

Supplementary questions: Medical Advisory Committee, NBH

Inquiry into the safety and quality of health services provided by Northern Beaches Hospital

- 1) You have noted that some of the difficulties faced by the Northern Beaches Hospital relate to inadequate funding support from the Northern Sydney Local Health District – for example, in relation to the activity profile and the caps placed on total activity, or the roll out of safe staffing levels. Can you estimate what additional funding would be needed to these issues?

In estimating the additional funding that would be required it is important to look at the funding gap that already exists based on the contract that was accepted for both the price of work performed and the volume of work performed.

1. Providing the care to public patients at a 5% discount (and subsequently 7%) compared to the NWAU (National Weighted Activity Unit) cost for each episode of care is a significant underfunding of the public care provided at Northern Beaches Hospital for public patients. This was entered into in the deed/contract but the issue of the 'price' underfunding has only been amplified by the increase cost of providing care across and after the COVID pandemic with significant increases to staffing, procurement and utilities.
2. Failure to pay for the volume of work provided at Northern Beaches Hospital has resulted in significant underfunding of the hospital. The hospital has maximised its efforts to redirect patients from the emergency department and to avoid admission of patients from the emergency department. This is best medical practice to avoid hospital if safe to do so. Thus, the decision to admit patients into the hospital for medical care is a medical and patient centred decision. At no point has the hospital closed its doors and thus the ability of the hospital to safely reduce its volume of work is zero, beyond what it is already being done. The greatest volume of work performed at NBH is medically indicated admissions. The whole of hospital length of stay project to optimise discharges (and thus reduce length of stay) have led to a situation at NBH where admissions are medically indicated and length of stay is optimised. Thus, all the volume of work in terms of admission and length of stay is clinical necessary and patient centred. Hence, the non-payment for this volume of performed worked has significantly underfunded the hospital year on year.
3. To take an example of extra funding that would be required for example to address the NSW Government commitment to safe staffing.

For NBH Emergency Department (ED) to meet the Definition (NSW Health Safe Staff Levels – Emergency Departments) for Level 5 and 6 ED, they would need to have the following nursing staffing ratios / levels:

1:1 patient: nurse ratios for generally occupied Resuscitation beds (all shifts)

1:3 ratios for ED generally occupied treatment spaces (all shifts)

1:3 Emergency Department Short Stay Unit (EDSSU) generally occupied beds (all shifts)
need an ED in charge / clinical NUM 24 hours 7 days per week

Triage 24 hours 7 days per week plus one additional 8-hour shift per calendar day.

This equates to a Staff Staffing Model FTE of 121.6 FTE.
Our current FTE is 101.7 FTE.

The variation would be 20 FTE required to meet the NSW Health Safe Staffing Model.

Modelling for safe staffing of team-based care for medical patients is outside of our scope, but is generally felt to require increased staffing in terms of medical, nursing and allied health

What other actions would be needed to address these issues if the Hospital was returned to public management?

The under recruitment and lack of junior medical staff is a significant issue with regard to inpatient medicine. From a ward perspective: The Junior Medical Officer (JMO) staffing provided from the LHD was supplied at a level pre-determined within in the deed based on activity numbers projected at the time that Manly and Mona Vale Hospital were operating. The complexity and number of inpatients cared for at NBH grew at a level greater than expected, so the agreed numbers were insufficient.

Additionally, the LHD provided JMOs at safe staffing levels for JMOs to manage “public” patients. It was anticipated that patients using their private health insurance would be managed by the admitting consultant alone, or with assistance from a Healthscope workforce. Despite the original planning and instruction, most disciplines adopted a teams-based approach where the JMO team and admitting officer would cover both public and private patients together (much as happens in public hospitals where private patients are managed in a public setting).

Healthscope endeavoured to meet the staffing shortfall by recruiting its own workforce. Unfortunately, lack of integration into the NSW health system and lack of ability to transfer leave entitlements meant that recruiting local staff was challenging (staff would lose NSW health entitlements eg sick leave and long service leave). International Medical Graduates recruited to fill Healthscope positions, would often transfer their employment to the LHD soon after arrival so that they had increased flexibility to work elsewhere in NSW Health (with associated transfer of entitlements).

The LHD whilst contracted to provide a certain number of JMOs was not obliged to fill all the positions, so would often allocate leave for JMOs rotated to NBH or reallocate the JMO staffing meant for NBH, to fill gaps in public LHD hospitals.

The constant short fall of JMO staffing, at least within medicine, meant that the senior medical workforce was constantly needing to fill gaps, with inherent risks when trying to do the tasks of more than one person.

2) Do you have any concerns about the current electronic medical record and patient administration systems used at the Northern Beaches Hospital?

The current electronic medical record (EMR) is utilised across the hospital and has evolved over the seven years since opening. There are, despite work to augment the

system, areas of the hospital where the EMR still does not function to a level that is acceptable to clinicians.

From an ED perspective:

1. EMR does not show live data reporting e.g. triage times and discharge times (as raised by the Audit Commission report and subsequently investigated internally by NSLHD).
2. Not being able to triage in EMR (triaging can only occur in an alternative computer system called Webpas) is a clinical risk as vital signs from triage observations cannot be seen in EMR, meaning clinical deterioration cannot be easily observed. This will be addressed with the new triage module for EMR which will be implemented at the end of this month (November 2025).
3. Lack of integration with EMR from community and other LHD hospitals. The Clinical Health Integration Exchange (CHIE) was anticipated to integrate data but is a sub-standard work around.

From an anaesthetic perspective.

- 1- No electronic anaesthetic record.
- 2- Anaesthetic records and printouts required to be scanned and then downloaded into system at a later date.

From an internal medicine perspective:

When NBH first opened, there was no mechanism to share medical records with the LHD. Healthcare teams managing patients who had received care elsewhere in the LHD, including those with complex problems, were reliant on patients to relay details of their prior care. Contacting medical records at other hospitals in the LHD to access past information was time consuming and did not allow information in time sensitive situations.

Work was done on the strengthen the CHIE where information was meant to be shared between NBH and the LHD. Unfortunately, whilst NBH information was usually pulled through into the CHIE, frequently information from other providers was often not, resulting in a patchy sharing of information,

Having a different EMR to the rest of the LHD meant that rotating JMOs had to learn to use an entirely new system. All EMRs have idiosyncrasies, and a new EMR is like learning a new language. It meant that changeover of staff and orientating new staff from the LHD had an unnecessarily high level of complexity.

As a stand-alone the EMR used at NBH had promise. Updates to improve patient notes and integration with other platforms (Olympus, [Philips Intellispace](#)) allowed results to be pulled into the medical record. The emeds module was intuitive to use and visually like the paper medical charts it was meant to replicate. Where the EMR was always substantially below standard was in the results display. Abnormal results do not flag a different colour. Each result needs to be clicked in to, to display the result. Trends were not easy to demonstrate beyond a period of 3-10 days. When attempting to view results from more

than 30 days ago, the system would crash. In simple, healthy surgical patients this is not a substantial risk. In complex comorbid medical patients, it is.

Within medicine, cardiology often requires time critical access to cardiac investigations to determine if emergent coronary angiography is required.

Medical Digital Imaging and Communication in Medicine (DICOM) image sharing across the district is necessary to assist in acute patient management. This includes coronary angiography, echocardiography and CT scans. For instance, if a patient presents to the emergency department with chest pain, the decision to perform a coronary angiogram is influenced by previous imaging that may have been performed at another hospital. Prompt access to reports and imaging assists early diagnosis and treatment. It may also reduce duplication of tests, saving time and costs.

3) From your experience, in what ways could the negotiation and management of the Project Deed have been improved?

The project deed was bi-directionally limiting and was set up without agility to enable Northern Beaches Hospital to be as effective for both the local community and for the Northern Sydney Local Health District/NSW health. The interpretation of the deed was not that of strategic partners aiming to utilise the hospital to be at its most effective.

To improve the project deed

1. NBH should have been set up as an affiliated health organisation with contractual negotiation directly with NSW health much like St Vincents hospital has been set up as its own Health District. This removes the conflict of interest that exists between the district and the private operator where funding services at the private operator may reduce funding available for other services within the district
2. Contracting directly with NSW Health as a district would allow for service delivery specific to the patients of the Northern Beaches community
3. Contracting directly with NSW would allow the hospital on a contractual and dynamic basis provide services to both the district and other local health district to provide services in areas that the private sector excel e.g fixed volume elective procedural/surgical workload. Local health districts during and after COVID outsourced public work to private hospital providers to reduce wait lists and optimise patients care. NSLHD did not utilise Northern Beaches Hospital for this purpose despite undertaking wait list reduction work at North Shore Private Hospital.
4. Agility of the deed. In a strategic partnership both parties must work to each other's mutual benefit that means within any contract there needs to be an ability to review and adjust the contract to ensure that the aims, outcomes and control mechanisms are appropriate. A deed that was written well in advance of the hospital opening was also not going to be fit for purpose once the hospital opened. This was only compounded by the COVID pandemic. There were multiple opportunities to address this each year to amend the deed to the mutual benefits of the community and NSW Health as a whole. An example being restricted services. NBH has the operating capability to provide restricted services to both public and private patients. Limitations within the deed created a disparity between the care provided for public patients compared to private and not because the services could not be provided or were not clinically indicated. Transferring patients for restricted services that could be performed was not patient centred, not cost effective, and only exacerbated bed

block issues at the tertiary service Royal North Shore Hospital. The lack of agility in the deed and strategic partnership did not allow NBH to be all it could and wanted to be for the local population

5. Abatements and key performance indicators (KPI). The use of KPIs within the deed was designed to ensure best practice. However, setting the performance targets higher than the performance targets of peer hospitals as well as having them fixed at set benchmark of performance not achieved by peers. Further to this the abatement process was financially punitive if those benchmarks were not met. Peer hospitals who are under performing as relative to NBH are under no punitive financial arrangement. Conversely there was no financial benefit for over performance i.e. no positive counter to the abatement in areas where the hospital excelled e.g. in elective surgical wait list performance. In principle any KPI needs to be benchmarked to your peers and not fixed at the higher percentile and not adjusted. A financial disincentive does not help create an environment of patient centred care.
6. Memorandum of understanding for junior doctor numbers and recruitment. A lack of continued service with NSW when working at NBH was an impediment to recruiting of highly skilled doctors in training. The lack of obligation from the district to provide the number of junior doctors and the inequity of distributing of vacancies favouring other hospitals in the district. As above NBH acting as an independent affiliated health district working directly with NSW health and avoiding the conflict of interest that the district faced in terms of prioritising of allocations away from NBH.

7. **4) Can you outline any areas where you believe the Deed was imperfect and could have been improved? Noting this, how might future PPPs be better designed?**
8. **As above**

What changes would you propose to the KPI regime to ensure higher levels of care are delivered? For example, are there indicators beyond timeliness or activity volumes that could be included in future KPI regimes?

The KPI regime should be dynamic, as well as being realistic in the outcomes measured. Having expectations set too high made them difficult to fulfill. An example of this is a KPI where the target is 100% (antibiotic cover for caesarean sections), it is impossible to do better than this, but abatements are charged when the 100% target is not met.

The KPI regime should also be 2 way. If KPIs are exceeded, then abatements for other KPIs could be offset.

5) From your experience, what challenges at Northern Beaches Hospital are unique to the Hospital, and what challenges contrast with other hospitals in the public system?

1- A rigid deed that did not allow the services to be optimised for the benefit of the local population and a lack of strategic partnership that could enable NBH to provide more services to the population of NSW as a whole e.g. wait list reduction surgery

2-Community support. A small proportion of the community were against the hospitals based on a number of different factors e.g. the concept of a public private partnership, the location in Frenchs Forest rather than in Mona Vale or Manly, the closing of closing of much beloved hospitals at Manly and Mona Vale.

3- Political weaponisation. The different model of care has been used for political gain. Events at the hospital have been weaponised against the private operator but also against the staff. The staff who were public servants at Manly and Mona Vale hospital and who had limited choice but to work at NBH have endeavoured to make the hospital a success. However, the lens through which we are viewed by the public is soured by the political ideology against the hospital. In other public hospitals the staff feel supported by the overall systems of government arounds hospitals e.g. politicians and NSW health. Conversely at Northern beaches the operator and then by extension the hospital and its staff have been attacked in parliament, mainstream media and social media. No other hospital is held to the same high standards as Northern Beaches Hospital and no other hospital is so furiously attacked by all sides when it falls down against its own high standards. It is common to hear patients say 'Thank you for my care. It has been excellent. This is nothing like what is portrayed in the media'

6) Do you think there are any circumstances or contexts in which a public-private partnership model for public hospitals in NSW could be successful in the future?

Yes, but it would need to be in specific circumstances.

1- A politically neutral environment

2- A commitment to a strategic partnership by all involved

3- A flexible deed/contract that adapts to the demands of the partnership year on year

4- Setting the operation outside of an existing health district and contracting directly with the Ministry of Health

5- Engagement and consultation with clinical experts who understand how the service can and will be delivered.

6- Utilisation in more discrete circumstance e.g as an elective service provider where the volume of work can be controlled. By contrast, emergency care and most non-procedural medical care has a community expectation of being operated by NSW Health. Furthermore, emergency and non-procedural medical care is volume is uncontrolled. The presentations are undifferentiated, and length of stay is variable. All those factors limit the ease of a contractual relationship for the provision under private public partnerships.

7) What do you think is the best pathway forward, to ensure that the Northern Beaches community receives the best quality integrated health services and clinical outcomes?

When the Northern Beaches Hospital was proposed as a solution to the aging healthcare infrastructure on the Northern Beaches it was to rectify the identified deficits. Mona Vale and Manly Hospital needed substantial updates. There was also a long-standing lack of a major private facility for the Northern Beaches community. NBH promised to provide both

a new public hospital with a capacity to provide private services. With a high proportion of the community paying for private health cover (~70%) the Northern Beaches Hospital has provided a range of private services for the community that did not previously exist e.g. interventional cardiology, robotic orthopaedic surgery, breast cancer surgery to name a few. Further to this it has excelled in the provision of these services with a highly effective and efficient procedural service with no waiting list breaches on the public side and performing 20000 private operations per year. The senior medical workforce have welcomed the clarity provided in the take over of the hospital by the state government and the plan to provide public care to the community. There is a risk that in losing the private hospital services that the community have come to rely on, they will be forced to go further afield and away from their support structures or join the public wait list locally. Without a co-located private hospital, but instead private in public and public healthcare, we predict that there will be a substantial reduction in utilisation of private health insurance. There would be no evident benefit of using private health insurance, or point of difference and patients would likely elect to be public patients, decreasing a revenue stream for the district.

The solution proposed by the senior medical workforce is a co-located private hospital. The emergency department and public inpatient care will be provided by the district as a public hospital with provision for private in public emergency admissions. This will allow integration of the public care to the greater district services. From a private viewpoint, the hospital was always designed to be split after 20 years and although there are some contractual and logistic considerations none of them are difficult or insurmountable. Engaging with the senior workforce who have made the hospital a success over the last seven years despite a difficult political climate and a not fit for purpose deed would be an excellent start point. As those senior clinicians are residents and committed to continuing the journey of the Northern Beaches Hospital as a world class facility for both public and private patients.