Special Commission of Inquiry into Healthcare Funding

Witness Outline

Name: Dr Ross Kerridge

Professional address: John Hunter Hospital, Lockout Road, New Lambton Heights, NSW 2305

Occupation: Senior Staff Specialist, Anaesthesia and Perioperative Medicine, John Hunter Hospital

1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

A. Role

1. I am currently a Senior Staff Specialist Anaesthetist at John Hunter Hospital and Conjoint Associate Professor at the University of Newcastle. I have worked most of my 43-year career as a full-time clinician in the New South Wales public hospital system.
2. I have also held multiple positions within the Australian & New Zealand College of Anaesthetists and the Australian Medical Association (NSW).
3. Throughout my career, I have had a strong interest in the benefits to patients and the health system from continuous innovation. For example, from 1989, I led the establishment of the "Perioperative System", which is now the standard model of care for managing elective surgical patients in Australia and has been emulated internationally. In 1990 during my time at Liverpool Hospital, I was part of the team that introduced the Medical Emergency Team (or Rapid Response Team) which has caused a dramatic improvement in the care of deteriorating patients. I have been involved in many other similar system improvement initiatives during my career.

B. The relationship between clinicians and management

4. During my career I have observed gulfs develop between clinicians and different levels of management which has led to widespread staff dissatisfaction, frustration, and burn-out across the health system.

5. In the past there have been genuine and successful efforts to engage management and clinicians in developing system improvements, such as the Greater Metropolitan Transition Taskforce and the Maggie program in Hunter New England.
6. The Garling Commission made recommendations to address the disengagement it identified between management and clinicians. Many of these were implemented, like the Agency for Clinical Innovation. However, it seems to me those changes have become de-energised.
7. In order for improvements to be made, management must be engaged in seeing what is happening at the clinical "coalface".
8. I have seen some clinician-driven innovations result in great improvements, but other examples of waste, inefficiency, and poor-quality outcomes that have not been addressed. I believe there is a systemic problem of management not appreciating just how much waste occurs at the frontline due to things that would be simple to change. Twenty years ago I was engaged in a quality improvement program that identified multiple improvements that could be made rapidly without large increases in funding. Changes of that kind can make the system more efficient but to implement them, the executive management must be engaged and have an appreciation of what's happening on the frontline.
9. In my view, changing the culture of disengagement between clinicians and management so they work together to innovate and change clinical processes has great potential to improve the efficiency and productivity of the health system without increasing funding.

C. Medical Staff Councils

10. The Medical Staff Councils (MSCs) are intended to be a conduit between clinicians and management. Ideally, MSCs should mediate when issues arise in a clinical department, as well as escalating issues and proposed solutions to the General Manager or Chief Executive as required. However, even though the existence of MSCs is mandated, MSCs do not have

mandated administrative support, which is needed for clinicians to be more actively involved. It would be beneficial for MSCs to have administrative assistance, from someone whose role is not just secretarial, but also to help build a positive culture where doctors are keen to work.

11. Given the "gulfs" between clinicians and management, it is important that the MSC fosters a culture of engagement. From my experience, culture has often been driven by the personalities of people in leadership roles like the Chief Executive, General Manager or Chair of the MSC. I think that it is important that governance structures are strengthened so that the fostering of good culture is sustainable, and not simply reliant on the enthusiasm, capability or personality of a particular person. At John Hunter Hospital, Covid showed that the MSC could really band together and work with the General Manager to solve problems. That experience has given people a sense of what is possible.

D. Example 1:- Innovations in perioperative care – pre-operative medical assessments

12. One advancement in the perioperative care has been arranging for earlier medical assessments of a patient to be undertaken, prior to an operation being formally scheduled. For example, if a patient is recommended for a knee replacement, a medical assessment is first undertaken to determine if the patient is a good candidate surgically, the most suitable timeframes for the operation, and if there is anything that can be done to improve the patient's health status prior to the operation.

13. This process can also include early consideration of medical optimisation or frailty interventions, or whether diversion to a different program would be preferable, for example, physiotherapy, or weight loss. This helps avoid a patient being told at the 'normal' pre-operation check-up (typically two-four weeks before a scheduled operation) that the clinical advice is not to proceed with the knee replacement due to their current health status. We

should not waste the patient's time on the waiting list. Sometimes we also see a patient who should be moved up the wait list because they clearly need surgery sooner.

14. There are some exciting changes with preparation for cancer surgery, and for these patients in particular it is important that the medical assessment is multi-disciplinary to provide a fulsome overview of a patient's health. For example, I once saw a patient who was scheduled for cancer surgery two weeks after chemotherapy had ceased. He felt he was okay to proceed and indeed I considered he was clinically ready for the operation. However, formal CPET (cardiopulmonary exercise testing) revealed that the patient was not doing as well as he appeared, which was ultimately correct as the patient collapsed at the gym the day following the appointment. The operation was rescheduled to allow the patient time for further monitoring and improvement, and the surgery was later undertaken with no issues.
15. It is also important that this process involve collaboration with primary health care providers, in particular with general practitioners and allied health practitioners.
16. It would be of great benefit for clinicians to share a standardised comprehensive summary of the patient information. This should be created at the first instance of care and updated as the patient receives care through the hospital and in the community, and readily accessible whenever it is needed. Part of hospital routines used to include documentation of a comprehensive clinical summary of the patient's health status being done by junior doctors when the patient was admitted. In practice, this no longer occurs, and there are issues with clinicians being able to access this information even where it exists in the complex mix of paper and electronic information systems we now use. It seems that the promise of 'perfect' electronic record systems has become the enemy of making current information management at the clinical coalface 'good'.

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D. Examples 2:- Innovations in perioperative care – extended post-operative care

17. There have also been some recent developments in approaches to post-operative care that can result in better patient outcomes and system efficiencies. For example, a recent innovation in the approach to post-operative care is to keep high risk patients in an extended recovery care ward for 12-18 hours following an operation, which avoids having to admit them to ICU as a precaution but means they're getting higher level care than in a standard post-op ward. A recent study by Professor Guy Ludbrook and co-workers from Adelaide has found that extended recovery care for patients triaged pre-operatively as high risk has benefited patient safety and outcomes, and reduced their total time as an inpatient.
18. Another innovation has been in using a geriatric model of care post-operation, by having a geriatrician attached to general surgery. At John Hunter in Newcastle (and elsewhere) this has improved patient safety, and reduced length of stay.

E. Examples 3:- Other clinician-led Innovations

19. I have identified many other examples of opportunities for system improvement and waste avoidance that have been identified by clinicians who feel engaged with 'the system'. Some have been successfully implemented; others have become sources of frustration, disappointment and burn-out for those clinicians who feel they are being ignored by management.

F. **A Clinical Review Authority**

20. In the past (e.g. to the Garling Inquiry) clinicians have suggested developing an external body with authority for clinical review of system performance, adverse events and near misses, with similar powers to a Coroner, (including that evidence can be taken on oath or affirmation), but (unlike the coroner) overseen by people who have clinical knowledge in

order to identify what 'really' is happening or has happened in a system, clinical unit, or a case.