The Royal North Shore Hospital inquiry: an analysis of the recommendations and the implications for quality and safety in Australian public hospitals

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ABSTRACT

- In October 2007, the New South Wales Parliament appointed a Joint Select Committee to inquire into the quality of patient care at Royal North Shore Hospital (RNSH).
- The inquiry was initiated in response to the publicity and complaints surrounding a patient who had a miscarriage in the toilets of the RNSH emergency department waiting area.
- The Committee held four public hearings and received 103 submissions. It handed down 45 recommendations in its report on 20 December 2007.
- There has been criticism from clinicians and others that the recommendations are too general and will not effect significant change for the severe systemic problems affecting the hospital.
- This article represents the view of some of the clinicians who work at RNSH, and who gave evidence at the inquiry, on the recommendations and some possible solutions for the health system in general.

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In October 2007, the New South Wales Parliament convened a Joint Select Committee to conduct an inquiry into several allegations of poor patient care at Royal North Shore Hospital (RNSH) in Sydney.[1] RNSH is a major teaching and referral hospital, with internationally recognised specialty units and a reputation as a centre of clinical and research excellence.

The inquiry was initiated in response to an incident involving a patient who had a miscarriage in the toilets of the RNSH emergency department. This incident was widely reported in the media and occurred primarily due to a lack of immediate bed availability for assessment and treatment of the patient in the emergency department at the time she presented. There was general agreement that the miscarriage was inevitable and there was no medical mismanagement.

The Revd Hon Fred Nile (Christian Democratic Party, NSW Legislative Council) chaired the Joint Select Committee of both houses of NSW Parliament, with four members of the Australian Labor Party (Government), two Coalition members (Opposition) and one Independent member. The inquiry's broad terms of reference (Box) focused principally on matters relevant to RNSH, but the Committee was given scope to apply its findings and recommendations to any hospital in NSW if considered appropriate. The Committee received 103 submissions and held four public hearings involving 78 witnesses, including the NSW Minister for Health, NSW Department of Health bureaucrats, clinical staff and patients.

Findings and recommendations of the RNSH inquiry

The Committee handed down its final recommendations in its report released on 20 December 2007.[1] The 45 recommendations included 17 further "reviews", and other suggestions for "monitoring", "reporting", and "prioritising discussions", as well as developing and implementing clinical service plans for both RNSH and its parent body, the Northern Sydney and Central Coast Area Health Service (NSCCAHS).

Inquiry's terms of reference (points 1 and 2)[1]

1. That a joint select committee be appointed to inquire into and report on the quality of care for patients at the Royal North Shore Hospital, and in particular:

(a) clinical management systems at the hospital,

(b) the clinical staffing and organisation structures at the hospital,

(c) the efficiency, effectiveness and appropriateness of resource allocation and utilisation within the hospital, and in particular the operation of the Emergency Department,

(d) the effectiveness of complaints handling and incident management at the hospital, and

(e) operational management of Royal North Shore Hospital in general but in particular, the interaction between area and hospital management as it relates to hospital efficiency, effectiveness and quality of care.

2. That the committee consider any strategies or measures in place or proposed for improving quality of care for patients at the hospital which may also benefit New South Wales' public hospitals. ◆

The clinicians at RNSH were supportive of the inquiry and hopeful it would address a number of long-term administrative and structural issues in the hospital. However, it is fair to say that many of the hospital clinicians and others who gave evidence at the inquiry were disappointed with the recommendations, which were generally thought to be too broad and lacking in specific details to effect any significant improvements in the hospital's major administrative and budgetary issues.

A key element consistently stated in evidence given at the inquiry was the lack of clinical governance at the hospital. There was a clear disconnect between clinicians and hospital management, which was manifest at many levels. The clinicians had only advisory input (seldom heeded) into the planning of clinical services, and there was poor delineation of the hospital's role both as a local community hospital and as a tertiary referral hospital. It was argued at the inquiry that the hospital was chronically underfunded, resulting in large recurring annual budget deficits and a focus on budget targets rather than excellence in clinical outcomes as a primary objective. The Committee recommended a number of reviews to confirm these deficiencies, but gave no clear direction for fixing the problems.

The inquiry was advised by the Australian Medical Association (NSW) and by other clinicians that RNSH needed an extra 70 beds opened immediately to bring the hospital bed occupancy to an acceptable 85% level. Despite this, the Committee subsequently recommended that the NSCCAHS should "work with senior clinicians to determine if the RNSH needs additional beds".[1]

As a result of the funding problems, many other serious deficiencies were noted, including:

- a dysfunctional information technology system;
- a radiology department lacking a picture archiving and communication system (PACS);
- obsolete or broken equipment unable to be replaced or repaired;
- inadequate cleaning (miraculously addressed after years of neglect on the weekend before the Committee members visited);
- a dysfunctional and depleted human resources department;
- endemic bullying;
- a Medical Staff Council sidelined from input into decisions regarding the provision of clinical services both for the hospital and the NSCCAHS; and
- doctors who were either not aware of or unable to report adverse incidents through the NSW Health Incident Information Management System.

The presence of all these factors in a seriously stressed system, with the hospital operating at and above 95% capacity, resulted in inefficiency and created a high-risk environment for adverse events. In response to these issues, the inquiry recommendations included statements such as "development and implementation of a … clinical services plan by April 2008", "a review across all Area Health Services … to ensure that the percentage of Information Technology infrastructure and support funding is at appropriate levels", and "NSCCAHS [should] ensure that the recommendations from incident reporting are implemented".[1]

When benchmarked against other Australian hospitals, RNSH is actually relatively safe and is one of the few hospitals that measures its adverse events by a quality assurance (QA) process. Dr Ross Wilson (Director, Quality Assurance Royal North Shore [QaRNS] Program) stated in evidence that the adverse event rate at RNSH is about 9%, compared with 16% for other Australian hospitals.[2] He stated that "the rate of adverse events [at RNSH] is lower than anywhere that we know and that despite the increasing complexity of its caseload, the hospital's adverse incident rate has remained steady over the past 10 or 12 years".[1]

This begs the question: if RNSH is relatively safe compared with other Australian hospitals, what is happening at other hospitals where adverse incidents are less well measured?

Dr Jeffery Hughes, an orthopaedic surgeon, gave evidence at the inquiry that although the QA process at RNSH recorded patient misadventures, little had been done to correct many of the problems identified due to lack of resources and staff as a result of the hospital's significant budget constraints.

NSW Government response

RNSH was the scene of another widely publicised incident in November 2005: the tragic death of a teenage girl, Vanessa Anderson, after she was hit in the head by a golf ball. Her case was referred to the Deputy State Coroner, who noted in his January 2008 report that he was aware of a number of previous inquiries into the NSW Health system, which "was testimony to a health system that is labouring under the pressure from the demands placed upon it".[3] He noted that:

> … the same issues are … identified, not enough doctors, not enough nurses, inexperienced staff, poor communication, poor record keeping and poor management. These are systemic problems that have existed for a number of years and regrettably they all surface in the death of Vanessa Anderson. … the Government of the day has the responsibility to provide adequate resources, training and staff to ensure the delivery of appropriate and timely medical services … It may be time that the Department of Health and/or the responsible Minister consider a full and open Inquiry into the delivery of health services in NSW.[3]

The NSW Government subsequently announced a Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals, with broad terms of reference and a relatively short timeframe. If significant recommendations are made by this Special Commission, it remains to be seen whether the NSW Government has the will to provide the resources necessary to implement them.

Following the announcement of the Special Commission, the NSW Minister for Health announced the state government's response to the RNSH parliamentary inquiry on 22 February 2008, stating that the government had accepted 43 of the 45 recommendations and that their "response details the significant action that has already been taken to implement those recommendations".[4]

Despite this "response", there is still a significant shortage of inpatient beds at RNSH, with only four new beds opened so far (12 of the 70 needed were promised by the NSW Health Minister at the time of the inquiry), no immediate increase in the budget, and the recent resignation of the hospital's eighth General Manager in 11 years. The major problem with the government response is in its generalisations and vagueness. Many of the inquiry's recommendations are only "supported in principle" and some of the "supported" responses are largely meaningless.[5] A good example of this is Recommendation 42: "That NSW Health in conjunction with the Clinical Excellence Commission examine the use of systematic audits of medical records, such as QaRNS." There is no mention of the scope or timeframe of this review, nor of any action that might follow.

One of the more positively supported recommendations relates to "the monitoring of trust funds be[ing] improved".[5] This will be a litmus test of the NSW Government's commitment to addressing a number of the problems revealed by the inquiry. The management of trust funds raises issues of probity and competence in managing millions of dollars of donated funds for health research and development and other specific reasons. Evidence given at the inquiry suggested mismanagement and inappropriate allocation of some bequest monies, which are a vital source of support for RNSH. Rectifying this situation requires no additional resources, but it does require a change of culture in hospital administration, with transparency, tight financial management and reporting, and the close involvement of experts in the disciplines for which the money is targeted.

Problems in the public hospital system

The conditions that led to the recent adverse incidents at RNSH have been incubating for many years and are clearly endemic across the NSW public hospital system. So, what are the problems with the public hospital system, and why does the NSW Government seem unable to fix them?

Shortage of beds

Lack of public hospital beds and resultant access block have been major problems for a number of years, with many hospitals operating at unsafe bed occupancy levels. Access block in Australian emergency departments due to overcrowded inpatient wards has been shown to prolong hospital length of stay and is associated with increased mortality.[6-8]

The Australian Institute of Health and Welfare noted that between 1999–2000 and 2003–04, there was an 8.5% increase in separations from Australian public hospitals (ie, admissions) and an 18% decrease in public sector beds per 1000 population.[9] Furthermore, the number of acute care hospital beds per 1000 population in Australia decreased from 4.8 in 1990 to 3.6 in 2005, compared with the Organisation for Economic Co-operation and Development (OECD) average of 3.9 per 1000.[10] The Productivity Commission's recently released *Report on government services 2008* shows that NSW has 2.9 available beds per 1000 population, while the Australian average is 2.7 per 1000,[11] indicating a significant shortage in Australia compared with other OECD countries.

Clinicians who gave evidence at the RNSH inquiry stated that the number of beds in the NSCCAHS was even lower than the NSW average, due to its relatively high number of private hospital beds. The Australian Medical Association has calculated that Australia needs another 3750 beds (including 1000 in NSW) to achieve a safe occupancy rate of 85%.[12]

Poor coordination of care

The federal–state funding "blame game" has also contributed to the stress on public hospitals, as it militates against coordination of care between general practitioners in the community and hospitals. When the condition of patients with chronic disease in the community or a nursing home deteriorates, GPs often have no choice but to refer them to hospital for assessment and treatment. Furthermore, when older patients or those with chronic disease are ready for discharge from hospital for further rehabilitation or nursing care, there are often no suitable nursing home or rehabilitation beds available.

GP Super Clinics, as proposed by the newly elected federal Labor Government,[13] will not solve the problem of treating people with chronic medical conditions, as these complex patients often require specialist inpatient treatment and expensive diagnostic technology.

Shortage of specialists

Previous inquiries into aspects of patient care in NSW public hospitals (eg, Camden and Campbelltown Hospitals) have found that patients admitted to hospital are at increased risk of adverse outcomes, and even death, if there is not early involvement and supervision of junior medical staff by appropriately trained medical specialists.[14] Bodies such as the Australian Medical Workforce Advisory Committee have also recognised that there is a national shortage of specialists (eg, in emergency medicine[15] and obstetrics and gynaecology[16]). State governments have not adequately supported hospital training positions, leading to the current shortage in most specialties and a rise in the locum medical workforce.

Many young doctors in NSW choose to work as locums, where they can earn up to three times the rate of a full-time hospital resident medical officer.[17] These doctors often work in emergency departments of urban or rural hospitals and are often involved in adverse incidents due to lack of training and supervision, as seen in the inquiry into Camden and Campbelltown Hospitals.[14] Moreover, the cost to NSW Health of employing this locum medical workforce has been estimated to be $30 million more than the cost of employing full-time junior medical staff.[18]

Shortage of nurses

It is only possible to open more beds if there are sufficient nurses to staff them. In 2005, Australia graduated 28.7 nurses per 1000 practising nurses, which is low compared with the OECD average of 45.7 per 1000.[19] Furthermore, Australia is one of the few OECD countries to have decreased the number of practising nurses (by 0.8 per 1000 population) from 1990 to 2005.[20]

It is well known that a significant proportion of registered nurses have chosen to leave the NSW public hospital system. It was reported recently in the media that NSW loses 4200 nurses every year (10% of the workforce), despite a record 2368 graduates starting this year.[21] The acting president of the NSW Nurses Association stated that an ageing workforce was a major reason for the shortage of nurses, with many more nurses retiring than newly graduating into the system.[21]

The RNSH inquiry heard that the largest group of nurses working in the emergency department were in only their second year after graduation and, at any one time, there was a shortage of between five and 20 nurses in the department's total nursing workforce. There was also a lack of senior nurses to mentor junior nurses, as many of the more experienced nurses had either left the system or reduced their working hours.

It is pleasing to note that Prime Minister Rudd has announced a comprehensive 5-year plan to bring back 10 000 of the 30 000 qualified nurses who have left the public hospital workforce.[22]

Some solutions

Professor David Penington, an experienced reviewer of the Australian public hospital system and former Vice-Chancellor of the University of Melbourne, recently stated in a newspaper article on health care reform that "incidents such as a miscarriage in an emergency department [are being] used as a measure of hospital quality" and that we have a "hospital system under financial stress and no measures of quality associated with funding".[23] He also stated that, according to good evidence from the United Kingdom, if we support research in our major hospitals, it is possible to achieve improvements in the quality of care by attracting high-quality staff, and embracing innovation and constant assessment of the quality of outcomes. Penington notes that:

> Initiatives have been taken related to safety and quality in hospitals, such as development of the Australian Council on Safety and Quality in Health Care and the National Institute of Clinical Studies, but to date these have had limited impact.[23]

Would a federal takeover of public hospitals deliver a better and safer system? There would be definite advantages to having one funding source, which would eliminate the funding blame game between state and federal governments, but doubt remains that the federal Department of Health and Ageing would have the ability or the resources to administer a national public hospital system. This doubt was raised in the previous federal government's mishandling of the hasty and poorly planned takeover of the Mersey Hospital in Devonport, Tasmania. The new federal Minister for Health is now working with the Tasmanian Health Minister "to provide a safe and sustainable hospital service" for the area.[22] A single funding source would also streamline provision of care for the aged and those with chronic disease in the community, as well as the more difficult areas of disease prevention and Indigenous health, which will require a long-term focus to achieve satisfactory solutions.

There is also a clear need to rationalise the number of hospitals providing acute medical or surgical care, due to limitations in both staff and resources; these decisions must be made independently of political considerations.

The new federal government is committed to a review of the Australian health system with a National Health and Hospitals Reform Commission.[13] It has also threatened a takeover of public hospitals if state governments fail to meet certain benchmarks by 2009, such as:

- reducing preventable hospitalisations and readmissions;
- reducing non-urgent "accident and emergency" presentations;
- decreasing waiting times for people requiring elective surgery;
- increasing access to medical and specialist services in the community; and
- providing more appropriate non-acute care for older Australians.

How they intend to measure these benchmarks is not stated.

The new federal government is heading in the right direction by linking increased funding to hospital performance by publishing "scorecards" that compare performance between equivalent hospitals.[24] The ability already exists to compare similar hospitals for events such as unexpected deaths, complications of treatment, infection rates and length of stay. However, such performance comparisons will require support with extra resources and funding, as this work is labour-intensive, and will require political will to address problems as they are identified. It was disappointing that the first meeting of the Australian Health Ministers' Conference under the new government did not take up the federal Health Minister's proposal for a public hospital scorecard approach, but they did agree that "further work was needed to identify specifically which performance areas should be included".[24]

One of the challenges for hospital administrators and funding bodies is to measure the quality of care provided in public hospitals, publish the results and provide adequate resources and staff to ensure a safe and equitable level of health care. Health Ministers and their departments should seek advice and implement recommendations from clinicians who are clinically active rather than from bureaucrats who have little or no clinical experience and are motivated by concerns related to meeting budget targets. Until there is recognition that the community has a right to know what quality of care is being delivered in all public hospitals, and governments acknowledge they have a responsibility to provide safe and appropriate care, there will continue to be adverse events and unnecessary deaths in our public hospitals.

Competing interests

None identified.

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