Submission

No 30

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Organisation: Section of Cardiology, Royal North Shore Hospital

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Submission

to

The Joint Select Committee of the NSW Parliament

(established to enquire into the quality of care for patients at Royal North Shore Hospital (RNSH))

by

the 18 Members of the Section and Department of Cardiology - RNSH

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EXECUTIVE SUMMARY

The current publicity surrounding a number of very unfortunate and even inexcusable events at RNSH has exposed a widespread systemic ill that is affecting the whole NSW Public Hospital network. **However, RNSH is a special case**. There is strong, irrefutable, documented evidence of creeping and advanced decay at RNSH which was once an internationally respected Centre of Excellence based on its outstanding Clinical Care, Research & Development, and Education and Training. In 2004 RNSH served 1,110,698 people (16.4% of the NSW population) in the Area designated as the "Northern Sydney Central Coast Area Health Service (NSCCAHS)" but is close to passing the "point of no return" with its demoralised and disenfranchised Medical staff and the lack of adequate resources at the clinical coalface. While RNSH was regarded as the "Best Hospital in the Country" after its Accreditation Survey in 1988 by the Australian Council on Healthcare Standards (ACHS), **by 2007 this peak Standards Accreditation body ranked the hospital in the lowest decile nationally.**

The question must be asked who is responsible for this tragic decline and what are the reasons behind the current sub-standard management profile at RNSH.

The Governance of RNSH is clearly not up to the standard required to run such an institution. It is run by a grossly overstretched "Area CEO" whose responsibilities span not only a huge geographical area, but also a mind-boggling assortment of healthcare facilities. The CEO answers only to the NSW Health Department since the abolition of Hospital/Area Boards. His main administrative seat has been 60km from RNSH in Gosford. Other crucial departments/services such as Finance, HR and IT have been removed and "centralised" at Macquarie Hospital in Gladesville, with the result that access to these core resources, including their leaders, is severely rationed. The hospital has been "led" for the last 11 years by a succession of 8 short-term, disempowered "General Managers". With progressive amalgamations – the entities rapidly metamorphosed from *RNSH* to become *RNSH/Northern Sydney Health (NSH),* and thence *RNSH/NSH/ Northern Sydney Central Coast Area Health Services (NSCCAHS).* There was also the associated misfit merging of Ryde and RNS Hospitals, so RNSH ceased to be an entity, which has led to confusion, especially with funding transparency and its allocation. This is immediately obvious from recent NSCCAHS Annual Reports in which it is impossible to work out who works for and at RNSH, and what resources are devoted to that campus. In the Area's 111 page 2004/05 Annual Report, RNSH/Ryde as an entity rates merely 2 pages and is featured after Gosford, Woy Woy, Wyong, Hornsby Ku-ring-gai, Manly, and Mona Vale Hospitals as well as Long Jetty Healthcare Centre. No hospital of similar standing in the world would be so well disguised and deprived of its rightful and hard earned place in its sphere of operation. The amorphous umbrella of the current Area structure is totally ill equipped to deal with the major issues confronting RNSH in the areas of Clinical Management Systems, Clinical Staffing and Organisation Structures, let alone effective and appropriate Resource Allocation.

Transparency and Accountability became early casualties of these drastic, ill-conceived and "one size fits all" hastily introduced changes. This followed the virtual dismantling of all significant organs of independent input into decision-making and Review, such as the Medical Staff Council and the previously mentioned Hospital Board.

The Resource Allocation and Clinical Management Systems for individual Departments at RNSH clearly suffer under current constraints. Therefore the 1st step must be to provide

structures specific to the needs of RNSH as an entity in its own right. Such a move would promote much needed transparency in Resource Allocation.

However, a further imminent threat to the proper functioning is that corporate memory, already drastically eroded, will be extinguished and irreplaceable staff will vote with their feet and leave for more favourable climates both nationally and internationally. With the ominously looming Medical workforce shortage, this is not a fantasy. The first drift is likely to be simply into the ample Private Hospitals in the Area that provide a dependable, supportive, stimulating and pleasant work milieu. If all other things were equal, the huge financial differential between the Private & Public systems would not be the determining factor for these Medical professionals. BUT – other things are far from equal between the two systems. The situation is not helped by the severe lack of funds and their means of allocation for vital equipment for clinical services. The use of Trust funds needs also to be overhauled.

RNSH has some remaining Departments that perform to world class standards, but even these are under threat due to deterioration in its general fabric, and its governance and administrative functions .Examples exist at least in the fields of Anaesthesia and Pain Management, Cardiology, Bone and Joint Disease, and Interventional Neuroradiology. In each of these specialties and to a great degree in several others, there is concentrated excellence derived from services and programs that involve innovative and leading edge Clinical Care, internationally recognised Research & Development ranging from Basic/ Molecular Science to Translational Research, a strong Academic and Teaching/ Training presence, and a well established R&D funding base. However, the general lack of adequate and efficiently allocated funds to, and on the campus, has only been counterbalanced in these areas by outstanding individual talent, dedication and entrepreneurship. These Departments have survived and even thrived *despite* the Area's systemic ills, having bypassed the problems through competitive research grants, their own Foundations with private donations, and industry support. Their own Foundations have also heavily supported clinical initiatives such as emergency triage and aggressive interventional treatment of impending heart attack on a 24/7 basis. They have funded two fulltime Chairs in Cardiology at RNSH and established and funded an Education and Rehabilitation community outreach for those with heart problems. RNSH attracted the first hospital headquartered Cooperative Research Centre (CRC) in Cardiac Technology (CRC-CT) that had a 7yr budget of $44million and returned $4.5mill cash to RNSH. Such existing capabilities are due to be enriched within 12 months with occupation of the new $91mill state of the art, University of Sydney co-funded Research and Education Building. But there is real concern that the current crisis on campus may lead to severe curtailment of the existing community support in the form of donations, industry collaborations and clinical trials as well as the attraction of staff, including international-standard R&D groups. Such support presupposes Governance and Management that is transparent, efficient and accountable.

This submission, unanimously supported by the 18 Specialist Cardiologists of RNSH, is EVIDENCE BASED, so that it mirrors the day to day professional practices of these staff members.

We, the Specialist Cardiologists at RNSH recommend the contents of this Submission to the Joint Parliamentary Committee of Inquiry in the belief that it will be considered to have arisen for concern for a great institution that is under threat of real, serious and lasting reversals. We also hope that **rational discussion, and development and implementation of a Rescue and Development Strategy will be firmly EVIDENCE BASED.**

1. Clinical Management Systems at the Hospital.

- **Clinical Management Systems have become unresponsive to the needs of patients, staff and the community that is served by RNSH.**
  Management invariably determines the Resource allocation on the basis of the "bottom line" which is arbitrarily determined in a totally opaque process. A telling witness to these Clinical Management Systems problems is the very poor performance of RNSH at its 2007 Accreditation Survey.

- **Medical Staff input into the planning and running of Clinical Management Systems has been eroded to the point where it has become irrelevant**. Doctors have been disenfranchised to the point where the only voice is to be heard in the "Divisions" which have become "bottom-line management silos". The former vibrant and effective Medical Staff Councils have become dispirited and irrelevant skeletons with meeting attendances at ~ 5% of their membership, indicative of their impotence and irrelevance.

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The Precipitous Fall in Standards at RNSH [1], [2]

The Australian Council on Healthcare Standards (ACHS): A Serious Systems Failure, Misrepresentation and "Denial".

The Australian Council on Health Care Standards is a "not-for-profit organisation dedicated to improving the quality and safety of health care through continual review of performance, assessment and accreditation" (www.achs.org.au).

The ACHS performed its three yearly survey of RNSH (April 30 – May 4, 2007) and after six months of further negotiation and discussion, the "Report Card" was eventually released in late October. RNSH barely fell over the line with a final gasp, being granted 12 months accreditation. **This factor alone qualified it to join the select LOWEST 12% of hospitals surveyed.**

The Sydney Morning Herald (p6, Oct 6-7, 2007) saw this as a case of "Royal North Shore Hospital failed to meet quality and safety standards". The SMH recorded an Executive Officer of the ACHS as saying that "RNSH was one of about 12% of hospitals that have been requested to fix problems and submit to a second check". "The council conducted a follow-up survey at the end of July to review progress and the hospital's accreditation was extended to September 29 to cover this additional review process". Yet, in the same SMH article the area health service "described the problems as 'minor'", stating that "the survey identified 'a number of administrative and record keeping issues that would have no impact on the care of patients'". An email was circulated to all staff by the hospital on 26 October stating that "RNSH has been awarded accreditation through the ACHS, until October 2008", and that "Staff are to be congratulated on their hard work and commitment to improving healthcare that has resulted in this accreditation".

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[1] Report of the Periodic Review for the ACHS Evaluation and Quality Improvement Program Royal North Shore and Ryde Health Service St Leonards, NSW . Organisation code: 11 00 91 Survey date: 30 April – 4 May 2007.Advanced Completion: 18 July 2007

[2] ACHS National Report 2003-2006

Despite this congratulatory email, the accreditation survey's outcome was no ringing endorsement of RNSH's standing. In fact it was quite the reverse no matter how the result was twisted or subjected to "spin". The bottom line is that RNSH has to substantially pull up its socks in many areas by March 2008 in order to clear the outstanding hurdles.

The approach to the current result by RNSH is representative of the worst in secrecy and misleading information to staff. It is contrary to honest appraising of staff of the reality of the situation and smacks of an unwillingness or inability to involve staff in working realistically to rectify the deficiencies. It merely extends and reinforces poor performance in the institution without bringing to account those who hide behind such failure. This is "denial" of the worst type.

This Survey outcome needs to be seen in the context that since its inception the ACHS has granted "Accredited" status, of one or other form, to 99.8 % (**all but one**) of health institutions surveyed.

The current RNSH achievement does not represent FULL Accreditation, which is awarded for three years. It is virtually impossible to get a significantly lower rating than that bestowed on RNSH.

The truth is that this "Accreditation" placed RNSH among the lowest 15% of national hospitals – both public and private, including some very small institutions. Yet less than 20 yrs ago a Medical Member of the ACHS Survey Team (Dr LA) remarked that RNSH had been considered to be "The Best Hospital in the country"!

So how does the ACHS score the hospitals it surveys?
Of five levels of "Criterion ratings" (**LA** – Little Achievement; **SA**- Some Achievement; **MA**-Moderate Achievement; **EA** – Extensive Achievement; and **OA**- Outstanding Achievement), RNSH received the middle score in each of the 7 reported "*Clinical Criteria*", each of the 3 "*Support Criteria*" and each of the 4 "*Corporate Criteria*". It is pertinent to note that although Extensive Achievement (**EA**) ratings were awarded on 943 occasions, and Outstanding Achievement (**OA**) ratings on another 26 occasions for the various criteria in different hospitals in 2006……..
RNSH failed to attract even one of these 969 higher levels of achievement in any category!

Thus RNSH certainly falls into the LOWEST DECILE of performers.

In January 2006 the Australian Commission on Safety and Quality in Health Care was established with Professor Diana Horvath AO appointed as the Chief Executive. An important aspect of the Commission's initial agenda is the national review of accreditation programs. This Commission will make recommendations that are expected to have significant implications for the ACHS and other providers of standards and accreditation programs.

In light of the current discussions on the desirability, composition, and roles and responsibilities of hospital Boards, it is also interesting to note the emphasis that ACHS Annual Reports place on its Board. It seems logical to argue that even allowing for the differences in operations and structures between Public Hospitals and an institution such as the Council, if the Standards setting and assessing body seeks legitimacy and efficiency through operating with a Board, the same would apply to the organisations that it Surveys and subsequently "Accredits".

The current scenario at RNSH with Accreditation is unfortunately reminiscent of much of the *modus operandi* of the Administrative and Management processes at the hospital, which do

the bidding of their Area masters. Feedback is severely censored and inadequate. There is denial of the problems identified, and there is no transparency in the whole process as far as staff are concerned. There is intense and in many respects panicked activity within the hospital for months leading up to ACHS Surveys, as the dust is wiped off previous, nearly three year old Survey recommendations. Very substantial resources – both financial and human, are suddenly mobilised to "fix" things for the Survey. The quantity and sources of these funds are not evident, but there is a strong perception that this is another substantial imposition on the hospital's budget, already heavily in the red.

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- **Perhaps the most damning indictment of the Systems' operation is the lack of acknowledgement** of innovation and superior health outcomes achieved through the expertise and sheer dedication of groups of dedicated Physicians and Surgeons.

  At RNSH this is epitomised by the Interventional Cardiology Service (eg Cardiac Intervention – ETAMI/SALAMI Programs), the assistance of the North Shore Heart Research Foundation (NSHRF) to the tune of ~$1.5 mill/yr – for Clinical and Educational/ Rehabilitation services, and Research & Development. Failure to acknowledge the impact of these achievements in an area of greatest impact on population health ie Heart Attack, is deplorable.

  The achievement of dramatically improved health OUTCOMES (as opposed to OUTPUTS) and the associated massive societal cost-savings by such leading-edge services has been "rewarded" by a cut in the budget. The extreme short-sightedness of Clinical Management Systems at RNSH is further underscored by the reluctance, bordering on hostility, to RNSH providing these services to "out of Area" patients from remote or even neighbouring Health Areas. The logic of this practice smacks of a belief that the funding for different Areas comes from a different planet, or somehow serves to advantage citizens of a foreign country.

- **Clinical Reference Group (CRG)**

  A "Clinical Reference Group" has been hastily convened by the new AREA CEO in early October 2007. Despite a request for Terms of Reference, these are still awaited in mid-November. The initial conditions for participation outlined by the invited Clinicians have been disregarded. As a result, the CRG has no clear remit or authority and its legitimacy and even its very existence must be in doubt.

  At the second gathering of the invited Clinicians the CEO tabled a series of 6 Reviews performed @RNSH over the past three years, which had lain idle. Clinicians present identified at least three other Reviews dealing with "Area Appointments", "Redevelopment of the RNSH site", and "Case Mix Data". The previous inaction on all these Reviews and their recommendations is most likely explicable on the basis of (i) lack of resourcing, (ii) frequent resignations of key staff, and (iii) the merry go round of "Acting Positions".

  After the 18 October meeting a "Management Action Plan" was circulated in which Specific Reference Groups (the "SRGs") chaired by chosen members of the CRG will be "held accountable" for delivery of the plans within their specific remit.

The Clinician invitees to the CRG had stated at the outset that for any ACTION PLAN to be viable and effective there must be adequate and specifically identified financial resources. This appeared quite logical and even self-evident in the current climate of severe fiscal tightening at RNSH. Regrettably the ACTION PLAN makes no mention of the provision of resources to be made available to address the multitude of Action Items listed and tabulated in the 20+ page document. This may be the true reason why none of the many Reviews' Recommendations have been implemented.

- **The Clinical management systems at RNSH have deteriorated immensely** since the creation of the unwieldy NSCCAHS, not least because of the abysmal lack of investment in Information Management & Technology. What exists in terms of IM&T support and development is principally offsite with inadequate, overworked, poorly remunerated and dispirited personnel who are often stressed and quite unable to respond adequately to the clinical needs of staff and patients

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GOVERNANCE

There is a Serious Disconnect Between the Clinical Management Systems @RNSH, the Organs of Governance, and the Executive and Senior Management.

- **"Corporate Memory" at RNSH is virtually absent in the Management and Administrative domains, with particularly serious consequences for Clinical Management Systems.** This has resulted from the frequent changes and brief tenure of middle and senior management over the past 10-15 years, as well as their dispersal across the Area in more recent times (**SEE TABLE as CASE STUDY #5**, page 26). Only low-middle and low level Admin & Management staff now remain to work at and for RNSH. This has been catastrophic for what was once a major Centre of Excellence in healthcare – including community outreach, R&D and Education/ Training. A recent case involving a senior RNSH medical staff member's appearance before the IRC is indicative of the overall situation[3].

- **Hospital Boards and even Area Health Boards have been abolished** (since **2005**). This leaves the Area CEO managing a budget of ~$1.4 billion without any independent and expert oversight. A powerless "Area Health Advisory Council (AHAC)" has been established to give a veneer of respectability, transparency and accountability to the draconian powers of the CEO. However, its more significant recommendations have often been rejected and its power to influence important aspects of RNSH's operations is minimal. This cosy arrangement allows consistent achievement of Executive KPIs and other "agreed" outcomes, even while RNSH is visibly decaying.

[3] Three appearances at the Industrial Relations Commission were necessary in 2nd Q 2007 for a Snr Staff Specialist to obtain Secretarial/Receptionist services. The RNSH/Area/Health Department were represented by the Deputy Head of HR and the newly appointed Business Manager of the appropriate Division at RNSH. One had been in the position for 4 weeks while the other had been at RNSH for 6 weeks. It became obvious throughout the three hearings that the NSW Health spokespeople "didn't have a clue" on the case. How could they? They never even visited the worksite and had no recall of any antecedents to the case.

- **The administrative emasculation of RSNH has involved the severe downgrading** over the years of its own CEO to Executive Director, and then to the current generation of "General Managers". The authorisations and effective decision-making capabilities of these GMs have been so circumscribed that all have found it unworkable. This in turn has led to the record turn-over of RNSH's leaders: 7-9 over 10 yrs (**SEE TABLE as CASE STUDY #5**, page 26). Such wholesale and continuing loss of "Corporate Memory" cannot be sustained without serious damage to a sophisticated institution and a purported "Centre of Excellence" such as RNSH. This phenomenon has inflicted near-fatal wounds on the hospital's operations in every sphere, from clinical standards to staff recruitment and retention, as well as the "Excellence" factors in R&D, and Education and Training. In the current climate of medical and nursing shortages it is too easy for these categories of valuable staff to simply "walk" to attractive greener pastures. And this is happening at an increasing rate among the highly trained and disillusioned staff who cannot be replaced for many years to come. The concept of "Team building" takes time and an attractive work milieu. It is this factor that makes for great hospitals and R&D institutions.

- **RNSH has weathered 7-9 changes of ED/GM during the tenure of the previous CEO**. No one asked the question as to "What was really going on at RNSH" to cause such a catastrophic turnover of the most senior Administrative position. No exit interviews were conducted of these key resignations of departing EDs/GMs. The opinions and advice of Senior Clinicians and Clinical Managers were not heeded.

- **The quite phenomenal staff turn-over – most noticeable among leaders of RSNH**, would raise serious ALARM BELLS in any major organisation. Yet in the $1.4 billion NSCCAHS and its predecessor NSHS, it hardly raised an eyebrow.

- **Victoria had its Enquiry into Governance of its Health Institutions in 2003[4].** This resulted in acceptance by the Government of all **45** of the Kibble, McKay and Bradley Committee's recommendations which included *inter alia* the establishment of 12 Metropolitan and 8 Regional Health Boards. The recent AMA national comparison of State Hospital performance ranks Victoria 30% above NSW[5]. At RNSH, framed photos of previous Hospital Board Members, displayed in its "Board Room" over the decades, were unceremoniously and secretly removed.

- **Unless there is a radical change in the current arrangement** with respect to Governance, the Executive and Senior Management, and the Clinical Management Systems @RNSH, the chasm cannot be bridged and RNSH will continue to deteriorate from its already precarious position as a purported "Centre of Excellence".

- **Also threatened is its role as a Tertiary and Quaternary Referral Centre** for at least 1.2 million citizens, the powerhouse for Education and Training in Australia's premier international gateway city, and the engine of Research & Development and Commercialisation. One of the greatest *potential strengths* of *RNSH's role in R&D and its Commercialisation, is its ideal location for TRANSLATIONAL Research* for which it provides the "dual carriage highway". This allows ideas and practice to flow

[4] Kibble, McKay & Bradley, Governance Reform Panel Report. August 2003 (www.health.vic.gov.au/governance)

[5] AMA Report into the Nation's Hospitals - Oct 2007

swiftly from "Bench to Bedside" – but importantly also in the reverse direction, so ideas from the fertile soil of clinical practice can readily move to the Clinician Scientists and Basic Researchers.

- **RNSH's geographical location has no peer in Australia.** A mere 10 minutes by car OR train from the CBD, 15-20 minutes by car OR train from the country's main international Gateway at Mascot, and with ready access (500m from its back entrance) to the grid of Motorways that lead north, south and west, the location of RSNH is unmatched.

- **The disconnect impacting on RNSH is partly related to the huge Area - 80Km from end to end,** of which it is a part, and due to the diverse and often conflicting needs and priorities that need to be accommodated. This arises from the very varied mix of small community hospitals, medium sized institutions and RNSH. The Area structure encourages the expedient movement of resources without any rational justification or trace of the deployments. In this respect, the removal of appropriate resources in Finance, HR and IM&T, and their centralisation at Macquarie Hospital is a major impediment to RNSH operating according to its intended role.

- **The detrimental effect on RNSH of the flattened pyramid with the current Area arrangement** is starkly evident from a glance at a typical NSCCAHS ANNUAL REPORT. Not one member of RNSH's top Management is mentioned in this Report which devotes a mere 1.5 pages (of 101) to RNSH. RNSH rates a mention after *nine* other hospitals in the Area such as Long Jetty, Wyong, Gosford, Hornsby & Kuringai, Manly, Mona Vale etc. RNSH ceased to have its own Annual Report with the advent of the NSAH ("From the Harbour to the Hawkesbury"). Any Visitor to RNSH would look in vain for meaningful information about this purported "Centre of Excellence" – a term used by the current Minister when she visited RNSH in October to address the newly convened Clinical Reference Group.

- **The Budgeting process and its effect on Clinical Management Systems.** Clinical Management Systems are severely impacted by the Budget which ultimately determines the Quality of Care through its direct effect on staffing, bed numbers and availability, the operation of the Emergency Department, the Operating Theatres, and Interventional as well as Diagnostic facilities and services. Capital expenditure and provision of crucial infrastructure necessary to even approach, let alone keep up with international standards of healthcare, and education and training has been grossly under-funded and poorly administered. (**see Further under BUDGET in Section 1(c))**.

RECOMMENDATIONS:

1. That RNSH be placed under the Governance of a highly professional Board free of significant political interference, by mid-2008

2. That the allocation of all staff attributed to RNSH be checked by a small (n=3-5 member) sub-Committee with membership of Clinicians and the Director of HR.
   - That the Clinicians to constitute a majority of the Sub-Committee, and
   - That Position Descriptions, including lines of Responsibility and Reporting, for all such staff be clearly articulated
   - That the Sub-Committee complete its Review by mid-2008 and make recommendations for reform
   - That the Sub-Committee continue an ongoing review function

3. That a suitably empowered and resourced Medical Staff Council be set-up at RNSH with effective representation on all significant administrative organs that affect the hospital's spheres of operation.

4. That Ryde Hospital be managed as a distinct, separate entity from RNSH with its own defined Budget, commencing Jan 2009

5. That Maxcquarie Hospital be managed as a distinct, separate entity from RNSH with its own defined Budget, commencing Jan 2009

6. That Budgeting and Accounting procedures be implemented that give regular, up to date and factual information that is readily available to all Senior Medical Staff

7. That RNSH commit to achieving full (3 Year) Accreditation by the Australian Council on Healthcare Standards (ACHS) at its next Accreditation Survey due in 2008.

8. That "Advisory" groups within RNSH be progressively changed to committees having representative membership with significant decision-making capability

9. That Transparency and Accountability become hallmarks of the operation of RSNH

10. That RNSH have its own professional ANNUAL REPORT commencing 2007/2008

1(b). Clinical Staffing and Organisation Structures at RNSH.

- ***Staff morale has dipped to such lows in recent years*** that staff now refer to the footbridge linking RNSH with its private neighbour – the North Shore Private Hospital, as the "Bridge of Sighs" in reference to the icon in Venice that evoked a similar emotional response.

- **No one seems to know how many people work FOR RNSH, how many work AT RNSH**, how many are F/T, how many P/T, how many are LOCUMS (Doctors), or from AGENCIES (Nurses) and what are their categorisations. RNSH is lumped together with Ryde Hospital which is clearly not a 3° or 4° R&D based Centre of Excellence. Even the Macquarie Hospital complex now features under the RNSH umbrella. RNSH no longer employs anyone – as it has no legal standing, and even the Area has lost this status. All are now employees of NSW Health which applies an absolute limitation on the quantity, quality and timely hiring of essential staff. While there are theoretic advantages of having all employees signing an undertaking to work in other geographic locations within the Area that are remote from RNSH, this policy leads to instability and the plugging of holes with endless personnel in "Acting" positions. Such employees have limited allegiance or identification with RNSH, creating a situation which also makes training and retention extremely difficult.

- **The mix between Staff Specialists who are 100% committed to the institution and VMOs who also service and crosws-fertilise the institution is essential**. Both categories have shown a steady decline because of the deterioration of the physical fabric/infrastructure, and other resources needed to effectively "practice their art" at RNSH. This has been compounded by the unresponsiveness and not rarely the incompetence of the management and administrative systems that are in place for its operation.

- **The Clinical Staff feel totally disenfranchised, their collegiality via the Medical Staff Council and Sections has been methodically fractured,** and their ability to actually speak to anyone with authority – either individually or collectively has evaporated. The chances of catching the CEO or even lesser management personnel such as significant Finance, HR or IM&T staff for a chat or discussion is virtually zero. An example was provided in the not too distant past where the long-serving CEO – even with his "minder", could not find the appointed meeting venue in a certain major Department at RNSH.

- **The result of the above situation has led to the virtual fleeing of Senior Medical Staff from RNSH –** which nowadays is much easier with the increased alternatives in the Private Sector. Yet the proximity of the Public and Private sectors at the RNSH campus is one of the best illustrations of the "win-win" outcome of such co-locations. Keeping senior medical staff "geographically local" has immense benefits for efficiency of service delivery, staff morale and health (via lower stress and less travel) and even more so for creation of a Centre of Excellence based on Research and Development, and Education and Training – of Medical Students AND Junior Mos (JMOs). The latter has recently become even more of an imperative with the shortage of doctors and nurses throughout the country. RNSH has a pivotal role to play in these vital areas of operation, not only in its own Area, but even far beyond.

RECOMMENDATIONS:

11. That a concerted, ongoing and appropriately resourced program be instituted to enhance Staff morale within RNSH

12. That RNSH recognise, acknowledge and reward its internationally competitive areas of excellence and take special care to assure their advancement.

13. That urgent action be taken to assure full, empowered and ongoing clinical input into the design and commissioning of the new RNSH

14. That specific steps be taken to demonstrate the hospital's commitment to its Workforce, their professional development, training and skills enhancement

15. That a realistic and achievable strategy be put in place to attract, promote and retain new specialist Medical and Nursing staff to RNSH, using its current burgeoning R&D infrastructure development and the building of the new RNSH Hospital.

16. That all new Appointments to RNSH be made in full consultation with the Med Staff Council and other Medical forums (eg Departments) taking into account the relationship with other hospitals in the RNSH "sphere of influence", especially the new "French's Forest Hospital".

17. That a concerted effort be made to establish/maintain a desirable balance between fulltime Staff Specialists and VMOs. This ratio will vary among specialties.

18. That RNSH vigorously promote itself as a UNIQUE ENTITY and as a Hospital Centre of Excellence that is R&D based, with the highest standards of Medical Education and Training – at least in its own sphere of influence, which currently comprises ~1.2 million people.

1(c). Efficiency, Effectiveness & Appropriateness of Resource Allocation & Utilisation within the hospital – in particular in the Emergency Department

Budgeting and Resources.

- ***The Budgetary process and the subsequent handling of the allocated moneys is totally opaque to RNSH staff, except possibly the anointed few.***
  The lack of transparency in the process of budgeting and resource allocation is a grave concern because of the impact it has in all spheres of the hospital's operations. The repeated outcome of the budgeting process is the promise of inadequate resources, and gross inefficiency in their delivery. The process is affected by multiple and often impenetrable layers of bureaucracy that impede decision making and add to needless administrative expenses. The dysfunctional budgeting causes staff stress and influences staff recruitment and numbers. Eventually it is the morale, satisfaction and quality of staff and their retention, in a highly competitive market for Doctors and Nurses, that suffer.

- ***The Resources claimed to be allocated to RNSH cannot be verified.*** This has been compounded by RNSH being joined to Ryde and Macquarie Hospitals. Staff and facilities have been shared in the Area - notably in HR, Finance and IM&T and high levels of Administration have been moved offsite from RNSH. ***The formula for attributing the cost of such staff between hospitals is secret – and possibly quite arbitrary.***

- **RNSH regularly receives its "Budget" in August** – nearly two months into the Financial Year. The year always starts with a deficit of several million dollars inherited from the previous year PLUS a 6-8% cut imposed on RNSH. Many aspects of the Budget are based on unreliable and often palpably false information[6], partly related to poor IM&T infrastructure, staffing and services. The Budget "bottom line" is generally regarded as having been manipulated during the closing months of the FY by the transfer of all manner of funds eg Trust Funds and Capital Expenditure Funds into the General Fund to bolster Management's performance. The resulting lack of Capital Expenditure funds for many years has led to a marked decline in the fabric, and effectiveness for clinical care of the 37 odd (and mostly very old) buildings that make up RNSH. There are recent reports of Workers Compensation Funds being spirited into General Revenue to balance the books. These practices, if proven, could raise serious issues of probity and liability.

- **Capital Expenditure has been a serious casualty of Budgeting and Resource Allocation.** The huge expenditure on large numbers of grossly overpaid and at times inferior Locums, and the constant need for Overtime occasioned by staff shortages and impossible bed occupancy rates is a recurring and serious drain on scarcely budgeted funds.

- **There is no responsibility at Departmental level since it was all moved to "Divisional silos"** which appear to have as their major remit the achievement of meeting the "bottom line" imposed on them.

[6] E.g. Leukemia "separations" comparison between Areas – refer Dr Chris Arthur correspondence

- **Raining Bricks @ RNSH.**
  Falling bricks from the 12 storey "Main Building" @ RNSH (merely 35yrs old) finally drew attention to the devastating effects of starvation of funds for Capital Expenditure @RNSH. Even so, action only followed when a brick fell on a bypasser. Emergency measures were taken including erection of scaffolding to contain the threatened areas of the façade. This resulted in a rather unique series of "tram tracks", still amply visible today. If this is the fate that befell the hospital's "glamour building", the state of the built environment comprising 36 odd other buildings on campus can only be surmised.

- **Cleanliness and dual sex occupancies.** The recent Health Department Enquiry by Professors Clifford Hughes and William Walters into the Janet Horska incident at RNSH led to a recommendation that the Emergency Department "Toilets be kept clean". That admonition is equally relevant to the whole of RNSH[7]. It is not uncommon to have patients complaining of blood stained toilets and floors, or toilets not having been cleaned between changes in bed occupancy. This phenomenon is related to poor supervision of cleaning staff and even more so to the 97%+ occupancy rate at RNSH which makes it necessary to newly occupy beds that are still "warm" from the previous occupant. Many patients also complain about the mixing of sexes in four bed wards which often offends their dignity and comfort.

- **Current "Window Cleaning to boost staff morale" [8]** – This recent initiative has had wide Press exposure. The fact that it is still incomplete and patchy in application some weeks following a very expensive "blitz" by contractors working over week-ends, is worrisome. Also concerning is the fact that cleaning has been confined to "patient and visitor areas" **This is another slap in the face for staff** and represents a failure to understand the non-aesthetic INFECTION implications of filth in hospitals. Unfortunately, "bacteria" don't differentiate between patient and staff areas!

- ***"How many beds does RNSH have"? This a simple question thatt has many answers.***
  Or perhaps it's just part of the culture of secrecy, lack of accountability and inefficiency that it is virtually impossible to obtain a meaningful answer to this question[9]. The answer should of course NOT include Ryde Hospital or any other institution. The ***status of the beds*** eg in use, closed etc should also be indicated. Further, the number should be broken down as – on any one day, in any one week, or the average over the year. One person dedicated to do the rounds for an hour each day could easily provide reliable figures without any "if and buts". These figures should be readily available. Yearly numbers used to be displayed on an "Honour board" in the foyer of RNSH, but this became an embarrassment with the rapid decline in numbers and the board was duly removed.

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[7] Horska Report by C Hughes & W Walters. In this context. late last year RNSH was described by a renowned visiting UK Vascular Surgeon (NF) who became aware of the frequent resistant and recurrent hospital acquired infections @ RNSH, as "the filthiest hospital I have ever seen".

[8] Window Cleaning NOTICE via email to all Staff from RNSH Management

[9] Minister Reba Meagher recently claimed that "the bed count had risen to 599 "acute beds" – an achievement that may be due to the one temporary bed that appears to have been added after the Janet Horska episode, to accommodate a patient who miscarries. Yet in the same article Dr Tony Joseph the RNSH based NSW Chairman of the Australasian College of Emergency Medicine puts the number between 350 and 400 beds (The Daily Telegraph, p2, 29 October 2007).

- **How NOT to "solve" BED BLOCK in the Emergency Department**
  (see also **CASE STUDY # 4, p25**)

  Ill-considered and hasty decisions taken "on the run" and under the influence of stress often lead to unforeseen and adverse outcomes. Such was the case when the long-festering issue of JMO Supervision & Training in the level 6 Cardiology Stress Lab again raised its head during the IMET Accreditation Survey in 2nd Q 2007.

  IMET specified that this issue be resolved immediately and as the highest Priority for Accreditation to be granted. An additional problem was that Chest Pain presenting to the ED was a major source of Bed Block which was receiving lots of publicity. So the Cardiology service was imposed upon to provide a "Chest Pain Clinic" to promptly clear such cases out of ED. This decision involved significant additional workload on the Stress Lab. Additional "resources" were promised, but were in reality actually *withdrawn* in respect of middle level Medical personnel (Advanced Trainees – ATs) involved in Training & Supervision of this service..

  The Results:
  (i) Bed Block has been merely transferred out of the ED to the Cardiology Service, and
  (ii) JMO Training and Supervision is not up to standard – a fact that has been communicated to those who failed to deliver the resources required and promised
  (iii) It is quite possible, even likely, that the IMET accreditation of RNSH in some areas has been jeopardised
  (iv) Additional and unnecessary Stress has been placed on ATs, Technical Staff and more Senior Supervisory/Training and reporting staff.

RECOMMENDATIONS:

19. That Departments and Sections be enfranchised and suitably resourced in a transparent manner BUT be required to run as viable Business Units with proper *local* Administrative and financial input/advice.

20. That the Capital Expenditure Budget be realistically funded, especially during the coming difficult 8-10 yr period spanning the new hospital development, when the current decaying infrastructure will place even heavier loads on this budgetary item.

21. That Capital Expenditure Budgets and Trust Funds @RNSH be quarantined to protect them from "raids" that have previously unfairly depleted them to fund deficits in Area budgets.

22. That all Departments be required to produce a significant Annual Report, to be made freely available on the Intranet +/- the Internet

23. That Electronic displays of real-time, objective "Bed-status" be displayed at least in the RNSH Entry Foyer and the Emergency Department. Such displays to include at least the statistics enumerated**.**

24. That operation of the Chest Pain Clinic and its components, including the Stress Laboratory in Cardiology, be re-evaluated and properly resourced wrto personnel so as to achieve the necessary standards of safety, efficiency and JMO Training and Supervision consistent with IMET requirements and standards.

1(d) The Effectiveness of Complaints Handling and Incident Management at the Hospital.

(See also CASE STUDIES #2 and #4)

Trust, morale, confidence and institutional identification

- **Institutional pride and identification are core attributes for any organisation,** particularly for one as complex and large as RNSH. These attributes will only be in evidence if the organisation's behaviour reflects the ideals that it purports to support and intends to practice. Lack of transparency in many facets of RNSH's operation, and questionable probity of statements by higher authorities and "Hospital Spokespersons" have led to a breakdown in trust and confidence in hospital administration, with severe impact on staff morale and their identification with the institution.

- **Trust in RNSH and in those controlling its fate has been repeatedly and severely fractured.** Two recent examples illustrate the point. The most blatant was the recent statement by Minister Meagher concerning "acute bed" numbers at RNSH (**See Footnote #7**) which was subsequently proven to be markedly inaccurate. Another example was the immediate denial by a "Hospital Spokesperson" of claims made by Dr P Blunt[10] concerning events surrounding the mismanagement of a patient's repeatedly delayed admission for surgery to RNSH.

- **The staff's lack of trust in hospital administration and in those dictating their terms of operation,** extends to many critical areas of the hospital's functions. Staff become understandably sceptical and even disbelieving of statements about the availability and utilisation of resources - both financial and human. RNSH staff are constantly being reassured from the highest levels of administration, the hospital "Spokesperson" and the Health Department and Minister that RNSH resources including cash, personnel and beds have been increased. Yet staff onsite see no evidence for this – quite the contrary. This is partly due to the constant in-house and extramural lack of transparency and accountability resulting in the subjective and distorted "spin" to which RNSH is so regularly subjected. Apples are compared with oranges and statements are often based on irrelevant and inaccurate information that is provided by the grossly under-resourced IM&T department.

- **An important "barometer" of the institution's caring** for the mental and physical wellbeing of its staff was its 2006 handling of the removal of the Staff funded Recreation Centre from the RNSH campus. This demonstrated any lack of empathy for staff welfare, their satisfaction with their worksite and the nurturing of a collegiate institutional identification to encourage and sustain morale.

Harassment & Bullying:
Stress and Trust – essential partners in any organisation

- When staff lack trust in the institution, and fail to believe that their welfare and worksite satisfaction is second only to that of the patients the substrate is created for

[10] One of the very rare cases where the Spokesperson subsequently apologised for its hasty and incorrect statement to the Press.

serious problems. When this situation is coupled with serious under-resourcing then the stage is set for high levels of stress among staff.

- Stress is often the antecedent to real, perceived or purported Harassment and Bullying. It is unlikely that the measures suggested by the recent Meppem-Dalton Report[11], which echoes the findings and recommendations of an earlier 2004 Report, will change the undesirable "culture" or practices unless the core issues underlying the problem are identified and rectified. It is unlikely that an edict from the CEO that "Zero Tolerance will apply to Harassment and Bullying" will lead to a lasting solution to this important problem that is intertwined with trust, morale and institutional pride.

- Officially Harassment and Bullying will no doubt disappear as a result of the current flurry of activity and publicity. But if it has its roots in employee stress and dissatisfaction/ disillusionment – which can be reasonably argued, then it will merely find expression in other, perhaps more subtle but equally damaging behaviours. The solution is likely to be intimately linked to appropriate and adequate resources – both financial and human, and their prudent use.

RECOMMENDATIONS:

25. That conditions for the physical and psychological/emotional welfare of RNSH Staff be methodically improved

26. That RNSH take pride in its Staff and provide incentives and facilities for their attraction to and retention within the institution

27. That dress code, possibly including the RNSH Logo and prominent Name Badges with Name and affiliation to Department/Service, be implemented

28. That effective on-campus recreational facilities be immediately established for Staff to cover the current "Transition Period" of redevelopment, but also to be incorporated into such redevelopment

29. That small group informal meeting facilities be established for Nursing and Senior Medical Staff. Such facilities to provide access to electronic communications incl Intranet and Internet facilities, newspapers and light refreshments.

[11] Review of Work Place Culture and Allegations of Bullying and Harassment. Meppem-Dalton Report 2007 – initially not available to Senior RNSH Medical Staff, and later only the "Conclusions" version was made available before finally the Full Report was widely circulated.

CASE STUDY #1

Self-Help in the Cardiology Service @RNSH

and how it has learned to survive and prosper – despite institutional obstacles and some close calls.

- **The progress of Cardiology services and the flowering of Innovation, Research & Development** and Education/ Rehabilitation services @RNSH over the past 20 years is an attractive Case Study of what can be achieved at such an institution despite severe bureaucratic impediments, inadequate funding and dysfunctional resource allocation based on opaque principles and practices.

- **RNSH Cardiology is a prime example of a highly effective PPP** in the provision of cardiac invasive testing (coronary angiography) and in the new era of interventional cardiology with angioplasty and stenting. These facilities are co-located on level 6 of the Public Hospital, linked by a bridge from the NSPrivate Hospital. The RSNH group has achieved international acclaim for its development of arguably the most effective acute Heart Attack service in the country, actively involving the NSW Ambulance Service in early triaging of impending heart attack (eg ETAMI and SALAMI studies). With this approach heart attack patients, often bypassing other Area hospitals, are transferred directly *THROUGH* the RNSH Emergency Department, saving vital time, preventing ED overload and lessening morbidity and mortality. Because of the rescue of "heart muscle" provided by this service, there is substantial saving to the community in terms of $ cost as well as Quality of Life and return to work.

- **What is not promoted, and not even acknowledged by the Area or NSW Health** is the fact that this service only came into being, and has continued its operation, solely because of the funding **provided by the North Shore Heart Research Foundation established by members of the Cardiology Department 20 years ago!** Such a 24/7 service takes a merciless toll on Cardiologist Staff, which is different to virtually all other specialties because these Physicians not only perform the life or death determining diagnostic and therapeutic interventional procedures in the catheter laboratories, but they also look after the same patients from the moment they arrive at RNSH and also after the procedures. They do not take time off in lieu of services provided after hours, which has been on a 1 in 5 roster basis.

- **The North Shore Hear Research Foundation (NSHRF) established and continues to provide** the salaries of two fulltime Professors in Cardiology working at RNSH. For several years it provided half salaries for two additional Senior Lecturers at RNSH to also perform the life-saving invasive procedures. Beside this, the Foundation provides annual grants to fund PhD students and Research Projects as well as equipment. All up the NSHRF has provided nearly $20 million to support such initiatives at RNSH. It also provided 1/3rd of the funds for a major refurbishment in Block 4 to allow cardiological laboratory research to commence in earnest on campus.

- **Further, the Foundation established the Northern Cardiovascular Education Centre 15 years ago** and fully funded its operation for the 1st 5 yrs from unconditional funds provided by ER Squibb and Sons – the international Pharma company. The NSHRF support continues to this day on a 1:1:1 basis with Pfizer Pty

Ltd and RNSH. The Centre has a highly valued role in population and patient education as well in cardiac rehabilitation.

- **The Cooperative Research Centre for Cardiac Technology (CRC-CT).**
  In 1992Cardiology @RNSH attracted the CRC-CT for a 7 yr funding period with a budget of $44 million. This involved collaboration with 4 Universities, 3 NSW hospitals, Industry – notably Telectronics Pty Ltd which was Australia's most successful and visible "icon" in the implantable medical devices field, and two CSIRO Divisions. RNSH was the first, and for several years the only CRC among 10 in the Medical Science and Technology Sector to be Headquartered at a hospital. A RNSH Cardiologist acted as the CEO of the CRC-CT. The success of this venture is unquestioned, and it brought extensive experience to the campus in terms of collaborative and cross-disciplinary ventures as well in Governance (including a prestigious International Scientific Advisory Committee), Budgeting and General Administrative functions. The intense Peer-Review by comparison with 52 other CRCs nationally – often in other Sectors, made for a vibrant, internationally competitive Joint Venture overseen by a high-level hand-picked Board.

  The CRC-CT trained a generation of "industry-ready" PhDs – among them the current Head of Cardiology at Westmead Hospital, and its research led to a valuable Intellectual Property portfolio that was acquired by an UK based devices manufacturer for $26 million in March 2002. As one of the 4 Lead institutions in the CRC-CT, RNSH gained $4.5 million in cash from this acquisition. RNSH derived immense benefits from its participation in this venture with its contribution being purely that of "facilities" – largely access to space. This episode demonstrates the benefits of linking good Governance, competent and responsive Administration and Management with high quality R&D talent for mutual benefit. At that time RNSH allowed fairly free rein to the CRC-CT venture and was happy to be represented on its Board which also had high level representation from the other major Participants. Subsequently the experience gained on the CRC-CT Board by the then CE of RNSH (NB) allowed him to spearhead a successful CRC bid in the field of asthma at RPAH where he went to work after resigning as RNSH CE.

- **There have also been extreme frustrations in Cardiology @RNSH** through the years of operating with outdated and substandard equipment in the Echocardiography Lab. Only last year a new machine was purchased for ~$400,000 from donated funds facilitated by one of the Cardiologists via the NSHRF.

- **Another "saga" unfolded only last year** with the urgent need to re-equip one of the Cardiac Interventional Labs when the equipment broke down yet again, but this time during a procedure – thus threatening the patient's life .
  (**see CASE STUDY #2 – "Waste in 3 Administrative Dimensions"**).

- **The Exercise Stress Testing Laboratory in the Cardiology Department** has also had its share of problems related to poor management which has been intertwined with Administrative staff changes and lack of resources. This has led to concerns about JMO Training in this Lab, with threats that the mandatory IMET Accreditation for the lab maybe curtailed for the present crop of JMOs working there. The Stress Lab is a central plank of the handling of chest pain which constitutes one of the most common and potentially dangerous presentations in ED. In recent months a new Chest Pain Clinic was established @RSNH but the promised resources have failed to materialise.

CASE STUDY #2

Waste in Three Administrative Dimensions

– (i) Patient Safety, (ii) Work Efficiency, (iii) Financial Waste from Tendering Outcome and Warranty Expiry.

Or: *Where some of the "beans" are spent at the Royal North Shore Hospital*

- **This Case Study examines the Cardiology Department's concerns about moneys wasted** in the administrative process dictated to RNSH by the Department of Health's protocols. It is our opinion that many millions of dollars of public moneys are being wasted by ill-conceived emphasis on "due process". The following case illustrates how completely dysfunctional the simple replacement of a piece of essential equipment has become. The issue warrants further scrutiny.

- **Treatment of heart attacks must be completed without delay**. At Royal North Shore Hospital we have successfully piloted a scheme whereby patients are brought straight from the ambulance, bypassing the overstretched emergency department, to the interventional laboratory, where the blocked arteries are opened with tiny balloons and repaired with small metal stents. The outcomes are dramatic and lives are saved. The process, however, requires the use of sophisticated digital angiographic radiology.

- **The aging equipment at RNSH failed in April 2006 during the treatment of a heart attack** victim. A desperate plea to the hospital's Administration for its replacement followed previous requests, which had been parked in the "wish list" for over than 6 months.

- **On April 28th 2006 an order was placed with the caveat** that the equipment be on site by the end of the financial year. The equipment was delivered by airfreight from Japan on **June 28th 2006**. One of the Specialist Cardiologists had met with the supplier and the builder who had installed the initial laboratory a decade earlier. A quote was received and an estimated completion date in early **August 2006** was given.

- **Then the "administrative process" took over.** The first of 2 Project Directors was appointed and deemed a "Cost Estimate" necessary. The estimate exceeded the builders quote by a factor of 3 (**$450,000 as opposed to $150,000**), due mainly to the anticipated consultancy fees. A request to the Administration to see a breakdown of the fees has been repeatedly denied.

- **The Project Director met with 3 private recruitment companies**. His choice of company then tendered for a Project Manager and a Principal Design Consultant. Their task was to prepare a tender prior to a preferred builder being appointed.

  The first Project Director provided Cardiology with a copy of a Health Department document called "Corporate and Clinical Support, Capital Strategy and Works". This document listed the administrators to be involved in the project: Divisional Manager, Project Director (2 ultimate appointments), Director of Capital Strategy and Works, Facility Planner, Project Manager (3 ultimate appointments), and Principal Design Consultant. This was before any builder was to be appointed.

- **In April 2007, Cardiology wrote to the Administration to express concern,** as a builder was yet to be appointed. The reply from the Project Director was that because of the "Shared Service Level Agreement" or something similar, another 3 weeks were needed before a builder could be appointed. By this stage, the high technology equipment was in danger of being damaged as it still lay in the hospital's loading dock. Some was accordingly **sent to "High Tech Storage' off site in the southern outskirts of Sydney** at Taren Point.

  The original builder with whom Cardiology had met 12 months earlier was eventually appointed and works commenced. The **final delay in September 2007** was due to the non-payment of invoices to the storage company who would not release the equipment from Taren Point. Meanwhile, the **12 month warranty** on the equipment had expired.

- More than **60 weeks** after the equipment was urgently delivered, the laboratory was finally **finished in October 2007**. The company graciously installed upgrades of both hardware and software at no cost!

- It might be asked how treatment of heart attack victims was managed during these difficult times. Fortunately, **the laboratory of North Shore Private Hospital is co-located** within the public "Cardiac Interventional" laboratory complex. Use of their facilities enabled treatment of public RNSH patients.

- **In contrast to the "due process" dictated by the Health Department**, a similar piece of equipment was installed in the Private laboratory in **6 rather than 60 weeks** during this trying time.

- **The Royal North Shore Hospital has a funding deficit for clinical services and patient beds**. It is impossible even to begin to calculate the costs of the administrative process described above. But if this experience is shared by other Departments in the hospital, many millions of dollars are being diverted from patient care. This is where some of the "beans" go.

- **Urgent rationalisation of the administrative process is required**. If clinicians applied this administrative process to their decision making there'd be no patients to worry about.

The Cardiology Department's second laboratory is due for replacement at the end of 2008!

CASE STUDY #3

A Shining Example of the "Possible"

The Northern Specialist Centre (NSC) @ RNSH

- **The Northern Specialist Centre** is representative of what can be done @ RNSH in a relatively autonomous Business Unit when the initiative and hard work of its staff is allowed some latitude in the running of its own affairs.

- **It shows the benefits of combining autonomy with adequate oversight and advice** from a dedicated "Management Committee" consisting 6/8 of Specialist Doctors. Some support from the hospital Finance department, but minimal interference from Area or hospital administration have been the essential ingredients of success. Even so it has been a constant battle for NSC to have a dominant voice in its own HR matters, and the Finance personnel have shown the typical rapid institutional turn-over, making strategic planning and responsible resource allocation and utilisation unnecessarily difficult. The NSC's significant move into a modern IT environment has been frustrated and greatly delayed by the poor resourcing and roll-out of state-of-the-art computer systems that would allow the NSC to communicate effectively with other staff and services at RSNH and beyond.

- **The NSC's operation also illustrates the broader benefits of cross-fertilisation across the NSCCAHS** region. It has helped establish a similar type of service at Gosford with the NSC Manager (JC) mentoring one of NSC's previous staff members (KH) during the set-up phase and with one day a month visit to the Gosford facility..

- **The Northern Specialist Centre is provided for use by Staff Specialists employed by RNSH** to facilitate exercise of rights to private practice under the Salaried Senior Medical Practitioners (State) Award. This arrangement keeps Specialists geographically local on the RNSH campus and serves to enhance the patient services and prestige in the region and beyond. NSC provides substantial financial return to RNSH, with its success attributable in large measure to its operation as a distinct Business Unit within RNSH.

- Located within North Shore Private Hospital (Level 4 Suite 9), the NSC operates 7.30 to 6.00pm Mon - Fri, has 12 well equipped private consulting rooms; one treatment room; reception area, and office space designed to provide a convivial, efficient patient and work environment.

The constantly expanding Practice caters for >57 specialists providing a variety of specialist medical and surgical services as shown in the Table:

Cardiology	Haematology	Psychiatry
Clinical Immunology	Hypertension	Renal Medicine
Clinical Pharmacology	Infectious Diseases	Respiratory Medicine
Endocrinology	Neonatology	Rheumatology
Gastroenterology	Neurology	Sleep
General Medicine	Nuclear Medicine	Upper G.I. Surgery
General Surgery	Oncology	Vascular Surgery

- **The Rooms have been recently fully refurbished and re-equipped** with modern computing hardware. A new software system is to be installed in the near future.

- **The location within North Shore Private Hospital** gives broad access to other specialists and laboratory facilities including radiology and nuclear medicine. Patients prefer the proximity to these facilities, including parking, the Ritazza Café, Flower Shop and Chemist.

- ***Staffing:***
  Staffing of NSC of 14.75 FTEs with the recent addition of a position for Health Information Services to retrieve records required on a daily basis to ensure continuum of care for its patients.

  The staff employed at NSC are all multi-skilled to ensure coverage of all positions, allowing it to be fully self sufficient without reliance on Temp or Agency Staff workers. Staff are supported to enhance skills to ensure they are fully aware of new practices and processes. This also supports progression of staff within the department.

- ***Revenue Generation:***
  The remarkable "turn around" within the NSC is best illustrated by its financial performance which has occurred since its management was effectively left to itself without significant interference. Other benefits have flowed in the form of additional resources for refurbishment, computer hard- and software and a very stable, productive and collegiate workforce that works particularly well at its interface with patients and Specialist Doctors.

Period	**Revenue**	**% Increase on previous Yr**	**Comment**
FY 2005/06	**$400,368**		
8 Months to 28 Feb '07	$513,053	**82.8%**	
FY 2006/07	$2, 600 000	**549%**	**Favourable** Cost Centre Budget

- ***IM&T:***
  NSC has new computer hardware to ensure the Doctor's quick reliable access to required sites such as radiology and pathology, as well as reference information on medications and treatment plans.

- ***Recent Refurbishment of NSC:***
  NSC completed a major renovation in Oct 2007 at a cost of $202,000 which was recouped from its yearly budget. This included (i) construction of an extra consulting room, (ii) full recarpeting and repainting, (iii) new computer hardware and software, (iv) new waiting room chairs, (v) refurbishment of existing work space, and (vi) Digital typing solution software to enhance correspondence.

CASE STUDY #4

Inept Administrative Pressure, IMET Accreditation & Lack of Resources

RNSH Accreditation by IMET; JMO Staff Training & Supervision; Chest Pain Clinic & Stress Testing Laboratory

- **It was indicated to Cardiology that resolution of JMO Training & Supervision was essential** to satisfying the Surveyors and the accreditation process. It was pointed out, unbeknown to the Cardiologist Supervisor of the Stress Lab facility, that the Council's Surveyors had raised these concerns at the previous survey some 4 years earlier, and that they still remained to be addressed in June 2007.

- **Carriage of the issues appeared to have been delegated to several layers of administration**, following its first raising by the DMS. Yet while the initial solution was sought through active intervention of the Supervisor to redesign resource-intensive services, no one subsequently asked him whether the proposed solutions were working. Even subsequent correspondence related to resources and IT initiatives went unanswered.

- **In the Exercise Stress Testing Laboratory JMOs deal with the highest risk outpatient diagnostic procedure in the hospital.** There can be serious and costly ramifications if the testing and supervision/Training is not of the highest quality. At this time the Cardiology Department was also pressured to establish the new "Chest Pain Clinic" in the Department rather than logically siting it in/near the ED because of resource constraints. Thus the ED "bed-block" was just shifted to the Cardiology Wards with added expense.

- **The promised resources for taking on the Chest Pain Clinic and the increased and heavier load** on the Stress Lab, including Advanced Trainee involvement, did not materialise.

- **Siting the Chest Pain Clinic in the Cardiology Ward & its Stress Lab had two other adverse consequences:** (i) less of the community referred chest pain subjects (normally about half the lab's load)can now be accommodated for Stress testing, which inhibits the "community outreach" and primary/preventive healthcare that is seen as an important part of the work, and (ii) the ED referred patients are at increased risk since a greater proportion have "Strongly Positive" stress tests requiring urgent action. The JMO and Technician training resources for this are particularly important. Beside the change to a more heavily loaded patient "mix", the number of stress tests has also gone up dramatically – (**2003:876**; **2005:1192**; **2007** 1009 to end Sep = **1345** whole year)

CASE STUDY #5

SNR POSITIONS – Movements 03/04 to 05/06 (Note: 06/07 unavailable as of 8 Nov 2007**)**

Position	2003/04 ANNUAL REPORT	2004/05 ANNUAL REPORT	2005/06 ANNUAL REPORT	2006/07 ANNUAL REPORT	Status as of Nov 2007	*RNSH ONLY* **NOTE:** No RNSH posns in NSCCAHS Annual Reports
CEO – RNSH – 1995 NSAHS 1996 – 05 NSCCAHS 2005-	Stephen Christley **(SES Band 7)**	Stephen Christley	Stephen Christley	**Unavailable as of 8 Nov '07**	***RESIGNED*/ ? Dismissed 2007**	**EDs/ Gen Managers (7-9 over 10 yrs)** Norman Full ED George Jepson ED Norbert Berend ED Andrew Bott (Acting) Joanne Fischer ED • **04/05** Debra Latta – GM ***RESIGNED*** • **05/06** Mary Bonner - GM
Dir Workforce Development			Jenny Becker- ***RESIGNED***	**Unavailable as of 8 Nov '07**		
Director Clin Governance Director, Clinical Services & Innov	Philip Hoyle **(SES Band5)**	Philip Hoyle	Philip Hoyle			
Dir Population Health, Planning & Performance		Paul Douglas	Paul Douglas ***RESIGNED***	Chris Fleming	***RESIGNED***	
Dir Finance,		Graeme Harding	Graeme Harding		***RESIGNED***	

Director of Clinical Operations	Linda Smith		Phillipa Blakey ***RESIGNED***	**Unavailable as of 8 Nov '07**	Julie Hartley-Jones	
Dir Finance, Corp Services & Performance		Linda Smith ***RESIGNED***				
Director of Operations	A Bott ***RESIGNED***					
Dire Nursing & Midwifery		Kylie Ward (Acting)	Kylie Ward (Acting)			
Dir Integ Health CareServ&ADN	Kathy Baker **RESIGNED**					
Dir Services Planning & Corp Strategy	Michael Roxburgh **RESIGNED**			**Unavailable as of 8 Nov '07**		
Chief Info Officer		Joe Abraham	Joe Abraham			
Director of Corporate & Clinical Support			Greg Chase			
Director of Corporate Communications		Elizabeth Ambler	Elizabeth Ambler	Elizabeth Ambler		
Director Area Mental Health			Nick O'Connor			