Reforming New South Wales public hospitals: an assessment of the Garling inquiry

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ABSTRACT

- The final report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals was published on 27 November 2008.
- The report acknowledges the challenges facing the New South Wales health system, including increasing numbers of patients, rising treatment costs, workforce pressures, and the breakdown of working relations between clinicians and management.
- Many of Commissioner Garling's 139 recommendations formalise aspects of clinical care that should and could be happening now if the system were better managed, including better supervision and training of junior staff.
- Commissioner Garling recommends that change should be driven by clinicians "from the bottom up", but does not adequately describe how this should happen.
- Implementation of the report's recommendations that will require strong leadership and continuing consultation with clinicians and the community.

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The final report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals was published on 27 November 2008.[1] The Inquiry was initiated after two highly publicised incidents at Sydney's Royal North Shore Hospital: the death of 16-year-old Vanessa Anderson following a head injury inflicted by a golf ball;[2] and Jana Horska's miscarriage in the emergency department toilets.[3] Media reports indicated widespread community concern about treatment at public hospitals and clinician dissatisfaction with the health system.

Over 10 months, Commissioner Peter Garling SC and his team visited 61 public hospitals, reviewed over 1200 submissions, held 39 public hearings, and analysed over 30 000 documents. Australian and international experts were consulted as part of an exhaustive investigation.

The report acknowledges that the New South Wales health system has entered a period of crisis, describing our hospitals as

> good by world standards, in many cases ranking towards the top, but too often unable to deal with the sudden increase in patients, the rising cost of treatment, and the pressures on a skilled workforce spread too thinly and too poorly supported in the dozens of administrative tasks which take them away from their patients.

A major problem is the "breakdown of good working relations between clinicians and management", which Garling colourfully likens to the Great Schism (of the Church) of 1054.

Commissioner Garling makes 139 recommendations that aim to modernise work practices, administration and equipment (Box). He argues that the reforms should be open and transparent, and should engage clinicians in designing new models of care and implementing changes at the clinical unit level. His model for reform has four pillars, three of which are new bodies:

- the Clinical Innovation and Enhancement Agency, which will build on existing clinician networks to identify and implement evidence-based best practice;
- the Bureau of Health Information, to interpret and report data regarding quality and safety of patient care;
- the Institute of Clinical Education and Training, to drive effective training of junior doctors, nurses and allied health professionals; and
- an enhanced role for the existing Clinical Excellence Commission.

Significantly, oversight of the reform process will be independent of the NSW Department of Health.

The report states that "the safety of the patients and the quality of their care is paramount". Many of the recommendations formalise what we know should and could be happening now if the system were better managed and organised: careful supervision of junior staff, multidisciplinary teamwork, evaluation of clinical processes, performance management of staff, regular ward rounds, structured handover of clinical information, improved organisational cultures, and engagement with patients and carers. Poor hand-washing compliance is indefensible. Improved "after-hours" staffing is long overdue. Illegible handwriting has been tolerated for far too long. Anyone concerned with patient dignity will applaud the condemnation of "genderless" wards, which have developed to suit hospitals and staff, to the horror of patients. The Commissioner does not comment on why these problems emerged. Some would suggest it is a reflection of the effective disempowerment of the community's control of its hospitals.

Interprofessional communication, trust and respect are key ingredients in effective organisations,[4] but have been lacking in NSW health services. Commissioner Garling argues that rectifying this will require an improved approach to information and communication, regular clinical and behavioural audits, and a system of "delegated authority", with clinical leaders as "the champions of the changes". He recommends that a medically qualified Executive Clinical Director be appointed in each area health service; but, without the other initiatives, one person can rarely make a substantial difference.

Bullying is covered in some detail in the report, but with little recognition that it is rampant at higher levels. Intimidation and intolerance of dissent threaten morale wherever they occur. This behaviour is unlikely to change quickly, and mere talk of a "Just Culture" program undermines the Commissioner's credibility. Bullying should be dealt with through dispersal of power — by establishing clear and transparent decision-making processes with genuine involvement of the community and clinicians.

The power of the hierarchical bureaucracy has generated widespread "gaming" of system performance measurement. The creation of a "virtual ward" at Shellharbour Hospital (described in Appendix 8 to the report) is a graphic illustration of the endemic culture of "spin". The Commissioner recommends establishing an independent Bureau of Health Information, but does not address the challenge of ensuring the information it collects is accurate. A body like this would be convincing if it had statutory evidentiary powers comparable to the Coroner or Auditor-General.

Major recommendations and proposed changes to models of care for New South Wales public hospitals[1]

Major recommendations

- Up-to-date information technology statewide by 2013
- A Bureau of Health Information to identify, develop and publish patient care measurements regarding access to treatment, clinical performance, safety and quality, cost, patient experience, staff experience, and sustainability
- A NSW Institute for Clinical Education and Training to oversee multidisciplinary postgraduate clinical education, to provide training in leadership and teaching, to evaluate performance of staff in training, and to build a hospitalist workforce
- A Clinical Innovation and Enhancement Agency to build on Greater Metropolitan Clinical Taskforce clinician networks to prepare evidence-based care guidelines, to recommend and implement changes to clinical practice "from the bottom up", and to liaise with NSW Health and private sector change managers
- Appointment of an Executive Clinical Director in each area health service to advise area chief executives
- A single statewide health service called NSW Kids to organise health services for children and adolescents

Proposed changes to models of care

- Supervision of junior doctors linked to performance agreements
- Electronic medical records by 2010
- Pharmacist review of every patient
- Enforcement of infection-control protocols
- Multidisciplinary ward rounds and handover protocols
- Improved discharge practices
- Clinical support officers to free up clinicians, especially nurse unit managers, for patient care
- Redesign of rostering to ensure presence of senior clinicians, including allied health professionals, 16 hours per day, 7 days per week
- Centralised workforce planning
- "Just Culture" policy to overcome bullying and intimidation
- Patient-centred key performance indicators (KPIs)
- Redirection of non-urgent presentations from emergency departments
- Separation of emergency and planned surgical lists
- Digital diagnostic imaging with statewide centralised reporting
- Closure of selected hospitals and services to allow "critical mass" (ie, sufficient patients for clinicians to maintain and develop their skills)
- Collaborative partnerships between clinicians and administrators ◆

As expected from a courtroom-honed mind, Garling has probed and exposed the key issues, and articulated what must happen. However, he falls short of adequately describing how. We applaud his support for "bottom-up reform driven by clinicians",[5,6] but are concerned that implementation mechanisms are poorly conceptualised and recommendations are not costed. There is little reference to the substantial evidence base regarding health system redesign and reform.

There have been previous inquiries in NSW, most notably Commissioner Bret Walker's investigation into Campbelltown and Camden Hospitals in 2004,[7,8] which resulted in strong recommendations about quality and safety, clinical training and health system restructuring. We wonder why we needed another inquiry so soon. When governments are struggling to govern and the media are strident, inquiries proliferate. Internationally, there are plenty of investigations that have given us reform recommendations on which to draw.[9]

The past two decades have seen a progressive centralisation of authority in the NSW health system, and disempowerment of both clinicians and the community. The restructuring that took place in 2005 — the final stroke of centralisation of power — is correctly identified by Garling as a failure. He says the system is sick. Sound diagnoses are made, and appropriate treatments, including some "radical surgery", are recommended.

On balance, there is more that is positive than negative in this report, and it is worthy of our support. The real challenge is effective implementation. This will require courage and political will (not evident in recent years); outstanding political, clinical and community leadership; open discussion; and community engagement to an extent not previously seen. The support of the government, opposition parties, the media and the community will be essential for any realistic chance of success. Will it happen? We don't really know, because Garling leaves it to the new agencies and the health system itself. Exacerbating this, the economy is fragile, and additional investments for reform will not be easily found. The response from the state government looms as very important, and is eagerly awaited.

Competing interests

None identified.

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