Submission

No 28

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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The Rev F Nile AO, MLC
Chairman
NSW Parliamentary Inquiry into Royal North Shore Hospital and Other Matters
Parliament House
Macquarie St
Sydney 2000

Dear Sir,

Please find following a submission on behalf of the Medical Staff Council of Royal North Shore Hospital for the NSW Parliamentary Inquiry in the Hospital and other matters.

Yours faithfully,

CM Fisher

This report is submitted as Chair of the RNSH Medical Staff Council. Although some specific examples and supporting evidence that may be presented orally is also based on my experiences as a clinician and Departmental Head, the issues are common to and no less important than in other Departments.

There are multiple issues confronting RNSH and NSCCAHS. This submission attempts to identify the underlying causes rather than the apparent issues or end products of the basic problems.

These include but are not limited to:

* lack of an Area Strategic Plan for Clinical Services (ie the clinical roles of RNSH and other hospitals are undefined) without which workforce, funding and equipment requirements cannot be determined nor distributed appropriately.

* lack of a capital equipment replacement plan at RNSH. There is strong data to show that capital and RMR funding for RNSH is and has been a fraction of other peer-sites.

> Unlike the reduced RDF allocation to NSCCAHS and hence RNSH, based on the Health Needs Index reflecting the enhanced survival of residents within the NSH), it cannot be argued that there a surfeit of quality and functional equipment on the RNSH campus. Rather most is outdated and may be a significant factor in the perceived financial inefficiencies of clinical care. A list of equipment purchased by the Hospital or Area over the last decade would be instructive to the Inquiry. It is contended that a lack of adequate equipment contributes significantly to inefficiencies, both clinical and financial. Lists of required equipment have been developed including that by the previous GM, Deb Latta.

* funding (via the RDF or otherwise) is output rather than outcome based.

> For example, at RNSH, although the apparent cost of treatment of patients with acute haematological malignancies is high, patient survival is also higher than elsewhere. It is not just how many services are provided (and at what cost) but also how well do the patients do.

> Not withstanding this, using the crudest measure of health outcome ie life expectancy, NSH patients age-for-age still have the highest survival in NSW, despite having the least amount of money (according to the RDF) allocated to their care.

* lack of meaningful interaction by management with clinicians

> this is not to say that clinicians are not involved but rather their involvement is token and their recommendations on strategic and critical issues either rejected, misreported or not minuted

> This is highlighted in the disenchantment of clinicians with the planning process for the new RNSH Hospital. For example, despite advice to the contrary, pathology services in the new hospital will either be off-site (histopathology) or do not appear to be anywhere (Blood Bank).

> Clinicians have consistently recommended an institute based model of patient care which has been consistently rejected.

The roles and responsibilities of Heads of Department at RNSH remain undefined. In reality, they have no financial responsibilities (requiring approval for most expenditures), no ability to appoint staff. Approval is required at an Area level to replace vacant medical appointments.

* lack of a reliable IT infrastructure and in particular a lack of a clinically focussed IT infrastructure.

This is core component of good clinical governance and its deficiency contributes to both financial and clinical inefficiencies.

Clinicians do not have ready access to dates of admission for booked patients nor receive data as a routine on care delivered (eg operations performed). Many have coped locally by developing individual or Departmental databases separate from the hospital system

Clinicians nor Departmental Heads do not routinely data regarding caseload (numbers of admissions, procedures, length of stay etc) in order to benchmark individual and Departmental performance

* lack of reliable data regarding clinical care and expenditure

There is a lack of accurate separations or cost-weighted separations data. Assurances have been given previously that inaccurate coding was not a problem (rather "it is clinicians that were the problem" but now undercoding is acknowledged to be an issue

Even simple data such as the number of discharges may be highly inaccurate, appearing to vary well beyond the suggested range of 20% according to the source of the data

Data is lacking regarding the adequacy of funding for the Statewide services actually provided at RNSH rather than merely the anticipated care (ie matching the actual costs of care with the funds provided). Prosthetic and Intensive Care utilisation for these patients in particular is high. In other words, it is not possible to determine if part of the RNSH's operating budget is used to cover shortfalls in funding for Statewide services)

no meaningful comparison is been made of actual versus theoretical separations

For example, allowance is made in the made in the RDF for the private-public mix, (the NSH area having the highest proportion of privately insured patients in NSW). However, the bulk of private in-patient services is undertaken in elective surgery. Clinicians perceive that substantial volumes of acute services on medical patients with insurance as well as urgent surgical services are frequently undertaken in the public sector often as Medicare patients (rather than in the private sector). The overall adequacy of funding for these patients in particular has been raised frequently by clinicians as possible area of under-funding.

The debate regarding budget and perceived inefficiency would be more productive if accurate data for **actual** funding and **actual** services delivered was available for RNSH. Comparisons with peers Hospitals would be more

meaningful if all used the same expenditure assessment methods. Despite assurances, the perception persists amongst many clinicians that RNSH is underfunded and undersized.

lack of availability of reliable financial data to clinicians

clinicians are committed to providing the best standard of care available but have been consistently criticised for being "too expensive". No hard data (other than summary data) as to how the Area and hospital budget is actually spent is been provided to clinicians to help identify possible areas of financial inefficiency for clinicians to address.

* the relatively high emergency load (both in the ED and operating theatres) is a particular problem for RNSH

* it has been already accepted that failure to meaningfully involve clinicians in important decisions has contributed substantially to the current situation at RNSH and that failure to address that process will not improve the situation. In other words, if clinicians do not become involved, things cannot be improved.

* clinicians also perceive issues with management to include:

- high turnover of senior managers with possible recent difficulties in recruitment to RNSH/NSCCAHS. A number of key positions are vacant or relieved. Not only have there been a large of General Managers at RNSH, the length of time when the position has been vacant or relieved is also substantial
- some managers unable to fulfil their assigned role:

  inability to address critical issues adequately

  failing to report critical issues upwards

  failure to act strategically

  typically placing financial concerns ahead of clinical considerations
- a lack of financial strategic planning (although there is a current financial problem, no long-term plan has been developed to address the issues)
- reluctance to allocate any financial resources to new or innovative processes even if they appear likely to save money (ie unpreparedness to spend a little to save a lot)
- confusion and conflict between Area and the Hospital roles and responsibilities

It is recognised that some changes in these issues have already been initiated, particularly following the new CEO taking up his position. However, the extent to which substantial and long-lasting improvement has occurred or will be sustained is far less apparent.