NSW MSEC

NSW MSEC INPUT TO THE NSW AUDITOR-GENERAL PERFORMANCE AUDIT INTO THE EFFICIENCY AND EFFECTIVENESS OF GOVERNANCE ARRANGEMENTS FOR LOCAL HEALTH DISTRICTS IN NSW

NOVEMBER 2018

Introduction

The NSW MSEC represents every doctor working within the public health system in NSW. It is not an industrial body, but exists to provide advice to the Minister and Ministry of Health (MoH) on matters of concern to every Medical Staff Council (MSC) and Medical Staff Executive Council (MSEC) in NSW. Each hospital MSC and District MSECs are legislated bodies under the Health Services Act (HSA), with the role of providing advice on clinical matters to the CE and Board of each LHD.

This response has been collated from MSEC experiences over the last few years and input received from MSCs in response to the circulated terms of reference of the audit. This response also relies on a NSW MSEC audit of Board governance conducted in 2017, recently updated for this Auditor General review.

There has been considerable concern building amongst MSCs about poor governance in the devolved LHD model and an erosion of the involvement of doctors in decision making, with declining numbers of doctors included in board membership since their creation in 2012. NSW MSEC input from MSCs highlights deficiencies in oversight of the Boards and CEs in respect of knowledge of and compliance with the Health Services Act provisions for engagement with Medical Staff Councils. Many boards have failed to invite MSC Chairs to Board meetings and involve clinicians in decision making. There is lack of clarity of the role of the MSC/MSEC Chairs when they are invited to meetings. Lack of active involvement has led to declining engagement. Lack of compliance with mandated Policy Directives of NSW Health (PDs) has been a significant problem in some LHDs with inadequate systems to address these issues within LHDs and within NSW Health when MSCs have escalated their concerns.

There is a lack of clarity about the responsibilities of Boards and Board Chairs in the investigation of MSC and stakeholder concerns, with boards refusing to be involved in “operational issues”, referring matters back to the Chief Executives. In the event that the operational issues raised by staff involves potential non-compliance with mandated policy directives, which the Chief Executive has already not addressed, refusal of the board to investigate further does not seem in line with the governance provisions of the Act and the NSW Health performance Framework. Both the Board Chair and CE sign the annual attestation statement claiming compliance with all policy directives, relevant legislation and engagement requirements with stakeholders under the Act, so surely an artificial demarcation between “operational” and “strategic” issues is not valid? It is not in line with the attached description of Board responsibilities which state “ensure effective clinical and corporate governance frameworks” (Attachment B)? NSW MSEC sought to clarify this issue of the roles and responsibilities of the Boards versus the Chief Executives with the NSW Health Secretary and Minister and await further information.

MSCs report a lack of oversight of Chief Executives and LHD Boards, in relation to governance, and whether they are complying with NSW Health Policies and enacting them with procedural fairness in line with other legislation, such as the NSW Ombudsman fact sheet for procedural fairness. Avenues for clinicians or MSCs to appeal against alleged breaches in following principles of fairness or application of mandated policy are limited. Improved systems of oversight and conflict resolution within the NSW health framework could avoid reports to the ICAC and Industrial Relations Commission, which are not only stressful for all involved but generate significant cost to the public purse.

The MSECs are not included in the formal structure of providing input to KPIs and audit measures that are submitted either to the LHD Boards or to NSW Health. Material provided to NSW health is provided by the LHD Boards who rely on inputs from the Chief Executives.

MSECs have not been involved in deciding which KPIs are included in the NSW Health Performance Framework, resulting in a disconnect in what Management and NSW Health are measuring and what may be important priorities for frontline clinicians.
For examples; there is a focus on numbers and times but less on quality and safety of care. There is no KPI for bullying scores arising from the People Matter Survey, hence no focus on this major workplace issue at LHD Board and Ministry level. Bullying is a cultural issue that is top down, which can be seen in available data. This is not being adequately analysed and addressed.

There is no KPI for waiting times for patient transfer between hospitals leading to patient and clinician frustration in attempting to ensure efficient transfers of care and equity of access for patients across the state. Failure to have a KPI for access between facilities results in enormous cost to the Health system.

In many hospitals Management choose not to engage with the MSC but to engage only with clinical Heads of Departments or with the Executive Clinical Director, who are often selected by Management for their roles and may be dependent on Management for their career advancement. This can make it difficult for clinicians in these roles to raise workplace and hospital performance concerns on behalf of other staff. Preferential engagement of Management with selected clinicians, rather than active engagement with the peer selected Medical Staff Council Chair and executive, who represent all doctors with appointments to the hospital, leads to a divided and disenfranchised medical workforce. If Boards and Chief Executives do not engage with elected MSC representatives, as described in By-laws and the Health Services Act, it prevents the MSCs from resolving valid clinical and workplace concerns, leading to a weakened model of audit and compliance, disengagement and unhappiness in the frontline clinicians.

A number of MSCs have provided examples of Clinicians who have raised concerns about clinical and corporate governance and have been targeted and silenced by actions of administration to remove the complainants from positions of influence. In some cases this has involved the use of HR processes that have not fully complied with mandated NSW Health policy directives. Staff from some LHDs has reported being threatened or intimidated for submitting IIMS, with examples provided of IIMS removed from the system or not processed. Clinicians who raise serious concerns about how a health service is being run, have in some cases then been described by managers to other clinicians, LHD boards and external agencies as "difficult" or even "a bully", without any clear evidence for such a view. This has the effect of undermining the individual and their professional reputation without their knowledge and deflecting attention away from the concerns they seek to address.

There is a disconnect between clinicians and some management in the role and use of the IIMS system. Some see the system as something that can get individuals, departments or hospitals in trouble for adverse outcomes. Patient-focused frontline clinicians see IIMS reporting as an opportunity to ensure patient safety, identify problems and improve care. Improvements to the transparency, audit and patient focus of this system are needed.

In summary, input to NSW MSEC illustrates major deficiencies in the current systems of governance arrangements for the Local Health Districts. There are significant opportunities for improvement of governance systems that would strengthen transparency, accountability, improve performance and reduce cost.

Questions posed by the Audit:

1. Are there clear roles, responsibilities and relationships between the Ministry of Health and Local Health Districts?

1.1 Holders of Governance related roles within the Ministry of Health and LHDs understand and fulfil their roles:

In some LHDs there is a lack of clarity about the role of the Board Chair and the Board members in providing oversight and accountability over the actions of the Chief Executive.
The LHD Board Chairs and Boards should have a role to ensure stakeholder and staff rights. Not all Boards provide this, some relying completely on input from the Chief Executive, even in the face of complaints from stakeholders relating to clinical and corporate governance issues. There seem to be no actions taken by some boards to check material provided by the CE or to engage with stakeholders and provide written feedback in the face of formal complaints about clinical and corporate governance.

Confidential examples of flawed oversight and engagement of some LHD Boards with stakeholders in the face of serious concerns about clinical and corporate governance systems are attached (Attachment A). The result in affected LHDs has been increasing staff unhappiness, staff resignations, disengagement and escalation of issues to agencies outside the LHDs (which may include NSW MSEC, AMA, NSW Health, the Minister, ICAC, Industrial Relations Commission and the Ombudsman). Compliance with the Health Services Act requirements for Board engagement with MSECs should work to avoid escalations and the expense to the public purse that this entails.

Following the NSW MSEC presentation to the Minister and Board Chairs in October 2017, the Secretary NSW Health directed Board Chairs to comply with the Health Services Act and NSW By-laws for engagement with staff and to improve transparency of Board deliberations (Minutes of meetings). The discussion generated and minuted at some LHD Boards, on receiving the Secretary's letter, indicates that not only were some not compliant with the By-laws relating to engagement with Medical Staff Councils, they were not aware of their obligations under the HSA, which is concerning. While there has been some improvement in transparency of Board minutes and some improvement in LHD Board engagement with MSCs noted in 2018, the response has been variable and still not 100% compliant. Given poor engagement with MSCs in some of these LHDs over past years, it is hard to re-establish a good system of clinician input where busy clinicians are unlikely to donate time to attending Board meetings if their input is not appreciated, minuted and likely to generate actions. Formal feedback from the Secretary to NSW MSEC following the presentation to the Council of Board Chairs in October 2017 is promised and over 12 months later, still awaited.

Due to a lack of Board and managerial transparency in some LHDs, it is often unclear whether these bodies do understand their governance responsibilities. In Attachment A, failure of the CEs and Board Chairs to address governance concerns and/or implement recommendations of external reviews in a timely way does imply a lack of understanding of these governance responsibilities. Additionally, a major flaw with governance systems as a whole in NSW Health is a lack of mechanisms to ensure compliance with governance policies. Even if appropriate bodies *understand* their roles and responsibilities, this still does not ensure they will carry them out. This issue will be explored further in the section discussing the effectiveness of the NSW Health Performance Framework in maintaining accountability and oversight.

Board members should all be formally orientated to their role. This should include education about the governance requirements of the board, board responsibilities under the Health Services Act and NSW Health by-Laws, relevant legislation, principles of procedural fairness and mandated NSW Health policy directives that the organisation is required to comply with. Lack of compliance with engagement of stakeholders seems to illustrate that formal education of board members has not been sufficient to date and this represents a major ongoing corporate risk to the organisation.

There is also a lack of understanding amongst stakeholders of the roles of different NSW Health bodies. Reviews that are managed by NSW Health seem to have all been conducted by the Deputy Director Systems Performance and Purchasing in recent years, while the roles and responsibilities of other parts of NSW Health such as People Culture and Governance less clearly defined. What is the formal role of the Clinical Excellence Commission (CEC) in governance? Its involvement in cases of MSCs raising concerns about clinical governance appears to be ad hoc and at the request of NSW Health (attachment A). If it has an independent audit and oversight role over LHD boards and NSW Health, should it not have a separate board without co-membership of board members to other parts of the organisation such as LHD Boards?

The role of the MSEC Chair at Board meetings is likewise unclear. According to section 18(1)(b) of Schedule 4A of the Health Services Act 1997, an MSEC Chair must be invited to Board meetings in the same way the CE is also an invitee. However, it is unclear what role the MSEC chair is supposed to perform. This issue will be discussed in further detail in the section about stakeholder monitoring of LHD performance.

1.2 Holders of governance-related roles maintain professional and effective relationships

The experience of many MSCs has been a lack of engagement of Boards in their governance role, with the MSEC survey showing 55% listed engagement as poor or very poor. The statement in a review document of one LHD is apt to the experiences in many of the others; “CORE values are not lived”. A professional approach to engagement would include an issues and risk register and action log arising from MSEC input to boards, transparently provided as an attachment to board minutes.

1.3 Ambiguity in roles and responsibilities is resolved with reference to devolution principles

When difficult issues arise in relation to alleged non-compliance with NSW Health policy in how a LHD is being run, there is a pattern of shifting responsibility between agencies and out-sourcing investigations. When concerns are raised with the Ministry and Minister, the common response received is “That is a problem for your Local Health District”, which under the current model of governance, is true in the first instance. However, who does intervene when the problem does lie with the CE and/or the Board and their own conflicts of interest prevent resolution in a procedurally fair and timely manner? There is a tendency to defend past actions without an examination of compliance with legislation and policy and an unwillingness of NSW Health to step in and adjudicate issues that may have legal and

industrial ramifications. There are blurred lines of responsibility when the boards underperform in providing governance and oversight of CEs.
Involvement by the MoH, at the request of a MSEC or the NSW MSEC, in recent years has been on an ad hoc basis. There appears to be no regular, transparent oversight of these sorts of issues by the MoH, nor any structure in place for the MoH to detect non-compliance of boards with governance requirements prospectively, before dysfunctional situations develop.

1.4 Key governance committees work cohesively with Local Health Districts

It is unclear which governance committees this question refers to. There is little clear information provided to frontline clinicians about governance systems in place. Does the CEC provide a governance committee that works with and provides oversight to LHD clinical governance units? Does the Ministry have a regular governance committee that works with LHDs?

The NSW MSEC presentation to the Minister in August 2017 and to Board Chairs in October 2017 highlighted the widely varying engagement with MSCs and MSECs as per the Health Services Act. Many LHD Boards did not routinely invite attendance at the Board by MSEC representatives, and in some instances refused access to the Board entirely. The survey conducted by NSW MSEC found engagement of Boards with MSCs was poor or very poor in >50%. Confirmed poor engagement was found on the AMA/ASMOF survey (presentation of data to Minister August 2017 attached).

1.5 Issues are effectively escalated and resolved at an appropriate level in NSW Health

The LHD boards do not seem to escalate matters to NSW Health for resolution – such as complaints from staff that the CE or management are not following mandated policy directives (PDs). It is very rare for LHDs to initiate reviews unless compelled to do so by MoH.
When stakeholders such as staff and MSCs escalate issues that they have been unable to resolve in an LHD to NSW Health, the investigation of the concerns is often outsourced to private consultants. This model can result in potential conflicts of interest where external providers are dependent on NSW Health for further consultancy work and may have a vested interest in providing reports and findings favourable to the organisation and NSW Health commissioning the report. The quality and depth of these reports is dependent on the terms of reference supplied to the reviewer as well as any unofficial briefing material about aims and requirements. Some reviews have been made transparently available – such as the external review of Bega Hospital. The open disclosure of this report was a refreshing

change in transparency, and the findings resonated with staff in other districts. A key finding was that in Bega and SNSWLHD, CORE values were not "lived". Principals of CORE values would dictate that the key findings and recommendations of external reviews should be transparently available to stakeholders. Otherwise the structure is not one of a closed feedback loop. In many cases complaints about management and governance are conducted with findings only released to the management that the complaint is about. This is a poor governance and accountability model.

It is difficult for the NSW MSEC to comment on resolution of certain issues, as in many cases the results of reviews and the implementation of their recommendations are not disclosed to staff, complainants or other stakeholders. There appears to be a disconnect between when an issue is 'resolved' in the eyes of the Ministry and when it is 'resolved' for the people involved.

In issues involving governance and bullying by managers, the Ministry's common response in recent years is to hand responsibility back to the LHD managers to fix their own bullying issues. Understandably, the stakeholders involved in such an issue do not consider it resolved when those who caused the problem are tasked with fixing it. Management-staff engagement is a relationship based on trust, and when that trust is eroded it becomes impossible for those involved to accept a solution that involves placing trust back into the hands of those whose actions have led to loss of confidence and trust. A no confidence motion of any MSC or MSEC in Hospital and/or LHD management should be a trigger for Board and Ministry oversight of governance and be reported and regarded as an adverse KPI that triggers an escalation in the level assigned to the LHD under the NSW Health Performance Framework until the issues generating no confidence are resolved. This issue will be further discussed in the section about monitoring of LHD performance by the community and stakeholders.

2. Does the NSW Health Performance Framework establish and maintain accountability, oversight and strategic guidance for Local Health Districts?

2.1 Service Agreements within the NSW Health Performance Framework provide an adequate accountability mechanism between the Ministry of Health and Local Health Districts.

Following is a breakdown of the key issues in providing accountability of LHDs within the *NSW Health Performance Framework*:

Section 2.5: Governance Requirements:

Governance requirements for NSW Health Services are established within relevant legislation, NSW Health Policy Directives and Policy and Procedure Manuals and articulated within the Corporate Governance and Accountability Compendium for NSW Health.

Effective implementation of governance requirements is a requirement of the Service Agreements. Overseeing compliance with governance requirements is a key role of boards culminating in the annual governance attestation statement processes. Identified concerns about effective governance conformance or performance will be raised by the Ministry and progress in addressing concerns will be subject to quarterly review by the Ministry, in conjunction with the Chair and Chief Executive.

- Governance is a key role of the Boards; however there is no formal system for the oversight of Boards. If Boards are ineffectual in ensuring appropriate governance is maintained, there is no other means left of ensuring compliance.
- There does not appear to be a system in place for verifying the truth of governance attestation statements. This will be discussed in the following section.
- Significant issues arise if any governance complaints are about the Board or the CE.
- The bodies responsible for maintaining governance are also the ones that report to the Ministry about the effectiveness of governance. It is unlikely they would report about their own failings.

Section 2.7: Staff and Stakeholder Engagement:

A key component of the framework is the ability of a Health Service to engage with staff, and to improve satisfaction and participation across all groups.

- The responsibility for reporting engagement with staff lies with the CE. Once again, it is unlikely the body responsible for engagement will report poor engagement.
- Data in the assessment of engagement and KPIs relating to engagement would clearly be more effective if they were collected from MSECs as well as CEs and Boards.
- There is no assessment of the quality of stakeholder engagement. That a meeting occurred and a box is ticked is vastly different from an effective meeting where respectful equal communication occurs and issues are able to be raised and followed on subsequent meetings.
- See next section for more detailed discussion on levels of staff engagement and satisfaction.

Section 3.2: Performance Review Process

The NSW Ministry of Health meets quarterly with the Chief Executive and senior management team for each health service through the performance review meetings. Where a performance issue is identified, the frequency of meetings may be increased until

the issue is resolved. Depending on the issues under review attendance by the Chair or other board members may also be indicated.

- Where the issue is poor engagement with staff, in terms of its quantity and/or quality, or complaints from an MSC relate to the poor performance of the CE or Board, it is unlikely these issues will be raised in such review meetings with the MoH.
- the MSC Chair or representatives of staff raising concerns are not invited to participate in these meetings in order to resolve the issues.
- There are no routine quarterly meetings of NSW MSEC and the MoH to review system performance in the current performance framework.

Section 3.2 Continued:

If an LHD is escalated, the Secretary of Health will advise the Chair of the LHD Board and the Chief Executive of the increase in performance level. If the escalation is to a level above 1 a senior member of the System Purchasing and Performance Division may attend the next meeting of the LHD Board for the Chief Executive, LHD Board and Ministry to discuss the escalation, the Performance Recovery Plan and actions required to re-establish performance levels to meet agreed trajectories and reduce the performance level for the LHD.

- Once again, this governance structure does not include engagement with Medical Staff Councils or clinicians, in the event that the concerns relate to structures of engagement or non-compliance with by-laws or mandated NSW Health policy directives.

Section 3.3: Performance Assessment

Response to performance concerns within the framework are not escalated or de-escalated solely on the basis of KPI results. Rather, KPI concerns act as signals that are viewed in the context of the health service's overall performance, including:
1. Implementation of Strategic Priorities and governance compliance;
2. The availability and implementation of governance structures and processes;
3. Whether there has been a significant clinical incident or sentinel event;
4. Whether there is a deteriorating trend for a particular aspect of performance – e.g. the health service may not have breached a critical performance threshold for any one indicator but is underperforming on multiple KPIs;
5. Whether there is a systemic performance issue for an individual facility and/or service

- The only information the Ministry is being given on governance compliance is from the CE - an issue if the CE is non-compliant or under reporting.
- As there is only one KPI referring to staff engagement, (explained below), it is unlikely to trigger a review based on underperforming on multiple KPIs.
- Essentially there are no triggers within the performance assessment section that would call the ministry's attention to a lack of governance by the CE and the board. As the

ministry is the only body with oversight over these bodies, it is a problem if governance issues are solely left to the CE to disclose.

A Note on Key Performance Indicators:

The only applicable KPI in the NSW Health Performance Framework for assessing staff health and performance is;

> *4.1: Staff engagement- people matter survey engagement index- variation from previous year.*

The Staff Engagement index is a composite measure measuring staff engagement with each other, with their work and with management. Combination of very different information into a single index obscures problems that would readily be apparent on closer examination of all the data. Clinicians (doctors and nurses) usually have a high level of engagement with their work, with patients and with co-workers in a common goal of caring for patients unless they are in a very toxic workplace. These engagement scores are usually high in health. Engagement with management however is much more variable across LHDs and within LHDs. The combination of these data sets skews both results.

Additionally, the KPI stipulates "variation from previous year". Variation from year to year in this weighted index will be low, as workplace engagement is unlikely to change suddenly. This lack of variation may mean that even if it has varied from bad to bad again or bad to a bit worse, the KPI will still not trigger a Ministry response. This KPI is the lone indicator of the extensive People Matter Survey data and its use as the only trigger for action on engagement is wholly inadequate.

Under this system, very poor staff-management and engagement will only be payed attention to when it affects multiple KPIs, or in other words; when the damage has already been done. A lack of engagement causes a gradual erosion of health services. When poor engagement and governance is only noticed when the entire running of a hospital deteriorates to such a degree as to affect multiple KPIs, clearly the system is flawed and the damage to the health service can be so extensive that it will take enormous cost and time to remedy. An analogy is that the current governance systems do not manage the cancer until it is metastatic, widespread, with extensive and possibly terminal consequences.

2.2 The NSW Health Performance Framework allows for adequate monitoring of Local Health District performance by the Ministry of Health, the community, and other stakeholders.

Currently the governance systems in place are not nearly enough to ensure the rights of the community and other stakeholders. The People Matter survey results for 2018 illustrate high rates of reported bullying: over 50% of staff witnessed bullying in one LHD and up to 27% personally experienced it. The survey data proves that bullying is a problem throughout

NSW Health, occurring regularly across multiple LHDs. In some LHDs more that 25% of the bullying is by senior managers (Table 1). Board Minutes from all LHDs on public websites *note* that the People Matter survey has occurred and results are available but rarely is there a minuted Board discussion of an LHD-specific analysis of local LHD specific results or variation across hospitals within their LHD is completely lacking. There is no LHD Board action plan required to combat this highly concerning data (Table 2) or incentive to even analyse the available data. In instances such as these, Ministry and stakeholder monitoring of LHD and performance is essential, however it does not appear to be occurring.

There is the potential for information provided to the LHD Boards to be filtered by the Chief Executives, who control the secretariat of the Board in most LHDs. The Chief Executives in many LHDs control access to the Board and Board agendas via the clerical support staff. This model may place significant control on the flow of information to the Board in the hands of one party, the CE, potentially limiting access to information submitted by other stakeholders and staff. This model may restrict Board access to the valuable insights of the senior hospital clinicians, but also has the potential to prevent senior clinicians and other stakeholders from being able to monitor the governance activities of the Board.

This concentration of control over information is intended to be countered by the invitation of MSEC Chairs to each Board meeting, as mandated in Schedule 4A of the *Health Services Act 1997*, as mentioned earlier. Not only has this not been observed in all cases, but there is no clear structure in place for the MSEC chair's role at the Board Meeting. There is no formally recognised right to provide a report directly to the Board for inclusion in the public record of the meeting nor description of an active role in Board function. In the *Health Services Ac*t the CE is an invitee to board meetings and provides reports to the Board. The MSEC Chair is also to be a regular "invitee," however it is not clear in the Act, the NSW Health Bylaws or any other NSW Health document whether their Board role is equivalent to the CE's. This results in a highly variable interpretation and practice of engagement with MSEC chairs in different LHDs. Some LHD boards not only invite but publish MSEC Chair reports with Board minutes. In areas where MSC chairs have not been invited or allowed to contribute formal input, staff are often disengaged. The Australian Institute of Company Directors would say that ex officio's are full members of the Board with full responsibility. Additionally, there is no process to ensure Board compliance with section 18(1)(b). If an MSC Chair is not invited to Board meetings, they have little power to change the situation, which further deteriorates engagement between staff and the Board. To allow appropriate MSC monitoring of LHD performance, it is vital that a real role is specified for the MSC Chair at Board meetings. This role should be sufficient to encourage continued attendance and engagement with MSCs.

Not all LHDs engage with MSCs and staff as required by the Framework. A NSW MSEC audit of material available on public LHD websites in August 2017 found that only 7 out of 17 LHDs and hospital networks had Board minutes that clearly listed MSC/MSEC Chairs as invitees to Board Meetings, as required by Section 18(1) (b) of Schedule 4A of the *Health*

Services Act 1997. There were large differences in the quality and transparency of material provided to stakeholders on public websites. A repeated audit in November 2018 of public board minutes, approximately a year after a letter from the Health Secretary directing Boards to comply with engagement, showed an improvement to 10 (possibly 11) out of 17 (Table 3). Transparency regarding Board minutes is essential for the community and stakeholders to monitor their actions. Clearly, the Board monitoring system at the Health Ministry Level is either ineffectual or non-existent, as these issues were not picked up since 2012.

Some CEs seek to control MSCs and MSECs by filtering MSC agendas and having executive/management staff (GM, DMS) as members of MSECs, rather than being invited guests to MSC meetings as per NSW Health By-laws. Some LHDs have clerical support for MSCs/MSECs which can act to control or filter meeting agendas and freedom of speech for staff to discuss matters of concern. Again, this issue has not been noticed or dealt with by the Ministry, and has been left to staff to either rectify or disengage.

Lack of compliance with the requirement for public meetings also has not been picked up by the Ministry. Some LHDs may technically comply with requirements to advertise a public meeting in at least one newspaper, but do not seem to fully embrace the spirit of engaging with the public by advertising sufficiently openly to attract and minute the attendance of members of the public or issues raised by them at an annual public meeting. Community Groups in some LHDs have been left to raise enough signatures on public petitions to have their issues discussed in Parliament (Push for Palliative Care – Orange for example), without engagement with the LHD Board to discuss and resolve issues in models of care and service provision.

As mentioned above, there appear to be no ways that the Ministry monitors the truth of the reports they receive from each LHD. Attestation Statements from all LHDs state that the Board has systems and frameworks ensuring clinical and corporate governance, and CEs make an annual statement that NSW Health Policy Directives are adhered to. However, it seems that no one checks whether these statements are true.

Feedback to stakeholders and complainants in other cases is often limited or absent. For correct monitoring to occur, it is vital that stakeholders a made aware of what actions have been taken by the Ministry to resolves certain issues. Often the response stakeholders receive is merely a reassurance that “action has been taken”, with no open disclosure of findings relating to corporate governance or disclosure of any changes to be implemented. This is not a transparent model and not one that is consistent with best practice for improving systems of governance in an organisation.

2.3 Performance monitoring provides appropriate oversight, including intervention and coordination where necessary by the Ministry of Health to address poor performance and promote efficiency in service delivery.

No routine oversight seems to occur of corporate governance and compliance with NSW Health PDs within LHDs.

There is a dual problem afflicting the NSW Health oversight system: those who have the power to enact change do not notice the issues, while those experiencing the problems have no avenue to fix them. As explained in the preceding section, stakeholders and MSCs have consistently complained to the Ministry about LHD governance failures. Even when these failures are subsequently proven in independent external reviews, it is not clear if any action is taken. This is either because no action was taken, or whatever actions were taken were not disclosed to stakeholders. Neither of these scenarios effectively address poor performance.
Staff, MSCs and other stakeholders have no power to enact change without the support of the CE and/or the Board. This is a significant issue when the concerns involve the CE or the Board. As previously noted, it is exceptionally difficult under the current LHD model to gain the attention of the Ministry, and then to get them to take (disclosed) action.

Where the methods of monitoring performance are ineffectual, it follows that measures to address poor performance are not being used.

Other related matters on which NSW MSEC has a view

Executive Clinical Directors – currently appointed by the GM and CE which does not fulfil the Garling suggested role of forming a bridge between management and Clinicians. It has been voted at NSW MSEC meetings and in the NSW MSEC survey data that these roles should be peer selected if they are to serve their purpose in improving communication between clinicians and management. If this role is to exist, separate to the role of the MSC chairs, the job description needs formal clarification and consistency across all LHDs. Some do not currently have ECDs.

Hospital Clinical Councils – the role and membership should be more clearly defined in by-laws. The role is currently seen as advisory and at the discretion of the hospital GM as to whether they bring issues to this group. The model would benefit from more elected staff rather than appointees by management, to allow engagement of all staff stakeholders. Agendas and minutes should be more transparently available to staff.

Nominations for Board membership from MSECs – should be acknowledged and some nominees included on the Board. Many MSCs complain of names submitted and never included on Boards.

Board Membership – There has been a steady erosion of the number of clinicians on LHD Boards since 2012. All clinicians with appointments to the LHD were removed as Board chairs without any corresponding increase in appointment of clinicians as Board members to replace them. It is noted that the best performing LHDs (mostly metro) have at least 50% clinicians, mostly doctors, on their Boards. The NSW MSEC suggests that this rule should apply across all LHD Boards.

An annual attestation statement from the Medical Staff Councils and Health Councils in each LHD should be considered as a means of providing better depth and honesty to clinical and corporate governance and as a means for Boards and the Ministry to detect problems.

Public Hospitals perform best when their authority is shared between an appropriately skilled bureaucracy and a committed and engaged senior medical workforce - provided by peer selected representatives. When the balance is tilted too far in favour of bureaucracy, medical staff disengage, which can lead to a crisis of clinical performance, quality and efficiency. This process is well advanced in many LHDs - Illustrated in the presentation to the Minister. LHDs with the worst survey scores for engagement are often those with the worst bullying scores in People Matter. Much of the performance of NSW hospitals is dependent on the professionalism of clinical staff (medical and nursing) who provide so much in unpaid time to quality patient care when they are fully engaged.
Consideration should be given to Ministry investigation of LHDs with worst annual People Matter survey Results. – Routine annual audit of the 3 LHDs with the worst scores for engagement and bullying. This is likely to have the effect of improving all results as LHDs strive to avoid audit.

Rural/Regional LHDs are most vulnerable – The CVs available on public websites show that many of the metropolitan LHDs have board members with enormous corporate, board and business experience and this is often in contrast to the skill set available on rural/regional boards. When it comes to having the skills and knowledge to understand the role of a board in providing governance and oversight and in checking the material provided to it, this may be an important factor, unless detailed training and support can be provided to board members with less corporate and governance experience. LHDs with the worst scores in surveys – see MSEC presentation are often the regional/rural LHDs. In these settings unhappiness and disengagement of staff can have larger impacts due to reduced staff pool and loss of critical staff mass. This can lead to further impacts on service provision and patient care.

There is no formal inclusion of the state level NSW MSEC in the NSW Health By-laws and yet prior to 2012 this group existed and met regularly with NSW Health Secretary and Minister. It has been re-created and has been instrumental in reviewing compliance with systems of Board engagement with clinicians and a variety of other issues. Inclusion of this state level NSW MSEC structure in by-laws/ health Services Act would create a formal structure for engagement with all clinicians at the level of governance and state-wide clinical directives. The group can also provide an avenue for escalation of MSEC concerns not dealt with by an LHD, within the governance framework structure.

Clinician engagement with the MoH and Minister at the state level could also be utilised to involve clinicians transparently in state-wide strategic service plans, creating cost-effective service development and equity of access to the many services that are not available within all LHDs – such as interventional neuroradiology, quaternary paediatric services and 24/7 interventional cardiology to name a few.

Inclusion of NSW MSEC under the Act and by-laws, with a role to support MSCs, improve engagement and provide annual KPI information independent of the LHDs would strengthen the model of governance. This would require a small budget allocation for clerical support.

The NSW Health Services Act describes how governance structures are supposed to operate but does not describe any actions or systems to address circumstances where mandated policy directives and NSW Health by-laws are breached.

There is no structure outlined whereby staff or MSECs can complain about non-compliance of a CE or LHD other than to the Minister. The only oversight of the Boards is that the Health Secretary can "provide governance, oversight and control of the public health system and the statutory health organisations within it."

No ramifications for non-compliance of CEs or Boards with procedures set out in the Act seem to be outlined.

Review of all Performance KPIs

Many current Performance Review KPIs are inadequate to convey the true picture of the quality and type of care provided by LHDs, and measures are often not well targeted. Workforce culture and engagement KPIs in fact provide illusory results. The minimal responses by CEs and Boards to the People Matter Surveys each year (Attachment) highlight the scant attention given to these measures in the absence of any formal KPIs, other than the one for a change in aggregate engagement index. It is unsurprising that scores for "Do you think any action will arise from this survey?" are so low across the entire health system. What actions do Boards take to address underperformance if detected, and what follow up occurs? Board Minutes are generally fairly opaque about this – and often include mention of reports from various committees, generally with a "Received and noted" in Board minutes only.

NSW MSEC would support a complete overhaul of the Performance Review KPIs, and would ask that new KPIs regarding management performance be developed and implemented.

Mandatory training for Executive staff in legislation and NSW Health PDs

Are there any compulsory training modules completed by all Hospital executive staff, as part of NSW Health and HETI requirements? Training should include detailed knowledge of mandated NSW Health policy directives, relevant legislation and procedural fairness principles. Details in Attachment A would suggest that mandatory training of executive staff (General Managers, Directors of Medical Services) has not been the case to date in all LHDs. Compulsory training for executive staff including AICD training in corporate governance could be a valuable risk management strategy for NSW Health.

Summary

- Adherence to the HSA, other regulatory requirements and mandated policy directives of NSW health should be a given. Adherence protects not only the staff but also managers and bodies responsible for governance. If all PDs are followed, Boards and the Ministry of Health can be assured that processes are being enacted appropriately. However, the systemic issue is that there are no routine audits in place to check that compliance has occurred.
- It is too easy to hide behind confidentiality provisions within processes, so detection of non-compliance can be difficult. However, even when detected, there appears to be little or no sanction for non-compliance with mandated policy.
- When there is a complete erosion of trust, it is almost impossible to repair it in the absence of transparent closed loop feedback to stakeholders.
- Under the current system there is a stronger gravitational pull towards maintaining the status quo and saving face rather than fixing major problems. The contractual arrangement between the Boards and the MoH is one of mutual desire to be thought well of by the other. The relationship between the Board and the CE is the same. Between this triumvirate, no party wants to make either of the others look bad. They have a vested interest in making everything appear to be in good working order. This is a disincentive to raise real issues among the bodies that have the power to enact change.
- Any organisation will have its measure of bullying, incompetence and corrupt behaviour. A robust system is one that can easily identify these behaviours and apply appropriate measures to ensure that everyone understands what is expected of them. A proportional response. That will provide a symbol and example to the rest of the organisation.
- A robust organisation allows for the occasional mistake to be made. IIMS, M&Ms and RCAs are regularly used by clinical units to identify adverse events and address them. It is drummed into clinicians to own their mistakes, apologise and improve systems

to prevent recurrence – open disclosure. There is reporting of any adverse incident, no matter how small. It should be expected that occasionally things go wrong. It is important to promote similar no-guilt, honest, transparent and robust systems of open disclosure and improvements in the event of corporate governance mistakes.

- However, no open culture of systems improvement seems to exist for administrative bodies within NSW Health LHDs. There appears to be a culture of cover-up, rather than disclosure of review findings and recommendations. Improved corporate governance procedures within the devolved NSW Health system would improve accountability and stakeholder confidence. There would be additional benefits in decreasing the risk profile and costs to the organisation.

Attachments:

Table 1 – People Matter Survey. Bullying and staff engagement by LHD 2018

Table 2 – People Matter Survey 2018 Board response on public website review by LHD

NSW MSEC presentation to the NSW Health Minister

Table 3 – 2018 review of LHD board material on public websites