Submission

No 48

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

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Summary.

1 RNSH is one of the largest teaching hospitals in NSW and is the major hospital in the Northern Sydney Central Coast Area Health Service (NSCCAHS). It provides a high quality service to 12% of the NSW population in its role as both a local community as well as teaching and tertiary referral hospital. However, it has been severely limited in its ability to deliver those services in the last 10 years or so by a lack of Strategic Planning. This has been as a result of an emphasis on meeting "budget" targets rather than deciding the best ways to provide a clinical service.

2 The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation dedicated to improving the quality of health care in Australia through continual review of performance, assessment and accreditation. The results of the 2007 ACHS survey of RNSH are noteworthy. RNSH initially failed to obtain accreditation and was given a further 6 months to improve standards. It was then granted 1 year of conditional accreditation from October 2007 for "moderate achievement". This is a low accreditation rating and is notable when 1233 facilities were granted full accreditation for 4 years. This is a significant departure from a previous ACHS rating as one of the top hospitals in Australia in 1988.

3 The Emergency Department provides an excellent clinical and training environment but is restricted in its ability to provide quality care by severe access block in the hospital as well as a shortage of senior medical and nursing staff. If a hospital such as RNSH consistently has 94% or greater bed occupancy that leads to access block, this seriously impairs the function of the Emergency Department and other critical care areas because these areas cannot get patients out of these areas into ward beds.

4 There seems to be limited or poor planning for resource allocation. Because the provision of services has been largely budget driven, this has resulted in saving money by closing beds as well as cutting back on basic services such as cleaning the hospital and maintenance of the building. Continued cost cutting has also contributed to poor staff morale and low rates of retention. Nursing

staff, in particular, are expected to work with fewer numbers and in wards fully occupied with complex patients. This leads to stress in the workforce and high rates of burnout and attrition.

5 Clinicians have been largely excluded or ignored in planning for the best and most appropriate way to deliver clinical care. The Clinical Council, the Medical Staff Council and hospital General Manager have little input into Executive decision making which has been increasingly concentrated at the Area Executive level and is largely based on meeting budget targets imposed by the Department of Health.

6 As RNSH provides care for large numbers of out-of-area patients who require access to specialised and critical care services and with a significantly aging population in the area, there should be a review of the Resource Distribution Formula (RDF) as there is some concern that it may not reflect the true funding requirements for RNSH and the Area.

RNSH provides excellence in teaching and research when compared to many other hospitals both in Australia and overseas.

The hospital has a large number of excellent inpatient teams, which provide a very high quality service both to the local community and to NSW for services such as neurotrauma, spinal injury and burns.

The provision of these statewide services adds significantly to the workload in the Emergency Department, the Intensive Care Unit and the hospital in general, as these patients require a significant amount of staff and resource input.

RNSH provides high level care in many disciplines including:

- Cardiology (RNSH is the only NSW hospital that provides a 24-hour interventional cardiology service)
- Cancer and haematological malignancies
- Trauma care including management of orthopaedic, spinal and hand injuries
- Neurosurgery, neurology, renal and other branches of medicine
- Intensive Care (The unit has an excellent reputation in clinical care and research).
- Interventional Radiology. (This is one of the few hospitals that provide a highly specialized service for the insertion of “coils” in bleeding blood vessels in the brain to treat subarachnoid haemorrhage).
- Emergency Medicine

- RNSH was also one of the first hospitals in Australia to introduce the use of Emergency Department ultrasound and this has become a standard of care in current trauma management.

Clinical Management and staffing issues.

Since the new organisational structure was introduced in 2006, decision-making is concentrated at the level of the Area CEO and there is little or no financial control at the level of General Manager and the Divisional level. There have been 8 General Managers at RNSH over the last 10 years, which has had a detrimental effect on the strategic planning for clinical services. This has resulted in a lack of corporate knowledge as well as an inability to make financial decisions without approval from the Area Executive. There has also been a high turnover of senior staff at the Area Executive level, which has resulted in discontinuity and uncertainty of service provision and planning. There was an Area Business Planning Forum in March 2006 to develop a Clinical Services Plan for the Area, which was to be delivered by July 2006, but this did not occur.

RNSH is considered to be one entity with Ryde Hospital, which is a mismatch both clinically and operationally. This has led to a loss of transparency with regard to allocation of funding. There is no operational cross over and very few medical appointments across both hospitals.

It is apparent that clinicians lack a voice with Management both at a Hospital and Area level and recommendations on strategic or clinical matters are not taken into account when critical or strategic decisions are being made about clinical care.

The RNSH Re-development Clinical Advisory Committee has expressed concerns regarding the planning for the hospital's $700 million redevelopment.

It is not clear how many beds are planned for the new hospital and the committee has has expressed reservations that the planned number of Operating Theatres and Intensive Care beds are too low to meet the demand for service provision.

These concerns have been exacerbated by the uncertainty around the planning for the Northern Beaches Hospital as it remains unclear what its role will be in the provision of clinical services for the NSCCAHS.

There have been a number of submissions by RNSH Radiology and other clinical staff at RNSH over a number of years to introduce a computerized Picture Archiving and Communications System (PACS), which would make hard copy of film almost redundant. This system is essential for the function of a modern acute care hospital.

The cost of introducing this at RNSH about 5 years ago was estimated at $1.2 million, which would have been recovered by removing the need for hard copy of films over a 3-year period. According to the Radiology department, this has not been progressed to date, as the Area Executive preferred to introduce a PACS system "Area wide" subject to the allocation of suitable funds. The fact that this has not been done has contributed to continuing inefficiencies in the provision many clinical services. There

is now a local web based Radiology service at RNSH, which is an improvement, but it is slow and does not connect with the rest of the Area Hospitals except for a local link with Gosford, which is slow and unreliable.

There is a clear need for an Area Wide PACS system so that imaging performed on any patient in a peripheral hospital can be viewed at RNSH and a decision can be made if the patient should be transferred to RNSH for treatment. The current lack of an Area-wide PACS leads to many unnecessary transfers and inappropriate use of the limited number of inpatient beds.
A PACS system has been in place for a number of years at other tertiary hospitals, is very well accepted and there are virtually no hard copies of the films available or required.

Hospital Beds

The unfortunate case of Jana Horska on 25th September 2007 highlighted the strain the hospital is under due to lack of inpatient beds which led to serious overcrowding in the Emergency Department (ED). This unfortunate case illustrates the responsibility of Hospital administration to provide doctors and nurses with the "capacity to treat" patients with care, privacy and dignity.

This incident resulting in a miscarriage in the ED toilet may not have occurred had there been an Emergency Department bed immediately available for Ms Horska to be assessed and treated.

There is agreement that there was very little that anyone could have done to prevent the miscarriage but if an emergency department bed had been immediately available, Ms Horska would have been treated with dignity and privacy.

The lack of a specific protocol was not a contributing factor to this incident, which could have occurred in any busy Emergency Department given the extent of access block that occurs in most NSW major hospital Emergency Departments.

It was disappointing to note that the subsequent investigation into the event by Professors Hughes and Walters did not recognise that the access block on that day was a major contributing factor to the incident. The fact remains that all the beds in the Emergency Department were full when Ms Horska presented and 16 out of 26 available beds were occupied by patients who were waiting for a ward bed, This is a common occurrence (rather than a spike in activity) and occurs because RNSH (and other hospitals) are, in general, operating at above a 94% occupancy rate.

If a hospital has more than 85% of ward beds constantly occupied, it becomes inefficient and patients build up in the Emergency Department resulting in access block and increased risk to patients as a result of this phenomenon.

The RNSH Annual Report in October 2006 notes that ambulance off-stretcher time had not improved from 2003/4 (about 30% of patients were taking longer than 30 minutes to be off loaded). This is a direct result of a failure to address the number of

in-patient beds available which impact on the ability of the Emergency Department to treat new patients arriving at the hospital.

Also in the 2006 Annual Report it was noted that " access block" had changed little since 02/03 and was still greater than 30%. The hospital target figure is 25%, which most clinicians would agree was too high and the target should be less than 10%. The inability to significantly influence "access" block despite a number of initiatives such as establishing a "patient flow unit" illustrates that there are simply too few beds in the hospital. Dr Stephen Christley, the previous CEO admitted this, in evidence before the Committee.

In October 2007, there were 406 beds available for acute medical, surgical or paediatric admissions out of a total bed base of 576 patients, which are clearly insufficient according to the high rates of bed occupancy and "access block".

I note also that 10 out of 24 wards (approximately 250 beds) in the main clinical services block have been either closed or converted to other non-inpatient services.

As has been suggested by the AMA and ASMOF submission the immediate provision of 70 extra beds for acute and elective patients would provide an occupancy rate of 85% given the current level of activity.

It would also appear that RNSH may also be under funded for total beds possibly due to the inclusion of the large number of private hospital beds, which are generally not available for patients with acute medical and some surgical conditions.

The OECD acute bed average is 4.1 per 1000 population whereas the average in Australia is 3.8 per 1000. The UK has 3.9 acute beds per 1000 population and almost all are in the public sector.

We also know that the number of acute beds in Australia has decreased from 6.4 per 1000 in 1980.

In NSW there are 1.1 acute care beds in private hospitals per 1000 but these are largely unavailable for acute cases due to high use in elective surgery etc leading to an effective bed total of 2.7 per 1000.

The acute beds available in the NSCCAHS are estimated to be about 1.6 per 1000 and possibly may be up to 1.8 per 1000 if the beds at the Sydney Adventist Hospital, which has an Emergency Department, are included.

This would seem to reflect the chronic access block those RNSH experiences in the Emergency Department due to lack of inpatient beds.

NSW Health should aim for 3.5 to 4.5 acute beds per 1000 population.

Other factors contributing to the high occupancy of inpatient beds are the aging population and the increased life expectancy for those with chronic illness and malignancy. There is currently no alternative pathway for these patients to access inpatient care when there is deterioration in their condition other than through the

Emergency Department.

There have been some models developed for the assessment and treatment of patients with chronic diseases by inpatient teams but these are constrained by lack of resources in most hospitals.

There also appears to be a shortage of “nursing home” beds which causes a block at the inpatient end by causing a delay in discharge of some elderly patients who need definitive placement or respite care.

The Emergency Department

The Emergency Department provides a very high standard of care and provides good training in Emergency Medicine as the clinical caseload is complex and varied.

The Emergency Department at RNSH is busy and attendances are increasing each year by 10% in 2004/5 and 6.8 % in 2006/7. In 2004/5 the total attendances were 42,312 and in 2006/7 were 49,903. The average attendance on weekdays range from 120-140 and on weekends is between 140-160 per day.

Attendances at Emergency Departments have increased significantly in the last 10 years as has the number of admissions to hospital, while the number of beds has decreased. The admission rate at RNSH has remained constant at 30- 40% and, as a result, more patients are being admitted into fewer hospital beds.

The Australasian College for Emergency Medicine commissioned a “snapshot” survey of all Australian Emergency Departments in June 2007 and found that, in NSW, 1 in 3 patients waiting for an inpatient bed stayed longer than 8 hours in the ED and 40% of Emergency staff time was being spent looking after patients who should have been in a ward bed.

Governments and health bureaucrats often state that the solution for Emergency Department overcrowding is to provide GP clinics co-located with Emergency Departments.

This is incorrect for a number of reasons.

Many patients are referred to the Emergency Department by their GP either for a 2nd opinion or for admission. The overall admission rate of these patients is approximately 25%.

Furthermore, as stated above, GPs are often forced to send unwell patients with complications of chronic illness or cancer to the Emergency Department for assessment and treatment as there is no suitable alternative other than an Emergency Department, which is open and available 24 /7.

It would not be sensible to put limited resources into alternate models of care such as “urgent care centres” or “polyclinics” for dealing with patients with chronic illness. If these patients deteriorate, they will commonly require investigation and treatment in

hospital and are usually not suitable to be treated in the community initially.

There is a case for enabling GPs to make early contact with the treating doctors for advice regarding management of these chronic conditions and, if possible, referring directly to the treating specialist. This may be a problem outside business hours.

It is also incorrect to assume that patients present inappropriately to the Emergency Department. Patients know when they should present to an Emergency Department for care (eg with chest or abdominal pain). The small number who perhaps could be treated by their local doctor do not occupy a bed in the Department and do not contribute to the overcrowding which is due to Emergency Department beds occupied by patients who should be in a ward bed.

RNSH Emergency Department Staffing

There are currently 9.8 FTE Emergency Physicians at RNSH. This number does not allow for 2 Consultants to be rostered for clinical duties from 0800-2400 hrs 7 days per week.

As the workload and case complexity in Emergency Departments increase, there is a need for a greater Emergency Consultant presence in the clinical area to deliver and supervise the delivery of care. There is a reasonable expectation that all care in Emergency Departments should be either given directly or overseen by a Specialist in the discipline as this applies to patients being treated by other specialties.

RNSH and hospitals with similar attendances and caseloads should have, as a minimum, 3 Emergency Consultants covering from 0800 – 2400 hrs.

Currently there are no minimum staffing levels for Emergency Physicians agreed by NSW Health in NSW.

NSW DOH has not accepted the Australian Medical Workforce Advisory Committee (AMWAC 2003) recommendations for Emergency Consultant numbers. AMWAC recommends 11-16 and 6-8 Emergency Physicians in major and regional hospitals respectively and this number should be regarded as a minimum for Emergency Department staffing.

The current shortage of Emergency Specialists in NSW becomes more apparent when compared with Victoria and Queensland.
NSW has 36 Emergency specialists per million population (a total of 234) compared to Victoria and Queensland with 52 and 44 per million population respectively.
As a starting point, NSW would require an immediate boost to Emergency specialist numbers by 104 to a total of 338 (currently 234) to reach a parity on a per capita basis with Victoria (currently 254). Victoria also has a smaller number of Accredited Emergency Departments.

With regard to trainees, only 50% of the NSW Emergency registrar positions are filled by local graduates and the remainder by overseas doctors or locums.

It is also of concern that NSW is only producing 50% of the required number of new Emergency specialists according to AMWAC recommendations (20 instead of 40 per year) over the last 3 years.
There should be the immediate implementation of recruitment and retention package for Emergency Trainees as previously agreed between ACEM and the Institute for Medical Education and Training (IMET).

There are currently discussions between the NSW Emergency Physicians and NSW Health to address the issue of recruitment and retention of the Emergency Medicine specialist workforce. NSW Emergency Physicians remain optimistic that a sustainable workforce plan will be developed in the near future.

Resource Allocation

There is a lack of an Area Strategic Plan for clinical services which makes it difficult to plan for the provision of services in a rational way.

There is also a lack of a capital equipment replacement fund for RNSH. Many departments request new equipment to replace old or end-of- life equipment and are told there is no budget for this. Hence many departments have relied on donations or other sources of revenue such as fund –raising.

There is some concern that although the land has been purchased at French's Forest for the new Northern Beaches Hospital, there is no definite plan for the building of the new hospital as stated in the 2006/7 Annual report.

The role of Ryde Hospital should be reviewed or clarified in that it seems redundant to have a small acute care hospital in close proximity to a major hospital such as RNSH with both hospitals competing for resources and staff.

What can be done now?

1. There should be the implementation of a plan to reduce the average bed occupancy rate at RNSH to less than 85% in order to bring access block in the Emergency Department to an acceptable level (< 10%). This would mean the immediate introduction of at least 70 acute care beds. This would provide a "capacity to treat" in the Emergency Department. This would also require an extensive nursing recruitment campaign.

2. There should be an immediate program to bring the RNSH emergency specialist and senior nursing staff to acceptable and safe ratios and to increase the recruitment and retention of the nursing workforce in general. This would require an immediate recruitment drive to achieve AMWAC recommendations as a minimum for the Emergency Specialist workforce, which would enable safe coverage of the Emergency Department 0800-2400 hrs 7 days per week.

3. There should be the urgent development of an Area Strategic Clinical Services Plan with strong clinical input from the medical specialists as well as nursing and allied health staff. The advice of the RNSH Redevelopment Clinical

Advisory Committee for the RNSH Redevelopment should be adopted by NSW Health as well as the Area and Hospital Executive if the new hospital is to meet the needs of the community.

4. There is an immediate need to employ full-time cleaners in the Hospital and to immediately abandon the practice of placing patients in mixed wards.

Dr Anthony Joseph

13TH November 2007