Submission

No 38

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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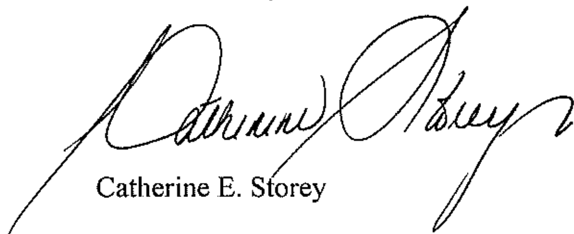
9th November, 2007

The Reverend F. Nile AO, MLC,
Chairman
Joint Select Committee Inquiry
Parliament House
Macquarie St
SYDNEY 2000

Dear Sir

Please find attached a report on behalf of the Department of Neurology of the Royal North Shore Hospital, for submission to the Joint Select Committee Inquiry to inquire into and report on the quality of care for patients at the Royal North Shore Hospital.

Yours faithfully



Catherine E. Storey

SUBMISSION TO THE JOINT SELECT COMMITTEE INQUIRY

ROYAL NORTH SHORE HOSPITAL

Prepared by
Clinical Assoc. Professor Catherine Storey

On behalf of
Department of Neurology
Royal North Shore Hospital

November, 2007

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3. **Summary**

The following submission to the "Joint Select Committee Inquiry to inquire into and report on the quality of care for patients at the Royal North Shore Hospital" (RNSH), is prepared by Clin. Assoc. Professor Catherine Storey, following consultation with members of the Department of Neurology and Neurophysiology, Royal North Shore Hospital.

1. Background

As this inquiry is to report on the quality of care for patients at Royal North Shore Hospital, I would like to preface my remarks with a re-assurance to the committee that the quality of care provided to patients by staff of the Neurology department at RNSH is excellent. The medical, nursing, allied health, clerical and ancillary staff with whom I work are committed to providing the best care for each and every patient who presents or is transferred to RNSH. However, the conditions under which this care is provided is at times frustrating and it is these frustrations that are taking their toll on the remaining staff. The staff who have remained at RNSH (and unfortunately there have been many highly regarded staff who have left the system in recent years) are all committed and dedicated to the public hospital system.

The department of neurology is a busy service. There are 3.5FTE staff specialists and 3 VMOs making up a complement of 9 neurologists, only one of which has a full time appointment. With this relatively small allocation of medical funding (in comparison to comparable services state and nationwide) we are able to provide a 24 hour, 7 day a week on call service, with point of first call to the Emergency Department, a senior neurologist.

We have 15 neurological in-patient beds, 8 of which are committed to the stroke service. There are on average 20 neurological in-patients at any time in RNSH, most of whom have been admitted as urgent admissions from the Emergency where, often many, remain as outliers in the Emergency department awaiting a bed on our ward. There is a busy neurology consultative service provided to the rest of the hospital averaging 2-3 consultations/day. Approximately 450 new stroke patients are admitted annually to the stroke unit at North Shore, one of the busiest services in the state. The service also accepts patients from the other hospitals within the area and from outside area for more specialised neuro-interventional procedures. The number of active members of our stroke team however, is well below the average for other NSW and national hospitals. The nursing complement and allied staff are particularly below accepted norms, yet our exceptionally good outcomes are maintained by sheer dedication of the current staff. The stroke unit also maintains a comprehensive database, which is in constant use as a monitoring tool, and we routinely perform an audit of the unit's performance on an annual basis to ensure that standards are maintained. Our outcomes are benchmarked against other units in the area and overall results compared with those of the Royal College of Physicians (UK).

Discipline	Your Site	NSW/ACT	Qld	SA	Tas	Vic	WA	All N=54
Clinical Psychology	0.1	0.1	0.0	0.1	0.0	0.0	0.0	0.0
Dietetics	0.2	0.5	0.3	0.3	0.3	0.3	0.4	0.3
OT	0.2	1.1	0.9	0.7	0.3	0.9	1.1	0.9
Physiotherapy	0.5	1.1	1.4	0.8	0.7	1.0	1.1	1.1
Speech Pathologist	0.5	1.0	0.8	0.6	0.4	0.6	0.7	0.7
CNC	1.0	0.9	0.3	0.5	0.8	0.4	0.4	0.6
Clinical Nurse Specialist	0.0	0.9	0.1	0.2	0.0	0.5	2.3	0.6
Stroke Research Nurse	0.3	0.2	0.4	0.4	0.0	1.0	0.0	0.4
Nurse Unit Manager	1.0	1.1	0.6	0.3	0.0	0.8	0.8	0.8
Neurologist	1.0	1.3	0.7	0.4	0.0	0.7	1.4	0.9
General Physician	0.0	0.2	0.3	0.2	0.1	0.2	0.1	0.2
Geriatrician	0.0	0.3	0.1	0.4	0.0	0.2	0.0	0.2

Table 1: Composition of stroke unit team membership and median FTE for a 10 bed stroke unit – results from the recent national audit undertaken by the National Stroke Foundation

The stroke unit also has an active programme of thrombolysis for acute ischaemic stroke and although the numbers are low, the activity compares favourably with state and national figures. (Table 2)

	Your site	Total (N=254)	NSW/ACT (N=54)	NT (N=5)	QLD (N=57)	SA (N=33)	Tas (N=4)	Vic (N=48)	WA (N=25)
% offering thrombolysis	YES	24%	32%	0%	16%	12%	50%	29%	24%
Number thrombolysed last year (Median and IQR)	6	4 (1 – 10)	2 (3 - 6)	NA	3 (1 – 7)	11 (6 – 13)	4 (2-5)	14 (2 - 22)	5 (1 - 11)

Table 2: Hospitals offering thrombolysis and the number of patients thrombolysed per site - results from the recent audit undertaken by the National Stroke Foundation

There is a weekly outpatient clinic attended by 2 neurologists, and a speciality neuro-genetics clinic attended by 1 neurologist. The weekly out-patients caters for general neurology patients referred from Emergency department, each alternate week, while at the other alternate weeks there is either a specialised multi-disciplinary clinic for the assessment of patients with motor neuron disease, or a movement disorder clinic. There is also a monthly multi-disciplinary clinic for the assessment and treatment of patients with spasticity.

The department is responsible for a comprehensive neurophysiology service (the only such service in a public hospital within the NSCCAHS). This provides studies such as EEG, nerve conduction and evoked potential recordings as well as more complex neurophysiological investigation including operative monitoring for spinal and neurosurgical procedures. The service also provides investigations for in-patients from Ryde, Mona Vale and Manly Hospitals, out-patients referred from other clinics at North Shore, as well as a limited general referral.

The teaching commitment for all members of the department is large, commensurate with a large Teaching Hospital. Teaching programmes are provided for the students of the Northern Clinical School, as well as many post-graduate activities, the training of advanced neurology registrars, basic physician trainees. All neurologists are involved in teaching throughout the year. Two weekly clinical meetings are conducted each week which serve as both educational and peer review activities for the unit.

There is also a significant amount of research activity carried out in the department. As well as basic research in neuro-genetics and movement disorders (all of which have attracted NHMRC funding), there are many ongoing clinical projects in epilepsy and stroke. Several of the neurologists are actively involved in the supervision of doctoral students, with several post-doctoral students continuing complex research projects. There are also several honours students under supervision each year.

Only 3.5 FTE staff specialists and 3 VMOs (0.3 FTE) neurologists support all of these activities. All members of the department are committed to the provision of the best quality care available for all patients, but the lack of support to the practicing clinician makes this task increasingly difficult to achieve.

2. Areas of concern

One of the constant overriding themes that has pervaded RNSH for the past decade has been that RNSH is an expensive institution to run. We are told that financially we are a "basket-case" over and over again. Yet there has never been an attempt, at least for this department to provide an explanation as to why this might be so. Attempts to reign in the budget are indiscriminate (such as total freezes on replacement of vacated positions), usually affecting smaller, more financially vulnerable departments that do not have a revenue- raising infrastructure independent from hospital finances. Many of the concerns for practicing clinicians are as a consequence of these financial restraints. From the position of the department of Neurology the following are our main areas of concern.

2.1. Lack of an overall area strategic plan for neurosciences

The Department of Neurology at RNSH has always assumed that it has a role as a tertiary referral centre for other neurology units within the area. RNSH has the only neurosurgical, neuro-interventional and neurophysiological service within NSCCAHS. Over the years patients who require these more specialised services have been referred to RNSH and it is often members of the Department of Neurology who facilitate this transfer and coordinate these patient's care. What is not clear is how the financial infrastructure of the area is structured to accommodate these more specialised and more costly procedures. It has always been a concern of this department that in the comparison's of costs of patient care across the area that these anomalies may not be adequately addressed in the cost allocations. For instance, a very ill patient seen and treated in Gosford for a day before transfer to RNSH, will have the same discharge diagnosis and coding as when that same patient is discharged from RNSH some weeks later. A length of stay of one day looks very favourable for a specific diagnosis, in comparison to a length of stay of many weeks.

There is at present an ad hoc agreement of transfer of patients across the area but there does not appear to be an overall strategic plan that sets out these arrangements in a formal or efficient manner.

Implication: If a strategic plan was in place, we might be reassured those financial considerations had been factored into the plan, and it should lead to a more efficient use of scarce resources.

2.2. Lack of documentary support for medical costings

We are constantly told of the expensive medical costs that are assigned to RNSH. All documents make reference to these high costs without explanation. Departments are never given any idea of how these figures are derived. This information has been asked for over and over again but there has never been any financial dissection of these costs, or any explanation as to how these costs are derived. The questions we have asked include whether there is account taken of University salaries when comparing one neurology department's medical costs to another? Or whether administrators' costs are included in an overall medical budget. If these high medical costs were made more transparent, and we can genuinely be seen to more expensive then I am sure that clinicians would be only too pleased to become part of the solution.

Attempts by management to curb these costs appear ill conceived by the practicing clinicians. One strategy was a blanket freeze on all positions vacated for whatever cause. For example our own department was denied a replacement departmental secretary for a period of approximately 9 months, during which time there was only sporadic answering of the telephone for the department, no discharge summary typing, sporadic clinic letter writing, neurologists left to do their own letters, organise rosters etc. This is an extraordinarily inefficient use of their scarce time. Following the death of one of our young neurologists, the position was only approved for re-advertisement after a period of some six months. During this time, the work-load was re-distributed amongst the remaining neurologists, while administration was continuously approached about the need to fill the position.

2.3. Poor data collection and management of data

Any attempts at challenging the allegations of excessive and expensive medical costs are met with the explanation that these figures are derived from DRG data. Data collection in this institution is far from satisfactory. We do not direct the blame solely at the coders; we are aware that there are many factors responsible for this huge deficiency. The stroke service at RNSH maintains its own independent data-base. On any occasion when this independent data has been compared with official data the data has been at significant variance. A recent review of stroke data collection identified that a single stroke type, which forms approximately 20% of all strokes admitted to RNSH did not even appear on the official data collection set. We are making our own arrangements to correct this problem now that we have identified the deficit, however, there appears to have been a severe short fall in the official response to this problem which has been recognised by clinicians for many years. Overall the department is of the opinion that the financial situation in which RNSH now finds itself is largely as a result of poor data management.

2.4. Lack of a capital works programme/ lack of effective programme for equipment replacement

There appears, from the clinical point of view, no capital works programme in place. The state of the building is appalling, the conditions under which we work are often substandard, while clinical areas lack a programme of maintenance.

There is also no coordinated programme across all service departments for a process of equipment replacement. The inability to replace equipment in a reasonable time frame leads to huge inefficiencies within the hospital. The malfunction of a piece of equipment in a department and a wait of a few days for a specific study which dictates patient's management, adds to a length of stay, can potentially add to a patient's distress and efficient management. Replacement of equipment is generally done on an ad hoc basis depending on critical need at the time and not according to any programme of replacement. Often various departments are in open conflict as to which will receive scarce resources to replace failing equipment.

The computers in the department of neurology were supplied as a donation from a government office, looking for a suitable charity to receive their computers after two years usage, we were indeed very grateful for this donation and they remain in use in our department after some four years. Most of the equipment in the Department of Neurophysiology has been purchased by donation from the hospital's very active charity committees.

A transparent, programme of equipment replacement would certainly improve efficiencies within the hospital.

2.5. Lack of continuity in management at both a hospital and area level

A further area of frustration to the individual clinician and to departmental efficiency has been the constant replacement of administrators at both an area and hospital level. We are sure that the record is available to members of the select committee. It is very difficult for each sequential manager to develop an understanding of the unique difficulties of each department as that department relates to the hospital and the area. From a clinician's perspective, there has been no continuity. Any problem or project that requires input from administration has to be reiterated with each and every manager.

With the establishment of the larger NSCCAHS and the removal of the administration to Gosford there seems to have been a total disconnection of management and clinician. This has been further exacerbated by the constant change in administrative positions, with a series of "acting" positions at both a hospital and area level. There has been no continuity, no ongoing processes of negotiation, and more importantly any corporate memory. There is a perception at the clinical level that there is no longer the staff to assist when problems arise relating to staffing and HR issues, as well as daily clinical problems.

2.6. Lack of I.T. infrastructure to support practicing clinicians

In this age of technology there is an appalling lack of IT support at RNSH. There is no access off site to any radiological imaging. Neurologists on call are often rung after hours by the most junior staff. This junior staff member is often the one who will be explaining an image from a CT scan etc. The neurologist has no access to any of the patient's radiological procedures or pathology results. Yet this facility is available at many other comparable hospitals in the state. We regard this deficiency as not being in the patient's best interest.

At RNSH we are in a fortunate position to have a very expert neuro-radiology service. Our stroke service has been attempting unsuccessfully for more than a year to arrange for an across area neuro-radiology meeting. It is envisaged that all hospitals of the area could discuss difficult studies to have the value of the expertise of the radiologists at North Shore as well as the input from their peers. This project, although eagerly awaited by all the area stroke directors, has failed due to the lack of IT support at RNSH. We feel that this project would benefit many patients across the area.

2.7. Lack of administrative support

Each medical member of the Department of Neurology is a busy clinician. Our aim is to provide the best medical care for the patient. However, this is not always an easy task for the Neurologist at RNSH. To run such a department requires a certain amount of support. We need to have input from those with business acumen, with HR training, with financial knowledge and IT expertise. Yet none of these facilities are readily available to the clinician. This leads to gross inefficiencies in the system, where busy clinicians are expected to fulfil many of these roles often encroaching on the time that can be spent in clinical activities. It is felt that a lack of financial assistance for the department has resulted in its present state where there are no available funds to replace equipment or supply research nurses to support clinical services as happens in many other clinical areas.

2.8. Lack of consultative process in hospital redevelopment project

The redevelopment of RNSH was originally seen by our department as a means to unite all clinical neuroscience in the hospital into one unit, with greater efficiencies, and improved clinical outcomes and the potential to become one of the foremost units in the country.

For many years various members of neurology, neurosurgery and related specialties met to discuss these concepts. It was a very exciting prospect. What happened was inexplicable. Gone were the years of planning of a structured unit of neuroscience and in its place was a fragmented, disconnected plan that neurology and neurosurgery would be separate entities, but also each would be split into out-patient and in-patient services.

At the present time, all neurology services are co-located. The one area subserves the department of neurology, the neurophysiology service for both in-patients and out-patients, the offices for the staff specialists, the meeting room and secretarial support, with the clinical out-patients adjacent to this area. In this way the department has developed a strong collegiate spirit. There are efficiencies with staffing and provision of equipment as well as efficiencies for the studies we perform on patients, and the provision of a safe environment for these studies to be performed. There was however, no acknowledgment of these effects in the redevelopment plans and no consultation from practitioners. Rather, there is to be a total disruption of neurology services with the plan that the department would operate from seven different locations. This will result in a total fragmentation of the service, with isolated recording rooms in the generic out-patient area, several offices in what was nominated a department of neurophysiology, separate to the offices for neurology, a separate recording room in the ward area. This was totally unacceptable. We could identify many areas that would lead to inefficiencies in patient care, potential hazardous situations, as well as the need for duplication of staff and equipment. There was also the potential for the disruption of the strong collegiate spirit that ensures an efficient and safe service. From a neurological point of view the redevelopment is a planning disaster. The clinician was completely excluded from the final design. Many of our current neurologists can see no future in continuing their association with RNSH if this plan goes ahead.

3. Summary

The Department of Neurology aims to provide the best of patient care and we have methods in place to ensure that this continues. However, in recent years there have been many changes at RNSH that have led to an increasing frustration and poor morale amongst all staff members. All remaining staff continue to do their best under increasingly difficult circumstances. We are told that this is an expensive hospital, yet those who are trying to maintain standards are not privy to the information upon which resource allocations are based. We are told to be more efficient within these existing constraints yet we know that there are many inefficiencies as a result of false economies that occur as a result of budget cut-backs. We are told that mechanisms must be in place to ensure that there are processes to ensure quality of care, yet we know that these programmes are not adequately funded or adequate infrastructure available for the practicing physician to maintain these processes. The redevelopment of RNSH was seen by many as the new way forward in efficiency of services, but sadly this too has been a most frustrating process and falls short of the promise that it once held for RNSH physicians.