Submission

No 32

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Organisation: Australian Medical Association (NSW) Limited and the Australian Salaried Medical Officers Federation (NSW)

Date Received: 9/11/2007

Parliamentary Inquiry Royal North Shore Hospital

Submission by

Australian Salaried Medical Officers, Federation (NSW)

&

Australian Medical Association (NSW) Limited

The doctors, nurses, allied health and support staff of RNSH provide an outstanding level of patient care

The problems with RNSH are not related to the quality or efforts of the medical, nursing and allied health workforce, they are a function of an over-stretched and under-resourced hospital and the failure to listen to staff on the front line.

1. Introduction

Australian Medical Association (NSW) Limited (AMA) and Australian Salaried Medical Officers, Federation (NSW) (ASMOF) welcomes the opportunity to make a submission to the Joint Select Committee on Royal North Shore Hospital (RNSH). However, we are disappointed about the short time frame to make submissions and the narrow terms of reference of the Inquiry.

AMA and ASMOF are the most significant organisations representing the industrial relations and medico-political interests of doctors in NSW.

AMA is a medico-political organisation that represents over eight thousand doctors in training, career medical officers, staff specialists, visiting medical officers and specialists and general practitioners in private practice.

ASMOF represents medical practitioners employed in the New South Wales public sector.

ASMOF is registered under both NSW and Commonwealth laws. It is affiliated with the NSW Labor Council and Unions NSW.

AMA and ASMOF make a joint submission to the Parliamentary Inquiry. In doing so, we seek to show the unity of the medical profession and to highlight the serious nature of the concerns regarding the functioning of all hospitals in NSW, including RNSH.

We also seek to express our strong support for the medical, nursing and allied health staff of RNSH, who continue to provide services of the highest standards.

The problems at RNSH are the result of a complex set of circumstances the consequences of which, whilst dramatically manifested at RNSH, are also being felt at most hospitals and health services in New South Wales.

The submission addresses the Terms of Reference and provides further detail regarding key factors about Royal North Shore Hospital performance which are in the public domain. In summary, these concerns are

- The failure to provide sufficient beds and resources to ensure safe service delivery
- Operation of the Emergency Department
- Workforce planning
- The failure of management structures to provide direction, support and accountability in the operation of a major teaching hospital
- The failure of clinical and corporate governance structures to ensure effective, responsive interactions with doctors

The submission then identifies in further detail major structural issues with the provision of health care at RNSH and in NSW, being:

- inadequacies in the structure and amount of Commonwealth funding to the States through the Australian Health Care Agreement; and
- Health service funding to the North Sydney Central Coast Area Health Service.

At the conclusion of the submission, we respond to Point 2 of the Inquiry

1.2 "Any strategies or measures in place or proposed for improving quality of care for patients at the hospital which may also benefit New South Wales' public hospitals."

AMA and ASMOF call on the Committee to

- ***Recognize the critical role of RNSH in the provision of health services in NSW and the dedication of the doctors, nurses, allied health and other staff in the provision of those services***

- ***Recognize that the focus on Area wide services at the expense of the identity of individual hospitals has not worked***

- ***Mandate the establishment of effective governance structures to obligate accountability by hospital and area executives in the delivery of health care services***

- ***Immediately increase the number of beds at RNSH by 70 and provide adequate resources to staff and operate these beds***

- ***Undertake an appropriate clinical services review involving meaningful and responsive consultation with doctors, nurses and allied health staff***

- ***Implement arrangements to address the serious issues in the senior management of RNSH and the Area, particularly effective measures to address the turnover of senior management staff***

- ***Review the allocation of funding to RNSH considering particularly the implications of complex and emerging clinical procedures provided at the hospital***

1.3 Royal North Shore Hospital

Royal North Shore Hospital (RNSH) lies within the Northern Sydney Central Coast Area Health Service (NSCCH). This is an area of NSW that extends north from Sydney harbour to the southern shore of Lake Macquarie and west to Wiseman's ferry. Geographically it covers 13 Local Government areas from Gosford and Wyong in the North to Mosman and North Sydney in the South.

RNSH is one of Sydney's largest public hospitals, established in 1885 it serves 12% of the NSW population, RNSH is also a major teaching, tertiary and referral hospital. Approximately one third of all patients come from with the four local Government areas of Lane Cove, Mosman, Willoughby and North Sydney, however, there are also significant out of Area admissions accessing complex and critical care services.

RNSH services a population with a high proportion of elderly patients. The NSCCHS 2006 Annual Report notes that 19.1% of patients in the area are aged over 75 years, compared with 16.4% in the wider population.

The hospital offers a large number of clinical, community and state wide services. The hospital is affiliated with the University if Sydney (Northern Clinical School) and the University of Technology, Sydney (nursing education).

During interviews and consultation with members from RNSH and also doctors who had trained or otherwise been associated with the hospital, the common theme was a sense great sadness at the demise of the hospital. A member said

"In 1988, RNSH was regarded by the ACHS as one of the top hospitals in the country. Now, we are struggling to be accredited."

The recent ACHS survey provides clear evidence of the demise in the hospital. In 2007, RNSH failed to obtain accreditation and was given a further 6 months to improve standards. According to the ACHS Annual Report 2003-2006 published in 2007, between 2003-2006, 1233 onsite ACHS surveys were undertaken. Of those surveys, 83% of facilities were granted full accreditation (full accreditation being for a period of 4 years). Only 1% of hospitals surveyed failed to achieve accreditation. RNSH was subsequently granted one year of conditional accreditation from October 2007. ACHS defines conditional accreditation as being "awarded when the organization has met all mandatory criteria at an MA level but has not met all non mandatory criteria at an MA level and the survey team finds a moderate or higher risk within the organization. (ACHS National Report 2003-2006 page 12).

The ACHS Survey said of RNSH that there were "a number of administrative and record-keeping issues".

AMA and ASMOF have interviewed and consulted with members and are aware of the submissions prepared by individual doctors and departments from RNSH. The submissions and comments address a range of factors which are seen to have contributed to the decline of RNSH. It is not the purpose of this submission to establish in detail the particular areas of concern for each department or Area of the hospital. We are able to instead comment on the consistency of the overall submissions. The message across all submissions is that the standards of patient care provided at RNSH remain

world class. What is instead being lost is the sense of pride and identity associated with a facility in which world class medicine is practiced.

The practice of degrading the identity and sense of belonging to a hospital has become widespread since the Amalgamation of Area Health Services in 2004. However, this degradation and the consequent loss of identity seem particularly pronounced at RNSH. While some teaching hospitals now have stronger clinical linkages with neighboring district hospitals, RNSH has been formally linked with Ryde Hospital to become the Royal North Shore and Ryde Health Service. Many doctors have cited significant frustration with this arrangement which is seen as diluting the identity and role of both facilities, to the benefit of neither.

Public hospitals are complex entities. They rely on more than doctors, nurses and allied health and other staff working to a high personal standard. Successful hospitals also ensure a sense of belonging and commitment to the facility and this must be fostered by government policy, NSW Health, Area Health Services and local management. This submission, based on input from doctors at RNSH and informed by interaction with doctors across NSW, sends a clear message that re-engagement with doctors is vital.

2. Response to Terms of Reference

2.1 Terms of Reference

ASMOF and AMA note the terms of reference of the Inquiry. We are particularly concerned that the investigation has been limited to RNSH, when the issues which have triggered the Inquiry are demonstrably applicable to all other hospitals throughout NSW. If the NSW Government had been genuine in seeking to improve the function and operation of NSW Public Hospitals, they would have allowed for a comprehensive state-wide review with adequate timeframes for submissions. Notwithstanding the limitations of the terms of reference, we maintain that all of the conclusions reached in our submission could be equally directed to all hospitals in NSW and as such, our submission reflects this.

We note that since the terms of reference were formulated, the review of the Jana Horska incident conducted by Professor Clifford Hughes and Professor William Walters has been completed. While we do not see Parliamentary Inquiries as the appropriate mechanisms for the review of individual clinical incidents, we believe the concerns expressed about the Hughes/Walters review are sufficiently grave to require the review process to be incorporated into the terms of reference for the Inquiry.

Our concerns regarding the review are as follows:-

- The review was conducted by doctors who are eminent in their fields and who are well respected by our Associations. However, there was

insufficient involvement by related specialists, namely Emergency Physicians.

- For reasons which are contested, there appears to have been inadequate consultation with Ms Horska. Irrespective of the reasons, it is inappropriate that a review should have been released without adequate consultation with the patient.
- The review has failed to recognise significant systemic issues such as the overcrowding of the emergency department. These findings are flawed and appear to have resulted from a lack of consultation with the staff involved in the care of the patient.

The outcome of the review leaves doctors and nurses with the clear message that genuine systemic issues will not be considered in the review of patient incidents. This is unacceptable and places doctors and nurses in a position in which they can still be held personally accountable for attempting to function in a system which does not provide them with adequate resources and support.

1a. Inquire into and report on the quality of care for patients at the Royal North Shore Hospital and in particular clinical management systems at the hospital

Interviews with RNSH doctors indicate that information management systems at the hospital are poor with doctors getting no useful data as to how they can impact upon the overall performance of the hospital. For example they are not provided with data of performance against targets or information about patient length of stay or cost data, so that they can identify measures that may be effective in improving hospital outcomes.

There were expressions of disappointment at the continual deferment of new data systems. RNSH has been waiting more than 10 years for a PAC radiology system to allow for the sharing of images from other locations. Members have advised of outpatient clinics without basic infrastructure such as computers and patient management systems.

A member said

"We have patients with complex illnesses attending our outpatient clinics and we cannot track who will be coming in on the day. We don't have a system to manage their complex medication requirements or to track their follow up. 8 doctors frequently have to queue up in the clinic to use the one computer or the one phone, trying to track results for patients. This is in a tertiary referral hospital."

Another member said:

"In about 30% of my outpatient clinics the old notes are not available. These are complex medical cases in which the previous records are essential. The result is scrambling around to locate letters, attempting to retrieve records

from often just one slow computer or the patient has to be rebooked. This is not satisfactory in a tertiary referral hospital."

Concerns were expressed at the lack of both operational and strategic management, with no accountability to regulate patient flow and an unhealthy focus on output rather than outcome based management, so a poor result is more likely to occur.

Typical of many, but not all hospitals, management ignores the views of clinicians.

1b. Inquire into and report on the quality of care for patients at the Royal North Shore Hospital, and in particular the clinical staffing and organisation structures at the hospital.

Notwithstanding presumed adjustment within the Resource Distribution Formula for treatment of patients residing outside the area's health service, there is a widely held view that the hospital is not adequately compensated for this workload, which was stated to be as much as 25 per cent and which is due to RNSH's wide referral network. This leaves the hospital perpetually under-funded and over budget.

A member working in medical oncology reported

"Our ward was cut from 25 to 16 beds about 5 years ago
A will bequest provided the $3 million to renovate the ward to provide 8 single rooms and 2x4 bed shared wards. Since then VRE has arrived. Our 8 single rooms are now prioritized to VRE patients from any other speciality in the hospital. This means Oncology admissions can be found scattered throughout the hospital.
The number of oncology patients treated at RNSH has increased dramatically. Protocols have changed, meaning more outpatient treatments; these are not counted on DRG lists.

The work load on the treating specialists has increased dramatically- We have been able to add 1 more staff member- no registrars, and I am told we treat almost as many patients as other hospitals that are covered by at least 10 specialists and 10 registrars- leaving no time for teaching/ research/- and adding many hours of unpaid overtime to our burden.

Because we have all just done this required work- putting in a required "business" case- to get more staff means little. I can't remember when we had an elective admission- except to 1 of our 2 dedicated chemo beds- (which were cut from 5 to 2)

Oncology patients hate hospital- it's an admission of defeat- but some don't have the home support and discharges are held up by lack of hospice or nursing home placement positions.

This cascading effect then means an extra burden through our casualty - the only way a neutropenic –septic patient- or someone with uncontrolled pain can be admitted. Those that need re-assessment with scans are put on waiting lists (due to cuts in radiology) thus blocking even more beds- that could be better utilized.

The treating specialist then faces the patient and relative anger that nothing seems to be moving forward- they are in a ward without appropriate nursing backup- having spent hours in the emergency department.

The Northern area cancer statistics show we have the largest cancer burden in the state per capita. Patients may be more wealthy, self funded retirees, (who have contributed their Medicare levy- and private health insurance) however, most of the time there are no beds available in the private hospitals available for acute oncology admissions. The whole thing is a mess with no evaluation of increasing need met by increasing resources. This is a good example of how cuts cascade through the whole of the hospital leading to extreme patient dissatisfaction and wastage but somehow the over - worked doctors have allowed it to happen by just trying to do more and more with less and less.

Because of budget constraints, insufficient administrative staff are recruited, so the load falls to doctors who then do not have time to manage patients' clinical needs.

The new organisational structure which has been in place for 18 months is less effective as there is now no financial control within each Division. The reduced leadership role for doctors in the Division also impacts upon the morale of staff and the effectiveness of services.

Doctors report being disenfranchised by the Area structure which has downgraded their hospital and removed the sense of identity and pride associated with the hospital.

The failure of clinical services planning is resulting in difficulties in establishing and maintaining clinical services networks.

1c. Inquire into and report on the quality of care for patients at the Royal North Shore Hospital, and in particular the efficiency, effectiveness and appropriateness of resource allocation and utilisation within the hospital, and in particular the operation of the Emergency Department.

Doctors advised that there was no meaningful capital budget so staff were lumbered with broken or outdated equipment. Reliance on outdated equipment impacts efficiency and in turn it becomes difficult for the hospital to demonstrate a business case for additional funding in competition with other health services.

It is noted that in the 2005/06 NSCCAHS Annual Report the net cost of services for the Emergency Program area reduced from $87.3 million in 2004/05 to $77.2 million, a fall of twelve per cent, whereas overall funding for the AHS increased by five per cent.

Members cited frustrations regarding availability of equipment, or even information about plans to replace or purchase equipment as a major frustration and blocks the efficiency of the hospital.

A member reported:

“I have recently been involved in the replacement of one of our ageing cardiac catheter laboratories. These labs are used in the emergency treatment of heart attack patients. In mid 2005, I alerted the admin of the need to replace the 10yr old equipment because of my concern regarding its reliability. No moneys were available. The equipment then failed during the treatment of a heart attack patient with near fatal consequences. The event was reported in about March 2006 and I received an urgent request from the hospital to provide admin with a requisition for new equipment. I was given 6 hours notice to have the request on the desk that afternoon. Fortunately, I had the relevant data and provided the requisition for $1.5 million. The money for the lab came from a fund on the proviso that the new equipment had to be on site by June 30th. I met with a builder who said he could have the new lab up and running by August 2006. The equipment arrived by airfreight from Japan on June 28th 2006 but at that point the "administrative process" took over.

The Health Dept protocols dictated that "cost estimates" be obtained. These exceeded the builders quote by $300,000 and the rot set in. A series of consultants and administrators were appointed, multiple project meetings were held but no installation of the equipment occurred.

The equipment remained on the loading dock of the hospital for more than 12 months. Some was then taken to a storage company in Sydney's southern outskirts.
The 12 month warrantee of the equipment expired. The job was eventually completed 60 weeks after the equipment was delivered. The final delay occurred because the storage company would not release the components because RNSH had not paid the storage invoices. A similar project was completed in the Private Hospital in 6 weeks. Safe patient care was only possible because the RNSH patients were able to be treated in the North Shore Private laboratory.

The cost of the above fiasco is impossible to measure but must be approximately $0.5 million. If the waste of this money on the upgrade of only one room in the hospital is replicated throughout the Area, then many millions of dollars is being diverted from patient care.”

There must be a clear program for consultation with medical staff on the updating of equipment suitable to the operation of a tertiary hospital.

See also comments in Section 3.1 regarding bed occupancy and funding.

1d. Inquire into and report on the quality of care for patients at the Royal North Shore Hospital, and in particular the effectiveness of complaints handling and incident management at the hospital.

Doctors advise that although they are made aware of complaints they are not provided with resources to deal with the identified problems. The Emergency Department has had about 40 complaints in the last 4 weeks.

The Australian Commission on Safety and Quality in Health Care provides guidance on complaint management. *Better Practice Guidelines on Complaints Management for Health Care Services* [July 2004] and *Complaints Management Handbook for Health Care Services* [July 2005] establish the following Guidelines:

1. Commitment to consumers and quality improvement
Leaders in the health care service promote a consumer-focused approach to complaints as part of a continuous quality improvement program.

2. Accessible
The service encourages consumers to provide feedback about the service, including concerns and complaints, and makes it easy to do so.

3. Responsive
The service acknowledges all complaints and concerns and responds promptly and sensitively.

4. Effective assessment
The service assesses complaints to determine appropriate responses by considering risk factors, the wishes of the complainant and accountability.

5. Appropriate resolution
The service deals with complaints in a manner that is complete, fair to all parties and provides just outcomes.

6. Privacy and open disclosure
The service manages information in a fair manner, allowing relevant facts and decisions to be openly communicated while protecting confidentiality and personal privacy.

7. Gathering and using information
The service records all complaints to enable review of individual cases, to identify trends and risks, and report on how complaints have led to improvements.

8. Making improvements
The service uses complaints to improve the service, and regularly evaluate the complaints management policy and practices.

Clearly RNSH and its staff are unable to respond in the fashion prescribed by the ACSQHC in the absence of sufficient resources to do so.

Doctors also report that where issues are raised, the systemic causes of the

concerns, such as insufficient resources, beds or staffing, are not addressed.

1e. Inquire into and report on the quality of care for patients at the Royal North Shore Hospital, and in particular operational management of Royal North Shore Hospital in general but in particular, the interaction between area and hospital management as it relates to hospital efficiency, effectiveness and quality of care.

The clearest failures in the operation of RNSH appear to be at a management level. Over the past 10 years, RNSH has had no less than 7 general managers (members are unable to recall exact numbers, most suggest the figure could be as high as 10). This is having a catastrophic affect on the strategic direction and operation of the hospital. At an Area Level, there has been a similar turnover of senior staff, and at present we are advised that the following senior positions are vacant or filled on an acting basis

RNSH
Decision Support Manager – Acting
Director of Nursing – Acting
Director of Finance – Acting
Clinical Director (Surgery and Anaesthesia) - vacant
Divisional Manager (Division of Medicine) - vacant
Deputy Director of Medical Services - Vacant

NSCCAHS
Director of Clinical Operations – Acting
Chief Financial Officer – Acting
Director of Finance – Acting

The frailty of the management structure is clearly demonstrated in the witnesses being called by the Area. Of the 10 witnesses, 5 are listed as acting. Of the remainder, most are extremely recent appointments. This is unacceptable and places the credibility of the management structure at question.

Members report that there is little effective communication between the hospital and the Area Management. They feel disenfranchised by the amalgamated Area structure and receive little or no effective feedback or strategic direction from hospital or Area management.

Any feedback received from the Area seems to be limited to unspecified concerns about budget.
Our members have indicated -

"Staff have become totally disengaged from administration over a number of years."

Staff are not only demoralised but burnout rates have been accelerated by the extremely poor work environment and work conditions."

"While resources are a major issue just pumping in more resources won't fix the problem unless a lot of the people, - staff as a community – issues are addressed. Management style needs an overhaul".

"It is output rather than outcome based"

"the bottom line, the hospital needs more money and more humanity and a focus on patient care, not budgets."

Clinical staff advises that all new positions have to be approved by AHS, with no discretion for appointment at the hospital level, so the approval process is tortuous and slow with 6 or 7 different people involved.

As a related outcome the RNSH Human Resources Department has been stripped of staff with now only 4 HR people to manage 5000 staff, which adversely impacts upon the ability of HR to respond to employment issues for existing staff and affects staff morale.

Within the AHS an inordinate proportion of junior staff have been appointed to senior positions in an 'acting' capacity. The lack of seniority at the AHS impacts its ability to negotiate with NSW Health head office and discourages timely decision making.

From the doctors' perspective the AHS has no workforce plan and no strategic direction.

A member commented:

"As the involvement of clinicians in decision-making has been intentionally discouraged, management has been changed frequently and generally staff have been discouraged from having any "loyalty" to their service or hospital… then the engagement of staff and reservoir of goodwill essential to running large public hospitals has disappeared and likely will never return. No more so the case than at RNSH."

2.2 Hospital Redevelopment

The dysfunction in the effective interaction between doctors and the hospital and Area Management is clearly evident in the planning surrounding the construction of the new hospital. For the record, AMA and ASMOF maintain grave concerns regarding the funding of the hospital through a public private partnership. Evidence from the UK suggests that such funding arrangements for hospitals are ineffective and not in the best interests of the delivery of quality health care. However, this is not the focus of this submission.

Of significant concern is that members have advised that they have been completely excluded from the planning process associated with the development of the new hospital.

A member has advised:

"The proposed redevelopment of the RNS campus has been undertaken using superseded architects plans of the hospital. As a result, the pathology laboratories were omitted from the redevelopment because the architects did not realise the current location of the laboratories, and were instead using plans more than 10 years out of date. As a result of this:

1. *A number of key laboratories are scheduled to be demolished as part of the redevelopment. These include such extraordinary oversights as:*
   a) *demolition of the Blood Bank*
   b) *Separation of the Anatomical Pathologists from the Histopathology Laboratory and their relocation to a distant site.*
   c) *Bisection of the Haematology Department and relocation of the Laboratory (and Clinical) Haematologists away from their Haematology Laboratory and many other impractical proposals*

2. *The laboratories that are not scheduled to be redeveloped are located in buildings that are 40+ years old - far older than the RNS building itself. The current main laboratories are actually housed in a lightweight structure sitting on top of the roof of the original outpatients building, and thus the floor of the laboratory (which is the roof of the original building) is not designed for load-bearing, and yet this is where some of the largest and heaviest laboratory equipment is necessarily located. The structural problems of the hospital building are present even more significantly in the current pathology premises, with aged and failing infrastructure that (in some cases) is physically unable to accommodate modern sophisticated equipment, computers and robotics.*

When we have drawn this to the attention of the architects, and to members of the AHS Executive, they reply that they acknowledge an error has been made, and yet no effort is being made to rectify this.

Clearly it is not too late to have this fixed. For if it is not fixed, how can the hospital pass its ACHS accreditation? It will truly be the hospital with no patients, as in the infamous "yes Minister" episode.

It is extraordinary that a redevelopment of this size can be being planned so as to have a hospital without an on- site pathology service.

The frustration evident in the above statement was echoed by doctors from many other sections of the hospital. They are angry, disenfranchised from the decision making process and costly, dangerous errors are being made in the planning process for the new hospital.

Similar concerns have been expressed with regard to mental and community health. Despite the evidence for devolution and decentralisation of community health services, RNSH is dismantling it's community health services and putting ever increasing pressure on Emergency Departments

and the hospital generally. It is proposed to further this "recentralisation" in the hospital redevelopment by closing community health centres located in central, non-threatening locations (located close to shopping or other service areas) and placing mental and community health services to the main hospital campus. This is against evidence of best practice and the advice of doctors and mental health workers.

Many critical decisions are also being delayed pending the development of the hospital. Given the most likely timeframes for the completion of the hospital are around 9 years, such delays are unacceptable.

3. Specific Issues Related to the Terms of Reference

3.1 Bed occupancy rates

New South Wales is not alone amongst the States & Territories and Australia is not alone amongst countries to face the problems arising as a result of high levels of acute hospital bed occupancy.

The UK Parliament Committee of Public Accounts report *Inpatient Admission, Bed Management and Patient Discharge in NHS Acute Hospitals* [24 February 2000], cited work undertaken by UK Department of Health's Economics and Operational Research Division which showed a clear relationship between high occupancy and the risk of cancellation of elective admissions. It established that at occupancy rates higher than 83 per cent the risk becomes pronounced.

University of York research which used a different methodology found very similar results.

The UK Parliamentary Office of Science and Technology report *Infection Control in Healthcare Settings* [July 2005] also found that the spread of health care associated infections is associated with:

- bed occupancy rates…Studies have found that lower occupancy rates are associated with lower MRSA rates.
- nurses tending many more patients than they used to thus potentially increasing the spread of HCAIs. The use of unregistered or poorly trained staff can compromise infection control practices.

The Australasian College of Emergency Medicine [ACEM] and the Australian Medical Association have identified that bed occupancy rates in excess of 85 per cent lead to elective surgery cancellations and delays in patients being transferred from Emergency Departments to inpatient hospital beds.

The 2005/06 NSCCAHS Annual Report identifies increasing occupancy rates [of equivalent beds] at RNSH peaking in 2005/06 at 94.2 per cent up from 88.9 per cent in 2003. The occupancy rate across the Area Health Service was 92.5 per cent in 2005/06

Clearly at these high levels of occupancy, hospitals struggle to cope with both elective and emergency demand.

A Royal North Shore Hospital with 600 beds and 95 per cent occupancy would need an additional 70 beds to achieve 85 per cent occupancy.

Members have noted:-
"Beds and wards have been closed, anything considered non essential has been closed. Wards are now offices"

3.2 Emergency Departments

The most current publicly available data on Emergency Department workload shows that for the triage categories, the following per cent of patients were treated within the benchmark time at RNSH:

	Cat 1 [immediately]	Cat 2 [10 mins]	Cat 3 [30 mins]	Cat 4 [60 mins]	Cat 5 [120 mins]
July 2007	100	79	61	66	85
Aug 2007	100	75	63	68	86
Sept 2007	100	76	70	72	89

This performance is about 90 per cent of that for other NSW teaching hospitals for categories 2-4 and the same for categories 1 and 5. The Australian Triage Scale sets the performance benchmark for each category as follows:

Triage Category	
1	100 per cent
2	80 per cent
3	75 per cent
4	70 per cent
5	70 per cent

On the ATS benchmarks RNSH falls short for category 2 and 3 patients.

With respect to the other key Emergency Department indicator the percentage of patients admitted within 8 hours of presentation is about 58 per cent. ACEM advises that whilst no degree off access block is considered acceptable, research has identified that the functionality of an ED degrades once access block exceeds 10 per cent of patients waiting admission. So the RNSH access block figure of 42 per cent is surely a cause of significant problems in the Emergency Departments.

The 2004 ACEM Report *Access Block and Overcrowding in Emergency Departments* states:

Emergency Departments are designed to deliver episodic acute care. This dictates their physical design, intended patient flow patterns and staffing structures and systems. The staff in some emergency departments spend 50 per cent of their time delivering inpatient care. This is something they are not trained or oriented for and their departments are not designed and equipped to do. This produces a number of adverse effects:

- increased adverse incidents such as medication error and missed diagnostic tests;
- service availability and performance degrades;
- increased length of inpatient stay;
- staff illness;
- high emergency medicine trainee drop-out rates because of work stress;
- loss of patient dignity and privacy.

Again RNSH is not alone with these problems. In 2007, ACEM surveyed Australian public hospitals which revealed a significant deterioration with thirty per cent more patients waiting more than eight hours for a hospital bed in NSW compared with 2004.

Members have advised:

"There is a high occupancy rate, and this has led to access block in the ED and pressures of medical and nursing staff"

The ACEM data were analysed by the Road Trauma and Emergency Medicine Unit of the Australian National University, which found:

'These figures are most consistent with a system which has passed the point of maximum efficiency and is now in a situation where even small changes in demand cause large changes in the number waiting.'

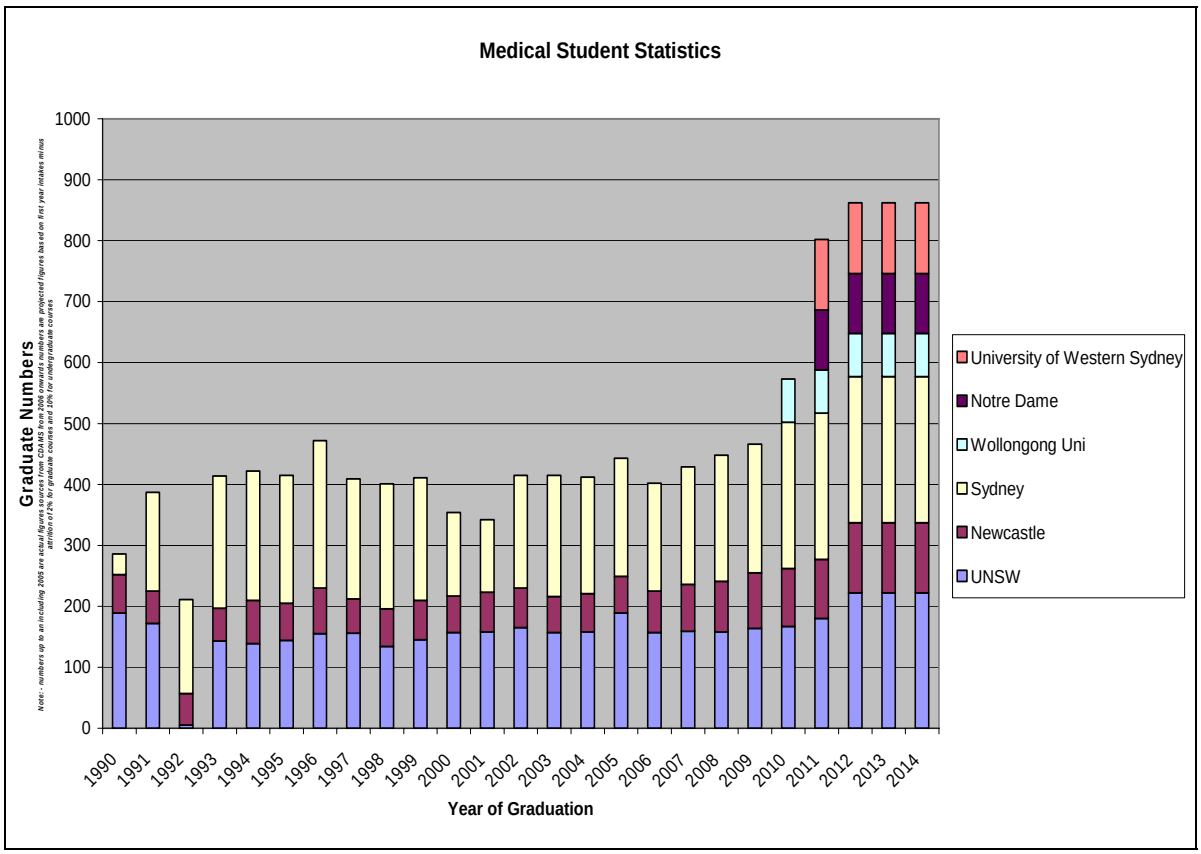
A January 2007 survey by the British Medical Association of emergency medicine doctors found more than a third of hospital emergency departments were not reaching the government's target dealing with patients within four hours. The main reason for this finding was a shortage of available beds, making it difficult for patients to be admitted.

The inability to move patients who are designated for admission from the Emergency Department to inpatient wards, so-called access block, is fundamentally due to inadequate numbers of inpatient beds, with extremely high occupancy levels impacting upon the ability of clinicians and hospitals to effectively manage patient flows. Other strategies to manage patient flows have been implemented with varying degrees of success; however in the

absence of sufficient inpatient beds these are only likely to have a marginal impact.

3.3 Workforce

Over the past five years, AMA and ASMOF have been advising NSW Health and the NSW Government of the potential concerns associated with the increased medical student numbers. While the policy initiatives have been generated by the Federal Government, NSW Health should have responded in a more timely fashion to the clear implications. The following graph sets out the proposed increases in medical students in NSW.



This lack of planning has an impact on hospitals such as Royal North Shore who will be unable to cope with the increased demand on supervision and teaching and will no doubt lead to poor patient outcomes. Furthermore, it is unquestionably an exhaustive financial and physical exercise to train these increased numbers if qualified specialist medical practitioners are not the end result.

Our members have also indicated that there is little formal workforce planning for medical staff. Comments from members in this regard included:-

"My major concern is inadequate funding for junior staff, administrative staff and staff specialists in our unit."

"The AHS has no workforce plan, where there is adequate staff there is no strategic direction or management"

"Ignoring and in fact deliberately increasing staff workloads and stress levels to unsafe and untenable levels by continuous cost cutting, bullying, pressure to meet arbitrary "benchmarks" [designed purely to make the DOH/Government look good]

There is an urgent need to implement a state-wide medical workforce plan. The plan must address how to appropriately supervise and train increased numbers of medical students and how to resource major teaching hospitals such as RNSH to undertake their vital role in this process.

Northern Sydney Central Coast Area Health Service must also implement an immediate workforce review to address the following issues -

- Loss of senior medical staff due to frustration and dissatisfaction
- Planning for medical staff required to undertake functions in accordance with the clinical services plan
- Streamlining of processes for recruitment of medical staff
- Succession planning for replacement of senior medical staff

3.4 Health Care Funding

3.4 (a) Health Service Funding - New South Wales

The NSW Government uses a range of mechanisms to allocate health resources, including performance management, targeted program funding and importantly the Resource Distribution Formula [RDF]. Using demography and future population projections as its basis, the RDF allows funding to be directed in a planned way to areas of NSW that are experiencing growing demand. The NSW Government asserts that since the RDF's inception in the late 1980s the degree of inequity in the allocation of the NSW health budget is five times less than what it was fifteen years ago. The achievement of greater equity in the allocation of health care resources has been an important objective of the NSW Government.

Formula funding, such as the RDF provides an explicit presentation of the criteria for funding and increases Government transparency in decisions. NSW Health provides detailed explanation of the current structure of the RDF in its paper, *Resource Distribution Formula Technical Paper [2005 Revision]*. Decisions about the RDF are overseen by a high level, representative advisory committee. The formula currently takes into account:

- age, sex, ethnicity, homelessness;
- mortality, education and occupation, rurality and ethnicity;
- Private utilisation, cross boundary flows, and cost variation.

The formula through numerous refinements has become an increasingly complex tool.

Nonetheless doctors at Royal North Shore Hospital assert that for all its sophistication the RDF is fundamentally flawed and unfair to the North Sydney Central Coast Area Health Service. Indeed, if funding was allocated on population alone, NSCCAHS would be entitled to 16.4 per cent of the State health budget, instead of the approximate 13.2 per cent it receives. In dollar terms this represents a disadvantage of about $250 million, which is about 25 per cent of the current budget.

The objectives of the Government to reduce inequity and to improve health outcomes across the State are laudable, however in the face of serious questions as to its fairness and with such massive shifts in funding external scrutiny and review of the RDF is warranted.

4. Recommendations – In Response to Terms of Reference Point 2

2. That the committee consider any strategies or measures in place or proposed for improving quality of care for patients at the hospital which may also benefit New South Wales' public hospitals.

4.1 Involvement of Doctors in Clinical Governance and Decision Making

In 2004, the Government implemented major structural changes to the governance structures of Area Health Services. Area boards were disbanded and 17 Area Health Services were reduced to 8. One of the consequences of the disbanding of the Boards which accompanied the amalgamation was the relative disenfranchisement of the hospital Medical Staff Councils. The previous Area structure allowed senior medical staff to have their views be represented. Because no effective structure replaced the dissolved boards at a local level, medical staff have become critically disengaged from the decision making process.

The lack of a formal process by which doctors could provide feedback to local hospital management has contributed to widespread concern amongst senior medial staff regarding the loss of identity of individual hospitals within the enlarged Area Health Services with consequent diminution in function, morale and goodwill. AMA and ASMOF submit that there has been sufficient loss of engagement of Medical Staff Councils and senior medical staff at Northern Sydney Central Coast Area Health Service.

The changes to the Area structure place excessive responsibility and decision making authority on the Chief Executive. The changes have also removed any effective oversight of Chief Executives. There is a need to ensure senior medical oversight of the Chief Executive and Executive in regard to clinical matters, in order to provide a safe governance structure in NSW public hospitals. Area Health Services must appropriately resource Medical Staff

Councils and Medical Staff Executive Councils if they are to carry out effectively these important functions.

Medical Staff Councils and Medical Staff Executive Councils must also have a clear role of oversight over Chief Executives in regard to medical/clinical matters. The function and operation of Medical Staff Councils and Medical Staff Executive Councils are established by the creation of model by laws under the provisions of the Health Services Act 1997. The only way in which effective oversight of Chief Executives and accordingly safe, credible clinical governance can be achieved is to amend the Model by Laws to ensure Medical Staff Councils and Medical Staff Executive Councils are able to appropriately fulfil their vital clinical governance function. These changes will be to the benefit of RNSH Hospital and all hospitals in NSW and will enhance the provision of patient care.

4.2 Beds/Clinical Services Planning

Access block remains a critical element in the operation of RNS. Access block impacts upon the function of the Emergency Department in regards to the ability of the ED staff to move patients out of the emergency department and into wards. Access block also impacts in the provision of elective surgical services with patients requiring surgery often being unable to be operated on due to last minute shortage of beds.

RNSH must receive additional beds to allow patients to be moved to safe, appropriate beds which are not located in storerooms. Patients should be in dedicated wards which are appropriate to their medical circumstances. The current, degrading practice of requiring men and women (in many instances, young women) to share wards, must cease.

In this regard, we call for the immediate opening of an additional 70 beds to address current bed block crisis and to return occupancy rates to safe working levels. It is recognized that this number may not be required in the longer term should efficiencies in clinical care and efficiency be able to be achieved with adequate IT infrastructure and replacement of outdated clinical equipment, however, our members would require clear evidence of such improvements.

In the longer term, RNSH and NSCCAHS requires immediate, comprehensive clinical services planning to ensure that appropriate clinical services and training opportunities are provided at appropriate facilities.

While clinical service planning must not be delayed by the pending redevelopment of RNSH and the Northern Beaches Hospital, decisions must be made regarding the location of the greenfields Northern Beaches hospital at Frenchs Forrest and construction on the hospital should commence without further delay. These ongoing excuses are having a devastating impact on the delivery of healthcare in the Northern Sydney Area.

4.3 Management Structures

It is evident to indicate that an urgent review of management structures is required at Royal North Shore Hospital. The succession of general managers at the hospital has resulted in a loss of leadership and direction which is impacting adversely across the hospital and the Area. AMA and ASMOF note advice from members across the state that since changes to the structure of the Area in 2004. The role and identity of individual facilities is being allowed to run down, with the focus instead being placed on the Area. It appears that this has been particularly significant at RNS, where the lack of hospital based leadership has allowed this large and vital facility to flounder.

There is little benefit in simply stating the need for a more stable management structure; instead, there must be a review of the reasons behind the instability of the management structure. Our advice from members at RNSH and other hospitals is that the key issue is the growing concentration of power and authority in the Chief Executive of the Area Health Service, leaving little autonomy or control for facility managers. This in term leads to frustration and conflict between the facility manager and the medical and clinical staff who feel that their needs are not responded to or even considered. We can only assume that this must result in similar levels of frustration and hence dissatisfaction for general managers.

In addition, while we acknowledge the savings inherent in some level of rationalization of back-office services, it is evident that such an approach is not appropriate for a facility of the size and complexity of RNSH. As such, there should be dedicated back office services allocated to RNSH to allow for familiarity with systems and reporting structures. We would submit that other facilities should also be reviewing the level of their dedicated resources, however, we note that this is outside the formal terms of reference of this Inquiry.

To rectify the deficits in the management structure, there should be a full review of the management positions of the hospital and the implementation of strategies to empower decision making and accountability at a hospital level.

4.4 Appropriate Information Systems and Infrastructure

Doctors have uniformly advised us that they are not provided with relevant, timely feedback about the operation of the hospital. They are aware that data is collected, however, it is not fed back to them in any form. Doctors must be seen as part of the management structure of the hospital. Heads of Departments should be entitled to reports on budgets, activity levels and staffing.

Doctors must be consulted regarding introduction of appropriate infrastructure and equipment to provide safe, high quality patient care. We support the individual department submissions made by doctors establishing the key infrastructure requirements.

AMA and ASMOF are also concerned that the existing structures for the feedback and reporting on incidents do not involve appropriate responses to doctors. This view was reinforced by the findings of the General Purpose Standing Committee 2 Inquiry into Complaints Handling released on 21 November 2006 which stated -

"Timely feedback regarding the outcome of investigations is another critical feature of investigations. The review has revealed frustrations among some healthcare staff that the outcomes of investigations are not adequately communicated back to them in a timely manner and recommends that NSW Health explore ways to address this issue."