Concord Repatriation General Hospital
Medical Staff Council
Meeting with the Executives

Thursday 27th June 2024

Location

Hybrid Format

In-person – MDT Room, Rusty Priest Building, Concord Repatriation General Hospital
Online - Microsoft Teams videoconferencing

Time

5:00pm to 7:55pm

Present

In-Person

Winston Cheung (Chair), Graeme Loy, Stewart Condon, Joseph Jewitt, Shaundeep Sen, Liz Veitch, Peter Katelaris, Mark Kol, Asim Shah, Matt Rickard, Marcus Seibel, Lloyd Ridley, Amy Kitajima, Huw Davie, Aviv Pudipeddi, Alice Cottee, Louise Waite, Dipti Mittal, Ghauri Aggarwal, Ilona Cunningham, Natasha Spalding, Vasi Naganathan.

Online

Avinash Suryawanshi, Belinda Hokin, Raoul Pope, Judith Trotman, Seyed Payam Yahyavi, Elaine Cheong, Lawrence Trieu, Ana Ananda, Steve Vucic, Anastasia Panis, Phil Visser, Veronica Wong, Robert Russo, Tam Bui, Kate Archer, Rachel Choit, Genevieve Mckew, Timothy Gray, Daniel Sumpton, Nic Kormas, Jarrah Spencer, Mark Cooper, James Burrell, Veronica Wong, Thomas Gottlieb, Charles Chan, Nicole Santangelo, Susan Gaden, Pamela Howson, Stephen Reddel, Kar-Soon Lim, Kim Hill, Matthew Peters, Owen Kang, Sandhya Limaye, Kirtan Ganda, Stephen Morris, Joseph Trieu, Liam Quinn, Veena Raykar, Leonard Kritharides, Michael Suen, Hao Xiang, Andrew Hallahan, Cameron Korb-Wells, Liwei Ren, Sean Riminton, Jason Han, Prunella Blinman, Kathy Woo, Rosalba Cross, Henry Cheung, Anthony Linton, Irene Tan, David Rowe, Lucy Morgan, Margaret Janu, Rodney Martin, Lisa Ng, Nicole Wong Doo, Prakash Damodaran, Dipti Mittal, David D'Silva, Laurence Gluch, Lewis Chan, Winnie Hong, Shanel Cameron, Mifanwy Reece, Sarah Aitken, Brian Plunkett, Mark Joseph, Mark Cooper, Bernie Zicat, Jessica Lim.

(95 attendees)

Welcome and Acknowledgement of Country

Winston Cheung

Welcomed the MSC and Executives to the meeting and acknowledged the Wangal People as the traditional owners of the land upon which Concord Hospital resides.

Apologies

Rob Loneragan.

Quorum

Quorum of 30 reached at 5.00pm.

Previous Minutes

No issues raised regarding previous minutes.
Chair asked to be informed if errors were found.

Vale

Siri Kannangara

Ana Ananda

Spoke in memoriam of Siri Kannangara, Rheumatologist, Sports Medicine Physician and former Head of Department at Concord Hospital. Siri had a distinguished career as a medical consultant for many national and international sports teams and organisations, including the Australian Olympic Team and Football Australia. Siri was also named a Member of the Order of Australia for his services to the community, and to rheumatology and sports medicine.

Minutes

Minutes were transcribed using Microsoft Teams.
Speakers were given the option to stop the transcription when speaking.

Open Agenda Session

Winston Cheung

Welcomed Graeme Loy (Chief Executive) to his first meeting with the Concord Hospital Medical Staff Council.

Concord is rebuilding.
Wants to look forward and be constructive.
The reconciliation process involves truth telling.

Acknowledged that Graeme had a difficult job ahead.
Acknowledged that there was a limited budget, and seemingly infinite demand.

Purpose of this meeting was to provide Graeme with the MSC members' perspectives, and to help him plan for the future.
There were a lot of important issues to discuss.

The first part of the meeting would be an open agenda session from 11 speakers, each speaking a maximum of 5 minutes. Other members of the departments may also speak briefly in support.
The question time afterwards would be predominantly for Graeme, with limited questions from the audience.

The second part of the meeting would be a closed session that would still be available to members attending online.

Graeme Loy

Thanked the MSC for the invitation to attend.

Important to spend time at Concord.
MSCs were critical to the interface with clinicians.
Management is not a didactic process, but a partnership and collaboration.

Times are tough, but hoping that the coming year will be better.
Important to have the conversations, be transparent, and to know what the problems are.

Will talk about the issues, including the finances, and how to move forward, as the meeting progresses.

Speaker 1 – Gastroenterology

Winston Cheung

Introduced the first speaker, Peter Katelaris (Gastroenterology Department).

Peter Katelaris

Thanked Winston and Graeme.

Head of Gastroenterology, and recently appointed Co-Stream Director for the Gastroenterology and Liver Service.
Wanted to present a list of things required for the department.

Gastroenterology Department has undergone major renovations and rejuvenation in the last 3 years.
In the last 3 years, half of the department reached retirement age and retired.

Decision made to transition most of the VMO positions to fractional Staff Specialists, thinking that this provided greater embedding of the staff into the hospital.
The new cohort of young Gastroenterologists with subspecialty skills has greatly enhanced the department.

Rejuvenating physical infrastructure. ACE Unit currently in final stage of refurbishment. This will see department through to Stage 2.
Endoscopy equipment has been replaced, which is midcycle in age. Two new anaesthetic machines and new manometry.

Department is now an elite centre for interventional endoscopy, with highly trained interventionalists who can perform major interventions, including major tissue resections and myotomies.
Have established a direct access colonoscopy service which embeds with national bowel cancer screening program.

Department has the best inflammatory bowel disease (IBD) service in the state. Training ground for many IBD specialists that lead other units.
Department is a major referral centre for state-of-the-art therapeutics.
New interventional service, with stricture dilatation and endoscopic ultrasound, attracts international fellows and has a vast publication record.

Liver service is very busy.
Reestablished gastrointestinal function laboratory with new manometry equipment - anorectal manometry, impedance monitoring, and GI function testing.

About to reintroduce a low-cost hospital ambulatory care service to replace the very unsatisfactory outpatient model of care that isn't working in any NSW public hospital.

Concord is a preferred site for advanced trainees to train, because of a very good group of Gastroenterologists who are willing to teach and train, it provides all the specialities, and has a good culture and environment.
Several members of the department have international reputations, and have key roles in international and national guideline formulation.

Many PhDs and other higher degrees, mostly out of the IBD service, and many awards for clinical, teaching and research excellence.

Very busy and active clinical trials program.

Department does its best to generate revenues.
Recently discussed with the coders to try and maximise revenue capture.

Department is a huge user of billable services in Pathology and Radiology.
Department provides a very low-cost ambulatory consulting service.
Has been trying to maximise revenue capture as much as can be done within capacity constraints.

However, not all roses and would like to focus on the pinch points.

Pinch point is focused on the ACE (Ambulatory Care and Endoscopy) Unit.
Two capacity constraints make the ACE Unit greatly underutilised.

There are three procedure rooms, all equipped, but rarely operate close to capacity.
The rooms need to close by 3:00 or 4:00 o'clock.

RPAH run their procedures to 5:00 or 6:00 o'clock and have full anaesthetic support in two of their three rooms.
Concord has the infrastructure, but not the staff.

If the department was a private enterprise, it would be considered greatly over capitalised for the productivity. It's not a private enterprise, but the same principles apply.

The bottlenecks are not equipment, infrastructure, or skilled doctors.
The pinch points are nurses.

There are too few endoscopy nurses to run concurrent rooms for more than one or two days of the week. Need to always close at three or four o'clock,
Two to four endoscopy RNs would greatly increase capacity.
That would mean improved service provision breaches, waiting time, revenues, etc.

The second issue is inadequate anaesthetic support for the ACE Unit.

Nearly all NSW public hospitals or district teaching hospitals have full anaesthetic support for routine endoscopy, as well as interventional endoscopy.
Up until recently Concord has been an outlier.

An issue of equity across the SLHD.
RPAH has two fully functional anaesthetic-led endoscopy rooms each day.

Concord has only one room anaesthetically supported, just for the interventional lists.
Uncommon to have a second room anaesthetically supported.

Gosford Hospital is the only other major hospital in this parlous predicament.
Procedures are performed safely at Concord, but the conscious sedation used at Concord is not the standard of care in NSW anymore.

Department has acquired two anaesthetic machines.
Another pinch point is the lack of one anaesthetic nurse.

Do not have anaesthetic services in the second room.
Aspiring to get the third room but would be happy with the second room for now.

Surgeons perform a lot of their endoscopy in the operating theatre.
Performing the endoscopies in the ACE Unit would free up theatre time and improve productivity.

Have been trying to obtain equity in anaesthetics in the SLHD and across the state for three years.

When ambulatory care service gets into full swing the service won't meet demand.
Metrics currently look good for breaches and waiting times, but won't stay good, because of no capacity to increase.

Extra support needed in IBD and liver clinics. But for a few nurses, the department is grossly underproductive for the investment in infrastructure.

Department is very proud of the service, works hard, and are a very committed group.
The bottlenecks constrain the volume of work that can be done.

Graeme Loy

Asked about the financial model for the clinic, including before the procedure.

Peter Katelaris

Have some VMOs, but mainly fractional Staff Specialists.
Bulk of procedures are done by Staff Specialists.
Not costing the hospital, because they are present anyway, and hospital gains the facility fee.
Hospital accepts referrals for public patients from VMOs who work in rooms.

Rejuvenating the ambulatory care service, that attracts a facility fee.

In the process of launching a hybrid model.
Privatised outpatients along public lines, with little cost to the hospital, and no cost to the patient.
Cost sharing between the doctors and the hospital.
Specialty clinics all run along usual facility fees.

In the procedure room, NWAU value depends on whether patient is inpatient or outpatient.
Endoscopy in all hospitals is mostly ambulatory patients.
Concord has a combination of both.

Has been a trend to push that into the community but it is a big, potentially uncaptured source of revenue.

Graeme Loy

Thanked Peter.

Speaker 2 – Colorectal Surgery

Winston Cheung

Introduced Matt Rickard (Colorectal Surgery Department)

Matt Rickard

Three points/themes are people, equipment (not buildings), and "what would you do if it was your mother?"

Will talk about the robot (robotic-assisted surgery), a functioning endoscopy unit, and progressing expansion, not reduction.

In 2024, the robot is needed for colorectal and urological surgery.
Not many people would have an open prostatectomy now.
Concord will wither without a robot, and patients will not want to come here.

Second point is the endoscopy unit.
Backing up Peter Katelaris' points.
Has been at Concord 20 years and has never seen all three endoscopy rooms working.

Doesn't think anyone at the meeting would have a colonoscopy with the proceduralist giving them the sedation, but that is how colonoscopy has been performed at Concord for years.

Unsafe and shouldn't happen in 2024.

All three rooms should work Monday to Friday, AM and PM.

Third point is he is tired, as Head of Department, in fighting to maintain the status quo.
Happy to fight for progress and expansion.
But the process to replace someone retiring or resigning is tiring.

The expenditure review recently cancelled the third fellow, who did on-call.
Didn't know position was up for expenditure review.

Department received an email saying it hadn't got up.
Had to fight.

Sent an email to Graeme a week ago but no reply as yet.
Frustrated with fighting to maintain the status quo.

Emphasised three points - the robot, the ACE Unit expansion, and the Heads of Departments tired of fighting to stop the "death by 1000 cuts".
Staff have lot of love for Concord.

Thanked Graeme.

Graeme Loy

Apologised that he will get to the email.

Speaker 3 – Research

Winston Cheung

Introduced Sarah Aitken (Academic and Vascular Surgery Department)

Sarah Aitken

Apologised for not being at meeting. At a ministerial meeting in Canberra.

Head of Surgery at the University of Sydney and chairs the Concord Institute of Academic Surgery. Oversees a research budget of over $1 million across Concord and University of Sydney.

Many projects directly impact patient care, including Vascular Geriatrics program - decreased hospital acquired complications by 20%. “Sip till Send” initiative - made a huge difference to patient experience in surgery and how long patients need to fast.

There are many hurdles to utilise research funds effectively at the hospital.

Currently unsustainable to bring research grants through the hospital and to administer them, because of the time required to approve briefs.
Average six months to have position briefs for approved for solely research-funded positions, that are not coming from general funds.

The paper record keeping for research expenditure via S1s is impossible to track.
Joseph's EA and the Director at the Institute of Academic Surgery spent a day chasing invoices.

This infrastructure lack around research is hindering ability to efficiently integrate and translate research into practice.

Now at the point where alternatives have to be looked at on where to take research funds and how to do research at Concord.

Suggests an expedited process for research expenditure, so that money can be used effectively.

Graeme Loy

In complete agreement.
Hates S1s.
Couldn’t believe requisitions were still on paper.

Has started process in expenditure review to automatically approve any position that's trust funded, clinical trials funded, or grant money funded, because funds aren't from the facility operational budget.
Hoping that will start to filter through.

Happy to have further discussions around how to make research work better.

Learnt the lesson in Western Sydney around having too many barriers for research.

Delegated authority to improve bureaucracy.
Created positions that were available to researchers in advance of that research or grant money coming in.

Vasi Naganathan

Co-Head of Research with Victoria Cogger, who heads the ANZAC Research Institute.

Asked for Graeme's view on looking at a different process to employ staff funded from grants, and whether research staff should be employed through the SLHD or the University.

Graeme Loy

Not sure what is not working other than everything.
Acknowledged that approval delays were too long.

Problem may be in the request process.
Expenditure Committee meets weekly, so there should be no more than one week delay at district level.

Will look at systems to give faster answers.

Speaker 4 – Respiratory

Winston Cheung

Introduced Liz Veitch (Respiratory Department).

Liz Veitch

Thanked Graeme Loy for coming to listen.

Spoke on behalf of the Respiratory and Sleep Medicine consultants.
Like Gastroenterology, they have consultants who are recognised internationally for their expertise.

Department has evolved enormously over the 20 years but has done this with minimal enhancements.
Now reached the point where department is exhausted, demoralised, and needs help.

Read out an email received from another consultant during the week:

> *"We are chronically understaffed. I'm sure you agree. Consequences are inevitable.*
> *Nurses leave. Others choose not to come here. Even consultants leave.*
> *It is much harder to rebuild. Unless the unspoken intention is for the eventual wind down and demise of the department and hospital.*
> *I hold no hope for the system as there is lack of transparency and accountability."*

Email was from a highly respected academic consultant who was mid-career.
The consultant was at a point in their career where they should be full of ideas, enthusiasm and ambition, for themselves, the department, and the hospital.

But instead, the department has a sense of hopelessness and disengagement.

Consultant staffing in the Sleep Medicine and Interventional Pulmonology services is under enormous strain. Staffing is by two consultants on small staff fractions, or VMOs.

Would only take a lengthy illness or a resignation for the services to fold completely.
A tenuous situation that would have enormous impact on many other departments in the hospital.

The Respiratory Department shouldered the bulk of the COVID work at this hospital, but it never obtained the consultant enhancement that they saw occurring in other parts of the district.

Department has the same three advanced trainee positions in respiratory medicine since 1986, and the same single respiratory CNC in the same time.
Can't think of another respiratory department in Sydney which has had no staffing enhancement for 30 years.

The Specialists do menial tasks due to chronic understaffing of administration and allied health staffing.

Department does not have enough space.

In 2004, when department moved to the renovated main building, the space was assessed as being 75% of space needs. No new space in 20 years.
Sleep and Lung Function laboratories are now at the point where they will fail accreditation based on space constraints.

Like everyone else, the department is constantly having to fight to replace equipment.
Process is lengthy and exhausting.

Because of these issues, department is struggling to meet the demands on the service and this situation will rapidly deteriorate in the next one to two years.

There is ongoing local population growth and ageing, which is constantly increasing the demand for outpatient services and diagnostic services.

A tsunami of lung nodules will befall department when the national lung cancer screening program opens next year.

Department cannot manage this screening program appropriately with current staffing.
There has been rapidly rising demand for Interventional Pulmonology for the diagnosis and management of lung cancer over a number of years.

Department has two of the foremost IP experts in Australia, in Professors Ing and Saghaie.
RPA Respiratory Physicians come here to do cases with them to learn their skills.

All these factors combine to create a really unenjoyable and unhealthy place.
Impacts significantly on the efficiency of the service.

Department has experienced unprecedented staff turnover in the last four years.

The needs have been raised repeatedly with the Executive.

Department appreciates the opportunity to speak with Graeme and to formulate a plan to address the needs.

Graeme Loy

Will await follow up meeting.

Speaker 5 – Neurosurgery

Winston Cheung

Introduced Raoul Pope (Neurosurgery Department).

Raoul Pope

Thanked Graeme.

Apologised for not being at the meeting in person.

Department of Neurosurgery was looking forward, but has been treated poorly, and historically still has issues that need to be resolved.

This report outlines the experience of the three Concord Neurosurgeons.

There are two neurosurgical departments within the SLHD, unlike SESLHD and Prince of Wales.
There has been a big erosion of culture at Concord Hospital under the leadership of the previous Chief Executive and the previous General Manager of Concord, since 2018.

In 2014, a district position paper recommended the reduction of neurosurgical services at Concord and centralisation to RPAH.
However, there was unanimous support by the Concord GM, Tim Sinclair, at the time and other Concord departments to keep the department running, under duress.

Department adopted a reduced scope of practise list of procedures based on available resources and infrastructure at Concord.
The restricted scope of practise was adopted by the district, and the department continued operating.

The first issue is the governance failure regarding equity and equity of resources between the RPA and Concord Neurosurgery departments, and the repeated attempts at diminishing Concord services.

In 2014, Concord had four neurosurgeons.
In 2016, there were two resignations and only one position was filled.
Concord has been one neurosurgeon short since then.

Over time, sessions for neurosurgery were reduced to accommodate the reduction in positions.

In 2023, the Bureau of Health Information cited Concord, with three Neurosurgeons, ranked sixth out of 11 hospitals for largest neurosurgical waiting list in NSW.
RPA, with double the number, at 6 Neurosurgeons, ranked 11 out of 11 hospitals for the waiting list.

Issues requiring escalation with Executive, defaulted to the neurosurgeons or stream leaders based at RPA, representing a major conflict of interest.

Issue two was the governance failure regarding clinician engagement of stakeholders, and failure to adhere to NSW health procurement policies, regarding the Stereotactic Neuro navigation machine.

The machine is like a GPS for brain and spine surgery, and is vital.
In September 2016, the Executive was alerted that the old machine was expensive and difficult to service.
In April 2018, the Executive was warned of expiry of the Service Plan, and inability to service a faulty machine. Obsolete hardware beyond warranty.

Escalation went through appropriate committees and due diligence.

There was no response from Executive.
No contingency plan. No risk mitigation plan.

In September 2018, there were 3 operative failures with patient compromise.
Two cases both identified on the IIMs 2.
Request for immediate action, for an interim loan machine, and procurement of a permanent machine.

The Executives commissioned a review by an RPA Neurosurgeon, with no terms of reference, and with the conflict of interest between the two departments.
The RPA Neurosurgeon did not agree that the machine was faulty.
Concerns were overruled.

In April 2019, three emails were received from the stereotactic distributor and the biomedical engineering department stating the machine was obsolete and unserviceable.

In March 2018, Biomed recommended decommissioning immediately, but department was forced to continue to use the machine.

In mid-April 2019, machine finally broke down completely during a case.
Department not provided with any governance directives by Executive about operational workflow, even though it was highlighted two and a half years earlier.

A loan machine took months to procure.

There was a failure of leadership, with no urgent meeting with the Department of Neurosurgery, the Medical Director, or the Executive, for a service agreement on how to manage brain tumours, where to send cases, what to do in emergency cases for non-tumour cases requiring stereotaxy, what to explain to patients, and the medicolegal ramifications.

The result was the loss of a core neurosurgical service at a major teaching hospital for six months.
That was unacceptable for patient care.
Neurosurgeons asked the Executive to borrow the spare machine from RPAH because they had two machines.
RPAH declined, in case the main machine broke.

Neurosurgeons sourced a machine from the Mater Hospital, but this was rejected by Executive citing insurance issues.

Neurosurgeons lobbied for procurement of both a loan machine and permanent replacement stereotaxy. Inadequate communication from the Executive with deflection to middle management.

Loan machine arrived six months later.
The new permanent machine arrived 17 months later.

Further problems with funding because Executive wanted to use Neurosurgery and Radiology trust funds to help pay for the equipment.

Third issue was governance failure of culture and approachability, the creation of Executive silos, egos, and failure of communication with stakeholders and clinicians.

Neurosurgery has an RPAH-based stream leader that is invited to all departmental meetings.
Communication failure with the Executive underpins all the other issues, dating back to the start of the Acting General Manager, in 2018.

The three neurosurgeons wanted to meet regularly with GM to discuss needs and concerns of the department. That frequency diminished quickly, as directed by GM.
Meetings only occurred with the Head of Department alone.

By July of that year, all meetings, phone calls, and email communication ceased between the department and the Acting General Manager.

The Head of Department was limited to liaising with the Medical Director, who was dismissive and deflective.

A complete a top-down communication system.

Clinical feedback was obstructed by middle management.
Excessive use of a growing number of non-clinical middle management to communicate with clinicians.

Middle managers having limited clinical knowledge or experience, who had no delegated responsibility or authority to make decisions. Successfully deflected, stalled or ignored issues.

Senior executive rarely responded to emails leaving no email trail.

Issue four was the governance failure regarding the commissioning of an external inquiry. No due process, such as no terms of reference, failure to consult stakeholders, failure to implement the inquiry recommendations, and withholding the report for 15 months.

In November 2020, the Department of Neurosurgery requested the historic, forced restrictive scope of practise to be removed.

The Acting General Manager suddenly commissioned an urgent inquiry into Concord Neurosurgery.

Initially it was to be undertaken by the Head of the Department at RPAH, which Concord Neurosurgery pointed out as a conflict of interest, and rejected.

Executive then arranged Mark Dexter (Westmead) to perform the independent review which the Neurosurgery Department supported.

Within three weeks the external review occurred.
There were no terms of reference for the review or consultation with the Neurosurgery Department.

The report was submitted to the Executive three months later.

Verbal and written requests to Executive for the report were ignored for 15 months.
Report was officially released to the Neurosurgery Department by the newly appointed Medical Director.

The report supported a full enhancement of the Concord Neurosurgery service.
Two key recommendations were outlined:

#1 Current restrictive scope of neurosurgical practise at Concord Hospital should be abandoned.
#2 Enhancement to the neurosurgical service at Concord Hospital, including:

> Reappointment of fourth neurosurgeon so parity to 2016.
> Recommendation for application to SET training for advanced trainees.
> Extra operating time to allow extra 2 full days of operating per week.

Executive ordered business case.

Only one of those recommendations have been facilitated - the removal of the restricted scope for practise.
All other have issues remain unresolved.

There are other examples of failure of the Executive to comply with NSW Health policies and procedures and the Code of Conduct.

The department was verified as one of four adversely affected departments by the culture review commissioned by the NSW Health Secretary.

The department supports a full independent inquiry into these matters, as we move forward with Graeme's new leadership.

Thanked Graeme for listening.

Graeme Loy

Thanked Raoul for presenting.

Speaker 6 – Endocrinology

Winston Cheung

Introduced Nic Kormas (Endocrinology Department).

Nic Kormas

Apologised for not attending in person.
Head of Department of Endocrinology and Diabetes.

Wanted to explain why the Endocrinology Department waiting list increased over the last three years from practically none to now a waiting list of about 700 people.

Endocrinology and Diabetes Services are primarily ambulatory services that protect people from developing both acute and chronic complications.

Department provides specialist tertiary care in endocrinology and diabetes.
Teaching three advanced trainees and numerous other medical officers.
Until 2021, the department had 21 clinics, of which eight were being performed by honorary VMOs.

This represented one third of the department's patient clinics.

In 2021, the district considered honorary VMO positions were no longer legal, because they were renumerated through Medicare Billings in an outpatient setting.

By 2022, no further honorary VMO contracts were renewed, therefore department lost eight clinics.

There were some staff specialist enhancements, but department remained four clinics short, in an environment where the diabetes incidence has been growing because of obesity and other factors.

The waiting list grew during COVID, because the department couldn't see as many people as before.

This year, the waiting list peaked at 700.

The diabetes redesign project planned for an additional 0.8 FTE Staff Specialist enhancement, but this did not eventuate.

The waiting list remains over 500, despite focus on discharging long-term stable patients, and not accepting out of district referrals.

Currently department is only prioritising Category Two referrals but can rarely see them in the specified 30-day window.

Category Three and Category Four referrals are not being given appointments, because department needs space for people who are discharged from the hospital or discharged from the Emergency Department, or any new Category Two referrals in the interim.

Handed over rest of presentation to and introduced Avi Suryawanshi (Director of Diabetes).

Speaker 7 – Diabetes Service

Avinash Suryawanshi

(Presented using a Powerpoint presentation)

Thanked Chair and Graeme Loy.

Director of Diabetes since 2018 and part-time Staff Specialist in Endocrinology since 2015.

Planned to outline how and why department got to where it is currently.
There have been unsuccessful efforts to troubleshoot the issues since 2018.

Firstly, the main problems are unprecedented increase in demand and inadequate resources.

Concord Diabetes Service manages large numbers of elderly patients, and patients with severe mental illness, due to collocation with Concord Centre for Mental Health (CCMH).
Complication rates are higher in this group, and the prevalence is almost 50% in patients with severe mental illness.

A 5-year audit of Concord Hospital showed that one in three people at Concord Hospital, who are admitted for any reason, will have diabetes.
More than 59% are above 65 years of age.

The number of admitted patient episodes at Concord Hospital in the year 2018-19 (pre COVID times) was 6043, a 31% rise since 2013.
The number of occasions of service just by medical team alone in that year was 3572, which is 336% higher than in 2013.

This has not been matched by resourcing.
There has been no medical Staff Specialist enhancement in Diabetes for more than 10 years.

There has been termination of HVMOs.
There is inadequate service provision in Diabetes.

The talk only focused on medical aspects, but similar situation exists in nursing, allied health and admin teams.

Has affected the MDT clinics that support the highest risk and vulnerable population groups.

The problem of chronic understaffing has been present for more than 10 years.
This is based on a comparison of bed to FTE ratio of Concord to several other hospitals in Sydney.

A lower ratio is better and higher is worst.

(Referred to Powerpoint slide)

Concord had a worse ratio (426) for a hospital of similar size such as Blacktown Hospital (136).

Has clearly had a significant impact on Diabetes team.

Waiting lists have exploded.

First available spot for a Category One or Two, which should be available within 24 hours, is 6 weeks.
The only way the department could support GPs and patients discharged from the hospital was by double-booking them.

All Diabetes clinics are double-booked 30 to 40%.
This has been a common occurrence for the past two years.

One Staff Specialist FTE at Concord Endocrinology is on call for 16 weeks, which is the worst in the state.

This has significantly led to staff frustration and burnout.

Further complicated by the new proposed model-of-care, which demanded more clinics, but gave no enhancement.

(Referred to Independent Gap Analysis slide)

1.6 FTE Staff Specialists at Concord, which has gone down to 1.4 FTE.
Independent gap analysis thought 1.8 FTE should be allocated to the service.

Enhancement approval of 0.8 occurred only on paper. Department actually received nothing.
Department had zero enhancement even with the proposed new model-of-care.
Also zero enhancement in the other Allied Health subspecialties.

Endocrinology Department has addressed this at every level in multiple meetings and forums.

At Concord, this has been discussed with just about every DMS and GM.
Since discussing the problem, five GMs have changed roles, and three DMSs.

A lot of effort put into building and discussing the business case.
Multiple briefs and business cases have been submitted to the CE.
First brief in August 2018.
Last brief in August 2023.
No formal response from the office of CE.

Department had been assured that they were number one priority for Staff Specialist enhancement in Endocrinology, area-wide since 2018.
Since then, eight part-time Staff Specialist appointments have occurred in other hospitals.
Fortunately, the Endocrinology Department has not lost their spot.
They are still number one.

Status quo is not a viable option.
Endocrinology cannot continue to function in current state.
Cannot offer quality service to colleagues and patients with the current capacity.
Status quo will lead to further explosion of waiting list and affect high risk patient groups.

Diabetes Service recommends an urgent allocation of 0.6 FTE in Diabetes (knowing the constraints with finances in the district).
Also needs a further allocation of 1.4 FTE to bring service to par with other Sydney hospitals.

Need adequate provision of senior nursing.
Diabetes has been asking for a CNC since 2018. That has been deferred altogether.
A Diabetes CNC will prevent costly readmissions.

Business case states 0.6 FTE will generate $334000, which is $125000 revenue, every year.

In summary, Diabetes Service is chronically understaffed and cannot continue to function.
The proposed model-of-care should be reevaluated before progressing with any implementation plans.

Department strongly recommends 0.6 FTE to allow department to have a breather, and then staged approach for the rest of the 1.4 FTE.

Emphasised that 0.6 FTE is the key for the department to even survive.

Graeme Loy

Will look at 2023 business case.
Sounds reasonable but needs to understand it.
Thanked Avi and Nic for presenting.

Speaker 8 - Radiology

Winston Cheung

Introduced Lloyd Ridley (Radiology Department).

Lloyd Ridley

Thanked Graeme for attending.

Well known that Radiology has fallen apart very publicly in the last five years.

Costing millions of dollars extra per year to provide the current service.
Currently a much lower quality service.

Tens of thousands of patients have been put at risk due to delayed results.
An unknown number of staff and patients have been harmed.
Unknown because no data is being collected.

A result of bad management decisions.
Not just one or two, but multiple decisions over the years have degraded the department.

Multiple staff have left, not just medical staff.
Over two thirds of the medical staff have left in the last two years.

The medical staff leaving is the reason for the backlogs.

Rather than addressing the causes, multiple new middle-managers have been appointed.
Multiple staff in the department have been subjected to bullying and intimidation.
Lloyd has received several code-of-conduct breaches for saying that there is a problem.

Many staff have been subjected to criminal investigation.
People within the Executive tried to blacklist medical staff.

There remains repeated dishonesty about the situation, including about the magnitude of the backlog, and the ability to recruit and retain.

The quickest and cheapest way to start the remediation process is Open Disclosure.
This is NSW policy and mandatory policy.
But hasn't happened.

Open Disclosure is mandatory policy because it works.

All of those involved in the administration of Radiology have a degree of responsibility.
For some, particularly at the district level, that responsibility is active.
Others at the local level, haven't spoken up for the department so far.

No one has been held accountable for the decisions that have caused such a major problem.

Without accountability, it is very hard to develop trust that the management has changed and that the toxic behaviours won't be repeated.

Hao Xiang

Supported what Lloyd said.

A lot of distrust between management and the Radiologists.

But on a positive note, the Interventional Radiology service, which Hao was a part of, almost completely fell apart and almost became non-existent at the start of 2023.
Concord had three months where there was only one Interventional Radiologist in the hospital.

Management team has managed to rebuild that.
Radiology now has a decent Interventional service.
Almost fully staffed. So progress has been made.

But trust definitely needs to be built.

Graeme Loy

Has already spoken to Lloyd.
No further questions.

Speaker 9 – Emergency Department

Winston Cheung

Introduced Belinda Hokin (Emergency Department).

Belinda Hokin

Thanked Chair and Graeme Loy.

Apologised for not attending in person due to illness.

Is a Staff Specialist in the Emergency Department at Concord.
Views presented were personal, and Belinda was not representing the Emergency Department.

History in the Emergency Department is complex.
Not possible to go into details at this meeting.

Purpose was to provide a quick summary and solutions which may be of benefit, to prevent a recurrence of the situations.

Emergency Department went through a period of significant turbulence related to bullying and harassment, which occurred over many years.
This was supported and sanctioned by both the local and the district Executive.

Documented bullying and other risk factors were deliberately ignored.

Emergency Department was essentially an unsafe workplace.
Many medical and nursing staff left.
The department was quite unsafe.

A number of Staff Specialists left.
Six Staff Specialists sustained significant psychological injury.
Of those, three remain at Concord.

The issues have never been investigated, acknowledged, or addressed.

Belinda has provided details in previous discussions.

In 2022, the new Director put in a lot of effort and work to improve the department.
Still in a rebuilding phase.

But there are challenges associated with the rebuilding.
Still ongoing shortages with both medical and nursing staff.

Specifically wanted to talk about Registrars and Registrar numbers.

These are currently at critical levels.

As a result, the Registrar night shift ratios have increased significantly.

The Registrars are burnt out and because of the amount of night shifts.
Struggling to meet WBA and teaching requirements.

Registrars have had enough.

Some of the Registrars have stated that they do not wish to work at Concord.
A few of the senior trainees maintain minimal fractions while locuming at other sites, because they don't want to spend all of their time at Concord.

Registrars have raised concerns about the quality of the teaching program and levels of supervision in the department.
One attends teaching at another facility.

The trainees have recently put these concerns in writing.
Trainees also expressed these concerns to the College in a recent accreditation visit.
The outcome of this accreditation visit is still pending.

Phil (ED Director) has actively worked with both local and district Executive, the trainees and Registrar group.
There are extensive plans to address each of the concerns, in both the short and the long term.
Belinda's understanding is he feels supported.

But based on the history, there are a few specific things that need to be considered to prevent the situation from happening again, and to try to move Concord forward in a positive light.

The first is to see monitoring across the district of accreditation standards for all college programs.

The problems in ED have been known for a while.
The recent accreditation was always going to be high risk, because of the previous college investigation since the last accreditation.

There have been missed opportunities to address some of the issues sooner.

Asked Graeme to consider an early identification system, coordinated by the district accreditation team, that can monitor and intervene throughout the entire accreditation cycle.

Would like to see an audit and review of the implementation of policies by Workforce.

Workforce has been complicit in problems at Concord.

There needs to be an expectation that when problems occur, the institution will act appropriately.

Asks for an audit and review of the way the hospital implements the bullying policy.
When the focus is on staff safety, monitoring, and prevention after a bullying complaint is lodged, the policy has already failed.

Would like consideration of the appropriateness of the LHD "gag" (confidentiality) clauses.
Understands why they exist - It is not appropriate for staff to undermine others behind their backs.

But the gag clauses make it much easier for the institution to repeatedly cover up problems.
They leave impacted staff feeling helpless and isolated, and prevent staff seeking the assistance and support of colleagues.

Would also like to consideration of pathways for clinicians in crisis.
EAP is not adequate.

Would like consideration of a specific pathway, introduced in cooperation with helplines, Ambulance services, and the Ministry, to allow bypass of the Emergency Department directly into mental healthcare for all clinicians in crisis who do not require emergency medical attention.

Finally, asked for a fully independent external review into events within Concord Hospital and the Emergency Department, in relation to bullying and harassment.

Trust in this institution was broken and healing cannot occur until trust is restored.
This cannot happen without accountability.

Thanked Graeme Loy.

Graeme Loy

Asked what was meant by "gag orders", and in what respect.

Belinda Hokin

"Gag orders" were about confidentiality clauses.
Staff who have an interaction with Workforce have a confidentiality order put in place.

Graeme Loy

Asked if this was about perception, when staff get investigated.

Belinda Hokin

Understood why confidentiality orders were necessary but described them as being very isolating and could prevent individuals from obtaining the help that they needed.

Graeme Loy

The issue is the interpretation of the order.
The confidentiality orders were there for a reason.

Winston Cheung

A major issue at Concord with many staff has been how individuals can get support in the circumstance of a confidentiality order that puts the potential support in conflict with that order.

Graeme Loy

Industrial bodies, support people and medical people are available.
His interpretation is there are people who can be used (who would not breach the confidentiality order).

Winston Cheung

Another big problem has been many staff have had a code-of-conduct action tabled against them, and don't want another code-of-conduct issued for breaking confidentiality.

Graeme Loy

Certainly not the intent or the design of that clause.

Thanked Belinda.

Speaker 10 – Intensive Care Services

Winston Cheung

Introduced Mark Kol (ICU).

Mark Kol

(Used a Powerpoint presentation)

Thanked Graeme for his time.

Lots of good things about the ICU.
Proud to be part of a highly functioning small team.

Wanted to talk about key issues and priorities for the ICU that are risks for the organisation and risks for the ICU.

The problems relate to the ICU capacity and staffing, the absence of an Outreach and Liaison service, and the absence of a functioning clinical information system.

(Referred to a diagram showing annual admissions to the ICU from 2005 to 2023).

Exponential growth in the rates of ICU admissions. 35% of that growth has occurred over the past eight years.

Since 2005, there's been no there's been no increase in ICU physical capacity to deal with the growth.
Increase managed through efficiency gains, but efficiency gains have been exhausted, to accommodate this level of demand.

The projected rates continue to rise at an exponential rate.

In 2016, in response to running into the hard limits, the ICU capacity, unfunded beds were opened in the unit next door.

There has been a strategy of crisis management through to now.
What was a crisis management strategy in 2009 to 2016 is now a business-as-usual strategy.

The surge beds are now occupied around 10% of any given day.

The predictions shown are broadly consistent with the LHD forecasts.

(Referred to slide showing Australian and New Zealand Intensive Care Society data comparing Level 6 ICUs)

Concord ICU is smaller than peers in available bed spaces and physical bed spaces.
Occupancy in the ICU is a surrogate for activity strain and quality of service.

Australian data suggests the optimal ICU efficiency is between 70 and 75%.
Performance working group benchmark is 70%.

The Concord median occupancy is between 85 and 90%.
In one in four days the ICU is beyond 90% occupancy.

In 8.5% of days, median occupancy was greater than 100%.

ICU is using unfunded surge beds to meet to meet the demands.

(Showed the ICU bed occupancy graph)

The distribution for demand is probably a normal distribution.

The true demand is significantly higher than what has been captured.
Graph only shows what ICU has been able to admit into surge capacity beds.

There is substantial demand that is unmet by the ICU.

In the last financial year, there were 66 patients who were deemed appropriate for ICU admission, but unable to be accommodated, as a result of the resourcing constraints.

These issues prompted an external review in 2022.

Review identified all the issues that were pointed out as major risks to the to the department and said that the ICU was strained beyond its capacity.

With rapidly climbing demand the ICU simply cannot meet the contemporary expectations about access to critical care for Concord.

There are substantial, complicated workforce issues.

The staffing workforce issues compound by an order of magnitude the demand issues.

In 2016, the college identified that the senior medical workforce was inadequate for the size of the department.

Today, the ICU has 3.9 FTE running a 24/7 service of a quaternary ICU with the subspecialty Burns.
This has major impacts on staff taking leave and TESL.

(Showed table)

Against other Level 6 ICUs in Australian and New Zealand, the senior workforce in the Concord ICU is staffed at half the median of the peer cohort.

This has been compounded by a relatively junior level of trainees.

Consultants may do 60 to 80 hours on site, before starting the on call.
Not unusual to have four or five calls overnight continually for a week.

The workforce issues are not just medical.

There are major nursing workforce issues.

Very high amounts of attrition post COVID.

Comparing to benchmark, nursing staff suffer from the same issues as medical.
But also have an absence of key nursing positions such as ACCESS nurses, research coordinators, external liaison nurses, and equipment officers.

Same applies to Allied Health.

They are all in significant distress.

In several areas, staffing does not meet CICM or ACCCN nursing standards for workforce.

These were all highlighted in the recent external review.

Concord ICU does not have a functional Outreach service.

Concord has rapid response service.
Compared to Level 6 ICU peers, per thousand patient separations, the MET calls rates are higher.
Concerningly, the proportion of declined admissions was double that of peers, when it came to appropriate ICU admissions.

The current service that has been provided using the existing ICU resources for many years.

(Showed slide of rapid response calls)

Since 2016, there has been an approximately doubling of the external workload just in MET calls and Clinical Reviews. This didn't take into account the other outside ICU activities.

An enormous workload that the ICU simply is not able to meet.

Compared to peer tertiary facilities, the ICU was not funded to provide an ICU Outreach service.

This is despite the ICU meeting the thresholds for a stand-alone ICU Outreach service.
The rapid response service is not under the governance of the ICU and is run by a single CNC.

There are no other resources to manage deteriorating patients outside the ICU.

This was identified in the external review as a key point of improvement for the ICU.

In terms of safety and quality, it impacts every department in the hospital, that the ICU doesn't provide a proactive Outreach service to pre-emptively identify people who are deteriorating.
There, have been clinical events that have harmed patients as a result.

Concord is one of the last two ICUs in New South Wales that does not have a functioning clinical information system (CIS).

In 2012, it was argued that the most sensible approach would be to would be to extend the existing RPAH CIS to Concord.
That was agreed to. The project has been active since 2017.

But the project has not been completed and has not been delivered.
Concord has been left with a hybrid paper-based system.

Medications errors occur in 70% of the patients discharged.
The current system is so complicated that it requires two medical officers and a pharmacist to do discharge reconciliation.

There are opportunity costs in patient safety, quality of service, efficiency, research, and governance, in the absence of a decent, functioning intensive care information system.

Impact is the ICU is clearly struggling to meet the demands for the facility and hospital services.

Particularly impacts on research, the Burns Service, the Emergency Department, and the ability for the ICU to support future complex innovative treatments such as CAR T-Cell therapy and the Impeller program.

ICU is increasingly struggling to provide equitable access to critical care, and the absence of an Outreach service, is a clear hazard to quality and safety, and for deteriorating patients in the facility.

The solution is to commission the second intensive care and move to a two pod intensive care system.

The intensive care next door is already built and ready.
It just needs to be resourced to run.

Need to use that economy of scale to address the issues of staffing, of equity and access, and use that to establish an Outreach service, and take over the governance of the rapid response system.

Need urgent resolution of the ICCA (clinical information system) project which has now been running for seven years without delivery of the key deliverables.

Thanked Graeme for his time.

Graeme Loy

Asked about the current paper-based hybrid system.

Mark Kol

Unmanageable for medications.
Takes about an hour to move patients out of the ICU because of the discharge reconciliation process and mistakes are made on 70% of discharges.

Waiting on signoff for 1.5 FTE positions to run the system.

The system has been paid for.
Phillips has signed off the contract.
But being held up predominantly by IT, waiting on a district roll out.

Graeme Loy

Asked to confirm that equipment, computers, monitors, keyboards, etc. are available.

Mark Kol

Because the process has been protracted, the ICU monitoring now is at end of life and needs to be replaced.

Graeme Loy

Thanked Mark for his time.

Speaker 11 – General Surgery

Winston Cheung

Introduced Mark Joseph (General, Breast and Endocrine Surgery)

Mark Joseph

Apologised that could not attend in person.

VMO since 1994.

Need access to a second emergency theatre.

After hours there are multiple modalities using one theatre.
RPAH has had two emergency theatres for many years.

Concord has diverse modalities from Ophthalmology to Orthopaedics to Abdominal surgery.
Sometimes patients wait three days to get into theatre.
Long weekends are a problem.

Need a second theatre to be staffed after hours.

Current provision for this, but very difficult to activate.
Once someone has been through the process, they are discouraged from doing it again.

This has been a money issue.
Makes a major teacher hospital vulnerable not to have an extra theatre after hours.

Graeme Loy

Thanked Mark.

Asked to confirm that Concord had one theatre after hours 24/7 and a second theatre on call.

Mark Joseph

Confirmed this was the case, but very difficult to activate.
Many hoops to get second theatre activated.
Has done it a couple of times. Not very encouraging to do it again.

Patient care is compromised because the surgeons have to wait.
Even 2-3 days for an appendix or cholecystitis can have big complications, such as a perforation.

Doesn't think it is acceptable.

Graeme Loy

Asked how many emergency theatres were run during the day.

Mark Joseph

Potentially two.
Usually one was dedicated to Orthopaedics.

Graeme Loy

Asked how many theatres there were at Concord.

Mark Joseph

Ten theatres.

Matt Rickard

Ten physical theatres, but only nine used.
One emergency theatre every day.

Certain allocated times for orthopaedics, some allocated time for other procedures such as ECT.
Have exceeded actual capacity, so utilise a rotating cancellation system.

Graeme Loy

Asked if there was any reason why tenth theatre couldn't be activated.

Matt Rickard

Apart from financial, the other issue is sufficient anaesthetic support.
Main constraint, as flagged by Peter (Katelaris) and others, is trying to recruit to anaesthetics and getting that workforce built up.

Kar-Soon Lim

(Anaesthetics)

Runs the Emergency Theatre every Friday.

Correct that only one Emergency Theatre is run most days of the week.
Sometime run as a half day at the end of a surgical list.

Often start on a Friday with 20 plus operations on the emergency list.
This means that a second theatre has to be opened on Saturdays.

Can be incredibly frustrating for the patients, the Surgeons, and for the Anaesthetists.

Trying to accommodate all the requests, but hospital should be funded to run a regular second emergency list every day of the week.
This would result in fewer cases out of hours.

Unfair on patients who need to wait five days to repair a broken finger.

Sarah Aitken

Ran the numbers during COVID.
Majority of emergency operating lists are done because elective cases are cancelled to do emergency cases on the elective lists.

Data has been presented.
But there was not a lot of compassion.

Graeme Loy

Asked about the workload to cancel elective surgery, admitting patients, then putting an emergency list there instead.

Mark Joseph

Cancelling elective surgery might be true for Vascular.
But everything else comes through A&E.

Winston Cheung

Asked Graeme for any comments before moving to second part of the meeting.

Graeme Loy

Needs to do more investigation to understand the issues.

Unusual to run just one theatre.
Lack of the information system in the ICU is mind boggling.

The talks today were not what he was expecting.

Thanked the speakers for taking the time to talk.

This is only a starting point of where we can go.
Ultimately the issue is the amount of money available to be spent.

A lot of prioritising to do.
Will sort out how to do that.

Gave short overview of finance issues facing SLHD.
The official line for the finances is a 5% growth.

Indication previously was to expect negative growth, but the growth is positive.
The positive growth is good for Concord's budget position.

Is addressing some of the activity discussions. Activity is not just about quality of reporting.
Other drivers for activity.

Need to do background work.

Winston Cheung

Thanked all the speakers today.

There were other potential speakers who did not speak today.
Some felt their issues were not as important as the others.

The problems discussed today were just the tip of the iceberg.
A lot of other problems.
Funding will be a major issue.

Graeme Loy

Sometimes issues are separated.
When the whole picture is looked at it makes more sense.

Thanked speakers again.

Commented on looking at reducing waiting lists, modifying theatre lists, looking at scale and cost-effectiveness.

MSC Feedback on Executives

The second part of the meeting was a closed, confidential session for MSC members to provide feedback on the Executives to Graeme Loy.

No transcript or minutes were taken at this session.

Executives were excused from this session.

Before this session started, there was discussion on how to manage conflicts of interest, confidentiality, and other matters of process.

Graeme Loy indicated that if MSC members did not want to discuss matters in front of others at this forum, confidential feedback could be provided to him directly, via his secretary Nerida Bransby, using email or letter, or an appointment could be made to meet with him.

This second part of the MSC meeting ran from 6:45pm to 7:55pm.

Meeting closed at 7:55pm.

Next Meetings

MSC Meeting with Executives – Thursday 25th July 2024 at 5pm
2025 MSC AGM – Thursday 12th June 2025 at 5pm