Submission to Parliamentary Inquiry into FSH

Thank you Chair and committee for allowing me the opportunity to speak to this inquiry. I am Dr Ian Jenkins, Chair of the Inter-Hospital Liaison Committee or the AMA(WA), as such I am ex-officio, a Director and State Council member of AMA(WA); I am also an Intensive Care Specialist at Fiona Stanley Hospital and Director of ICU at Fremantle Hospital.

As a member of AMA(WA)'s Council, I am aware that the AMA desires not to highlight problems with the reconfiguration of hospital services in WA and the commissioning and 'business as usual' operations at Fiona Stanley Hospital, but to work collaboratively with the government of the day to find solutions, improve services and efficiency and to assist preventing similar issues occurring at other health sites that are built from scratch (green-fields sites)- New Children's Hospital, Midland Hospital and Busselton Health Campus to name three or re-developed and expanded campuses- Albany, Rockingham and Armadale- also to name three.

Because of grave concerns about transitioning and operational matters AMA (WA) conducted a survey of clinicians' opinions about aspects of the commissioning and operation of FSH. 668 doctors responded to the survey. Respondents were made up of Interns (8%), RMOs (13%), Registrars (19%), Consultants (41%) and Heads of Department (6%).
Respondents were asked to comment on Fiona Stanley Hospital and also how the opening of Fiona Stanley Hospital has impacted their current work place.
59% of respondents feel that the commissioning of Fiona Stanley Hospital has been handled poorly or very poorly.
71% of respondents feel that the resolution of operational issues that have arisen at Fiona Stanley Hospital since its opening have been handled poorly or very poorly.

108 respondents identified as Senior Doctors who provide services at Fiona Stanley Hospital.
62% of Senior Doctors feel that the commissioning of Fiona Stanley Hospital was managed either poorly or very poorly, with 54% feeling that patient care and safety was compromised.
69% feel that the resolution of operational issues that have arisen since the opening of Fiona Stanley Hospital has been handled poorly or very poorly.
67% feel that new systems at Fiona Stanley Hospital have led to patient care and safety being compromised.

54% feel that staffing levels are not adequate to meet patient care needs.

The majority feel that research is not given adequate weight, time or resources and the teaching and training of Doctors in Training is not given adequate time or resources.

115 respondents identified as Doctors in Training (Intern, Resident Medical Officer or Registrar) that provide services at Fiona Stanley Hospital.

38% of DiTs felt that the commissioning of Fiona Stanley Hospital was managed poorly or very poorly, 41% felt patient care and safety was compromised during the commissioning.

55% of DiTs felt that new systems at Fiona Stanley Hospital have led to patient care and safety being compromised.

69% of DiTs feel that staffing levels are not adequate to meet patient care needs.

A majority of Doctors in Training feel that their teaching and training is given adequate weight, time and resources, but a majority of Doctors in Training feel that research is not given adequate time or resources.

Overall, Doctors who provide services at Fiona Stanley Hospital were asked to rate a number of statements relating to Fiona Stanley Hospital.

56% do not feel that management at Fiona Stanley Hospital are responsive to their concerns.

65% do not feel that feedback mechanisms are adequate and effective at addressing shortcomings.

68% do not feel that IT systems assist in providing efficient, high quality care to patients.

Only 26% feel that the outpatient department is functioning to a desirable standard.

Only 8% feel that CSSD services are safe, and according to standard.

65% feel that services provided by Serco (other than CSSD) are not adequate.

The areas of concern are:

1. **IT**

   The electronic patient record system (Bossnet) has caused significant reduction in efficiency. It is untried in major Australian hospitals, is supported by a relatively small company, does not interface, as installed with all the other applications and frequently crashes or freezes on users. Should the vendor not be able to continue to support there is severe clinical risk, as transfer of information to a new application would be difficult, time consuming and expensive. Support for IT applications through the interwoven labyrinth of Serco, Health Information Network and British Telecom is often tedious to obtain and slow to produce

results. The same system is being installed at the new Children's Hospital.

There was inadequate training in use of the new systems and inadequate support on site during commissioning. Outages are extremely frequent- when notifications of 'planned' outages are given it is with 15 minutes to about eight hours warning- hardly planned. A review of the Health Department's ability to provide modern, effective healthcare applications to new and redeveloped sites is desperately needed.

2. **Bed Numbers**

The original Reid Report recommended 1,000 beds on the FSH site by 2014 (so-called Phase II). There is already extreme pressure on beds at FSH due to:

a. Inadequate modelling of population growth
b. Higher than expected ED presentations, coupled with
c. Higher than predicted percentage admission rate from ED
d. As well as LOS longer than predicted (both last two had fanciful projections)

This has impacted on patient care. Patients are often transported, mid episode of care (i.e. half way through their admission) to another hospital e.g. Fremantle Hospital

There is now no money for further capital works- the ideal would be more beds on the FSH site- until that can occur an urgent review of the use of beds at Fremantle Hospital, RGH and Armadale is needed.

3. **Staffing**

The PWC report "SMAHS Reconfiguration Cost Modelling" dated 11 January 2011 used unrealistic predictions of reduction in staff/funded bed at FSH. Some of the effects of this have been publically seen- the urgent requirement for SERCO to drastically increase number of orderlies (called porters, because Serco has no Southern Hemisphere experience in healthcare services) and the lack of provision of Oncology services. Other effects remain hidden from public view- junior and senior medical staff unable to be allocated annual and other leave in a timely fashion, unsafe waiting times for orderlies, the need to clean patient rooms late in the evening/night. Many departments are already suffering under the strain of excess clinical demand versus staffing e.g. Oncology, General Surgery and Anaesthesia

4. **(Temporal) Stability of Leadership**

After two and a half years, WA Health has a substantive DG. SMHS last had a substantive

Chief Executive with Ms Nicole Feely, since then we have had an A/ED, who has now been seconded to a further acting role at the NCH. His role has been filled by seconding the ED from FSH, whose role has been filled by seconding the DCS at FSH to A/ED. The DCS role has been filled on a six month, acting contract by a British national. The previous Deputy Director Clinical Services has retired. NONE of the above named positions were filled by competitive interview process. I repeat- on the medical side, no position above Service Co-Director that I can identify has been filled by a competitive process. The recent independent review of clinical services recommended forming stability and longevity in senior management positions- to which the publically espoused response by the A/ED FSH (and the SMHS A/CE, privately) was that we should wait until Hospital Boards are formed before any changes in substantive senior positions- mid 2016!!

5. **Engagement with Senior and Junior Staff**

The Review Of Operational Clinical And Patient Care At Fiona Stanley Hospital conducted by the Australian Commission On Safety And Quality In Health Care And MMK Consulting in June 2015 recommended that "Senior management engage with a broader cross-section of clinical leads to hear first-hand of front line problems with consideration given to the establishment of a clinical council." **This is yet to happen.** Great disquiet was expressed at the inaugural meeting of the FSH Clinical Staff Association, held on 12 August, at FSH that there was no or little meaningful engagement by senior management above the level of Head of Service with clinicians, either senior or junior.

6. **Lack of Engagement with Primary Care**

There has been a shameful neglect of the vital role that primary care plays in keeping patients with chronic disease out of hospital, no engagement with the primary care sector in the catchment area and the issuing of appalling discharge summaries- appalling because of poor ICT applications and because of enormous workload thrust upon junior medical staff. The AMA(WA) would welcome meaningful engagement and dialogue in this area- it can only reduce costs, reduce admissions and improve patient safety and outcomes

7. **Directorate Structure**

The Review referred to above also recommended the formation of at least two further management streams- currently a very large part of the operations, workload and budget of the hospital sits in one stream- Service 4, which includes ED, ICU, general surgery and many

surgical specialties, as well as burns and trauma, whilst three odd bed-fellows (excuse the pun) of mental health, women's and newborn health and rehabilitation medicine are together in Service 3.

8. Research

Despite the rhetoric prior to opening with respect to medical research the hospital management have been obstructive and unhelpful at every turn in transitioning existing clinical research to FSH. FSH cannot be a 'flagship' hospital in the clever country without having a vibrant and successful research component. In addition, there is international evidence that just by performing research, current clinical outcomes are improved. Adding to researchers' angst is that the vast majority of transitioning research projects came with existing funding- the risk and cost to FSH was to be negligible.

9. Infrastructure/Building

The FSH build consumed an enormous amount of public funding. It is a fine structure. But there have been building issues (e.g. two inundation episodes, fault mortuary floor) that have been publically highlighted and others, not so highlighted. When project management is devolved to private enterprise (Appian Group, Alan Piper Consulting etc.) it is imperative that there is skilled, continuous, thorough, diligent, robust oversight of that work by a public entity. It is important that private sector entities contracted during the build have a proven track record in hospital projects of similar magnitude.

In summary, I must say FSH manages to provide, in the main, good care, in spite of the above fundamental problems, due to the hard work and dedication of the doctors, nurses, allied health and non-clinical workers at the coal-face. The out-sourcing of so-called non-clinical services to an untried (in the Australian setting) and, (as it now transpires) deeply flawed multi-national service company has added to the burden to our members and others. That is absolutely no transparency in the contractual relationship between the State and Serco is further cause for concern.