Submission

No 34

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Organisation: NSCCAHS

Name: Mr Matthew Daly

Position: Chief Executive

Date Received: 12/11/2007

NORTHERN SYDNEY
CENTRAL COAST
NSW HEALTH

Reverend the Hon. Fred Nile MLC
Chairman
Joint Select Committee on the Royal North Shore Hospital
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Reverend Nile

I refer to your letter of 31 October 2007 concerning the recently established inquiry into Royal North Shore Hospital, being conducted by the Joint Select Committee and the invitation to make a submission on the issues raised by the inquiry's terms of reference.

The attached submission, on behalf of the Northern Sydney Central Coast Area Health Service, which includes Royal North Shore Hospital addresses each of the terms of reference, including where relevant a link to State-wide policy and/or direction/s.

Please do not hesitate to contact me on telephone 0412 220 794 should the Committee require any further clarification or assistance.

Yours sincerely

Matthew Daly
Chief Executive

Date: 9-11-07

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Executive Summary

RNSH is one of the iconic teaching hospitals of the NSW public health system, with national and international reputations in a host of clinical specialties and with an enviable research profile, as evidenced by the flood of NH&MRC grants secured this year. It is a superb centre for teaching and training and a leader in primary health and health promotion initiatives.

However, it is apparent that RNSH has suffered a loss of staff engagement, particularly clinician engagement, in the governance of the hospital and secondly failed to fully implement a system for managing and responding to complaints.

The loss of engagement means a lost opportunity for managers to have the benefit, indeed necessary input, of clinicians into decisions about how to most effectively utilise resources. This disengagement has led to levels of frustration, cynicism and poor morale.

The lack of effective and meaningful partnerships with clinicians has also impacted on the hospital's capacity to make the right investment decisions and set priorities to live within budget allocations provided to it. This has been exacerbated by a lack of internal controls and poor business information systems that has seen staff grow beyond enhancement funding received by RNSH.

Upon the appointment of the new Chief Executive, on 24 September 2007, a Clinical Reference Group framework was established to respond to internal and external concerns raised about issues, some previously reviewed, at Royal North Shore Hospital.

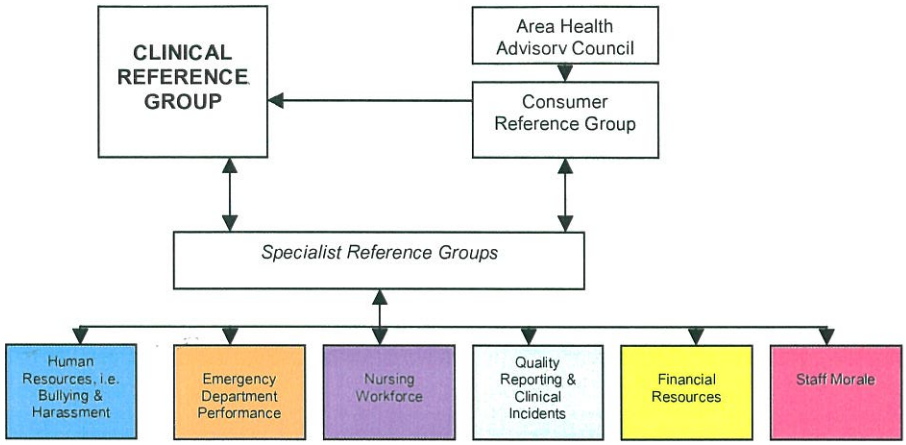
Chaired by the Chief Executive, the Group's membership comprises senior clinicians of RNSH, NSCCH AHAC Chairperson, selected Area executive staff, General Manager RNSH and limited external clinical leaders.

Reporting to the Clinical Reference Groups are Specialist Reference Groups, who will consider the specific groups of issues raised, including: -

- Human Resources, i.e. bullying & harassment
- Emergency Department Performance
- Nursing Workforce
- Quality Reporting & Clinical Incidents
- Financial & Workforce Resources
- Staff Morale

A Community Engagement Group has been constituted to provide input into identifying key issues, developing appropriate responses, and improving communication with the community. This improvement will be based upon the needs of the patient population, not upon service delivery imperatives, but working within the agreed resources of the Hospital.

The diagram below describes the interrelationships of the above groups:



Since the appointment of the new Chief Executive there has been overwhelming willingness of clinical staff, of all disciplines to come forward and say they want to be part of the solution. Hence the Clinical Reference Group, which is guiding the development of a management plan, supported by specialist groups including a community consultative committee, to re-establish RNSH as not just a superb teaching hospital but a great place to work.

This willingness is also manifesting itself in an active clinical division management structure re-established and led by the current General Manager, which will when fully developed help embed clinician involvement at the operational level.

RNSH has embarked upon a Turnaround Plan. The key elements of this plan are highlighted within the enclosed submission to this Inquiry. The plan is addressing management systems and support, access performance and staff engagement and morale.

But no hospital stands alone in a 2007 healthcare environment; the role of RNSH in the network of hospitals that make up NSCCAHS is not defined or clear to the clinicians or the community.

Clinicians from Wyong to St Leonards have made it clear that the Area Health Service lacks an area-wide clinical service plan. It will underpin decisions about how the resources within the Area Health Service will be applied and will aim to achieve equity of access and better outcomes for patients. The Plan will enable area wide clinical networks to be consistently developed across the full spectrum of services to enhance standards and deliver services as close as practical to where patients live. The implementation of this plan will be based on a partnership with the clinical network leaders and their advice will ensure this Area Health Service operates as a true network of inter-connecting and complementary health facilities delivering for its community.

INTRODUCTION

Legislative Council, *Minutes of Proceedings*, Item 14, p 290, 23 October 2007.

1. That a Joint Select Committee be appointed to inquire into and report on the quality of care received by patients at the Royal North Shore Hospital, and in particular:

    (a) clinical management systems at the hospital,
    (b) the clinical staffing and organisation structures at the hospital,
    (c) the efficiency, effectiveness and appropriateness of resource allocation and utilisation within the hospital, and in particular the operation of the emergency department,
    (d) the effectiveness of complaints handling and incident management at the hospital, and
    (e) the 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 and, effectiveness and quality of care.

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.

3. That any individual patient complaints identified in the course of the Inquiry be referred by the Committee to the Health Care Complaints Commission.

On 31 October 2007, Reverend the Hon. Fred Nile MLC, Chairman of the Joint Select Committee (the Committee) invited the Northern Sydney Central Coast Area Health Service (NSCCH) to provide a submission on the issues raised by the Inquiry's terms of reference.

This submission is made in response to that invitation. This submission identifies the many developments in NSCCH and in particular at Royal North Shore Hospital (RNSH). That information is complemented by a discussion of changes and events of most interest to the Committee as they relate to its terms of reference, as it identifies in its letter of 31 October 2007. For convenience NSCCH has divided the submission into the following sections:

1. Background – a profile of Royal North Shore Hospital (RNSH) and the scope and facilities of Northern Sydney Central Coast Health (NSCCH)

1.1 Governance structure of NSCCH

1.2 Communities served by NSCCH

1.3 Population of NSCCH

1.4 Health status of NSSCH residents

1.5 Private sector services in NSCCH

1.6 RNSH

2. Clinical management systems

2.1 Linkages between NSCCH and Individual Health Services including Royal North Shore Hospital
- 2.1.1 RNSH's role within the Area

2.2 Clinical Services Redesign
- 2.2.1 Emergency Department – RNSH
- 2.2.2 Mental Health – RNSH
- 2.2.3 Surgical Project – RNSH
- 2.2.4 Acute Aged Care and Rehabilitation – RNSH
- 2.2.5 Continuing Care – RNSH
- 2.2.6 State-wide Cardiology
- 2.2.7 Summary

2.3 Performance Monitoring and Management – NSCCH

2.4 Planning – Operational and Clinical Services
- 2.4.1 Area Healthcare Services Plan
- 2.4.2 Community Consultation and Engagement

2.5 Information Management and Technology
- 2.5.1 Current State
- 2.5.2 Future
- 2.5.3 Summary

2.6 Chapter Summary

3. Clinical staffing and organisational structures at the hospital

3.1 NSCCH Staffing Profile
- 3.1.1 Nurse and midwifery workforce
- 3.1.2 Medical workforce
- 3.1.3 Visiting medical officer
- 3.1.4 Locum usage
- 3.1.5 Allied health workforce
- 3.1.6 Registered Nurse to Enrolled Nurse Skill Mix

3.2 Staff Grievance Management

3.3 Code of Conduct

3.4 Workforce Challenges
- 3.4.1 Medical workforce
- 3.4.2 Specialist workforce
- 3.4.3 JMO training

6.10 RNSH Development

6.10.1 Scope
6.10.2 Research and Education Project
6.10.3 RNSH Campus development
6.10.4 Land divestment
6.10.5 Timeframe
6.10.6 Consultation

6.11 Capital Works

Documents supporting the submission have been included as **Annexures** and/or are referred to in relevant parts of the text.

1. BACKGROUND

Profile of Northern Sydney Central Coast Health (NSCCH) and Royal North Shore Hospital (RNSH)

1.1 Governance structure of NSCCH

NSCCH is one of eight Area Health Services within NSW. It is a public health organisation, constituted under the *Health Services Act*, and is principally concerned with the provision of health services to residents within its geographical boundaries.

Under section 25 of the *Health Services Act*, the affairs of an Area Health Service are managed and controlled by the Chief Executive of the service. Chief Executives are subject to the control and direction of the Director-General who, in turn, is accountable to the Minister for Health.

- The Chief Executive is responsible for the governance of the area health service and ensuring the area health service fulfils its statutory accountabilities.

The Chief Executive is supported by a health executive team:

- Director, Clinical Operations
- Director, Population Health, Planning and Performance
- Director, Workforce Development
- Director, Corporate Services
- Director, Clinical Governance
- Director, Nursing and Midwifery

These Directors have responsibility for Area-wide management and co-ordination of functions within their span of control. The management of individual health services within NSCCH report through the Director, Clinical Operations.

1.2 Communities served by NSCCH

From the Head Office at Gosford on the Central Coast, NSCCH provides public health services for communities north from Sydney Harbour across the Hawkesbury River to the southern shore of Lake Macquarie and west to Wiseman's Ferry. NSCCH serves 13 local government areas; Gosford, Hornsby, Hunters Hill, Ku-ring-gai, Lane Cove, Manly, Mosman, North Sydney, Pittwater, Ryde, Warringah, Willoughby and Wyong.

Health care to residents of these communities is provided by the following local health services within the Area Health Service:

- *Central Coast Health Service (CCHS)*
  Gosford Hospital, Wyong Hospital, Woy Woy Hospital and Long Jetty Healthcare Facility
- *Hornsby Ku-ring-gai Health Service (HKHS)*
  Hornsby Ku-ring-gai Hospital
- *Northern Beaches Health Service (NBHS)*
  Manly Hospital and Mona Vale Hospital
- *North Shore and Ryde Health Service (NSRHS)*
  Royal North Shore Hospital and Ryde Hospital

- *Northern Sydney Central Coast Area Mental Health Service*
  Macquarie Hospital
- Northern Sydney Central Coast Area Primary and Community Health Service
- Affiliated Organisations
  - Royal Rehabilitation Centre, Sydney
  - *Hope HealthCare North*
    Neringah and Greenwich Hospitals, Graythwaite Nursing Home and the Tom O'Neill Day Centre

1.3 Population of NSCCH

An estimated 1,124,250 people live in the area representing 16.4% of the population of NSW and 19.1% of the population are aged 75 years or more. It is expected that two groups with major health needs ('85 years and over' and 'late working age-early retirement'), will grow substantially in numbers and as a percentage of the overall population by 2011.

1.4 Health Status of NSSCH Residents

The mortality rate for NSCCH residents is significantly lower than for the whole of NSW, indicating a better health status. Cardiovascular disease is the most common cause of death amongst NSCCH residents with cancers being the second most common.

1.5 Private Sector Services in NSCCH

There are 23 privately operated hospitals and 15 day procedure centres in the NSCCH geographical area. The private sector provides 50.9% of all discharges from hospital of NSCCH residents with 1,837 inpatient beds.

There are some 200 organisations in the NSCCH area, both private and not-for-profit, that together provide 5,845 high-care places, 4,413 low care places and 1,670 community care places (at 30 June 2004).

1.6 RNSH

RNSH is part of the North Shore and Ryde Health Service (NSRHS). The executive team, which comprises six corporate executive and six operational executive members, report to the General Manager, who in turn reports to the Area Director, Clinical Operations.

The NSRHS is managed within three clinical divisions:

- Division of Medicine and Aged Care
- Division of Surgery
- Division of Women's Children's and Family Health

A divisional manager, alongside clinical directors, leads each division and is supported by management and financial accountants within a Decision Support Unit.

Established in 1885, RNSH is the major post-graduate teaching, referral and research facility in NSCCH, serving 12% of the NSW population. RNSH is affiliated with the University of Sydney (Northern Clinical School) and the University of Technology, Sydney. Many staff members hold conjoint appointments.

RNSH is also a hospital for its local community. More than one third of all patients come from the four local government areas of Lane Cove, North Sydney, Willoughby and Mosman.

RNSH is a major trauma centre, providing Area-wide services including intensive care and diagnostic clinical support for patients suffering multiple traumas.

The Sydney Simulation Centre at RNSH provides advanced emergency, surgical and intensive care training to clinicians from NSW and Australia including members of the Australian Defence Forces.

Clinical Services
Include aged care and rehabilitation, surgical services, immunology, dermatology, microbiology, ICU, palliative care, cardiology, cardiothoracic surgery, critical care, drug and alcohol, emergency medicine, trauma services, allergy, endocrine medicine and surgery, haematology, head and neck, ear nose and throat, gastrointestinal, medical imaging, mental health, neurology, obstetrics and gynaecology, oncology, ophthalmology, orthopaedics, paediatrics, pathology, podiatry, respiratory, renal, urology, vascular services.

Community Health Services
Include child, adolescent and family services, drug and alcohol, child protection, sexual health, carer support, Breast Screen, mental health, dental health and health promotion.

RNSH State-wide Service Responsibilities
Includes severe burn injury and spinal cord injury, genetics education and cerebrovascular embolisation.

RNSH Tertiary Service Responsibilities
Include neonatal intensive care, high-risk obstetrics, cardiothoracic surgery and medicine, radiotherapy, interventional neuroradiology, hand surgery, and renal.

2. CLINICAL MANAGEMENT SYSTEMS

Term of Reference (a) – Clinical management systems at the hospital.

This chapter outlines the clinical management systems in place across the Area and in particular focuses on RNSH's role within the Area, in terms of:

- Network development
- Clinical Redesign Program
- Area health service performance management
- Area-wide health service planning, and
- Information management systems.

As the tertiary level facility within NSCCH, RNSH is expected to provide a leadership role in both the delivery and development of services, in conjunction with the local community which it serves. Like other tertiary hospitals across the State, RNSH serves its local community and also provides a number of state-wide and specialist services.

This section will demonstrate that opportunities for a higher level of clinical leadership need to be developed, tapping into all hospitals within the Area, to benefit all patients regardless of where they access care in the Area Health Service.

2.1 Linkages involving RNSH within NSCCH

Examples where RNSH has forged formal linkages across the Area Health Service include the implementation of an area-wide triage in the field and local hospital by-pass primary angioplasty service; an optimal reperfusion strategy for ST elevated acute myocardial infarction. Preceding the State-wide initiative, RNSH had collaborated within NSCCH to provide an area-wide Ophthalmology service based at RNSH. RNSH also has commitments to neurosurgery; service focused cross appointments in urology, cardiology, nephrology and surgery to other hospitals of the Area, and resource support in high cost, specialised technology services in investigatory services.

RNSH has participated in the development of services in the context of significant change in the health care environment and policy including trends in relation to population ageing, managing demand for care, technological developments, issues of ensuring safety and quality, evidence-based health care and improved primary care strategies. In developing team-based care RNSH has needed to focus on the concerns specific to NSCCH, including a population skewed towards the older age groups and the impact of the large private health sector.

Key clinical leaders are in the process of being engaged in Area clinical governance structure reconfiguration including the development of Area-wide clinical Networks linking operational, policy and overall governance. This model includes two main elements: local health service based management drawing clinicians and management together operationally at a local level and with Area-wide Networks linking local operations, the Area Clinical Council and the Area Executive Team.

Successful clinical networking has not been uniform or consistent across all specialties.

The benefits, as seen in other Area Health Services such as Sydney South West Area Health Service (SSWAHS) and South East Sydney and Illawarra Area Health Service (SESIAHS), are improved efficiency and delivering improvements to care in terms of better equity of access to services and consistent patient outcomes.

2.1.1 RNSH's role within the Area

NSCCH has established networks in the following disciplines:

- Aged care
- Cancer
- Cardiology
- Emergency services
- Intensive care
- Paediatrics
- Renal
- Stroke
- Surgery (and Ophthalmology)
- Women's health

RNSH, as part of North Shore – Ryde Health Service (NSRHS) is the key hospital for cancer, cardiology, intensive care, renal, stroke, surgery and women's health networks. Additionally, the hospital is one of the state's major trauma centres and provides local and state-wide trauma services for patients suffering multiple traumas.

The clinical management structure for NSRHS is described below:

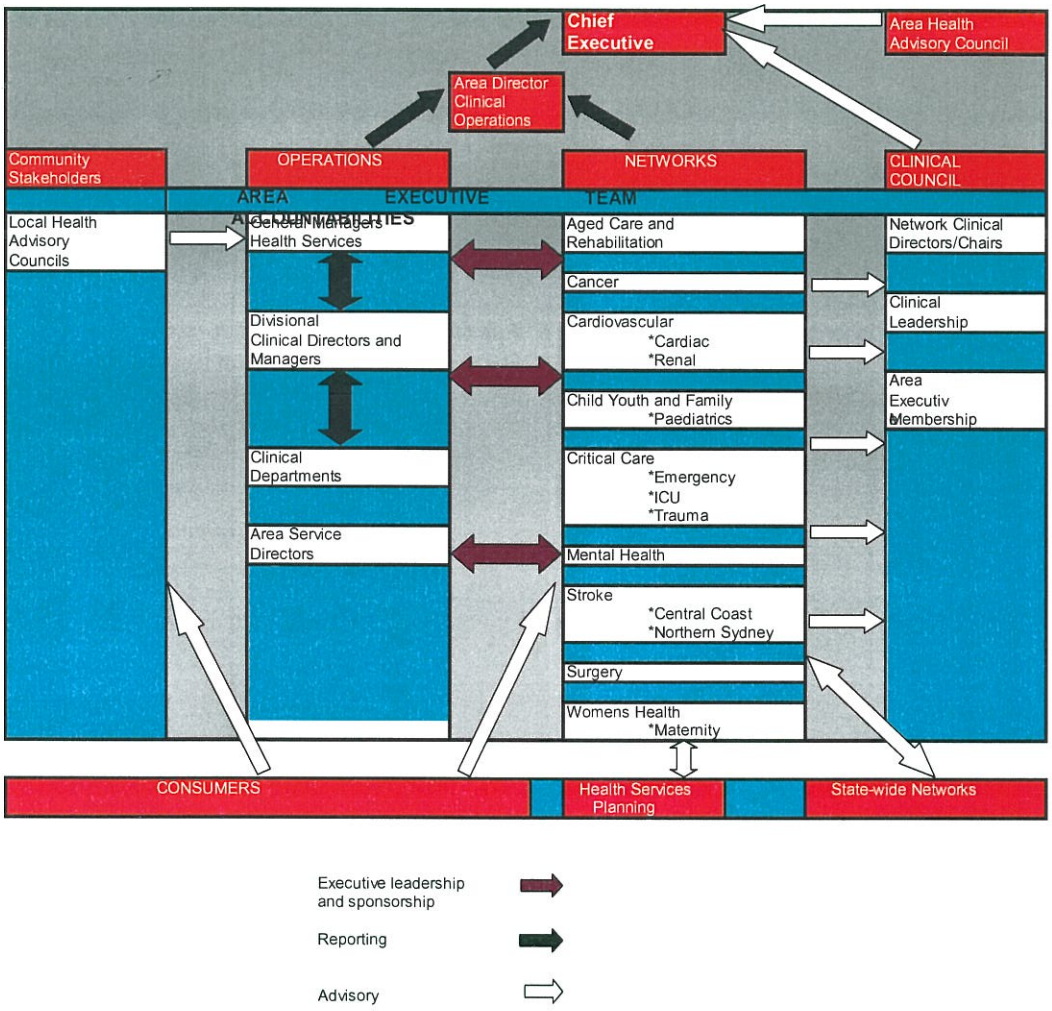
Operational Level
Each Division within the NSRHS is linked to an Area-wide network. The head of department and the divisional manager are members of the network leadership team. In some cases, the head of department may chair the network. Clinician engagement at the operational level is relatively new in the current divisional structure and significant benefits will flow to RNSH as this arrangement matures. Similarly, the Area-wide networks are at varying levels of establishment and sophistication.

Senior Management Level
Through network heads and general managers, all interacting through the Director of Clinical Operations with clinical services development, network development, clinical guidelines, procedure and policy development and clinical services implementation, being the main objectives.

There is an overwhelming need for the network clinical leaders to come together as members of a new Clinical Council to advise on the operational, policy and strategic development and performance of the NSCCH.

The key outcomes expected from RNSH's involvement in Area-wide service development initiative, is rational improvement in high quality Area-wide services and direction for more effective use of resources. This is an evolving process, and to be successful RNSH must be a key partner in

identifying, mapping, evaluating, overseeing and systematically improving the major care processes, advising on Area-wide resource allocation, development of a clinical service plan including, role delineation of facilities, advice on workforce planning, particularly cross appointment of specialist medical staff, implementing clinical guidelines for their major care processes and promoting consistent clinical policy and procedures for the major types of care.



Royal North Shore is expected to play a key leadership role in the development of clinical services across the Area. The development and maturity of the Clinical Networks is key to achieving sustainable, consistent patient care across the Area. The Networks are in different stages of development, and require further development and emphasis within a new Clinical Services Plan. To deliver these patient care benefits to RNSH and the NSCCH, will require significant Area clinical and executive leadership to provide an inclusive, competent and delivery focused network structure for NSCCH.

2.2 Clinical Services Redesign

As part of a NSW state-wide program, the Clinical Services Redesign Program commenced in NSCCH in August 2005 and has included RNSH.

Projects approved by NSW Health and undertaken at RNSH are as follows:

- Emergency Department - (RNSH)
- Mental Health - (RNS and Hornsby Hospitals)
- Surgical Patient Flow - (RNS and Gosford Hospitals)
- Continuum of Care Program
  - Acute Aged Care and Rehabilitation – (RNSH)
  - Continuing Care – (RNS/Gosford/Wyong Hospitals)
- State-wide Cardiology – (RNS and Gosford Hospitals)

2.2.1 Emergency Department – RNSH

This project commenced in September 2005 with PA Consulting being engaged as the external partner. The project was established to reduce delays in the emergency care journey; focusing on how the patients move through our processes of care and identifying constraints.

To achieve the objectives of the project, a weekly change cycle was developed to:

- Implement targeted action to reduce patient delay each week
- Highlight reasons for delay through real-time capture of data by emergency department staff (via an information technology system 'JONAH')
- Involve all areas that care for emergency patients in agreeing and taking action (buffer meetings)
- Identify and escalate reasons for delay outside the sphere of influence of the weekly change cycle.

The following areas of focus were identified for the implementation phase:

- Inpatient team review
- Bed not allocated
- Emergency doctor review
- Radiology
- Pathology
- Off-stretcher time
- Patient experience

Communication and stakeholder management were recognised as essential elements of the project however, the project team reported limited engagement and buy-in from the wider hospital departments and Executive.

The outcomes of the project were the development of the radiology room for on-site x-ray facility and streamlined pathology processes. It is of note that changes to the ordering and resulting of pathology has significantly improved the flow of patients through the emergency department.

The outstanding issues from this clinical redesign project are currently being addressed in the RNSH turnaround plan. The radiology issues are also being addressed in the current redesign project which is identifying constraints and producing solutions to ensure that there is a minimal delay for radiology investigations which has an impact on the flow of patients through the hospital.

2.2.2 Mental Health - RNSH

In 2005, the Clinical Services Redesign Program included a project to address mental health access block at Hornsby and Royal North Shore hospitals.

Solutions and Implementation
Implementation of solutions by the mental health services at RNSH commenced in November 2005 with the support of the Clinical Services Redesign Team. The local Mental Health Service Director provided governance at RNSH with the Area Director of Mental Health sponsoring the project. The following four projects were implemented at the Hospital:

- Increase and measure patient flow
- Effectively coordinate and 'mainstream' service management
- Update emergency department process and resources
- Make more effective use of medical expertise

Key initiatives implemented over this period at RNSH include:

- Implementation of performance dashboard and performance indicators
- Implementation of Estimated Discharge Date and Length of Stay reviews in the Mental Health inpatient unit.
- Implementation of Admission/Discharge electronic ward management tool
- Implementation of medical second opinion review system in inpatient units
- Agreement to inpatient numbers shared across more consultants
- Implementation of discharge planning role within inpatient units
- Commencement Clinical Nurse Consultant 16 hours/day, 7 days/week within the Emergency Department
- Education and orientation packages for emergency staff
- Review of rostering and agreement to 8 hours registrar/on-call mental health roster
- Implementation of referral pathways
- Agreement to governance structure for project rollout
- Review and redesign of Area bed management processes

The project team also identified potential areas for future improvement that the mental health service should consider. These include:

- Increase the availability of step down type facilities
- Address issues surrounding the very long stay patients at Macquarie Hospital.
- Further investigate the opportunities to leverage the federally funded GP Shared care arrangements.
- Review the effectiveness of community teams.
- Telemedicine.
- Capital programmes designed to create more flexible accommodation arrangements.
- A review of the cost structure of the Area's mental health service.

Following this implementation period the Area mental health service participated in the roll out of State-wide initiatives across NSCCH. Dedicated project officers were allocated from within the mental health service to implement the agreed solution set.

2.2.3 Surgical Project – RNSH

In February 2006, as part of the Clinical Services Redesign Program, NSCCH included a project aimed at improving clinical support processes such as admission, discharge, transfer and operating room scheduling. The overall objective of the project was to improve emergency access performance, length of stay and waiting times in NSCCH through enhancing these "patient flow" processes. PA Consulting was again engaged as the external partner.

Commencing in March 2006, in response to the urgent need to address long surgical waiting lists the Program then commenced examining surgical flow at RNS and Gosford Hospitals. The program sought to identify, design and implement common solutions to patient flow and support service issues at these hospitals.

Four projects were designed based around key issues identified during the diagnostic phase:

- Integrated pre-procedure registration service, consisting of
  - Ensuring Recommendation for Admission (RFA) and patient Health Questionnaires (PHQs) are accurate and complete at the time of submission
  - Developing an Integrated Booking Unit
  - Maintaining an accurate waiting list and ensuring compliance to the waiting list policy

- Optimising pre-procedure assessment
  - Implementing a pre-procedure assessment model that ensures timely identification and management of peri-operative issues, including ready access for short notice cases
  - Setting up a sustainable and cost-effective pre-procedure assessment clinic that includes a revenue stream.

- Re-engineered operating room processes
  - Improving communications and managing workflows and workforce to ensure patients and staff will be at the right place at the right time
  - Streamlining stock and equipment processing
  - Turning data into knowledge for informed planning and management - balancing capacity and demand

- Optimised patient flow across the surgical pathway
  - Implementing a communication strategy across the surgical pathway
  - Implementing a structured care delivery framework that incorporates discharge management
  - Improving systems that support patient transfers

  A fifth project was identified in the implementation planning phase which aimed to develop and implement an Area wide "pre-procedure pack", which includes the RFA form, PHQs, consent forms, and guidelines for pre-admission assessment regimes.

A series of actions, KPIs and ongoing activities were outlined and handed over to RNSH to ensure that the changes implemented were sustainable in the longer term.

Key initiatives implemented during this period included:

- Area RFA designed and agreed for implementation
- RFA audit tool in place
- Booking office roles redefined, position descriptions written, with new seating arrangements defined.
- Paper-handling processes streamlined at RNS to ensure previous co-location of Nurse Screener and pre-admissions clerical staff leads
- Implemented processes to comply with NSW Health Waiting List Policy including: Planning lists 6 weeks in advance, documented escalation and cancellation policies, document surgeon leave notification procedure
- Implementation of waitlist management tool, the TCI (To Come In) tool.
- At RNSH a level of billing existed previously amongst the anaesthetists. The opportunity to extend this to diagnostics was identified and a project plan endorsed to implement this using hospital revenue staff and experience.
- The responsibility for the full implementation of the new waiting list management process and day to day operations in relation to waitlist management and data quality rests with the admissions manager and waiting list coordinator (RNSH)
- In theatres, a new rostering system to ensure coverage of staff and development of the skill base

Installation of computers in each theatre with an interim solution has been designed to assist with data collection and reporting within the theatres. This project has been sustained and further work is underway to continue to improve the flow of patients through the theatres, ensuring maximum utilisation of resources.

2.2.4 Acute Aged Care and Rehabilitation – RNSH

The NSRHS Aged Care and Rehabilitation Project reviewed the journey of the older person and highlighted the gaps in the provision of aged care services across the service.

This initial work has focused on the acute care sector and has completed the diagnostic and initial solution design phase. An overview of the main issues identified is described below:

- Keeping people well in the community
- Responding to a crisis
- Providing hospital treatment – includes assessing range of needs, planning and preparing to return home
- Integrated service delivery management
- Research and training

This is now being rolled out in conjunction with the Northern Beaches Aged Care Project, which will result in improving the care of the aged care patient throughout the continuum of care, from home to hospital and return to home with a focus on appropriate early assessment and providing the care in the most optimum place for the patient. This will also include the care of patients with delirium and dementia who require specific assessment and care and requires more focus.

2.2.5 Continuing Care – RNSH

Commencing in December 2006, the Continuing Care Project at RNSH has provided extensive diagnostic scrutiny for each inpatient unit. The focus of the project has been to ensure that there is appropriate patient assessment so that effective, safe and timely discharge is carried out. A system is in the process of being introduced which identifies for each patient their estimated date of discharge (EDD), any constraints that may be in place to prevent safe and timely discharge and ensuring constraints are being addressed in a robust and timely way which will improve the systems across the hospital. This is known as the Nursing Unit Managers Tool, 'NUM Tool'. This process has formed the basis for the development of available business information to (NUMs) in the structure of Diagnostic Related Groups, (DRGs), Length of Stay, (LOS) and comparative data with peer hospital group performance. In addition to this information, involvement has been sought from the multidisciplinary team members led by the NUMs as the champion of the project. Nursing skill development has been undertaken with a focus on essential patient care and effective/efficient discharge planning. This has been provided during a four week 'blitz' where every nurse working on the in-patient wards was provided with a 'practice partner' for one hour per day to assist in identifying skills, raise consciousness of nursing interventions and enhance critical analysis of nursing care provision.

Target project outcomes include:

- 100% patients have a Discharge Risk Screen/Assessment
- Increase proportion of patients with an Expected Date of Discharge to 100%
- Decrease bed days in relation to admissions for specific Diagnostic Related Groups
- Reduced delays for multidisciplinary team consults
- Reduced numbers of patients with delayed transfer of care
- Increased proportion of patients treated as 'Day Only'
- Increased Day Of Surgery Admission
- Improved patient satisfaction
- Improved staff satisfaction
- Increase to and maintain emergency admission performance to 80%

This project is due to be completed at the end of November 2007. Once delivered, it is envisaged that the tool that has been developed will be rolled out across NSCCH.

2.2.6 State-wide Cardiology

The State-wide Cardiology Project commenced in NSCCH in late September 2006. The aim was to implement two identified key solution groups from State-wide diagnostic findings across the hospital.

The implementation status of the project is as follows:

- Implementation of formal bed management policies
- Extensive data collection and analysis to determine the need for change and progression of identified solutions for implementation
- Trial of chest pain clinical pathway
- Consideration of cardiac case manager

This work continues to implement the identified solutions for this project with an ultimate roll out to other parts of the Health Service.

2.2.7 Summary

Whilst staff are committed to improving systems and processes in order to improve the care for patients there have been varying degrees of the success of implementation of clinical redesign projects.

A clearer commitment to implementation of solutions with leadership shown at all levels of the organisation is required to ensure that changes are fully embedded following the redesign projects at RNSH.

2.3 Performance monitoring and management – NSCCH

On an annual basis the Director-General, NSW Health negotiates a number of performance agreements with the Chief Executive in order to assess the performance of both the Chief Executive and the management of NSCCH. The performance agreements for 2007/08 are:

- Performance Agreement 2007/08
- Primary Health and Community Partnerships Agreement 2007/08
- Patient Safety and Clinical Quality Program, Performance Agreement 2007/08
- Sustainable Access Plan Agreement 2007/08
- Disaster Preparedness Service Agreement 2007/08

Targets from these performance agreements cascade through the Area Executive Team by way of individual performance agreements. These performance agreements comply with the requirements of the Health Executive Service. In turn, Health Executives have performance agreements with their direct reporting staff.

Performance against these targets is continuously assessed via a number of mechanisms. These include, but are not limited to:

- Area Executive assessment through monthly Finance and Performance Committee meetings
- Monthly performance review meetings between Health Service and Area Executive Teams
- Monthly progress assessments to the Area Executive Team against the Area Operational Plan
- Monthly assessments against Sustainable Access Plan KPIs with NSW Health

The Finance and Performance Committee is required to be established under Part 5 of the *2005 Standard Form of By-Laws for public health organisations.* The Finance and Performance Committee within NSCCH operates in accordance with the Terms of Reference outlined in the *Corporate governance and accountability compendium, NSW Health*.

To support performance assessment at a health service level the Area regularly produces performance, activity and financial information that focuses on the key performance indicators from the performance agreements. These are alongside indicators that assist in assessing the

efficiency of services. Such indicators include, but are not limited to, length of stay, occupancy and day of surgery rates.

Information to support annual assessments for indicators that are population based is supported by material provided by the Department pf Health.

It is recognised that the information currently available to help clinicians and managers improve and manage front line clinical services needs to be provided in a more timely fashion; be delineated at a ward, specialty and clinician level; and include information about the case mix characteristics and costs. This information also needs to allow useful comparison with like facilities.

Over recent months a number of steps have been taken to enable this to occur:

- The two costing systems for NSCCH have been amalgamated. During this process, stakeholders were actively engaged to critique the cost allocation process in order to improve the accuracy of costing outcomes.
- An external audit was conducted in August 2007 to gain an independent assessment of the business information requirements of divisional managers and clinicians. The recommendations from this audit have been aligned with NSW Health's Business Information Strategy and an implementation plan is being drafted.
- Business objects programming support has been engaged to advance the rollout of business objects reports across the Area.
- An application has been made to join the Health Round Table to enable the provision of comparable information at a clinical, departmental and procedural level in health facilities.

2.4 Planning – Operational and Clinical Services

The *Corporate Governance and Accountability Compendium for NSW Health* outlines the key strategic planning structures and accountabilities for planning for Area Health Services. In addition, the *NSW State Health Plan* provides a strategic direction. NSCCH has a strategic plan that links to both the *NSW State Plan* and *State Health Plan*. This strategic plan is progressively achieved through the development and implementation, on an annual basis, of an Area Operational Plan. Both the strategic plan and operational plan are supported by a number of enabling plans.

The Area operational planning process involves a number of steps to encourage the involvement of health service management and senior clinicians. The steps taken to develop the 2007/08 operational plan are outlined below:

- Area Executive Team 2 day planning workshop to determine the priorities for 2007/08
- Senior management and clinician planning day where the priorities from the AET planning workshop were considered and amendments made
- Release of draft priorities January 2007 for development and consideration at a health service level, including financial and resource implications

- Consideration of feedback from health services by Area Executive Team in March 2007
- Changes made and draft operational plan discussed with health service management teams June 2007
- Communication strategy and material developed for release July 2007

2.4.1 Area Healthcare Services Plan

The amalgamation of Areas in 2005 led to a requirement for all new Areas to develop an Area Healthcare Services Plan. This overarching document identifies the key strategic directions for the Area Health Service for a defined period (five years with a broad outlook to ten years), providing a clear foundation, and detail for further planning and operational decision-making within the Area Health Service. It represents a big picture view of an Area Health Service's current situation, anticipated future needs, and priorities for action in the short to medium term, assuming a particular operating environment.

The NSCCH Plan remains in draft form only.

Since that time the Area has been developing a series of clinical service plans across key priority services including critical care, aged care and rehabilitation, cancer services, renal services and surgical services.

All of these individual clinical service plans need to be considered in unison, as part of resolving the Area Healthcare Services Plan as a priority. This will provide a comprehensive and holistic view of clinical services across the Area, including how each hospital facility is delineated within a networked model of service provision.

The new Chief Executive has asked that a Clinical Services Plan be developed as a priority by clinicians, for implementation by Area with Clinical Networks within the next 6 months. This will be developed through a clinician led Area-wide clinical services planning process being established to enable a plan to be recommended to the Chief Executive. Although the timeframe fro the plan is challenging, progress is underway building on those already developed Networks.

2.4.2 Community Consultation and Engagement

NSCCH is required to incorporate the views of clinicians, consumers and the community in the planning, delivery, monitoring and evaluation of health services provided by the Area Health Service.

Like other Area Health Services, the peak community engagement body is the Area Health Advisory Council (AHAC). The role of AHAC is to facilitate the involvement of providers and consumers of health services, and of other members of the local community, in the development of policies, plans and initiatives for the provision of health services.

The working relationship between the Chief Executive, the area executive team and the AHAC is critical to the successful development and implementation of plans and the improvement of clinical services.

It is recognised that the relationship between AHAC and NSCCH can be strengthened. The AHS intends to do this through the increased delivery of

timely, meaningful performance and financial information; increased engagement by AHAC in Area-wide planning processes, and through proactive requests for advice on strategic matters that impact on either the community or clinicians.

AHAC's responsibilities also include supporting the operation of local community participation committees. These committees have been established across the Area to advise on local health service needs, health service planning and community consultation. The General Manager for the Health Service chairs the committee. Membership comprises 6 – 8 representatives of the local community plus a representative from AHAC. The community representatives are elected to the committee for two years through an 'expression of interest' process. The committees meet five times per year.

2.5 Information Management and Technology (IM&T)

NSW Health has been pursuing an IM&T strategy since 1999. The cornerstone of this strategy is the electronic medical record program, (eMR), which incorporates software applications to facilitate safe efficient care for the patient and deliver economies in resource utilisation.

This strategy has undergone a number of revisions in response to changes in funding and clinical priorities. In June 2006, the NSW Government approved a request to bring forward the allocation of $40M to the eMR project to support an accelerated and expanded scope for the eMR project to enable roll out to 188 hospitals.

Under this strategy, the electronic medical record (eMR) project is scheduled to be rolled out across NSCCH 2007- 2010; with the RNSH rollout to occur during late 2007 and 2008.

The IM&T plan for the NSCCH has four components:

- A comprehensive infrastructure that enables individual Area Health Service staff to be effective in the way they work and in the way they communicate with patients/clients, health care professionals and staff in other services.

- A suite of integrated clinical information systems that is accessible over the telecommunications infrastructure. The core of these information systems will be based upon eMR Link (Cerner Suite of Products) that supports clinicians to make evidence based decisions to support the management of patient care across the entire pathway.

- A set of data warehouses, intranets and information tools that draw information from the clinical information systems and make it available to information users in easy to use views and enquiry tools.

- A comprehensive set of user support capabilities that progressively increase the IM&T skills of staff and help them be fully productive through the use of information and technology.

2.5.1 Current State

RNSH as the Area tertiary referral hospital does not have sophisticated clinical or management information management systems. Historically

there has been historically an underinvestment in information technology and consequently there are many legacy applications running on older technologies or paper based, for example – medical records. The systems are generally isolated and not well integrated. The situation on the Central Coast is different where they have had a clinical repository in place for some years. The same system is currently planned to be rolled out across RNSH in early 2008

Systems can be categorised as either clinical or business. There are over 200 applications in use across the Area and RNSH including:

- Electronic patient management systems
- Paper based medical records
- Paper based outpatient appointment systems
- Mini PACS –print X Rays
- Cancer care system
- Varis (Radiation Oncology)
- CBord Diet System
- OTIS (Operating Theatres)
- EDIS (ED)
- EDNA (Ambulance)
- ObstetriX (Maternity)
- IIMS (Incident Information Management)
- HIE (Health Information Exchange)
- CIAP
- Intranet/Internet
- Clinical Costing
- Oracle Financials
- IProcurement
- Electronic bed boards

The clinicians across RNSH, particularly in radiology, have been seeking a Picture Archiving Communication System (PACS) for many years. They have been successful in implementing a mini PACS, but it has limited functionality when it comes to long term storage and subsequently x-rays are still on film. A project is currently underway with NSW Health and the Department of Commerce to procure a new Radiology Information Management system and PACS at RNS and Ryde Hospitals.

Recent improvements and enhancements that have been made include upgrading the Corporate Network to Ethernet, replacing and upgrading the communications infrastructure, many application servers and rolling out approximately 400 additional PCs.

2.5.2 Future

The new IM&T strategy for NSW Health shifts the focus of IM&T from technological capability to patient centred care. Three key programs drive the strategy:

- Patient access strategy
- Patient safety and quality
- Shared corporate services

The implications for NSCCH and specifically RNSH are the eMR, shared corporate services systems and the infrastructure consolidation programs. The infrastructure consolidation program will reduce costs and improve the

quality of our information technology systems by consolidating hardware under one umbrella. NSCCH is actively participating in this program with all new clinical systems housed at the Liverpool Data Centre.

NSCCH has an innovative Information Communications Technology Strategy 2007- 2010. The focus is on the implementation of the next phase of eMR, (new emergency department system, theatres, discharge referrals and electronic order entry) the corporate IT solutions (payroll, HR) and the business information strategy (BIS). The BIS will provide dashboards which will automate a single set of data tools across NSCCH linking clinical, workforce and financial data to optimise utilisation of resources. The strategies also include the replacement of the 'Health Information Exchange' with a 'Business Information Warehouse' with greater visibility of data and improved reliability and performance. Frontline clinical staff will have improved access to real time data.

2.5.3 Summary

Although RNSH has lagged in the development of up-to-date and functional IT systems and has a number of non-integrated systems, there is now a clear strategy in place which identifies the needs of the services at the facility and addresses those needs through the roll-out program. Crucial to this is clinician support and the implementation of PACS, which is fundamental to the active engagement of clinical staff, medical clinicians in particular, in the next crucial stages of the roll-out of eMR.

2.6 Chapter Summary

As the sole tertiary service within the Area, the hospital is a net importer of patients for specialist services both from within and outside the Area Health Service and as such provides a wide range of high quality services to the population of Northern Sydney, the NSCCH, NSW and beyond. More needs to be done for RNSH to optimise its key leadership role in service development and delivery across the Area.

In order for RNSH to successfully fulfil its role as the Area tertiary hospital the following need to be achieved:

- Uniform strong leadership within clinical networks
- A strong Clinical Council to provide appropriate advice to the Chief Executive
- Sustained implementation of the clinical redesign programs
- Further development of the hospital divisional structures
- Continued focus on building and fostering the relationship between the Chief Executive and the newly established Clinical Reference Group, which is vital to achieving the Chief Executive's turnaround plan for RNSH and renewing public confidence and staff morale.

3. CLINICAL STAFFING & ORGANISATIONAL STRUCTURES

Term of Reference (b) – the clinical staffing and organisation structures of the hospital, and in particular the operation of the emergency department.

Workforce challenges across NSCCH are being recognized, articulated and planned for. In order to address these challenges, there needs to be a real understanding of the Area Health Service's staffing profile; the ability to monitor workforce performance indicators and workforce capability; the capacity to introduce strategies and initiatives to both address these challenges and drive the agenda for the future direction.

Like other health organisations NSCCH is affected by both national and local issues; nationally there are forecasted shortages within the nursing, allied health and medical workforces[1].

The local issues which will pose the most significant challenge to planning the NSCCH workforce, include ageing of both the population and NSCCH employees. The projected increased ageing population for NSCCH is one of the highest for any health service in NSW and parts of the geographical region have recorded some of the lowest socioeconomic measures in NSW.[2]

3.1 NSCCH Staffing Profile

The NSCCH workforce consisted of 11,981 Full Time Equivalent (FTE) salaried employees as at June 2007. A full breakdown of the salaried staff profile as at June by controlled entities and departments is shown in the table below.

The staff profile is reported by professional alignment, controlled entities and departments, including; medical, nursing, allied health and support workforce alignments.

NSCCH FTE Employed as at June

Controlled Entities and Departments	FTE June 2005	FTE June 2006	FTE June 2007
Medical	1,010	1,083	1,128
Nursing and Midwifery	4,880	4,984	5,164
Allied Health	1,048	1,059	1,080
Other Prof & Para Professionals	622	615	622
Oral Health Practitioners & Therapists	100	102	100
Corporate Services	607	553	506
Scientific & technical clinical support staff	784	790	804
Hotel Services	806	752	787

1 Australian Health Ministers' Conference- National Health Workforce Strategic Framework, April 2004 , P32
2 SEIFA (2001) (ABS Socio-Economic Indexes for Areas) contains four indexes including: Advantage Disadvantage, Disadvantage, Economic Resources and Education and Occupation, identifies residents of the Central Coast LGAs are 'less well off' than the residents of the Northern Sydney LGAs on all measures and residents of Wyong are 'less well off' than the NSW average on all measures and "less well off" than residents of all other NSCCH LGAs.

Maintenance & Trades	145	150	140
Hospital Support Workers	1,482	1,468	1,578
Other	76	68	72
Total	11,560	11,624	11,981

Source: Local Health Information Exchange

Notes:

1. FTE calculated as the average for the month of June, paid productive & paid unproductive hours.
2. Staffing table excludes Third Schedule Facility employees and all non-salaried staff such as contracted Visiting Medical Officers (VMO).

3.1.1 Nurse and Midwifery Workforce

The NSCCH nursing and midwifery workforce increased by 3.6% from 2005/06 to 2006/07, refer table below, which provides a breakdown by professional nursing and midwifery categories.

NSCCH Nursing & Midwifery Staffing Profile

Nursing & Midwifery Professional Categories	*NSCCH FTE at Jun 07*	*RNSH FTE at Jun 07*
Assistant in Nursing	75.39	19.06
Clinical Nurse Consultant	183.87	46.78
Clinical Nurse Educator	77.74	30.20
Clinical Nurse Specialist	569.16	155.97
Enrolled Nurse	613.59	82.90
Trainee Enrolled Nurse	152.24	35.03
Nurse Educator	19.46	3.63
Nurse Manager	126.45	24.60
Nurse Practitioner	7.85	2.00
Nurse Unit Manager	229.35	56.17
Residential Care Nurse	8.88	0.00
Registered Nurse	3,100.41	820.96
Total	*5,164.38*	*1,277.31*

3.1.2 Medical Workforce

The senior medical workforce consists of staff specialists, clinical academics, visiting medical officers (VMOs) and honorary medical officers.

Specialists are employed or contracted in accordance with NSW Health awards or directives across almost all disciplines, with RNSH having a significant range of sub-specialist services provided by relevant specialists and the other health services within NSCCH being served by a mix of general medicine/surgery and some subspecialty services.

The junior medical staff mainly comprises interns (first postgraduate year), resident medical officers (second and subsequent years) and registrars (most in their fourth or subsequent years after graduation, who have commenced a specialty training program). In addition there are relatively smaller numbers of career medical officers and a few fellows, who are generally near or at the end of their specialty training but doing further subspecialty training in research. (A smaller number of fellows, who have completed their specialty qualification, are appointed under specialist arrangements.)

The current numbers of salaried medical staff in NSCCH at June 2007 is 1,128 FTE. This does not include visiting medical officers (VMOs) or contract medical officers. The NSCCH medical workforce increased by 4.16% from June 2006 to June 2007. The table below notes a breakdown by professional salaried award category.

NSCCH Medical Staffing Profile

Medical Professional Categories	*NSCCH FTE at Jun 07*	*RNSH FTE at Jun 07*
Career Medical Officer	60.74	4.70
Intern	96.60	26.15
Registrar	338.61	155.45
Resident Medical Officer	274.38	87.35
Staff Specialist	317.11	127.85
Other [3]	40.86	23.81
Total	*1,128.29*	*425.31*

Source Local Health Information Exchange

3.1.3 Visiting Medical Officer

Understanding the VMO workforce by specialty is complicated by the degrees of sub-specialisation, the numerous databases recording the medical administration details and difficulties in recording the primary work location for multiple hospitals and facilities. In May 2006 the number of individual VMO contracted by 'sessional' or 'fee for service' rates within NSCCH was 586 Medical Officers, 68.6% of these VMO are located within the Northern Sydney sector of the NSCCH.

Attempts to secure appropriate specialist staffing cover in emergency departments, including evening and weekend presence, have included the creation of some additional positions and at RNSH, Ryde and Northern Beaches the involvement of VMOs to supplement the predominantly staff specialist workforce.

3.1.4 Locum Usage

Shortfalls in the medical workforce, particularly within the public hospital systems, have traditionally been met with the use of agency doctors (also known as locum doctors). Emergency departments account for more than half of locum expenditure.

3.1.5 Allied Health Workforce

NSCCH professional categories defined as core allied health disciplines[4] have increased by 1.98% from June 2006 to June 2007 and represents 9% of the FTE of the total salaried NSCCH workforce. The current

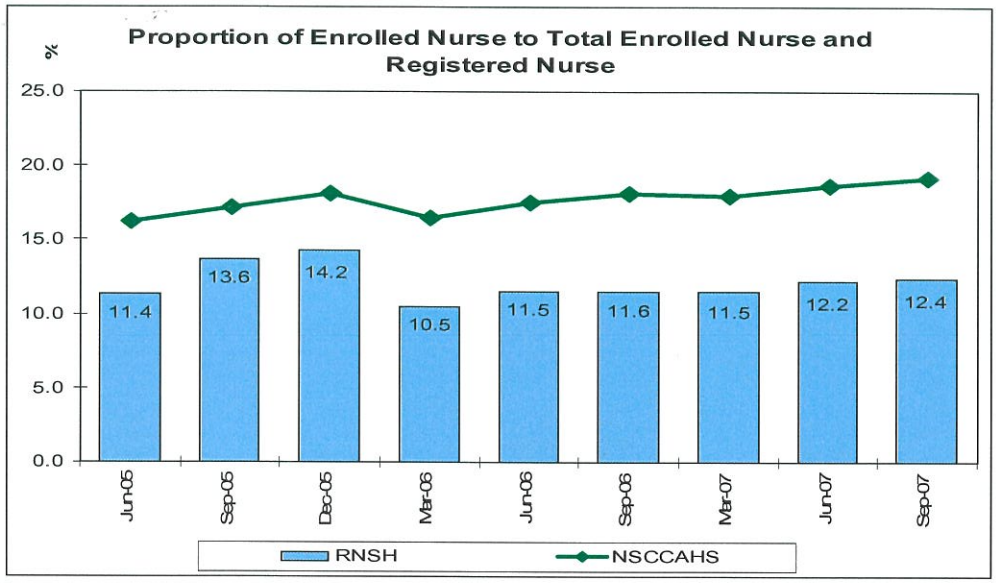
3 Includes medical practitioners in the following medical salary award categories; Clinical Academics, Agency Doctors, Postgraduate Fellow

[4] The Allied Health workforce is defined as professional staff employed within the disciplines of audiology, nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, podiatry, psychology, social work and speech pathology, and includes allied health assistants working within these disciplines.

numbers of the allied health staff in NSCCH at June 2007 is 1,080FTE.

3.1.6 Registered Nurse to Enrolled Nurse Skill Mix

NSCCH uses a guide of RN: EN skill mix ratio of 80:20. Currently the proportion of Enrolled Nurse to total Registered Nurse within NSCCH as of September 2007 is 18%. Comparisons with RNSH at 12% are shown in the table below:



Source: NSCCH Payroll System

3.2 Staff Grievance Management

Staff complaints concerning staff relationships or workplace culture can range from simple complaints raised with the direct line manager through to serious allegations of misconduct. The management of such complaints is directly related to the nature of the complaint and with whom the complaint is lodged. NSCCH has policies and procedures on grievance handling/dispute resolution, bullying and harassment, performance review and counselling and discipline to guide managers in dealing with the wide range of complaints that staff may raise.

Managers are responsible in the first instance for addressing and solving complaints raised with them. When the complaint is of a serious nature the manager is able to seek advice and/or involvement from the Human Resource (HR) department.

HR are likely to become involved in complaints around allegations of bullying and harassment or discrimination, dissatisfaction with the managers decision, employment relationship or contractual issues, or general grievances raise about interpersonal relationships between staff. HR has developed a risk management strategy to both escalate and monitor all staff grievances.

The recently established Professional Practice Unit (PPU) at NSCCH provides the organisation with improved coordination and faster resolution of all complaints, including those originating from staff.

3.3 Code of Conduct

NSW Health has issued a Code of Conduct policy (PD2005_626) which has been implemented across NSCCH. Compliance with this Code of Conduct policy is mandatory for all NSW Health staff, and there is a requirement for all staff (new and existing) to sign a document, acknowledging they have read and understand the policy.

From January 2007, a process was introduced across NSCCH to ensure all new staff "signed off" on the new Code of Conduct at the commencement of their employment with NSCCH. General Managers and service directors were provided with information and resources for their managers and their staff to support the new Code of Conduct policy implementation, and this has enabled effective compliance of our existing staff with the Code of Conduct policy.

Processes introduced as part of the implementation have enabled compliance with the Code of Conduct policy to be embedded as 'business as usual" by incorporating the process in recruitment and orientation processes for new staff and by ensuring it is part of the performance review of existing staff.

3.4 Workforce Challenges

Like other Area Health Services, NSCCH is facing a number of workforce challenges. Outlined below are some of these and action NSCC is taking to meet them.

3.4.1 Medical Workforce

Shortages have not previously impacted upon RNSH; however the impact of national shortages is now being experienced. Vocational training positions for specialist training are becoming increasingly difficult to fill. In particular this impact has been identified in surgical and emergency medicine specialty training. Unaccredited 'service' positions are also proving difficult to recruit to. There is also a reliance on junior and locum staff to fill shortfalls.

The key medical workforce challenge at RNSH is managing the shortage of some senior, and in particular, junior medical staff vacancies. Historically, RNSH has been, and remains a preferred employer for both senior and junior medical staff.

Strategies have been implemented to address an increasing reliance on junior and locum medical staff. These strategies include:

- Increased scrutiny of skills of medical locums using a procedural skill check list.
- A committee to review and support junior medical staff that appear to be under performing.

3.4.2 Specialist Workforce

There are significant specialist workforce shortages including emergency medicine, general medicine, neonatology, neurosurgery and intensive care at RNSH. New VMO staffing models have been introduced in emergency medicine to address critical staffing shortages, to ensure appropriate

levels of supervision of junior medical staff, and to redress the reduced number of emergency medicine trainees.

The ability to plan medical staff needs for the next quinquennium appointments process in 2009 will be guided by the Area's Clinical Services Plan (CSP) once finalised.

3.4.3 JMO Training

Despite the growing number of Interns expected to graduate from new medical schools over coming years, and the need to identify suitable training positions and funding for them, relative shortages of suitably experienced junior medical staff over recent years are likely to continue for the next few years. This has resulted in considerable reliance on locum medical officer appointments, particularly for emergency departments, at most hospitals across the Area. Planning for training programs and recruitment into the three realigned networks that will operate across NSCCH from January 2008 is under way. These networks will link RNSH and Ryde with secondments to Port Macquarie; Hornsby with Manly and Mona Vale; and Gosford with Wyong and Woy Woy.

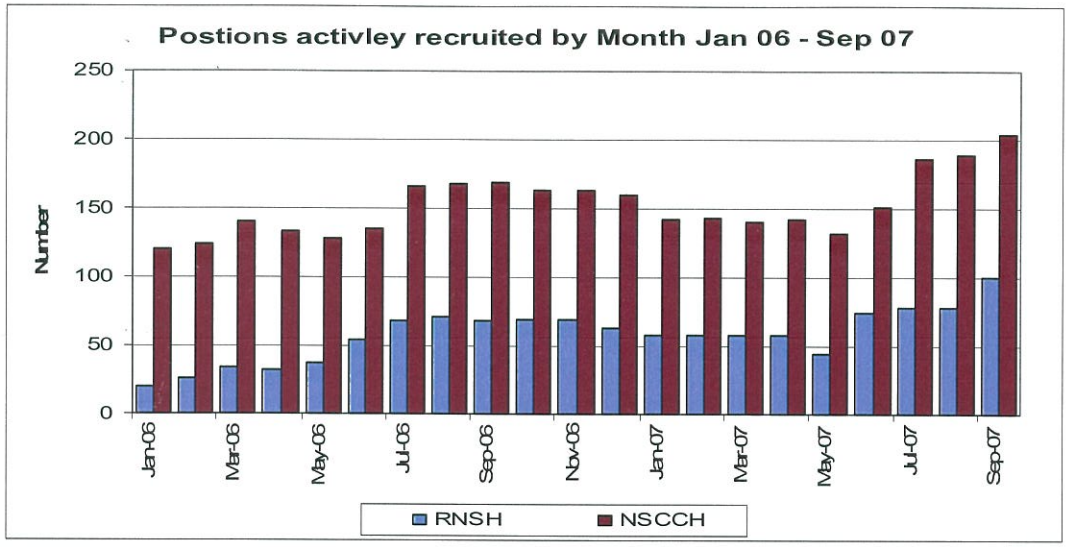
3.4.4 Nursing

There has been a gradual, but significant increase of nursing vacancies at RNSH, which currently has 50% of total vacancies for NSCCH.

Monitoring Nursing Vacancies
Nursing vacancies are reported monthly for each facility within NSCCHS. The table below notes the positions being actively recruited by month for NSCCHS and RNSH since January 2006 until September 2007. In addition the table below notes the vacancies at RNSH increased from January 2006 until June 2006 then stabilized until July 2007 when the reported vacancy rate climbed to 70FTE and currently stands at 100 vacant FTE. It is worth noting, and as reported by NSW Health (*DOHRS Nursing Workforce Numbers – August 2007)* the following breakdown demonstrates how current vacancies are being filled through additional staff.

- 39 FTE agency nurses
- 29 FTE paid overtime
- 70 FTE casual pool

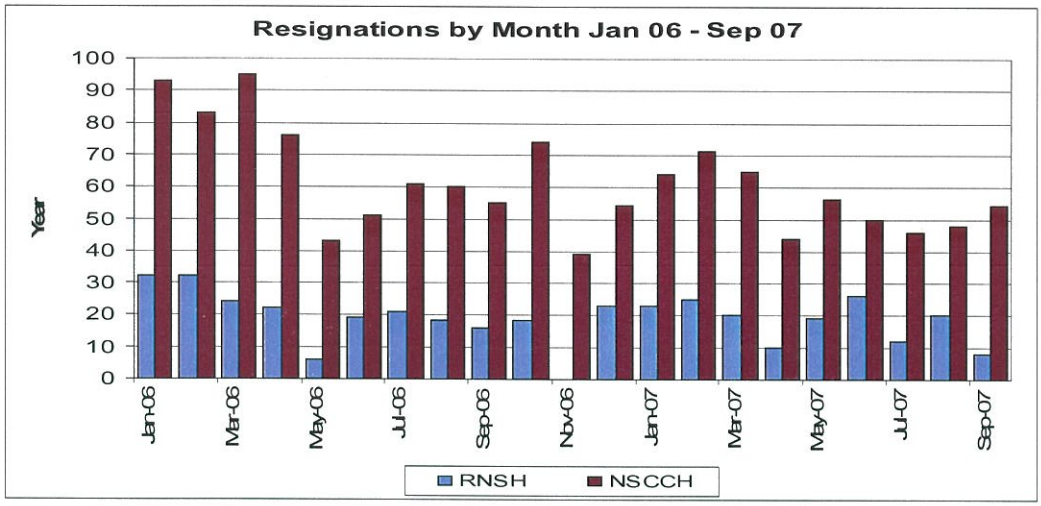
It is also worth noting that 51FTE are currently on paid or unpaid maternity leave, which explains the additional FTE required to fill the vacancies.



Source: Nursing DOHRS

Monitoring Nursing Resignations and Turnover

For NSCCH the average nursing resignations per month for YTD is 55 FTE compared to 65 FTE in 2006. At RNSH the average nursing resignations per month YTD is 18 FTE compared to 19 FTE in 2006 (refer to the table below). Although the overall number of resignations has decreased for NSCCH, the resignation rates at RNSH, whilst reducing, is at a slower rate.



Source: Nursing Web DOHRS

Nursing Reconnect Strategy

The nursing reconnect strategy is a NSW Health funded program, which assists nurses who have been out of the nursing workforce for a period greater than six months to return to clinical practice. The program allows the nurse to be supernumerary for a total of 152 hours (full-time or part-time) allowing time to adjust to the workplace and to consolidate skills. In summary there have been 223 nurses enquiries of which 79 were for RNSH.

New Graduate Registered Nurses Recruitment

NSCCH offers a 12 month new graduate registered nurse transition program. While there are variations across NSCCH, with the total number

and length of rotations, all new graduate registered nurses receive an extended orientation program and are supported throughout the program with five study days, which are aimed at enhancing the new graduate's skills. The total number of new graduate registered nurses (NG/RN) recruited and retained since 2005 and during 2006 was 284.

- During 2005 RNSH required 100 NG/RN and 89 were recruited with 75% being retained at the end of 2005
- During 2006 RNSH required 100 NG/RN and 94 were recruited with 55% taking up permanent positions and 15% electing to undertake a further rotation.
- For 2007 RNSH have requested 110 NG/RN. The total number of first preference applications received for RNSH were 129 and 110 letters of offer have been sent.
- In 2008 the first cohort of Bachelor of Midwifery students will register and enter the workforce. RNSH have 5 positions available and have offered 5 positions to completing midwives.
- NSCCH has developed a new partnership with the University of Tasmania (UTAS) and the curriculum provides a new model of clinical placement for undergraduate nurses leading to direct employment opportunities after graduation.

Trainee Enrolled Nurses

NSCCH offers the Trainee Enrolled Nurse (TEN) course in conjunction with Technical and Further Education facilities (TAFE). The theory component is provided by TAFE, whilst the clinical component is provided by NSCCH. Trainee Enrolled Nurses are included as part of the direct patient care numbers required within the clinical units. Funding is provided to enable super-numerary time for orientation, as well as two days following each TAFE block. The table below provides an overview of the number of TENs recruited and retention rates since 2005 for NSCCH and RNSH.

NSCCH Trainee Enrolled Nurse Status Summary

	Year Commenced / completed	Recruited	Completed	Retained as EN number	Retained as %
NSCCH	2005/2006	176	159	101	64%
	2006/2007	187	161	98	61%
RNSH	2005/2006	37	37	29	78%
	2006/2007	40	32	19	59%

Source: AHS Enrolled Nurse Education Unit Data Base.

Royal North Shore Hospital Nurse Taskforce (Specialist Reference Group)

On 25 September 2007 the newly appointed Chief Executive met with a number of nurses from across the clinical units at RNSH to discuss a number of their concerns. From that meeting, eleven issues were identified and an action plan has been developed. Regular meetings have been scheduled with the Chief Executive, Area Director of Nursing and Midwifery, General Manager RNSH, Acting Director of Nursing and Midwifery RNSH where progress is reported against the action plan.

Nursing recruitment and retention is a key issue of this plan.

Since 4 October 2007 there have been 49 enquiries to the advertising campaign at RNSH resulting in 25 new starters in nursing, including casual nurses.

Climate surveys undertaken within the former Central Coast Area Health Service (CCH) and Northern Sydney Health Area Health Service (NSAHS) in 2003 both identified management competency as a significant issue to be addressed.

3.5 Performance Review

An effective staff performance review system is vital in potentiating workforce capacity and is a mechanism for increasing staff satisfaction and ensuring individual career goals are aligned with the goals of the organisation.

NSCCH has a range of performance review tools available for managers to use with their staff. Area Workforce Development has been working on a performance review project to both simplify and standardise the tools and implement an education and training package to support staff in using these tools.

It is an expectation that all managers undertake a performance review with their staff at least once every 12 months.

Current compliance with this expectation is poor and remains an important challenge for the organisation.

To improve this, the health service performance agreement between NSCCH and NSW Health which reflects performance indicators and targets relevant to each AHS will be disseminated throughout the organisation using a system which ensures clarity, focus and accountability by relevant officers.

This system will include having clear performance agreements in place for management staff, cascading the organisations deliverables. Routine reporting of organisational performance against these indicators and targets is to occur.

A web-based performance management system for senior medical practitioners has recently been implemented at RNSH. This process involves annual performance appraisal/review of all senior medical practitioners practising at RNSH. A review of scope of clinical practice is also conducted as part of this annual appraisal.

A successful pilot was conducted in the RNSH/Ryde Division of Women's, Children and Family Health in September/October and the system is being rolled out across NSRHS in November 2007.

The system will assist in achieving alignment of service delivery with the organisation's strategic objectives and facilitate service, workforce, and capital planning.

A web based performance review system will be developed for the entire organisation, following the pilot of the medical performance tool. This will provide a user friendly performance methodology, with built in support, allowing the organisation to monitor ongoing compliance.

3.6 Credentialing for senior medical practitioners

Credentialing and delineation of clinical privileges of senior medical staff is an important component of a quality safety system to ensure delivery of high quality and safe patient care. The Australian Council for Safety and Quality in Health Care published National Standard Credentialing & Defining Clinical Practice, initialling in 2002 and revised in 2004.

Following advertising and consideration by duly constituted interview panels, all senior medical and dental appointments, including those for Career Medical Officers (CMOs), are considered by the Medical and Dental Appointments Advisory Committee (MDAAC) with review of proposed appointees' credentials and recommendations made to the Chief Executive on appointments and the granting of clinical privileges.

Solutions to address further involvement of clinicians in decision making will be reflected in the introduction of a Senior Medical Appointments Review Committee (SMARC), which is clinician driven and will determine, by priority which medical positions should be recruited. Clinicians will also lead the review process for drug usage, health technology decisions and participate in key roles in the Area Clinical Network Service Planning.

Senior medical practitioner categories that are credentialed to practise at RNSH include Staff Specialists, VMOs, Clinical Academics, Honorary Medical Officers, and Consultant Emeritus. Implementation of strategies to improve the coordination of senior medical workforce and appointment processes across the Area is in progress, with further development of policies and procedures related to recruitment, credentialing and defining of scope of practice in accordance with the role of health services and facilities, and the operations of the Area Senior Medical Workforce Unit.

Consistent with accepted practice, formal credentialing does not exist for pre-vocational and vocational trainees (junior medical trainees). Junior medical staff are credentialed through a process of competency assessment. Skills training and competency assessment is conducted as part of junior medical officer orientation through the use of skills stations. Ongoing skills training and competency occurs utilising the resources of the Northern Sydney Simulation Centre located on the RNSH campus and in-house trainers.

3.7 Leadership development

Building leadership and management capability has been highlighted on a number of levels, for example NSW Health has developed a program for staff specialist medical officers who are department or divisional managers in the area of leadership and resource management to ensure improved outcomes for patients. NSCCH has had representation on the NSW Health steering committee responsible for the development of this program.

Continued development of NSCCH managers is essential to improve and create effective relationships with all clinicians.

- A program previously developed and implemented successfully in Central Coast predominantly for nursing and allied health leadership development, was rewritten as the curriculum for state-wide multi-professional implementation, at the request of the CEC.
- 40 NSCCH participants are due to complete the program in clinical leadership program in January 2008.
- A further 40 NSCCH participants are due to commence the program in January 2008 program.
- A program of orientation for divisional management appointees, which focused on management skills, was conducted. This was co-operatively developed by Area Workforce Development and Area Clinical Operations.
- Senior medical staff were encouraged to attend the state-wide program developed for medical managers.

3.8 Workplace Culture - RNSH

It is apparent that for some time RNSH has had a culture in which bullying and harassment have been a concern.

In 2003 a report was commissioned into nursing management practice and organisational culture at RNSH, known as the Kilkeary and Stow Report.

Most recently these concerns from staff at RNSH have resurfaced prompting an external review commissioned in July 2007 by the Acting Chief Executive. The findings and recommendations of the 2003 review were incorporated into the 2007 review, authored by Meppem and Dalton, into workplace culture and allegations of bullying and harassment at RNSH.

Their report, released in September 2007, and its findings raised major concerns about the way staff grievances were managed and indicated significant bullying and harassment behaviour by managers and supervisors at RNSH. Since the release of the report other staff at other NSCCH facilities have also raised similar concerns.

An action plan to manage and implement the recommendations to the Meppem - Dalton report has been developed. Implementation to date includes the facilitation of mandatory training sessions at RNSH (124 managers attended as at 6 November 2007), development of a frequently asked questions and answers (FAQ) on bullying and harassment and staff grievances will be incorporated into brochures and circulated for all NSCCH staff and regular communiqués issued reminding staff of the bullying and harassment policy.

In addition, a Specialist Reference Group has been formed to manage the bullying and harassment issues and report implementation to the Clinical Reference Group.

Specific recommendations include:

- The resolution of outstanding grievances to HR notified and the development of an appropriate and effective escalation of any new grievances identified.
- The development of an appropriate education and training package for all staff to ensure a workplace culture of zero tolerance to bullying and harassment.
- The introduction of mandatory education on bullying and harassment for all managers and supervisors.
- Education on effective grievance management for all staff.

3.9 Marketing Strategies

Universities - During 2007 NSCCH nursing staff attended university career markets throughout Sydney, Newcastle and Wollongong providing information about the benefits of working for NSCCH, new graduate program and how to apply for a new graduate position. Information flyers were emailed to all universities throughout NSW requesting that the information be forwarded to all nursing students. A user-friendly site was set up on the NSCCH internet site 'Nursing in Sydney' for student nurses to access information and allow them to apply for a new graduate nurse position on-line with links to NSW Health Nursing and Midwifery website.

Secondary Schools – Staff participation at secondary education career markets within the Northern Sydney and Central Coast regions providing information about, assistant in nursing, trainee enrolled nurse and undergraduate university education programs.

3.10 Partnerships with Universities

NSCCH has a number of affiliations with Universities, particularly in relation to providing clinical placement and training for undergraduate students of all professional disciplines.

The new partnership established with UTAS provides accelerated nursing undergraduate courses and oversees nursing postgraduate placements which lead to permanent appointment. A further positive aspect of this relationship will be appropriate resourcing of clinical placements.

3.11 Research – Medical Research Unit

Supporting the excellence in the delivery of patient care, attracting high quality clinicians across all professional disciplines. A key focus in 2007 was to secure the partnership between the NSW Government and the University of Sydney to jointly fund the 'state of the art' Research and Education Building, which is a key part of the Royal North Shore Hospital redevelopment. The State Government has committed $61.36M and the University of Sydney $30M to provide accommodation for 350 'basic science' researchers in addition to 4 floors of educational facilities. NSCCH has long held the philosophy that Research and Education support excellence in the delivery of medical care, through the development of novel treatments, technologies and by attracting high quality clinicians across all professional disciplines. The advantage of having basic research co-located in the environment of clinical care is that diagnostic and treatment gaps inform the research, and research provides solutions to improve clinical outcomes. Refer Annexure 1.

The success of RNSH researchers is demonstrated by their success in the most recent NHMRC project grant round. Over 40% of submitted projects were funded (15 grants) totalling over $5million in comparison to the national average, which is in the mid 20% range.

3.12 Monitoring Safe Hours at RNSH

A template for term handover for junior medical staff at RNSH is being trialled to improve orientation to clinical terms. Roster changes are being implemented to manage double shifts on weekend days, and to quarantine hand back time to the ward teams on Monday morning. These initiatives will reduce work loads for junior medical staff on weekends, and improve communication about patient care. Additionally departmental and ward activity is being monitored on a daily basis to ensure appropriate levels of junior medical staff and levelling of work loads across the clinical teams.

3.13 Summary

NSCCH recognises the value of a flexible and adaptable workforce and the challenges this will pose over the next decade. Specifically, the ability to introduce new models of care and change existing roles to meet increasing levels of activity and incorporate future technological advances will be incorporated into the NSCCH strategic workforce planning direction. Priority issues which will be addressed include:

- Single integrated information system and the inability to identify vacancies and skill shortages in key areas poses significant challenges to longer term and evidence based planning processes.
- Inadequate level of employee details captured and maintained centrally on the clinical workforce; principally medical and nursing, to inform the long term workforce decision making process.
- Development of management capability at all levels, where integral to achieving the "employer of choice" status, is strategies and policies which achieve robust performance management procedures and development plans.

4. RESOURCE UTILISATION

Term of Reference (c) - Efficiency, effectiveness and appropriateness of resource allocation and utilisation within the hospital, and in particular, the operations of the emergency department.

4.1 Allocation of resources across NSCCH

4.1.1 Notification to NSCCH

On an annual basis, NSW Health formally notifies each Area Health Service, including NSCCH, of an initial allocation. On 29 June 2007, the NSCCH received its initial budget allocation advice for 2007/08.

The Chief Executive has the responsibility to ensure that a clear link exists between funding and delivery of services. The Chief Executive is also responsible to ensure that budgets identify what will be delivered within the funds provided and authority and accountability is devolved to all levels of budget holders. The budget allocation letter and its attachments specify:

- the quantum of allocation,
- conditions of subsidy,
- specific budget provisions,
- accountabilities,
- targets for priority areas and
- performance reporting requirements.

4.1.2 Budget Allocation within NSCCH

Facility and divisional budgets are developed by updating the existing historical budgets with the adjustments outlined in the NSW Health budget allocation letter. The Director of Finance (DOF), NSCCH leads the budget allocation process within NSCCH and the process is facilitated by the Area's finance department staff. Budget principles and allocation of budget enhancements and efficiencies are negotiated by the Area Executive.

Budget allocation letters (finance and activity) are issued by the Chief Executive to all facility, major cost centres and Third Schedule Hospitals. Health Service executives, facility/divisional directors and cost centre directors/managers have clear accountability for their functional areas of responsibility.

4.1.3 Chief Executive budget setting responsibilities

In devolving budgets, the Chief Executive approves:

- the budget and activity targets for hospital and other major cost centres
- the net cost of service budget and also a cash budget to ensure NSCCH can pay its commitments (payroll, creditors, VMOs, loans, etc) as they fall due
- whether non-cash budgets should be held centrally
- whether overhead budgets are held centrally and if so details of each budget

- who has responsibility and therefore receives an allocation letter
- where the overhead budget is then included in program Reporting (e.g. Mental Health) the component of such budget is to be specifically detailed in the letter to program directors and other budget managers
- of the other reserves/provisions not allocated including those yet to receive NSW Health approval for the release of cash (e.g. growth, enhancement or state-wide service funds)
- the devolution/accountability (as appropriate) of Department of Health Procurement and Internal Efficiency strategies
- the devolution (as appropriate) of internal health service budget strategies
- financial delegations

4.1.4 Responsibilities of Facility/Divisional Directors/Managers

The budget allocation letters to facility/divisional directors/managers outlines their specific budget allocation and responsibilities including:

- Budget compliance
- Achievement of strategy targets
- Reporting (budget performance and strategy targets) requirements
- Ensuring NSW Health State-wide procurement reform benefits are achieved by using relevant State contracts
- Key performance indicators
- Financial delegations compliance

4.1.5 NSCCH 2007/08 Budget Principles

In addition to the requirements of the *Accounts and Audit Determination* the following additional principles were applied to the application of budget responsibility for the 2007/2008 financial year:

- Funding reserves will not be retained centrally for future allocation to meet operating deficits.
- Adjustments to budgets, other than approved enhancements received from the State or Commonwealth funds, cannot be made without approval from the Chief Executive, Area Executive and the Director of Finance.
- Where an expenditure commitment to the Area will be incurred, delegation holders are required to identify the cost centre and budget element from which the purchase will be funded and certify that there is sufficient budget available.
- Full time equivalent staff (FTE) must be fully funded.
- To meet the creditors KPI and liquidity management measures determined by NSW Health it is imperative that all employees adhere strictly to the purchasing and procurement guidelines and the delegations process and all invoices are processed in a timely manner.
- The 2007/2008 budget allocation reflects the successful achievement of a number of strategy initiatives to be undertaken by the NSCCH.
- Monthly performance review (operational and financial) processes must be established within each health service/division to assess progress against targets (operational, financial & KPIs).
- It is the responsibility of managers to ensure the sharing and transparency of all data with clinical staff on the basis of seeking advice on how to achieve priority KPIs and budget.

4.2 Budget Allocation to RNSH

The allocation of the 2007/08 initial budget to NSRHS has been made on the above processes and principles.

The initial expenditure budget for RNSH has increased annually by 7.6% in 2006/07 and again by a further 2.7% for 2007/08. The 2007/08 initial expense budget excluded the hospital's allocation for workers compensation premiums ($4.3M in 2006/07). When this is factored in the real increase in 2007/08 is in the order of 4%. Actual initial expenditure budgets were:

2005/06 $323.3m
2006/07 $348.0m
2007/08 $357.5m

The initial net cost of services funding, reflecting the impact of internally generated revenue is $281.7m, $300.6m and 304.7m respectively.

4.3 Capital Budget Allocations

4.3.1 NSW Health Capital Program

NSW Treasury Asset Management Plan (TAM) underpins the development and implementation of the NSW Health Asset Acquisition and Forward Capital Works Program. The NSW Health Asset Acquisition and Forward Capital Works Program is generally a 10 year plan and is based on the strategic state-wide health service needs and objectives. Currently the state-wide health service needs and objectives are contained in the March 2007 State Health Plan. The NSW Health Capital Investment Plan (CISP) is based on this Plan.

NSCCH is required to update and confirm their service objectives and capital proposals in the CISP annually in June each year. NSW Health requires the submission of a functional brief with service requirements, order of costs, proposed program and funding source to support all proposals over $250K. These submissions include service development/need, capital infrastructure, equipment replacement and technology.

NSCCH seeks internal advice re service needs requiring capital expenditure annually from senior management and service directors. The proposals are evaluated according to NSCCH approved criteria and submitted to NSW Health for consideration and approval for inclusion on the CISP.

The evaluation includes change in service development/change/need, recurrent cost implications, safety compliance, high technology equipment life cycle, and services infrastructure and community issues. This evaluation is submitted via NSW Health for Government consideration and determination.

NSW Health's annual capital budget is determined by Government and capital proposals are evaluated by NSW Health as to their priority for delivery within the program budget.

In 2007-2008 financial years, NSW Health also required submission of proposed capital expenditure under $250K. The request included minor

capital works, equipment replacement and other infrastructure requirements. The same evaluation procedure applies to capital proposals under $250K.

NSW Health capital allocation in respect of RNSH under this program totalled $24.3m in 2005/06, $36.1m in 2006/07 and $42.5m for 2007/08.

4.3.2 Local Capital

Local capital represents Replacements, Maintenance and Repairs (RM&R) greater than $10,000. This budget allocation is part of the recurrent budget received from NSW Health. The actual amount applied to this is determined as part of the forward estimate process that occurs in April each year.

In the forward estimate process the amount allocated to local capital is determined after considering the budget requirements for operating expenses and the non capital balance sheet movements. Consequently, the amount allocated to local capital is consistent with the overall budget.

Within NSCCH the budget is split between the health services having regard to historical expenditure levels, additional requirements (and their prioritisation) and available funds. In general, the facility needs and requirements for this line item exceed funds available.

Capital items funded from local sources are shown in the following table:

	Area RM&R Funds $'000	Special Purpose and Trust Funds $'000	Total $'000
2005/06	4,130	1,184	5,314
2006/07	1,228	3,475	4,703
2007/08 YTD 1st Qtr	190	419	609

4.4 Growth Funds and Amalgamation Savings

Since July 2005 area amalgamation savings have been redirected to fund growth of clinical services.

The NSCCH met its obligations in respect of the savings benefits from amalgamation. These savings gained from the amalgamation of the former Central Coast Area Health Service and the former Northern Sydney Area Health Service were subsequently used to fund growth in front line clinical services. In 2005/06 the savings represented $3m and an additional $6m in 2006/07, i.e. a total contribution to growth funding of $9m over the past 2 years from this source.

The growth funding budget allocation component for RNSH was $15.8m in 2005/06, $13.6m in 2006/07 and $1.7m in 2007/08.

Included in the growth funding to RNSH in 2006/07 was an allocation of $10.9m which was reallocated from within the Area Health Service, with a further $0.7m in 2007/08.

4.5 Financial Performance - RNSH

The financial performance against budget at the Net Cost of Services position for RNSH reflects an annual adverse position. The hospital exceeded its budget allocation by $16.2m in 2005/06 and $12.3m in 2006/07. The main contributor to the adverse trends has been significant growth in employee related costs.

In accordance with budget principles and as part of the financial management process there is a need for divisions/health services to constantly identify and review strategies designed to maintain a balanced budget position. These strategies do not impact the actual budget allocation but represent programs designed to allow the division/health service to bring actual expenditure to within budget.

This includes a significant component directed at improving clinical utilisation and efficiency. To support this assessment case mix information has been provided at an enhanced service related group level, for each facility compared to their peer. This information will be supplemented with clinical costing information when available.

Clinicians are being actively encouraged to examine the information and provide feedback on opportunities for improvement, highlight data integrity issues and ask questions in regard to clinical coding standards or classifications.

4.6 Revenue - RNSH

A component of RNSH revenue is derived from patient fees representing private patient bed fee income and Department of Veteran Affairs payments and is an important component of the annual budget. This revenue represented 54.2% of total hospital revenue in 2005/06, 57.3% in 2006/07 and has increased to 60.5% in the current year (September 2007 Year to Date).

An external review conducted by VHIA Management Services in September 2005 identified this as an important source of funding available to the hospital which had scope for improved performance.

4.7 Role of the Area in Supporting and Reviewing Hospital Budgets

A matrix structure is used at NSCCH. This matrix allows performance to be evaluated on a clinical division and hospital basis. Clinical divisions operate across health services (for example - NSRHS). Medicine; Surgery & Anaesthetics; Women's Children & Family Health, Sector Operations; and Business Units are the clinical divisions under NSRHS. A Divisional Executive is appointed to each clinical division. Hospital reporting is also made available each month to ensure that performance of the various hospitals is evaluated. The primary focus is on clinical divisions.

Budgets are provided to clinical divisions/facilities by expense or revenue categories called line items. These line items are consistent with those used by NSW Health. Expense and revenue line items added together form a Net Cost of Service (NCOS) total. Total Expenses, Total Revenues and NCOS are the top level measures used in evaluating clinical divisions/hospital performance. Performance is also measured at the line

item, groups of line items and account level. Account is the lowest level used in measuring performance and includes such items as coffee, tea, stationery, motor vehicle insurance and interest. Some line items have been grouped together to form reportable categories. An example of this is Total Employee Related which includes salaries, overtime, annual leave, long service leave, superannuation and workers compensation.

Monthly reporting is on clinical division/facility and consists of budget – actual – variance on the month and year to date. Forecasts providing an estimate of where the clinical division/ facility will be at June are submitted by the General Managers.

It is intended for NSCCH to acquire a management information tool such as PowerBudget or ProCube for budgeting and management reporting purposes. At present the Area makes use of an interrogation script into the Health Information Exchange (HIE) database, Access databases and spreadsheets to prepare budgets and monthly reports. Application of a more appropriate system will provide greater efficiency and wider access across the Area facilities to financial information.

4.7.1 Budgeting

Subsequent to receipt of the budget allocation letter from NSW Health, Area finance advises each health service of their initial internal allocation of that budget.

Clinical divisions /hospitals (including NSRHS) then have the responsibility and discretion for allocating budgets at a cost centre level, subject to some specific constraints. They are also responsible for the flowing of budgets across months and are encouraged to cash flow according to either historical activity trends or planned service growth.

Throughout the financial year, as budget supplementations are received, Area finance seeks advice from clinical divisions/hospitals on cash flow requirements for the new budget supplementations received from NSW Health.

4.7.2 Month End Reporting Process

Clinical divisions/hospitals review monthly results, investigate issues and prepare a narrative report to Area Finance. A standard template and format is used for this process. This narrative report requires commentary related to their financial performance and seeks reasons for significant variation against budget. Financial, activity and staffing measures are all captured in this report. During the month end period, significant dialogue occurs between Management Accountants attached to health services and Area Finance. Topics such as charges, budgets, full time equivalent staffing (FTEs) are regularly discussed.

End of year forecasts (projections) are submitted to Area Finance from the General Managers providing an estimate of where the clinical division/hospital/health service will be in financial terms. Area Finance assesses the reasonableness of these projections and submits the adjusted set to NSW Health.

4.7.3 Area Executive Team Review

The monthly results, when finalised, are tabled at the monthly Finance and Performance Meeting. The Area Executive Team and staff from the Performance Unit and Finance discuss results, with action taken as appropriate.

4.7.4 Health Service Performance Review

Performance meetings with individual health services (Central Coast Health Service, Northern Beaches Health Service, Hornsby Ku-ring-gai Health Service, North Shore Ryde Health Service and Mental Health) are conducted monthly with members of the Area Executive Team. The role of these meetings is to evaluate activity, financial and staffing performance of each health service. Various budget achievement strategies are discussed. Area finance provides advice and support to General Managers and management accountants on financial issues.

4.8 Casemix

The term 'casemix' refers to the type or mix of patients treated by a hospital or unit. A hospitals casemix is determined from specific inpatient stay data collected by hospitals.

The data collected on each inpatient episode includes:

- demographics of patients such as date of birth, aboriginality, admission weight (neonates);
- inpatient stay details such as admission and discharge dates, discharge destination/status, care type, mechanical ventilation hours; and
- diagnoses and procedures relevant to the patient during their inpatient stay.

To manage the large amounts of data a classification system is used that groups inpatient separations into clinically homogeneous groups that are expected to consume similar amounts of resources. This classification system is known as Diagnosis Related Groups (DRGs).

Within NSCCH casemix information is used to support teaching and research and on an adhoc basis at the request of either management or clinicians. Casemix information has not been routinely used to assess the efficiency of practice against like hospitals, or improvements in efficiency over a period of time.

This has been recognised as a major blockage to improving the efficient use of resources across the area. Accordingly analysis based on DRGs is starting to be provided at a facility and clinician level and will be routinely provided from now on. An application to become a member has been lodged with the Health Roundtable to support state, national and international benchmarking with like facilities.

4.8.1 Clinical Costing

Clinical costing is a process of determining the "true" cost of treating patients. Each input utilised to treat a patient is determined, costed and assigned to the relevant DRG.

NSCCH has the clinical costing system PCM (Power Cost Manager). This system enables the costing data to be combined and grouped accordingly by patient, episode and DRG. The information that is available can be very useful in reviewing work undertaken and determining areas that are "costly" or areas that work "efficiently".

The information generated from the PCM has not been widely used to support the assessment of efficient costs. Stakeholders, until recently, have not actively engaged in the maintenance of the data and costing rules which has meant the data has not been robust. Over recent months this has changed with the increasing involvement of clinicians and managers in this process. The results for the 2006/07 financial year will be available for use within the next month. Clinical costing will be used more extensively in the budget setting and financial management process.

The clinical costing returns that are submitted to NSW Health titled 'episode funding returns' are benchmarked with peer hospitals to determine relative efficiency.

4.9 Delegations Manual

Northern Sydney and Central Coast Area Health Service is required under the *Accounting Manual for Public Health Organisations* and the *Accounts and Audit Determination for Public Health Organisations* to maintain a Manual of Delegations to record details of delegations of responsibility and authority, using a tiered structure approach, described below: -

Level 1 - Chief Executive
Level 2 - Executive
Level 3 - Facility Management
Level 4 - Divisional Management
Level 5 - Department Heads
Level 6 - Cost Centre Managers

Each level has varying degrees of delegated authority appropriate to carrying out the functions required for the positions recorded under each level. Delegations are made to position, not a person, and are specific to the position's role. The delegation to a position is specific and is not transferable.

Any new positions to be added to a level must first be recommended by a staff member with a current level 2 or 3 delegation and then approved at a meeting of the mandatory Finance and Performance Committee.

4.9.1 Purchasing and Approval for Payment

Requisitions must have the signatures of at least 2 staff members, one signature requisitioning the purchase and the other approving the purchase or payment.

Approvers must be listed on the delegation manual. The purchase must be within the Approvers delegated dollar limit. Note that where the source of funds is the Special Purpose and Trust Fund, the trust fund manager's approval signature must be obtained prior to forwarding the requisition for processing by Accounts Payable or the Purchasing Department.

5. COMPLAINTS HANDLING & INCIDENT MANAGEMENT

Term of Reference (d) – the effectiveness of complaints handling and incident management at the hospital

NSCCH and RNSH operate within the NSW Health Policy framework, including:

- NSW Health Patient Safety & Quality Plan (PD 2006_609)
- Incident management (2007_061)
- Open disclosure (PD 2007_040)
- Open Disclosure Guideline (GL 2007_007)
- Complaints Policy (PD 2006_073)
- Complaints Guideline (GL 2006_023)
- MCCC (PD 2006_007)
- MCCC Guideline (GL 2006_002)
- NSW Health Code of Conduct

To these have been added a number of locally developed policies and protocols, including protocols for handling the interface between RCA and Clinical Audit, the interface between RCA and performance management of individuals and a detailed set of guidelines for open disclosure.

Committee Structure
Across NSCCH the complaints and incident management system is directly overseen by the 'Area Quality and Improvement Committee' (the required governance committee that includes consumer representation) this committee reports to the Area Executive Team meeting via the Director, Clinical Governance. Minutes and reports arising from the meetings are also issued to the Clinical Council, the Audit and Risk Management Committee and the Area Health Advisory Council.

Within RNSH the complaints and incident system is overseen by the Executive Committee and the Quality and Safety Executive Committee, both of which include clinical leaders.

The NSCCAHS Area Complaints Committee includes representation from the Patient Representatives / Complaints Managers from each NSCCAHS site, the Clinical Governance Unit, the Manager of the Area Executive Unit (Chair) and the Health Care Complaints Commission. This Committee meets monthly to discuss complaints management and trends.

5.1 Identification of Complaints and Incidents

Active efforts are made to ensure that patients, families and staff know how to register an incident or a complaint. This information is included within patient admission information packages. There is a prominently positioned (in main lobby entrance of RNSH) Patient Representative Office and telephone operators and executive support staff are made aware of where to direct inquiries, and the NSCCH internet website has a clearly described process. There is also a permanently rostered member of senior staff who acts as Senior Complaints Officer (usually the Director of Clinical Governance) – such roster is published on a weekly basis and communicated to appropriate staff, including switchboards.

5.2 Complaints Registration

Complaints are registered in the Incident Information Management System (IIMS). Who enters the notification depends on how the complaint is made. Complaints are resolved as close as possible to the level of care delivery, and most complaints are investigated and resolved at clinical unit level. Further details of the IIMS system and its performance are provided below in Section 5.12.

Complaints are required to be rated for severity at the time of entering into the IIMS and the more serious complaints are automatically escalated to executive level (e.g. Divisional Head). The system at RNSH is described in detail below.

Serious complaints and incidents that meet certain criteria are treated as "reportable incidents". These are submitted as Reportable Incident Briefs ("RIBs") to the Department of Health and require sign-off by the General Manager, the Director of Clinical Governance and the Chief Executive. Such RIBs are required to be processed within 24 hours.

5.3 Complaints and Incident Investigation

Formal complaints investigation is primarily done at divisional level within facilities (e.g. Division of Medicine, Division of Surgery) and is usually coordinated by the patient representative. Executive support is provided by a nominated Executive member, usually the Director of Medical Services or Director of Operations.

Incident investigation depends on the severity of the incident. All incidents (including complaints) are required to be recorded in IIMS, and are rated for severity using a Severity Assessment Code (SAC) of "1" to "4", "1" being the most serious. All Clinical SAC1 incidents have a mandatory Root Cause Analysis (RCA) undertaken. SAC 2 incidents are required to be investigated, but not necessarily using Root Cause Analysis. SAC3 and SAC4 incidents and complaints are usually investigated by the relevant clinical unit or division, but may trigger a more formal investigation if the circumstances warrant it (e.g. a "near miss"). RCA teams comprise clinical staff not directly involved in the incident. Support for investigation of incidents is provided by the RNSH Quality and Risk Management Unit (QRMU), the Clinical Governance Unit (CGU) and the QaRNS (Quality @ Royal North Shore) clinical audit unit.

5.4 Training

Education programs about incident management policies and procedures have been in place since 2005. Three RCA workshops have been conducted per year since 2005, and over 330 NSCCAHS staff are now trained in this method of incident investigation. Tools have been developed to support clinicians leading these investigations and a member of the Clinical Governance Unit supports each RCA team.

Further training has been provided covering such areas as incident recognition and notification, incident investigation, extraction of local unit reports from IIMS and Open Disclosure. Further details of training with respect to IIMS and Open Disclosure are given below. Education is provided each year at the orientation sessions for new Junior Medical Officers, and regular sessions are provided to other frontline staff.

Education sessions for frontline clinical staff commenced on 9 September 2007 and to date have been provided to 15 wards/clinical units. When education has been provided to all clinical areas, sessions will be scheduled for non-clinical/corporate departments.

5.5 Engagement with Complainants

Good practice requires ongoing active communication with complainants on the needs of the complainant, the course of investigation, findings and corrective action at individual and system level.

At hospital level, communication about the complaint process is primarily through the Patient Representative's office. For the more serious complaints, an executive level person is usually involved as well (e.g. the Director of Medical Services).

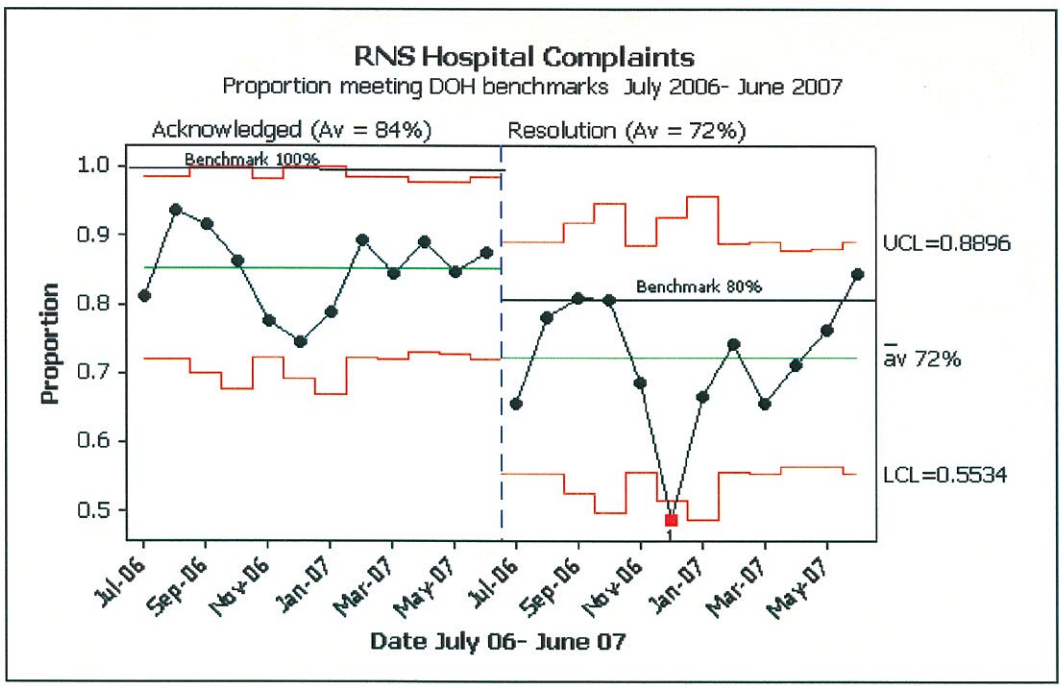
At Area Level, the establishment of the Professional Practice Unit (PPU) now provides an improved focus for engagement with complainants. The PPU is further described in Section 5.10 below.

5.6 Complaints System Performance

The NSCCH and RNSH strive to achieve the State-wide benchmarks for complaints handling, being:

- 100% of complaints acknowledged within 5 days
- 80% of complaints are finalised within 35 days

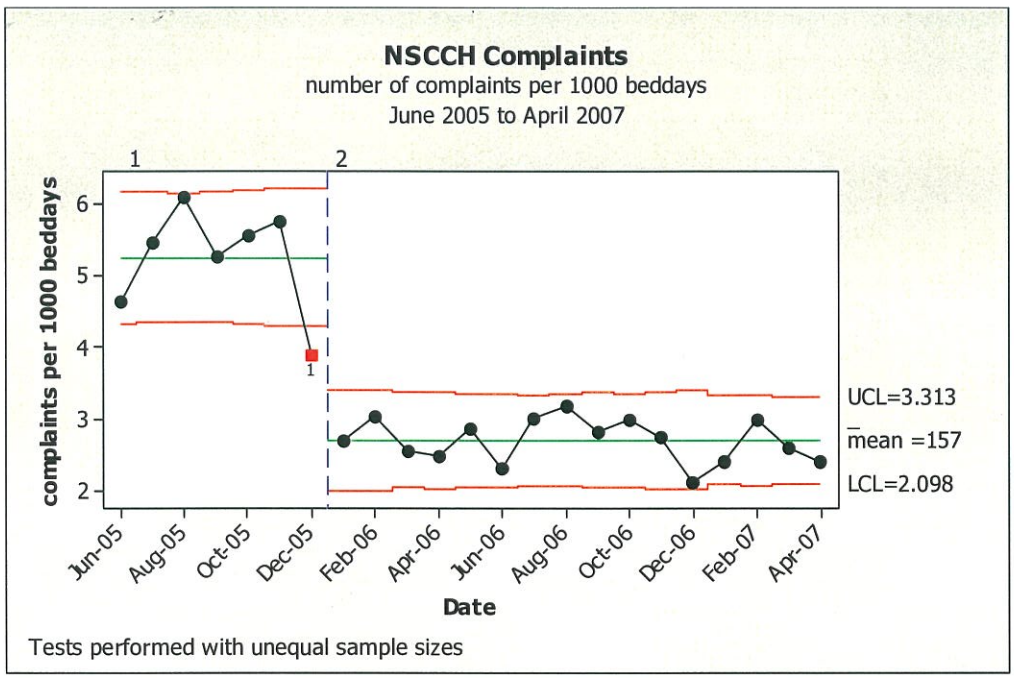
Performance at RNSH in acknowledgement of complaints is improving. The resolution benchmark has recently been exceeded (refer below).



RNSH Complainant Satisfaction 01.07.06 to 30.06.07 showed 5.3% of complainants were unsatisfied with complaint resolution. 3.7% were unresolved, of whom 3.3% unable to contact complainant to provide feedback and 0.4% the complainant was NOT the patient and the patient did not consent to investigation or release of information.

5.7 Trends in Complaints

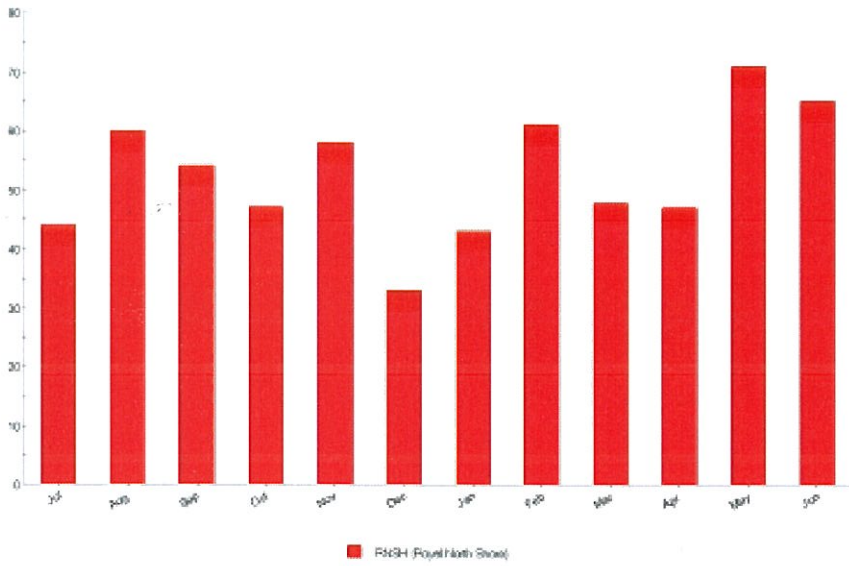
There has been a general decline in the number of recorded complaints. While this is possibly due to improved performance, it may be an artefact of changed registration mechanisms for complaints in IIMS. Further education (commenced November 2007) is being provided to staff reinforcing the importance of entering complaints using the IIMS complaints form.



In June 2005 all of NSCCH were using IIMS to record complaints. In some health services, complaints are entered directly into IIMS and in others they are centrally entered. In January 2006 the number of complaints entered across all Health Services decreased by a statistically significant amount and has remained lower. The mean in 2005 was 269 since January 2006 this has reduced to a mean of 157 or 2.7 per thousand bed days.

Complaints Incidents - by Month and Organisation

aims



Date Range: 01/Jul/2005 to 30/Jun/2006
Organisation: RNSH (Royal North Shore)

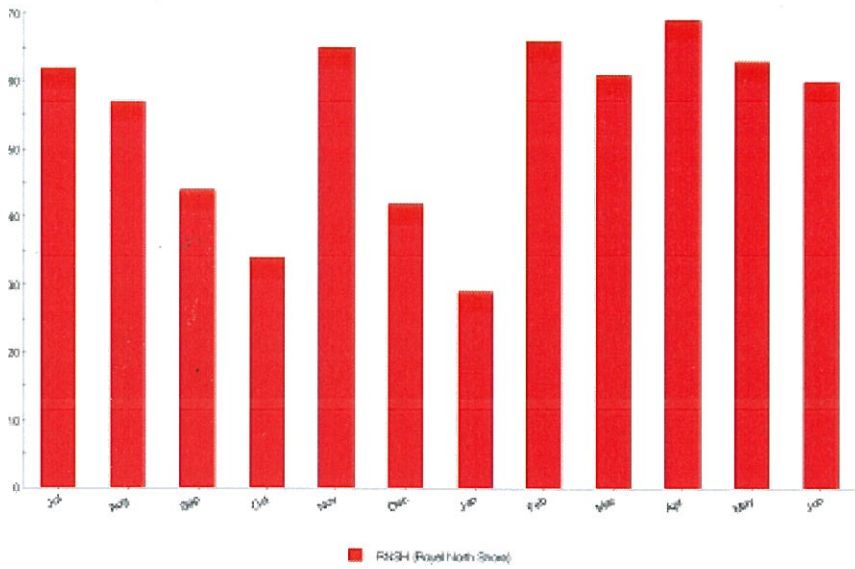
Month	Organisation
	RNSH (Royal North Shore)
Jul	44
Aug	60
Sep	54
Oct	47
Nov	58
Dec	33
Jan	43
Feb	61
Mar	48
Apr	47
May	71
Jun	65
Totals	631

This is an enumerative report - Each incident is recorded only once.

02/Nov/2007 07:01am *AIMS Analyser: rep_60_0000_AIMS_Chart* *Page 1 of 1*

Complaints Incidents - by Month and Organisation

aims



Date Range: 01/Jul/2006 to 30/Jun/2007
Organisation: RNSH (Royal North Shore)

Month	Organisation
	RNSH (Royal North Shore)
Jul	62
Aug	57
Sep	44
Oct	34
Nov	65
Dec	42
Jan	29
Feb	66
Mar	61
Apr	69
May	63
Jun	60
Totals	652

This is an enumerative report - Each incident is recorded only once.

02/Nov/2007 07:06am AIMS Analyser: rep_60_0000_AIMS_Chart Page 1 of 1

5.8 Complaints Management at RNSH

The Patient Representative Office coordinates to the management of patient complaints at RNSH, including complaints received from the patient/complainant and complaints received via the Health Care Complaints Commission, or other source.

Complaints are managed in accordance with *NSW Health* and *Northern Sydney Central Coast Area Health Service* (NSCCH) policies, including:

PD2006_073 Complaint Management Policy
GL2006_023 Complaint Management Guidelines

CM2005_001 NSCCH Complaint Management Policy (Superseded)
PD2006-007 Complaint or Concern about a Clinician – Principles for Action

The majority of complaints are managed by the relevant operational unit and management structures, but the underlying issues are recorded, analysed and acted upon through the governance and risk management structures.

Investigation reports include identified systems changes and/or actions taken to prevent recurrence. It is the responsibility of the Operational Manager to ensure that local actions are implemented where necessary. All written complaint responses are reviewed and signed off by the appropriate RNSH or NSCCH Executive Manager (i.e. Chief Executive, General Manager, or delegates).

Verbal complaints received by the Patient Representative are referred either to the local department/ward manager (for non-serious complaints with severity assessment code of 3 or 4) or to the senior operational manager (serious complaints with a SAC of 1 or 2).

Any complaint that involves an allegation of an impaired practitioner or serious breach of code of conduct is referred to RNSH Executive Management, Human Resources Manager, and the Relevant Senior Operational Manager for investigation in accordance with the NSW Health Policy *PD2006_007 Complaint or Concern about a Clinician* and the NSW Health *Code of Conduct.* Strong links have been forged with the Area's newly formed Professional Practice Unit (PPU).

If serious patient incidents and/or health systems issues are identified by the Patient Representative, these are referred to senior management and to the Quality Units (Quality & Risk Management Unit (QRMU) &/or Quality Assurance Royal North Shore (QaRNS)) for further review.

5.8.1 RNSH Complaints Process

The Patient Representative acknowledges all complaints within 5 days of receipt and aims to resolve all complaints within 35 days. When complaints are not resolved within 21 days, the Patient Representative contacts the complainant to apologise for the delay and to advise of progress with investigations. Regular contact with the complainant is maintained if delays continue past 35 days.

The Patient Representative also provides an advocacy service for complainants and provides advice about patient rights and other avenues for lodging complaints, including the Health Care Complaints Commission, Minister for Health, and NSW Ombudsman.

All complaints are recorded in the IIMS database. The data from the IIMS database is analysed by the Clinical Governance Unit each quarter and annually, with reports to the Area and RNSH Executive management teams regarding complaint trends.

On average there were 60 complaints lodged at RNSH per month for the 2005-2006 and 2006-2007 financial years. The major complaint issues were:

2005-2006			2006-2007		
Treatment	27.3%	(n=226)	Treatment	22.0%	(n=179)
Communication	26.1%	(n=216)	Communication	22.9%	(n=186)
Access	21.5%	(n=178)	Access	27.8%	(n=225)
Corporate	15.0%	(n=124)	Corporate	14.0%	(n=113)

The complaints management process at RNSH is shown in Annexure 2.

5.8.2 Advocacy and Information Service

The Patient Representative Office also provides an advocacy and information service for patients / health consumers, and participates in quality projects, including education of frontline staff in effective complaints handling and conflict resolution strategies.

During its recent Survey (April 2007), the Australian Council on Healthcare Standards (ACHS) survey team commented:

"The health service has an excellent system for incident and complaint management based upon its Incident Management Policy and its Complaints Management Policy and utilising the IIMS incident reporting system. Incidents entered into the system are monitored twice each day and appropriate action is taken and monitored. Severity assessments are allocated to each incident and there is a process for the upwards reporting of incidents with a SAC rating of one or two...

...there was evidence that the managers are using data from the system to identify opportunities for improvement. The management of incidents with a SAC rating of three or four is handled at manager level and it was noted that this was being done particularly well in Maternity services where a process of reflexive practice was being introduced.

Patient complaints are sensitively handled through the patient representatives. The principles of open disclosure of an adverse event are evident in the system to manage incidents and complaints and there is evidence that open disclosure is being rolled out across the organisation.

The Executive monitor reportable incident briefs and root cause analyses through quarterly reports. These data are used to identify trends and opportunities for further improvement "

Source: ACHS, RNSH, EQuIP Periodic Review Report P61.

5.8.3 Improvements in Complaints Management at RNSH

Investigation skills
In March 2007, the Patient Representative Office developed a new complaints investigation report template to improve the investigation and reporting of complaints at RNSH by frontline managers.

Issues Communication
In May 2007 the Patient Representative Office drafted and trialled a new Executive Brief to be used as a formal mechanism to alert RNSH Executive

Management Team to systems issues that arise out of complaints and which have not / or cannot be effectively managed at a lower management level.

Patient Information
In 2007 a new Area-wide *NSCCH Patient Rights and Responsibilities Brochure* was endorsed and distributed to all patient care areas at RNSH. In June 2007, the Patient Representative Office conducted a survey of current inpatients to seek their feedback about the content and format of the brochure. The results were overwhelmingly positive.

Decision-making
A regular weekly forum has been recently developed for review of complaints at RNSH. Attendees include the General Manager, the Patient Representative Manager, the Director of Operations, the Director of Medical Services, the Director of Nursing, the Area Professional Practice Unit Manager and the Area Director of Clinical Governance.

The Patient Representative Manager now attends the weekly Incident Management Committee meeting in an attempt to achieve better integration of incident and complaints management throughout the organisation. The Patient Representative Manager reports to the committee all serious complaints with a Severity Assessment Code (SAC) of 1-2, and any complaints that involves a clinical incident.

5.9 Professional Practice Unit

The Professional Practice Unit (PPU) was established on 8 October, 2007, based on a model that has operated successfully in SESIAHS and SWSAHS. The PPU is intended to promote a culture that supports open and unhindered reporting of grievances and concerns, whether raised by patients or by staff. The PPU augments established processes within the Area Health Service, by providing an independent avenue for patients and staff who are not satisfied with the handling of their concerns. It works closely with the Directorates of Clinical Governance and Workforce Development.

The PPU's major brief is the transparent, fair and objective investigation and management of serious patient complaints and staff grievances. While its initial focus is RNSH, it will eventually be extended to the whole area.

Matters can be referred to the PPU by patients, relatives and staff. Incidents identified in the media that require further investigation are also handled by the PPU.

A brochure to inform patients and staff about the PPU and its role has been developed and is available at all sites (Annexure 3).

A Professional Practice Committee, to be established by the end of November, will oversee the system for dealing with clinical and staff management issues, including processes for referral and management of individual cases referred to the committee, monitor referrals to professional registration bodies and to advise the Chief Executive regarding serious performance issues and the conduct of investigations.

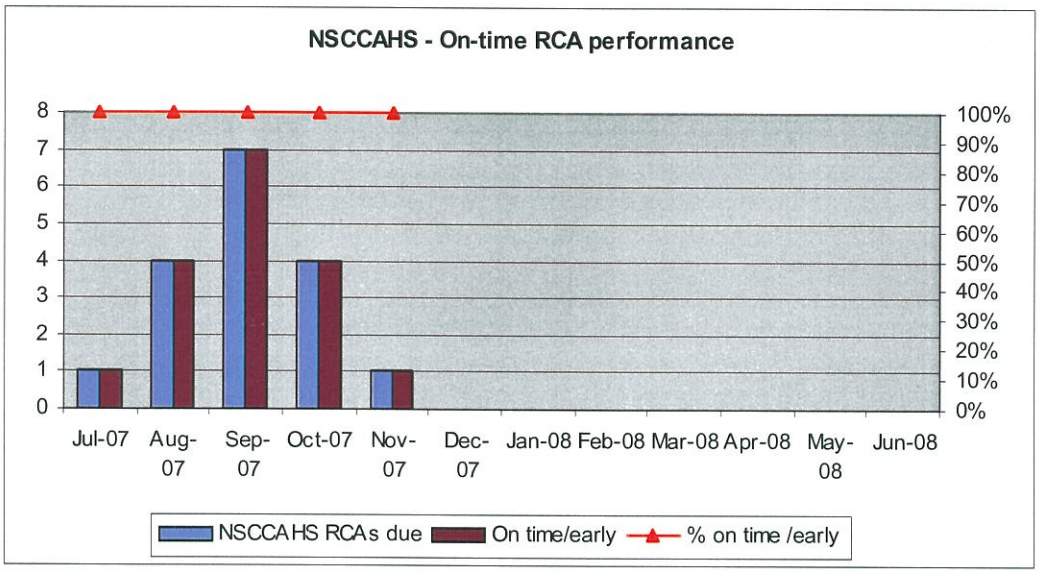
Activities undertaken by the PPU in its first month of operation include:

- Assisting staff in handling complex complaint matters, especially those with significant risk
- Making recommendations arising from complaints
- Undertaking daily ward rounds at RNSH
- A weekly meeting with the General Manager, Director of Operations, Director of Nursing and Director of Medical Services at RNSH, and the Director of Clinical Governance to discuss current complaints
- Daily liaison with RNSH Patient Representatives over the management of contentious complaints.

Since its establishment the PPU has assisted in the management of 16 staff grievances and 24 patient complaints.

5.10 Incident management

All serious incidents (SAC1 and SAC2 and selected SAC3 incidents) are investigated, using RCA (SAC1 and selected SAC2) or alternative methods (SAC2, SAC3). Benchmarks for completion of SAC1 RCAs have been met.



Regular trended analyses are provided and have informed the Area Quality and Safety Plan. Three key areas in need of addressing are medications errors, detecting and managing the "deteriorating patients" and in patient falls management. These are addressed in the Area's Quality and Safety Plan (Annexure 4).

Clinical Units are strongly encouraged to review their incidents, and have been given training on report extraction. Outcomes and changes arising from investigations are required to be fed back to RCA teams and incident notifiers, but this is not formally measured.

- Using the QaRNS Clinical Audit process as an 'error trap' for missed incidents. A process in place whereby, QaRNS advises the RNSH Quality and Risk Management Unit (QRNU) of suspected non-reported incidents, and the QRNU then organises entry of the incident into IIMS and a RIB as appropriate.
- An education program for staff, with particular attention to units with a low rate of reporting.
- Ensuring that staff are aware of the benefits to patient care from reporting.

A twice-yearly meta-analysis is undertaken of RCA causal statements to better understand and address the general system issues that may underlie the specifics. The meta-analysis and the action required are considered by the Area Executive Team, the Quality and Improvement Committee and the Clinical Council.

Recommendations from incident investigations are logged in a database and completion is tracked. Since August 2005 145 SAC 1 incidents within NSCCAHS incidents have been investigated using this methodology. Since 2003 RCA investigations have generated 500 recommendations and to date 75% of these have been implemented. RNSH has implemented 62% of its RCA recommendations with a further 28% currently in progress.

Where completion of a recommendation turns out not to be feasible or to be redundant, a formal review and sign-off mechanism is used to either recast the recommendation, to transfer responsibility or to otherwise deal with the identified risk.

All SAC 1 & 2 reportable incidents are tabled monthly at NSRHS Executive meetings. A report on the progress of implementing RCA recommendations is tabled quarterly at NSRHS Executive. A formal committee for incident and complaint management is being established and its function will include a review of all incidents and will also include recommendations from coroners and QaRNS reports. SAC 2, 3 and 4 incident trends are analysed

5.11 Incident Information Management System (IIMS)

IIMS is intended to assist clinicians, managers and other health care workers to minimise clinical risks by managing health care incidents as they occur. The IIMS software provides a consistent means of identifying, tracking and managing clinical, workforce and corporate incident information across the NSW health system.

IIMS was introduced across all of NSRHS in May 2005, following an extensive Area wide education and training program in late 2004 and early 2005.

The system started with reporting of clinical incidents and complaints and in July 2007 a third category, ("property and security hazard") was introduced. The remaining category of "staff, visitor and contractor incidents" will be introduced in early 2008.

NSCCH has contributed at a state level by advising on further enhancements to IIMS to ensure accurate and appropriate information about incidents is captured.

To date, priority has been given to ensuring a timely response to SAC1 and SAC2 notifications. All such high level incidents are reported using the Reportable Incident Brief and are followed up by divisional managers. A workshop is planned for November 2007 to reinforce the importance of incident reporting, and will be followed up by targeted education at clinical unit level.

Across NSCCH 86% of SAC 1 notifications entered into IIMS are actioned within 24 hours as required by policy. RNSH has in the last 12 months submitted all RCAs (n=6) to NSW Health within the 70 day legislated timeframes.

SAC 3 & 4 incidents are usually managed by the clinical unit but can be escalated to the division, the hospital or the Area if the assessed risk cannot be mitigated by the unit. Approximately 55% of SAC 2, 3 & 4 have updated information recorded in IIMS updated within 5 days of notification. A training program for clinical units is being implemented to improve this performance. Additional incident management training is provided by the RNSH Quality and Risk Management Unit as required.

5.12 Clinical Audit

RNSH has a very comprehensive clinical audit system that is managed by QaRNS (Quality @ Royal North Shore). QaRNS is a program of the Northern Centre for Healthcare Improvement and reports to the Chief Executive through the Clinical Governance Directorate. QaRNS commenced in 1989 as an outcome of NSW Health supporting increased clinical audit activities. It operates by reviewing the medical records for:

- all patient deaths
- all unplanned transfers to intensive care areas
- all unplanned returns to the operating rooms.

As a result of these reviews, the cases with real or potential breaches in standards of care are referred to the appropriate department, with attention being drawn to the issue(s) of concern. The department undertakes "peer review" of the case and reports back to the peak Clinical Review Committee with its assessment and the actions it plans to undertake.

QaRNS has successfully engaged clinicians and satisfied accreditors over many years, and has meant ensured that RNSH has led the way in having a comprehensive mortality review process. The IIMS introduced across NSW Health now provides for all serious incidents to be the subject of a Root Cause Analysis (RCA).

There are also multiple clinical unit audit programs.

The Clinical Review Committee (CRC) reports to the General Manager and the committee chair meets with the General Manager every month for briefing on issues of concern. The CRC membership is multidisciplinary, contains senior management and clinical groups, and most recently includes a consumer representative. There is a close link with the root cause analysis processes through having their recommendations also considered at this weekly meeting.

The focus is preventing future incidents, and the process is subject to qualified and non-waivable legal privilege under the Health Services Act.. To ensure that system issues are properly communicated, the Director of QaRNS attends the RNSH Quality and Safety Executive meeting monthly, and also regularly briefs the General Manager on issues of concern.

QaRNS also undertakes

- Routine random record audits to understand the incidence of various adverse events
- Specific reviews at the request of the General Manager or other senior staff.

A protocol has recently been implemented to strengthen links between QaRNS and RCA, including making sure those serious incidents found through the QaRNS process are notified by the relevant clinical unit as Reportable Incidents and subjected to RCA outside the QaRNS process. This will ensure that serious events are all subject to Open Disclosure, without being impeded by legal privilege.

5.13 Open Disclosure

NSCCH and RNSH are committed to Open Disclosure, including participation in development of the original National Standard, selection as a pilot site and a leading role in development and delivery of training.

Consistent with the NSW Health approach, attention during 2007 has been paid to "high level" disclosure for serious events. It is intended to address "general disclosure" during 2008: materials are currently under development.

Key elements of the NSCCH and RNSH system are:

- A clearly communicated ethic. Successive Chief Executives have given the Open Disclosure process explicit support.
- Integration of Open Disclosure with incident management, especially patient/ family support, staff issues, quality improvement and risk management. A protocol to guide these links has been developed.
- Establishment of a network of 30 expert "mentors" to advise and assist staff with disclosure. The mentors include nurses, allied health staff, doctors and managers.
- Training for mentors, clinical and management staff:
  - February 2007 - NSCCH "mentor" training for senior clinicians and administrators (50 participants from across NSCCH including 8 from RNSH). Mentors are intended to provide expert peer support, but not necessarily to participate in disclosure.
  - June and September 2007: NSW Health led training for a further 40 NSCCAHS participants (7 from RNSH) and a reinforcement workshop for the previously identified mentors.
  - August 2007 onward: Ongoing training and presentations targeted at Division and Service level in local Health Services and Mental Health to develop skills and to reinforce local support structures for open disclosure.
- Clearly defined area support through the Directorate of Clinical Governance Patient Focus Program.
- Clearly defined local leadership, through the Director of Medical Services and Divisional Managers. The RNSH Incident Review meeting includes consideration of Open Disclosure.

- Accessible information. This includes:
  - Ensuring the Open Disclosure policy and guidelines from NSW Health (formally endorsed by NSCCH), are available on the NSHCCH policy website,
  - Local procedure guidelines and resources supporting implementation at health service/ divisional level, and
  - A procedure for integrating incident notification and TMF notification.
- Development of protocols and procedures to assist with potentially difficult issues e.g. links to RCA report provision
- Performance monitoring:
  - All Reportable Incident Briefs now require details of initial disclosure. The Director of Clinical Governance reviews all RIBs submitted and verifies that initial open disclosure has occurred. If it has not, a disclosure plan is developed. A new RIB form has been implemented Area-wide to ensure disclosure information is properly documented, as open disclosure was not consistently recorded in the past.
  - A system has been developed for assessing the rate of disclosure for serious incidents.
  - NSW Health is developing a methodology for patient family follow-up evaluation.

5.14 Accreditation and Quality System Assessment

All NSCCH facilities are currently accredited, including RNSH, which was amongst the first hospitals to be accredited under the new EQuIP 4 standards.

The CEC "Quality Systems Assessment" (QSA) is a new initiative for the NSW Health system and is a key component of the NSW Patient Safety and Clinical Quality Program. It is entirely compatible with, and indeed enhances, the ACHS EQuIP Accreditation Program, with more detailed attention to safe practice.

The QSA survey tools were trialled earlier this year across the State and NSCCAHS Division of Women's & Children's Health piloted the Stream/Cluster/Network Activity Statement.

The Assessments will take place during November/ December 2007 at Area, Facility and Clinical Unit level, and will involve each facility across NSCCH (i.e. Northern Beaches, Central Coast, North Shore Ryde, Area Mental Health and Hornsby Kur-ring-gai). Clinical unit surveys will be completed at clinical unit level across the Area Health Service as follows:

Health Service	Number of Clinical Unit Surveys to be completed
Central Coast	8
Northern Beaches	7
North Shore Ryde	8
Area Mental Health	9
Hornsby Kur-ring-gai	7

As part of this process, Area Mental Health Executive will also complete a Cluster/Network Survey.

The 2007 surveys will collect baseline data that will be used to assist with

the identification of state wide policy and program gaps, provide a source of verification and measure the degree of effectiveness in the implementation of policies, performance monitoring and risk controls.

Each year a different targeted area will focus on the previous 12 months QSA in relation to the extent and degrees of deficiencies in practice and it will assess the degree of clinical risk.

Results will also allow benchmarking against peer hospitals/clinical departments and provide the NSCCH, NSW Health and CEC with data to establish state priorities for patient safety improvements.

5.15 Quality Improvement

NSCCH has on its staff a number of recognised leaders in quality and safety. Dr Ross Wilson, Director of the Northern Centre for Health Care Improvement and of QaRNS was the lead author of the Quality in Australia Healthcare Study and is an internationally recognised expert on quality, safety and improvement.

The Northern Centre for Healthcare Improvement established in 2005 works in association with the Area Clinical Governance Unit undertaking an extensive education program, national and international research into quality and safety and provides consulting services on improvement.

Complaints and incident experience influences the Area's and Hospital's improvement plans. The Area's Quality and Safety Plan (Annexure 4) details the Area's approach to the major identified clinical risks.

Progress in the various improvement programs is overseen by the Quality and Improvement Committee and the Area Executive Team, which receive regular detailed reports on progress and outcomes. Reports are shared with the Clinical Council and the Area Health Advisory Council.

The Area's Clinical Governance Unit has a major role in supporting safety and quality improvement, and operates three major programs:

- The Patient Safety Program, which covers
  - The Incident Reporting System (establishment, support, training, system improvement)
  - Data analysis, including preparation of detailed reports
  - Support for improvement programs i.e. falls prevention, medication safety, infection prevention and control
  - Direct improvement programs, including wound care, pressure area prevention, patient nutrition, blood safety, pathology specimen labelling
  - The Safety Alert program
  - Training in incident investigation

- The Patient Focus Program, which covers
  - Open Disclosure
  - Complaints system
  - End of life matters
  - Support for ethics of practice
  - Patient surveys

- The Compliance and Evaluation Program, which covers
  - Quality System Assessments (CEC)
  - Coordination of Accreditation
  - Quality Awards

These programs are reported in detail to the Area Executive Team, the Quality and Improvement Committee and the Clinical Operations Committee.

The CGU works closely with the various facilities and services (e.g. by technical support for improvement programs), and meets with quality professionals from throughout the Area through the Quality Improvement Network, which is a peer support group for quality staff.

There is an opportunity to better integrate quality improvement and governance activities within the Area. This would require more explicit directorial responsibilities of the Director Clinical Governance for the assessment, selection, implementation and accountability for patient safety and quality improvements in the Area. This would need to be responsive to the local needs of the facilities.

It is planned that a review of quality and safety governance, priorities, and improvement will be undertaken by a panel, chaired by Dr Wilson and including a consumer representative.

6. OPERATIONAL MANAGEMENT

Term of Reference (e) – the 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 and, effectiveness and quality of care.

6.1 Executive Management

RNSH is part of the NSRHS. The executive team, which comprises six corporate executive and six operational executive members, report to the General Manager, who in turn reports to the Area Director, Clinical Operations. The Operational Executive reporting to the General Manager operates through a Clinical Divisional Structure, and has responsibility for the provision and management of clinical services.

A divisional manager, alongside clinical directors, leads each division and is supported by management and financial accountants within a Decision Support Unit.

This structure has resulted from:

- The amalgamation of RNS & Ryde Hospitals and their respective Community Health Services in 2003.
- A review of management and governance structures across NSCCH in 2005 (as a result of the area amalgamation) which recommended the alignment of management and governance structures across the AHS. The recommendations of that review are detailed in the document entitled "Management and Governance Structure, Northern Sydney Central Coast Health, Review and Recommendations to Area Executive". (Croome V. Oct 2005).

In December 2005 following further consultation across the Area Health Service, a new management and governance structure for the Clinical Operations Directorate were proposed.

6.2 Divisional Structure

While the RNS & Ryde Health Service had in operation a divisional management structure, there have been a number of changes implemented over recent years. There have been a number of changes to the executive team at RNSH since July 2002, outlined below:

- five personnel in the role of General Manager at RNSH; this includes three permanent appointments and two acting appointments.
- two personnel in the Director of Medical Services role at RNSH, this includes the current incumbent.
- five personnel in the Director of Nursing role at RNSH; this includes three permanent appointments and two acting appointments including the current acting DON.

There have been a number of changes to the executive team at RNS since July 2002.

6.3 Corporate and Clinical Support Services

Corporate and Clinical Support (C&CS) functions at RNSH are provided through the Area Division of Corporate & Clinical Support, in collaboration with the local hospital management. This division is responsible for the delivery of the following services to RNSH and other facilities within NSCCH.

6.3.1 Corporate Support, Shared Services and Business Units

- Environmental- Cleaning, Waste Management & Linen Management*
- Food Services* including retail outlets
- Internal Materials Management including Mail distribution*
- Security, Parking & Fleet Services*
- Buildings & Grounds maintenance
- Child Care Services*
- Capital Strategy & Works (Capital Works <$10m)
- Patient transport*
- Medical Imaging
- Central Sterilising Services
- Bio-Medical Engineering*

Most services* are ISO accredited

6.3.2 HealthSupport

NSW Health established Health Support to manage the delivery of shared corporate and business services across the NSW Health System. Within the C&CS division the following developments have occurred:

- Linen supply services are now provided through a state-wide linen service with local staff distributing linen within the hospital
- Food services are currently under co-management Health Support /NSCCAHS with a program to move the full management and service delivery responsibilities to HealthSupport from mid 2008.

6.4 Committee Structure

Governance is supported by a committee structure with strategic and operational direction assigned through the NSRHS Executive Committee. Five peak committees report to the NSRHS Executive, and provide both strategic and operational support for the organisation. The peak committees were developed to correspond to Accreditation Standards. A member of the NSRHS Executive chairs each peak committee, which has a number of sub-committees covering various topics.

The NSRHS Executive Committee is responsible for determining the strategic direction of the organisation, and ensuring that the direction is consistent with NSCCH and NSW Health Strategic Direction. It is also responsible for the performance of the organisation and the operational management.

6.4.1 Peak Committees

NSRHS Continuum of Care
The objective of the committee is to ensure that there is a coordinated and effective assessment system to identify current and ongoing patient care needs and that the patient is provided with the relevant information regarding care management, consent and documentation, infection and falls risk prevention. In addition to this the committee monitors the organisations adherence to clinical polices and procedures.

NSRHS Human Resources Management Committee
This committee is responsible for appointments, scope of practice and training issues, as well as general staff issues and workforce planning. The committee is also responsible for the supervision of staff grievances and conflict matters, facilitating resolution of issues and development of strategies to enhance a positive work culture throughout the organisation.

NSRHS Information Management Committee
The objective of the Information Management Committee is to focus on Information Management and Technology issues relevant to North Shore Ryde Health Sector. The committee is also required to provide input into the NSCCH strategic planning process for Information Management. Local action plans are developed and monitored, and there is a strong link with the Area Committee to ensure that local actions support and operationalise the Area Strategic Direction.

NSRHS Environmental Health and Safety Committee
The objective of the Environmental Health and Safety Committee is to provide a forum for issues relating to safety and environmental issues, and to support a culture of risk management, and develop systems and processes issues to be raised and effectively managed. The committee is also responsible to ensure facility compliance issues are managed, as well as Hazardous Substances and Dangerous Goods are stored, handled and disposed of according to Environmental Protection Authority legislation.

Access and Redesign Steering Committee
This committee was recently set up to coordinate and monitor the progress on access and redesign projects, and report on deliverables against agreed KPIs. The meeting provides information to the General Manager in order to assess project priorities and resource allocation.

The latest version (version 4, recently released) of the Australian Council of Healthcare Standards, of which North Shore Ryde Health Service is accredited, contains some changes to the Accreditation Standards. In order to ensure that the Committee Governance structure aligns with the new Healthcare Standards, the Committee Structure is currently under review. It is expected that a number of minor changes will be made following completion of the review process.

6.4.2 RNSH Representation on Area Committees

There are a number of Area committees that include representation from RNSH. These are:

Committee	RNSH Rep	Chair
Area Executive Team	General Manager	Chief Executive
Finance & Performance	General Manager	Chief Executive
Area Clinical Operations	General Manager	Director Clinical Operations
Area Performance Review	GM, DOps, DON, DMS, Div Mgrs	Director Clinical Operations
eMR Link Clinical Operations	Director of Operations	Director Clinical Operations
Area Management Accountant Meeting	Manager – Decision Support	Director of Finance
Area Blood Transfusion Meeting	Director of Medical Services	Amanda Thompson
Area Radiation Safety Committee	Director of Medical Services	Director of Medical Services NSRHS
Area Medical Workforce Advisory Committee	Director of Medical Services	Director of Workforce Development
Area Surgical Services Committee	Divisional Manager – Surgery	Director Clinical Operations
Models of Care Committee	General Manager	Director of Clinical Governance
Area Executive Committee	General Manager	Chief Executive
Area Clinical Council	General Manager	Area Director of Mental Health
Children and Family Executive Meeting	Manager Primary and Community Health	Area Director of Child and Family Health
Family NSW Steering Committee	Manager Primary and Community Health	Area Manager Community Health
Multicultural Access Committee	Manager Primary and Community Health	Area Manager Community Health
Primary and Community Care Managers Meeting	Manager Primary and Community Health	Area Manager Community Health
Pandemic Planning Community	Manager Primary and Community Health	Counter Disaster Manager
GP Collaborative	Manager Primary and Community Health	Executive Officer Division of General Practice
Area Infection Control	Director of Nursing and Midwifery	Area Director of Nursing
Area Directors of Nursing Meeting	Director of Nursing and Midwifery	Area Director of Nursing
Area Nursing and Midwifery Council	Director of Nursing and Midwifery	Kathy Angstmann
Area Policy Committee	Director of Nursing and Midwifery	Pauline Chapman

6.4.3 Advisory Committees

In addition to the committees that support governance there are three advisory committees:

Clinical Reference Group
The new Chief Executive has established this Group to improve clinician and staff engagement in governance. One of its first priorities is to provide advice to both the General Manager and Chief Executive on the implementation of recommendations from a number of reviews since 2004. The group's membership comprises senior clinicians of RNSH, NSCCH, AHAC Chairperson, Chair RNSH Staff Medical Council, selected

Area Executive staff, General Manager NSRHS and limited external clinical leaders. This group meets fortnightly and has a number of specialist reference groups that will take responsibility for addressing various aspects of the recommendations.

The Chief Executive has assigned responsibilities for executive sponsorship of the Specialist Reference Groups as follows

- Human Resources Bullying and Harassment
- Emergency Department Performance
- Nursing Workforce
- Quality Reporting & Clinical Incidents
- Finance & Workforce Resources
- Staff Morale

Staff Consultative Committee
This Committee meets on a bi-monthly basis, to raise issues and concerns from staff and their representatives, and to advise on workforce culture throughout the organisation. The committee is chaired by a member of the Human Resources Department, and the General Manager and the Director of Operations are both members of the committee

Clinical Redevelopment Advisory Group
This Group meets on a monthly basis to provide clinical advice on issues pertaining to the Redevelopment Planning process. The General Manager chairs the committee, and membership incorporates senior medical personnel and redevelopment planning personnel. The committee discusses issues relating to model of care and the physical layout of services in the new Hospital.

6.5 Delegations

Refer Section 4.9.

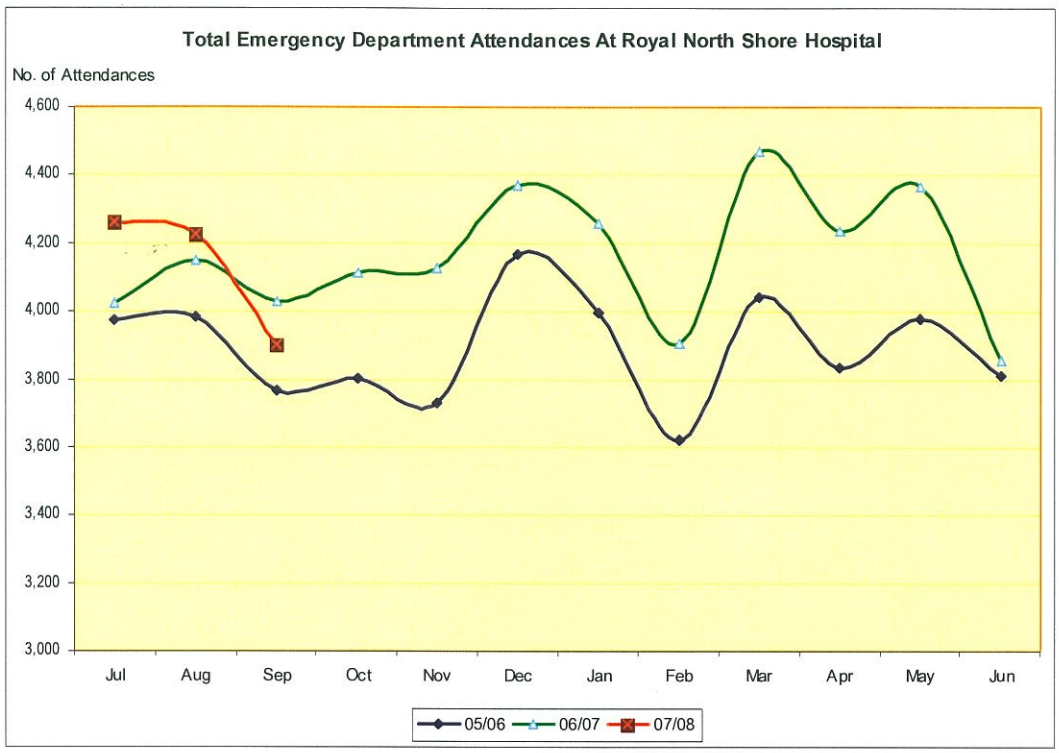
6.6 Hospital Performance

The NSW State Health Plan has as one of seven strategic directions 'creating better experiences for people using health services'. The targets set under this strategic direction include 'achieving specified national benchmarks for timely access to emergency departments and surgical treatment by 2008 and maintaining them in the face of increasing demand'. These targets, and the performance against these for RNSH, since July 2005, are described below.

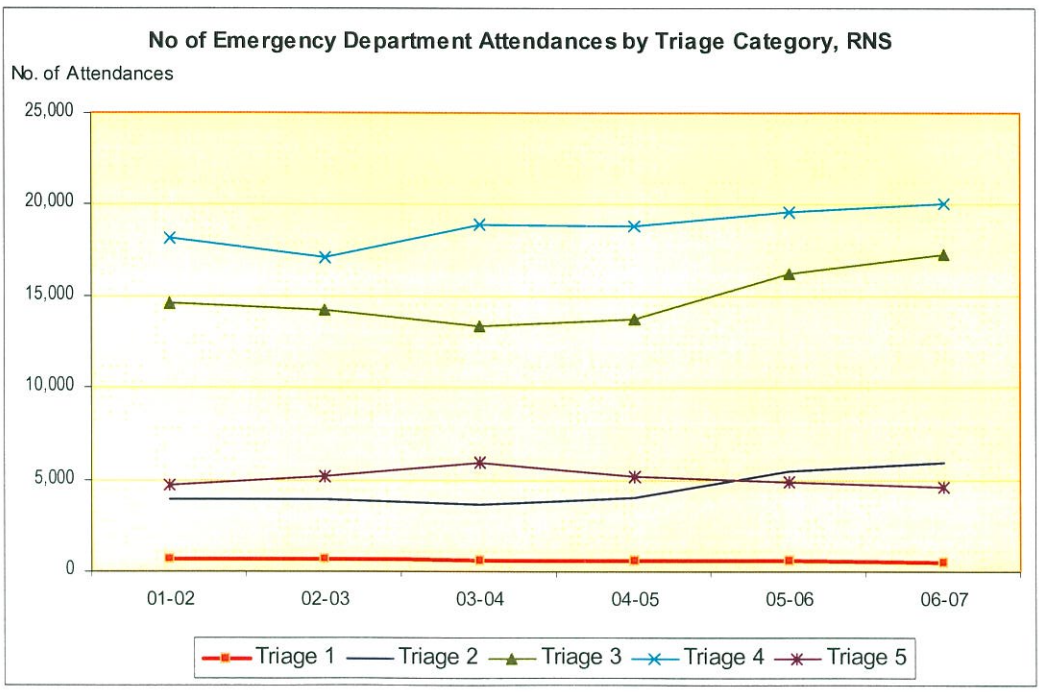
6.6.1 Emergency Department

Targets: Overall Targets regarding triage performance are to achieve and maintain benchmarks on average across the hospital system by 2008. Progress on targets is measured each month.

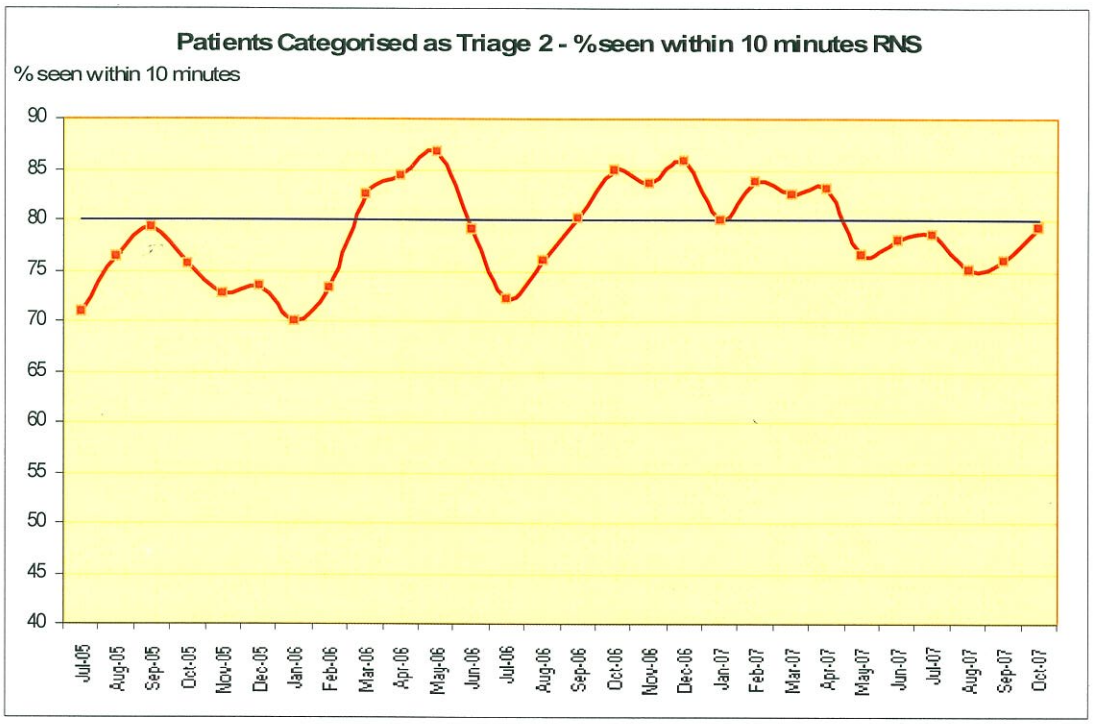
Emergency department activity at RNSH, since July 2005, is depicted in the following graphs:

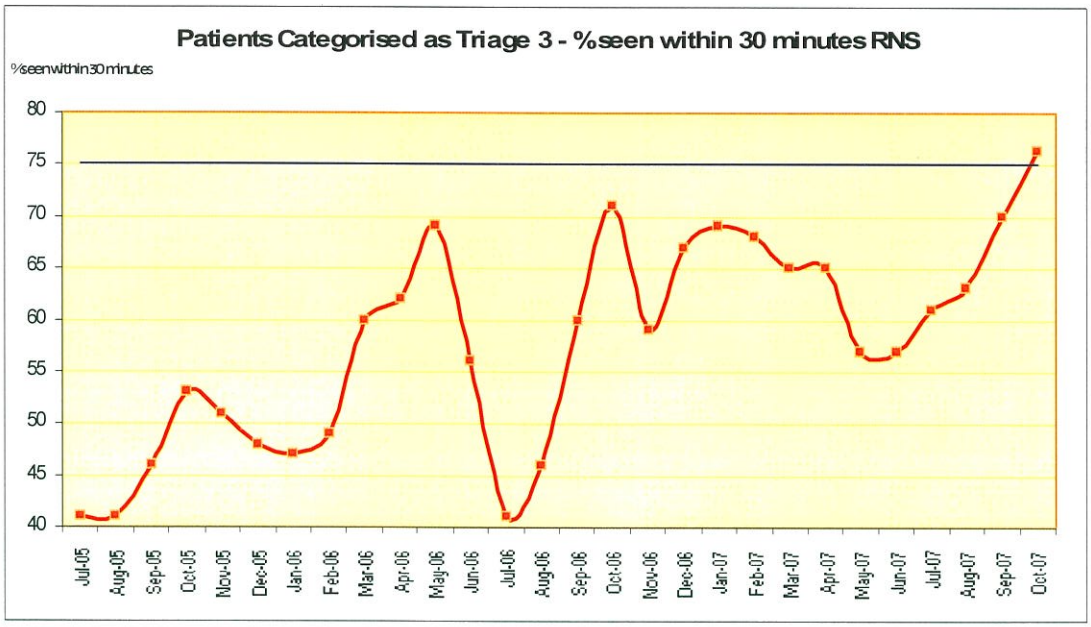


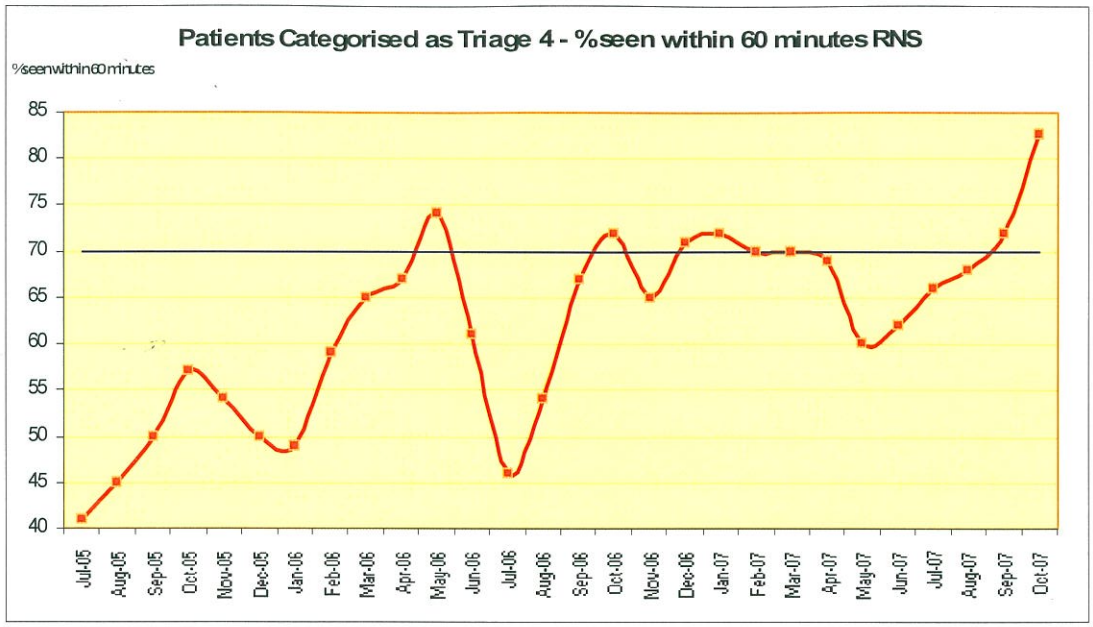
Attendances at RNSH emergency department have increased year on year since 2005. This growth in presentations, particularly in the more complex cases (see triage attendance graph) is being experienced across NSCCH and state wide. There has been a reduction in emergency presentations in September 2007 below that of previous years, which is not reflected across the Area or indeed the State.



The emergency department performance of RNSH against benchmark, since July 2005, is depicted in the following graphs:






Patients Categorised as Triage 4 - %seen within 60 minutes RNS
%seenwithin60minutes
85
80
75
70
65
60
55
50
45
40
Jul-05
Aug-05
Sep-05
Oct-05
Nov-05
Dec-05
Jan-06
Feb-06
Mar-06
Apr-06
May-06
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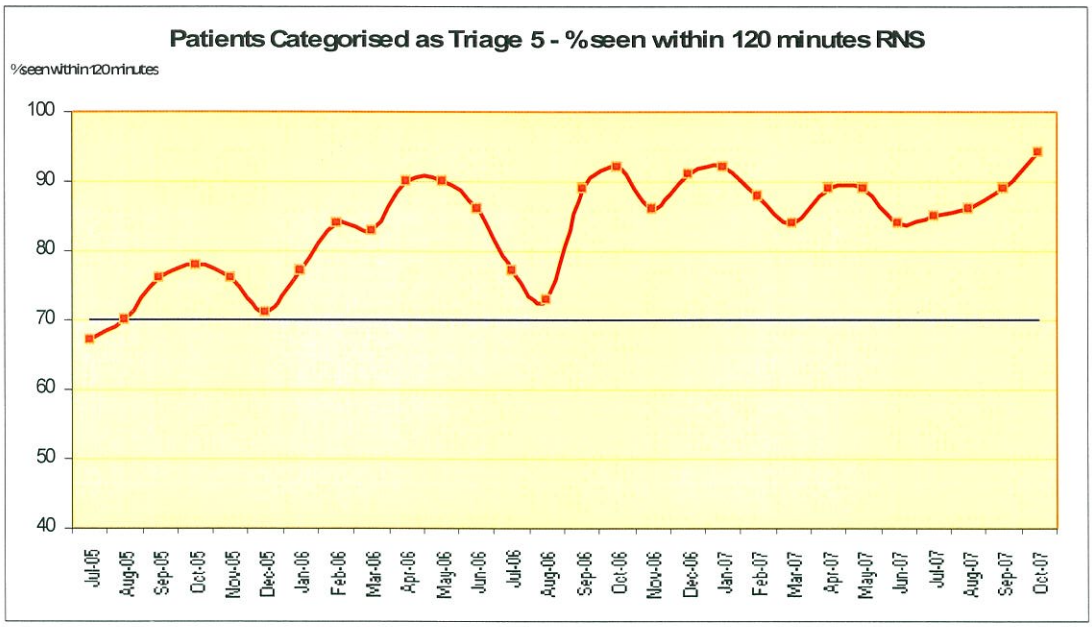
Patients Categorised as Triage 5 - %seen within 120 minutes RNS
%seenwithin120minutes
100
90
80
70
60
50
40
Jul-05
Aug-05
Sep-05
Oct-05
Nov-05
Dec-05
Jan-06
Feb-06
Mar-06
Apr-06
May-06
Jun-06
Jul-06
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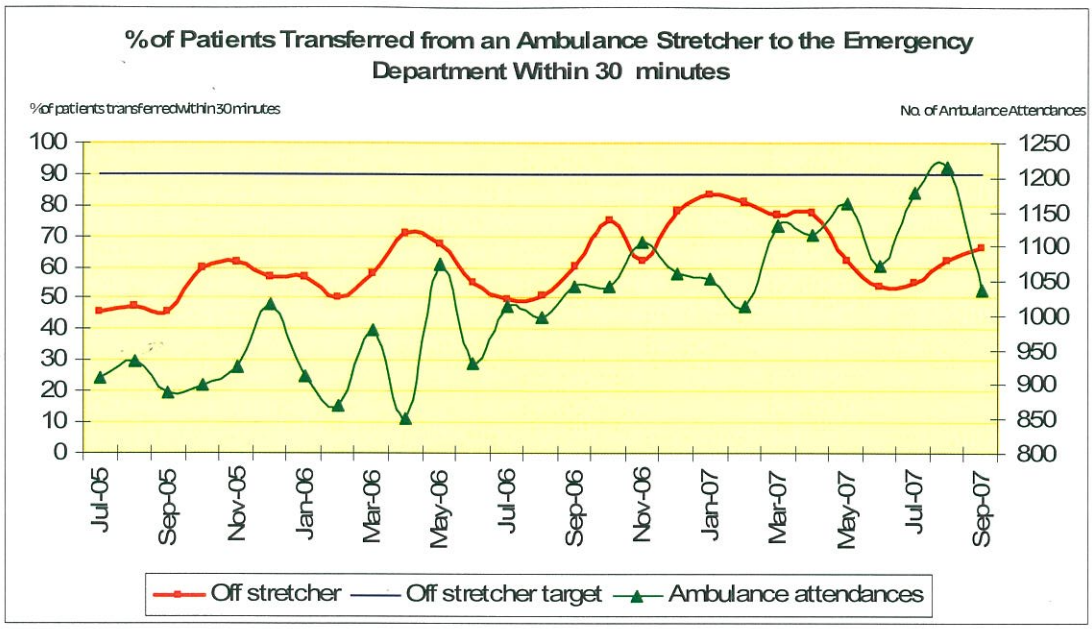


The percentage of patients being admitted from the RNSH emergency department to a ward, intensive care unit or operating theatre, within 8 hours, has not achieved sustainable improvement since July 2005 and remains below the benchmark target of 80%. The clinical redesign projects that have been undertaken include:

- Access Block Performance Project, Accenture 2004
- Emergency Care Journey, PA Consulting, September 2005 (2.2.1)
- Process mapping in Emergency Department (currently underway as a result of the Ben-Tovim Report, 2007)
- Mental Health Access Block, 2005

Improved triage performance has been achieved as a consequence of the implementation of a number of initiatives that include (2.3):

- Implementation of a 'fast track' zone
- Implementation of an Emergency Medical Unit within the emergency department
- Introduction of clinical initiation nurses (CINs)
- Identified doctor specifically for triage 2 patients

In order to achieve the benchmarks set by NSW Health further improvements are required, including improved management of inpatient bed capacity.

The initiatives that are underway to release capacity form part of the Turnaround Plan.

The Turnaround Plan that is currently in place will address this performance.

The elements of the Turnaround Plan are as follows:

The plan consists of 24 strategic initiatives with the purpose of improving Emergency Access Performance. As a result of these initiatives, all Emergency Department access performance targets have improved, with the exception of Emergency Admission Performance (EAP), which has shown improvement but has not achieved target.

Other initiatives which are currently being addressed to improve the EAP include:

- reduction in number of patients with extended length of stay
- increased percentage of patient discharges at weekends
- increased capacity of bed availability through improved discharge rate
- development of management systems and processes to identify and improve demand and capacity
- identifying areas of opportunity to reduce operating costs through standardisation, substitution and improved demand management

A Patient Flow and Redesign Steering Committee is in place to coordinate and monitor the progress of each initiative and report on deliverables against key performance measures. The meeting provides information to the General Manager to enable her to assess priorities and resource allocation.

Previous review of the emergency department has recommended the following to support enhancement of operational performance:

- Process mapping to enable improvement in clinical systems and processes. Improvements have been made and additional opportunities have been identified and are currently being implemented.
- The demand escalation plan has been reviewed and updated for the hospital. Further refinement will be required to align with the proposed area wide escalation plan.
- The predictive tool which combines historical based data with real time activity information assists staff to identify the number of patient discharges required to match expected demand on a daily basis. Ongoing refinement of the quality of data and its interpretation continues.
- Clinical redesign and planning of the discharge process enables patients and their family, as well as members of the multi disciplinary clinical team, to have improved knowledge of the estimated date of discharge of the patient. This initiative is ongoing.

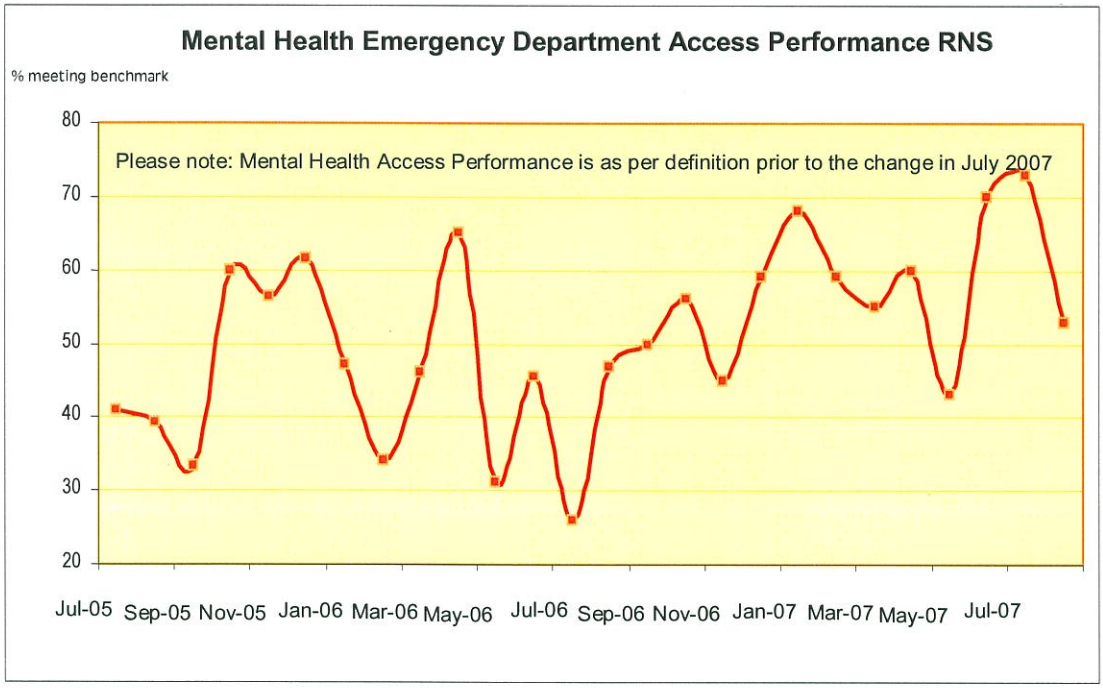
  In addition to the process improvement initiatives highlighted above, other quality initiatives that have been undertaken to improve the care to patients that present to the emergency department include:

  - Introduction of intravenous cannulation enrolled nurses, February 2007
  - Advanced nurse protocols at triage to provide analgesia and x-ray ordering
  - Extended hours psychiatric clinical nurse consultants
  - Early interpretation of ECG results, faxed from ambulances to determine the most appropriate facility to care for the patient's presenting cardiac condition.

- Credentialing of emergency physicians to perform emergency focussed ultrasound within the department to prevent waiting for a medical imaging appointment.

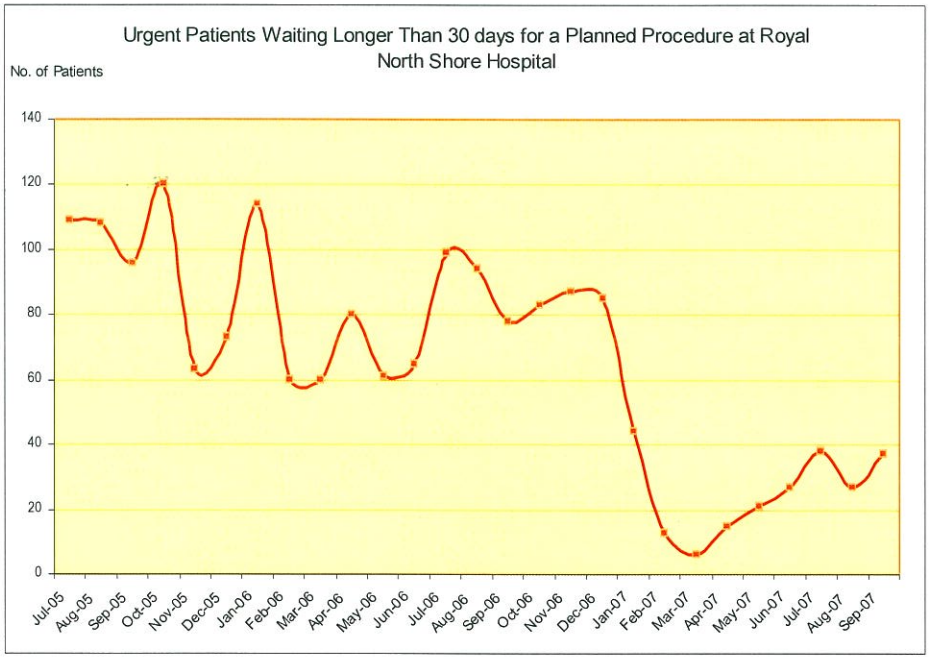
Mental Health Access

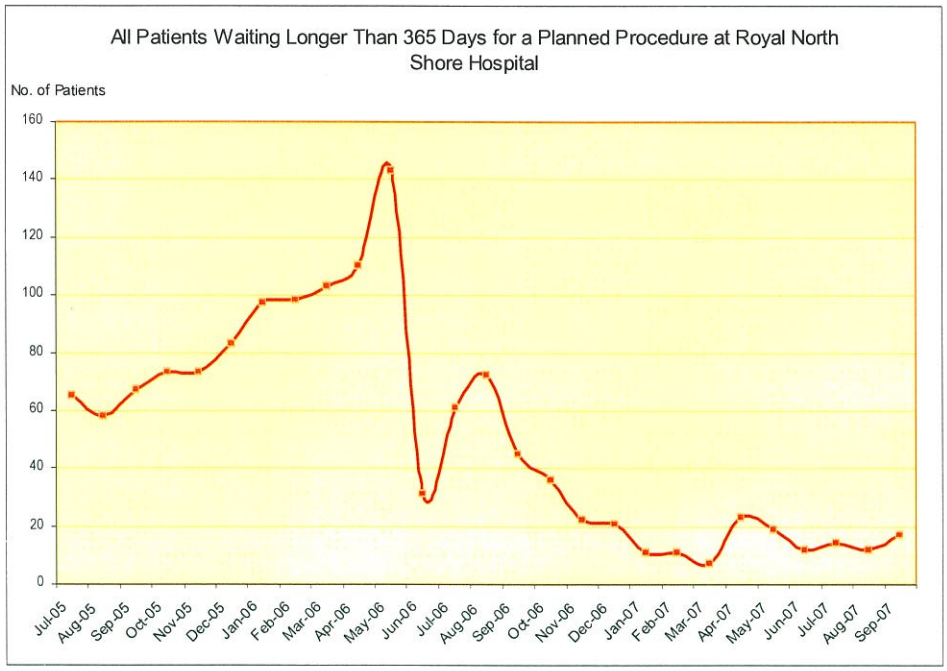
As previously mentioned, the Mental Health Redesign Project carried out in 2005 identified a number of initiatives which impacted on the performance at RNSH. Improvements were demonstrated initially but lost ground again in 2006. Further redesign initiatives through the state-wide programme have improved the performance at RNSH, however further work is required to bring the performance to benchmark levels. This includes review of working practices within the inpatient unit; more rapidly facilitated discharge to the community, greater networking across mental health services for utilisation of inpatient capacity, as examples. Close working relationships between the mental health service and the general service maximise the ability to improve the mental health emergency patient experience (refer graph below).



6.6.2 Surgical Performance

The surgical and medical waiting list performance of RNSH, since July 2005, is depicted in the following graphs:



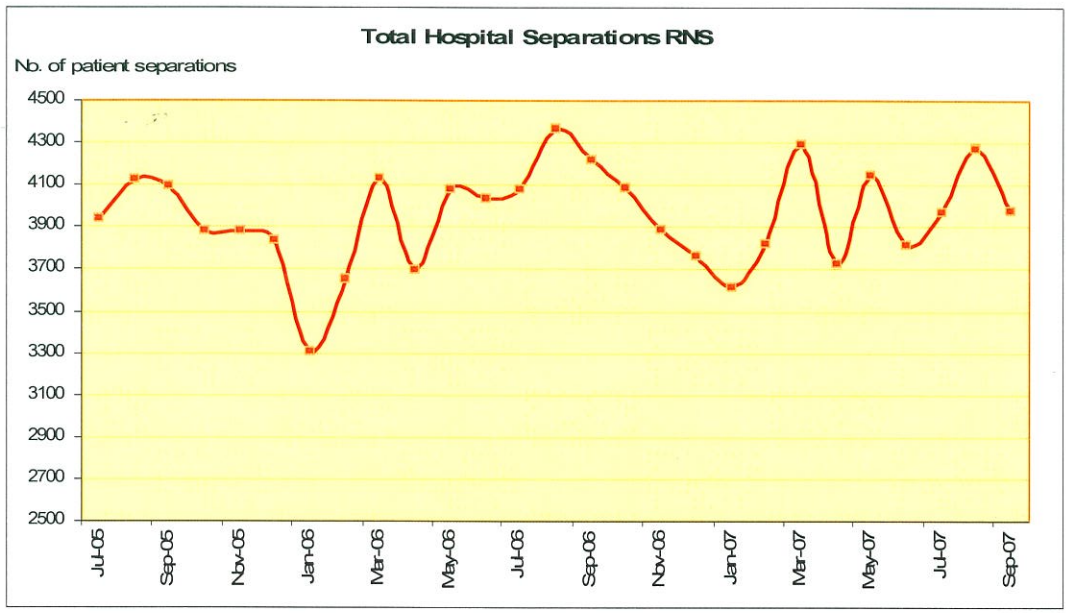


There has been a reduction in both the numbers of urgent patients waiting greater than 30 days for a planned procedure, and the number of patients waiting longer than 365 days. The benchmark of 0 patients waiting has not yet been achieved; however a plan is in place to deliver this level of performance. The Clinical Services Redesign Program is currently running within NSCCH and targets a number of areas for operational improvement. As a result of work being performed in the program, improvements in the hospital are planned in the area of elective access performance. Key areas

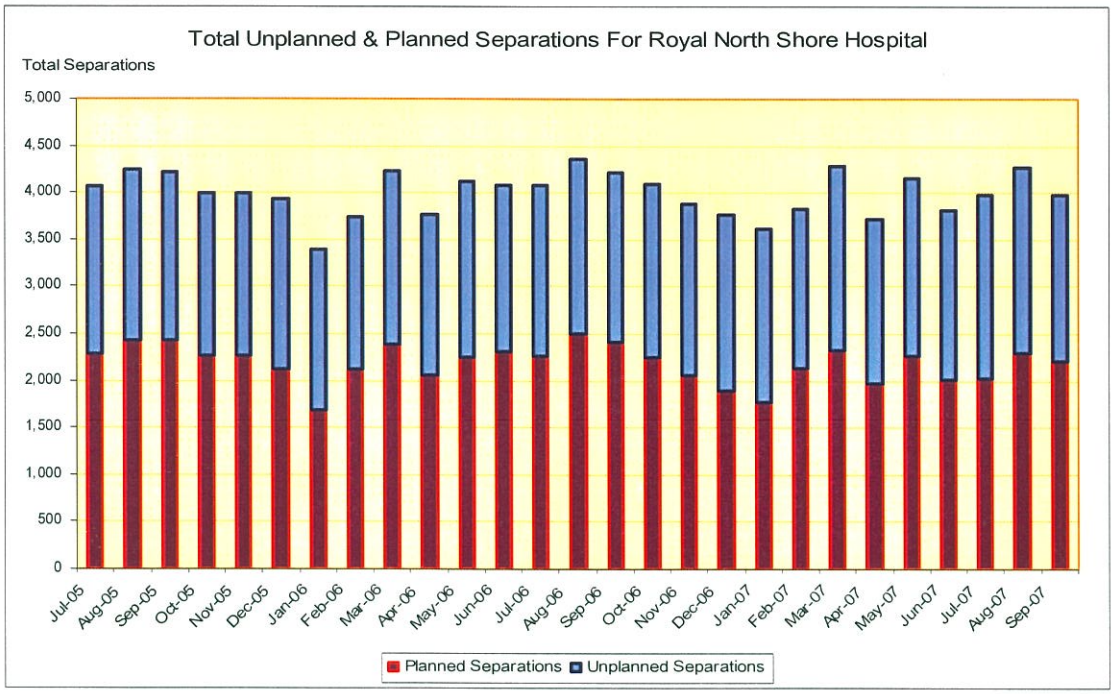
of focus include: admissions, overdue and long waiting lists and cancellations.

6.6.3 RNSH Activity

Activity at RNSH, since July 2005, is depicted in the following graphs:



There has been little change in the total number of patient separations, within RNSH, since July 2005. There has also been little change in the mix of planned and unplanned separations.



6.6.4 Bed availability

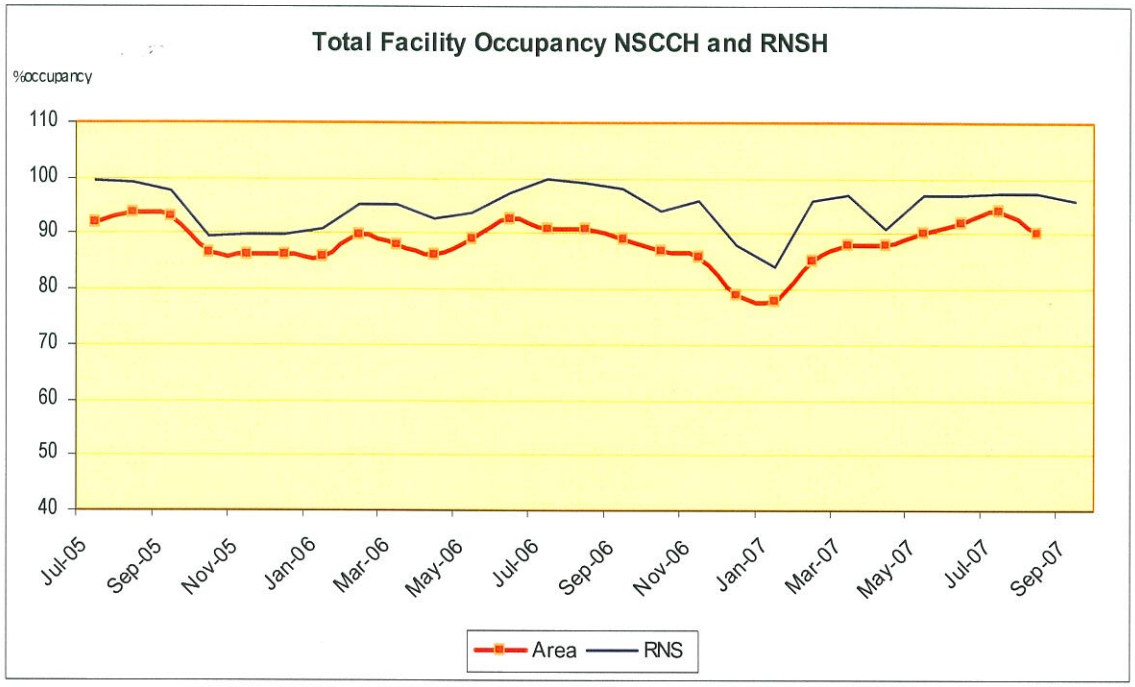
There has been an increase in the number of beds over the last 2 years predominantly due to investments in capacity through the sustainable access program. Additional funding has been provided for 53 bed and bed equivalents, including 3 ICU and 7 short stay beds, since July 2005.

A breakdown of the number of average available beds by category, as at June 2007, is shown below:

Beds	Average Available Beds
Day Only (excludes renal, includes EMU)	28
Medical/Surgical	322
Acute Spinal	19
Acute Geriatric	25
ICU	36
Paediatric	20
Maternity	32
NICU/Special Care	25
Bassinets	24
Burns/Plastics	12
Renal Dialysis Treatment Chairs	18
Drug and Alcohol	14
Mental Health Psychiatric Acute Beds	24
Grand Total Beds	599

6.6.5 Occupancy

The average monthly percentage occupancy at RNSH regularly exceeds that of the Area (refer graph below). While the target for optimal efficiency is an occupancy of on average 85% RNSH is on average at 90%. It is of note that the average length of stay across the Area as at June 2007 was at 4.3 days, compared to RNSH for the same period was 4.5 days.



Modelling has also been carried out across the Area to ensure maximisation of efficiency in bed utilisation. The modelling examined potential practice change and identified that for all patients that are in hospital longer than one day, if they are discharged after 4pm, if the discharge time was brought back to 12:00 midday, then every day at RNSH 25 beds would be made available. This change of practice as well as other strategies to improve bed utilisation are part of the Turnaround Plan.

6.6.6 Financial Performance

The financial performance of RNSH is covered under Chapter 4.

Resource Utilisation of the Emergency Department

The total expenses budget for the RNSH emergency department, for 2007/08 is $17.869 million. Since July 2005 there has been a year on year budget and FTE increase. Between 2005/06 and 2006/07 the emergency department expense budget increased by $1.313 million (8.8%), and between 2006/07 and 2007/08 there was an increase of $1.574 million (3.5%)

There has been a slight change in FTE numbers over this period. The additional positions that have been appointed to include:

- 2.4 cannulation enrolled nurses
- 1 extra senior resident medical officer
- 2 staff specialists to support EMU
- 1 junior registrar to support EMU

Since July 2004 nursing FTEs have increased from 75.9 FTEs to 84.6 FTEs as a result of the EMU development and growth funds (these FTEs include productive and unproductive hours (i.e. maternity leave).

6.7 Employee Performance Management

The General Manager has a performance agreement that includes delegated targets from the Director of Clinical Operations. The performance agreement complies with the requirements of the Health Executive Service.

The governance for performance management at RNSH rests within the divisional structure, and each manager is responsible to ensure the Performance Management Policy is adhered to. Copies of the performance management reports are housed in personnel files.

6.8 Quality, Safety and Patient Involvement

6.8.1 Quality and Accreditation

NSRHS is accredited under ACHS. A full accreditation survey was undertaken in October 2004, achieving 2 year accreditation. A periodic review was undertaken May 2007, and 12-month accreditation was achieved. Although NSRHS is accredited until October 2008, a focused survey will be undertaken in May 2008, where the surveyors will focus on recommendations from the Periodic Review. The next full survey will be conducted May 2009.

The Quality and Risk Management Unit provides a number of support functions to assist in corporate management, including the provision of project support for improvement activities, maintenance of data relating to incidences and complaints etc, as well as reporting on corporate and clinical risks. The Quality and Risk Management Committee is currently under review to establish closer links between complaint management, incident management, coronial reports and QaRNS.

6.8.2 Community Consultation

The NSRHS Community Participation Committee was established in mid 2006 with the first meeting occurring on 26 July 2006. This committee is advisory and was developed using a common area framework.

The committee is chaired by the General Manager and consists of six community representatives from across the health service, two staff representatives and a community member who provides a link with the AHAC. The committee provides quarterly written reports to AHAC.

The committee's primary purpose is to provide advice to the health service on local health needs, health service planning and delivery and community consultation as per the terms of reference.

The committee continues to meet quarterly and work to an agreed action plan with the next meeting scheduled for 15 November 2007. Regular reports are received regarding selected DOH key performance indicators, culturally and linguistically diverse community statistical profiles, complaints and appreciations.

Its members are also involved in other community and consumer consultation processes across the health service, for example several Clinical Redesign Projects. A number of representatives have been further involved with Clinical Redesign by assisting to record patient journeys and document their experiences as consumers. Two members have agreed to also participate in the Consumer Reference Group recently established by the Chief Executive to provide input into identifying key issues, developing responses and improving communication with the community.

6.8.3 Patient Satisfaction Surveys

A number of patient satisfaction surveys have been conducted at RNSH over the past few years. These surveys have been undertaken both internally and by external parties such as Press Ganey. The following information provides a snap shot of prior RNSH surveys.

- Corporate services conduct bi annual food and environmental services surveys. Action plans are developed and implemented within resource restraints. Results of surveys are on the intranet

- September 2002 – March 2003 RNSH participated in a Press Ganey study of consumer expectations of the hospital and consumer expectations of hospital nurses. Surveys were posted to patients post discharge and 192 participants responded. There was a consumer satisfaction rating of 88.30% relating to the extent to which the hospital's nurses consistently meet the patients' most important expectations of them.

- June/July 2004. Forty-two patients were surveyed who had been admitted via the emergency department in relation to the use of the Multi Disciplinary Admission Form (MDAF). Patients responded very positively to the appropriateness of the questions in the form, the manner in which the form was administered from nurses and doctors, and the planned care of the patients. Patients were also asked to comment on any aspect of their emergency department care.

- June 2006. Patient representative office conducted a satisfaction survey of the new Rights and Responsibilities brochure. While there was only a 17% return rate, there were positive responses re the knowledge of the existence of the brochure and its usefulness.

- Maternity Unit conducts regular monthly patient satisfaction surveys and key issues are addressed. Results are discussed with the Ward Staff, and information is trended to determine where overall improvement resources should be placed. The midwifery group practice also conducts patient satisfaction surveys in order to improve service

delivery.

6.8.4 Management of surgical waiting times

All aspects of allocating procedure dates are arranged through Registrars allocating dates in liaison with the Consultant and booking clerk, or Consultant's private rooms allocating dates in liaison with the booking clerk.

The Admissions Manager is also the Waiting List Coordinator and is responsible for the management of the waiting list and ensuring adherence to NSW Health policy. This position is also responsible for training of the booking clerks, liaising with medical staff on waiting lists, and escalation of issues to the Divisional Manager.

Cancellations at short notice or extraordinary cancellations are decided upon by Divisional Manager negotiating with individual surgeons in the case of a lack of beds, Divisional Manager, Theatre Nurse Manager and Surgical Services Coordinator deciding on lists to close and approved by the Clinical Director for reduced capacity due to nursing shortages.

It should be noted that theatre cancellations due to nursing shortages results in minimal patient cancellations due to the prospective management that decides theatre availability. However it clearly does result in reduced capacity for elective patients.

A more proactive model of managing surgical waiting lists will shortly commence with the appointment of an Area Waiting List Manager. This role will facilitate patients' timely access to a theatre list consistent with the clinical urgency code attached to the patient by the surgeon.

This approach can overcome barriers to timely access to treatment where they exist between surgeons or between hospitals and has been highly successful in other AHS' in delivering 0 targets for long wait and overdue urgent surgical patients.

6.9 Planning

6.9.1 Operational planning

Both the NSRHS Operational Plan and the NSCCH Strategic Plan are underpinned by the NSW State Health Plan that sets out the vision and direction of NSW Health. This plan sets out requirements and ensures Area Health Services have a unified strategic view for both performance and the development of services.

There is a clear need, both for the capital redevelopment and a sustainable service profile, for RNSH that an area wide Clinical Services Plan be developed. This plan needs to articulate not only the role and service profile of RNSH, but of all hospitals in the AHS to ensure each facility has the capacity to meet its service profile, that fosters Area-wide clinical networking and that services are provided where and when appropriate to meet community demands.

6.9.2 Capital work and equipment planning

Funding for Capital Items and Capital Works can flow from a number of different sources, either through Area Capital Plan Allocations, Department/Ward Special Purpose and Trust Funds, donations or bequests, or through fundraising events/functions. To ensure that funding allocation is based on a risk management methodology, the following process is used to prioritise and risk rate capital requirements throughout NSRHS.

The need for Capital is identified through the Divisional Structure, with Departments and clinical areas raising the requirement through to the Divisional Executive. Each Division maintains a prioritised log of requirements that is regularly reviewed. The Divisional capital lists feed into the North Shore Ryde Health Service list of required capital equipment and capital works, which are prioritised across Divisions using a risk rating methodology. The NSRHS Capital Equipment List and the NSRHS Capital Works List is provided to the NSRHS Finance and Performance Executive Meeting for discussion and endorsement on a bi-monthly basis. Funding is allocated based on the order of the prioritised lists.

Items purchased from the lists, any new items required, or any current item for which there has been a change in the risk rating, are discussed at a separate bi-monthly meeting involving the Divisional Managers, Site Manager for Ryde Hospital, Manager of Primary and Community Health and the Director of Operations. As items are funded and come off the lists, Divisions are asked to supply additional items for prioritising at this meeting.

Departments, wards and units are expected to identify equipment requirements that present a significant risk for the organisation. They are asked to complete the Capital Equipment/Works Risk Identification and Assessment Template for each item and feed the information through to the appropriate Division or Directorate. Divisional Managers and Directors maintain a list of required Capital Equipment and Capital Works for their Division/Directorate, and undergo a risk assessment exercise to ensure a current prioritised list of requirements is available. The Capital Equipment/Works Risk Identification and Assessment Template is used for this purpose. In addition, Divisional Managers and Directors ensure that all items submitted for the NSRHS Capital Lists are appropriately Risk Rated.

A fundraising allocation meeting is held monthly and attended by the General Manager NSRHS, Chair of Research NSCCH, Director of Operations NSRHS and the Manager of Fundraising Department NSRHS. The purpose of the meeting is to identify whether donated funds are tagged to a particular department/service/equipment, research or education, or if they can be used for equipment under the discretion of management.

It is accepted that from time to time items require immediate and urgent replacement that could present significant clinical risk to the organisation, in terms of patient safety and patient care. These items are risk rated using the Capital Equipment/Works Risk Identification and Assessment Template, and raised through the Divisional Managers or Directors, complete with any additional information/justification that supports the urgency, to the Director of Operations. Funding is sought either through the Area Capital Plan, RMR or through untied donations.

6.10 RNSH Redevelopment

6.10.1 Scope

Royal North Shore (RNSH) Hospital and Community Health Services is currently undergoing a $702 million redevelopment to deliver a new main hospital building, new community health facilities and new research and education facilities.

This $702 million redevelopment is the biggest health capital project in NSW and represents a significant investment in the future health and well-being of our community. The aim is to deliver quality health care services and purpose-built facilities which represent good value for money and can meet the future health care needs of a growing and rapidly ageing community.

6.10.2 Research and Education Project

RNSH is renowned for its clinical training and education, and has a major research focus in areas such as pain research, cancer research, bone and joint research and cardiovascular research. The purpose-built new research and educational facility currently under construction at RNSH will deliver significant benefits from new research and training synergies and opportunities, research discoveries, improved clinical practice and workforce education.

The new building will include four floors of education, teaching and learning facilities including the library, Northern Clinical School, Sydney Simulation Centre, Learning & Development services. The Research & Education Building will also include seven floors of space for up to 350 laboratory-based researchers, with potential for expansion at a later stage to accommodate a total of 500 researchers in the future.

This $91 million building, procured via managing contract, is a joint partnership between NSW Health and the University of Sydney.

The completion of this building is critical to the delivery of the RNSH Redevelopment as it will allow for the consolidation of research and education activities into a central facility, allowing the centre of the campus to be redeveloped for the new main hospital building. Construction of the Research & Education Building is well underway and it is expected to be complete in late 2008.

6.10.3 RNSH Campus Redevelopment

The redevelopment of the wider RNSH campus will include the delivery of a new main hospital building and facilities for community health, with car parking, retail areas and improvements to the public domain (landscaping, heritage precinct and public amenities).

The new hospital building is intended to meet changing trends in healthcare with welcoming, patient-friendly environments and purpose-built treatment areas for new ambulatory and multi-disciplinary models of care.

This redevelopment project is to be procured through a joint venture with the private sector as a Public Private Partnership (PPP). Three consortia are bidding for the tender to build the new facilities and operate the corporate support services such as catering, security, building maintenance and linen services for 28 years. Clinical services will not be delivered and operated by the successful consortia. The announcement of the successful consortium is scheduled for mid 2008.

The main components of the project are:

A new Acute Services Building (main hospital building) with an approximate capacity of 462 new beds plus additional capacity for 106 chairs (e.g. to delivery chemotherapy and dialysis outpatient and dental care). It includes capacity for 16 new operating theatres (in addition to the two existing operating theatres which will be retained) plus 11 major procedure rooms, a new emergency department, Cancer Care Centre, new facilities for medical imaging and diagnostic services and a full range of outpatient (ambulatory) services. In addition obstetric, maternity, paediatric, special care nursery and burns beds currently in the Douglas building will be retained, therefore bringing the total number of beds in the redeveloped RNSH Hospital to 626.

A new community health building will bring together a number of community health services currently scattered across the RNSH site, along with other community-based services including the Sydney Dialysis Centre (currently located at Darling Point). This new building will act as a major " hub " for the delivery of community health services enabling clients to access a range of services in a "one stop shop" for the first time. Planned services in the new community health building include Drug and Alcohol, Community Mental Health, Aboriginal Health, Sexual Assault, Sexual Health, Dental, Genetic Education, Health Promotion, Health Care Interpreter Service, Community Aged Care and Rehabilitation, Northern Sydney Home Nursing, Renal Services, and Child and Family Health.

6.10.4 Land Divestment

A Concept Plan for the redevelopment was publicly exhibited in 2006, prior to being submitted to the Minister for Planning, and approved in December 2006. This Concept Plan identified surplus land for divestment and subsequent residential and commercial development. Future development will include the provision of affordable accommodation for carers, students and staff, and a new Child Care Centre; however, this is not expected to occur until after the completion of the new main hospital building and community health facilities.

6.10.5 Timeframe

2006

- Development of a Project Definition Plan
- Development of the Concept Plan (master plan) for public exhibition and approval by NSW Minister for Planning
- Award of contract to Bovis Lend lease for construction of the Research & Education Building Project
    - Expressions of interest for joint venture for RNSH and Community Health Services Redevelopment and short listing of three consortia

2007

- Start of construction on Research & Education Building Project
- Engagement (consultation and briefing) with short listed consortia
- Announcement of joint partnership with University of Sydney for an additional $30 million for Research & Education Building Project
- Lodging of tenders for the major hospital and community health services redevelopment due November 2007

2008

- Tender evaluation and selection of preferred tenderer (successful consortium) due March 2008
- Contract execution and financial close expected July 2008
- Site works commence for hospital and community health facilities (late 2008)
- Completion of new Research & Education Building (late 2008)

2009-2013

- Construction of new hospital and community health facilities

6.10.6 Consultation

NSCCH has conducted an extensive program of consultation and communication in relation to the RNSH redevelopment project. User consultation has been ongoing since 2002, with a high degree of clinician involvement in formal planning groups and in structured briefings. At least 10 separate consultative processes (some still current) have been undertaken to engage all users. Community consultation has included public information sessions and the exhibition of the Concept Plan, and general information disseminated via the local media and on the internet. A program of communications to staff and the community has included the establishment of project publications, a web site and various media activities.

Ongoing consultation with hospital and community health facility users will continue as programmed until commissioning of all facilities is completed.

6.11 Capital Works

In addition to the major campus redevelopment, RNSH has completed a number of minor capital works projects within the last 12 months, including:

- Renovation of the Day Surgery Centre – Providing improved functionality for patient care, as well as improved amenities for patient comfort.
- Renovation to the 23 Hour Care Centre – Providing improvements in physical layout to better meet the needs of short stay patients, and improved patient flow through the unit.
- Establishment of a New High Dependence Unit with the Intensive Care Unit – To provide improved step down care for patients. This involved extending the building to establish office space to free up clinical space.
- Renovation to the Ophthalmology Clinic – Involving some minor changes to clinic layout to better utilise available space, and to make

the environment more pleasant for patients. (Day Surgery, 23 Hour Care Centre, HDU, and Clinic managed as 1 project with budget of $6.87million)

- Renovation to Orthopaedic Ward – Painting of the Ward Area, with minor works to reception and common areas to improve functionality and make the environment more pleasant for patients.(Budget of $40,000)
- Installation of New Cardiac Catheter Laboratory – Installation of new machinery and monitoring, as well as refurbishment of observation room to improve functionality. (Budget of $1.2million)
- Renovation of the Northern Specialist Centre is currently underway – Increasing the number of clinic rooms to better meet the growing needs of the community, as well as making the environment more pleasant for the patients. (Budget of $0.7million)
- Repairs to the façade of Main Building – Safety risk as parts of the façade were coming loose and falling. (Budget of $2.5million)
- Replacement CT scanner – Minor capital works to install new machine. (Budget of $1.79million)
- Refurbishment of Breastscreen – Improved functionality of unit, as well as creating a more pleasant environment for the patients. (Budget of $0.8million)

ANNEXURES

Annexure 1	NSCCH Research-Focus on RNSH
Annexure 2	Complaint Process Chart
Annexure 3	NSCCH Professional Practice Unit Brochure
Annexure 4	NSCCH Health Care Quality & Safety Plan 2007-2008

Northern Sydney Central Coast Area Health Service Research- Focus on RNSH

Medical research within NSW has undergone major restructuring in the last 4-5 years. The State Government recognized the value of investment in medical research, both for the undisputed improvement in health outcomes and the economic returns on investment. The Ministry and subsequently the Office of Science and Medical Research was formed with the specific agenda of developing a medical research strategy to underpin a co-ordinated and effective collaborative approach at both a State and National level to maximize research opportunities and returns within NSW. As part of this well articulated plan and its interface with the overarching 'Metropolitan Strategy" the Northern Sector of Sydney has been designated as a site in which research will drive not only the goal of investment in intellectual capital, but also economic and community development. Hence, the development of a cohesive Hub for Health and Medical Research has been developed based at RNSH, involving The NSCCAHS, The University of Sydney and private investment.

The merger of two existing area health services into the Northern Sydney Central Coast Area Health Service (NSCCAHS) has led to both opportunities and challenges particularly in the last 3 years. The 'mission' of the Area Service recognizes that research, both formal and informal, is integral to the activities of the NSCCAHS and supports excellence in clinical care. The existence of excellent research supports recruitment and retention of leading clinicians and scientists. The majority of 'laboratory-based' research occurs within the Royal North Shore Hospital precinct. However, clinical research is distributed across the entire Area, with considerable strengths in both the Northern Sydney and Central Coast sectors and expansion of clinical trial activity offers enormous opportunities to improve patient outcomes. A forum was held in Feb 2007 to develop an Area wide research plan. The meeting was facilitated by Dr Norman Swan and had broad representation from the Area Health Service and our major University partners, The University of Sydney, The University of Newcastle and The University of Technology. This formed the basis for the Strategic plan for research which will guide future direction and activity for the next 5 years.

A key focus in 2007 was to secure the partnership between the NSW Government and the University of Sydney to jointly fund the 'state of the art' Research and Education Building, which is a key part of the Royal North Shore Hospital redevelopment. The State Government has committed $61.36M and the University of Sydney $30M to provide accommodation for 350 'basic science' researchers in addition to 4 floors of educational facilities. We have long held the philosophy that Research and Education support excellence in the delivery of medical care, through the development of novel treatments, technologies and by attracting high quality clinicians across all professional disciplines. The advantage of having basic research co-located in the environment of clinical care

is that diagnostic and treatment gaps inform the research, and research provides solutions to improve clinical outcomes.

Examples of research within the NSCCAHS revolutionizing care exist within pain management, acute stenting of blocked arteries after heart attack, and in the setting of 'threatened' limbs where blood flow has fallen below a critical level and amputation is regarded as an inevitability. In all cases application of research emanating from RNSH has improved outcome. Techniques for the diagnosis of cancer and antenatal diagnosis of fetal abnormalities have been developed and refined by researchers within RNSH, and diagnostic kits have been adopted into clinical practice.

Many other examples of the relevance of research impacting on clinical diagnosis or treatment are evident in the areas of diabetes, kidney disease, maternal and perinatal health, bone and joint pathology and neurosciences. Each of these areas comprises "key" areas of research interest within the NSCCAHS and of the Kolling Institute, the major occupant of the RNSH Research and Education Building. Current funding does not provide the "fit out" for 100 of the 350 researchers, which is a current challenge for researchers and supporting Foundations.

The success of RNSH researchers is demonstrated by their success in the most recent NHMRC Project Grant Round. Over 40% of submitted Projects were funded (namely 15 grants) totaling over 5 million dollars in comparison to the national average which is in the mid 20 percent range. This led to the Age newspaper from Melbourne highlighting RNS Research Success. (The success is even more impressive than highlighted in the Age reporting).
"Royal North Shore a leader in research"
http://www.theage.com.au/news/National/Royal-North-Shore-a-leader-in-research/2007/10/17/1192300817348.html

Over 80%of successful grants were supported by initial project seeding (amounting to $250K pa expenditure within the RNS/Ryde/Northern Beaches sector). Clearly this seed funding leverages large returns to NSW and should be continued. Budgetary constraints suspended any commitment in 2007, which if continued will reflect in research success in the future.

Research within the Area Health Service (and RNSH) has been supported by a robust Governance Structure supported by the Chairman of Research, Prof C Pollock, the Area Business Unit, key researchers, Institute Heads and the Key Researchers. Commercialisation of research outcomes is managed by BioMed North, which now returns income on initial investment in commercial strategies, with a patent portfolio growing from 10 patent families to now 21 active patent families. Licences have increased from one to eight (plus 3 IP evaluation agreements); Annual licence income has gone from zero to over half a million

dollars in 2006-2007 ($511,000); One inventor has received over $130,000 in royalty payments to date (after patenting costs have first been paid back). Milestone payments predict this trajectory will increase exponentially.

Challenges ahead include:

1. Fit out of the remaining research floors
2. Secure funding basis for operational costs in the setting of funding cuts specifically directed to research
3. Development of Governance Structures that appropriately recognize University and Community interest and investment in medical research
4. Smooth transitioning of researchers to the new facility with appropriate relocation of ancillary facilities to support research
5. Transparent and supportive business practices within the AHS that enhance research outcomes.(including isolation of all research funds from general fund management)
6. Contractual arrangements re management of Intellectual Property with our Partners
7. Clarification of liability, particularly in Clinical Trial settings.

Carol Pollock (31/10/07)

Appendix 5.15

NSCCAHS Health Care Quality & Safety Plan

2007-2008

2 April 2007

Contents:

NSCCAHS Health Care Quality & Safety Plan

1. Introduction – Why have Quality and Safety Plan?

While, ideally, quality should be the *result* of a well ordered and operating system of care, and therefore should not need attention in its own right, the health system is far from that ideal, and the need remains for strategies directly aimed at improving quality and safety.

Health care is a high risk industry, with a relatively high rate of adverse outcomes, despite more than 10 years of concerted effort to increase patient safety. The Quality In Australian Health Care Study[1] showed that between 10% and 14% of inpatients experience some form of adverse event during their episode of care, of which approximately 50% were preventable . While there has been dispute regarding the precise rate, there is no doubt that health care historically has had a high adverse event rate, and there is little reason to believe that the rate has fallen significantly[2].

Major quality issues within NSCCAHS - which are consistent with the national and international experience - include

- Nosocomial infection
- Medication errors
- Falls
- Pressure areas
- Delays in identifying deteriorating patients
- Unreliable clinical communication
- Poor handover of care between sectors
- Failure to deliver appropriate care, and continued use of inappropriate care
- Failure to use effective technology
- Lack of skilled staff
- Poor teamwork

Practical clinical governance systems are still developing in most parts of the Area. Clinical Divisions, having just been formed, do not yet deal systematically with improving clinical care and its outcomes, and have neither information nor structures for dealing with complex governance issues. Networks, which are essential to developing best practice standards to apply across the area, are just in the process of being established. Except for those pertaining to access and financial performance, performance management systems are still embryonic. More fundamentally, there is limited formal knowledge of what care is delivered, and underdeveloped systems for knowing whether the right care is properly delivered. This not only makes some problems invisible, but also masks a large number of very positive achievements.

These ongoing quality problems and immature systems have a major impact on patients, families, staff, organisational performance, culture and reputation. In economic terms alone, the preventable cost of poor quality in hospitals is high, being estimated as at least $1.2Bn in Australia in 2000[3]. This is likely to be a major underestimate, but even so translates to approximately $30M annually for NSCCAHS. In short, Quality and Safety remains a major issue for the organisation, its consumers and its staff.

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[1] Wilson, RM; Runciman, WB; Gibberd, RW; Harrison, BT; Newby, L; Hamilton, JD. "The Quality in Australian Health Care Study". *Medical Journal of Australia*. 163(9):458-71, 1995.

[2] Bernstein AB, Hing E, Moss AJ, Allen KF, Siller AB, Tiggle RB. *Health care in America: Trends in utilization.* Hyattsville, Maryland: National Center for Health Statistics. 2003.

[3] Fletcher, M: *The Quality of Australian Healthcare: Current Issues and Future Directions*, Health Financing Series, Volume 6, Commonwealth Department of Health and Aged Care Canberra 2000

The Quality and Safety Plan is an opportunity to rethink the Area's approach to ensuring quality and safety, through an area-wide strategy. While much of the Plan is centrally mandated, and is formally required as part of the Area's suite of operational plans, it is also an opportunity to systematically align the various activities and elements of the Area to the important task of ensuring safe, effective care.

2. NSW Health Requirements

The DOH template states that the Quality & Safety Plan is to "implement systems and processes required to deliver the statewide Clinical Quality and Patient Safety strategy within the Health Service". This is required to include

- A focus on the patient journey
- Clinical risk identification, management and mitigation strategies
- Improvements in adverse incident notification, investigation and management
- Clinical governance structures and quality systems implementation;
- Implementation of Root Cause Analysis recommendations and other identified quality and safety improvement strategies
- Targeted incident and adverse event reduction strategies.
- Capacity building in quality and safety across the Area

The *NSW Clinical Quality & Patient Safety Plan* lists the following additional strategic objectives:

- Monitoring of Clinical governance and quality systems implementation
- Mechanisms for the development of new improvement opportunities in clinical quality and patient safety
- Integration of Area Health Service, Clinical Excellence Commission and NSW Health priorities.

The preceding *NSW Patient Safety and Clinical Quality Plan* (PD 2005_609) listed mandatory "standards" and "functions", which presumably still have force:

Standards:

1: Systems to monitor and review patient safety.
2: Policies and procedures to ensure patient safety and effective clinical governance.
3: Incident management system to manage incidents and risk mitigation strategies implemented to prevent reoccurrence.
4: Complaints management systems in place and complaint information used to improve care.
5: Systems to audit a quantum of medical records to assess adverse events rates.
6: Performance review processes established.
7: Audits of clinical practice are carried out and strategies for improvement implemented.

Functions:

1. Structural establishment
2. Incident management system
3. Performance measures for the IIMS
4. Complaints
5. Death reviews
6. CQI support
7. Communication training
8. Policy development
9. Clinician performance management
10. Internal reporting
11. External reports

Each function has detailed "criteria". Appendix 1 provides a detailed status report against the criteria and standards, most of which have been met. The elements that require further implementation are detailed in the table below, . In summary these are:

- Performance Reporting & Evaluation;
- Unit Level Governance;
- Mortality & Peer Review;
- Complaints Management and
- Staff Performance Management

Achievements against the NSW Patient Safety & Clinical Quality Plan to date

Major Area achievements to date include:

- establishment of the clinical governance system at Area level;
- implementation of IIMS at all sites;
- timely RCA of all SAC1 incidents,
- high rates of implementation of RCA recommendations;
- policy implementation (e.g. incident management);
- system improvements, including
    - surgical flow redesign,
    - improved access performance,
    - pressure care systems,
    - correct site surgery implementation,
    - service rationalisations to support safer care,
    - reporting systems for patient safety,
    - multiple patient safety and quality programs and projects.

A full listing of CGU projects and status at 26th July 2006 is given in the CGU Workplan (See Appendix 2)

Table 1: OUTSTANDING ELEMENTS OF NSW HEALTH PATIENT SAFETY & CLINICAL QUALITY PLAN (2005)

Heading in PSCQP PD 2005_906	Element	Current Compliance	Comments	PSCQP reference	State Q&S plan 2006 element	NSCCAHS Q&S Plan 2007 Element
Clinical indicators and performance information	Clinical indicators, performance measures and Area targets show patient safety and improving performance	Low	Very few collected, not systematic	1.3	Clinical governance and quality impl	Performance evaluation
Safety monitoring, reporting & performance	Services are meeting their performance targets for patient safety Benchmarking occurs	Moderate Low	Reporting in place but only sporadic improvement in outcomes demonstrated to date Infection control benchmarking occurs but little action results	1.4,1.7	Clinical risk identification, management and mitigation strategies	Performance reporting & evaluation
Public reporting	Performance information on patient safety is accessible to public	Moderate	Occurs to AHAC and in Annual report, but not on Web	1.6	Clinical governance and quality systems impl	Public reporting
Incident management system	Patient safety/incident management as a standing item on Unit meeting agendas	Low	Not systematic	2.4	Clinical governance and quality systems impl	Unit level governance
Incidents involving death of a patient	Deaths within 45 days monitored to determine if practice changes are needed	Moderate	Not systematised or evaluated	3.4, 5	Improvements in adverse incident management	Mortality & Peer review
IIMS	Timely action on SAC 2, 3 & 4 incidents +/-	Moderate	Not routinely monitored or fed back	3	Improvements in adverse incident management	Unit level governance
Complaint monitoring and review	Complaints dealt with on time and feedback is provided to complainants	Moderate	Timeliness not reliable	4.1	New improvement opportunities	Complaints management
Record review processes	An appropriate system of chart review is implemented and leads to changes in practice .	Low	Only occurs at RNSH	5.1, 5.2	New improvement opportunities	Mortality & Peer review
	The results of record reviews and investigations are reported to management	Moderate	Requires risk register	5.2	Clinical governance and quality impl	Mortality & Peer review
Peer review processes	Health services have developed a system of peer review	Low	Not systematised or linked into divisional structure	6.1. 6.2	Clinical governance and quality impl	Mortality & Peer review
Communication training	Communication programs established in each AHS	Low	Awaiting CEC lead	7	New improvement opportunities	Special programs
Clinician performance management	AHSs have a methodology for clinician performance management, Senior clinicians participate	Low	Not systematised	9.1, 9.2	Clinical governance and quality impl	Staff performance management
Internal reporting	Report on clin performance management, appointment etc			10.1	Clinical governance and quality impl	Staff performance management

3. Effective Quality and Safety Systems

While the *NSW Health Patient Safety & Clinical Quality Plan* and the *NSW Health Clinical Quality and Patient Safety Plan* remain the core content of this Plan, they should be seen as launching points – "necessary" for quality and safety, but not "sufficient". This is because the greatest gains in quality and safety come from system wide action, rather than systems specially developed for patient safety and quality. In other words, the quality and safety plan should be enabled by, and in turn enable, the area's other operational plans: the NSCCAHS Operational Plan 2007/8; Clinical Services Plan; Asset Strategic Planning; Information Management and Technology Plan ; Research and Teaching Plan; Financial Management Plan ; Risk Management Plan.

Before describing the proposed approach, a brief look into the literature is helpful: if significant resources are to be used on systems of critical importance, it is sensible to pause and consider the evidence.

3.1 Strategies for ensuring quality

There is a great deal of dogma in the literature, but little evidence on the most effective way of improving quality and safety. A review conducted by Øvretveit for the WHO European Office found little evidence to support given quality-specific initiatives, noting that:

> "...a strategy is more likely to be successful if it is chosen with a knowledge of alternative approaches, adapted to the situation, reviewed and adjusted to changes and pursued consistently by committed management. It is possible that a policy and financial context that rewards greater safety and quality is important, as is active and transparent management of the balance of quantity, cost and quality of service" [4]

Øvretveit goes on to highlight the importance of financial, cultural and other conditions surrounding implementation, noting that effectiveness is improved by consistency and flexibility without sudden change.

Table 2: Some commonly used quality interventions[5]
Systematic reviews
Increasing resources
Reorganization
Strengthening management
Standards and guidelines formulation and implementation
Patient empowerment and rights
Quality management system
Quality assessment and accreditation, internal or external
Total quality management (TQM) and continuous quality improvement (CQI)
Quality collaboratives
Re-engineering
Quality indicator comparison
Benchmarking
Risk management and safety strategies
National quality strategies

To this might be added less direct improvement activities, such as medico-legal experience, OH&S etc

[4] Øvretveit, J *What are the best strategies for ensuring quality in hospitals?*, Health Evidence Network (HEN) at http://www.euro.who.int/HEN/Syntheses/hospitalquality/20031124_4

[5] ibid

These findings suggest that major systemic improvement in quality and safety is more likely to result from generally directed action and operating conditions, than from specific quality and safety systems. The question then becomes: **how can health care organisations best be configured to achieve a high standard of quality and safety**?.

3.2 Health As a High Risk Industry

As noted in the introduction, health care is a recognised "high risk" industry. In a review of the topic[6], Gaba identifies two analytical frameworks : Normal Accident Theory and High Reliability Organisation Theory.

TABLE 3. HIGH RELIABILITY ORGANISATION THEORY vs NORMAL ACCIDENT THEORY

High Reliability Organization Theory	Normal Accidents Theory
Accidents can be prevented through good organizational design and management	Accidents are inevitable in complex and tightly coupled systems
Safety is *the* priority organizational objective	Safety is one of a number of competing objectives
Redundancy enhances safety; duplication and overlap can make a "reliable system out of unreliable parts"	Redundancy often causes accidents: it increases interactive complexity and opaqueness and encourages risk-taking
Decentralized decision making is needed to permit prompt and flexible field-level responses to surprises	Organizational contradiction: decentralization is needed for complexity but centralization is needed for tightly coupled systems
A "culture of reliability" will enhance safety by encouraging uniform and appropriate responses by field-level operators	A military model of intense discipline, socialization, and isolation is incompatible with democratic values
Continuous operations, training, and simulations can create and maintain high-reliability operations	Organizations cannot train for unimagined, highly dangerous, or politically unpalatable operations
Trial and error learning from accidents can be effective and can be supplemented by anticipation and simulations.	Denial of responsibility, faulty reporting, and reconstruction of history cripple learning efforts

Source: Modified from S. Sagan, 7>ie *Limits of Safety* (Princeton, NJ: Princeton University Press, 1993),Table I.

The inherently pessimistic "Normal Accident Theory" (of which Reason's "Swiss Cheese" analogy is the best known example) sees accidents as ultimately inevitable in complex and tightly coupled systems[7], such as hospitals. While further defences can and should be erected, they carry with them the risk of increasing the opacity and complexity of the system, and thus, paradoxically, increasing risk. It follows that by just building more defences, an organisation will soon reach a ceiling of quality and safety.

Indeed, according to Gaba health care is particularly vulnerable to "normal accidents". Not only is it extremely complex at the patient, therapeutic and organisational levels, but, notwithstanding official rhetoric, very few health care organisations operationalise safety as a top goal. In part this reflects asymmetrical information and concern about safety (as opposed to "production") because safety is harder to plan for and to measure. Furthermore, feedback about safety is inherently weak and ambiguous compared to production and resource use information.

TABLE 4. ASYMMETRY OF SIGNALS OF SAFETY vs. SIGNALS OF PRODUCTION

Production	Safety
Feedback about production is easy to measure reliably and nearly continuously ("revenue," "earnings," "expenses") and indicates success in a positive fashion	Traditional measures of "safety" are indirect and discontinuous, making them noisy and difficult to interpret or even deceptive
Success is indicated "positively" (e.g., increasing earnings), is obviously reinforcing, and has high salience (the bottom line is the "bottom line" for a firm)	The feedback is provided "negatively" (fewer accidents or incidents), and has little reinforcement value of itself, making it achieve high salience only after an accident or a scary near-miss

[6] Gaba, David M : "Structural and Organisational Issues in Patient Safety "*California Management Review* Vol 43, no 1 Fall 2000; p 86

[7] "Tight Coupling" refers to direct, short-time frame interactions between system elements

The relationship between the application of resources (money effort, time) and production goals is relatively certain, making it easy to utilize feedback	Even when interpreted correctly the relationship between application of resources and safety goals is relatively uncertain, making it hard to utilize the feedback

Source: Constructed from J. Reason, *Human Error* (Cambridge: Cambridge University Press, 1990), pp. 203-204.

Other factors that reduce the reliability of health care processes are:

- Decentralisation of decision-making, with little accountability at clinical unit and individual clinician level
- Few economies of scale, meaning that large numbers of autonomous units need to be convinced before change will be adopted
- Low compliance with standardised protocols of care and policies
- Weak organisational control on safety behaviour
- Weakly regulated practice e.g. the use of technologies
- Lack of required, resourced ongoing training
- Inefficient sanctions for breaches (tort law misses some culpable behaviour while punishing some correct behaviour)
- Poorly developed performance monitoring systems, especially in low volume settings
- The "normalisation of deviance", that is, complacency in the face of ongoing minor errors and outmoded practice. Recent successes with "care bundles" show how minor change can have a large impact.
- "Structural secrecy", whereby knowledge and decisions are compartmentalized by units, which have incentives to contain rather than share issues more widely.
- Cultures that emphasise blame, and create incentives to hide errors or problems
- A tendency to minimise reporting bad news up the chain of command.

In a thoughtful critique of HROT, Marais points out that exemplar High Reliability Organisations such as aircraft carriers tend to not in fact to be the interactively complex, tightly coupled systems that HROT claims to have dealt with. The availability of detailed technical process knowledge means that system interactions can in principle be planned and guarded against: this is contrary to "interactive complexity". Similarly, the organisations typically have large built-in redundancy (e.g. multiple overlapping checks), and are not in fact "tightly coupled". Marais points out that for most complex systems there is a a far higher level of uncertainty- technical, political and economic. The central issue is therefore not the technical design of systems per se, so much as creating the best possible decision-making environment.

3.3 The way forward

High Reliability Organisation Theory proposes that acceptable levels of quality and safety performance can be reached, but this requires:

1. An unequivocal organisational goal of high reliability and safety
2. Provision of conditions and tools for achieving those goals (structure, training, procedures and regulations)
3. Measurement of attainment of the goals (accident investigation, prospective surveillance, quality management)
4. Effective action if the goals are not met

A goal of high reliability and safety

While it is simple to state " quality and safety are our highest goal", as Marais points out there is usually conflict between safety and performance goals, and in practice a choice must be made between optimising performance and optimising safety[8]. Furthermore, that choice is affected by wide range of external and internal influences, ranging from overt politics, to mandated targets, to personal factors in decision-makers such as desire for career advancement. The challenge is therefore not to proclaim one goal to the exclusion of others, but to assess the risks and to know how much risk is acceptable.

In Health Services, there are interesting and complex ethical issues surrounding such choices. First, while the careers and reputations of decision-makers may be at risk, the lives that are most affected are not usually involved in the discussion, at least at a policy level. Second, at a societal level, the tensions between access to services, quality and funding barely remain undiscussed: unrealistic expectations abound, and quality/ performance tradeoffs remain implicit. Third, in the absence of a societal consensus and overt policy, the burden of decision-making is typically passed down to clinicians and patients, whose marginal resource decisions are constrained by a system that neither the clinician nor patient feels able to influence.

To overcome this requires:

1. Knowledge of the risk, how to reduce it, and the opportunity cost of investing in risk reduction
2. Knowledge of how much risk is acceptable (Marais p7)
3. Governance structures that include accountability to an responsibility for the people affected by the decisions

As will be seen below, multidisciplinary clinical governance structures overseeing explicit care process, informed by evidence on current and best practice, can go far towards meeting those conditions.

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[8] **Marais, K Dulac N, Leveson N *Beyond Normal Accidents and High Reliability Organizations: The Need for an Alternative Approach to Safety in Complex Systems* MIT Engineering Systems Symposium 2004: http://esd.mit.edu/staging/symposium/pdfs/papers/marais-b.pdf**

[11] Degeling, P; Winters, M; Maxwell, S; Coyle, B; Hoyle,P: *A Project to Map the Cultural and Psycho-Social Predispositions of Staff in RNSH and to Assess the Implications for Reform* University of Durham and Northern Centre for Healthcare Improvement, 2007 (in press)

Drawing on the earlier discussion and DOH expectations, an inherently positive set of quality and safety objectives can be envisioned, consistent with achieving a high reliability organisation.

VISION FOR NSCCAHS AS A HIGH RELIBAILITY ORGANISATION:

- *Best practice care is delivered*
- *Quality outcomes are a recognised high level objective*
- *Quality improvement is a valued activity*
- *NSCCAHS is a learning organisation*
- *Staff have the skills to deliver or support high quality care*
- *Quality and Safety is integrated into operational systems and methods*
- *Policies support quality and safety*
- *There is continuity of care for all users of the service*
- *Explicit care processes are systematically improved*
- *Major risks are managed*
- *Consumer needs are met*
- *Consumer expectations are understood and inform our operational activities*
- *There is internal accountability*
- *There is external accountability*
- *Quality & safety problems are found and understood*
- *Adverse events are identified, investigated and prevented*
- *Positive links are maintained with the CEC and the DOH*

The table below applies this vision to quality and safety systems within NSCCAHS, to estimate of the current level of achievement and its consequence for achieving reliability.

The "vision" elements are expanded in greater detail in the body of the Plan (see section 4), at which point the proposed actions are also detailed.

TABLE 5: Q&S IMPLICATIONS OF HIGH RELIABILITY ORGANISATION THEORY

High Reliability Principle	Vision	Current status	Consequence for reliability
1. Set goal of high reliability and safety	Quality outcomes a recognised top level objective	Q&S implicit rather than explicit in Strategic and Operational Plans	Not an organising principle for mainstream activity
	Quality improvement as a valued activity	Tend to be about avoiding negative outcomes, rather than about achieving positive outcomes	Relatively weak incentive for Q&S; Cultural dissonance between Q&S advocates and mainstream clinicians and managers
2. Provide conditions and tools for achieving the goals (structure, training, standards, procedures and regulations)	Q&S discourse integrated to operational systems and methods	Divisional structure now in place, but oriented towards financial and access performance targets, rather than the care production process.	Clinical leadership now in place, but will need to maintain focus on managing the care system.
	Policies support Quality & safety objectives	Effective policy system developed	Continue roll-out of policies
	Standards & policies in place for evidence based, best practice clinical services	Networks still poorly developed	Lack of credible forums for standardising practice
	Explicit care processes systematically improved	Care process mapping not systematically undertaken	Care production systems and performance not understood
	Best practice care is delivered	Early uptake of standardised care approaches	Good progress on selected care types, primarily episode-related care processes.
	All staff have skills in clinical governance	Very uneven CG skills both clinicians and managers	Failure to identify and deal with problems in care systems

High Reliability Principle	Vision	Current status	Consequence for reliability
3. Measure the attainment of goals (accident investigation, prospective surveillance, quality management)	Quality and safety problems are found and understood	IIMS now implemented. Relatively weak uptake by doctors, but high risk incidents well captured.	IIMS gives a skewed profile of incidents and priorities for intervention
	Adverse events are investigated and prevented	RCA system implemented, inc action & issue tracking	Good RCA-derived understanding of serious events
	There is an incentive to report	Inconsistent reporting back on inv outcomes to units & staff	Few incentives to report
	Q&S performance is measured and reported	Measurement primarily oriented towards other operational goals: Access performance; financial performance	Area performance system sends message quality and safety are of secondary importance unless there is a major event. Reinforces "blame culture", as positives less able to be tracked
	Care meets consumer needs	Good experience with Clin Redesign tools	Expertise in system improvement available
		Few specific Q&S outcome goals in perf monitoring	Quality investments down-prioritised, and only up-prioritised when there is a dramatic event
	Processes of care are systematically improved	Care processes not monitored and reported	Failure to integrate quality and economic decisions
			Care outcomes largely invisible, at organisational level except for catastrophes.
4. Take effective action if the goals are not met.	Accountability includes Q&S outcomes	Goals not explicit, except for IIMS/ RCA	Achievements not measured or reported
	Positive achievements routinely reinforced	Negative consequences for serious lapses, but few positive consequences for achievement	Reinforcement of blame culture

4. The Quality & Safety Plan

An inherent problem with quality and safety planning is that the "discourse" is inherently negative – "harm", "problems" and "issues" far outweigh the opportunities for positive reinforcement. This in turn creates a dissonance with the mainstream clinical culture, which is centred on the inherently positive task of care delivery. The challenge is therefore to develop a plan that treats quality, safe care as intrinsic to the positive operations of the Area, so that demonstrated outcomes become a source of pride and satisfaction to staff & organisational stakeholders. A similar challenge is found in risk management, where the issue is not only negative risks, but also capturing opportunity.

Importantly, this does not mean overlooking specific issues or denying the bad outcomes that occur. In fact, the high reliability approach is characterised by a preoccupation with failure, either real or potential (see the table below). Where the high reliability approach differs is in positively applying that understanding to improvement, which necessarily means a culture that values learning and minimised blame.

Organizing for Reliable Work
adapted from Karl E. Weick & Kathleen M. Sutcliffe, "Managing the Unexpected,"Jossey-Bass, 2001

1. **Preoccupation with failure**: "to constantly entertain the thought that we have missed something."
2. **Reluctance to simplify interpretations**: e.g. diverse checks and balances, adversarial reviews, and cultivation of multiple perspectives.
3. **Sensitivity to operations**: Resources are deployed so that people can see what is happening, can comprehend what it means, and can project into the near future what these understandings predict will happen. In medical care settings sensitivity to operations often means that the system is organized to support the bedside caregiver.
4. **Cultivation of resilience**: capability to improvise and act without knowing in advance what will happen.
5. **Willingness to organize around expertise**: Let decisions "migrate" to those with the expertise to make them...so that there is a better matching of experience with problems.

The issue of "culture"

In 2003, Best Practice Australia was commissioned by the then Northern Sydney Health to undertake a Climate Survey of all staff. Amongst other findings this survey showed that NSH was (like the vast majority of peer organisations) "in a culture of blame", with significant numbers of employees pessimistic about the future and reporting low morale. Communication and a failure of management to manage were seen as major negatives. However, all was not grim – staff generally enjoyed the work, and reported that the top expectation their managers have of them is quality work.

These findings are somewhat reinforced by a parallel ethnographic study of RNSH[11], which found that

The current study shows that the ongoing failure to achieve reform at the clinical unit level is in itself a major issue, not just for the "organisation", but also for its staff and managers. The accounts of decline, loss, betrayal by the managerial class denote a sense of alienation, while the perception that some groups, such a senior doctors, are not managed at all generates deep scepticism about the organisation's commitment to change.....

However, there were also grounds for optimism:

Staff assessments of the organisation shows that the official goals of reform, sound resource use and good outcomes, are being recognised by clinicians. Furthermore, the accounts of rebirth, the finding that the majority of respondents were at RNSH by choice, and the generally resilient nature of most respondents ("dominant, venturesome, self assured, tough minded and enthusiastic") shows that the cultural conditions for clinical reform are present, albeit in a latent form

In short, while there are limits on achieving a quality and safety culture, there is an underlying positivity about clinical work people and doing it well. If Weick and Sutcliffe's observation is accepted that:

"(one should) think of your culture as a source of strength (it is the residue of your past successes!)[12]*"*

then the challenge becomes to harness those cultural strengths.

In a related paper Degeling and Carr[13] describe the invidious position of managers who are caught between the forces of senior management Realpolitik and jealously guarded clinical power. In their view effective leadership is closely related to authority, and requires "authorisation " both by the institution (e.g. clear and steadfast senior management commitment) and by the "followership", which typically requires consonance with the subcultures of those who are to be led.

In their report on RNSH, Degeling and his colleagues suggest that if the goal of efficient, high quality care is to be achieved, structures and practices are needed that:

- Link the clinical and resource dimensions of care;
- Balance clinical autonomy with accountability ;
- Systematise care processes
- Implement team approaches to clinical care and evaluation

Specifically, this entails the strategic development of clinical units so that they can oversee the major types of care that the unit produces. The leaders of those units must be authorised by senior management, which means a clear vision, strategy and steadfast support regardless of short term distractions. To quote Degeling and Carr

...the success of the reform is ...in the day to day basis the reform is mirrored in behaviour, at all levels, particularly in the behaviour of senior management as evidenced by their willingness to resist pressures (to back down)...

The "vision" elements outlined in Section 3 are a generally positive set of objectives, and are likely to be seen as compatible with both clinical and managerial cultures.

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[12] Weick, K & Sutcliffe, K *Managing The Unexpected* Jacksonville Florida February 28, 2005

[13] Degeling, P and Carr "A Leadership for the systematisation of health care: the unaddressed issue in health care reform" *Journal of Health Organisation and Management* Vol 18 No 6, 2004 399-414

The plan, presented below as Table 6, maps the various components and requirements contained in NSW Health Plans, Policy Directives and the related standards, function and criteria to the vision elements. To these have been added current and planned activities within the Area, including the area's Operational Plan, to form the bulk of the NSCCAHS Quality and Safety Plan.

5. Implementation

As shown above, the greatest and most efficient gains in Quality and Safety Strategy come from eliciting quality and safety from the broader activities of the health service. It follows that implementation of the quality and safety plan should be carried, wherever possible, by general parts of the health service – quality and safety should emerge from the way things operate.

In a practical sense, this means that the various quality and safety actions detailed in this plan should, where feasible, be the responsibility of general units, with only an irreducible rump of hard-core quality activities vested in the quality-specific parts of the health service.

That having been said, there is a need to monitor, verify and improve safety performance, and to support that, an reporting system is required to allow effective governance of the plan.

Specifically, it is proposed to use a "three-pass" process to allocate responsibility:

1. Allocation of activities to suitable general units
2. Confirmation of the core Q&S components, to be carried by clinical governance and other quality-specific units
3. Agreement on the performance reporting system, including measures, reporting and governance.

This will be launched at the Area Management Board planning workshop to be held in April 07

Various enabling actions will also be undertaken to support implementation, including:

- Training in quality, safety and improvement for managers
- Further development of the quality performance monitoring system
- An overhaul of the governance system, to more effectively align quality governance with mainstream governance

TABLE 6: QUALITY AND SAFETY PLAN 2007/8 Aim: A high reliability organisation, that consistently gets the care right, first time.

STRATEGY	VISION	GOAL	METHOD	ACTION	OUTCOME	RESPONSIBILITY	PLAN LINK
A. Constitute Q&S as a core goal	Quality outcomes a recognised high level objective	Clear positive statement of Q&S as a goal	Q&S targets as core accountabilities	**A1** Include in senior mgmt and clinical staff Perf Agreements.	All Perf Agreements and Perf mgmt processes include Q&S accountabilities	DWD	Q&S Plan
	Quality improvement as a valued activity	Improvement recognised	Celebrations	**A2** Annual quality carnival/ awards	Knowledge and achievements are shared	DCG/ C&EP	Q&S Plan
		Cultural influences understood	Safety culture survey	**A3** Conduct safety culture/climate survey	Cultural attributes understood	NCHI/DWD	Q&S Plan
		Active development of an "improving" culture	Build into leadership and management development programs	A4 Include improvement in development and training programs	Widespread knowledge of improvement methods	DWD	Workforce Action Plan
		Sharing achievements	Podcasting	**A5** Develop web site	Website meets user needs	DCG/ C&EP	Q&S Plan
B. Implement effective Clinical Governance & Quality systems	Q&S integrated to operational systems and methods	Promote and support Divisional and Unit Level Governance;	Define baseline Q&S system standards e.g. care process variance analysis, mortality review, infection control, IIMS analysis	**B1** Include standards in HS, Div and unit plans, terms of reference and performance reports	There is effective Divisional and Unit level clinical governance	DCG	Operational Plan
	Explicit care processes systematically improved	Major care processes for each gov entity clearly understood, assessed, reported and acted on	Care process map by Division and network	**B2** Clinical Redesign projects High cost DRG project	Three major care types brought under process control by each clinical division in each Health Service	DCO/ GMs	Operational Plan
	All staff have skills in Clinical Governance	Train clinical and managerial staff in Clinical Governance	Management Development Program	**B3** Divisional and Senior HS Mgmt staff Mgmt Devel have CG training	All staff with a managerial role have the skills for effective clinical governance	DWD	Workforce Action Plan
			CPI training	**B4** CPI training offered to all staff	60 staff are formally trained in CPI	NCHI	Workforce Action Plan
	Policies support quality and safety	Policies and procedures to ensure effective clinical governance.	Specific policy development e.g. Open Disclosure	**B5** DOH and Area Policy Directives implemented and verified	There is demonstrated compliance with policy directives	DCG/ PFP	Q&S Plan
	Best practice care is delivered	Evidence based care	Process achievement and variance monitored and reported and acted on as part of perf mgmt	**B6** Major process variance addressed through operational systems	Care is demonstrably evidence-based	DCO	Area Operational Plan
		A focus on the patient journey	Clinical Redesign projects	**B7** (See CR Plan)	(See CR plan)	DCO	Area Operational Plan

STRATEGY	VISION	GOAL	METHOD	ACTION	OUTCOME	RESPONSIBLITY	PLAN LINK
C. Targeted incident and adverse event reduction.	Manage major risks	Implement Specific systems	Infection Control system	**C1** Implement AIPAMS	Infection Control governance standards met	DNMA	
			Clinical Redesign projects	**C2** (See CR Plan)	(See CR plan)	DCO	Area Operational Plan
			Blood safety system	**C3** Blood Prod plan	Blood product use complies with best practice	DCO	Area Operational Plan
			Open disclosure system	**C4** Implement OD	OD occurs consistent with DOH policy	DCG/PFP	Q&S Plan
			Medication safety	**C5** Establish D&T service	There is effective governance of medication safety	D Corp S (??)	Area Operational Plan
			Medication Reconciliation	**C6** Roll out SSSL ADE to other sites	Fewer errors at pt of adm. t/f and d/c	DCG	Q&S Plan
			Evidence-based anticoagulation	**C7** Trial anticoagulation system at RNSH	Reduced anticoagulation incidents, improved compliance with evidence	DCG	Q&S Plan
			Management of deteriorating patients	**C8** Develop area-wide standard and system	Deteriorating patients are identified and effectively treated	DCG	Q&S Plan
			Pathology Labelling	**C9** Continue implementation of Pathology Labelling Program	All specimens correctly labelled	DCG (PSP)	Q&S Plan
			Patient Identification	**C10** Develop area-wide standard and system	All patients identified	DCG (PSP)	Q&S Plan
			Wound care	**C11** Develop area-wide standard and system	Wound care is evidence based and effective	DCG (PSP)	Q&S Plan
			Pressure care	**C12** Continue roll-out of pressure area prevention program	Pressure areas do not develop in inpatients of NSCCAHS	DCG (PSP)	Q&S Plan
			Nasogastric tube safety	**C13** Develop area-wide standard and system	There are no serious adverse events from use of N-G tubes	DCG (PSP)	Q&S Plan
			Falls prevention	**C14** Develop and implement falls prevention policy	Falls incidence is significantly reduced	DCG (PSP)	Population Health Plan
			Beds, Mattresses & Care Environment	**C15** Develop area-wide standard and system	All beds and mattresses meet safety and comfort standards	DCG (PSP)	Q&S Plan

STRATEGY	VISION	GOAL	METHOD	ACTION	OUTCOME	RESPONSIBLITY	PLAN LINK
			Bariatric Care	**C16** Develop area-wide standard and system	Bariatric patients are treated respectfully and safely	DCG (PSP)	Q&S Plan
			Integrated Risk Management System	**C17** (See RM plan)	RM plan implemented	DCG	Risk Management Plan
			Central Venous Catheter CPI	**C18** Develop and impl protocols	Central line infections reduced to zero	DCG (PSP)	Q&S Plan
			Communication training	**C19** Link with CEC	A Clinical Communication improvement program is developed	DCG	Q&S Plan
			Nutrition	**C20** Better Nutrition plan	All inpatients are properly nourished	DCG	Q&S Plan

STRATEGY	VISION	GOAL	METHOD	ACTION	OUTCOME	RESPONSIBLITY	PLAN LINK
D. Care meets consumer needs	Internal accountability	Performance Evaluation & Reporting (internal)	Care processes, IIMS, RCA, indicators, infection, mortality	**D1** IIMS, RCA, indicators, (incl infection), mortality in core perf reports	RCA fed back to units & linked to Open Disc	DCO	Area Operational Plan
				D2 Evaluate outcomes of RCA recommendations	RCA a demonstrated effective tool for improvement	DCG (PSP)	Q&S Plan
		Unit level ownership of outcomes	Audit clinical practice	**D3** A Clinical Audit Program is present at all inpatient sites	All clinical units undertake systematic audit	DCO	Health/ Service Plans
	External accountability	Performance Evaluation & Reporting (external)	DOH Perf Agr, QSA, ACHS, web	**D4** Link Perf Agr and QSA to action plans	DOH Perf Agr targets met	DCO	Area Operational Plan
					QSA conducted	DCG	Q&S Plan
		Patient Satisfaction	NSW Pt Satisf survey	**D5** Participate		DCG/PFP	Q&S Plan
		All services accredited	ACHS accreditation	**D6** An efficient system for preparation for accreditation is developed and implemented	Accreditation achieved all relevant sites	DCG/C&EP	Health/ Service Plans
			ISO accreditation		Accreditation achieved all relevant sites	D Corp S	Health/ Service Plans
			NATA accreditation		Accreditation achieved all relevant sites	D Corp S, Dir PaLMS	Health/ Service Plans
		Benchmark safety performance	Measure adverse event rate	**D7** Routine sampled record review at all inpatient sites	Incidence of adverse events determined at all inpatient sites	NCHI	Health/ Service Plans

STRATEGY	VISION	GOAL	METHOD	ACTION	OUTCOME	RESPONSIBILITY	PLAN LINK
E. Risk management	Quality & Safety problems are found and understood	High level analysis of risks	Clinical risk identification, management and mitigation strategies	**E1** Quarterly RCA meta-analysis	Risk mitigation strategies implemented to prevent incident reoccurrence.	DCG (PSP)	Q&S Plan
			Implementation of Root Cause Analysis recommendations and other identified quality and safety improvement strategies	**E2** Link RCA recommendations into Risk Register	Risk mitigation strategies implemented to prevent incident reoccurrence.	DCG	Q&S Plan
	Adverse events and near misses are identified, investigated and prevented	Mortality and serious adverse event analysis	Implement standardised mortality & peer review policy and system;	**E3** Develop and implement mort review policy	All deaths of NSCCAHS patients subject to audit and review	NCHI	Q&S Plan
		Improvements in adverse incident notification, investigation and management	Increase medical and Allied Health reporting in IIMS	**E4** Education, awareness and feedback on IIMS reporting rates	All categories of staff use IIMS to notify incidents	DCG (PSP)	Q&S Plan
			Implement "reporting-back" systems from IIMS to units	**E5** Audit feedback on SAC 2,3,4	Staff receive feedback on actions from notified incidents	DCO	Health/ Service Plans
		Effective complaints management	Complaints management systems in place and complaint information used to improve care.	**E6** Implement Complaints Management Policy	Complaints handling meets DOH performance benchmarks	DCG/PFP	Health/ Service Plans
		Known hazards are risk managed	Alerts are made known to those who need to act	**E7** Refine alert system	Safety alerts are effectively communicated and acted on	DCG (PSP)	Q&S Plan
F. Performance development	Staff have the skills to deliver or support high quality care	Staff Performance Management	Performance review processes finalised	**F1** Mandatory Perf Rev all Senior Medical and Managerial staff	All staff have regular performance review	DWD	Workforce Action Plan
G. Integration of Area, Clinical Excellence Commission and NSW Health priorities.	Positive links with CEC and DOH	System-wide collaboration	Encourage partnership	**G1** Participate in specific projects	DOH and CEC expectations met	DCG	Q&S Plan
				G2 Actively inform CEC, DOH and other organisations of our direction and achievements	NSCCAHS forms effective partnerships for improvement	DCG	Q&S Plan

Appendix 1: NSCCAHS achievements against NSW Health Patient Safety & Quality Plan (PD 2006_609)

Key:	~~Green~~	Satisfactory compliance Jan 07
	Orange	Moderate compliance Jan 07
	Red	Low compliance Jan 07

Function 1 Structural establishment

Description: Establish a specific Area wide Clinical Governance Unit

Performance measures:

~~1.1 Organisational structure agreed and staff appointed to roles ✓~~
~~1.2 The 2005/06 Workplan is signed off by the Chief Executive ✓~~

Component Criteria

~~1.1 Committee structure~~
~~• Patient safety and quality improvement embedded across all aspects of the service ✓~~
~~• Committee structures in place to effectively support patient safety and quality improvement ✓~~

~~1.2 Clinical governance unit~~
~~• CGU established to manage patient safety and clinical quality risks ✓~~

1.3 Establishing clinical indicators and performance information
• Selected clinical indicators, performance measures and established Area targets demonstrates patient safety and improving performance +/-

1.4 Monitoring and reporting performance information
~~• Performance information on quality and patient safety is monitored, analysed and reported ✓~~
• Area benchmarks its performance and makes improvements in patient safety and clinical quality as a consequence of benchmarking practices +/-

~~1.5 Using performance information to improve patient care~~
~~• Evidence that performance information has been used to guide planning and resource allocation, patient safety risks and system issues requiring improvement ✓~~

~~• Area has strategy to reduce clinical and patient safety risks ✓~~

1.6 Public reporting
• Performance information regarding patient safety is readily accessible to public +/-

1.7 Patient safety performance
• Services are meeting their performance targets for patient safety and performance is improving over time +/-

Function 2 Incident management system

Description: Management of clinical incidents in the NSW Health system.

Relates to Standard 3. An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Performance measures

~~2.1 For SAC 1 incidents, the RCA team has signed off the report within 55 days of the incident date ✓~~

~~2.2 80% of RCA recommendations implemented within stated time frame ✓~~

~~2.3 A structure is in place for analysis and action of SAC 2, 3 and 4 incidents, Designated staff nominated to action findings. ✓~~

2.4 Clinical units include discussion of incident management (i.e. patient safety/incident management) as a standing item on meeting agendas ×

Component Criteria

3.1 Notifying and assessing incidents

~~• Environment and culture which supports incident reporting ✓~~

~~• Systems in place to notify and record incidents ✓~~

~~• Incidents examined to assess an individuals contribution to incident ✓~~

~~• All incidents assigned a SAC rating, investigated within prescribed timeframes and reported as required ✓~~

3.2 Investigating incidents

~~• High risk incidents are investigated to determine reason for occurrence and prevent future recurrence ✓~~

~~• Investigations undertaken in timely manner by multidisciplinary team in accordance with NSW Department of Health guidelines ✓~~

~~• Recommendations from investigation teams aim to reduce the likelihood of recurrence, are practical and relate to the issue ✓~~

3.3 Implementing recommendations

~~• Recommendations arising from investigations are implemented ✓~~

~~• Recommendations improve patient safety ✓~~

~~• Incident data is trended to determine whether system wide improvement is required ✓~~

~~• Outcomes and changes arising from investigations fed back to RCA teams and incident notifiers ✓~~

3.4 Incidents involving death of a patient

• System in place to monitor deaths and determine if practice changes are needed ×

Function 3 Performance measures for the Incident Information Management System (IIMS)

Description: There is staff designated for the implementation of the IIMS across all facilities within this financial year.

Relates to Standard 3. An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Performance measures

~~3.1 Incidents notified have recommendations for action entered ✓~~

~~3.2 Completion of recommendations monitored ✓~~

~~3.3 Timely action on SAC 1 incidents ✓~~

3.4 Timely action on SAC 2, 3 & 4 incidents +/-

Function 4 Complaints

~~**1. Single Point of Contact:** Provide a single, publicly recognisable point of contact for the receipt and management of serious complaints from members of the public and staff.~~ ✓

~~**2. Designated Senior Complaints Officer:** A Senior Complaints Officer will be available 24 hrs per day, 7 days per week to ensure appropriate action is being taken to resolve serious complaints.~~ ✓

Relates to Standard 4: Complaints management systems are in place and complaint information is used to improve patient care.

Performance measures

~~4.1 Appointment and implementation of designated Area Senior Complaints Officer to deal directly with serious complaints~~ ✓

~~4.2 A system in place to enable reporting of and management of complaints~~ ✓

Component Criteria

4.1 Complaint monitoring and review

~~• Systems are in place to record, monitor and review complaints~~ ✓

• Complaints are dealt with in a timely manner and feedback on the outcome of investigations is provided to complainants +/-

~~4.2 Systems improvement~~

~~• Where necessary, complaint investigations recommend changes in practice to prevent recurrence and such recommendations are implemented~~ ✓

~~• Complaint data monitored and analysed to detect trends and determine whether system-wide improvement is needed~~ ✓

~~• Processes are in place to address the systems issues identified by complaints~~ ✓

~~• Information on complaints is reported to NSW Department of Health and other relevant authorities~~ ✓

~~4.3 Management of complaints or concerns about individuals~~

~~• Complaints or concerns against individuals are dealt with according to Departmental policy and within relevant timeframes~~ ✓

Function 5 Death reviews

Description: Ensure that all deaths in health services are reviewed and that untimely deaths are referred appropriately to the Coroner, the Special Committee for Investigating Deaths Under Anaesthesia (SCIDUA), the Special Committee for Investigating Deaths Associated with Surgery (SCIDAWS), the Maternal and Perinatal (M&P) Committee and other appropriate committees. +/-

Relates to Standard 3. An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Performance measures

5.1 System in place to screen all deaths within 45 days of the event +/-

Component Criteria

3.4 Incidents involving death of a patient

• System in place to monitor deaths and determine if practice changes are needed +/-

Function 6 Continuous Quality Improvement (CQI) support

Description: Provide ongoing support to clinicians and managers for the implementation of quality policies and procedures in accordance with A Framework for Managing the Quality of Health Services in NSW, NSW Health, 1999.

Relates to Standard 2. Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

Relates to Standard 6. Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

Performance measures

~~6.1 Each public health organisations identifies and systematically improves five (5) major care processes per year ✓~~

Component Criteria

5.1 Record review processes
• Health services have developed an appropriate system of chart review.
5.2 Systems improvement ×
• Recommendations arising from chart review investigations bring about changes in practice ×
• The results of reviews and investigations are reported to management/Area executive ×
• Feedback is provided to staff on the results of chart review
6.1 Peer review processes
• Health services have developed an appropriate system of peer review ×
6.2 Systems/performance improvement
• Matters identified via peer review that require more in depth review are investigated accordingly ×

Function 7 Communication training
Description: Improve the processes of communication between clinicians and patients/families including the provision of communication training to all clinical staff in conjunction with the Clinical Excellence Commission (CEC).

7.1 Communication programs have been established in each AHS ×

~~**Function 8 Policy development**~~
~~**Description:** Develop Area specific policies associated with patient safety, ethical practice and management, complaints handling, referral of deaths to the coroner and procedures that apply to management of complaints or concerns about clinical staff including appointment, credentialing and performance review of senior clinical staff.~~

~~Support clinical operations to ensure local and statewide policies relevant to patient safety are implemented across the Area.~~

~~**Relates to Standard 2.** Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.~~

~~**Performance measures**~~
~~8.1 AHS have implemented policies to ensure patient safety including policies addressing;~~

• management of incidents and complaints ✓
• complaints or concerns about a clinician ✓
• introduction of new interventions ✓
• implementation of correct patient/procedure/site model policy ✓

8.2 Systems are in place to prompt timely review of policies relating to patient safety and clinical practice ✓

Component Criteria

2.1 Policies and procedures developed
• Health services have developed patient safety policies and protocols. Core set must include:
– incident management ✓
– complaint management ✓
– complaints or concerns about clinicians ✓
– new interventions ✓
– correct patient/site/procedure ✓

2.2 Policies implemented
• Systems are in place to quickly and efficiently disseminate new polices to health facilities in the Area, including NSW Department of Health directives and safety alerts ✓
• Policy and procedures on patient safety have been implemented across the Area. ✓
• Patient safety policies and protocols are regularly reviewed and updated ✓

2.3 Detailed policy review for new interventions
• The Area policy on new interventions is consistent with NSW Department of Health guidelines. ✓
• Risk assessments are undertaken before new procedures are introduced. ✓
• An implementation plan is prepared for each new procedure introduced by the Area ✓

2.4 Correct Patient, Procedure, Site policy
• Health Services have developed an implementation plan for NSW Department of Health Model Policy on Correct Patient/Site/Procedure ✓
• All procedural teams within the Area adhere to the five keys steps identified in the model policy ✓
• Health Services test compliance with the model policy ✓

Function 9 Clinician performance management

Description: Develop an appropriate performance review framework with clinical staff, provide advice and support to clinical operational staff engaged in clinician performance review and report on progress.

Relates to Standard 2. Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

Relates to Standard 4. Complaints management systems are in place and complaint information is used to improve patient care.

Relates to Standard 6. Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

Performance measures

9.1 AHSs have identified a methodology for clinician performance management ×
9.2 Senior clinicians are engaged in performance management ×

Component Criteria

~~4.3 Management of complaints or concerns about individuals~~

~~• Complaints or concerns against individuals are dealt with according to NSW Department of Health policy and within relevant timeframes.~~ ✓

~~6.2 Performance improvement~~

~~• More in depth review of clinician performance is undertaken where clinician performance issues are identified within incident management or practice review activities.~~ ✓

Function 10 Internal reporting

Description: Regularly report to the Chief Executive and Area governance structures on the Area-wide effectiveness of:

10.1 implementation of performance management, appointment and credentialing policies and procedures for clinicians ×

~~10.2 management of complaints or concerns about individual clinicians in accordance with Departmental policies and standards.~~ ✓

~~10.3 management of serious incidents and complaints including their investigation, analysis and recommendations~~ ✓

~~10.4 implementation, by responsible managers and clinicians, of the recommendations arising from RCA and other processes used in handling serious incidents and/or complaints, and~~ ✓

~~10.5 provide a regular summary report of clinical incidents, quality indicators and recommendations on Area-wide actions necessary to improve patient quality.~~ ✓

Relates to Standard 5. Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates. ×

Relates to Standard 7. Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented ×.

Performance measures

10.1 Review of the status of implementation of performance management, appointment & credentialing policies & procedures for clinicians ×

~~10.2 Management of complaint or concerns about individual clinicians~~ ✓

~~10.3 Implementation of recommendations arising from RCA & other processes used in handling serious incidents &/or complaints~~ ✓

~~10.4 Summary report of clinical incidents, quality indicators, recommendations on Area-wide actions necessary to improve patient safety~~ ✓

Function 11 External reporting

~~**Description:** Provide reports to the Clinical Excellence Commission and the Department as agreed by the NSW Department of Health.~~ ✓

Relates to Standard 5. Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates ×.

Relates to Standard 7. Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented ×.

Standards

The NSW Patient Safety and Clinical Quality Program is based on standards against which a health service's quality system will be assessed. These standards are derived from existing Departmental policies and guidelines that are familiar to health service staff, administrators and clinicians building upon existing frameworks, programs and initiatives currently well established in all Area Health Services.

Standard 1
~~Health services have systems in place to monitor and review patient safety.~~ ✓

Standard 2

~~Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.~~ ✓

Standard 3

~~An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.~~ ✓

Standard 4

~~Complaints management systems are in place and complaint information is used to improve patient care.~~ ✓

Standard 5

Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates. ×

Standard 6

Performance review processes have been established to assist clinicians maintain best practice and improve patient care. ×

Standard 7

Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented. ×

Appendix 2: Clinical Governance Unit Workplan July 26 2006

ALL ACTIONS INC COMPLETE

Clinical Governance Unit - Workplan 2006

LEGEND
= DOH requirement
= Deleted
= New
~~strikethrough~~ = completed

✓ = complete
✓× = substantial progress
× = not commenced

	Function	Element	Detailed elements	CGU/NCHI lead or support?	CGU/NCHI lead	Service partners	Original Tar	Target date	Measure	Status	Status May 1st 06	Risk rating	Notes
1	**Structural establishment**											Low	
~~1.1~~		~~Clin gov structure agreed by AHS~~		~~Lead~~	~~DCG~~	~~Exec~~	~~Jan-05~~		~~Sign off by CE~~	~~✓~~	~~Complete~~	~~Low~~	
~~1.2~~		~~Director, NCHI appointed~~		~~Lead~~	~~DCG~~	~~CE~~			~~Appointed~~	~~✓~~	~~Complete~~	~~Low~~	
~~1.3~~		~~Program managers appointed~~		~~Lead~~	~~DCG~~	~~Workforce~~	~~Jun-05~~		~~Appointed~~	~~✓~~	~~Complete~~	~~Low~~	
~~1.3.1~~			~~Patient Focus~~	~~Lead~~	~~DCG~~		~~Jun-05~~		~~Appointed~~	~~✓~~	~~Complete~~	~~Low~~	
~~1.3.2~~			~~Patient Safety~~	~~Lead~~	~~DCG~~		~~Jun-05~~		~~Appointed~~	~~✓~~	~~Complete~~	~~Low~~	
~~1.3.3~~			~~Evaluation & Compliance~~	~~Lead~~	~~DCG~~	~~Internal audit~~	~~Jun-05~~	~~Feb-06~~	~~Appointed~~	~~✓~~	~~Acting Project mgr in place~~	~~Low~~	
			~~Quality System Analyst~~	~~Lead~~	~~DCG~~			~~Feb-06~~	~~Appointed~~	~~✓~~	~~Appointed~~	~~Low~~	
~~1.3.4~~			~~Education Program (NCHI)~~	~~Lead~~	~~Dir NCHI~~		~~Jun-05~~	~~Apr-06~~	~~Appointed~~	~~×~~	~~In recruitment - external~~	~~Low~~	
~~1.4~~		~~Workplan signed off by Exec and CE~~		~~Lead~~			~~Jun-05~~		~~Sign off by CE~~	~~✓~~	~~Approved~~	~~Low~~	
~~1.5~~		~~Qual Gov Committee structure~~		~~Lead~~	~~DCG~~	~~Exec~~	~~Jul-05~~		~~Sign off by CE~~	~~✓~~	~~Approved~~	~~Low~~	
~~1.5.1~~			~~Quality & Improvement committee meets~~	~~Lead~~	~~DCG~~	~~Exec~~	~~Jul-05~~		~~Initial meeting held~~	~~✓~~	~~Met 17th June 05~~	~~Low~~	
~~1.5.2~~			~~Quality System Committee meets~~	~~Lead~~	~~DCG~~	~~Sectors~~	~~Jul-05~~		~~Initial meeting held~~	~~✓~~	~~Meeting 17th July 05~~	~~Low~~	
~~1.5.3~~			~~Integrated Risk Management Committee meets~~	~~Lead~~	~~DCG~~	~~Exec, internal audit, workforce~~	~~Jul-05~~		~~Initial meeting held~~	~~✓~~	~~TOR drafted. Initial meeting~~	~~Low~~	
~~1.5.4~~			~~NCHI Advisory Board meets~~	~~Lead~~	~~Dir NCHI~~		~~Jul-05~~	~~Jul-06~~	~~Initial meeting held~~	~~×~~	~~Deferred indefinitely~~	~~Low~~	~~Deferred indefintely~~
2	**Clinical Incident management**												
~~2.1~~		~~SIP implemented~~		~~Lead~~	~~DCG~~	~~Exec, sectors~~	~~Jun-05~~		~~SIP in place~~	~~✓~~	~~In place~~	~~Low~~	
2.1.1			RCA system	Lead	PSP Man	Sectors	Ongoing		RCAs <65 days 90%	✓	Achieved	Low	
2.1.2			RCA recomm implemented	Support	PSP Man, DCG	Sectors	Oct-05	Feb-06	80% CE approved r	✓	Achieved	Low	Reporting system in place. Reliant on Compliance of Services
~~2.1.3~~			~~RIB reporting through IIMS~~	~~Lead~~	~~PSP Man~~	~~Exec, sectors~~	~~Jul-05~~	~~Jun-06~~	~~RIB notification thro~~	~~✓~~	~~Achieved~~	~~Low~~	
~~2.1.4~~			~~IIMS implemented~~	~~Lead~~	~~PSP Man~~	~~Sectors~~	~~Jun-05~~		~~All sectors using IIM~~	~~✓~~	~~Implemented in all services~~	~~Low~~	
2.1.5			Analysis of incidents	Lead	PSP Man	Performance	Oct-05		analysis and action	✓	Reports provided to QAIC &	Low	
2.1.6			Incidents risk rated	Lead	PSP Man	Clinical ops	Oct-05		Incidents risk rated	✓	Training given to all facilities	Low	Compliance
2.1.7			All clin unit meetings include discussion of incident management	Support	DCG	Clinical ops	Oct-05	Mar-07	100%	×	Facility system now in at RNS, Ryde, NBHS, HKH, Wyong, GDH. Should be in all by June 06	Medium	Link to mortality review

ALL ACTIONS INC COMPLETE

LEGEND
= DOH requirement
= Deleted
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Clinical Governance Unit - Workplan 2006

	Function	Element	Detailed elements	CGU/NCHI lead or support?	CGU/NCHI lead	Service partners	Original Tar	Target date	Measure	Status	Status May 1st 06	Risk rating	Notes
3	**IIMS implementation**												
~~3.1~~		~~IIMS clinical incident reporting~~		~~see above~~	~~see above~~	~~see above~~	~~see above~~		~~see above~~	~~✓~~	~~see above~~	~~see above~~	~~see above~~
4	**Complaints**												
~~4~~		~~Coordinated Area Incident Response System (CAIRS)~~		~~Lead~~	~~DCG~~		~~Jun-05~~		~~Program manager~~	~~✓~~	~~PD developed~~	~~Low~~	~~Redesign of previous pt Focus program~~
~~4.1.1~~			~~Sub-program workplans developed~~	~~Lead~~	~~PFP Man~~	~~Quality Units, workforce~~	~~Aug-05~~		~~Signed off by DCG~~	~~✓~~	~~Broad outline~~	~~Low~~	~~Subsumedin CAIRS~~
4.2		Complaints system established		Lead	DCG	Clinical Ops	Jun-05		Complaints group fo	✓	In place	Low	
4.2.1			Designated senior complaints officer 24X7	Lead	DCG		Jun-05		Roster in place	✓	DCG in role, specified in exec roster	Low	Done
4.2.2			Area complaints management policy	Lead	CAIRS Mgr	Clinical Ops	Jun-05		Policy adopted by E	✓	Approved	Low	Performance measured
~~4.2.3~~			~~Complaints recorded in IIMS~~	~~Lead~~	~~PFP Man~~	~~Clinical Ops~~	~~Sep-05~~		~~Module activated~~	~~✓~~	~~In place~~	~~Low~~	
4.2.4			Support system for complaints mgrs	Lead	CAIRS Mgr	Sectors	Jul-05		System established	✓	Requires further formalisatic	Low	Part of CAIRS
4.2.5			Training & awareness for front-line staff	Lead	CAIRS Mgr	Workforce	Jan-06	Dec-06	Awareness package	×	System to be designed. Likely to be Nov/Dec	Low	
4.3		Area-wide reporting system											
~~4.3.1~~			~~Process indicators reported to QAIC~~	~~Lead~~	~~PFP Man~~	~~Performance~~	~~Sep-05~~		~~Indicators reported~~	~~✓~~	~~Completed~~	~~Low~~	
~~4.3.2~~			~~Content analysed and reported to QAIC & Exec~~	~~Lead~~	~~PFP Man~~	~~Performance~~	~~Sep-05~~		~~Content analysis tak~~	~~✓~~	~~Completed~~	~~Low~~	
4.4		Patient satisfaction											
4.4.1			Patient satisfaction surveys in place	Lead	PFP Man	Sectors	Jun-05		Surveys completed	✓	First cycle completed	Low	**Move to PPP**
4.4.2			Patient satisfaction analysed and reported to QAIC, Exec and other committees	Lead	PFP Man	Performance	Jul-06		Report to QAIC	✓	Analysis referred to QAIC in	Low	**Move to PPP**
5	**Death reviews**												
5.1		System in place to review all deaths within 45 days of th		Lead	NCHI	Clinical Ops	Dec-05	Dec-06	System established	✓×	Facility system now in at RNS, Ryde, NBHS. Advanced implementation at HKH, Wyong. Should be in all by June 06	Medium	Complexity
5.1.1			Clinicians know how to put a case forward for M&M review	Lead	NCHI	Clinical Ops	Dec-05	Dec-06	100% on sample su	×	Facility system now in at RNS, Ryde, NBHS, HKH, Wyong, GDH. Should be in all by June 06	**Medium**	Complexity
5.1.2			Event recognition & reporting system	Lead	PSP Man	Clinical Ops	Aug-05	Dec-06	System established	✓	Local screening occurs but this requires validation	Medium	Complexity
5.1.3			Triage & referral system	Lead	PSP Man	Clinical Ops	Aug-05	Dec-06	System established	✓×	Local systems in place	Medium	Complexity
5.1.4			Clinical governance process designed	Lead	DCG & Dir NCHI	Clinical Ops	Aug-05	Dec-06	Signed off by QAIC	✓×	Now part of broader Clin Gov system	Low	
5.1.5			Qualified privilege committees established	Lead	DCG & Dir NCHI	Legal officer	Dec-05	Dec-06	Committees in all se	×	Facility system now in at RNS, Ryde, NBHS, HKH, Wyong, GDH. Should be in all by June 06	**Medium**	Legal complications
5.1.6			Data analysis system	Lead	PSP Man	Performance	Sep-05	Dec-06	Mortality data report	✓	Quality System Analyst appointed, data being collated	Low	Complexity
5.1.7			Links to risk management system	Lead	PSP Man	Exec	Sep-05	Dec-06	Links documented	✓×	Planned	Low	
5.1.8			Reporting on performance to QAIC & Exec	Lead	PSP Man	Performance	Feb-06	Dec-06	Report to QAIC	✓×	Quality System Analyst appointed, data being collated	Low	
5.2		Mandatory reporting of deaths to SCIDUA, SCIDAWS a		Lead	DCG	Clinical Ops	Aug-05	Dec-06	Proportion reported	×	Some reporting occurs. CEC reviewing system	High	Resistance
5.2.1			Clinicians aware of responsibility	Lead	DCG	Clinical Ops	Dec-05	Dec-06	Sample survey	✓×	Not commenced. CEC reviewing system	Medium	Complexity
5.2.2			Tracking system implemented	Lead	PSP Man	Clinical Ops	Dec-05	Dec-06	Sample survey	✓×	Not commenced. CEC reviewing system	Medium	Complexity
5.2.3			Reporting on performance to QAIC & Exec	Lead	PSP Man	Performance	Feb-06	Dec-06	Report to QAIC	✓×	Not commenced. CEC reviewing system	Medium	Validity of measures

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6	**CQI Support**												
6.1		NCHI education program established		Lead	Dir NCHI	Workforce	Jul-05		CPI program design	✓	Planned	Low	
6.1.1			CPI internal training	Lead	Dir NCHI	Workforce	Jul-05		CPI course conduct	✓	CCH Course conducted, RNSH/ NBHS cost reduction trining	Low	
6.1.2			CPI external training	Lead	Dir NCHI		Jul-05		CPI course conduct	✓	External courses continuing	Low	
6.1.3			Short courses: quality tools, CPI for execs	Lead	Dir NCHI	Workforce	Aug-05	Dec-06	Short course conduc	×	Awating appoinment of NCH	Low	
6.2		Links to other area programs established											
6.2.1			CSRDP	Support	Dir NCHI	CSRDP Comm	Jul-05		Participate in CSRD	✓	DCG exec lead for MH ED project	Low	
6.2.2			Patient safety	Lead	PSP Man; Dir NCHI	Workforce	Jul-05		Safety projects supp	✓	Ongoing e.g. correct site, pressure care	Low	
7	**Communication & Training**												
7.1		Process improvement (see NCHI education program)		Lead	Dir NCHI	Workforce	Jul-05		see above	✓	see above	Low	
~~7.2~~		~~Safety Improvement Program training~~		~~Lead~~	~~PSP Man~~	~~Workforce~~	~~Jul-05~~		~~Program designed~~	~~✓~~	~~In place~~	~~Low~~	
~~7.2.1~~		-	~~RCA training~~	~~Lead~~	~~PSP Man~~	~~Clinical Ops~~	~~Jun-05~~		~~Staff trained~~	~~✓~~	~~Ongoing~~	~~Low~~	
~~7.2.2~~			~~RCA train the trainer~~	~~Lead~~	~~PSP Man~~	~~Clinical Ops~~	~~Jun-05~~		~~Trainers trained~~	~~✓~~	~~In place~~	~~Low~~	
7.3		Communication	to be developed	Lead	DCG	Exec	Mar-06	Open	To be developed	×	Awaiting CEC decision	Medium	Complexity
8	**Liaison between Health Service & CEC**												
8.1		Collaboration with CEC on programs and policy develop		Lead	DCG & Dir NCHI	Exec	Jun-05		Demonstrated liaiso	✓	In place. Wyong review	Low	
8.2		Support for Quality System Assessment		Lead	DCG	Exec	Aug-05	Apr-06	QSA strategy signed	✓	Piloting QSA Jul 06	Low	
8.2.1			Appt A/Accreditaiton Manager	Lead	DCG	Performance, Internal audit	Aug-05	Apr-06	Program signed off	✓	In place	Medium	Complexity, buy in
8.2.2			Link to performance agreements	Lead	DCG	Performance	Dec-05	Apr-06	Successful QSA	✓	In place	Low	
8.3		Participate in state level policy & system development		Lead	DCG		Jun-05		Attendance	✓	In place	Low	
8.3.1			CGU Directors meeting	Lead	DCG & Dir NCHI		Jun-05		Attendance	✓	In place	Low	
8.3.2			DOH committees & working parties	Lead	DCG & Dir NCHI		Jun-05		Attendance	✓	In place	Low	
9	**Policy Development**												
9.1		Develop clinical policy governance system		Support	DCG	Mgr Exec Unit	Aug-05	Apr-06	Policy system in pla	✓	In place	Low	
9.1.1			Policy prioritisation	Support	DCG	Mgr Exec Unit	Aug-05	Jun-06	Policy prioritised ex	✓	In place	Low	
9.1.2			Links to risk man etc	Lead	DCG	Exec, Internal audit	Jul-05	Jun-06	Risk and policy links	✓	Designed in principle	Low	
9.1.3			Performance measures	Lead	Accred Mgr	Performance	Aug-05		Policy implementati	✓	Pt Safety indicators in place	Low	
9.2		Review policy implementation		Support	Accred Mgr	Internal audit	Mar-06	Dec-06	Key policies verifiec	×	Not commenced	Low	QSA, Accreditation
10	**Clinician performance management system**												
10.1		Build system capability		Support	DCG	Clinical Ops; Workforce	May-05	Jun-06	Clin perf mgmt syst	×	Planned	Medium	**Move to Workforce**
10.1.1			Evaluate system	Support	CEP Man	Clinical Ops; Workforce	May-05	Jun-06	Clin performance m	×	Awaiting development of pla	Medium	**Move to Workforce**
10.1.2			Training for line managers	Support	NCHI	Workforce	Dec-05	Jun-06	Line managers knov	×	Not commenced	Medium	**Move to Workforce**
10.1.3			Links to risk man etc	Support	DCG	Exec	Dec-05	Jun-06	Clin at risk identif w	×	Awaiting development of pla	Medium	**Move to Workforce**
10.1.4			Performance measures	Support	CEP Man	Performance	Dec-05	Jun-06	% Clinicians having	×	Awaiting development of pla	Medium	**Move to Workforce**
10.2		Quality & safety dialo	Line mgrs est dialogue with sen clin re Q&S	Support	NCHI	Clinical Ops	Dec-05	Open	N/A	×	Awaiting CEC decision	Unknown	DOH developing guidelines
			Guidelines for dialogue & interaction	Support	NCHI	Clinical Ops; Workforce	Dec-05	Open	N/A	×	Awaiting CEC decision	Unknown	DOH developing guidelines
10.3		Assist with clinical performance issues		Support	DCG	Clinical Ops; Workforce	Jun-05		Survey re CG suppo	✓	In place	Low	
11	**Integrated risk management**												
11.1		Design integrated risk management system		Lead	DCG	Exec	Aug-05		IRM committee worl	✓	started	Medium	Complexity
11.1.1			Policy	Lead	DCG	Exec	Aug-05		IRM policy signed o	✓	Approved by mgmt Bd	Low	
11.1.2			Governance systems	Lead	DCG	Exec	Aug-05	Jun-06	Risks documented a	✓×	System in place at area leve	Low	
11.1.3			Data systems	Support	PSP Man	Performance	Aug-05	Feb-06	Risk register functio	×	Project support to be recruit	Medium	Technically difficult
11.1.4			Evaluation	Support	CEP Man	Internal audit	Dec-05	Jun-06	Audit completed	✓×	Not commenced	Low	QSA, Accreditation
12	**Accreditation**												
~~12.1~~		~~Area accreditation strategy~~		~~Lead~~	~~DCG~~	~~Exec~~	~~Dec-05~~	~~Apr-06~~	~~Strategy signed off~~	~~✓~~	~~Complete~~	~~Low~~	
12.1.1			Coordination of accreditation activities	Lead	CEP Man	Clinical Ops	Nov-05	Apr-06		✓	Acting Project mgr in place	Low	
12.1.2			Core documentation	Lead	CEP Man	Clinical Ops	Nov-05	Jun-06	Documentation avai	✓	Draft 2004	Low	
12.1.3			Link outcome to action systems	Support	CEP Man	Clinical Ops	Nov-05	Jun-06	Action plans in plac	✓	ad hoc	Low	
12.1.4			Liaison with accrediting bodies	Lead	DCG, CEP Man		Jun-05		N/A	✓	ad hoc	Low	

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13	**Quality and Safety review issues**												
13.1		Communication of safety alerts, notices etc		Lead	PSP Man		Mar-06	Aug-06	System verified	✓	Audit designed, workign grou	Low	
13.2		Clinical data management		Support	DCG	ISD	Jul-06	Open	N/A	✓	Project level links	Low	
13.3		New Clinical Technology		Support	CEP Man	Clinical Ops	Dec-05	Open	Policy used routinel	×	Policy issued	Medium	**Move to PPP**
13.4		Best practice guidelines		Support	NCHI	Clinical Ops	Dec-06	Open	Protocols for major	×	Planned	Medium	**Remove**
13.5		Blood & Blood Products Utilisation & Practice Improvem		Lead	DCG	Clinical Ops; PaLMS	Dec-05	Nov-06	Clinical & Performai	✓	Labelling FMEA done; proj officer in place; committee established	Medium	Complexity
14	**Selected specific programs**												
14.1		Infection Control & Prevention											
14.1.1			Governance established	Lead	PSP Man			Dec-05		✓	Committee in place	Low	
14.1.2			Project manager appointed	Lead	PSP Man			Dec-05		✓	Mgr appointed	Low	
14.1.3			Business plan developed & submitted	Lead	PSP Man			Feb-06		✓	Outline developed at workshop Dec 05	Low	
14.1.4			Business plan implemented	Lead	PSP Man			Feb-07		✓	Drafted	Medium	
14.1.5			Hand Hygiene Campaign	Lead	PSP Man			Feb-07		✓	Program launched	Low	
14.1.6			External review	Lead	PSP Man			Oct-06		✓	Commissioned	Low	
14.2		Open disclosure	System Design & implementation	Lead	CAIRS Mgr			Oct-06		×	Pilots selected, strategy dev	Medium	
14.3		Correct site procedure	Implementation & verification	Lead	PSP Man			Sep-06		✓	Progam 70% complete	Low	
14.4		Pressure care	Implementation & verification	Lead	PSP Man			Jul-06		✓	Rolling implementation	Low	
14.5		Wound care	Scoping	Lead	PSP Man			Jul-08		✓	Program launched	Low	
14.6		Mattresses & beds Pr	Scoping	Lead	PSP Man			Dec-06		×	Scoping just commenced	Low	
14.7		Nutrition program		Support	DCG			Jun-07		✓	Recruitment complete	Low	
14.8		Medication Safety program		Support	DCG			Dec-06		✓	Proj officer recruited	Low	
14.8.1		National Inpatient Medication Chart		Lead	DCG			Mar-07		✓	Proj officer recruited	Low	
14.9		Safer Sys Saving Lives		Lead	PSP Man			Feb-07		×	Awaiting funds	Low	

The Professional Practice Unit is <u>NOT</u> responsible for:

- All complaints that arise in NSCCAHS
- Grievances between our staff unless they have serious clinical implications
- General performance concerns or non clinical disciplinary issues
- Allegations of corrupt conduct or other misconduct not associated with patient care (ie fraud).

  (These issues will remain primarily the responsibility of service or line managers).

CONTACT DETAILS

<u>AREA PROFESSIONAL PRACTICE UNIT</u>

8am to 5pm Monday to Friday except public holidays

Mary Dowling
Manager, Professional Practice Unit
Telephone: 9926 8418
Facsimile: 9926 6025
Email: madowling@nsccahs.health.nsw.gov.au

Key healthcare facilities administered by Northern Sydney Central Coast Area Health Service

North Shore and Ryde

Royal North Shore Hospital
Ryde Hospital

Central Coast

Gosford Hospital
Wyong Hospital
Woy Woy Hospital
Long Jetty Hospital

Northern Beaches

Manly Hospital
Mona Vale Hospital

Hornsby Ku-ring-gai

Hornsby Ku-ring-gai Hospital

Mental Health

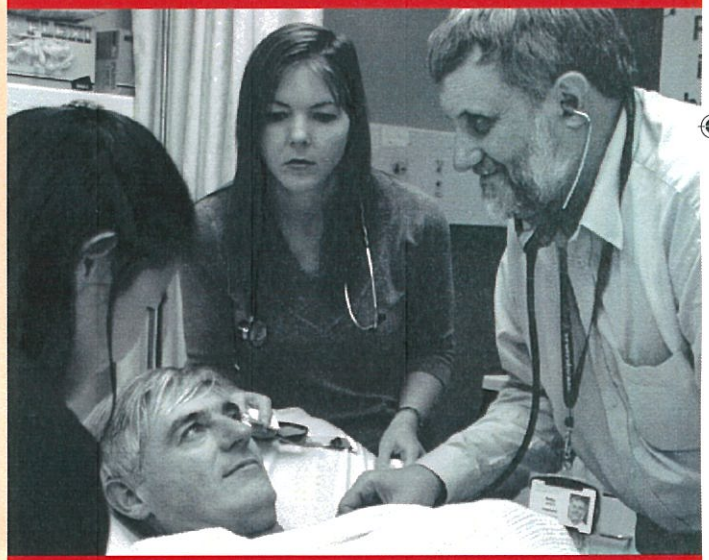
Macquarie Hospital

Primary and Community Care

CATALOGUE NUMBER 09283

Professional Practice Unit

Providing Specialist Assistance in the Management and Investigation of Professional Practice Issues



NORTHERN SYDNEY CENTRAL COAST
NSW HEALTH

When members of staff should contact the Professional Practice Unit

If you have a concern about an area of professional practice which you feel should be investigated, or if you are in a managerial position and would like assistance with the investigation of a professional practice issue we are available to assist with all aspects of the management and/or investigation of a concern about a member of staff.

If a patient or relatives have a complaint or concern

The hospitals and healthcare facilities that make up Northern Sydney Central Coast Area Health Service (NSCCAHS) aim to deliver the highest possible standard of healthcare.

If you have any concerns about the treatment provided to you, or a relative, you are encouraged to communicate this to your healthcare facility at the local level. You can expect any complaint, verbal or written to be dealt with quickly by the hospital's complaint service. Your issue will not adversely affect the service you receive.

When patients or relatives should contact the Professional Practice Unit

If you feel your concern has not been resolved then you are invited to contact the Professional Practice Unit, we want to resolve your concerns to your satisfaction.

Our Professional Practice Unit offers an alternative for you and your relatives if you are not happy with the care or treatment provided in any of our facilities.

Our approach

The Professional Practice Unit conducts transparent and objective investigations into serious complaints and grievances. We plan, manage and conduct investigations with a view to ensuring that all of the relevant evidence is analysed and that all of the interested parties have the opportunity to make their position known in a fair and impartial forum.

We aim to

Continue to build on ethical work standards, practices and professional conduct across NSCCAHS.

- Ensure effective responses to complaints and conduct issues.
- Strengthen incident management and reporting systems.
- Support clinical and managerial staff through relevant training education and advice to enable system-wide reliable and timely investigations.

How we work

The Professional Practice Unit staff have legal clinical and mediation skills to appropriately and promptly assess concerns and grievances of patients, relatives and staff.

Contact with families and consumers in individual cases under investigation by the unit is carefully managed to ensure communication is swift, accurate and confidential.

The Professional Practice Unit works closely with the Clinical Governance Unit, Workforce Directorate, Nursing & Midwifery, Senior Medical Staff Unit and other units of the Health Service.

The unit assists in training programs for the staff of NSCCAHS in relation to the:

- Code of Conduct and Ethical Practice
- Investigation of serious consumer complaints

In its investigative function the Professional Practice Unit liaises with external agencies including:

- Health Care Complaints Commission
- NSW Ombudsman
- Independent Commission Against Corruption
- NSW Coroner
- NSW Department of Health
- Employment Screening and Review Branch
- Anti-Discrimination Board of NSW