

Supplementary
Submission

No 37a

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Date Received: 23/11/2007

Summary

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

Dear Reverend Nile,

I am the former Chief Executive of Northern Sydney Central Coast Area Health Service (until July this year) and gave evidence to the Inquiry at its request on 12th November. I also provided a submission to the Inquiry.

I would appreciate the opportunity to respond to a number of factual errors in the submission by NSW Health. This response is not intended to duplicate evidence already given by myself or others to the Inquiry.

I would appreciate also this letter being made a public document. Please regard this letter as a supplement to my previous submission.

Points raised by the Department and my responses are as follows.

1. Financial Management.

a. The DoH submission outlines concerns in 2005 regarding RNS financial performance and the initiation of a number of reviews. It documents improvements over 2005/6 and then recurrent concerns in 2006/7. The DoH provides figures purported to indicate that NSCCAHS had received similar budget increases to other Areas over a number of different timeframes.

When I commenced as CEO of the then Northern Sydney Area Health Service (NSAHS) in March 1997 the Area was in a difficult financial position. Over succeeding years the Area initiated an active program of Corporate Services reform and generated sufficient savings to maintain the Area's financial position and make targeted investment in service growth and service developments such as the well respected APAC (Hospital in the Home service). This was in an environment where the NSAHS's share of state health budget to Area Health Services went from (to use the same timeframes as the DoH has used in its submission); 10.9% in 1994/5, to 10.1% in 1998/9 to 9.1% in 2008/9.

The 1998/9 Resource Distribution Formula (RDF) had estimated the NSAHS's RDF share at 10.3%. In 2004 the Area's share was below this target. NSAHS is the only Area ever to have fallen from above to below its RDF share. NSAHS wrote to the DoH regarding the significant and damaging cumulative under-funding of the Area over the current and previous financial years against RDF share and additionally the cost of

statewide services. At that stage the Area's intention was that increased funding expected under the correct application of the RDF would restore capital funding and allow increased investment in IT, as well as providing funding for, in particular, some of the RNS state and Area wide specialty services.

The 2005 revision to the RDF had significant formula changes. The Area's target share reduced to 9.1% from 10.3% (though changes to the treatment of Mental Health means that these figures are not directly comparable). This was a devastating blow to the former NSAHS.

b. Regardless of arguments regarding the validity of the RDF formula, the challenge for management is to provide the best possible services within the given allocation.

For NSAHS and then NSCCAHS in 2004/5 the expectation of increased funds was not realised, and the Area worked with the DoH and independently in identifying savings strategies. As the DoH has identified, the Area's strategies yielded results, but in 2006/7 the Area again experienced financial pressures.

In meetings with the DoH in November 2006 NSCCAHS reported on strategies to meet financial objectives for 2006/7 and also attempted to raise strategies viewed by the Area as necessary for 07/08 to achieve budget in that year. NSCCAHS was of the view that the higher than benchmark DRG (casemix) costs achieved by RNS and some other former NSAHS hospitals was a result of the small volume services across hospitals as a result of the high volume of elective care being provided in the private sector. NSCCAHS saw the need to accelerate consultation around service configuration to achieve financially and clinically sustainable services, to enable investment in IT and capital, and to ensure quality services in the presence of current workforce shortages (see planning section later).

Over the early months of 2007 the NSCCAHS Operational Plan for 2007/8, developed in draft form at planning sessions in late 06/early 07 (which had involved senior clinicians) was refined through consultation with AHAC, clinical council and health services. An implementation and a consultation document were developed. I and members of my Executive had briefed each health service executive and were to conduct staff forums in late July, followed by Medical staff council meetings. The Department had provided no feedback on the plans within that document that related to consultation on service reconfiguration, and I had set up a meeting with the incoming Director General to discuss this. Prior to that meeting occurring as arranged, I met with the Director General in the meeting in which we agreed on a change of leadership. In that meeting it was indicated by the Director General that any proposal regarding service change was unlikely to be supported by the DoH. It was for this and other reasons that I chose to leave the Chief Executive position.

Prof Carol Pollock's references in her Area Health Advisory Committee (AHAC) reports to budget issues and lack of finalising of operational and clinical services plans, as quoted by the Department in their submission, were a result of AHAC's understanding and

support of the need for the strategies to be implemented. AHAC sought to gain DoH engagement in approving and supporting the Area's plans. They were not a criticism of the Area's management.

In Appendix 1, I raise issues regarding the financial data presented by the Department of Health in their submission. The data as presented does not, I believe, truly represent the financial realities for NSCCAHS or RNS.

On a final matter regarding finances, the DoH claims the AHS had poor control of FTE numbers. To the contrary, the AHS had very tight controls, the impact of which was the subject of evidence to your inquiry. FTE increases were in clinical areas. The majority related to funded enhancements, activity increases, or areas where clinical review had indicated the need for staffing levels to be increased to ensure safe care.

2. Planning and engagement/morale

The DoH has alleged a lack of clinical service planning at Area level and a lack of clinical engagement.

Prior to the merger of NSAHS and CCAHS both former Area Health services had clinical services plans. The CCAHS plan was known as the Health Access Plan and was in the process of implementation through the Gosford and Wyong Hospital redevelopments. The NSAHS plan was known as the Strategic Resources Plan (SRP) and had involved consultation with many hundreds of clinicians (much as the SESIAHS plan referred to in the DoH submission). The SRP had identified that there was a need to rationalise services on the Northern Beaches and in North Shore/Ryde so that there was functionally a single acute hospital for each of the respective populations. It had also identified a number of clinical services enhancements.

There was clinician dissatisfaction in the former NSH because the funding had not been able to be found to address the majority of issues identified, and for those who supported service reconfiguration, the pace of change was seen to be slow.

In response to the requirement to produce a clinical services plan for the new NSCCAHS, the approach taken by the Area's executive was to rely on the consultative processes undertaken in the two previous plans, to establish a steering committee to identify where consultation was required on specific issues, to gain Clinical Council input into the new plan, and to develop more detailed sub plans as networks became established that would own their implementation.

The key reasons for this approach were;

- a. Clinicians did not want to participate in a process until they could see that its outcome was fundable (a legacy of the SRP process)

- b. There was therefore a need to work progressively to fund previously agreed outcomes, and this required an initial focus on service changes that would deliver returns for reinvestment
- c. There was a need to focus the Area's limited planning resources on the Northern Beaches Hospital and RNS Hospital projects.

The Northern Beaches project in particular was essential for the ongoing provision of viable acute health services for that community. Seven years of clinical and community consultation had delivered an outcome—a new major acute hospital for the Northern Beaches with a complementary role for Mona Vale Hospital, and strong primary care services. We could not lose focus on delivering that outcome. I believe that the delivery of an agreed position with that community was a significant achievement for all involved, planners, clinicians and community members.

The Area Health Services Plan remains draft as it has not been approved by the DoH

A number of network plans are in place, and action on service planning and reconfiguration between RNS/Ryde were part of the 07/08 Operational Plan, with early clinical consultation having commenced and clinical leadership evident.

The Chair of the RNS Medical Staff Council and other RNS clinicians were part of Clinical Council and AHAC.

I will not redetail the clinical management structure being implemented for NSCCAHS, but only reiterate the underlying philosophy of a clinician management partnership. Progress was being made, though there was still some way to go. I was pleased to see Dr Ross Wilson's positive comments on these changes in his evidence to your Inquiry

The other issue raised, related to lack of clinician engagement in the RNS redevelopment. Early in the RNS project, there was a consultative process with good involvement, chaired by a clinician. There was agreement on a service model for the new RNS redevelopment. Subsequent DoH review of the proposal for the RNS redevelopment led to significant change. Probity constraints, as a result of the possibility that the project would be delivered as a public private partnership were seen to necessarily limit clinician involvement at this time and this led to disenchantment. I believe that the majority of the concerns expressed by clinicians have been addressed as a result of good work by the current project team.

3. IT and information

The lack of capacity to invest in IT was a frustration for the former NSAHS executive. Contrary to the DoH submission (but as acknowledged in the Area's submission) there were good clinical IT systems in place at the former Central Coast AHS.

Investment in IT by the DoH over the years up until about 2005 was not equitable. IT infrastructure tended to be upgraded as part of major capital redevelopments, and the

Areas with better IT tended to get funding for new projects. This was acknowledged by the DoH in implementing a more structured IT strategy in around 2005.

For the former NSH there was a need to upgrade its IT network to enable more modern systems to be implemented. This took time and resources and was finally completed last financial year. Despite running legacy systems the NSAHS was able to optimize information from them, and won an award for its web based financial information system. As part of the change to statewide IT application implementation much of this overlay has been lost and it is acknowledged that at the present time data is not as accessible as desired. This will change as the statewide applications are fully implemented.

Lack of ability to free up funds for IT (and other capital investment) was a continual frustration for all within the former NSAHS. The initial part of this letter dealing with Financial Management puts a context to this issue.

Some of the frustration expressed by clinicians relates to the availability of benchmarking information. This is not an IT issue, but more relates to different costing methods between Area Health Services. The Department is providing leadership in addressing that issue.

4. Access Performance.

In common with many other hospitals across NSW and Australia there is a need to improve access performance at RNS. The DoH submission contains subjective judgments regarding RNS engagement with the redesign process, with some of which I and others of my former management team do not agree.

In looking at the reasons for NSCCAHS poor access performance in the first part of 2007 it is worthy of note that June 2007 NSW Health Monthly Performance report bed data shows only a 6% increase in beds and bed equivalents for NSCCAHS (and SSWAHS) since March 2005, compared with a 10 or 11% increase in beds/bed equivalents for SWAHS, SESIAHS and HNEAHS.

The relatively smaller percentage increase in beds/equivalents in NSCCAHS and an increase in the number of ambulances RNS was expected to accept per hour under the ambulance matrix are a likely contributor to RNS's poor performance. This proposition does not negate the need for a continued focus on process improvement at Hospital and Area level

5. My Departure from the CE role

In leaving the CE role I believed that a fresh approach on a number of issues, and new leadership, might facilitate progress for RNS and for NSCCAHS. My hope as a result of

this Inquiry is that the hardworking staff of RNS should be supported and respected in doing their difficult and important work in providing care, and that there is a lasting benefit to RNS, its patients and the community it serves.

I would like to again emphasize that in my view many of the issues at RNS are an end result of an Australian Health system in which individuals with private health insurance access elective surgery at up to 2 ½ times the rate of those without private insurance, and the lack of sensitivity to that in the NSW RDF.

Thank you for the opportunity to respond to the DoH submission.

Yours sincerely

Dr Stephen Christley

Attachment: Appendix 1

Appendix 1

There are 3 areas where I would question whether the data provided by the DoH in its submission provided a reasonable basis on which to draw conclusions.

Issue 1

On the matter of funding for RNSH, the department in its submission has quoted figures for the RNS budget for 07/08 compared to 06/07 stating an increase of 4.1 million.

Reference to the 2005/6 NSH Annual report (see table below) shows how the DoH expresses budget changes from base budget one year to the next year.

Budget Allocations for the 2006/2007 Financial Year
After Initial Allocation Letter 30th June 2006
Grouping NCOS \$'000 Value
Initial Annual Budget from 2005/06 1,117,409
Award Increases 33,368
Growth – SAP 6,213
Growth – TACP 1,216
Growth – General 3,400
Growth – Savings -12,206
Escalations – Net Adjustments 2,108
Other Budget Supplementations (Mental Health) 3,203
Total Enhancements as at 1-Jul-06 37,302
Initial Budget for 2006/07 1,154,711

Unless the budget increase of \$4.1 million as quoted for RNS is greater than the increased costs of salary and wages award increases and goods and services inflation in the preceding financial year, and any announced service enhancements, then the figure may represent a **reduction in the RNS funding for existing services**. There should be transparency in the figures provided to the Inquiry.

Issue 2

The DoH has quoted NCOS general fund general to illustrate the budget performance of NSCCAHS.

The Health service budget is made up of a number of programs. Looking at Net Cost Of Service result overall the results were

For 2004/5, an unfavourable NCOS variance of \$8million. (For 2nd half 04/05, a \$9.3m favourable NCOS variance) (Source, NSCCAHS 04/05 Annual report)

For 2005/6 a favourable NCOS variance of \$15,628 million. (Source, NSCCAHS 05/06 Annual report)

For 2006/7 the Area reported an unfavourable NCOS variance of \$2.791 million. (Source, 06/07NSCCAHS Unaudited Financial Statement)

Regardless of these differences it is agreed that the Area has significant financial issues

Issue 3

The Department claims that funding for NSCCAHS has increased roughly in line with the other Areas.

The combined Area has in fact gone from 14.4% share of the budget to Areas in 1994/5 to 13.8% in 1999/2000 to 13.3% in 2007/8 according to RDF documentation.

The only way I can interpret this is that the significant increase in Mental Health funding to the former CCAHS, which experience a more than doubling of Mental Health beds must be included in the DoH calculation.

If this is the case then the increase in funding for services other than mental health for NSCCAHS is less than that for “all 8 Areas”

In nay event the figures for the old NSAHS show a significant decrease in budget share.