Supplementary Submission

No 33a

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Summary

NSW HEALTH
DEPARTMENT
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3rd December 2007

Reverend the Hon Fred Nile MLC
Chair
Joint Select Committee on the Royal North Shore Hospital
Parliament House
Macquarie St
Sydney NSW 2000

Dear Reverend Nile

Re. Department of Health Supplementary Submission to the Joint Select Committee Inquiry on the Royal North Shore Hospital.

Please find attached a supplementary submission from the Department of Health. I have had the benefit of reading the transcripts and formed the view that some of the important issues raised could benefit with additional clarification. The topics covered include workforce, the capital redevelopment, efficiency and hospital capacity.

Thank you for the opportunity to provide this additional material and I trust it will be of assistance to the Committee in its drafting of the final report.

I look forward to receiving the Committee's final report and I would like to take the opportunity to acknowledge the assistance of the Parliamentary staff working with the Joint Select Committee.

If you require anything further please do not hesitate to contact Deborah Willcox, Director, Executive and Ministerial Services (9391 9642)

Yours sincerely

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1. WORKFORCE

A number of comments have been made about workforce in evidence and submissions. I feel that some additional clarification is needed to correct inaccuracy and place these assertions in context and provide the following additional information:

1.1 Number of Emergency Department clinicians:

It has been asserted that New South Wales needs to increase the number of Emergency Department physicians by about 104 to become at least equivalent to Victoria.

According to the Australasian College for Emergency Medicine (ACEM) Annual Report the number of Fellows of the College in NSW as at September 2007 was 234 compared to Victoria with 254. These figures are a headcount not a full time equivalent therefore it is difficult to draw any conclusions about how many hours of Emergency specialist staffing is available for Emergency Departments in either State.

Service models and other workforce roles determine the number of emergency specialists required. An expert group is being established to consider the optimum staffing profile in Emergency Departments. There have been significant changes in service delivery models in emergency and this work is continuing. It is therefore timely to update and take into account the new service models and workforce roles, such as nurse practitioners and hospitalists, in considering our future emergency workforce needs.

In relation specifically to Royal North Shore, statements were made that the Department of Health submission had provided incorrect data in relation to the number of Emergency Department specialists employed in the Emergency Department at the Royal North Shore Hospital.

The Department's submission states there are 10.55 Emergency Department staff specialists at the RNS, in contrast to the evidence of clinicians who indicate they have 9.8 positions, of which 8.8 are filled.

As part of the special case before the Industrial Relations Commission regarding emergency specialists, the Australian Medical Officers Federation (ASMOF) and the NSW Health Department conducted a survey of doctors on the specialist roster in Level 3 – Level 6 Emergency Departments.

The Department and ASMOF submitted a joint report on the survey to his honour Justice Boland in July 2007 as part of the Emergency Specialists case before the Industrial Relations Commission. The survey report identifies 10.55 FTE doctors on the specialist roster at Royal North Shore emergency department with a further 1 FTE vacancy.

Preliminary results of a subsequent survey in September 2007 indicate a current staffing of 11.3 FTE including a vacancy of 1.5 FTE. The discrepancy of 0.25 FTE will be further discussed with the Area Health Service to assist in clarifying the situation.

1.2 Status of the Australian Medical Workforce Advisory Committee (AMWAC) guidelines:

The Australian Medical Workforce Advisory Committee (AMWAC) was a national group created to support projection modelling for medical staff. The AMWAC conducted two separate reviews of the Emergency Medicine workforce over a period of six years with conflicting recommendations.

The Australasian College for Emergency Medicine (ACEM) was represented on the review and in developing the 2003 AMWAC report the College recommended staffing benchmark numbers to be used to project workforce requirements. The evidence or methodology used to support the development of these benchmarks is not apparent from the report itself.

The final 2003 report noted that the AMWAC recommendations were made on the basis of a particular service model and that jurisdictional implementation may be modified by any significant changes that occur over time to service delivery models.

Since 2003 there have been significant changes in service delivery models in emergency and this work is continuing. It is timely to update on any previous reports and take into account the new service models and workforce roles, such as nurse practitioners and hospitalists, in considering our future emergency workforce needs.

It is worth noting that the lack of alignment between service and workforce planning informed a review of Health Minister's Advisory Council Committees in 2006, following which AMWAC was disbanded.

NSW Health is establishing an expert group to consider optimum staffing profiles for Emergency Departments to meet the agreed service model. A range of reports including AMWAC will inform this work.

1.3 Concerns regarding the number of specialists to train young emergency physicians:

Based on the ACEM Annual report NSW has 234 Fellows of the College, which represents 27 % of all emergency physicians nationally and is a 13 % increase since September 2006. This means that NSW has the second highest number of specialists in Australia and together with current vacancies would most likely mean that NSW has the highest number of specialist positions available.

Trainees can only train in hospitals that have been accredited by the professional college representing specialists (ACEM). As at October 2007 there were 30 hospitals accredited for training by ACEM in NSW compared to only 21 hospitals in Victoria.

Royal North Shore is accredited by the ACEM to allow for trainee specialists to train for the maximum training time of 2 years.

The number of emergency medicine trainees (provisional and advanced trainees) increased in NSW by 13.46 % between 2005 and 2006 (208 to 236).[1]

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[1] MTRP 2005 T3.2 & 3.11 and 2006 T 4.2 and T 4.5.

Funding has been announced to support implementation of Area Health Service based service and training networks to provide for expansion of emergency specialist trainee rotations to outer metropolitan and rural/regional centers and so increase the number of training sites even further.

1.4 Use of Locums:

There was a statement that 50 percent of positions in emergency medicine are filled by overseas trained doctors and locums.

Ethnicity and/or country of qualification is not a determinant of clinical competence and the payroll system does not therefore record the country of origin or the country of initial qualification of staff working in the public hospital system. It is therefore not possible to comment on the number of doctors who graduated from international medical schools and are working is particular areas of the health system

It is of concern that over the past ten years there has been little growth in Australian medical graduate numbers, this together with an international shortage of medical staff means that Australia struggles in meeting community requirements for these professionals. To supplement this shortage, health services engage a range of strategies including international recruitment and use of doctors who choose to work extra shifts to support their incomes. Regardless of whether a doctor is an Australian or international graduate, those working in the NSW public hospital system must be registered by the NSW Medical Board.

1.5 Staff Specialists Award:

Recent events in the Industrial Relations Commission may be of some relevance to the Committee when considering the complex issues around workforce.

A new Staff Specialists (State) Award (the Award) was made on 28 April 2006. A new Emergency Physician Staffing Determination was also agreed to as part of the negotiations of the new Award. The Determination allowed for a 25% allowance payable (up to $58,000 pa) to any Emergency Physician that agreed to work at least 15 clinical shifts at locations beyond the scope of their normal work location/s (regional locations).

The Department agreed on the understanding that the new Award provisions would be implemented (i.e. working 5 days per week as opposed to the current practice of 4 days per week) and as a consequence more shifts would be made available at the primary location and for the special service shifts in the regional locations.

Despite it being an agreed award provision, emergency physicians commenced an industrial campaign against any proposal to roster them over 5 days per week, or to reduce their "non clinical" rostered time. The emergency physicians wanted the 25% allowance to be paid essentially as an attraction and retention allowance without any change to their current work practices.

After a number of iterations, including private conferences before Boland J of the NSW Industrial Relations Commission, the Department and the Australian Salaried Medical Officers Federation (ASMOF) agreed to accept the IRC determining the basis and preconditions for paying the special service allowance.

Boland J handed down his recommendation on 6 August 2007 which recommended payment of the Special Service allowance on the terms put forward by the Department, namely that the emergency physician:

- enters into a rostering arrangement as determined by the employer over five days per week; and
- provided fifteen clinical shifts per annum at locations outside the work locations clause under the Award.

The position description implementing the above is close to completion and it is hoped it will be released to the system shortly.

2. REDEVELOPMENT OF ROYAL NORTH SHORE HOSPITAL

The redevelopment of Royal North Shore Hospital is to date the State's single largest capital investment in health at a cost of $702 million. The development is being delivered via a private public partnership and a considerable amount of planning work has been done and with clinician involvement. The process of identifying a proponent has slowed some of that consultation for commercial reasons.

A number of clinicians have expressed concern as to the level of engagement they have experienced in this important process and question the adequacy of the planning to date. Under the new Chief Executive, the engagement of the clinicians will be considerably accelerated over the coming months particularly as the planning needs to be refined.

The planning of health services is an iterative process; involving detailed studies of population demand, clinical consultation and scenario modelling in an effort to ensure we can continue to meet the needs of the community well into the future.

2.1 Outline of the planning process

Since the early 1990s, long term acute inpatient demand modelling in NSW has been based on the projection of specialty service and age-specific trends in admission rates and length of stay. This methodology has been subject to regular review and clinical consultation as part of improving and refining the methodology and being able to take advantage of increased data availability and computer processing capacity.

The most recent version of this approach is ***aIM2005 (Acute Inpatient Modelling tool)***, a program that allows health service planners to model demand and supply scenarios within a defined population catchment. The program allows health service planners to project future activity by taking into account the main drivers of future demand for health services – trends in hospital admissions, population growth and population ageing.

The methodology used is broadly consistent with that of long-term projection tools used in other jurisdictions in Australia and internationally including the United States of America, Canada and the United Kingdom.

The projections produced assume that the *pattern* of service provision remains broadly similar to the current pattern of service delivery (e.g. location of services, patient flows), and this is then tested through clinical consultation. However, more importantly, the program also enables health service planners to undertake **scenario modelling** at the local level to model the possible impacts to changes in service

provision such as the opening of a new hospital, impact of clinical networking or providing new clinical services at existing hospitals.
The projections relate to acute care; defined as care in which the clinical intent or treatment goal is to: manage labour (obstetric); cure illness or provide definitive treatment of injury; perform surgery; relieve symptoms of illness or injury (excluding palliative care); reduce severity of an illness or injury; protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; perform diagnostic or therapeutic procedures. (Australian Institute of Health and Welfare, 2007).

The *aIM2005* model is based on three main sources of data – the New South Wales Admitted Patient Data Collection, small-area population estimates and population projections (sourced from the Australian Bureau of Statistics and the New South Wales Department of Planning).

In addition the modelling reflects recent trends in clinical practice. The projections outline the volume and type of work that can be anticipated if population projections are correct and the trends in service utilisation continue into the future.

Where utilisation rates in some specialties were variable, these rates were reviewed with specialists from the clinical specialities, which guided decisions regarding the rate to be used for projections. This qualitative component of the modelling revealed important trends in clinical practice.

It is important to note that service planning is not undertaken on a facility-by-facility basis in isolation of the service planning networks operating across Area Health Services.

The major assumptions incorporated into the modelling for future activity at the Royal North Shore Hospital included:

- Continuation of the broader role of RNSH in the provision of state-wide services, such as spinal, burns and trauma;
- Achievement of the day surgery target of 60% by 2011;
- The impact of the changes to the resident veteran population on public hospital demand;
- 90% of non-tertiary, non-emergency patients from the Central Coast treated at RNSH and Hornsby hospitals will be treated locally by 2011;
- Flows for Western Sydney residents would continue, as the flow patterns indicate that the vast majority of patient flows between the two Areas constitute 'natural flows' and are not amenable to flow reversal strategies
- That some Northern Beaches residents currently travelling to RNSH for non-tertiary care would receive treatment at the new Northern Beaches hospital; and
- The percentage of care provided in private hospitals in Northern Sydney would not change.

As a result of using *aIM2005*, there was an increase in the estimated number of acute bed numbers. This was a result of the revised population forecasts contained in the *aIM2005* and a shift in the planning horizon from 2011 to 2016. The requirement for overnight acute care beds (excluding mental health, maternity and paediatrics) increased from 267 to 300.

NSW Health will work with the new Chief Executive to ensure the engagement of clinicians, nurses and allied health professionals is both rigorous and complimentary

to the planning process and ultimately delivers for the community that will benefit from this redevelopment.

3. EFFICIENCY OF ROYAL NORTH SHORE HOSPITAL

The issue of poor financial performance was outlined in the Department's primary submission. It is clear that a lack of clinical engagement has limited clinicians' access and input into financial information and analysis. The establishment of the Clinical Reference Group is the first step in addressing this problem.

Some clinicians have raised concerns about the accuracy of the cost data presented in the NSW Health submission. It should be noted that the Department's comparison utilises data provided by the Area Health Services.

To further assist the Committee in its assessment of efficiency and resource utilisation the following additional information is provided.

	RNS 07/08	RNS 06/07	NSW Peer average 07/08	NSW Peer average 06/07
Average staff cost Total expenses ($000)	136	146	123	131
Number of separations per FTE	18.4	18.7	21.7	22.2
Number of occupied bed days of FTE	73.2	74.1	79.4	88.1

In summary, these figures highlight that the RNS, has higher staff costs, with fewer separations and lower occupancy as compared to its peers.

In addition, there has been reference to New South Wales as it compares with Victoria in terms of cost.

New South Wales costs are higher than Victoria across some key areas[2]:

(1) 6.4 percent higher nursing cost per weighted separation

(2) 9.3 percent lower for salaried/sessional staff cost per weighted separation

(3) 164.9 percent higher VMO payments per weighted separation

(4) 68.6 percent higher private patient cost per weighted separation;

This results in a *total medical labour cost 22.7 percent higher* per weighted separation than Victoria.

[2] Australian Hospital statistics 2005-2006

4. HOSPITAL CAPACITY

A number of clinicians raised the issue of occupancy rates in the context of complaints about hospital capacity, claiming that 85% occupancy was the accepted benchmark.

As yet there is no accepted universal 'standard' percentage occupancy benchmark for hospitals. There is still much debate in the literature and research about what constitutes a safe, efficient and cost-effective level of hospital occupancy.

Many acknowledge that an acceptable occupancy rate probably sits in the 80-90% range but this is still greatly dependent on hospital type, size, scale and complexity. In the short term, hospital occupancy can legitimately oscillate quite markedly with demand.

NSW Health is however aware that Royal North Shore Hospital occupancy rates have ranged between 88 and 94 percent over the last two years. This is consistent with peer hospitals over the same period. The development of strategies to manage demand is key. The learnings from the clinician driven initiatives across the system are invaluable.

It is widely accepted that the provision of additional beds is not the single answer to meeting the ever-growing demand for services. The Clinical Service Redesign Project is a fundamental plank in supporting the health care needs of the community, as is sustainable access planning and the development of alternative models of care for groups of patients such as the elderly.

As identified in detail in the Department's primary submission Royal North Shore has been less efficient than its peers; performing less work at a higher cost. However, in response to the access strategies being implemented by the new Executive there are positive signs of improvement.

The latest performance information provided by the hospital shows a strong upward trend across the key emergency department performance indicators. Triage category 3 performance continues to improve, and at 84 per cent is well above the national benchmark of 75 per cent of patients treated within 30 minutes. Similarly, triage category 4 performance continues to show very strong improvement, with the most recent result of 89 per cent being well above the national benchmark of 70 per cent of patients treated within one hour. Performance has also improved on the benchmarks for patients entering the emergency department from ambulance and moving from the emergency department to a ward bed.