Submission

No 49

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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The Rev the Hon Fred Nile AO, MLC

Chair, NSW Parliament Joint Select Committee on the Royal North Shore Hospital

Parliament House

Macquarie St

Sydney 2000

Dear Sir

Please find attached my submission as Director Medical Services North Shore and Ryde Health Service, to the NSW Parliament Joint Select Committee on the Royal North Shore Hospital.

Yours sincerely

Dr Sharon Miskell

I am making this submission to the NSW Parliamentary Inquiry into Royal North Shore Hospital in my capacity as Director Medical Services North Shore & Ryde Health Service.

I completed 5 years of undergraduate medical training at Royal North Shore Hospital in 1977, and returned to RNSH in September 2005 when appointed as Director Medical Services. My motivation in returning to work at RNSH was threefold: I wanted to make a positive contribution to an organisation to which I am indebted for my professional training and career; I was aware that the organisation was in difficulty and wanted to contribute to efforts to redress this; I was honoured to be associated with an internationally recognised health care institution providing the highest standard of clinical services, teaching & education and research.

My submission summarises those key issues which I believe currently need to be addressed as a priority in order to achieve improved corporate and clinical governance at Royal North Shore Hospital.

These include:

- *capital plan and budget for RNSH*. There is currently no capital plan nor capital budget at RNSH. A capital risk register was commenced in May 2007 to assist the Executive in identifying and managing the clinical risks associated with old and broken equipment. In 2004/5, capital equipment needs of approx $30m were identified. This would now approximate to $50m at today's values. Funding to purchase replacement equipment is largely dependent on bequests and donations. Equipment has to be loaned from North Shore Private Hospital, and loaned on consignment from suppliers. The resultant risks to patient care include an operating table for cardio-thoracic surgery which has a broken spindle and is unable to be repaired and needs replacement; drill bits for complex Ear Nose and Throat surgery which can break mid-procedure; operating theatre laser equipment which is too old to be serviced by the supplier and for which parts are no longer being manufactured; and lack of equipment to provide interventional bronchoscopy including stenting, laser and ultrasound which is standard of care at a tertiary referral hospital for treatment of advanced lung cancer and other respiratory disease assessment.
- *strategic clinical services planning framework for NSCCHS*. In June 2006 Northern Sydney Central Coast Health Service (NSCCHS) re-structured, and a new Divisional structure was implemented in NSCCHS to achieve efficient and effective operational management of the four health services in NSCCHS, including North Shore and Ryde Health Service. At the same time, a new Clinical Network structure was to be implemented for NSCCHS to provide a strategic planning framework for NSCCHS. This has not occurred. Clinical Networks currently exist for Critical Care, Emergency Medicine, Cardiology, Paediatrics and Maternity Services, which were in existence prior to the re-structure in June 2006. The result is the absence of a strategic framework for service, workforce and capital planning at RNSH.
- *peer reference cost data analysis for RNSH*. The NSW Hospital Cost Data Collection provides comparative average hospital costs by cost bucket. 2005-6 data shows that RNSH has the highest total cost per weighted separation compared with other A1a tertiary referral hospitals, and that inpatient medical and nursing costs at RNSH are the highest compared with peer group. Since 2005, RNSH Executive and

clinicians have requested Area Executive to provide analysis of this data to understand why RNSH is reported as cost-inefficient and specifically those factors which are contributing to these high peer referenced costs, in order to achieve improvement in cost-efficiency. These factors include service category assignment, medical record documentation & coding accuracy, cost centre assignment, and inpatient fractions. This information has not yet been provided.

- *clinical services plans for NSCCHS*. There are currently no clinical services plans for NSCCHS with the exception of Mental Health. A number of clinical services plans including renal, paediatric and maternity are in draft form. The consequence is that the North Shore & Ryde Health Service has been unable to progress re-configuration of clinical services delivery at both RNSH and Ryde Hospitals to achieve a role delineation of minor risk/day 'cold'surgery at Ryde and overnight/emergency 'hot' surgery at RNSH. Nor is it possible for RNSH/Ryde to either effectively or efficiently role delineate with other health services (eg Hornsby) without an Area Strategic Clinical Service Plan. This delineation has been achieved in other Area Health Services with significant efficiency gains and reduced length of stay and delays to surgery.
- *medical workforce plans for NSCCHS*. A direct result of the absence of an Area Clinical Services Plan is that it has not been possible to develop medical workforce plans for either NSCCHS or RNSH/Ryde. As a result there is no strategic planning framework for making decisions about appropriate staffing levels and classification (ie either VMO or Staff Specialist) for the senior medical workforce nor the junior medical workforce.
- *delegated approval of new/replacement senior medical practitioners appointments at RNSH*. Delegated authority to appoint senior medical practitioners was removed from the North Shore & Ryde Health Service Executive in October 2005. The current process to obtain Area Executive to recruit replacement senior medical practitioners is resource-intensive and contributes to significant delays in recruitment to vacant positions. Approvals of new Staff Specialist position have been 'frozen' since October 2006 due to budget pressures, notwithstanding identified need.
- *clinical information systems at RNSH*. There is no regular reporting nor reliable data to provide clinician department heads at RNSH with monthly clinical and financial datasets which includes total separations, cost-weighted separations, length of stay, line item cost-centre reports. This information is essential to enable department heads to effectively manage departmental activity and budget, and to benchmark performance.
- *management capability and capacity of North Shore & Ryde Health Service Executive*. The juniority & instability of Executive appointments is an ongoing concern. The Executive consists of 13 positions of which 5 are currently acting positions. Appointments have been made to Executive positions where the appointees have no prior tertiary experience, and have been appointed beyond their competency. The juniority and inexperience of the RNSH/Ryde Executive is in

stark contrast to the seniority and management competence of senior clinicians at RNSH.

- *stability of Area Executive appointments.* There have been resignations from the positions of Chief Executive, Area Director Clinical Operations, Area Director Population Health, Planning and Performance, and Area Director Finance since July 2007. At both NSCCHS/RNSH & Ryde, there have been 29 resignations of key personnel, either executive or direct reports, in the previous two years since September 2005.