICU) [p7].

115. The Nomination Document made broad assertions of bullying, intimidation and a culture of reprisal at Concord Hospital, but gave no specific examples. It proposed that the MSC become a forum to support those who have been bullied, intimidated or harassed and to ensure access for staff to industrial lawyers [p10]. After A/Prof Cheung was elected Chair, the MSC raised issues of bullying and risks to patient safety but without specificity, preventing any ability to adopt usual dispute resolution processes.

116. From early in A/Prof Cheung's tenure, the MSC conducted itself as though an oversight body. For example, following the May 2022 MSC meeting, A/Prof Cheung wrote to Dr Genevieve Wallace, then General Manager of Concord Hospital, on 22 May 2022 (**MOH.0010.0394.0001**) requesting current numbers and skill mix of nursing staff and a response to avenues that had and had not been taken to address workforce shortage. On 6 June 2022 A/Prof Cheung wrote to Dr Wallace (**MOH.0010.0395.0001**) advising of his view that the MSC should have approval over all mandatory training set by SLHD.

117. From May 2022 onwards, there were a number of meetings and communications with A/Prof Cheung to clarify the role of the MSC. These were held with the General Manager of Concord Hospital and the Director of Medical Services, Clinical Governance and Risk.

118. On 23 June 2022, Dr Andrew Hallahan, Executive Director of Medical Services, Clinical Governance and Risk, sent me an email advising of the challenging dialogue and out of scope demands from the MSC meeting on 23 June 2022 (**MOH.0010.0397.0001**). On 27 July 2022, minutes from the MSC meeting on 23 June 2022 (**MOH.0010.0398.0001**) were distributed.

119. On 12 October 2022, A/Prof Cheung sent a letter to the SLHD Board requesting a meeting of the Board, the MSC and Nursing and Allied Health Staff (**SCI.0012.0108.0001**).

120. On 13 October 2022, I was contacted by Mr John Ajaka, SLHD Board Chair, who informed me that A/Prof Cheung had made several attempts to contact him to ensure he had received the letter and to obtain his mobile number. The attempts included A/Prof Cheung contacting Mr Ajaka's previous employers including Parliament House. Mr Ajaka was on holiday overseas at the time. He asked me to have a phone conversation with A/Prof Cheung that day to say that this behaviour was inappropriate and I did so. On that same day, I sent a response to the letter of 12 October 2022 seeking to arrange a meeting between myself, Mr Ajaka, Dr John Sammut, SLHD Board Member and Chair of the Clinical Quality Council, and A/Prof Cheung (**SCI.0012.0069.0001**). On 18 October 2022 I sent a letter detailing the steps that should be taken in the future to contact the SLHD Board (**MOH.0010.0400.0001**). A meeting was arranged for 15 November 2022, two days after I was due to return from leave.

121. I am aware that on 9 November 2022, a summary was provided to the SLHD Board Chair outlining concerns raised by A/Prof Cheung, noting that there was a lack of information to enable investigation but listing all the steps undertaken to respond to concerns raised (**MOH.0010.0416.0001**).

122. On 15 November 2022 the meeting which I proposed on 12 October 2022 was held. At this meeting, A/Prof Cheung raised concerns in relation to the independence of the accreditation process, quality and safety, the performance of Concord Hospital in the People Matter Employee Survey and bullying, harassment and protection of staff from reprisals. I invited A/Prof Cheung to provide specific examples of his concerns that could be responded to. He indicated that he could not disclose for reasons of confidentiality at

which point I advised of the appropriate escalation process for concerns of bullying and harassment and the comprehensive governance processes in place.

123. Following that meeting, on 16 December 2022, after discussion with the Board, I sent a letter to A/Prof Cheung (**MOH.0010.0006.0001**) addressing his concerns regarding bullying, harassment and poor culture raised in the letter dated 12 October 2022 and at the meeting on 15 November 2022.

124. On 1 February 2023, I received an email from Dr Sammut raising concerns in relation to A/Prof Cheung's request to present at the SLHD Clinical Quality Council on 22 February 2023. I shared those concerns because the SLHD Clinical Quality Council is a forum for presentation of high-level trend analysis regarding clinical safety backed by data and advanced preparation of material for consideration. I agreed with him that this request was not appropriate and that he should escalate his concerns through the appropriate channels (**MOH.0010.0401.0001**).

125. On 2 February 2023, I sent an email to A/Prof Cheung organising a meeting between myself, Dr Hallahan, Dr Sammut and the MSC (**SCI.0012.0073.0001**).

126. On 21 February 2023, in response to A/Prof Cheung's request for a meeting, I held a meeting with Dr Sammut and representatives from the Emergency Department, Radiology, Nursing and Neurosurgery. A/Prof Ridley spoke on behalf of the Department of Radiology and A/Prof Cheung was in attendance. A series of follow-up meetings were also held with certain departments.

127. During the first half of 2023 the MSC focussed on the backlog of radiology reporting and the apparent staff shortages in the Radiology Department. I was unable to disclose that a PID had been made.

Draft Terms of Reference

128. From May 2022, A/Prof Cheung also began circulating draft TOR for the MSC. The proposed TOR had the effect of expanding the powers of the MSC beyond the purpose as set by the Model By-Laws, in effect giving the MSC powers of oversight akin to the Board and making the Executive accountable to the MSC. The draft TOR provided by A/Prof Cheung at Annexure N of his statement dated 16 July 2024 is an incomplete document and does not include all the MSC sub-committees which were proposed to be set up. The full version of the document is exhibited to this statement (**MOH.0010.0403.0001**).

129. Between May 2022 and April 2023, there were a series of meetings held between members of the Executive and A/Prof Cheung to discuss the TOR. On 28 July 2022, I attended an MSC meeting during which I advised of the function of the MSC. I stated that the voice of the MSC and representation across the hospital is valued and welcomed the involvement of members of the MSC in existing committees and highlighted opportunities for clinician involvement in the organisation. The minutes from this meeting (**MOH.0010.0399.0001**) were distributed on 23 August 2022.

130. After being unable to resolve the issue, I also met A/Prof Cheung on 21 April 2023 with Dr Wallace and Dr Hallahan in relation to the TOR. At that meeting, I provided him with a letter dated 21 April 2023 (**SCI.0012.0079.0001**) directing him to withdraw the draft TOR because they were outside the lawful role of an MSC in accordance with the SLHD By-Laws and NSW Health Model By-Laws. I reminded A/Prof Cheung that he was required to comply with lawful and reasonable directions given to him in accordance with the NSW Health Code of Conduct and to treat the letter as a direction. I explained the content of the letter to him at the meeting. It was agreed that Dr Hallahan would assist A/Prof Cheung with drafting the TOR. At the end of our meeting A/Prof Cheung thanked me for clarifying the role of the MSC.

131. On 5 May 2023, I received an email from A/Prof Cheung (**SCI.0012.0008.0001**) informing me that he would provide a response to my letter of 21 April 2023 once he received a response from Dr Hallahan, who had sent him a further draft of the TOR. I then asked Dr Hallahan to meet with A/Prof Cheung again and did not have further involvement with this issue.

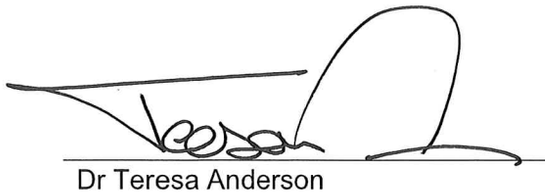
Vote of No Confidence

132. On 15 June 2023, Dr Rosalba Cross, on behalf of A/Prof Cheung, emailed the MSC (**SCI.0012.0014.0001**) regarding a motion of no confidence in the Chief Executive to be voted on at the MSC meeting on 22 June 2023.

133. On 30 June 2023, A/Prof Cheung sent a letter to the SLHD board (**SCI.0012.0084.0001**) advising of the MSC vote of no confidence in the Chief Executive.

134. On 4 July 2023, following the no confidence vote in me, Mr Ajaka wrote to A/Prof Cheung (**SCI.0012.0083.0001**) and invited him to a meeting with two Board members and Mr Philip Minns, Deputy Secretary. I understand that Mr Ajaka advised A/Prof Cheung that the Board had confidence in me and requested that A/Prof Cheung provide a chronology of events leading up to the no confidence vote. To my knowledge that has

not been provided. I was not present at that meeting or subsequent meetings with Mr McDonald of ProActive ReSolutions and A/Prof Cheung. To date, I remain uncertain as to the precise allegations asserted by A/Prof Cheung.



Dr Teresa Anderson

Sally Lee

Witness: [insert name of witness]

30-7-24

Date

30/7/24

Date