Submission

No 37

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Date Received: 12/11/2007

Introduction

My Name is Dr Stephen Christley

I appear before the inquiry as a private citizen at the committee's request

I was CE of Northern Sydney Central Coast AHS from its formation in January 2005 until July 2007

Prior to that I was Joint CEO then Administrator of Northern Sydney and Central Coast AHSs from January 2004 to December 2004, CEO of Northern Sydney AHS from February 1997 to July 2004 and CEO of Central Coast AHS from March 1995 to February 1997

I am currently President of the Australian Healthcare and Hospitals Association

Background

Royal North Shore Hospital (RNS) has a long tradition in the provision of excellent patient care.

In the past, prior to the proliferation of the large number of private hospitals which currently exist, RNS was stated to be the largest "private hospital" in the country. RNS is located in the part of Sydney whose residents have the highest level of private insurance in Australia.

In the former Northern Sydney Health Area approximately 70% of all surgical activity takes place in the private sector. The public sector (with the valuable role of the Adventist Hospital in Hornsby Ku-ring-gai) deals with the emergency workload for the entire population. There has been a significant shift in activity to private hospitals over the past decade which has had a significant impact on elective activity in RNS. At the same time emergency attendances have continued to grow, and the emergency demand relative to hospital capacity has increased in proportion.

For clinicians there is a contrast between a private sector which has more predictable activity and the capacity to fund growth in activity and profit from it, and the demands of a public sector becoming more focussed on the 24 hour a day requirements of emergency activity. This is particularly the case for surgeons who have expressed much frustration at RNS over recent years. There have also been revenue impacts, with billings to private practice trust funds reduced.

In common with health systems across Australia, access to emergency services and elective surgery are issues for RNS. The health service has been acknowledged nationally and beyond for the innovative approaches it has taken to resolve access issues and improve efficiency, including the development of a 23 hour surgical ward, ambulatory care service, better coordination of discharge processes and its Acute Post Acute (hospital

in the home) service, and for its use of the 23 hour Ward And ambulatory care services to facilitate treatment of emergency as well as elective patients.

Comparative data shows that RNS performs well on casemix adjusted length of stay, and NSCCAHS as a whole has the lowest rate of inappropriate admission to hospital. Both of these are seen as indicators of appropriate and quality patient care

In recent times the hospitals access performance has slipped.

Terms of reference

Quality of care at the hospital

Regrettably, it is clear that adverse events do occur in hospitals. National evidence is that 1 in 10 patients will suffer some form of adverse event in hospital, with 2% being permanent or severe. One in 300 will die as a result of an adverse event.

RNS has a system of notification of incidents, now using the system standardised across the State. It also has a systematic audit of sample records investigating care issues (QARNS..Quality Assurance Royal North Shore) . There is review and reporting on care issues by a clinical committee, and issues are followed up with department heads. The General Manager is advised of relevant issues by the Head of QARNS, and an annual report is provided to the GM, the CE, and to the Department of Health.

At the time I was CE, complaints were handled through a single point (patient support office) and were investigated as appropriate either by departmental, divisional, hospital or other clinicians and managers.

Quality performance data was reported through the local Quality unit and the Clinical Governance Unit. The Area management Board, Clinical Council and Quality Council reviewed the data. A variety of Quality improvement projects were in place across the Area. I am aware of no evidence through complaints or SAC 1 reports that would indicate systematic issues at RNS.

Clinical Management/Organisation structure

The clinical management systems of the health service (Royal North Shore/Ryde) are based on clinical divisions each with a Clinical Director and Divisional Manager. This is a common structure across each health service in the AHS which has been implemented over the past year or so. Within each division there are sub accountability levels which again are intended, as far as possible to be common across Health services so that, for example, the clinician/management team responsible for delivery of maternity services in RNS Ryde can relate to their colleagues in the other health services to develop clinical care models, protocols, staff training packages etc. without needing to go through unnecessary management layers. These subdivisional accountability levels were not fully

implemented at the time that I left the CE role for NSCCH, and hence the Area structures (Networks) were in varying stages of development. The Clinical Leaders of these Networks, Professional leaders and management formed a Clinical Council which had just been revise to reflect the developing clinical management structure

A review about 2 years ago showed a need to improve alignment of cost centre structure with accountability structure at RNS. This is not fully corrected and will need to be to fully implement the new structure, if that is the intention of the new Chief Executive.

The implementation of the new structure was supported by a management development program.

I have found generally strong clinical leadership around matters of quality and patient safety at RNS/Ryde. At times, as in all health services, issues have arisen that have required change to be implemented and I have seen the hospital respond well to these situations. Any large organisation will always require ongoing attention to systems maintenance and issues that arise. It is a brave person who would claim perfection.

Resource allocation.

One of the aims of the new structure was to create management units that were comprehensive enough to be able to look for process improvements and efficiencies within them, and to remove artificial barriers to multidisciplinary developments.

Over the past ten years the allocation to RNS from the Area has increased at a greater percentage that the percentage increase of budget to the Area. This has been achieved through targeted use of growth funds and redirection of funding realised through corporate service efficiencies.

In relation to funding for the emergency department, there has been specific funding from the government/department of health for a range of initiatives including an Emergency Medical Unit. There has been a significant investment by the Department of Health in Clinical Redesign in the emergency department and other areas.

Growing demand continually places pressure on health budgets. This is not unique to RNS or to NSW Health. The challenge is to increase efficiency, reduce service duplication through effective networking and manage demand (through prevention, through better clinical management including linkages between hospitals and primary care).

Continually striving to improve patient care and outcome and reduce error is the common thread to the strategies that continue to be required. There is a strong commitment to these goals at RNS and within NSCCAHS.

I believe there is a need to look at the impact of the private sector on the public sector. As stated earlier I believe that the high level of private hospital utilisation for elective work,

and the substantial reliance on the public sector for emergency work has an impact that requires national and state review

Relationships

Many of the changes to corporate services that have been made over the past ten years have not been popular with some as they require following particular processes to order goods, or to procure equipment or capital works, but they have generated significant savings and form part of the savings approach of all health systems nationally. They also ensure compliance with various standards and requirements and OHS obligations. Health in NSW is moving to more standardised administrative and care processes backed by standardised IT. There is solid evidence to support these changes, though the balance between standardised process and professional initiative will require close attention. Again, some of these changes are not universally accepted

The relationship between the Area and Hospital/Health service is primarily conducted through the Clinical Operations Division. There is a monthly Performance meeting where Financial, access, quality and other indicators are reviewed and strategies discussed and tracked. There is a close relationship between the Clinical Governance Unit and General Managers/Service Directors and their Quality units and between Health service clinical support units and the Finance and performance units of the Area. Various mechanisms exist for communication between corporate service units and health service management. KPIs for Area Corporate units are provided to Health service managers .here have at times been tensions between RNS and Area managers. Health is complex and the interplay between accountabilities is at times also complex, particularly in times of change. In general I have found a real willingness to work together, which has increased over time as new structures and accountabilities bed down.

Stephen Christley