Submission

No 33

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Organisation: NSW Health

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NSW HEALTH
DEPARTMENT
www.health.nsw.gov.au

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 Submission to the Joint Select Committee Inquiry on the Royal North Shore Hospital.

The Department welcomes the opportunity to provide input into this important inquiry.

The attached submission has been prepared to provide a broad policy, regulatory and legislative context to assist the deliberations of the committee in understanding the environment in which Royal North Shore Hospital operates.

A range of system-wide data and information is presented in order to provide the opportunity for comparison between Royal North Shore Hospital and other peer hospitals within the NSW health system.

The Northern Sydney and Central Coast Area Health Service will provide a separate submission for the consideration of the committee. The Area submission will address issues involved in the direct operational management of the Hospital, which are properly matters for the Area and Hospital management.

If the committee requires any further information as a result of its deliberations or as a result of witness testimonies, the Department would gladly provide a supplementary submission for the committee.

For further information please contact Ms Deborah Willcox, Director Executive and Ministerial Services on (02) 9391 9642 or by email at Deborah.willcox@doh.health.nsw.gov.au.

Yours sincerely,

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NSW HEALTH

NSW Department of Health

Submission to the Joint Select Committee on the Royal North Shore Hospital

November 2007

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EXECUTIVE SUMMARY

New South Wales has an excellent health system – one of the best in the world.

Royal North Shore Hospital is an essential part of that system and a hospital with a proud history of service to its community and the State.

All health services, both in NSW and across the developed world, are under pressure from increased demand, greater complexity and severity of illness, new technologies, more expensive medication regimes, ageing population, workforce pressures and finite resources.

Royal North Shore has had difficulty meeting these challenges in recent years, particularly in the key areas of financial management and patient access. Staff morale has also been a key issue at the hospital.

Area Health Services and their facilities operate in a complex environment and senior management have always had to balance competing priorities.

The NSW Government has implemented significant reform, supported by substantial additional investment, particularly in increased hospital bed capacity, improved Emergency Department access, additional elective surgery, and improvements in clinical quality and safety systems.

This year the NSW Government is investing $12.5 billion in health, making health the largest portfolio, with almost one third of the State Budget.

Increased investment at Royal North Shore Hospital and across the state has come with expectations that patient access to treatment and care will improve.

In healthcare, managers have a core responsibility to balance financial performance, achieve access targets and ensure appropriate standards of quality and safety.

It is often claimed that Royal North Shore Hospital management have concentrated on access targets and standards of patient care at the expense of financial discipline or conversely, that quality or access issues are caused by limited funding.

However, financial problems are generally symptomatic of wider organisational difficulties and failures in leadership and governance across a range of key areas. The signs of organisational dysfunction have been evident at Royal North Shore Hospital.

There has been increasing concern over the deterioration of the financial position of Royal North Shore Hospital. In spite of significant levels of government funding that the Royal North Shore, a pattern of failing to achieve financial balance has persisted and become more marked.

The financial management of the Hospital has been characterised by:

- A failure to set and agree budgets to a clear, routine annual timetable
- Evidence of senior clinicians being dislocated from the formal management structure and not owning financial recovery plans
- Lack of investment in basic business IT to inform and support management decisions and controls

- An organisational history of failing to deliver cost improvements
- Poor establishment controls, demonstrated by rapid increases in either permanent or temporary staffing levels

The Department has taken significant action to assist the Northern Sydney and Central Coast Area Health Service management to address the situation and there were some intermittent signs of improvement but unfortunately these were not sustained.

The submission demonstrates that Royal North Shore Hospital has received comparable levels of financial and other resources compared to peer hospitals but has delivered below-average performance in relation to patient access, particularly to emergency services.

Opportunities for benefits from the Sustainable Access Plan, including Clinical Redesign, have not been fully realised at the Hospital despite active Departmental engagement and support.

There have also been indications of low staff morale at Royal North Shore, most recently evidenced in a report by Vernon Dalton and Judith Meppem into allegations of bullying and harassment at the Hospital.

Concerns regarding ongoing financial problems, poor patient access performance and low staff morale – particularly amongst clinical staff - led to a change in leadership of the Northern Sydney and Central Coast Area Health Service, with the appointment of a new Chief Executive.

The new Chief Executive has developed a comprehensive plan to turn things around at Royal North Shore, including:

- Improving management capacity and capability.
- Identifying the internal problems and taking action to resolve them
- Re-engaging clinicians in the hospital in joint decision making through the implementation of a clinical management structure.
- Introduction of sound internal controls coupled with creation of a clinical management group committed to the organisation recovery and growth and willing to take on budget management responsibilities.
- Implementation of clinical system redesign strategies to improve patient access.

Medium and longer-term actions to improve the governance and performance of the hospital include:

- Improving the information available to the organisation and strengthening risk management.
- Reconfiguration of clinical services as a result of the $702 million redevelopment of the Royal North Shore Hospital and Community Health Service. The redevelopment will include a new main hospital building with new operating theatres and procedure rooms, a new emergency department, new day stay and ward areas and new community health facilities on the campus.

The Department is actively supporting the Chief Executive in the implementation of his improvement plans.

1. BACKGROUND

1.1 Royal North Shore Hospital

Royal North Shore Hospital has been looking after people for almost 120 years. As one of Sydney's oldest and most well-respected hospitals, Royal North Shore is renowned for compassionate patient care, world-class research and commitment to educating the health professionals of the future.

The Royal North Shore Hospital continues to be a national and international leader in cancer diagnosis and treatment, cardiovascular disease, spinal cord injury, severe burn injury, neonatal, intensive care, neurosurgery and pain management, critical care and anaesthesia.

It is a renowned leader in research into critical areas of patient care such as 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 outcomes. 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.

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 five million dollars in comparison to the national average, which is in the mid 20 percent range.

The Committee's understandable interest in those areas where Royal North Shore has been experiencing particular challenges in recent times, such as the Emergency Department, mean that the focus of this submission is also on those parts of Royal North Shore's performance which have been problematic.

The submission therefore covers only a small part of the overall activity of Royal North Shore Hospital and it is not intended that this focus obscure the good work performed by the entire hospital and its staff.

1.2 The Role of the Public Health System

The Minister for Health sets the policy direction for the public health system and approves how the overall Health budget is to be allocated to Area Health Services and other public health organisations. The State Plan and State Health Plan underpin service planning and resource allocation decisions within the public health system.

Informed by the State Plan and State Health Plan, the Department of Health, provides the policy, planning and governance framework for the provision of health services within the public health system.

The Department has responsibility for regulating and monitoring the performance of Area Health Services and other public health organisations in accordance with statutory responsibilities. This is primarily achieved through an annual performance agreement process, which sets key corporate, clinical and population health targets, and regular review of performance against those targets.

Within Government policy parameters the Director General negotiates, determines or, as a party, arbitrates the employment conditions for staff of the NSW Health Service working in the public health system.

The Department also sets the policy framework within which employer delegations for the recruitment, discipline, safety and welfare of staff are exercised by Area Health Services.

Since 2005 the Director General has been responsible for the appointment of Chief Executives of Area Health Services and the overall administration of senior health executives working in area health services.

The governance of each Area Health Service rests with the appointed Chief Executive. Area Health Services are charged with promoting, protecting and maintaining the health of the residents of their areas, and providing care and treatment of patients through the conduct of public hospitals and other health services. Achievement and maintenance of adequate standards of patient care and services are a core responsibility of Chief Executives.

Area Health Services must discharge their statutory responsibilities within their established budgets, which are comprised of a number of sources of funds, primarily Government funds and private patient revenue.

Each Area Health Service has a specific statutory duty to ensure the efficient and economic operation of its hospitals and other health services and use of its resources. Each Chief Executive is responsible for how their Area's share of the Health budget is to be internally allocated to hospitals and other health services, and for the management and standards of care of those hospitals and other health services.

Chief Executives and other managers within an area health service have delegated responsibility for the recruitment, discipline, safety and welfare of NSW Health Service staff working within their organisations.

1.3 About this submission

The Department of Health's submission aims to inform the Committee deliberations by providing:

- The broader policy, regulatory and legislative context in which Northern Sydney and Central Coast Area Health Service and Royal North Shore Hospital operates
- System-wide data and information to provide the opportunity for comparison between Royal North Shore Hospital and other peer hospitals
- Information regarding the specific supportive and corrective interventions provided by the Department to Northern Sydney and Central Coast Area Health Service and Royal North Shore Hospital.

The Department's submission does not address issues regarding direct operational management of the Hospital - which are properly matters for the Area and Hospital management - except where these interface with the broader policy and governance functions of the Department.

2. CLINICAL MANAGEMENT SYSTEMS

2.1 Overview

Clinical management systems are those structures, processes and behaviours that facilitate the delivery of quality healthcare to the community. Clinical management is about the way in which the available resources – financial, human and capital – are managed to deliver the best possible care.

Key elements of clinical management include:

- Organisational leadership – administrative, managerial and clinical
- Effective planning and appropriate models of care
- Appropriate information systems to support decision making
- Clear governance frameworks
- Performance assessment and improvement mechanisms
- Effective clinician and consumer engagement

Good clinical management in the public health system involves the capacity to manage highly complex organisations, with multiple stakeholders and interest groups, within an environment of finite resources and uncapped demand.

Sound clinical management is a core role of Area and Hospital managers.

The Department of Health supports clinical management at the Area Health Service and local hospital level through:

- The development and dissemination of system wide policy and protocols
- The establishment of system-wide governance mechanisms addressing key areas of performance, both corporate and clinical
- The development of programs and resources to practically support Areas and hospitals in the implementation of state-wide priorities such as hospital performance improvement, quality and safety and clinical redesign
- The development of, and ongoing support for state-wide service networks
- The establishment and ongoing support for a comprehensive community and clinical engagement framework – from the peak Health Care Advisory Council to local Area Health Advisory Councils, and specialist Health Priority Taskforces
- Establishment of strategic, whole-of-health Information Technology projects
- Expert advice to Area Health Services on a range of issues including, legal, employee relations, financial, workforce and asset management

The following are key areas of importance in the context of clinical management system issues raised at Royal North Shore Hospital. The submission covers some other areas in more detail in later sections.

2.2 Clinical redesign and new models of care

The $70 million Clinical Services Redesign Program supports Area Health Services and their hospitals to redesign operational processes to improve the quality of care and the patient experience from the beginning of the patient journey in the

community, through their arrival and treatment at hospital, until their return to the community.

The program funds external partners to work with clinicians, patients and managers to map current processes, and identify and implement improvements from the perspective of the patient's journey.

Over 75 projects have been undertaken across the system and real improvements are being achieved and sustained. One of the keys to success is the existence of committed and enthusiastic clinical leaders and strong executive sponsorship to drive and sustain improvements at the local level.

The lessons from individual projects are being used to develop new, innovative models of care that can be shared across the system.

Clinical Service Redesign Program

So far over 75 Redesign projects have been successfully implemented across the NSW health system. These projects are tackling some of the issues causing the greatest strain on our health system including:

1. Reducing the time people wait in an emergency department for a hospital bed (despite increasing demand for services)
2. Reducing the time people wait to be transferred from an ambulance into an Emergency Department
3. Removing inappropriate delays for surgery (in early 2005 over 10,000 people were waiting more than one year)
4. Increasing patient and staff satisfaction
5. Creating new more flexible patient centred models of care

The projects are classified under eight streams of activity:

1. Surgery
2. Mental Health
3. Aged & Chronic Care
4. Emergency Care
5. Cardiology
6. Acute Care
7. Performance Management Development
8. Patient Flows

Models of Care are now available for each of these streams of activity on ARCHI at www.archi.net.au/e-library/build/moc

This year the Department has established a clinical redesign "school" – a structured training program aimed at developing the capacity of staff – both clinical and administrative – to drive and manage improvements in clinical service delivery at the local level.

The Department has been working with Northern Sydney Central Coast Area Health Service, hospital managers and individual clinicians to identify, fund and support clinical redesign projects since the program's inception in 2004.

Clinical Redesign Projects have been undertaken in the following areas at Royal North Shore:

- Emergency Department
- Mental Health
- Surgery
- Cardiology
- Aged and chronic care.

While some a number of potential improvements were identified and improvements strategies developed, implementation has been limited. A number of factors have contributed to the less than optimal benefits realisation at Royal North Shore when compared to other hospitals with more sustained success. These factors include:

- An absence of clear executive and clinical leadership
- A lack of engagement between executive leadership and clinical leadership
- A culture of professional 'silos' and resistance to change
- An unwillingness to be proactive in the management of projects and resources and
- A lack of clearly defined roles and responsibilities for staff

The issues identified, and strategies developed, through these projects remain valid.

The Department is continuing to work with the Area Health Service to build capacity and clinical management structures at Royal North Shore Hospital, to support the implementation of improved models of care for patients.

2.3 Information Technology

The Department has a strategic plan to guide the implementation of state-wide information technology projects including the Electronic Medical Record and the Electronic Health Record. These systems aim to improve the quality and safety of patient care, as well as making it easier for treating clinicians to keep track of up-to-date information about their patients.

Prior to the establishment of the new model for the design and delivery of Information and Communications Technology (ICT) systems consistent with the strategic plan, Area Health Services had significant autonomy in prioritising investment in ICT within their areas.

An historical lack of planning and investment in ICT within the Northern Sydney and Central Coast areas mean that some of their facilities, including Royal North Shore, are without some of the basic information technology tools – common in other Areas – to support effective clinical decision making.

In contrast, the Hunter New England and Sydney West Area Health Services are examples of Area Health Services that recognised the potential for ICT investment to reap major rewards in supporting direct clinical priorities.

Some of the tools developed by these Area Health Services have been adopted as model systems and are now being rolled out across the State by Health Technology. These include:

- The Length of Stay Tool developed in the Hunter New England Area
- The electronic 'Bedboard' developed by Sydney West, a system that provides ward staff with a visual display of bed availability and occupancy and assist with patient flow.

The take-up of systems such as this in the Northern Sydney and Central Coast Area, and as a consequence the Royal North Shore Hospital, has been affected by the historical decisions of the predecessor Health Services not to prioritise investment in ICT.

Under the new state-wide strategy the Department works collaboratively with Areas to ensure they have the skills, knowledge and support to successfully implement state-wide programs at the local level.

The state-wide endorsed Patient Administration System (PAS), which is the fundamental building block for the capture of patient demographic data, is necessary for the roll out of the electronic medical record and other applications such as the Bedboard and standard emergency department systems.

The PAS has now been rolled out on the Northern Beaches and Central Coast and is due to be implemented at Ryde in December and at the Royal North Shore Hospital during the first quarter of 2008.

Other key state-wide information technology projects managed by the Department include:

Electronic Medical Record
The Electronic Medical Record (EMR) is a clinical information system where patients' details are entered once and are then accessible to all authorised clinicians. It will replace many of the paper forms in the paper medical record. All authorised clinicians will have access to the EMR, enabling them to:

- Review patients' progress and order treatment or tests from any workstation.
- Continually review results and outcomes as well as alter care as required.
- Be prompted with alerts and allergies at the time of ordering tests, as well as checking for duplicate test orders.
- Compile discharge referrals for General Practitioners with automatic feeds from other systems, such as radiology or pathology.
- Better manage the availability of resources such as operating theatres, Catheter Lab, ICU and ward beds with advanced resource scheduling.

The EMR will benefit patients by

- Reducing the amount of times they are asked to repeat their demographic and past clinical information.
- Improved, coordinated scheduling with clear instructions for patients being booked for Outpatients Clinics and diagnostic testing.

- Improved communication between the hospital and carers in the community with the provision of clear follow-up instructions and details of current treatment provided upon discharge from the hospital.

State-wide Medical Imaging Program

The State-wide Medical Imaging Program being implemented through HealthTechnology will provide an integrated digital imaging and radiology information system to all Area Health Services in New South Wales. The program will improve imaging capabilities by replacing outdated analogue, 'wet-film' processing with digital technology. The new digital technology will be delivered by the introduction of Picture Archive and Communications Systems (PACS) and Radiology Information Systems (RIS).

During 2007/08, $11.1 million is being invested to roll out the program at Nepean Hospital, Royal North Shore, Liverpool and Coffs Harbour Hospitals. The PACS and RIS is expected to be established in the Nepean by May 2008 and in the Royal North Shore, Liverpool and Coffs Harbour Hospitals by the end of June 2008. This roll out will provide four key hubs for the further state-wide implementation in coming years.

Corporate IT Systems

Matching the clinical ICT activity is the drive for quality corporate systems and support to more effectively manage resources, workforce and assets.

Major organisational reform focussing on minimising the time and effort spent by staff, particularly clinical and frontline staff, carrying out corporate service type activities such as rostering and budgetary management is underway. New corporate IT systems will be implemented and integrated in a standardised format across the state to provide tools for corporate staff to work smarter and more efficiently.

The corporate systems programme includes systems and tools that will significantly benefit the health system by improving workforce management tools, enhancing revenue and financial management systems and advanced asset management tools.

The Department recognises the significant impact that effective information technology has on managing patient care and resources. The Department will continue to actively work with Area Health Services to maximise their knowledge and experience in this area.

2.4 Clinician and consumer engagement

Effective engagement with clinicians and health consumers is an essential part of good clinical management systems.

The Department supports a comprehensive formal consultative framework that involves clinicians and consumers.

The Health Care Advisory Council (HCAC) is the peak clinical and community advisory body providing advice to the Director-General and Minister on clinical services, innovative service delivery, health care standards and performance management and reporting within the health care system. The HCAC is established under the *Health Administration Act 1982* and is chaired by the Rt Hon Ian Sinclair AC and Professor Judith Whitworth AC. The HCAC meets regularly with the Minister.

Health Priority Taskforces (HPTs) provide advice to the HCAC, Director-General and Minister on policy directions and service improvements in each of 12 high priority areas of the NSW Health System: Aboriginal Health, Chronic Aged and Community Health, Children and Young People, Critical Care, Greater Metropolitan Clinical Taskforce, Information Management and Technology, Maternal and Perinatal Health, Mental Health, Population Health, Rural Health, Sustainable Access, and Workforce Development.

Following amendments to the *Health Services Act 1997* in 2005 Area Health Advisory Councils (AHACs) now operate in each Area Health Service. Made up of local clinicians and community members, they provide advice to the Area Health Service Chief Executive on planning and delivering health services. Each AHAC is required to develop a Charter and report annually to the Minister and Parliament.

The Northern Sydney and Central Coast AHAC is chaired by Professor Carol Pollock.

The Northern Sydney and Central Coast AHAC 2006/07 Annual Report reveals that the AHAC, and in particular the Chair, has been very active in seeking to strengthen community and clinician engagement. The need for improved clinician engagement is raised as a particular concern and the Council's annual and monthly reports identify the need for greater involvement of clinicians in planning and improved sharing of budgetary and operational information.

In her 'Year in Review' the Chair notes that the Area has faced challenges in five key areas:

- Budgetary
- Operational (including information technology)
- Workforce
- Turnover in management
- Planning for the Royal North Shore and Northern Beaches redevelopments

While acknowledging that many of these issues are inherent in all areas of the health system, Professor Pollock notes that a combination of these factors has placed additional stress on staff.

Clinical service planning is an essential component of effective clinical management systems, and the planning process provides an important opportunity for clinicians and the community to work to work together to develop a strategic plan for the Area's clinical service and to identify the major priorities for the future.

Professor Pollock's report notes that the lack of progress in finalising area wide operational and clinical service plans has affected the Areas capacity to meet its challenges.

The South Eastern Sydney Illawarra Area Health Service's plan provides a useful example of effective clinician engagement forming the basis of effective clinical services planning.. The Plan, which is available on the Area's website (www.sesiahs.health.nsw.gov.au), outlines strategic directions for the Area's clinical services; provides a blueprint for delivering networked health care; and describes new approaches aimed at improving access to quality health services.

Importantly the Plan was developed through clinician-led consultations, via workshops, interviews, meetings and emails, with over 30 clinical groups and

divisions; over 600 individual staff and clinical partners; General Managers and Executive Directors of hospitals; consumer representatives from the peak consumer group; and representatives from the NSW Department of Health.

Further consultation on the draft Plan included a structured consultation process lead by the Chair of the Area Clinical Executive Committee and included over 150 senior medical staff; over 570 general staff (including nursing & allied health) and over 50 health consumers.

The Area's Clinical Executive Committee assisted in the analysis of strategic issues and provided a point of critical review for the Plan. It involved 23 members from the spectrum of clinical specialties and facilities across the Area Health Service.

In contrast, to date Northern Sydney and Central Coast Area Health Services has taken a more top down approach to consultation and the Area's plan is yet to be completed.

2.5 Management Capability and Leadership

Strong and effective management and leadership are essential to any organisation's success in meeting their goals, delivering good service to consumers' satisfaction, and operating effectively and efficiently. It is even more critical at a time of great change.

NSW Health is committed to improving the leadership and management skills of senior clinicians and administrators. These roles demand comprehensive knowledge, skills and expertise in financial, human resource, strategy and performance planning and management integrated with knowledge of the health environment and specific demands of patient care.

A significant investment in enhancing the performance management of health professionals and corporate staff has been made. For example, between February and August 2007, 366 Staff Specialists in receipt of the managerial allowance attended the Leading for Improved Clinical Services Program.

In 2007 clinical managers also participated in the Clinical Excellence Commission clinical leadership programs with training in clinical practice development, staff management and interpersonal skills. 17 Staff Specialists from Northern Sydney and Central Coast Area Health Service participated in the program.

Area Health Services also play a vital role in developing the management capacity of their staff. For example Sydney South West Area Health Service, in partnership with the University of Tasmania, has developed a health management program, leading to tertiary qualifications, with a practical focus that caters to various levels from trainees to senior managers.

The role of nursing leaders in role modelling appropriate behaviours and identifying where clinical nursing standards of care are not at an appropriate level is vital to the delivery of quality patient care. Critical to this at the unit and ward level is the position of Nursing Unit Manager (NUM). The Department of Health has commenced a major project to better enable NUMs in their management roles. The project will both identify barriers to NUMs effectively carrying out their roles and up-skill NUMs to enhance their management capacity.

Northern Sydney and Central Coast Area Health Service has also developed a program targeting senior nursing leaders such as Directors of Nursing who are responsible for supporting NUMs in their roles and monitoring the standard of nursing care across an organisation.

3. CLINICAL STAFFING AND ORGANISATION STRUCTURES

3.1 Health Workforce Overview

Like health systems around the world, NSW Health is experiencing a shortage of health professionals in the face of increasing demand and complexity.

The Productivity Commission highlighted this shortage:

> *Australia is experiencing workforce shortages across a number of health professions ... With developing technology, growing community expectations and population ageing, the demand for health workforce services will increase while the labour market will tighten.* [1]

Similarly, quantitative work undertaken by the Australian Medical Workforce Advisory Committee (AMWAC) and the Australian Health Workforce Advisory Committee (AHWAC) found:

- An estimated shortage of between 800 to 1300 GPs in 2002 (or around 4 to 6 per cent of the current GP workforce) (AMWAC 2005);
- An estimated shortfall of between 10 000 to 12 000 nurses in 2006 and between 10 000 and 13 000 in 2010 — requiring at least a doubling of current graduate completions (AHWAC 2004a); and
- Current and emerging shortages in the majority of medical specialties which led to recommendations for increases in training intakes (AMWAC 2004).

In other health occupations, the Department of Employment and Workplace Relations (DEWR) has recently identified shortages in a number of occupations including dentists, hospital and retail pharmacists, occupational therapists, physiotherapists, speech pathologists, podiatrists, diagnostic radiographers, radiation therapists, nuclear medicine technologists, pathologists, psychiatrists, registered nurses and sonographers (DEWR 2005)." [2]

The *OECD Health Data 2007: Statistics and Indicators for 30 Countries* note that:

> *Despite the relatively high level of health expenditure in Australia, there are fewer physicians per capita than in most other OECD countries. In 2004, Australia had 2.7 practising physicians per 1,000 population, below the OECD average of 3.0. On the other hand, there were 10.4 qualified nurses per 1,000 population in Australia in 2004, a higher figure than the average of 8.6 in OECD countries.* [3]

Clearly, the capacity of a single state jurisdiction to significantly influence workforce supply is constrained, given that two of the key supply drivers – university places for

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[1] Productivity Commission (2006), Australia's health workforce: key points issued with research report, 19 January 2006 http://www.pc.gov.au/study/healthworkforce/docs/finalreport/keypoints (accessed 23.10.07)

[2] Productivity Commission (2005), Australia's health workforce: research report, 22 December 2005, p 12 http://www.pc.gov.au/study/healthworkforce/docs/finalreport (accessed 23.10.07)

[3] Organisation for Economic Cooperation and Development (2007) Briefing note for OECD Health Data 2007: How Does Australia Compare, www.oecd.org/dataoecd/46/38/ 38979536.pdf (accessed 1.11.07)

locally trained professionals and immigration processes for overseas trained medical graduates are controlled by the Australian Government.

An underinvestment in university training and the resultant shortage of locally trained health professionals puts real pressure on the NSW Health system, making it difficult to staff facilities – particularly in rural and regional and outer metropolitan locations – and increasing the systems reliance on expensive locum staff.

NSW has engaged actively in trying to influence the Australian Government to increase the local workforce through increased university training places for doctors, nurses and allied health professionals.

Following pressure from NSW, the number of university places has been increased. In 2007, NSW was successful in obtaining an allocation of an additional 110 medical places in universities.

In addition NSW has also obtained the following new increased intakes[4] of:

Nursing	446	Mental Health Nursing	110
Dentistry	20	Oral Health practitioners	20
Medical Imaging places	40	Nutrition & Dietetics	10
Occupational Therapy	17	Pharmacy places	10
Physiotherapy	28	Podiatry	23
Psychology- Clinical	38	Speech Pathology	20

The 2008 intake will be[5]:

Nursing	200	Indigenous Health Care	5
Occupational Therapy	25	Pharmacy	10
Podiatry	10		

However, this year NSW sought an additional 1769 nursing university places from the Australian Government for 2008 and just 200 were funded . Similarly, NSW sought additional medical, dental and allied health university places, with very few funded.

NSW is also participating in the Council of Australian Governments (COAG) health workforce agenda including:

- Implementing national assessment processes for overseas trained doctors
- Improving consultation on health related university places
- Implementing a single national registration and accreditation scheme
- Developing options to improve service delivery in rural and remote areas

3.2 NSW Health Workforce

In spite of the structural constraints on NSW's capacity to increase workforce supply, workforce planning at a state-wide level is critical in responding to trends such as the impact of an ageing population and ageing workforce on staff numbers.

[4] Includes both undergraduate and postgraduate places & 10 Masters of Midwifery and UTAS 150 places

[5] Includes both undergraduate and postgraduate places

The NSW State Health Plan identifies *Building a sustainable health workforce* as a key priority for NSW Health.

The Department is working with Areas to develop strategies to improve

- Workforce planning
- Recruitment and retention
- Workforce flexibility and career pathways
- Staff satisfaction

The NSW public health system is the largest health care employer in Australia with more than 90,997 full-time equivalent (FTE) staff.[6] Of this workforce 66.4% of staff are health professionals- doctors, nurses, ambulance officers, dentist and allied health professionals. [7]

Since 2005 the numbers of medical, nursing, allied health and ambulance staff have risen while the number of corporate administration positions has been reduced. All health services have retained the savings they made through amalgamations and the reduction in administrative staff numbers.

Number of Full Time Equivalent Staff (FTE) Employed in the NSW Department of Health and Health Services as at June 2006

	June 2003	June 2004	June 2005	June 2006
Medical	6,112	6,357	6,462	6,826
Nursing	32,550	33,488	35,523	36,920
Allied Health	6,323	6,563	6,848	7,122
Other professional and para-professionals	4,222	4,036	3,431	3,383
Oral Health practitioners and therapists	988	976	990	1,008
Ambulance Clinicians	2,815	2,935	3,019	3,155
Corporate Services	5,441	5,469	4,996	4,523
Scientific and technical clinical support staff	4,922	5,019	5,831	5,944
Hotel services	8,330	8,181	8,326	8,242
Maintenance and trades	1,311	1,281	1,246	1,221
Hospital support workers	9,933	10,037	10,723	10,709
Other	322	385	350	353
TOTAL	**83,270**	**84,727**	**87,745**	**89,406**
Medical, nursing, allied health, other health professionals, oral health practitioners and ambulance clinicians as a proportion of all staff	63.7	64.2	64.1	65.3

Source: Health Information Exchange and Health Service local data

Since 2005 there has been an increase in full time equivalent of:

- 856 medical staff
- 2,578 nursing staff
- 539 allied health professionals, and
- 288 uniformed Ambulance staff.

This represents an increase of 4,261 full time equivalent frontline staff over the last three years.

[6] Health Information Exchange (HIE) June 2007

[7] NSW Department of Health (2006) Annual Report

Northern Sydney and Central Coast Area Health service compares favourably to other Areas in increases in full-time equivalent staff, with the second highest FTE increase in the metropolitan area:

Health Services	Variation between June 03 & June 07		Variation between June 06 & June 07	
	FTE	%	FTE	%
Northern Sydney Central Coast	1,199	11.1	358	3.1
South Eastern Sydney Illawarra	508	3.7	81	0.6
Sydney South West	1,010	6.3	232	1.4
Sydney West	1,650	14.1	527	2.0

Remuneration and conditions for NSW Health staff compare favourably with those in other States. Many occupational groups have received significant increases in recent years. NSW nurses are the highest paid in Australia.

3.3 Nursing workforce

Targeted strategies to increase the number of permanent nurses and midwives employed in public hospitals have resulted in a steady increase in numbers over the past five years. In January 2002, there were 34,004 permanently employed nurses - both full and part-time. By August 2007 there were 42,081 nurses employed in permanent positions- a net increase of 8,077 (23.8%).[8]

These targeted strategies continue, with $37.9 million allocated in 2007/08 to the development of the nursing and midwifery workforce. Key strategies include

- Trainee Enrolled Nurses
- Study Leave for nurses
- Education and Skill Development Programs
- Nurse Re-connect
- Scholarships
- Overseas Recruitment
- School-based traineeships

A comparison of peer hospital employment of nurses through Nurse Reconnect demonstrates that Royal North Shore Hospital has benefited from participation in these sorts of Departmental initiatives:

	2002	2003/04	2005/06	2007/09	Total
Royal North Shore	60	34	19	2	115
St George	28	11	16	2	57
RPA	30	22	7	3	62
Westmead	25	8	2	2	37

Note: The number of positions being actively recruited have decreased at RPA and Westmead over the last five years while RNSH and St George have remained constant.

[8] Nursing DOHRS August 2007

Over the last few years the Department has worked closely with the Nurses Association to implement the reasonable workloads clause in the Nurses Award. The Department of Health has developed and implemented a range of workload management tools and systems to assist in easing the pressure on the nurse workforce. Reasonable Workload Committees at each facility, comprising management and frontline nursing staff, provide a mechanism for raising workload concerns and resolving them outside an industrial framework. Active and functional committees require the commitment of both management and nursing staff.

Royal North Shore Hospital has struggled to achieve active staff participation in its Reasonable Workload Committee. This appears to be a symptom of the ongoing problems with staff morale at Royal North Shore Hospital, which has most recently been encapsulated in a report by Vernon Dalton and Judith Meppem in September 2007 into allegations of bullying and harassment at the Hospital

3.4 Organisational culture

While Area Health Services and hospitals are responsible for the day-to-day management of staffing issues, the Department develops and promotes state-wide employee relations policies aimed at supporting best practice employment practices and creating safe, fair, productive workplaces. The NSW Health Code of Conduct provides a clear statement of the expectation that NSW Health Service staff act ethically, fairly and co-operatively. This document is required to be distributed to each member of staff, who in turn is required to provide written acknowledgement that they have read and accept the Code.

The Department has disseminated a revised grievance management policy containing practical case studies and advice to assist health service managers in handling and resolving grievances in the workplace in a sensitive and fair way.

A considerable amount of attention has been given to anti-bullying strategies in recent years. The Department has developed a number of initiatives to support Area Health Services in preventing workplace bullying and to effectively and promptly manage workplace bullying, should it occur. These include:

- Development of a zero tolerance to violence policy and detailed guidelines, which includes and acknowledges bullying as a form of workplace violence. The policy and guidelines were also supported by posters and brochures for use and dissemination throughout NSW health workplaces.

- Development of a training package: *A Safer Place to Work: Preventing and Managing Violent Behaviour in the Health Workplace*, which includes a module specifically relating to preventing and managing bullying behaviour.

- Release of NSW Health Guideline on the Prevention and Management of Workplace Bullying, which provides detailed advice to managers and staff on how to prevent workplace bullying using a risk management approach, advice to staff on how to report workplace bullying and what they can expect in response to their complaint, and advice to managers on how to effectively respond to and manage the complaint.

The Dalton-Meppem Report revealed an unacceptable organisational culture that fostered and tolerated bullying behaviour and which failed to actively and effectively address its root causes and apply the relevant policies.

3.5 Organisational structures

With the exception of the Chief Executive and second tier executive, Area Health Service and Hospital organisational structures have not been mandated by the Department of Health. Area Health Services are able to develop structures suitable for their geography, demography and service and staff profile.

As discussed in the section on clinical management, meaningful engagement of clinicians in clinical services planning, which guides the distribution of resources across an Area Health Service, and in meeting financial accountabilities, is essential. Many Area Health Services have put structures in place to achieve this such as Area Clinical Advisory Councils, comprising a range of leaders including Area executives and heads of clinical streams and networks.

Nurse Unit Managers are the backbone of a hospital's clinical management system, supported by professional nurse leadership. The Department expects the role of nurses and nursing leadership to be properly recognised in the organisational structures of area health services and hospitals.

In mid-2006 nursing staff in Northern Sydney Central Coast Area Health Service expressed serious concerns over the lack of nursing leadership positions and lack of nursing leadership support for NUMs in the Area's proposed organisational restructure. The Department of Health convened a series of meetings between senior executives of the Area Health Service and representatives of the Nurses Association in order to achieve a resolution of the Area structure that better reflected nursing leadership.

4. RESOURCE ALLOCATION AND UTILISATION

4.1 Overview

The NSW Health budget has increased significantly over the past decade.

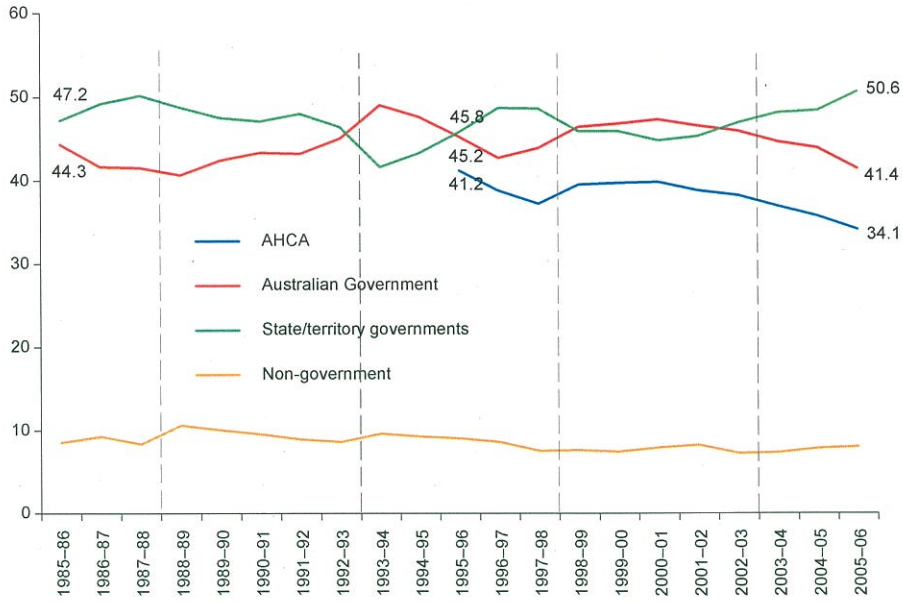
At $12.5 billion the NSW Health expenses budget for 2007/08 represents 28 per cent of the total NSW State Budget and is a 7.1 per cent increase on the previous year.

The Health Budget is predominantly made up of NSW State Consolidated Fund contributions, contributions from the Australian Government through the Australian Health Care Agreement and other special purpose funding and revenue obtained by the health system through fee for service work.

The key Australian Government funding source for NSW public hospitals is the Australian Health Care Agreement (AHCA), under which the Australian Government provides funding to the States and Territories to support the provision of public hospital services.

NSW and the other States and Territories have expressed ongoing concerns about the adequacy of the funding provided by the Australian Government to public hospitals.

Share of total public hospital funding Aust, 1995-96 to 2005-06



Source: Health Expenditure Australia 2005-06, Australian Institute Health and Welfare (Oct 07)

The Australian Government has been contributing a smaller and smaller share of public hospital costs each year. In 2000 it contributed 50% of the cost of running and

maintaining public hospitals across Australia. In 2005 that share had dropped to 45%[9].

Independent assessments indicate the Australian Government is now paying about $1.1 billion a year less than it originally agreed[10]. Data published recently by the Australian Institute of Health and Welfare suggests that the gap is even wider, with the Australian Government under funding public hospitals by $2.2 billion. Based on population share, this means that NSW is missing out on $750 million in Australian Government funding every year.

Under the current Australian Healthcare Agreement, the NSW Government's share of public hospital funding increased from 61% in 2003/04 to over 63% in 2005/06 and during the same period the Australian Government's share declined from 39% to less than 37%.

It is clear that redressing the share of funding to public hospitals provided by the Australian Government needs to be a priority for the next Australian Health Care Agreement.

Given that NSW Health operates within a necessarily finite budget, one of the most pressing challenges facing the Department is to ensure an equitable distribution to Area Health Services, and to ensure those resources are used as efficiently and effectively as possible to meet the needs of the community.

The Department of Health is responsible for allocating and monitoring the allocation of the Health budget. The Department allocates budgets to Health Services and Health Service Chief Executives determine and allocate budgets to hospitals and other facilities.

The financial management obligations of Chief Executives include monitoring and governing health service facilities to ensure the health needs of their communities are met within the available budget and that liquidity management is appropriate so creditors are paid in accordance with trading terms.

The Department has an established reporting framework through which financial performance is monitored and issues of concern identified and resolved.

4.2 Resource Distribution Formula (RDF)

Funding to Area Health Services is guided by population health needs as defined by the Resource Distribution Formula (RDF). The RDF is a refinement of the Resource Allocation Formula, which has been used since the 1980s as a planning tool to guide the allocation of funding to Areas and to monitor progress towards the achievement of fairness in funding.

Prior to the establishment of Area Health Services, funding was primarily to hospitals, which were funded largely on an historical basis. Resource distribution reflected the historic distribution of hospitals around the Sydney CBD (St Vincents, Royal Prince Alfred, Royal North Shore, Prince of Wales).

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[9] Caring for our health? Report by Australian State and Territory Governments, June 2007
[10] ibid

The key principle guiding the development of the RDF is to enable the various geographic populations to have comparable access to services, given their health needs and the costs of delivering services. The RDF is not used to allocate funding to individual hospitals but rather to determine Area Health Services share of resources.

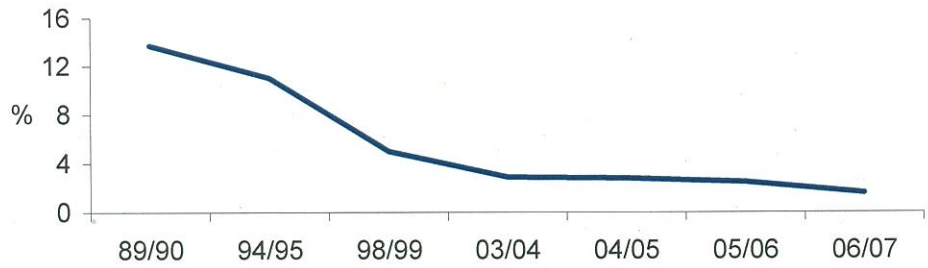
Using demography and future population projections as its basis, the RDF allows resources to be directed in an equitable, planned and rational way. As the utilisation of private health services affect a population's use of and demand for public sector services, the RDF also considers this in determining the share of resources for an Area Health Service.

Since the adoption of the RDF in the late 1980s, considerable progress has been made in reducing the inequities in funding across NSW.

In 1989-90 on average, Areas were 13.7% away from what would constitute an equitable share based on the RDF. In 1994-95 they were 11% from their RDF target share.

On average the 8 Area Health Services are currently within 2% of their RDF target share.

Weighted average distance from RDF target for 8 NSW Area Health Services



Funding to NSW Area Health Services is guided by a resource distribution formula.(RDF) which aims to provide an indication of equitable shares of resources taking account of local population needs. The current policy is to ensure that allocation to all Area Health Services is not less than two per cent of their RDF target. Factors used in estimating local need include age, sex, mortality and socio-economic indicators.

In considering the 2007/08 level of funding it was identified that Northern Sydney and Central Coast Area Health Service was 2.1% or some $20.3 million over its equitable share of resources.

4.3 Northern Sydney Central Coast Area Health Service - Budget

All Health Services in NSW face the challenge of delivering quality health care to patients and clients within their allocated budget.

In 2007/08 the initial cash allocation to Northern Sydney Central Coast Area Health Service is $1,219.5 million. This level of funding and increase is consistent with the average increase across all Area Health Services.

Comparative increases in Budget: NSCC AHS

	NSCC	All 8 Areas
Increase on 2006/07	5.1%	5.8%
Increase on 1999/00	93.0%	88.2%
Increase on 1994/95	157.3%	157.8%

But while the level of funding provided to Northern Sydney Central Coast Area Health Service has been on a par with other Areas, its performance has not, as demonstrated by:

- The performance of Royal North Shore Hospital on key performance indicators including access and emergency department performance compared to its peer hospitals over the same period under similar pressures
- The unfavourable budget results of Northern Sydney and Central Coast Area Health Service and the Royal North Shore Hospital
- The relative high cost of procedures at Royal North Shore Hospital compared to peer hospitals.

The financial management accountability of Chief Executives and health services is assessed against Net Cost Of Service General Fund General budget performance and general creditors payment performance.

The following table outlines Northern Sydney Central Coast Area Health Service Net Cost of Service Results for the 3 years ending 30 June 2007, showing that they were over budget in 2004/05, slightly under budget in 2005/06 and then over budget in 2006/07.

NCOS GFG		Budget	Actual	Result
2004/05	- Expenses	1,232.1	1,256.1	+24
	- Revenue	222.6	236.7	(-14.1)
	NCOS	1,009.5	1,019.4	+9.9
2005/06	- Expenses	1,287.2	1,280.9	(-6.3)
	- Revenue	247.4	241.7	+5.7
	NCOS	1,039.8	1,039.	(-0.6)
2006/07	- Expenses	1,396.4	1,409.1	+12.7
	- Revenue	265.2	264.1	+1.1
	NCOS	1,131.2	1,145.0	+13.8

( ) indicates favourable

The Area's Creditor performance over the same period was as follows:

Creditors over Benchmark	$000
June 2005	3,790

June 2006	Nil
June 2007	Nil

4.4 Northern Sydney Central Coast Area Health Service – financial performance

When poor performance at Northern Sydney Central Coast Area Health Service was identified via the Department's reporting mechanisms extensive steps were taken to assist the Area Health Service to improve its financial management. This began with regular meetings between Area and Departmental staff where the contribution of Royal North Shore Hospital to the poor financial performance was identifies. The issue of the Area's financial management was subsequently elevated to the Director General – Chief Executive level.

In early 2005 the then Director General met with the then Chief Executive and it was agreed that:

- The Department would co-ordinate a high level financial review of Royal North Shore Hospital
- Assistance would be provided to develop the Area Financial Plan
- Financial advisory services would be provided through a forensic accountant (Ferriers)
- A 'bottom up' review would occur of Royal North Shore Hospital through independent financial improvements experts (VHIAA)

The reviews commenced in late May 2005.

From July to September Ferriers and VHIAA conducted their reviews with Ferriers finalising their report in August and VHIAA in September.

Ferriers were engaged to review budgeting and management reporting processes to identify opportunities for enhanced management of expenses and revenues. A range of risks were identified and management responses agreed, with clear responsibility assigned to Area Executives.

VHIAA were assigned to review systems and processes to identify opportunities to make savings or to increase revenues. Their report was finalised 2005 and identified scope for improvement in respect of:

- Culture
- Management accountability
- Medical staff management
- Revenue generation
- Area/Hospital role clarification

The review recommendations were generally accepted and the Area Health Service established an implementation and monitoring process. VHIAA also assisted the Area Health Service to review strategy implementation and progress.

Discussion on the Area Financial Plan continued during 2005/06 without finalisation as the Area's performance showed a substantial improvement on 2004/05.

The Area financial reports showed acceptable performance for the remainder of 2005/06.

In early 2006/07 a budget risk was identified due to slowness in the Area implementing agreed savings strategies and some deterioration in the budget situation occurred. However the previous year financial result indicated that positive changes had occurred.

Discussions continued on the Area's proposed Financial Plan, particularly around potential impact on service delivery.

Concerns regarding financial performance were identified early in the 2006/07 financial year. Meetings commenced between the Departmental and Area finance staff. The November financial report (issued in December) did not reflect the level of improvement expected and a meeting between the Chief Executive and Director General took place at which the Area gave a number of undertakings.

A further meeting was held with the Director General in February 2007. Whilst the January report indicated some improvement, underlying issues were not being addressed and new concerns arose regarding the potential impact of proposed savings strategies on service delivery.

Further meetings occurred between the Chief Executive and Director General and Acting Director General, at which the Area continued to revise both its budget projections and its savings targets. The Chief Executive continued to give assurances that he was pursuing strategies to improve the financial situation.

In April 2007 the Department expressed serious doubts about the Area's capacity to effectively monitor and govern its facilities to ensure budget compliance.

The newly appointed Director General met with the Chief Executive in mid-July to discuss concerns regarding budget, hospital performance and clinical management issues. The Director General and Chief Executive agreed on the need for a change in leadership to expedite the process of necessary structural change.

Following his appointment, the Acting Chief Executive, had discussions with the Department, which agreed to:

- provide support to understand the Area's financial challenges and develop the Area's budget strategy
- defer the issue of Executive/facility allocation letters until around 31 August 2007 and
- assist with the development of a 3 year Financial Plan.

Over the 6 week period to 31 August 2007 significant analysis and review occurred of various data sets which supported:-

- the view that using the principles of Episode Funding, facilities generally had significant capacity to improve budget performance whilst still doing the same or more activity;
- that during 2006/07, the Area had increased its cost base over fundable levels and had not been diligent in achieving budgets the Area set for facilities and it did not achieve specific strategy initiatives;

- that compared to other health services revenue performance could be improved;
- that highest demand growth was on the Central Coast.

4.5 Royal North Shore Hospital - 2007/08 Budget

Advice to the Department on the initial 2007/08 Budget and other Key Performance Indicators approved by the Area compared to the initial 2006/07 budget is:-

Initial Budget	**2007/08**	**2006/07**	**Variation**
Expenses $M	357.5	348.0	+ 9.5
Revenue $M	52.8	47.4	+ 5.4
NCOS $M	304.7	300.6	+ 4.1
Other KPIs (outputs)			
Separations - Acute	47,412	46,996	+ 416
Total	48,439	48,676	- 237
Cost Weighted Separations	55,624	55,795	+ 171

The internal distribution of the Budget is determined by the hospital in collaboration with the Director of Clinical Operations and Chief Executive.

4.6 Royal North Shore Hospital – Efficiency

In addition to undertaking a monitoring and support role to ensure appropriate accountability and effective financial management, the Department also supports Areas in ensuring efficient utilisation of public resources in the interests of the community.

For many years Area Health Services have provided data about their hospitals using case weighted activity as a benchmarking performance measure.

Since around 2000 it has been referred to as Episode Funding. It represents the average cost to achieve an occasion of service, such as a hip replacement.

The Department publishes Peer Reference costs and guidelines for public health organisations to follow in submitting Episode Funding related data. Hospitals are compared with their peers to assess how each is performing in relation to the cost of an occasion of service.

Whilst annual comparative data is the ultimate goal, quarterly high-level data is also submitted and returned to public health organisations in a comparative format.

Area Health Services and other public health organisations are required to:

- Review the accuracy of data
- If data is poor, to take corrective action to improve accuracy; or
- If data is reliable and performance is poor, investigate causes and take action to improve areas of inefficient practice.

Concerns have been raised by public health organisations over inconsistent practices across the health system in preparing data. To address this, a number of actions are now in place including:-

- introduction of a standard clinical costing system and business rules;
- introduction of a standard chart of accounts and associated business rules;
- having submitted data reviewed by Internal Audit .

Chief Executives are required to use the principles of Episode Funding to improve performance of their hospitals where data reflects less than average efficiency.

Royal North Shore Hospital is categorised as Principal Referral Hospital Category A1a. Its peers include Royal Prince Alfred, Concord, Liverpool, St George, Prince of Wales, Westmead and John Hunter Hospitals.

In respect of Royal North Shore, 2006/07 preliminary data available to the Department identifies for acute activity:

Targeted cost weighted separations (CWS)	49,041
Actual cost weighted separations (CWS)	48,923
Target expenses budget	$184.7M
Actual expenses	$202.8M
Peer Reference Cost (PRC)	$3,766
Actual Reference Cost	$4,146
Actual Cost Variation against PRC	$18.6M

This means that compared to its original targets Royal North Shore did slightly less work than planned, was $380 per cost weighted separation more expensive than the peer average, and based upon actual cost weighted separation, was $18.6 million over the peer average. In other words, if Royal North Shore operated with the same efficiency as the average of its peers it would have performed its activity for $18.6 million less. This represents a significant potential saving or the capacity for the hospital to perform significantly more services within existing funding.

Using final 2005/06 data, the following table shows the relative efficiency of the peer group hospitals, with 1 being the average. Based on this data, Royal North Shore is the most expensive (or least efficient) hospital of its peer group.

	NSW
Royal North Shore	1.1
Royal Prince Alfred	1.03
Concord	.98
St George	.98
Prince of Wales	1.00
Liverpool	.94
Westmead	1.07
John Hunter	.91

4.7 Capital Works

Approximately $4.9 billion has been spent on completed NSW Health capital works since 1995. This has been spent on major building and/or upgrading health facilities,

support infrastructure for specialty programs, major equipment purchases and IM&T projects.

In 2007/08, $714 million has been budgeted for the building, redevelopment, upgrade and refurbishment of public hospital and health facilities across NSW.

Since 1995, over $116 million has been spent on major capital works projects and equipment at the Royal North Shore Hospital, including (but not limited to):

Refurbishment of the Angiography Suite ($1.2M) completed in April 1995:

- Refurbishment of the Cummins Ward ($1.3M) completed in December 1997.
- Purchase of a Linear Accelerator ($1.8M) in Mar 1998.
- Replacement of lifts to main building ($2.0M) completed in Sep 2002.
- Repairs to facade of main building ($1.5M) completed in Jun 2004.
- Linear Accelerator Replacement ($1.0M) completed in Jun 2004.
- Replacement Gamma Camera ($0.5M) completed in Jun 2004.
- Construction of a new paediatrics obstetrics emergency building ($54.6M) completed in Jul 2004.
- Replacement of Bi-plane neurointerventional radiology suite ($2.2M) completed in Jun 2005.
- The second stage of the refurbishment of the hospital façade ($2.5M) completed in Jan 2006.
- NSCCAHS Capital Equipment Purchases ($1.4M) in Jun 2006.
- Burns Unit Upgrade ($0.5M) completed in Jun 2006.
- Minor Radiotherapy Equipment purchases ($0.4 M) in Jun 2006
- Replacement CT Scanner purchased ($1.8M) in Jul 2006.
- NSCCAHS Supplementary Equipment purchases 2005/06 ($7.1M) in Aug 2006.
- Provision of RNSH High Dependency 23-Hour Care and Day Surgery Facilities ($6.9M) completed in Jun 2007.
- Royal North Shore Hospital Redevelopment Stage 2 - Pre-Project Works ($13.8M) completed in Jun 2007.

By contrast, just $14.9 million was spent on major capital works projects and equipment for the Hospital in the period 1987/88 to the end of 1994.

Royal North Shore Redevelopment

The $702 million redevelopment of the Royal North Shore Hospital and Community Health Service will be the biggest health capital works project in NSW and includes a new main hospital building with new operating theatres and procedure rooms, a new emergency department and new day stay and ward areas. There will also be new community health facilities on the campus, close to public transport, but separate from the main hospital building.

The new, high quality working environment will provide for more convenient and better integrated patient care across disciplines and help attract and retain staff.

Planning for the redevelopment project has progressed over a number of years and has involved a wide range of stakeholders. Area Health Service planning for the redevelopment, involving clinicians and consumers commenced in 2003, with confirmation of a patient centred operational model as the preferred model for the redevelopment in 2005.

A redevelopment clinical advisory group was established in March 2006 and meets on a monthly basis with the General Manager to discuss a wide range of issues involved in the redevelopment project. Consultations and briefings with staff groups continue on a regular basis.

Consultation on the design of the redevelopment occurred in October and November 2006 and involved all clinical and non-clinical departments. The focus of these consultations was on the patient centred model of care, which was refined with clinician input prior to the release of tender documentation in 2007.

As part of the overall redevelopment of the Royal North Shore Hospital, the NSW Government has committed more than $61 million to the construction of a new purpose-built facility for education and research. In September this year, the University of Sydney committed $30 million towards the facility. This contribution will allow for the construction of an additional four floors specifically designed for medical research, allowing the new 10-storey building to accommodate up to 350 researchers. The consolidation of research and education into a new, purpose-built facility will create a dynamic environment with a greater capacity for teams to share knowledge as well as resources.

Construction of the Research and Education building commenced in February 2007, with the concrete structure is now significantly advanced.

Tenders for the redevelopment of the main hospital building were called in late May 2007 and close on 16 November 2007. Subject to development consent for the successful designs, construction works are anticipated to commence on the main hospital in late 2008 following completion of the Research and Education building.

4.8 Emergency Department resource utilisation and performance - Comparative data

In 2004/05 there were approximately 2 million attendances at emergency departments across NSW. In 2006/07 this had risen to 2.3 million -an increase of 15 percent. Over the last five years the growth has been 14 percent with the highest growth in persons aged 75 years and over (20 percent) and with an increase of children by 5.3 percent.

Patients who are attending emergency departments are also sicker, as evidenced by the much higher growth (16 percent) in the rate of admissions from the emergency department to an inpatient ward. The growth in demand in NSW is steady and consistent with national trends.

The following table shows the 10 Emergency Departments with the highest volume of Emergency Department attendances, and the growth in attendances over the last 12 months.

	Presentations			
Hospital	2005/06	2006/07	Growth 05/06 to 06/07	% Growth
John Hunter	55,331	58,117	2,786	5.0%
Liverpool	51,794	57,211	5,417	10.5%
Royal Prince Alfred	49,960	54,962	5,002	10.0%

St. George	49,392	53,707	4,315	8.7%
Penrith-Nepean	46,368	50,994	4,626	10.0%
Royal North Shore	**46,696**	**49,900**	**3,204**	**6.9%**
Westmead	45,669	49,779	4,110	9.0%
Children's Hosp (Westmead)	45,822	48,903	3,081	6.7%
Gosford	46,375	48,581	2,206	4.8%
Wollongong	43,359	47,782	4,423	10.2%

The following table shows the Emergency Departments with the highest rates of growth in presentations over the same period:

	Presentations			
Hospital	**2005/06**	**2006/07**	**Growth 05/06 to 06/07**	**% Growth**
Liverpool	51,794	57,211	5,417	10.5%
Bankstown/Lidcombe	33,823	38,987	5,164	15.3%
Royal Prince Alfred	49,960	54,962	5,002	10.0%
St. Vincents	35,206	40,156	4,950	14.1%
Campbelltown	39,490	44,275	4,785	12.1%
Penrith-Nepean	46,368	50,994	4,626	10.0%
Wollongong	43,359	47,782	4,423	10.2%
St. George	49,392	53,707	4,315	8.7%
Westmead	45,669	49,779	4,110	9.0%
Prince Of Wales	40,677	44,609	3,932	9.7%

Royal North Shore Hospital's Emergency Department is not the busiest, and it is not in the top 10 across the State in terms of demand growth.

The following table shows the number of admissions from the Emergency Department to a general ward, ICU or operating suite for the 10 highest volume Emergency Departments:

Hospital	**Attendances admitted to general ward, ICU or via operating suite**	
	June 07	**% var from June 06**
John Hunter	16,368	9.5
Liverpool	19,896	19.4
Royal North Shore	**16,314**	**6.5**
Royal Prince Alfred	15,440	24.1
St George	18,253	7.5
Westmead	16,428	4.9
Gosford	15,484	0.9
Penrith-Nepean	16,562	12.0
Wollongong	11,496	6.0
Childrens Hospital Westmead	8,347	10.5

Royal North Shore is experiencing growth in the number of patients admitted from the Emergency Department, however its rate of growth is lower than the rate of growth of many of its peers.

The following table summarises the level of senior medical specialist staff and treatment spaces in these Emergency Departments:

Hospital	Attendances 06/07	Emergency Specialist FTE*	No. of ED beds/ treatment spaces**	EMU beds**
John Hunter	58,117	8.75	35	16
Liverpool	57,211	10.125	40	10
Royal Prince Alfred	54,962	8	32	8
St George	53,707	10	24	12
Penrith-Nepean	50,994	11.4	34	16
Royal North Shore	**49,900**	**10.55**	**32**	**5**
Westmead	49,779	10	35	7
Childrens Hospital Westmead	48,903	6.3	24	0
Gosford	48,581	7.8	26	0
Wollongong	47,782	8.35	32	0

Sources:
*Joint Department of Health-ASMOF Survey covering period 18 to 22 June 2007
**Phone survey Area Bed Coordinators November 2007

This table shows that while Royal North Shore has lower than the average number of attendances for this group of hospitals, it has above the average numbers of staff specialists and around the average number of beds and treatment spaces.

A key contributor to Emergency Performance is the capacity of a hospital to admit patients from the Emergency Department to a ward bed. As noted above, Royal North Shore had a lower number of admissions from the Emergency Department than a number of its peers and a lower rate of growth in admissions over the last year.

The average occupancy rate provides an indicator of the hospitals capacity to absorb admissions. A comparison of bed occupancy rates for peer hospitals is made in the following table:

Hospital	Bed Occupancy Rate	
	2005/06	2006/07
John Hunter	87.6%	86.6%
Liverpool	96.4%	100.4%
Royal North Shore	**90.4%**	**89.8%**
Royal Prince Alfred	92.9%	87.8%
St George	93.6%	88.5%
Westmead	89.7%	90.2%

Royal North Shore Hospital's bed occupancy rate is around the average for its peer hospital group.

However, while Royal North Shore Hospital has below average attendances and growth, and average bed occupancy rates when compared with its peers, it falls below that of some of its busier peers on key indicators of Emergency Department performance.

Emergency Admission Performance measures the percentage of patients transferred from the Emergency Department within 8 hours. The following table compares the Emergency Admission Performance of the 10 highest volume Emergency Departments:

Hospital	Emergency Admission performance % admitted within 8 hrs of active treatment	
	June 06	June 07
John Hunter	81	82
Liverpool	64	76
Royal North Shore	**66**	**66**
Royal Prince Alfred	65	69
St George	67	75
Westmead	73	71
Gosford	76	74
Penrith-Nepean	65	71
Wollongong	65	74
Childrens Hospital Westmead	74	79

This comparison shows that not only was Royal North Shore the poorest performer in Emergency Admission Performance in 2006/07, many of its peers managed to substantially improve their performance in the face of greater demand pressures than those facing Royal North Shore.

The following table shows the percentage of patients transferred to Emergency Department within 30 mins of the ambulance arrival for the 10 highest volume Emergency Departments:

Hospital	Off Stretcher Time performance	
	June 06	June 07
John Hunter	77	75
Liverpool	79	63
Royal North Shore	**55**	**54**
Royal Prince Alfred	73	66
St George	64	65
Westmead	83	75
Gosford	65	61
Penrith-Nepean	86	66
Wollongong	75	64
Children's Hospital Westmead	97	98

The decline in off-stretcher time performance for most Areas reflects unprecedented growth in Ambulance transports and a particularly busy winter. However, Royal North Shore Hospital's performance was significantly poorer than that of its peers in 2006, and in 2007 remained well below the peer average.

The following table provides a comparison of Triage performance for 2006/07:

Hospital	Triage Category				
	Triage 1 *Immediately life threatening* **% treated in 2 minutes***	**Triage 2** *Imminently life threatening* ***% treated in 10 minutes****	**Triage 3** *Potentially life threatening* ***% treated in 30 minutes****	**Triage 4** *Potentially serious* **% treated in 60 minutes***	**Triage 5** *Less urgent* **% treated in 120 minutes***
John Hunter	100	95	79	80	90
Liverpool	100	80	64	70	91
Royal North Shore	**100**	**81**	**60**	**65**	**87**
Royal Prince Alfred	100	89	70	73	85
St George	100	86	66	75	91
Westmead	100	90	58	58	75
Gosford	100	71	60	63	84
Penrith-Nepean	100	78	50	62	85
Wollongong	100	88	66	67	83
Childrens Hospital Westmead	100	100	68	62	79

*Triage benchmarks are set by the Australasian College of Emergency Medicine

4.9 NSW Sustainable Access Plan

Improving patient access to core Hospital Services has been a key priority for the NSW Government in recent years.

In 2004/05 NSW Health implemented the *Sustainable Access Plan* to increase hospital capacity and to redesign how care was delivered to patients by frontline clinicians.

This Plan is focused on addressing the major pressure points that contribute to unnecessary delays in patient journeys by improving:

- emergency admission performance
- off-stretcher time
- triage times
- surgical waiting times and
- hospital length of stay

The combination of increased capacity, clinician-led system redesign and adoption of innovative models of care had led to substantial improvements in hospital performance.

Northern Sydney Central Coast has shared in the benefits of this initiative – with funding for more than 200 additional beds and bed equivalents since 2005/06. Royal North Shore Hospital has been a major beneficiary within the Area, with funding for an additional 53 beds, including three additional ICU beds and seven short stay.

But increased capacity alone is not sufficient to deliver efficient performance, real improvements have been achieved where increased capacity has been accompanied by improvements to models of care through clinical redesign and other processes.

As outlined in the earlier section on clinical management systems, Royal North Shore has failed to realise the full potential of such processes, despite Departmental support and funding for a range of Clinical Redesign projects.

Models of Emergency Care

New models developed for emergency care are focused on changing the way patients are managed as they journey through the ED. They are aimed at:

- early assessment, fast tracking and early initiation of clinical care
- reducing the delays that patients currently experience
- providing alternative options to the current 'one-size-fits-all' system
- providing appropriate locations outside the ED for patients who need only a short stay admission
- using short stay beds for patients who need a further period of intensive assessment or investigation and observation but not necessarily admission to a traditional long stay bed
- promoting direct to ward admission for certain conditions
- ensuring that people with minor injuries / illness are treated and discharged in a more efficient way
- realigning staff roles to ensure quicker flows
- increasing the use of the skills and experience of clinical staff to commence investigations and treatment whilst patients are waiting to see a doctor
- provide faster access to care:
  - with an emphasis on the clinical team commencing care, rather than 'waiting to see a doctor'
  - reducing the total time spent in an ED
  - standardising care to reduce variation for conditions such as chest pain.

From NSW Dept of Health *Models of Emergency Care* March 2006
http://www.archi.net.au/__data/assets/pdf_file/0008/14939/MoC_Emergency.pdf

NSW Health, Ambulance and Area Health Services have also worked collaboratively to develop strategies to manage demand in emergency departments. These include:

- Introduction of the Ambulance Liaison Officer to work collaboratively at the local area with hospital and Area Health Service staff to address issues as they arise and longer term Ambulance/hospital issues.

- Ambulance Release Teams (ART), are periodically located in hospitals to continue the management of ambulance patients, which allows the release of ambulance crew from hospitals to provide emergency health care and transport to a hospital.

Senior Ambulance staff work with senior hospital and Area Health Service managers to clear system problems and blockages.

Northern Sydney and Central Coast Area Health Service has two Ambulance Liaison Officers (ALO). The area of coverage is delineated geographically with one managing issues associated with the Central Coast the other for the North Shore and Northern Beaches.

The ALO for the North Shore and Northern Beaches is based at Royal North Shore Hospital and maintains regular attendance and contact with key personnel at the hospital including (but not limited to) ED staff and management, bed manager, patient flow unit and executive staff.

This has ensured that there is strong collaborative working relationship. The ALO maintains a high presence at RNSH during times of peak demand and works closely with key stakeholders to facilitate the timely movement of ambulance patients and ensure that collaborative strategies are implemented to achieve triage benchmarks.

Northern Sydney and Central Coast Area Health Service receives a comparable share of the growing health budget and has equal access to the targeted initiatives provided through the Sustainable Access Plan. Royal North Shore Hospital has comparable levels of Emergency Department resources and lower volumes of attendances and less demand growth than other comparable hospitals. And yet Royal North Shore underperforms on all of the key indicators of Emergency Department Performance.

Questions of efficiency – explored in the preceding section – are clearly relevant to understanding this underperformance but more fundamental is the issue of well-developed clinical management systems.

4.10 Managing patient access performance

The Department's preferred approach is to build the capability of Area Health Service and hospital executives to manage their own clinical and business environments in a sustainable way. Where real improvement is not achieved through this approach, a more direct intervention by the Department occurs.

The Department holds monthly performance review meetings with Chief Executives, Directors of Clinical Operations, Directors of Nursing, Directors of Population Health, Performance and Planning, General Managers and Area Patient Flow Manager. At these meetings areas for improvement are highlighted and examples of how successful hospitals are dealing with these challenges are provided.

Opportunities are provided to expose poorly performing hospitals and Areas to successful strategies used by other hospitals and Areas in managing the difficult challenges of improving performance in the face of rising demand.
Comparison between peer hospitals and Area Health Services is encouraged to engender a sense that improvement is both possible and desirable and Area Health

Services and hospitals are provided with examples of ways in which Redesign can improve performance.

The Department has supported the introduction of new Models of Care that are known to be effective, such as Fast Track Zones and EMUs. These models were implemented in Emergency Departments in Northern Sydney and Central Coast, including at Royal North Shore Hospital.

Areas are also supported through Knowledge Management system, including

- Master Classes at which International and National experts provide information to hospital managers about how to actively manage for performance. The Director of Clinical Operations of Northern Sydney and Central Coast and General Manager of Royal North Shore Hospital were frequent attendees at these sessions
- the ARCHI web site, in which a library of successful solutions is maintained

Following ongoing concern regarding hospital performance at Northern Sydney and Central Coast Area Health Service, an external review team was commissioned by Department of Health and reported its findings in July 2007.

The review found that Northern Sydney and Central Coast Area Health Service needed to focus on the following areas:

- Improving clarity of management accountabilities for performance
- Improving engagement of senior inpatient clinicians in access and patient flow matters
- Improving access to diagnostics from the Emergency Department
- Demand and escalation policies
- Strategic use of data
- Improving communication between hospital management and clinicians
- Engaging Visiting Medical Officers (VMO) in improving patient flow and facilitation of timely discharge

Since July the following actions have occurred to ensure implementation of the review recommendations:

- One of the successful Clinical Service Redesign Program partners has been engaged to support the Area Health Service executive in implementing the recommendations
- Regular meetings have occurred between the Department and the new Chief Executive and Director of Clinical Operations to track implementation of solutions.
- Two senior Departmental staff with expertise in Patient Flow and Emergency Department improvement strategies have been seconded to work with Royal North Shore management and staff to improve Emergency Department and Patient Flow systems from September to November 2007.
- Weekly visits by senior Departmental officers to meet with management and monitor implementation of access improvement strategies at Royal North Shore.

5. PATIENT SAFETY AND CLINICAL QUALITY , COMPLAINTS HANDLING AND INCIDENT MANAGEMENT

5.1 Overview

Improving patient safety and clinical quality underpinned by robust complaints handling and incident management systems has been another priority area for the NSW Government.

It should be noted at the outset that the former Northern Sydney Area Health Service, and Royal North Shore Hospital in particular, have historically been leaders in the development and use of clinical safety systems. Many of the processes and principles that inform the NSW Health Patient Safety and Clinical Quality Program were first articulated by clinicians at Royal North Shore.

The NSW Patient Safety and Clinical Quality Program, which commenced in May 2004, provides the framework for improved patient safety and clinical quality in the NSW public health system.

The aim of the Program is to ensure that all significant adverse incidents are reported and reviewed so that education and remedial action can be applied both locally and system-wide where appropriate.

Components of the program include:

- the establishment of the Clinical Excellence Commission (CEC)
- the establishment of Clinical Governance Units (CGU) in all Area Health Services
- Systematic management of incidents and risks, including the Incident Information Management System (IIMS)
- policy setting and standards development, and a quality assessment program for all area health services.
- The development of initiatives and resources to support proactive improvement in targeted areas.

The Program is underpinned by guiding principles including:

- Openness about failures – errors are reported and acknowledged without fear of inappropriate blame and patients and there families are told what went wrong and why
- Emphasis on learning – the system is oriented towards learning from its mistakes and extensively employs improvement methods
- Obligation to act – to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit
- Accountability – the limits of individual accountability are clear. Individuals understand when they may be held accountable for their actions.
- Just culture – individuals are treated fairly and are not blamed for the failures of the system
- Appropriate prioritisation of action – action to be taken is prioritised according to the available resources and directed to those areas where the greatest improvements are possible
- Teamwork – is recognised as the best defence against system failures and is explicitly encouraged and fostered within a culture of trust and mutual respect.

The Department is responsible for the development of the essential components of the NSW Patient Safety and Clinical Quality Program with lead responsibility for:

- Setting standards for Area Health Service Quality Systems
- Developing policies on quality and safety that need state-wide implementation
- Developing and reporting on system wide quality indicators
- Monitoring and analysing serious clinical incidents, and taking appropriate action such as advice and warnings to the health system
- Overseeing state-wide clinical governance issues
- Overseeing consistency implementation of the NSW Patient Safety and Clinical Quality Program.

Area Health Services are responsible for ensuring that the program is implemented locally, including the establishment of Clinical Governance Units and Clinical Governance Committees.

Clinicians together with managers are responsible for the quality of health care delivered at the local level – within their clinical area or location. Clinicians are expected to engage actively with clinical quality and safety, including reporting of adverse incidents and participating openly in root cause analysis processes.

5.2 Clinical Excellence Commission (CEC)

The Clinical Excellence Commission has an important role in assisting Area Health Services to achieve and maintain adequate standards of patient care through system analysis and system improvement.

The CEC was established to be a catalyst for change and improvement in healthcare service delivery in NSW and by making it demonstrably better and safer for patients and a more rewarding workplace. Current projects and programs include:

- Blood Watch Program
- Central Line Associated Bacteraemia in Intensive Care Units
- Children's Emergency Care Project
- Clinical Leadership Program
- Medication Safety Project
- Safer Systems Saves Lives
- Towards a Safer Culture Project (Phase 2)
- Quality System Assessment Program, and
- Venous Thromboembolism Prevention Program.

Further information regarding the above programs and projects can be viewed online: http://www.cec.health.nsw.gov.au/about.html

5.3 Complaints Handling and Incident Management

NSW Health has done extensive work in the area of complaints and incident management and continues to review and update these policies and guidelines. The latest version of the complaints management policy directive and guidelines provide Area Health Service with guidance to the handling healthcare complaints.

The policy directives provide a set of principles which must be addressed when managing complaints and any concerns about the quality of health services and is applicable to all staff working in the NSW health system, whether employed or contracted.

5.4 Incident Information Management System

The Incident Information Management System (IIMS) was implemented across the public health system in 2005 and records all complaints and incidents by the facility/location within the Area Health Service. The information collated provides clinicians and managers with a capacity to identify and learn about risks before they translate into incidents and to effectively use this knowledge to improve the safety and quality of clinical care.

Each complaint and incident is prioritised is to ensure that a standardised, objective measure of severity is allocated. This enables an appropriate level of investigation to be conducted and enhances transparency especially for patients and relatives. The Severity Assessment Code (SAC) is used to prioritise all notifications. The SAC is a matrix that takes into account both the consequences of the incident (or near miss), and the likelihood of recurrence of the incident (or near miss) to apply a numerical rating. The SAC score is to be applied to all incidents and complaints.

SAC score guides the level of investigation and the need for additional notification. All SAC 1 incidents are escalated to the Chief Executive of the Area Health Service and notification to the Department of Health. All serious incidents and complaints (SAC 1) are subject to a local level Root Cause Analysis (RCA). This allows both timely review of issues arising at a local level and also allows the Department to consider statewide implications from individual incidents or trends.

The Patient Safety and Clinical Quality Program also uses IIMS to produce regular *Reports on Incident Management in the NSW Public Health System*, which provide information to the public about statewide trends. To date three reports have been released, covering 2003-04, 2005, 2006.

The Reports can be viewed at:

http://www.health.nsw.gov.au/pubs/2006/patient_safety_3.html

http://www.health.nsw.gov.au/pubs/2005/pdf/patient_safety.pdf

http://www.health.nsw.gov.au/pubs/2005/pdf/incident_mgmt.pdf

The 2007 Report will be a joint report between NSW Health and the CEC, and is due by the end of 2007.

Further information can be obtained from the PD2007_061 Incident Management Policy http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_061.pdf

5.5 Root Cause Analysis

In 2004, in line with recommendations made by the Walker Special Commission of Inquiry, the Health Administration Act 1982 was amended to

- Require all SAC 1 incidents to be subject to an RCA;
- RCA Teams with a statutory privilege, to protect their internal documentation from being released;
- Provide for reports of an RCA, including a description of the incident, a causal statement and recommendations tyo be exempt from the privilege.

The Amendments also included a provision for the new RCA provisions in the Act to be reviewed in 2008. NSW Health has recently begun this review in accordance with GPSC No2 2006 Report, which suggested fast-tracking the review.

5.6 Open Disclosure

It is an underlying principle of the NSW Patient Safety and Clinical Quality Program that the public health system operates in an environment of openness about failure, where errors are reported and acknowledged without fear or inappropriate blame, and patients and their families are told what went wrong and why.

Compliance with the NSW Health Open Disclosure Policy is mandatory and a component of performance agreements with the Area Health Services. Health Service Chief Executives are required under the policy to ensure that staff in their Health Service acknowledge when an incident has occurred and initiate an open disclosure process.

Chief Executives are also required to ensure that resources are available to enable implementation of the required open disclosure education and training, and the open disclosure process. As part of the state-wide rollout of open disclosure, a two tiered education program is being conducted.

Responsibility for the implementation of Open Disclosure in each of the Area Health Services lies with the Director of Clinical Governance. The Area Health Services have developed individual governance structures, implementation models and have demonstrated a high level of commitment and support for the initial roll out of Open Disclosure training.

An extensive staff education and training program regarding Open Disclosure is underway across Area Health Services.

The new policies and training program will assist Royal North Shore Hospital to improve its practices in relation to open disclosure. The newly established Professional Practice Unit will also strengthen open disclosure practices.

5.7 Role of the Health Care Complaints Commission - Complaints Handling

The HCCC is an independent body with responsibility for dealing with complaints under the Health Care Complaints Act 1993.

The 2005-06 Health Care Complaints Commission Annual Report indicated that the HCCC received 3023 written complaints in 2005–06, an increase of 7.4% on the 2816 complaints received in 2004–05[11].

In comparing the number of complaints received to the occasions of service within the health system, the commission noted in its 2005-06 Annual Report (p.20) that,

> *"It should also be understood that the number of complaints to the Commission, compared to the number of occasions on which health services are provided, is very small. .....[complaint received regarding the] Emergency Departments in public hospitals, the Commission received 107 complaints in 2005–06. There were over 2 million Emergency Department attendances in NSW in the same period."*

Our Commitment to quality and safety

Ensuring patient safety and excellence in health care is a top priority for NSW Health.

The incident management system has been in place since May 2005 and provides a comprehensive systematic mechanism to enable incidents to be electronically notified and investigated.

When things do go wrong we have systems in place to ensure that we learn from mistakes and act to make the system better.

NSW Health has for the past three years published an annual report on incident management. NSW is the first system in Australia to do so.

Another important initiative of the New South Wales Patient Safety and Clinical Quality Program has been the statewide implementation of the open disclosure policy.

The open disclosure policy ensures that patients and their carers are informed that an incident has occurred, that an investigation will be undertaken and that patients and their carers will be advised of the results of the incident investigation process.

[11] Health Care Complaints Commission, Annual Report 2005-06, P.5.'

6. THE WAY FORWARD

A number of important changes have taken place at the Northern Sydney and Central Coast Area Health Service in recent months.

Upon commencement in September 2007, the new Chief Executive immediately developed a comprehensive improvement plan for Royal North Shore Hospital, including:

- Improving management capacity and capability.
- Identifying the internal problems and take action to resolve them
- Re-engaging clinicians in the hospital in joint decision making through the implementation of a clinical management structure.
- Introduction of sound internal controls coupled with creation of a clinical management group committed to the organisation recovery and growth and willing to take on budget management responsibilities.
- Implementation of clinical system redesign strategies to improve patient access.

It is anticipated that these plans will be outlined in more detail in the Area Health Service's submission.

The tragic incident of Ms Jana Horska's experience in the Emergency Department at Royal North Shore was the subject of an independent review which made a number of recommendations for substantial, system wide improvements to the treatment provided to women presenting with threatened miscarriage.

After considering their recommendations of the report, the Government has agreed to provide new funding of $4.5 million in the current financial to expand the early pregnancy services available to women across New South Wales including:

- 14 new portable ultrasound scanners will be provided to areas that do not already have that type of service – including Royal North Shore
- Rapid assessment and advice from special new early pregnancy units in major hospitals staffed by trained and skilled specialist nurses
- A network of early pregnancy assessment services to offer clinical assessment and advice, providing a network of specialty services including ultrasound, scanning, diagnosis, and other support and advice services
- Expanded antenatal clinics to rural and regional communities
- Access to social workers and counsellors
- 24/7 telephone advice service
- Strengthened partnerships with GPs

The Department looks forward to working closely with the new management team at Northern Sydney and Central Coast Area Health Service to improve Royal North Shore Hospital, to ensure that it continues to provide excellent health services to its community and to NSW into the future.