Submission

No 54

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Submission to the Committee conducting the Parliamentary inquiry into the Royal North Shore Hospital (RNSH)

I refer to the Inquiry's first term of reference and make the following complaints submission related to the Medical Oncology service:

1. *.. a joint select committee... inquire into and report on the quality of care for patients at the Royal North Shore Hospital, and in particular:*
   (a) clinical management systems at the hospital
   (b) the clinical staffing and organization structures at the hospital,
   (c) the efficiency, effectiveness and appropriateness of resource allocation..

(a) Clinical management systems in Medical Oncology

The Medical Oncology service at the Royal North Shore Hospital is severely lacking a modern IT infrastructure to support **inter-departmental communication** for **patient care**, in addition to its inability to record and **track** relevant statistics on cancer incidence, **patterns of care and treatment outcomes**. An accessible data base allowing Emergency Department and On-call Medical Oncologists access to patient letters will greatly enhance acute care via the emergency department. The minimum provision to record such episodes of care in the electronic patient record will allow for continuity of information across clinical services – currently this is dependent on a "paper trail" that often goes missing. This communication is vital in minimizing risk to patients receiving

strong chemotherapy drugs. Furthermore a modern day electronic chemotherapy prescription program is required to minimize chemotherapy prescription errors.

This lack of modern IT infrastructure places RNSH behind the all the major metropolitan Cancer Services, including the new Macarthur Cancer Therapy Centre in Campbelltown Hospital. **The solution is to purchase a modern IT program relevant to cancer practice** – such a request has been submitted by the new Director of Cancer Services. However, historically, the budgetary shortfalls of the hospital have meant that minimally essential equipment such as this are not supported.

(b) the clinical staffing and organization structures at the hospital; and
(c) the efficiency, effectiveness and appropriateness of resource allocation..

(b) Modern medical Oncology practice is predominantly an outpatient service. It is also a pivotal consulting service that bridges other disciplines – surgery, diagnostics including diagnostic medical specialties and pathology. The scope of medical oncology service has increased greatly over the last decade and new minimum standards of multidisciplinary team care have been mandated by the NSW Cancer Institute under the Cancer Act.

Consequently standard hospital patient demographic information based on inpatient services do not accurately reflect the size of the service, nor its greatly increased consultancy-based workload. As such arguments for additional staffing are difficult to mount and gain institutional support. **It has been widely acknowledged amongst its peer group that the Medical Oncology Department of Royal North Shore Hospital has been relatively understaffed compared with its comparative major metropolitan teaching hospital departments** – Sydney Cancer Centre, Westmead and St George Hospitals (see Appendix I).

Consequently there is diminished quality in patient care as cancer patients are seen less frequently in order to meet the workload and research and teaching has suffered. Furthermore, the registrar base in the Medical Oncology department has not been expanded to meet the increased clinical workload. This has adversely affected the quality of the advanced training experience at RNSH. **The immediate solution required to re-establish the RNSH Medical Oncology department as a centre of excellence in service provision and specialist training is to increase its medical workforce** (at least 1 FTE Medical Oncologist and 1 additional registrar position).

(b) and (c). In **1998 RNSH established the "privatized" Ambulatory Care unit and shifted the existing dedicated outpatient medical oncology clinic** from its location adjacent to radiation oncology to the main building, consolidating outpatient haematology, renal and medical oncology services into one unit. Whilst this model of care worked well in terms of efficiency in centralizing nursing care and common overlapping treatments eg blood transfusions, it **diminished the overall quality of cancer care,** particularly for patients receiving both chemotherapy and radiotherapy by **de-centralizing the service** - as the distance between the units is substantial, and **de-identifying the "cancer clinic".**

It is worth noting that this move was undertaken for the financial benefit of the newly formed "Division of Medicine" and was not recommended by the Medical Oncology department. Similarly sized cancer services such as St George Hospital have managed to preserve their co-located medical and radiation oncology clinics whilst also establishing an Ambulatory care unit. **A solution is not expected in the current hospital physical framework, however a mantra to encourage co-location of necessary services in the proposed new hospital is vitally important, as once built this cannot be reversed.**

Yours sincerely,

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Dr Nick Pavlakis

Appendix I

The 2001 Australian Medical Workforce Advisory Committee (AMWAC) identified that there will be an increased shortfall in the Medical Oncology workforce between 2001-2011. Conservative estimates of the RNSH clinical load based on the incomplete data bases available, indicate that the current Medical Oncology establishment sees in excess of 1200 new patients/ year and provides in excess of 9800 outpatient consultation episodes annually and in excess of 4500 chemotherapy outpatient episodes per year. These figures represent service to a population of at least 800, 000 by 4.45 FTE Medical Oncologists, a ratio of approx 0.56 FTE Medical Oncologists per 100, 000. This is well short of the recommendation in the 2001 AMWAC report for the Medical Oncology workforce of 1.4-1.6 FTE per 100,000, even allowing for the 3 Medical Oncologists in private practice (0.93 FTE per 100,000).