REPORT ON PROCEEDINGS BEFORE

PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO THE SAFETY AND QUALITY OF HEALTH SERVICES PROVIDED BY NORTHERN BEACHES HOSPITAL

At Macquarie Room, Parliament House, Sydney, on Friday 17 October 2025

The Committee met at 13:20.

PRESENT

Mr Jason Li (Chair)

Ms Jenny Leong

PRESENT VIA VIDEOCONFERENCE

Mr Clayton Barr (Deputy Chair)
Mr Michael Regan
Mr Anthony Roberts
Mr David Saliba

The CHAIR: Welcome to the Public Accounts Committee inquiry into the safety and quality of health services provided by Northern Beaches Hospital. I am Jason Yat-Sen Li, Chair of the Public Accounts Committee. I am joined by my colleagues Mr Clayton Barr, Deputy Chair and member for Cessnock; Mr Michael Regan, the member for Wakehurst; the Hon. Anthony Roberts, the member for Lane Cove; Dr David Saliba, the member for Fairfield; and Ms Jenny Leong, the member for Newtown. I acknowledge the Gadigal people, who are the traditional custodians of the land on which we meet here at Parliament. I also pay my respects to Elders past, present and emerging of the Eora nation, and extend that respect to other Aboriginal and Torres Strait Islander people who are either present or are viewing the proceedings on the internet.

Before we commence, I would like to make a statement relating to this inquiry. The Committee notes that there are matters involving Northern Beaches Hospital that are or may be subject to legal proceedings and coronial inquiry, including the potential for investigations to lead to possible criminal charges being laid. The Committee will therefore conduct this inquiry in a manner that respects the sub judice convention. This convention aims to preserve the principle of comity between the legislative and judicial branches of government. It means the House voluntarily constrains debate or inquiry into those matters that may be prejudicial to ongoing police or other investigations or that may impact court proceedings or interfere with natural justice.

In order to safeguard the integrity of any external proceedings or investigations and inquiries, the Committee has resolved to focus on systemic matters relating to the hospital. Today's proceedings will not inquire into or receive evidence on the circumstances, clinical treatment or investigatory responses relating to individual incidents or any matter before the courts or under investigation to which the sub judice principle should apply. I therefore request that when giving evidence, witnesses focus on issues specified in the inquiry's terms of reference and avoid naming any individuals or referencing specific clinical incidents. In particular, witnesses are instructed not to comment on particular matters that are the subject of the coronial inquiry relating to the death of Master Joe Massa or any matter under active coronial or other investigation.

The Committee will be taking a cautious approach to the conduct of today's hearing, and it may decide to pause the broadcast or conduct portions of today's hearing in private, if it deems it necessary. It is also important to remember that there are limits to the protections given to witnesses participating in Committee proceedings like this. What witnesses may say or do during the course of these proceedings is fully protected by parliamentary privilege. However, outside of these proceedings a witness only has limited protections for the evidence that they have given. I strongly urge witnesses to be careful about any comments they may make to the media after the conclusion of the proceedings, or to others after they have completed their evidence. Please seek the advice of the Committee staff if you have any further questions about publication of your evidence and comments on these proceedings. The Committee would like to thank all the witnesses who are appearing before the Committee today, and all the stakeholders who have made submissions. We appreciate all of the input you have provided to the Committee for this important inquiry. I declare the hearing open.

Mr BOLA OYETUNJI, Auditor-General, Audit Office of New South Wales, sworn and examined

Ms SUSIE HARWOOD, Assistant Auditor-General, Performance Audit, Audit Office of New South Wales, affirmed and examined

The CHAIR: I welcome our first panel of witnesses. Thank you for appearing before the Public Accounts Committee today to give evidence. Please note that Committee staff will be taking photographs and videos during the hearing. The videos and photos may be used for social media and public engagement purposes on the Legislative Assembly social media pages, websites and public communication materials. Please inform the Committee staff if you object to having photos and video taken. Can you please confirm that you've been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

SUSIE HARWOOD: Yes.

BOLA OYETUNJI: Yes, confirmed.

The CHAIR: Do you have any questions about this information?

BOLA OYETUNJI: No.

SUSIE HARWOOD: No.

The CHAIR: Would you like to make a short opening statement before the commencement of questions?

BOLA OYETUNJI: Thank you for the invitation to provide evidence to this inquiry. In April this year, I tabled a performance audit report on the Northern Beaches Hospital. The scope of the audit was to assess the effectiveness and efficiency of the Northern Beaches Hospital public-private partnership in delivering public hospital services. The audit criteria explored whether NSW Health agencies ensure the effective and efficient delivery of publicly funded hospital services from the Northern Beaches Hospital, and whether the operator of the Northern Beaches Hospital effectively delivers public hospital services. The audit examined these questions with a focus on two clinical areas: the emergency department and general surgery. I used my "follow the dollar" mandates for this audit, which allowed me to access key personnel at the hospital who do not work for the State Government. I need to acknowledge the cooperation we received from Healthscope during the audit.

In planning and conducting this audit, the performance audit required quality of data. That was crucial for the performance audit. To make findings and form a conclusion, I needed to be reasonably confident in the data that we used. That said, there are some unusual patterns in the data I set out in Exhibit 9 on page 22 of the report, showing the distribution of patient time in the emergency department. This data, which was analysed by the Audit Office, shows a significant spike in the total time in emergency just before the four-hour mark. Four hours is the threshold at which abatements for the time in emergency KPI are applied. Although this pattern does not affect the financial penalty applied, it is an unusual pattern that potentially obscures actual performance and casts doubt over the accuracy of emergency department data. The data is used to apply abatements and to monitor the performance of Northern Beaches Hospital.

I understand Northern Sydney Local Health District did investigate further, as required in my report, and is best placed to update the Committee regarding its view on this anomaly. The report contains a number of findings that are relevant to this inquiry about the safety and quality of health services in the Northern Beaches Hospital. My conclusion in the report relates to the scope of the performance audit, which was to assess the effectiveness and efficiency of the Northern Beaches Hospital public-private partnership. The terms of this inquiry are far broader than the scope of my audit, but we are happy to take any questions that the Committee has.

The CHAIR: Thank you, Auditor-General. We will now move to questions from the Committee. Before we begin the questions, I wish to inform the witnesses that they may wish to take a question on notice and provide the Committee with an answer in writing within 14 days after receiving the questions. What was the original impetus for the Audit Office undertaking the performance audit in the Northern Beaches Hospital?

BOLA OYETUNJI: There was a referral by Mr Regan, the member for Wakehurst. In 2023, because of that referral, the Office reviewed whether we should put that in the annual work program. Because of the public-private partnership complexity, we thought it was important to put it on the Audit Work Program, which we did. However, we really didn't start any audit until May 2024, and that was because in April, Mr Regan approached me to do the audit. The member for Mackellar in the Federal Parliament, Dr Sophie Scamps, also approached me, and Zali Steggall. Looking at the documents I was provided, I thought it was merited to do the audit. So in May 2024 we started the audit of the Northern Beaches Hospital public-private partnership.

The CHAIR: Given that we have limited time today, I wanted to go to the crux of the issues here. You note in your audit report that Northern Beaches Hospital had met many of the KPIs, not most of the KPIs that had been set for it, and yet deficiencies remained and serious adverse events occurred. What, in your view, explains this apparent discrepancy between the meeting of the majority of performance KPIs and yet the remaining serious deficiencies in care and in systems and processes?

BOLA OYETUNJI: In the hospital system there will be different activities. At Northern Beaches, again, as I said, we looked at two clinical areas. We looked at the emergency department and the general surgery. We found that in certain areas, yes, they were doing very well and some of these serious adverse effects were actually from the areas that were not doing very well. So we made sure that we had a balanced report. Now I must also say, though—and it was in our report—that the data that we were looking at, we just used NSW Health data. So the analysis that we reported was NSW Health data. The scope did not go into the veracity, completeness and accuracy of the data. The reason why we looked at the emergency department data was because it was one of the two areas of focus. Again, we were not concluding whether that data is right or wrong. We just saw the anomaly and we then asked the northern Local Health District to investigate it. That was how we included it in our report.

The CHAIR: Along the same lines, did your audit find any systemic weaknesses in the way that the deed or the key performance indicators [KPIs] were designed and/or enforced?

SUSIE HARWOOD: I think with regard to the KPIs and how they were enforced under the terms of the deed, and that question of were there any systemic failures, we did identify—particularly when it came to the integration of the Northern Beaches Hospital within the district and the health system more broadly—that there were some, I guess, structural barriers to how the services that were provided by the hospital might be adapted, over time, so that they could fit in effectively and integrate in the way that was anticipated as part of the deed. In

the report we set out a number of different examples of where the contract itself—largely the need for the health district to go to the service provider, to Healthscope, to ask for a proposal and a cost to set out what those additional services might look like and what those costs of the services might be—did act as a structural inhibitor to integration of the hospital into the broader network.

When it comes to the question of KPIs, there's some proviso there by reference to the scope of the audit report. Our audit was very much looking at the efficiency and the effectiveness of the health district in managing the deed. It was very much looking at the efficiency and effectiveness of the operator in delivering the services under the deed. The KPIs that were established in the deed were to set the expectation for Northern Beaches Hospital in its performance as part of a public-private partnership. While we made observations about how that compared to the performance of other peer hospitals, the real focus was what was the performance of the hospital by reference to those KPIs, and to some extent made the assumption that the health district, in negotiating the public-private partnership [PPP], those KPIs had been set so that there were the right parameters in place to ensure the safety of the services that were being provided at the hospital.

In terms of the scope of the audit report, as mentioned by the Auditor-General, we did very much focus on the emergency department because it's the largest part of the business, if I can call it that, at Northern Beaches Hospital, as well as general surgery. While we did some analysis over all of the available KPIs, the focus was very much by reference to those available KPIs that were directly relevant to emergency services and to planned surgery. What I would say is we found some practices that could be improved in terms of the auditing of data that's relied upon to understand what the performance is under those KPIs. Exhibit 9 is an example of where we found some areas for improvement, in terms of how data analysis is carried out, to have a more granular understanding of what the performance of the KPIs is. While the audit was focused on our findings relevant to those KPIs, to some extent it raises questions about the quality of the data for the other KPIs, as well as other expectations and measures that may not be KPIs that the hospital needs to be performing to.

The CHAIR: Just on the data, I note that in the report of the parliamentary inquiry from 2019-20, it said that New South Wales has the contractual rights to require an audit of the data used for performance management and reporting from Northern Beaches Hospital. To your knowledge, has that audit not been requested? There has been no audit of that data undertaken by Northern Beaches Hospital, or had it not been requested?

SUSIE HARWOOD: We do touch on the audit of some of the data within the audit report. So there was an audit that was undertaken, or there are audits or analysis that's undertaken, of some of the datasets. We've made some commentary to say that that process could be improved. So it's certainly discussed between the district and the hospital, or Healthscope, the operator. And there are activities that are undertaken to test the veracity of the data. But in the audit report, we identified that there were opportunities to improve those processes.

The CHAIR: So it didn't reach the level of assurance of an audit as such? It was looked into, but it wasn't a formal audit as such of the data with that level of assurance provided?

SUSIE HARWOOD: I think that's probably a fair assessment. It's an evaluation or a further analysis of the data rather than an audit per se, but we probably need to take that on notice, as to what the exact parameters were and the visibility that we had of those as part of the audit.

BOLA OYETUNJI: And the one we put in the report was specific to the coding. The health district that did the audit on the coding saw some anomalies, and that's also reported in our report, which shows that there's a level of specific audits of some of the data. In a risk-based audit environment, maybe coding at that time was where the risk was highlighted to the Local Health District, and that's why they did the audit of that specifically. Usually with a risk-based audit, if there are no emerging risks in any specific data—again, because of financial resources—you may not necessarily go there.

The CHAIR: But to be clear, you saw no evidence, or there would have been at least some investigation and there was no evidence found, of any deliberate manipulation of the data?

BOLA OYETUNJI: We did not specifically go into whether the data was manipulated or not. And that's why, again, Exhibit 9 shows that there's an anomaly. What does that mean? Could it be manipulation of data? Could it be system breaches? We didn't go into that investigation.

The CHAIR: If I can paraphrase the Assistant Auditor-General's evidence around the adherence to the KPIs—if I understood your evidence correctly, you're saying that there was a real focus on the literal terms of those KPIs by the health department about whether they were met and an assumption that, if those KPIs were adhered to and met, issues of safety and quality would be looked after. In other words, the KPIs were almost sacrosanct and there was no broader inquiry beyond those KPIs about the quality of care?

BOLA OYETUNJI: That would be correct. Because also there's the accreditation by the National Safety and Quality Health Service. So that will also give that confidence that the safety measures are adhered to. It's only when hospital-acquired complications start that you start thinking about whether there are things to look at. Do you want to add to that?

SUSIE HARWOOD: No, I have nothing further to add.

Mr ANTHONY ROBERTS: I just want to unpack the clinical governance and quality assurance arrangements at Northern Beaches Hospital. As to your position, were they consistent with other public hospitals?

BOLA OYETUNJI: From the evidence that we had, it is consistent because the clinical governance, you have different structures, different committees and things like that. We believe it's similar to other hospitals.

Mr MICHAEL REGAN: One of the main findings of the performance audit was the lack of integration into the wider health network. Can you explain what this means practically in more detail for both patients and staff?

SUSIE HARWOOD: Yes. In the report, we covered off on a number of areas that we considered as being, I guess, inhibitors to integration. In summary, happy to go into these in more detail if it's useful. The examples that we drew out in the report were that there are some commercial disincentives or costs to integration and, to some extent, that goes to those structural inhibitors that I was speaking to earlier. In instances where NSW Health may be seeking to add additional services, if they're not already provided for under the terms of the deed, then the typical arrangement would be—and the examples that we point to—a request to the provider to, effectively, provide a quote for what those services might look like. That has meant that, the examples that we show in the report, the offering isn't commercially favourable, so the preference has been to continue to provide those services via other public health hospitals rather than via the Northern Beaches Hospital, because there hasn't been the commercial advantage that underpins the services that were already allowed for within the deed.

There have been some structural barriers to services that haven't been included in the schedule. When I talk about structural barriers, it's slightly different to commercial barriers. We pointed to an example around paediatric acute mental health beds and the difficulties in having additional beds added to the hospital. We understood that there were some operational difficulties there that went beyond just the commercial kind of cost complications of adding additional services under the deed. There was also intended to be a 90 per cent reduction of less complicated planned episodes at the Royal North Shore Hospital, which is the principal referring hospital. That reduction of 90 per cent hadn't been achieved during the period of the audit. There were examples around Hospital in the Home. There had been some difficulties in participation in Hospital in the Home.

There was an example with regard to newborn and paediatric emergency transport services, which relates to the types of services that can be provided at Northern Beaches Hospital and the use of cameras—effectively, for support. When there are certain patients that are in care, those cameras aren't available in the hospital, so it means that the services are reliant on phone calls and notes rather than having that camera interface. The final example I'll give is differences in the electronic medical records systems so that they're not integrated into the broader district network. There are some inhibitors there in terms of timely access to information and also ease of access to information. It's a system that's managed at Northern Beaches Hospital, and is different to the other systems within the district.

Mr MICHAEL REGAN: I was going to ask my second question about the public-private partnership structure, because one of the findings was that it creates tension between commercial imperatives and clinical outcomes. You kind of covered it off a bit so I might skip to question three. I understand that you received a lot of submissions into the audit and also met with a lot of the staff. Do you have any comments or reflections on perhaps how the public-private partnership shaped the culture and staff experience within the hospital? Are there any operational or cultural silos, in your view?

BOLA OYETUNJI: Generally, what we saw was that in a private-run system, the system is intended to—on the process efficiencies side—bring that efficiency into the system. So there's a difference between how a public hospital is run and what the staff were seeing. And that's why I think some of the things we heard from the staff were the stress level and the hours they have to be in the hospital. And sometimes they believe—and this is why I also mentioned the staffing level—that if there were more nurses for patients that would have made the job less stressful. Now, is that because of the commercial imperative? Most likely, yes, because I think when you run a public hospital with an equity firm, there's always going to be the need to drive efficiency. And, as the assistant Auditor-General mentioned, even when you have free cash flow, do you invest in upgrading the system or do you use that to pay down your debt? That's just normal in a process like that. So we didn't find that they were doing anything wrong, but just running the business and trying to run it efficiently.

Dr DAVID SALIBA: Thanks very much for coming today. I just want to do a bit of a deep dive into the public-private partnership model. I had a read of your report, and I just want to highlight some points and just get some feedback, and probably make some statements as well pertaining to that. The first one relates to the discount for services. In your report you state:

> The Northern Sydney Local Health District pays Healthscope a discount on the state price for public hospital activity at the Northern Beaches Hospital. The discount in part recognises the efficiencies that Healthscope is expected to achieve in operating the hospital.

What were the efficiencies?

BOLA OYETUNJI: The efficiency is that the local health district paid a percentage less than would have been the cost in a public hospital. It makes sense in a transaction like that, where there's a lot of public patients that come in that will also be converted to private patients. Part of that transaction is that the private operator is also making enough business and margin in the private hospital by pulling from the public patients coming through. So that's how it could be negotiated that, yes, we're going to pay less than a normally run hospital. There's no other upside to a public hospital.

Dr DAVID SALIBA: Does that seem like a bit of a cop-out? Because you've got emergency and acute care. Basically, you're going to the people of the Northern Beaches and saying, "Hey, we are going to provide a level of health care, but we're going to pay less than what other areas get. So we're expecting the same with less resources." Wouldn't that automatically put pressure on the staff and everyone else there to deliver what would be extant requirements everywhere else?

BOLA OYETUNJI: Ordinarily yes, but when you're negotiating a deal like that with the licensee private hospital, that's the only reason it can happen. And you're right. If it's not there—

Dr DAVID SALIBA: Sorry to cut in. But there is a bit of a problem with what you said—not you, but in a sense that we're negotiating a deal with what is people's lives. I find that fundamentally wrong from a PPP model, where basically what's happened is a deal has been negotiated where there's a profit margin for what is emergency care to vulnerable people.

BOLA OYETUNJI: No, not really, because it's not the profit margin in the public hospital.

Dr DAVID SALIBA: But there's a discount.

BOLA OYETUNJI: Yes, it's a discount. But the discount doesn't mean that you discount the services. That's why the KPIs actually had a higher level of expected outcomes. Dr Saliba, I must say, this isn't an audited thing—we didn't audit that part—but it's not uncommon.

Dr DAVID SALIBA: But you can't provide the same level of services when you're paying less. That's the first thing. The second thing is we don't know the KPIs because the project deed has redacted points in it.

BOLA OYETUNJI: Yes, but Healthscope signed to the deal to provide the service at the level that was agreed in the deed.

Dr DAVID SALIBA: But we don't know because it's been redacted.

BOLA OYETUNJI: In the deed, the level of expected public service is actually in the top quartile.

Dr DAVID SALIBA: Here is it in your report: "A redacted version of the project deed is published on the NSW Treasury website consistent the requirements of the" blah blah blah. "Redacted details include the value of the maximum payment amount, targets for abatable measures, and failure points that apply when target and performance thresholds are not met by Healthscope. "

BOLA OYETUNJI: Yes.

Dr DAVID SALIBA: Broadly speaking—it's a statement, not a question now—I've just got concerns because you've got this PPP model that's paying less for what is meant to be the same services because of efficiencies, but we now know that the hospital's operating under a system of two systems in one—one for administrative patient care and the other one with the medical care. Then we have integrated workforce issues as well. I'm just looking at this now. To be fair, I didn't really know much about this. When I'm reading it, it's just this PPP model was not fit for purpose. It looked as if—by your report as well; I'm reading what the report says—there's a whole litany of stuff. We've got the data. You've got that spike in data which we can't explain in terms of the four-hour mark. It liked look like Mount Everest compared to, like, Fairfield hill in terms of just prior to four hours. We've got this redacted deed. In terms of the public consultations, public submissions to you guys, it states:

> Most of the contributors reflected negatively on their experience with the Northern Beaches Hospital. Many contributors were concerned about the quality of care they experienced or witnessed at the hospital. Other contributors spoke of challenges with how the hospital communicated with them ... Staffing issues, such as understaffing and related resourcing issues, were raised by patients and their families, as well as staff at the hospital.

I'm just looking at this going well, of course, because we're paying them—whatever that deed and that arrangement was, that PPP model—we're paying them less. The discount's an issue.

BOLA OYETUNJI: Yes, but I think the issue—and I must say, that's why we're talking about the commercial imperative and clinical outcomes. That's a key part. I don't believe it is paying them less. I think it's just because it got to a stage where—

Dr DAVID SALIBA: But we know that, though. Sorry to cut in, but Healthscope apparently, according to your report, came back asking for revisions.

BOLA OYETUNJI: Yes, that's correct. Again, I'm just telling you what is the balanced point of view. We concluded—of course you know what our conclusion is on that. But just to add to some balances, in 2018 the deal was struck with the risk allocation. In 2019, again, you know that private equity bought into it. Private equity—again, not audited—can only buy into a business when the cash flow is good. What was not seen was COVID in 2020 that derailed a lot of assumptions. The question, maybe, that you're pointing out is after the 2020 parliamentary inquiry, should something have been done? I think that's a different thing.

But I don't believe that when you want to drive—if you pay someone less and they agree to it, and you have the right KPIs—maybe what I should also mention is that some of the KPIs do not measure the right patient outcomes. That's a different thing. That's why if you want to set up a PPP like that, the robustness of the KPIs—and it's done in Western Australia—that will then make sure, Dr Saliba, that, yes, if I'm paying you less and you've agreed to a higher quality outcome, how do I measure that? That's the key.

I don't think it's the fact that—they've agreed to a transaction. They've now made the transaction. Now you could question why did they agree to say we're going to pay a percentage less and we're going to deliver a higher patient outcome. But at that time they would have used their model. And the modelling I'm saying is that, and especially the way private equity works, they will have calculated—and I'll give you one example, Dr Saliba. If you have a private hospital that has to source its own patients, it will take longer for them to get the volume compared to where you have a hospital that has a public hospital section that has a lot of supply of patients coming in, and the agreement that some of those patients can be converted to private if they have private insurance. Again, I'm not going to go to the modelling of how those things can work, but my point is—

Dr DAVID SALIBA: But I guess here right now, what is critical—and I'll wrap it up because I know time's going to escape us—for health care, from what I've learnt as a member of Parliament, is an integrated healthcare network.

BOLA OYETUNJI: That's right.

Dr DAVID SALIBA: When we look at this public-private partnership model here, noting the systems issues, noting—so some of the points that you said there about COVID coming in and how that was a bit of a shock to the commercial assumptions, which really suggests there are flaws with the model to begin with. But also, again, the comment in your report about the health workforce saying that by allowing Healthscope to find efficient modes of service delivery, including with respect to workforce, Healthscope is more willing to accept a discounted price for services. Basically, there are all these little intricacies that suggest there isn't great integration. From a Healthscope perspective or that hospital's perspective, it's like, well, we're getting less resources and we've got that commercial imperative as well, as you've previously mentioned. These are compounding factors that lead to not exactly the best outcome. Do you think that public-private partnership models, such as the arrangement here, in terms of the deed and in terms of what we know in your report, are fit for purpose for emergency and acute health care in New South Wales?

BOLA OYETUNJI: While I would not be able to comment on this as a policy because I don't have the remit to do that, what I can say—and this is in one of our recommendations—is for a PPP to work well, I don't think you can use 48 KPIs. I think the one that works well in Western Australia, it's over 100 KPIs. Because you have to start measuring—and this is probably to your point—every aspect of the activity and transactions to make sure that services don't fall. The only way it can work is through the robustness of the KPIs, that does not drive unintended consequences, but makes sure that we measure the positive patient outcomes. And there are ways to do that; that can be done. So to answer your question, I'm not commenting on this policy, but it can be done well.

Dr DAVID SALIBA: Can I just put for the record, though, that the conclusion in the Auditor-General's report was:

> The Northern Beaches Hospital public-private partnership is not effectively delivering the best quality integrated health services and clinical outcomes to the Northern Beaches community and the State – the standard required under the arrangement and the key objective of the project deed.

I just want to make it clear for the record that PPP models such as this just did not work. And so we have to—

BOLA OYETUNJI: In this instance, yes, that's correct.

Dr DAVID SALIBA: Well, it's the report. That's what the report says.

BOLA OYETUNJI: That's correct.

The CHAIR: Thank you for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

BOLA OYETUNJI: Yes, we will.

The CHAIR: Thank you. The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee. We kindly ask that you return these answers within 14 days.

(The witnesses withdrew.)

Dr DAVID JOLLOW, Director Women's Health, Member of the Medical Advisory Committee, Northern Beaches Hospital, sworn and examined

Dr ANNE GREER, Director Anaesthetics and Pain Medicine, Member of the Medical Advisory Committee, Northern Beaches Hospital, affirmed and examined

Associate Professor MATTHEW MORGAN, Director Adult Intensive Care, Member of the Medical Advisory Committee, Northern Beaches Hospital, affirmed and examined

Associate Professor VIJAY SOLANKI, Director Cardiac Services, Member of the Medical Advisory Committee, Northern Beaches Hospital, affirmed and examined

Associate Professor PATRICIA HULLAH, Director Adult Medicine, Member of the Medical Advisory Committee, Northern Beaches Hospital, sworn and examined

The CHAIR: Before we get started, I'd like to reiterate some points I made during my opening statement earlier today. The Committee notes that there are matters involving Northern Beaches Hospital that are or may be subject to legal proceedings and coronial inquiry. We will therefore conduct this inquiry in a manner that respects the sub judice convention which aims to preserve the principle of comity between the legislative and judicial branches of government. I therefore request that, when giving evidence, witnesses focus on issues specified in the inquiry's terms of reference and avoid naming any individuals or referencing specific clinical incidents. In particular, witnesses are instructed not to comment on particular matters that are the subject of the coronial inquiry relating to the death of Master Joe Massa or any matter under active coronial or other investigation.

It is also important to remember that there are limits to the protections given to witnesses participating in Committee proceedings like this. What witnesses may say or do during the course of these proceedings is fully protected by parliamentary privilege. However, outside of these proceedings, a witness only has limited protections for the evidence they have given. I strongly urge witnesses to be careful about any comments they may make to the media after the conclusion of the proceedings, or to others after they have completed their evidence. Please seek the advice of the Committee staff if you have any further questions about the publication of your evidence and comments on these proceedings.

I welcome our next panel of witnesses. Thank you for appearing before the Public Accounts Committee today to give evidence. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

PATRICIA HULLAH: Yes.

VIJAY SOLANKI : Yes.

MATTHEW MORGAN: Yes.

ANNE GREER: Yes.

DAVID JOLLOW: Yes.

The CHAIR: Thank you. Do you have any questions about this information?

PATRICIA HULLAH: No.

VIJAY SOLANKI : No.

MATTHEW MORGAN: No.

ANNE GREER: No.

DAVID JOLLOW: No.

The CHAIR: Before we move to questions from the Committee, would any of you like to make a short opening statement before the commencement of questions?

DAVID JOLLOW: Thank you for the opportunity to appear today. We represent the Medical Advisory Committee [MAC] of the Northern Beaches Hospital. The MAC is made up of the clinical directors covering all parts of the hospital. In addition to being members of the medical staff at Northern Beaches, we are all proud members of the Northern Beaches community. Most of us live on the Northern Beaches. Our families are there; our patients are there. Most of us work at other hospitals, but our being here today is a sign of how much Northern Beaches Hospital matters to us. The community and the doctors of the Northern Beaches campaigned for decades to replace the two crumbling small district hospitals at Manly and Mona Vale with the new hospital. Our

community was sick of having to get to Royal North Shore Hospital to receive specialised care. There was also no significant private hospital service on the Northern Beaches, so our community also had to travel for that.

When the then Coalition Government finally agreed to a new hospital, we were surprised to discover it was in Frenchs Forest and it would be a public-private partnership. This was not what the doctors and the nurses wanted, although many of us understood what the former Government was trying to achieve. Despite our reservations, we left the public hospital system and we did everything we could do to make it work. We believe Northern Beaches Hospital has delivered and continues to deliver high-quality public and private hospital services to our community. Not only did we build an exceptional public service—a service which particularly came into its own during COVID—but we've built a world-class private hospital service for the people of the Northern Beaches.

We understand there will be changes to the way that Northern Beaches Hospital will be run, and we support the decision to return many services to the public hospital system. However, we believe any inquiry into the quality and safety of a health service needs to consider all aspects of the health service. For the Northern Beaches, this needs to include how our community continues to access high-quality public services as well as high-quality private services. This has brought convenience and choice for Northern Beaches residents in access to elective surgery, inpatient care and high-quality specialist services that we didn't have previously. This has also supported continuity of care when discharged. We believe it's possible to provide both a strong public hospital service and also to retain a private hospital service, and we are happy to discuss that plan. We welcome your questions.

The CHAIR: Before we begin the questions, I inform witnesses that they may wish to take a question on notice and provide the Committee with an answer in writing within 14 days after receiving the questions. So you don't have to answer right away. You can say, "I'll take that question on notice."

Mr MICHAEL REGAN: Firstly, thank you very much for engaging with this inquiry and appearing today, and for all your work at the hospital since its opening in 2018. I just really want to thank you for your submission. I've got it here in front of me as well. It outlines your position and experience so clearly, so thank you for that. I acknowledge that this inquiry is mainly retrospective, but it would also feel remiss to not acknowledge that there are live negotiations and decisions being made right now about the future of the hospital, so I wanted to ask a question about that. You acknowledge in your submission the challenges and constraints on Northern Beaches Hospital because of lack of integration into the Northern Sydney Local Health District. Looking forward, what do you think are both the opportunities and the risks of being reintegrated into the Northern Sydney Local Health District [LHD]?

DAVID JOLLOW: I might answer that if that's okay. I think there are a lot of opportunities, Michael, moving forward to be more integrated into the Northern Sydney LHD. One of the things that has hampered Northern Beaches over the years is that lack of integration. And sometimes from a clinician point of view, it's hard to tell whether it's just the systemic issues with electronic medical records or the way the deed's put forward and the way that that runs in the hospital. But also, to be completely frank, it's sometimes hard to tell whether it's because there's an ideological opposition that the LHD may have to the public-private partnership. It's fair to say it was very controversial at the time and it's continued to be very controversial, the PPP, from a hospital point of view.

I think the opportunities really revolve around that increase in integration with the public hospital system, in general, with electronic medical record systems, outpatient systems that we can't use, community services in the area that are actually hard to access for patients who've been to Northern Beaches Hospital, even though it's local. I think the opportunities are manyfold, and I think that's why the senior medical staff at the hospital are of the opinion, in general, that reintegrating the public hospital aspect of Northern Beaches should go ahead. I think a lot of people were very uncertain about how it would work over the years, and I think in hindsight, for all sorts of reasons, reintegrating the public aspect of the hospital back into Northern Sydney LHD makes absolute sense. There are lots of opportunities.

The risks that we've got to be careful of is—I'm allowed to say this; I'm an obstetrician—we don't want to throw the baby out with the bathwater. Ultimately, there are so many positive things that have come out of Northern Beaches Hospital over the years, the way that the hospital has grown over the last almost seven years means that we're in a situation, as I said in my opening statement, that we are really giving high-quality care to patients of the Northern Beaches that they didn't have in the old days at Manly and Mona Vale. I think we've really got to be careful that we don't go backwards. We know that having a high-quality public system is important, but also having a high-quality private system is important to take the workload off the public hospital aspect. They're the risks that we're particularly concerned about.

Mr MICHAEL REGAN: What is the model where you think we can have both public and private, and the benefits of both? I know you're very strong on it, so I think it's a nice way to share it. Then I will hand over to Anthony and Clayton.

DAVID JOLLOW: Thanks, Michael. I think we have to go back one step. Looking back at the terms of reference for this inquiry, I think most people would realise that the hospital was designed to be split in 2038. It was actually physically designed to have a private and a public hospital in the same building. Really, the model that we've put forward to the LHD and to the Ministry revolves around effectively splitting the same building into private and public aspects of the same hospital in the similar way that other hospitals, like North Shore public and North Shore private or Westmead Private and Westmead public, work together. The only difference is that they would physically be in the same building.

If you've actually physically been in the building—which I know you have, Michael—it's very easy to figure out a way that these two parts of the same health service could be run conjointly for the benefit of public patients and the benefit of private patients. So we've put together a model of care which, in summary, looks at about 350 public beds in the hospital and about 120 or 130 private beds in the hospital, so we can continue to provide those high-level services that we're providing at the moment, but also having the ability to keep the senior medical staff working in the building consistently to make sure that we can continue to look after public patients like we have been for the last seven years.

Mr ANTHONY ROBERTS: Thank you for your service, all of you. I know the amount of hard work our doctors and nurses undertake. About 85 per cent of residents on the Northern Beaches have private health insurance. I suppose what I'm trying to get at here is what do you think the impact on health services on the Northern Beaches will be if the hospital reverts back to just being a public hospital?

DAVID JOLLOW: I think if it reverts back to being a completely public hospital, a lot of the services will be exactly the same as they are now. The emergency department will work beautifully. Emergency admissions to the hospital work well under the public hospital system. That's why we agree with the LHD coming back in to provide those services. I think our concern is, though, that a lot of people on the northern beaches have become very used to and are very happy with being looked after at Northern Beaches Hospital for their elective surgical work.

I think our main concern really is that if we can't continue to provide those private services locally, what will happen is that a lot of that elective surgery work will end up on a public waiting list, which could potentially significantly impact the wait time for people to get surgery on the public waiting list because the numbers will increase dramatically. So a ballpark figure of approximately 20,000 private operations happen at Northern Beaches Hospital every year, and about 11,000 to 15,000 public. So that 11,000 to 15,000 public cases would suddenly become 30,000 public cases, which would have to be done with constrained resources and staffing levels. So that's our main concern from that point of view.

Mr ANTHONY ROBERTS: Just to follow on from that, if you're a specialist currently working within the private side of the hospital on the Northern Beaches, what are the risks of those specialists turning around and saying, for example, "Well, I'm going to work out of North Shore"?

DAVID JOLLOW: I think the risks are very high. A lot of us on the Medical Advisory Committee were working at Manly and Mona Vale previously. So we've been committed to the area for a very long time, but also we've been able to attract new specialists to the area to provide services locally that we didn't have previously. The obvious example is Vijay, down the end, with interventional cardiology—who had to leave the Beaches for interventional cardiology. So we could fall into a situation where, if a service like that that is run privately at Northern Beaches Hospital at the moment—if I'm an interventional cardiologist and I suddenly need to take all my work to another hospital to get it done, then I might just leave Northern Beaches altogether because there'd be no real reason for me to be there if I can't actually provide my services locally. So that's the concern.

Obviously interventional cardiology is very important. But also the interventional cardiologists actually run the heart attack service. So we're lucky to be in a situation where—previously we couldn't look after patients with heart attacks on the Northern Beaches. They had to all go to Royal North Shore. But we're able to look after those now. Then we'd find ourselves in a situation where all those patients are suddenly back into an ambulance, back to St Leonards rather than getting looked after at Frenchs Forest. That's just one example.

Mr ANTHONY ROBERTS: Yes, along Military Road in peak hour.

Mr CLAYTON BARR: I just have one question, and it's around a turn of phrase, but it's important. In your submission at 1.3, you use a turn of phrase that I believe is contrary to what the Auditor-General has told us. I believe the Auditor-General said that health data isn't necessarily interrogated or audited; it's just believed. But at 1.3, you are saying that for Northern Beaches Hospital, its performance on key indicators is based on verified

independent data. I'm just wondering why you chose that phrase because the Auditor-General is telling us that that that's not necessarily the case.

DAVID JOLLOW: I don't work in the emergency department, unfortunately, but my understanding was that when the Auditor-General looked at that data, it was verified by Northern Sydney LHD to be accurate. So I'm not sure why the Auditor-General gave the impression that that data was inaccurate.

Mr CLAYTON BARR: No, I'm not saying the Auditor-General said it was inaccurate. I think the Auditor-General was saying that they don't have the ability to peek behind what's reported and verify or interrogate, so the data is believed up-front. I just thought that you were using a turn of phrase there that was saying it was verified or interrogated.

DAVID JOLLOW: I suppose that terminology there is really saying that there's no reason to think that that data was inaccurate. So I'm sorry if we said that in slightly the wrong words.

Dr DAVID SALIBA: Firstly, I could just tell by the work that you all do that you're very accomplished. The work that you've done over your decades of service would have saved countless lives. I just want to make that quite clear now and thank you so much for everything you've done, sincerely. My big thing is more about the public-private partnership [PPP] model and my concerns about whether or not that's setting you all up for success. You've got to work within the constraints that you've got to work with. That's what I'm pretty much perusing. The first aspect of what I want to ask there is about integration issues. I know that in your submission you talked about the ability to get junior medical officers [JMOs] and that integration aspect of that. From a staff generation perspective, that's important. Can you just give us some comments?

DAVID JOLLOW: About the JMOs specifically?

Dr DAVID SALIBA: Yes. Basically, your staffing, the staffing constraints that are derived from the PPP model and what you have to overcome to address that.

DAVID JOLLOW: Did you want to talk about that, Matt?

MATTHEW MORGAN: Yes, I'll talk to that. There are difficulties with JMOs. It is multifaceted. It is partly in terms of network positions and in terms of what exists with the memorandum of understanding for JMO allocation. What we have difficulty with is those positions being adequately filled by the network. At Northern Beaches, because there is no forced sending the doctors to Northern Beaches, we do end up having a number of positions that are network positions across the network not filled specifically at Northern Beaches, when they are filled elsewhere. Examples are given in the submission. Further to that, the issue is that we have to recruit further doctors on top of the allocation from the district to provide further services and give an adequate number of JMOs.

That's made more difficult because they have to have a break in service from NSW Health. They have to become employed by Healthscope. They have to work on a different medical practitioners award, which is different to the one they're employed with when they're on the New South Wales state award. That is a friction point in the ability to attract and retain junior doctors. It comes as a mechanism of the deed and the memorandum of understanding that is created. They're definitely limiting factors to our ability to recruit and retain adequate staff. I think we also have to be aware that at the present moment in time, we have a junior and senior medical force across the entirety of New South Wales that is at industrial action or have been undertaking industrial action with regard to their pay and working conditions. Overall morale of junior doctors and senior medical workforce is low in New South Wales, and we are not a unique hospital in terms of having a low-morale junior workforce or having difficulties with recruitment and understaffing within that junior workforce.

Dr DAVID SALIBA: Could I just ask about that as well? I know you've got your separate award with respect to staff. I've seen that in one of the submissions. By virtue of this PPP model, the integration and your constraints in terms of being able to recruit people, do you have to pay overs then? Do you know what I mean by that? Do you have to pay more to recruit and retain medical staff than other hospitals?

MATTHEW MORGAN: No. The Medical Practitioners Award is relatively aligned to the state award. However, it is different in terms of some of the smaller dot points on it. I can speak from a personal viewpoint in the intensive care unit. We take a lot of pride and effort in recruiting juniors with enough experience that can keep the hospital safe. We do that by providing a very strong and robust teaching service, and giving them access to an excellent clinical workload. There are other areas of the hospital that have struggled to recruit and maintain an adequate workforce. With that, there have been associated costs in terms of supplying locums, the cost of which I would not be able to say and would have to take on notice.

Whenever you appoint a locum, be that in any hospital across the private or the public, it comes at a greater cost than having an employee doctor who's a member of your staff. What we'd always prefer and what we individually, in each department, work very hard to do is to try to maintain adequate junior medical staffing who

are employees and who are adequately trained and continue to be supported in their continuing professional development so that they provide the best care to the patients of the Northern Beaches and avoid the use of locums. But they are, to answer your question, a cost.

Dr DAVID SALIBA: You get where I'm coming from, in the sense that you've got staffing constraints structurally because of you being dislocated from the health district and may not be able to entice people to want to come across to you and break their continuity of service. On top of that, overall, there's a discount that's meant to be provided because of the efficiencies that the PPP model provides, which seems counterintuitive from your staffing constraints that you're saying. On top of that, I note that somewhere it says that you're not required to provide safe staffing levels, particularly in the ER—not you, but the actual system. The other aspect of what I want to ask is, in your submission, there is the junior medical staff situation, but does Healthscope actually bear some responsibility under the deed to provide that staff?

DAVID JOLLOW: There are a couple of points to that. One thing is that, like Matt said, there is a certain number of staff on rotation from the district, which is important from a training point of view, but also for staffing the hospital. Part of the cost of that is that, even though Healthscope has to give a discount for the cost of their services, they actually have to pay a premium for the junior medical staff that are on rotation from other hospitals of nine per cent, on my understanding. That's the first cost.

The second cost, like Matt said, is that we actually have to employ our own staff because there are just not enough junior medical officers on rotation from Hornsby and North Shore to staff the place. That's where we have to get extra staff from that point of view. But the difficulty as well, as you'll probably see in our submission, is that if the district, for whatever reason, decides not to send junior medical staff at short notice, there's no recourse to insist that they send staff. Then, to replace those people at short notice, you're paying locums to come along and work for a premium. That's just the example from the junior medical staff point of view. There are several reasons why it's very difficult, on occasion, to get the right number of junior medical staff.

Dr DAVID SALIBA: Would that impede staffing in the emergency rooms?

DAVID JOLLOW: It would impede staff in the whole hospital.

Dr DAVID SALIBA: You accept that this PPP model didn't exactly set your team up for success, from a staffing perspective?

DAVID JOLLOW: We couldn't agree more.

PATRICIA HULLAH: Can I just acknowledge that we weren't set up to succeed for the patients of the Northern Beaches, but we're doctors and we're clinicians. Where we saw deficiencies, we worked to fill them. Where there wasn't the junior doctor doing the tasks that junior doctors do in every other public hospital in New South Wales, it was the senior staff doing them because, at the end of the day, it falls to us that patients are our responsibility. That's why it has been such a challenging time. We're not asking to go back to that. What David has been speaking to is very different. At the moment, it's a PPP, but we treat the public and private very similarly. What David is speaking to is separate, private and largely elective procedural—not just surgery, but procedural. Then the public is managed the way we're used to managing it, hopefully staffed with junior doctors, allied health and nursing so that we can continue to give good, safe care.

Dr DAVID SALIBA: It just goes to my point. I was just bemused by the fact that services could be provided for less. That just puts an impost on your team to say, "All right, we've got to do more with less." I used to be a cop, so I'm used to just dealing with situations if they popped up. I felt like in this scenario, in terms of what the deed is and what the structure was, you just have to bear the brunt of it all. Apart from staffing, are there any other structural issues that you felt let yourselves down from the PPP model?

PATRICIA HULLAH: The lack of integration and the Electronic Medical Records system [eMR] has been really challenging. Both Vijay and I worked with the providers for the eMR to try to get it as set up as well as possible, but the truth of the matter is that Northern Beaches Hospital is not a private hospital. It was managed by a private hospital, but we are largely delivering public health and, with the complexity of that, the eMR just couldn't suit those services. A lot of our patients move between different service providers in the LHD. Mona Vale Hospital is public, and we can't see what's happening there because our eMRs aren't integrated. I think that's been really challenging, and it's not because of us. We would have loved to have used the same eMR, and we've got all of these fancy workarounds. When different staff, like Dave, work at the LHD as well as at Northern Beaches, we'd be texting each other asking to log on to the LHD eMR because it was just so challenging to manage with it not being integrated. That big lack of integration has been challenging.

VIJAY SOLANKI: Just to elaborate in terms of the cardiac side of things, we provide a 24/7 acute heart attack service to the hospital, to both public and private patients. By not having that integration, we can't see

imaging or records of patients that may have presented to Royal North Shore Hospital in the recent few months or years. That information would have changed management in terms of what we would have done with that patient when they presented to our emergency. That lack of integration and sharing of imaging of coronary artery disease was a factor in some of the patients' management, but I just wanted to highlight that we only have the acute heart attack service for all patients because we are able to do angiograms on private patients as well.

As we've said earlier, 70 per cent of the community on the Northern Beaches have private insurance, and this is important because currently we can't do elective cases on public patients. The reason we can provide a 24/7 service is that we have highly trained nursing and medical staff. In order to maintain their skill set, they need to have a large volume of patients coming through. But if there's a reduction in volume, experienced nursing staff will leave the hospital and, unfortunately, this has already started to happen. The nurse lead of the cath lab has resigned from the hospital, stating that there's a lack of certainty about the future of services that the hospital will be able to provide, and today happens to be their last day. It is concerning, and there's still uncertainty about what's going to happen in the future. This does need to be addressed quickly before we lose more highly skilled nursing and medical staff, and we really don't want to drive an extra hour to go to Royal North Shore.

Dr DAVID SALIBA: One hundred per cent. Take a step back, because I know that in your opening statement you made mention that it wasn't exactly what you agreed with, in terms of the model. Some of the constraints that the doctors have just mentioned, were they articulated as part of the consultation when this PPP came into the fray?

DAVID JOLLOW: Definitely. I suppose, to a certain extent, a lot of us were involved in the clinical service planning for the new hospital. Obviously, at the time, we were going from two level 4 hospitals to one level 5 hospital, so there was obviously a plan on expansion on the services that we could provide at Northern Beaches, and that was fantastic. A lot of the services we provide now were things that we wanted to provide in the past but weren't able to. Those patients had to be transferred to Royal North Shore. That was a big positive. But, to be completely honest, a lot of these issues that seemed little at the time, or that it seemed like there was going to be a workaround for, like the electronic medical record, were just something that—we didn't realise at the time what a huge difference it would make or, if we did realise what a huge difference it would make, unfortunately, some of our concerns weren't listened to.

Dr DAVID SALIBA: When did this come into the fray—2014 or whenever it was? I'd imagine that a couple of years later—in the 2010s or whatever—when that would have been articulated, nothing happened.

DAVID JOLLOW: Nothing happened.

Mr MICHAEL REGAN: I think you have touched on it a bit in your responses, but in 1.6 of your submission you state that key recommendations from the 2019 parliamentary inquiry were never implemented, including recommendations 2, 3 and 13. Can you expand on what those recommendations were and why you think they have not been implemented?

DAVID JOLLOW: I might hand this over to Vijay, but recommendation 13 is really partly what we've been talking about: provide all coronary intervention treatments that we've been providing for private patients this whole time. The parliamentary inquiry suggested that those types of interventions should be allowed for public patients as well, and that never eventuated.

VIJAY SOLANKI: Yes. That's a majority of interventional cardiology types of procedures, which include pacemakers; defibrillators; treating abnormal heartbeats, like atrial fibrillation, to prevent strokes; and cardiothoracic surgery in public patients. We've been very restricted in what we can do with public patients, and it's been very difficult—because we all treat the patients the same when they hit emergency and hit the ward, but then we have to have a different plan of management if they're public or private. There are unfortunate discussions between hospitals to try and decide where the patients are going to be treated, and a lot of the time the patient has to be treated at the tertiary hospital, Royal North Shore, which often delays management of the patient, inconveniences patients and adds to the wait times at Royal North Shore and the bed block. There have been numerous instances where this is an issue in management of patients locally.

Dr DAVID SALIBA: I just want to say thank you so much, sincerely. I know it's been tough, but as I said, your service would have dictated so many lives being saved. Thank you.

The CHAIR: I'll join the thanks. I think the evidence today that you've given has been really valuable. It's given a layer of nuance, I think, to your submission. In reading your submission, it could come across as defending the PPP. I think it's clear from your evidence now you're not defending the PPP; you're defending the work that the staff at the hospital have done. You've done your very best under the circumstances. The PPP created a number of barriers for you to work through, but still you've done your very best to deliver the services that you can. I hope I've paraphrased that correctly.

DAVID JOLLOW: Yes, that's great. Thank you, Chair.

The CHAIR: Before we go, could I just ask a final question to you as physicians. Could you envisage a situation where the private operation of acute health services or an emergency department could work well?

DAVID JOLLOW: Gee, you've thrown the cat amongst the pigeons, there. I haven't seen it work in practice. I know the PPP that we're talking about here, what seems to work effectively in other states, especially Western Australia—there are multiple places where that works. I suppose locally, even though it's not a PPP in the sense of the word we're talking about here, but the local example would be St Vincent's Hospital, where there's an outsourcing of services to do a different provider. I think it's possible, but I think it's very difficult to do, and going back to what the Auditor-General had to say previously about KPIs and what sorts of things you measure ultimately, in any system, whether that's health care or education or whatever, it's a normal response for people to work towards their KPIs to make sure that the KPIs are ticked off. So on the one hand, you want a million KPIs to make sure that everybody gets looked after appropriately, but you've also got to be sensible with what you measure, because you can't measure everything. My personal feeling is, in modern day New South Wales, it would be very difficult to do.

The CHAIR: Does anybody else have any other thoughts on this one?

PATRICIA HULLAH: The question was a privately operated emergency department, with public patients?

The CHAIR: Yes.

PATRICIA HULLAH: I think we tried, and I think the politics of New South Wales has made it very challenging, so I don't think that's what I would be advocating for either.

The CHAIR: Great. Thank you very much for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

DAVID JOLLOW: Of course.

PATRICIA HULLAH: Yes.

The CHAIR: Thank you. The Committee staff will also email any questions taken on notice today and any supplementary questions from the Committee. We kindly request that you return these answers within 14 days. Thank you very much. The Committee will now adjourn and reconvene at 2.50 p.m.

(The witnesses withdrew.)

(Short adjournment)

Adjunct Professor ANTHONY SCHEMBRI, Chief Executive, Northern Sydney Local Health District, NSW Health, sworn and examined

Professor MICHAEL NICHOLL, Chief Executive, Clinical Excellence Commission, NSW Health, sworn and examined

The CHAIR: Welcome back, everyone. I welcome our next panel of witnesses. Thank you very much for appearing before the Public Accounts Committee today to give evidence. Can you please confirm that you've been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

ANTHONY SCHEMBRI: I have.

MICHAEL NICHOLL: Yes.

The CHAIR: Do you have any questions about this information?

ANTHONY SCHEMBRI: No, thank you.

MICHAEL NICHOLL: No

The CHAIR: Before we get started, I reiterate some points I made during the opening statement earlier today. The Committee notes that there are matters involving Northern Beaches Hospital that are or may be subject to legal proceedings and coronial inquiry. We will therefore conduct this inquiry in a manner that respects the sub judice convention, which aims to preserve the principle of comity between the legislative and judicial branches of government. I therefore request that when giving evidence, witnesses focus on issues specified in the inquiry's terms of reference and avoid naming individuals or referencing specific clinical incidents. In particular, witnesses are instructed not to comment on particular matters that are the subject of the coronial inquiry relating to the death of Master Joe Massa, or any matter under active coronial or other investigation.

It is also important to remember that there are limits to the protections given to witnesses participating in committee proceedings like this. What witnesses may say or do during the course of these proceedings is fully protected by parliamentary privilege. However, outside of these proceedings, a witness only has limited protections for the evidence they have given. I strongly urge witnesses to be careful about any comments they may make to the media after the conclusion of the proceedings or to others after they have completed their evidence. Please seek the advice of the Committee staff if you have any further questions about publication of your evidence and comments on these proceedings. Would either of you like to make a short opening statement before the commencement of questions?

ANTHONY SCHEMBRI: I have no formal statement other than to acknowledge the submissions that have been put forward by community members and by various hospital staff, and to acknowledge the hardworking colleagues at Northern Beaches Hospital. We're pleased to be here to assist the Committee.

The CHAIR: Thank you. Would you like to make an opening statement, Mr Nicholl?

MICHAEL NICHOLL: No, thank you.

The CHAIR: We'll now move to questions from the Committee. Before we begin the questions, I inform witnesses that they may wish to take a question on notice and provide the Committee with an answer in writing within 14 days of receiving the questions. What, in your view, was the overall intent and objective of the public-private partnership [PPP] arrangement that was put in place for Northern Beaches Hospital?

ANTHONY SCHEMBRI: I think there were a number of components, primarily to improve the healthcare delivery on the Beaches. Mona Vale Hospital and Manly Hospital were certainly not at a contemporary infrastructure standard—the care being delivered there was, of course, excellent. The PPP allowed the opportunity for the establishment of the new physical environment of the hospital, and to bring a higher level of services than that was provided at Manly and Mona Vale hospitals.

The CHAIR: We've heard evidence today—and it's reflected in a number of submissions as well as the Auditor-General's report—of this fundamental tension between commercial pressures and imperatives, and the imperative of providing patient care. Can you reflect on how you feel that was mediated through the PPP, the project deed and through the KPIs and, in hindsight, whether you think the balance was appropriate? What could, in hindsight, have been improved.

ANTHONY SCHEMBRI: The PPP certainly brings a level of complexity to the running of the health service and the KPI regime. There are abatements that may provide incentives for the operator to focus in certain areas of the delivery of their healthcare service.

The CHAIR: And the specific PPPs? I think the Auditor-General, in his evidence today, was commenting that the PPP regime that was in place largely was adhered to, yet the submissions speak of—and I think it's on the public record—a number of serious adverse events. Would you reflect on the adequacy of those KPIs and the regime that was put in place to mediate the commercial side of things, and the imperative to provide patient care?

ANTHONY SCHEMBRI: I think the KPI regime is very similar to the performance framework for all local health districts in New South Wales, the difference being the abatement schedule. Certainly there has been, over the course of the operating period, a number of very serious adverse events and inquiries that have identified that there are opportunities for improvement at Northern Beaches Hospital in the delivery of clinical services.

The CHAIR: Can you comment at all on any differences that you know between the KPI regime in the project deed for the Northern Beaches Hospital and other private-public-type arrangements, for instance, with St Vincent's Hospital?

ANTHONY SCHEMBRI: Yes. I should declare I was the chief executive of St Vincent's for 10 years, so I'm quite familiar. They are essentially the same KPIs that are applied to Northern Sydney Local Health District; to the affiliated health organisations that deliver emergency department services such as St Vincent's, for example; and also with Northern Beaches Hospital. But the primary difference is around the abatement schedule with Northern Beaches. That's a different arrangement to, say, St Vincent's and certainly the local health district.

The CHAIR: With St Vincent's, there was not an abatement-type regime?

ANTHONY SCHEMBRI: That's correct.

The CHAIR: Were they not penalised for not meeting the KPIs?

ANTHONY SCHEMBRI: The performance management framework applies. However, there were not the same financial penalties, that's correct.

The CHAIR: In your view, would it make any substantive difference that under the St Vincent's arrangement, one counterparty was St Vincent's Health and, in this respect, the counterparty was a private equity group?

ANTHONY SCHEMBRI: I have a couple of observations. St Vincent's, of course, is a not-for-profit. The other non-government organisations that deliver health care under the Health Services Act are not-for-profit organisations—Calvary, Tresillian, Karitane, for example—and Northern Beaches, of course, being operated by Healthscope, is a for-profit organisation. There are fundamental differences in the arrangement there.

The CHAIR: I note that, as the Local Health District, you are at the table across all different levels of the governance of the project deed and the operation of the hospital, both from a strategic level and from an operational level. At pretty much every level of the hospital's operations, the Local Health District is at the table. I think it is public knowledge that there are these tensions between commercial decisions, like staffing across staffing levels and investment in IT systems. How did you seek to manage those tensions whilst understanding the imperative to deliver the best level of patient care?

ANTHONY SCHEMBRI: You're correct that we have a governance framework where the district has an oversight obligation under the deed. However, not being the operator of the facility, there is a limit as to our instruction and direction around the delivery of services. A good example is the digital health ICT system. The deed doesn't dictate the kind of digital health ICT solution. It's very different at Northern Beaches to what the New South Wales health system and the district provides. We try and work very collaboratively with Healthscope and with Northern Beaches around opportunities for improvement, where we can share resources and collaborate to improve the service. But, ultimately, because we're not the operator, it is a decision for Healthscope.

The CHAIR: Would it be true to say that you were really captive to the constraints of the project deed and the KPIs, in that you only had that to work with?

ANTHONY SCHEMBRI: Yes.

Mr MICHAEL REGAN: I have a couple of questions straight up off the back of what we heard today. We heard from members of the Medical Advisory Committee. In their submission, in many ways, they have felt "constrained and isolated by Northern Sydney Local Health District". What's your response to this? They gave an example of the junior medical officers [JMOs] and inclusion in programs, such as safe staffing levels et cetera. What's your view on that, Anthony?

ANTHONY SCHEMBRI: The deed does provide constraints on the ability for the Local Health District to fully integrate with the hospital in the same way that we can with, say, Ryde or Hornsby or Royal North Shore.

As the operator, the operator is responsible for the workforce profile. Whilst we can and have actively encouraged Healthscope to look at safe staffing in the emergency department in the same way that Royal North Shore or Hornsby hospital have, Healthscope—it is ultimately their decision. There are issues on the integration with our IT digital health systems. It's very well known, those challenges. In relation to junior medical officers, the district employs a number of JMOs, about 120 approximately. That number is agreed at the start of the year with Healthscope, as to what they believe is their needs and requirements for JMO staffing. The district then recruits to that level. On occasion, as you'd appreciate, due to sick leave, due to parental leave et cetera, there are vacancies at times and the district does everything we can to ensure that we're able to rotate JMOs into those positions. But, ultimately, Healthscope has, as the operator, the responsibility for JMO rostering and staffing.

Mr MICHAEL REGAN: Looking forward, with the anticipated reintegration of the Northern Beaches Hospital into the Northern Sydney Local Health District, what do you think are the risks and opportunities from the perspective of improving healthcare services for the Northern Beaches?

ANTHONY SCHEMBRI: Northern Sydney Local Health District is a part of the taskforce that has been established by the Government to look at the future operating model for the Northern Beaches Hospital. Can I say, as the Chief Executive [CE] of the district, if it is the decision of Government that the hospital is to return to public hands, we would very, very warmly welcome the Northern Beaches Hospital community into the district. I acknowledge that many of the staff at the hospital are also Northern Sydney Local Health District staff. They're former Manly and Mona Vale hospital staff, so it would be great to welcome them back. I think there are many opportunities, none the least the opportunity to bring Northern Beaches Hospital in line with the statewide development around the Single Digital Patient Record. This is a clinical transformation across the system that will bring extraordinary benefit not only to patients and their carers but to staff experience, to the clinical outcomes and how we're able to reduce waste in the system by having the one record. That's one example.

The opportunity to fully integrate the Northern Beaches into northern Sydney's clinical networks, to integrate the hospital in line with our workforce profiles and staffing, such as Birthrate Plus in maternity, nursing hours per patient day for our nurses, and the opportunity, particularly also around leveraging our academic partnerships, our Kolling Institute, being able to bring research and clinical trials in a way that previously the community may not have had access to—I see many, many opportunities. To be frank, I would be absolutely thrilled for the hospital to become part of our district.

Mr CLAYTON BARR: On that last point about the opportunities that are available going forward, why did we all do each other a disservice by not writing those opportunities into the deed in the first instance, so that there was this opportunity to flex and grow and bend? Those opportunities could have been made available to the private operator as well, but they weren't written into the deed, as I understand it. Was that a missed opportunity?

ANTHONY SCHEMBRI: The deed doesn't specify some of those opportunities—like, for example, compliance with the same IT digital health solution that NSW Health operates. It doesn't specify that the same workforce profiles are required. The deed requires the operator to deliver a safe, quality service. I think, with the opportunity for the hospital to come into public hands, it gives us an opportunity to address those issues.

Mr CLAYTON BARR: Can I go to the IT systems, please? The 2019 inquiry indicated that there were at least two IT systems operating that didn't talk to each other, and the recommendation was that that be fixed. Clearly it wasn't. Whose responsibility was it to enact that recommendation, which was accepted by government?

ANTHONY SCHEMBRI: What I can say is that, in the emergency department, there are two IT systems that are in operation at the Northern Beaches. There is a patient administration registration system and the electronic medical record. They don't talk to each other. Healthscope and the operator have been taking a number of steps to address that. I can only speak for the time that I've been in the role, over the last two years. We've been actively working with the operator to address that issue. A similar issue was around the Newborn and Paediatric Emergency Transport Service [NETS] cameras, and the lack of the cameras. Part of the challenge for the operator in installing them was that the IT systems didn't integrate well with NSW Health. Thankfully we've been able to address that now, and those cameras are in operation.

Mr CLAYTON BARR: Professor Schembri, I think you've misunderstood my question. Within the deed, when there is a need to update IT systems, improve IT systems or get IT systems working together—which was the recommendation—whose responsibility was it to do it and make sure it was done?

ANTHONY SCHEMBRI: The operator.

Mr CLAYTON BARR: So the Local Health District didn't have responsibility to make sure that was enacted by the operator. We just trusted that they would follow the recommendations. Is that right?

ANTHONY SCHEMBRI: We have an oversight responsibility.

Mr CLAYTON BARR: Yes, you do.

ANTHONY SCHEMBRI: However, not being the operator, we are not able to enact. We work as closely as we can with the operator to see that those improvements occur, but it is ultimately the responsibility of the operator.

Mr CLAYTON BARR: Under the PPP, the model that was applied here, it didn't matter what recommendations were made or accepted by the government of the day et cetera—and we wanted to see that happen in the hospital—NSW Health had no ability to enforce those changes?

ANTHONY SCHEMBRI: There is the ability, under the deed, to issue breach notices, for example, or improvement notices. There is a very high threshold for that. We chose to work collaboratively and cooperatively, and to share resources where we could, to see those improvements made.

Mr CLAYTON BARR: I am really sorry, team and Chair, but there is a lot to unpack. Can I go to the question of JMOs and the provision of JMOs as part of the sharing arrangement? The submission from the Northern Beaches Hospital [NBH] Medical Advisory Committee is that, already this year, the Hornsby hospital JMO network have identified for NBH that they will be unable to supply four out of the 16 JMO posts for the remainder of this year. That's not just a sick day. That's not just occasionally, "We can't get the numbers." This is the public system saying, "We can't provide you what we're supposed to provide you in a long-term period." Are you aware of that, and is that okay?

ANTHONY SCHEMBRI: I have met on a number of occasions with the Medical Staff Council, who have raised concerns with me directly around the allocation of JMOs and a concern that there was a disproportionate preference to district hospitals above Northern Beaches. When I became aware of that, I instructed our JMO unit and our Executive Medical Director to conduct a review, and they found that there was no disadvantage applied to Northern Beaches, or no preference applied to Hornsby or Ryde or North Shore. There was a proportional allocation of JMOs to Northern Beaches. Unfortunately, and particularly during the later period of the calendar year, there are a number of vacancies in JMOs for a number of reasons. It's not unique to Northern Sydney. But we worked very hard to ensure that that allocation is fair and reasonable to Northern Beaches.

Mr CLAYTON BARR: The last sentence of that paragraph says, "Meanwhile, all JMO posts at Hornsby Hospital are completely filled."

ANTHONY SCHEMBRI: I would have to take that on notice. I'm not sure.

Mr CLAYTON BARR: It's in the submission. I can tell you it's 5.12 on page 8.

Ms JENNY LEONG: Thank you for appearing before the Committee today. I'll start at where we're at now. What do you see as the best way forward to ensure that the Northern Beaches community are actually receiving the best quality health services that they need? I say that in the context of talking about the KPIs that were set—talking about the abatement regime that was in place. Correct me if I'm wrong, but it sounded like there was almost no regime that could have existed for the governance and the oversight that would address the fact that decisions were being made on a commercial and a profit basis, rather than on an alternative, which was the primary health needs of the people accessing the service.

ANTHONY SCHEMBRI: If I can express a personal opinion as the CE, we would look forward to the opportunity for Northern Beaches to be returned as part of our health service. We believe the opportunities around improvements in workforce, in digital health, ICT, the broader opportunities around research, access to clinical trials, and the direct ability that I have, as Chief Executive, for clinical governance oversight would be improved and enhanced.

Ms JENNY LEONG: In terms of looking to this—and it's very difficult. I acknowledge that the reality is that we are having a very bland conversation about what has had direct, life-altering and horrific impacts on people. That is the scope of what this inquiry is, and I acknowledge that. I feel sick to my core about the fact that we are doing it in this way. But that's where we are. Acknowledging that, with all your experience at St Vincent's and in your current role, can you envisage a scenario where there would be a PPP-style arrangement that would be able to work to deliver the best standard of public health care for the people of New South Wales? Is it just that we got the contract details, the governance model, the KPIs and the abatement regime wrong or is there a fundamental disconnect between those two elements?

ANTHONY SCHEMBRI: I think that there are examples in the state where there is the provision of public services by private providers that have delivered high-quality services over many generations, St Vincent's being a very good example of that. The deed for—

Ms JENNY LEONG: Can I just interrupt there? Maybe I wasn't clear in my questioning. You talked earlier about St Vincent's being a not-for-profit. I was talking about for-profit providers. My apologies for not being explicit.

ANTHONY SCHEMBRI: I think that for the for-profit, the commercial imperatives will always place challenges and tensions in the delivery of public health services. That is a personal view.

Ms JENNY LEONG: Did you want to add anything, Professor Nicholl?

MICHAEL NICHOLL: I think, from a quality and safety perspective, one of the difficulties we have is that we've got separate pieces of legislation that cover public hospitals and private hospitals. The requirements are different across the two. There will always be a tension, I think.

Dr DAVID SALIBA: Anthony, I think we know each other. You used to manage Fairfield Hospital back in the day, yes?

ANTHONY SCHEMBRI: I did. I was the General Manager of Fairfield for many years. It's a wonderful community in south-west Sydney. I love it.

Dr DAVID SALIBA: Professor, there's regulation, legislation, rules and processes. It gets full-on. Then you add this extra layer with respect to this PPP. You made a statement there about two standards. Is that right? What I'm trying to say there is: Shouldn't health care be just the one standard?

MICHAEL NICHOLL: If that was regarding my comments, it certainly wasn't around two standards. It's just that there are different legislative requirements. The standards are well covered with respect to the national standards through the Australian commission. Those standards, as applied through the hospital accreditation system, are the same across public and private. There are not two standards.

Dr DAVID SALIBA: With respect to that, you've got separate requirements and we're saying that the standards should equate to the same outcomes, but we're not seeing that here.

MICHAEL NICHOLL: I'm not sure what outcomes you're referring to.

Dr DAVID SALIBA: The fact that we're having this inquiry. Anthony just made mention about the PPP models and the limitations there. Is that a fair assumption or no?

MICHAEL NICHOLL: From the Clinical Excellence Commission [CEC] perspective, we're a statutory health corporation. We're separate from the Ministry. We do have visibility of the serious incidents that occur across the state, whether they be in public or private facilities. With respect to Northern Beaches, if we compare it to equivalent level 5 hospitals across the public system in New South Wales, they are not an outlier. They have similar outcomes to other hospitals of equivalent role delineation.

Dr DAVID SALIBA: With respect, we just heard from the staff saying that there were issues pertaining to the requirements placed upon them, particularly staffing and everything else, and they have to cover the brunt of that.

MICHAEL NICHOLL: No, I was speaking very specifically about serious adverse events, when we compare serious adverse events across similar hospitals of the same role delineation as Northern Beaches Hospital, compared with public hospitals. My comments are only with respect to serious adverse events.

Dr DAVID SALIBA: What about patient care? Put adverse events to the side. What about overall patient care in PPPs versus public hospitals and the pressure placed on the staff and doctors, particularly at Northern Beaches Hospital? Given the deed, given the fact that we've got different systems and processes in place there, and given the filling of JMOs, as Anthony has just stated, is it really at the same standard or is it really two standards?

MICHAEL NICHOLL: I can't really comment on that. The determination of functions that my particular organisation has is restricted to public hospitals in New South Wales. The similarity across the two pieces of legislation that relate only to serious adverse events is the only visibility I have. With respect to the other aspects of safety and quality, that monitoring is done through the Local Health District, or the Ministry through the Local Health District.

Dr DAVID SALIBA: Anthony, can you—I want someone to comment on this, to be honest with you. This is the whole purpose behind the inquiry and it's one of the key terms of reference. Who can comment as to the, as I put it, two standards—separate requirements, different standards, different pressures placed on the staff?

ANTHONY SCHEMBRI: It would be fair to say that there are different standards when it comes to workforce staffing rosters, for example. In New South Wales public hospitals, we have nursing hours per patient

day and Birthrate Plus for maternity services. Those standards don't apply to the deed. The operator is responsible for staffing as they see it. That would be one example.

Dr DAVID SALIBA: On that, in respect to your oversight function and the fact that we've got delineations here pertaining to staffing, hours and working conditions, would that not have an impact on patient care?

ANTHONY SCHEMBRI: We work very closely with the operator, on a monthly basis through our oversight function, to ensure that the operator is providing a safe, quality service. It is the operator's prerogative around how they staff the organisation.

Dr DAVID SALIBA: I totally get it but, in your supervisory role, do you feel like the staff at Northern Beaches Hospital had to do more with less and weren't supported as best they could be to ensure patient care?

ANTHONY SCHEMBRI: What I can say is that I have met recently, on a number of occasions, with the Health Services Union, the Nurses and Midwives' Association and the Australian Salaried Medical Officers Federation [ASMOF], the doctors' union. They have raised with me that there are a number of issues around inadequate staffing of the hospital that they believe create additional challenges in the delivery of care. I've put those concerns to the operator.

Dr DAVID SALIBA: With respect to that, you've got a deed that's in place. Do you feel like the deed enabled that to happen?

ANTHONY SCHEMBRI: To be frank, the deed is very frustrating to me as the Chief Executive of the district, because I don't have the same ability to influence the operations, workforce, systems and processes as I do with other hospitals in my district.

Dr DAVID SALIBA: This is a very important point: Who recommended all of this? You made a comment, and I typed it down as you said it. You said that the PPP's purpose was to bring, basically, a level at that hospital that will be able to merge those two other smaller hospitals at level 5 care. Who said, "All right, we've got an established public hospital process that can do that, but we're instead going to do the PPP?"

ANTHONY SCHEMBRI: It was the government of the day.

Dr DAVID SALIBA: So it was the Government. It wasn't a recommendation from NSW Health.

ANTHONY SCHEMBRI: I would have to take that on notice. I wasn't there at the time, but that's my understanding.

Dr DAVID SALIBA: The crux of it is that the PPP's purpose wasn't to bring that level of care to the region. That could have been done from a public hospital perspective. The PPP way that this would have happened. That's what I'm trying to say. In order to stand up the hospital, the PPP wouldn't be the sole option.

ANTHONY SCHEMBRI: There are, of course, other options. There would have been other options, yes.

Dr DAVID SALIBA: With that, in terms of your oversight function—and you've had these meetings—how much resources would you have to spend as part of the public funds to oversee this hospital?

ANTHONY SCHEMBRI: At times it is burdensome. In my Office of the Chief Executive, I have a team of staff who are charged with administering the deed and the partnership.

Ms JENNY LEONG: Can I jump in on that, Mr Saliba, and just ask what level of resourcing from the health district and level of funding would be placed on managing the private partnership? I am happy for you to give a general answer and then take it on notice if you want to give more detail. I'm just curious to know—people would assume, in New South Wales, that our public health budget is being used to provide health care. I'm interested to know what the level of staffing and resourcing is to manage a contractual private partner relationship.

ANTHONY SCHEMBRI: I have a team comprising an executive director. I then have a senior project officer. I have a data quality manager and administrative officer. But then, of course, a proportion of my time and my executive time is spent also administering the deed and the contract.

Ms JENNY LEONG: Do any of the other public hospitals under your remit have that level of executive and staffing support to be able to manage a relationship—so, sitting centrally to manage the relationship with another entity?

ANTHONY SCHEMBRI: No, the arrangement is not replicated for the other hospitals in my district.

Ms JENNY LEONG: I appreciate this is going slightly outside your remit, but given you opened the door by mentioning that you had been at St Vincent's, was there a similar level of resourcing, in terms of managing that relationship, that you're aware of at the Sydney Local Health District in relation to managing that partnership with St Vincent's?

ANTHONY SCHEMBRI: It was a different arrangement because the St Vincent's health network has a direct service agreement with the Ministry of Health, so it was a direct arrangement. There wasn't an intermediary Local Health District like there is in the case of Northern Beaches.

Ms JENNY LEONG: Thank you. Sorry to jump in there, Mr. Saliba. I just thought it was useful to see what that resourcing looked like.

The CHAIR: Could I also jump in around the staffing levels? Given the rollout of safe staffing levels at public emergency departments, could you compare for us the nurse staffing levels at, say, Royal North Shore Hospital and Northern Beaches Hospital?

ANTHONY SCHEMBRI: As part of the transition assessment team that we are working with—the taskforce—we have identified that there is a different staffing ratio in the emergency department at Northern Beaches when compared with a peer hospital. I am happy to take that on notice with further detail.

Dr DAVID SALIBA: I guess the key thing here is this concept of efficiencies that are able to be provided under the PPP model, which will enable the Government to pay a discounted rate. What are your views on that? Because the implication there, in my mind, is you guys aren't efficient in the public sector, in respect to patient care.

ANTHONY SCHEMBRI: Whilst it is correct that there is a discount that is applied to the purchase of public activity at Northern Beaches, there are also concessions. For example, the full suite of NSW Health policies doesn't apply to Northern Beaches Hospital. The public sector salary and conditions don't apply in the same way and, over the course of the operating period, there has been additional supplementation provided to the operator.

Dr DAVID SALIBA: What do you mean by that?

ANTHONY SCHEMBRI: For example, during COVID times, there have been additional payments made to the operator, and there has been a change to the discount regime over time, for instance.

Dr DAVID SALIBA: For consistency purposes, if it was up to you—and I know this is probably a loaded question—PPP or private, with respect to patient care, model-wise?

ANTHONY SCHEMBRI: Sorry, do you mind just repeating?

Dr DAVID SALIBA: Would you say that the public model is probably a bit more fit for purpose for patient care, compared to the PPP—noting staffing constraints, system integration issues, integrated healthcare network, deed issues, ambiguities, oversight and everything else?

ANTHONY SCHEMBRI: I believe that the New South Wales public health system provides a whole range of benefits to the community that are in addition to what a single private operator is able to provide.

Mr ANTHONY ROBERTS: Can you outline the key initiatives that were undertaken to address the recommendations of the 2019 Legislative Council inquiry? Also, if you're able to add to that, the actions that are still outstanding in response to those recommendations?

ANTHONY SCHEMBRI: Of the recommendations, there were two that were not supported by the government of the day relating to Mona Vale Hospital. The other recommendations have been completed.

Mr ANTHONY ROBERTS: There's nothing outstanding?

ANTHONY SCHEMBRI: I don't believe so.

Mr ANTHONY ROBERTS: Can you also give me some insight on the actual benefits that the PPP has brought to the Northern Beaches?

ANTHONY SCHEMBRI: One of the benefits is in relation to the physical infrastructure. As I know you are aware, the former Manly and Mona Vale hospitals—the built environment had challenges. The new hospital provided at Northern Beaches at Frenchs Forest provided new infrastructure for the community. There was also an uplift of the role delineation from the former Manly/Mona Vale hospitals to the role delineation today at Northern Beaches.

Ms JENNY LEONG: Can I just jump in on that and just understand those two benefits that you've just outlined? Obviously, the first one, anyone can deliver the infrastructure with the money, right?

On the second one—so that those of us who don't understand the operations of hospitals are clear—is an uplift in the role delineation also just a matter of if there are the funds available to resource and do that, or is that something that the private sector brings that the public could not offer? I'm not sure what that means in that context.

ANTHONY SCHEMBRI: Thank you for clarifying. The role delineation sets out the level and complexity of health services. The former Manly/Mona Vale hospitals were at level 4 for the majority of services. Northern Beaches is, for the majority of services, at level 5, so it has a higher complexity and more complex services. That's the general overview. The PPP arrangement, through its funding, has enabled that role delineation to be increased.

Ms JENNY LEONG: In both of the examples you just gave of the benefits, the actual benefit is simply that the funds were available to deliver those things.

ANTHONY SCHEMBRI: Yes.

Ms JENNY LEONG: So using public funds to deliver a public hospital could have realised those same benefits.

ANTHONY SCHEMBRI: Yes.

Mr MICHAEL REGAN: Can I jump in and reflect on some of the comments that were made today. Anthony, do you accept that if private services are not maintained at the hospital, there is a risk that the Northern Beaches community may lose services that it's basically come to expect and enjoy since the amalgamation happened in 2018? Because that is being strongly suggested by others, including those who were here today.

ANTHONY SCHEMBRI: Could I perhaps answer by saying there are three buckets of patient care. The first is public patients in a public hospital; the second bucket is patients who elect to use their private health insurance in a public hospital; and the third is a true private-private or private-plus, where there is greater flexibility in, say, the waitlist policy. In our hospitals in northern Sydney, there is the provision of private services so patients are able to exercise their right to use their private health insurance in a public hospital in northern Sydney.

I would not envisage that that would be any different in any future operating model, so clinicians will be able to continue to admit private patients into the public hospital. Of course, there is that third bucket, the private-plus. We are currently working through a range of options. Can I acknowledge the Medical Staff Council and the Medical Advisory Committee for their cooperation. My colleagues and I have met on a number of occasions now, both at that level but also at the department level, to really understand that private-plus. That is currently all being synthesised and worked through as part of the taskforce.

The CHAIR: Is there anything else that the witnesses would like to add to their evidence today?

ANTHONY SCHEMBRI: Not from me, thank you.

MICHAEL NICHOLL: No, thank you.

The CHAIR: Thank you for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to further questions?

ANTHONY SCHEMBRI: Yes, thank you.

MICHAEL NICHOLL: Certainly.

The CHAIR: The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee. We kindly request that you return the answers within 14 days.

(The witnesses withdrew.)

Associate Professor PETER THOMAS, Chief Operating Officer, Northern Beaches Hospital, affirmed and examined

Mr TINO LA SPINA, Chief Executive Officer, Healthscope Group, affirmed and examined

Ms KATHRYN BERRY, Interim Chief Executive Officer, Northern Beaches Hospital, affirmed and examined

The CHAIR: Thank you for appearing before the Public Accounts Committee today to give evidence. Please note that Committee staff will be taking photos and videos during the hearing. The photos and videos may be used for social media and public engagement purposes on the Legislative Assembly's social media pages, website and public communications materials. Please inform the Committee staff if you object to having photos and video taken. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

PETER THOMAS: Yes.

TINO LA SPINA: Yes.

KATHRYN BERRY: I have.

The CHAIR: Do you have any questions about this information?

PETER THOMAS: No, not at all.

TINO LA SPINA: No.

KATHRYN BERRY: No.

The CHAIR: Before we get started, I reiterate some points I made during my opening statement earlier today. The Committee notes that there are matters involving Northern Beaches Hospital that are or may be subject to legal proceedings and coronial inquiry. We will therefore conduct this inquiry in a manner that respects the sub judice convention, which aims to preserve the principle of comity between the legislative and judicial branches of government. I therefore request that when giving evidence, witnesses focus on issues specified in the inquiry's terms of reference and avoid naming any individuals or referencing specific clinical incidents. In particular, witnesses are instructed not to comment on particular matters that are the subject of the coronial inquiry relating to the death of Master Joe Massa, or any matter under active coronial or other investigation.

It is also important to remember that there are limits to the protections given to witnesses participating in Committee proceedings like this. What witnesses may say or do during the course of these proceedings is fully protected by parliamentary privilege. However, outside of these proceedings, a witness only has limited protections for the evidence they have given. I strongly urge witnesses to be careful about any comments they may make to the media after the conclusion of the proceedings, or to others after they have completed their evidence. Please seek the advice of the Committee staff if you have any further questions about publication of your evidence and comments on these proceedings. Would any of you like to make a short opening statement before we go to questions?

TINO LA SPINA: Thank you, Chair, and members of the Committee for the opportunity to appear before you today. I want to start by acknowledging the extraordinary professionalism, resilience and dedication of the team at the Northern Beaches Hospital, who have continued to deliver high-quality care to our community under intense public scrutiny and, at times, deeply distressing circumstances. I've spent a great deal of time at the hospital since becoming Healthscope CEO, and what I've witnessed the staff having to endure has been both humbling and, frankly, at times heartbreaking. Our people have been spat on, shouted at, had their tyres slashed and been unfairly vilified. Yet they show up every day to care for patients with compassion. They deserve all our respect and our thanks.

Healthscope has proudly operated Northern Beaches Hospital since its opening in 2018 under a public-private partnership with the New South Wales Government. As the New South Wales Audit Office noted in its report, the project deed has "delivered material cost savings to the New South Wales Government but has presented operational, financial and workforce challenges for Healthscope". Despite these limitations, Northern Beaches Hospital has consistently delivered high-quality services. The hospital meets the same national quality standards as all New South Wales public hospitals, with independent health data showing that we are performing comparably or better to peer hospitals, despite receiving less government funding.

It is important to note that, due to the project deed, the hospital is held to a higher standard than any other public hospitals in New South Wales. The project deed includes 82 key performance indicators and imposes top percentile performance expectations. The Audit Office report acknowledged that "no New South Wales peer B1

public hospital would have met the Northern Beaches Hospital emergency treatment performance targets". Yet Northern Beaches Hospital continues to meet or exceed many of these targets. I'm not suggesting our hospital is perfect—no hospital is. However, based on objective measures, we consistently outperform our peers. Our focus remains on fostering a culture of transparency, continuous learning and continuous improvement.

The Government has made its policy position on public-private partnerships clear. That's why Healthscope has been engaging in good faith with the New South Wales Government on an early handback of the hospital, as allowed for under the project deed. I want to make it clear that we are in no way seeking a windfall gain. We are seeking a resolution that is in the best interests of our people, our patients, our doctors and the broader Northern Beaches community. I am proud of our performance, I am proud of our people and I am proud of the care provided to the Northern Beaches community. I look forward to your questions.

KATHRYN BERRY: Thank you, Chair, and members of the Committee. I appreciate the opportunity to appear before you today and represent my dedicated team and put on record the excellent performance of the Northern Beaches Hospital. I am really proud of the 2,500 committed people working at the Northern Beaches Hospital who provide essential healthcare services to the local community. Their professionalism, compassion and skill has been unwavering, even as they have faced the emotional toll of recent incidents and the weight of ongoing public scrutiny. They have been deeply impacted by these developments, and I want to sincerely thank them for their continued commitment to patient care and for their support of one another.

I do want to take the opportunity to acknowledge that, when an incident occurs within our hospital, it has a profound impact on everyone involved. I wish to express my deepest sympathies to all those affected. We continue to ensure we learn and implement changes from these events, taking significant steps to strengthen our systems and processes with patient care front of mind. Our team focuses every day on improving patient outcomes and Northern Beaches Hospital continues to perform strongly against key clinical measures. Staff transfer patients from ambulances to the care of the emergency department within the recommended 30-minute time frame, 90 per cent of the time. That's compared to 80 per cent of the time at peer hospitals. That means ambulances are back on the road faster. This benefit is recognised by paramedics in their submission to this inquiry, who stated that "the emergency department of the hospital was of the same quality as or better quality than any other in Sydney".

Furthermore, in the last quarter to the submission date, the Northern Beaches Hospital performed 100 per cent of public patient elective surgeries on time, compared with the state system which achieved a rate of 84 per cent. Our care is recognised by the Northern Beaches community. Over the last seven years, our people have cared for over 880,000 patients. Despite the ongoing public scrutiny, we have seen 3 per cent growth in public patients admitted to our hospital in the last 12 months.

Our focus on our patients is further reflected in patient experience data, where 95 per cent of respondents rated their experience at the hospital as good or very good as, of May 2025. The Clinical Excellence Commission has also recognised our culture, noting that the hospital staff are a committed and professional workforce, with a shared focus on delivering safe, high-quality care. I would now like to wrap up by highlighting the positive feedback provided to this inquiry via submissions from members of the public. These submissions reflect the hard work, professionalism and compassion of our staff and the efficiency of our operations. I am really proud to see our efforts recognised by the Northern Beaches community, who we work to serve every day.

The CHAIR: Before we begin the questions, I inform the witnesses that they may wish to take a question on notice and give the Committee an answer in writing within 14 days after receiving the questions. I don't think it's any secret what the nub of the issues are today. I think it has been acknowledged that there have been systemic failures in the PPP and the operation of the hospital. What do you think the root causes of those failures have been? Is it because of the ownership and the commercial pressures due to the ownership? Is it because of the strictures of the PPP deed and the way the KPI regimes were put in place? Were there market reasons for this? We'd be interested in hearing your assessment of what has caused this to not work out.

TINO LA SPINA: Let me perhaps start, and then I'll let my colleagues here join in and supplement. I don't accept that there have been failings in the system or there have been systemic failings. I think, on any objective measure—of our KPIs and the performance of the hospital—we stand by those. I've been with Healthscope now since February this year, and I certainly have not seen any instances where anybody at the organisation is putting dollars ahead of patient care. Our mode of operation is we want to be the best place for care, we want to be the best place to work and, if those two are true, then the third, being financial, will look after itself. It is not the primary focus of Healthscope. I'll also say that the PPP model in and of itself can work. It has been seen to work in other jurisdictions, so I wouldn't put it to a PPP model itself. Yes, there are integration issues. Those integration issues are capable of being, or have been capable of being, addressed, and they haven't been

appropriately addressed. Hence that obviously does frustrate the contract. But I might ask Kathryn or Peter if there's anything else that they want to add.

KATHRYN BERRY: I think, in saying that, there are the failures that have led us here—we've just had representation from the Clinical Excellence Commission here today, who state that the outcomes for our patients that they see are similar to peer hospitals. We also have our accreditation standards that we have to meet. We perform well in our clinical indicator data, our hospital-acquired complications [HAC] data. Yes, we have three HACs that haven't met target, but the rest of the HACs do. I think that would be similar across our peer hospitals. I don't think that that is the failure. Whether you're talking about the PPP being a failure—I think that's a different matter to the hospital being that failure. The hospital is not a failure.

The CHAIR: I acknowledge the distinction between the hospital and the PPP. Before we go to the PPP, in respect of the hospital, it has been asserted by a number of witnesses and submissions that one of the main problems was the digital systems in place, the patient records. The 2019 parliamentary inquiry dealt with some of those issues. The issues were known. What was the reason that system wasn't rectified in all these years?

TINO LA SPINA: Maybe I'll start and then I'll hand on to Kathryn. The system that we chose to use at Northern Beaches—and let's all accept that we probably weren't all here at the time that that was done. Notwithstanding, it was done in the full knowledge of the state. The state endorsed the choice of the electronic medical record [eMR] system that is currently used by Healthscope. There was an option, if they wanted to go through and use another system, to do that. It was going to be more expensive, and they could have chosen to fund that through the deed. The decision was made to move ahead with the eMR that was chosen at the time. There is nothing systemically wrong with the eMR. That particular eMR is used in other hospitals across the country as well, and can work. There have been integration issues, which we have fixed along the way. We accept that. But there's nothing systemically wrong with that particular system.

The CHAIR: Can I clarify what you just said. Are you saying that at the time when the hospital deed was formed, the state at that time had a choice of implementing the same eMR system that was in place in public hospitals but chose to keep the current system, the Telstra system, in place because of cost reasons?

TINO LA SPINA: I can't know what was in the minds of the people at the time. I've made inquiries as to how we got to this point at the time and whether it was a unilateral decision that Healthscope made at the time. I'm informed that it was not a unilateral decision that was made at the time. There were options. We could have gone with the same system that the state had used. Yes, that would have been a far more expensive option, and the state had the option to fund that at the time. That is what I've been told.

The CHAIR: Are you aware of when, approximately, those discussions were being had?

KATHRYN BERRY: It was prior to the hospital being operationalised and the eMR being put in place.

The CHAIR: So during the period between the announcement in 2014 and the commencement of the hospital operations in about 2018—within that period?

KATHRYN BERRY: Yes, that's our understanding. As Tino noted, we weren't part of those discussions, but that's our understanding.

The CHAIR: Have there been discussions within the hospital's Healthscope management about the potential of replacing that system with a system that would integrate more fully with the public hospital system?

TINO LA SPINA: I might ask Peter to talk about this in a minute as well, but the issue of integration is far more complex. In other words, there's integrating the system and then there's integrating the data and having the data flows. I think as some of our doctors on the Medical Advisory Committee [MAC] alluded to earlier, that is a fundamental problem, that lack of integration there, in that we don't get access to patient data that has previously been in other public hospitals. That can be addressed. There are ways to address that, but that has been a choice not to address that. That's not necessarily a failing of the system. There are ways to better address that, but just fixing a system won't fix that. We need to be able to have access to all of that data. If I'm sitting here today, having been in the business for some time, I would urge the Committee to take that recommendation on board. They should be able to have data flows to provide the best historical record of a patient that presents at our hospital.

The CHAIR: Sorry, just to clarify, are you saying that it would have been possible to have workarounds where you get the data feeds—and whereby, for a new patient coming into Northern Beaches Hospital, you could see their clinical history through the public system—but you were prevented in implementing those solutions because the health district wasn't prepared to do that?

TINO LA SPINA: Unless I'm mistaken, I think it's more a philosophical view of the sharing of the patient record with Northern Beaches Hospital.

KATHRYN BERRY: The patient record does get shared, but there is a time lag, which I think some people have mentioned today. All data in our records basically gets transferred overnight so that people in the district can see it.

TINO LA SPINA: That's one way, Kathryn.

KATHRYN BERRY: Yes, that's one way. That's going from us through to the district.

The CHAIR: But when somebody comes to the hospital emergency department in an ambulance and they've got a long and extensive and complex clinical history, how do—

KATHRYN BERRY: We can't see their data.

The CHAIR: That's the nub of the issue. In order to see it, you would need to either have the same system integrated with the public hospital system, or you would need to have, as Tino said, some sort of direct link.

TINO LA SPINA: Sorry, you need two things. You would need the system in place first, I agree. But then the system without having the access to the data flows is worthless in that regard, so you'd need to ensure that you've got the data flows.

The CHAIR: I understand that. The question is were these scenarios worked through where no solution was able to be found in the five or six years since the parliamentary inquiry reports, such that nothing was really done—it was just too hard?

PETER THOMAS: I think it's difficult. The system that we're talking about is something called the CHIE, so it's basically Clinical Health Information Exchange. What we tried to do over the last two or three years is Northern Sydney Local Health District eHealth was to look at the timing of that, to try to get more contemporaneous flow. Because the issue that we have is the whole record doesn't update until after midnight, which means that there's a time differential. Looking at the timing was one potential solution for that. But given the volumes of patient data that flow out of Northern Beaches, that was very difficult. A working party was set up with Northern Sydney Local Health District and Northern Beaches and the Healthscope IT central corporate team, but that was difficult and we weren't able to achieve that. Again, I think the limitations are the flow of information between two systems, not just the system itself—so interoperability.

TINO LA SPINA: Peter, have there been conversations about the flow of the data back to Healthscope?

PETER THOMAS: I suppose we've talked about that in both directions, particularly because we have patients that come from Mona Vale urgent care centre to Northern Beaches. There is limited access. There are two of the physicians in ED who can see into the Northern Sydney Local Health District eMR for patients that transfer rapidly between the two services. But that's very limited and it's not across the whole service of Northern Beaches nor Northern Sydney Local Health District.

The CHAIR: So discussions were had, but a solution wasn't forthcoming. It's an ongoing problem that is not resolved.

PETER THOMAS: That's correct.

The CHAIR: Can you give us a view as to why it's an ongoing problem? Is it a technical problem? Is it a philosophical problem? Is it a cost? Is it that to implement a solution would just be overly costly? To be clear, we are not taking issue with any individual here. I think the Committee understands the strictures of what has gone on here. There is no philosophical pre-judgement within this Committee about private sector versus public sector. The private sector operates in order to create value for its shareholders. There's absolutely nothing wrong with that. This is not about attributing blame. We're trying to understand what went wrong with the arrangement from the beginning in order to make sure, first, that it doesn't happen again, and second, to ensure that whatever is put in place for the residents of the Northern Beaches and the community can work most effectively.

PETER THOMAS: I acknowledge those points. I think the key thing, if we look at some of the system improvements in our Northern Beaches eMR that we made in the past six or seven years—even for small interoperability changes, that has taken a lot of time. It's taken a lot of technical development on behalf of the provider of our eMR. In terms of trying to have our eMR integrate with the whole of the NSW Health system, it would be a significant technical difficulty. I'm not an IT expert, but certainly if you have a look at the improvements we've had to make just for interoperability with some of our third-party providers, such as pathology imaging providers, that has taken two or three years to actually develop the technical solutions to allow

that to happen. I think the eMR at Northern Beaches is very good if it's talking within the same system. But I think, as we've seen across Health and simply with the introduction—or pending introduction—of the single digital patient record, interoperability with third-party systems is actually the biggest issue that we face, and it's predominantly a technical one that takes time, resourcing and technical solutions.

The CHAIR: Is the current system in place at Northern Beaches Hospital interoperable with other Healthscope hospitals? Is it interoperable within your ecosystem, just not with the public ecosystem?

TINO LA SPINA: No, we don't use the eMR, other than in Melbourne Private Hospital. We don't use it in any of our other private hospitals at all. We don't run an electronic medical record. We have different systems and processes in the rest of our network.

KATHRYN BERRY: A paper-based medical record.

The CHAIR: It's perplexing why the system was put in place in the first place.

Mr CLAYTON BARR: I want to stay on that topic for a moment, if I can. There might be 10 different medical IT systems out there. They might all be fantastic and wonderful. I make no judgement. When the hospital was being built and the decision was being made about IT, philosophically, why would you potentially choose an IT system that was different from the public ecosystem that you're meant to interact with? Philosophically, why might a private provider choose a different system with all these complications foreseeable?

TINO LA SPINA: I think it's one thing to ask whether all the complications were foreseeable at the time. It was incumbent on the private operator at the time to put in place whatever systems and processes to ensure the operation of a safe hospital. On any objective measure that we've got here today, we've been able to show that we operate either at the same level as peer hospitals or, in many cases, at a better level than our peer hospitals. That is based on objective data. I just want to tackle the assertion that, for some reason, the hospital itself has been a failure. I just don't accept that comment that was made previously. There are many things that we would do in our hospitals that are different to the other public hospitals, but that doesn't necessarily mean that they're worse. They're just different. It's well within the scope of the project deed at the time. That was done in collaboration with NSW Health at that time. That's my understanding.

Mr CLAYTON BARR: I'll take out the word "foreseeable". Would there not be an obvious potential for a problem by choosing one system that was different from another system?

TINO LA SPINA: At the time, I am informed, the option of going with the same system that the state has elsewhere was explored. It was a significantly higher cost, and there were conversations with the state at the time about including that cost in the delivery of the PPP and absorbing that. They could have that choice, and they declined to go that way.

Mr CLAYTON BARR: Was the decision made based on cost?

TINO LA SPINA: By the state? Probably.

Mr CLAYTON BARR: No.

TINO LA SPINA: Yes, by the state.

Mr CLAYTON BARR: By the private operator that chose a system that wasn't as expensive as the public health system.

TINO LA SPINA: Respectfully, I reject that. The people at the time were there to put in place a PPP in accordance with a project deed and were bidding on that and provided financials associated with that. There were different ways of doing that and they had options associated with it. If the state wanted to go the more expensive option, it could've chosen to do so. It decided not to.

Mr CLAYTON BARR: So the private entity had no choice to make here? They were instructed that they needed to accept the different type of IT?

TINO LA SPINA: No, that's not the case at all. That's not what I'm saying. I'm saying that in the bidding for operating the public hospital in the PPP, a bid was put forward, a template was put forward, and everyone knew what was going to be invested in at that time and what system was going to be purchased. If the state wanted to go in a different direction, it knew that it was going to have a different cost outcome to it, and it chose to stay in that same direction, which, by the way, we're comfortable with. We don't believe that system has compromised the quality of the hospital, based on any empirical data that we have.

Mr CLAYTON BARR: I think that the Medical Advisory Committee was suggesting that there were some difficulties, and the 2019 upper House inquiry into the operations suggested that there were difficulties in this exact space.

TINO LA SPINA: Yes, I think that there were difficulties in this exact space. What I am saying is that, through the hard work of our doctors and staff and the workarounds that are there, we've been able to ensure that we have a safe operating hospital that has performance indicators that are better than its peer public hospitals. There's a question about the outcomes, and I'm more focused on the outcomes of the hospital and ensuring that it continues to deliver high-quality services for the community of the Northern Beaches. On any objective measure, I think that that is the case. I'm yet to see an objective measure where that's not the case.

Mr CLAYTON BARR: That's a nice segue to the other thing I want to ask about, which is the quality of the data and the integrity of the data. Right there, you're talking about the outcomes that the hospital is meeting or exceeding. The Auditor-General indicated that he would like to interrogate the data a little bit more deeply and check whether or not it was reliable. The Auditor-General was not saying it was wrong but, as auditors always like to do, he was saying, "Scratch beneath the surface and show me." Do you accept the Auditor-General's commentary that there needs to be some further examination of data?

TINO LA SPINA: I'll let Peter comment on that and I'll come back.

PETER THOMAS: The comments about the emergency department [ED] spike and the data that the Auditor-General referred to this morning are important, because they highlight some of the potential issues that we have to deal with at Northern Beaches. This was related to what we call the discharge time. The discharge time is meant to be within four hours if a patient leaves the emergency department. Unfortunately, our system is not the same as the NSW Health system. FirstNet is a part of the eMR that works in the emergency department, and there's a function in that system where nursing or medical staff can click a button and it says, "This patient is ready to depart", and that gives the timing. At Northern Beaches in the eMR, we don't have that function, so it has to be a manual process that is done by the nursing staff, usually after the patient has left, going back through the record to check that timing. It's a manual process.

Northern Sydney Local Health District was asked to investigate that data as an example of potential discrepancies in data. We actually received a letter back from that independent audit this week that confirmed, in the first instance, there was no deliberate attempt to manipulate the data. When they looked at the data of each sample of the patient records that were taken, it demonstrated that, in fact, although there seems to be a big spike, the majority of those patients actually left before that spike was recorded—i.e., the majority of patients that they looked at left before the four-hour period. But because of the manual nature, it was easier for the nursing staff to do the time stamp just before the four hours.

That has been confirmed. The cause of that was this disconnect with the IT system that we have in the eMR, which doesn't have a particular function that actually tracks and triggers that KPI in NSW Health. I think it's a good example. The Auditor-General brought it up because it does look unusual when you look at the data. But that has been investigated by an internal audit by Northern Sydney Local Health District, and it has been shown that, in fact, the data was accurate. In addition to that particular KPI, the performance in Northern Beaches is assumed to be better because, when they looked at the records, the patients left significantly before the four hours in some cases. But because of the manual retrofit, that's what had to happen.

TINO LA SPINA: I don't think that the Auditor-General was implying any lack of integrity on behalf of our nurses. They certainly have my 100 per cent support, and my trust and faith that they're doing the right thing. I reject any assertion that someone's doing the wrong thing there.

Mr CLAYTON BARR: Mr La Spina, the Auditor-General made no comment about the nurses at all.

TINO LA SPINA: I know. You're raising it. You're raising the issue now about the quality of the data. All I'm saying is, given that it's the nurses who are preparing the data and entering that data in as well, I just want to make sure that there's no inference on the record that there's any wrongdoing on behalf of our nurses, who work tirelessly to do an amazing job each and every day.

Mr CLAYTON BARR: I also want to make it very clear that I am absolutely not inferring that the nursing staff, who work incredibly hard, have done anything wrong here.

TINO LA SPINA: Okay, great.

Mr CLAYTON BARR: That was nowhere near my line of questioning. But I want to ask this question on the back of that—just so everyone's clear, we're talking about page 22 of the Auditor-General's report, Exhibit 9. If we can have an unusual anomaly like that, on that one set of data about time in ED, is it not possible

that there are other anomalies in the data upon which we are relying to satisfy ourselves about the performance right across the board of, in this case, Northern Beaches Hospital?

TINO LA SPINA: I'll get Peter to come in.

PETER THOMAS: I think the importance of figure 9 in the Auditor-General's report is that, when they looked at all of the data that we reported on, that appeared to be somewhat unusual in the way that data presented. If we look at our other KPIs that are reported through the BHI—the Bureau of Health Information—some of those data points aren't actually collected or given by Northern Beaches. For example, transfer of care actually comes from the NSW Ambulance service in terms of providing that data. I think when we have a look at the auditor's report and when we also have a look at our records in terms of hospital accreditation, we have our operational KPIs through the BHI, then we have our safety quality KPIs that are looked at through the framework of the national standards. That data is provided as raw data across the systems and, therefore, is open to interpretation by the relevant bodies.

Some of those things are automatically collected as part of our surveillance systems, and some of those are collected by third parties that work in collaboration with Northern Beaches Hospital. I think that the importance for me is, when we look at the Auditor-General's report, there was a set of data that looked unusual and they brought attention to that, quite rightly. They were able to drill down on that data in a way that showed it was—again, because we were reporting on the KPI, where the public system has mechanisms in the eMR to just track and trigger that KPI, but we have to do a manual process. But that is probably the key one, and it's related to ED eMR, which is FirstNet in the system, which we don't have as part of our eMR.

Mr CLAYTON BARR: So there's no need to be concerned about any of the other data.

PETER THOMAS: I think I'm confident that there's not, and it has been scrutinised also, for example, by the national accreditors.

Mr ANTHONY ROBERTS: From your perspective, what could have been done better to support the success of the Northern Beaches PPP?

TINO LA SPINA: I think that's a great question. Given that there are successful PPPs that operate not only across the country, but also across the globe, I think that's a very good question worth examining. From my perspective—and I'll hand over to the guys as well in just a minute—some of the integration issues that can be addressed are not hardwired into or legislated into a project deed. In fact, they can be dealt with, as long as you've got the goodwill to do that on both sides and looking for the success of the hospital. As I've said, the hospital itself is a fantastic operating hospital on any objective measure. Frankly, with the better integration, it could put less pressure on our people. We heard from our doctors before, who I'm in awe of because they put a hell of a lot of effort—they've got their personal pride in there and their personal effort—into making that hospital a success as well, and all of our people that work there every single day.

But those integration issues are not issues with a PPP. They're things that can be dealt with. Anyone that enters into an agreement for 30 or 40 years—to suggest nothing's going to be done or reviewed over the 30 or 40 years doesn't make any sense, right? But it does require goodwill, and it does require both parties coming to the table to try to work out the right solution. With respect, someone made the comment earlier today that there needs to be the political will, and I'm probably here to suggest that that political will hasn't been there, of late. Peter, have you got any comments?

PETER THOMAS: I think it's important to understand—I'm a clinician that spent many years in the public sector before coming to Northern Beaches Hospital. I think it's very important that we have KPIs, because KPIs are a way for us to define the parameters of safe patient care, quality patient care, and operational, as well as, in some cases, financial performance. But I think one of the difficulties is that there's a significant number. Eighty-two KPIs is a lot to report on. There were more than 100 KPIs when the hospital first opened. Over time, we've been able to look at what are the most important KPIs and then try and work through some solutions to that. But going back to Tino's point, I think one of the biggest issues we've had is interface and interoperability with the public system.

We have an emergency department that sees between 65,000 and 70,000 patients a year. That makes us as busy as North Shore Hospital in the district, and patients inevitably flow between Northern Beaches Hospital and the public services, both at the tertiary level and then back out to community services. I think members of the Medical Advisory Committee articulated that also, in the questions from the Committee, that the seamless flow of patients from Northern Beaches Hospital into some of the public services is difficult. Some of the restrictions we have, even as a level 5 facility—there are certain procedures or certain clinical pathways we're not allowed to follow and we will send those patients to North Shore.

In terms of how it could work better—I suppose a review of a KPI regime that was initially quite onerous without necessarily the mechanisms to collect all of the KPIs. The second would be to think genuinely, for all of us, when we put the patient right at the centre of a pathway of care, what is the best thing for the patient? That isn't always best managed through a contractual mechanism. It's actually best managed through what is best for the patient at that point in time. Are they in the right place? Can they have the care that they need? I think that's something that's really important—how could we have made the PPP be more successful? I think it's important to have contractual obligations, I think it's important to have governance, I think it's very important to have KPIs, but I think it's also important to make sure that we always have the patient at the very centre of every pathway of clinical care.

Mr ANTHONY ROBERTS: Chair, I've just got one more question, and that's a good segue about patient care. What do you think is the best pathway forward under the PPP model we should be moving towards, to provide the best possible medical care and outcomes for the people of the Northern Beaches?

TINO LA SPINA: I'll give you a comment in a minute, Peter, but as I've said, the PPP model is not a failure. Can it be better? Yes, but the hospital itself provides excellent service to the people of the Northern Beaches community, and better than many of its peers. That is unequivocal, and the data is there. Having said that, we accept that the Government has made a policy decision where PPPs have no further place in delivery of public hospital services. They've actually introduced legislation to that effect, and having our people work outside current policy guidelines and receiving all of the backlash didn't make sense. It's within that context that we've been talking to the state about handing back the public hospital, not because we believe it's been a failure from anything that we've done; we think that the successes speak for themselves. Yes, we're not perfect and I'll accept that, but no hospital is, and all I would say is we're "less" less perfect than other public hospitals. Peter?

PETER THOMAS: I think one of the important things was reflected in the submission from the MAC and the comments earlier. I'm also a resident of the Northern Beaches. My family lives on the Northern Beaches, and it's our local hospital. The most important thing when we think about the decision that the Government makes regarding Northern Beaches is that we have a significant number of services for our community, whether it be public or private patients, and those extended level of services. The most important thing, the absolutely most critical thing for the Northern Beaches community, is that those services are maintained at Northern Beaches in whatever way possible.

Professor Schembri talked about service level 5, or role delineation level 5. Currently at Northern Beaches, there are a significant number of services that in a public service would be part of a role delineation level 6 service. That is really important when we think about the future of the Northern Beaches Hospital, and whatever decision the Government makes, to ensure that we don't lose those services for the population of the Northern Beaches community, because that has significantly enhanced the wellbeing of the population and taken a significant amount of work and pressure off the public services, in particular North Shore, that, as you know, has significant problems with bed block and is a very busy service.

KATHRYN BERRY: There was the question earlier to Professor Schembri about what were the benefits of moving over to a public model. But Dr Jollow earlier today said, "Don't throw the baby out with the bathwater." There have been some significant benefits to having a private hospital. Northern Beaches would not have some of the services that we have—like cardiology and the PAPA STEMI service [Pre-hospital assessment for primary angioplasty and ST-elevation myocardial infarction]—if we didn't have private services. I've worked in private hospitals—I trained in a public hospital—but I've worked in public hospitals for around 30 years now. The way the doctors, our clinicians, our nurses and midwives work at our hospital to build a hospital that offers an amazing service for the community, you can't lose that. The public-private partnership allowed that because it promoted innovation and development of services that we couldn't have done in a public hospital LHD framework.

Ms JENNY LEONG: Ms Berry, I'll follow up on that comment first. I asked in the previous session a question in relation to the benefits, or what were seen as the benefits, of that. In relation to the comments that you just made, if the funds were available, would that be able to be delivered in a public hospital setting? When you say that it wouldn't have been able to be delivered for the people of the Northern Beaches—the cardiology et cetera—presumably those things could be delivered if the public funds were available.

KATHRYN BERRY: For public patients—in a private hospital model, I know there is discussion about private patients in a public hospital.

Ms JENNY LEONG: I appreciate we're talking about different pools.

KATHRYN BERRY: You could provide services for public patients. But then you have the no private patient model and—I think the doctors mentioned this earlier—you could not prioritise a private patient through the elective surgery model over a public patient. That's unethical. It should be whichever patient's sicker. So you

would severely run the risk of having overrun of services in a public hospital if you didn't have a private hospital. But, yes, if you wanted to fund a level 6—as Peter said, we offer a lot of level 6 services as a private hospital—you could offer level 6 services in a public hospital. It's just the volume.

Ms JENNY LEONG: So the volume and the funds.

KATHRYN BERRY: Yes.

TINO LA SPINA: But the elective surgery—

KATHRYN BERRY: Elective surgery is different, yes.

PETER THOMAS: If I might add some context to that, it's true that if you fund a hospital and you bring the right specialists and nursing staff in, you can certainly provide level 6 services in a public hospital. We already do across the state. Most of the local health districts will have at least one level 6 service within the local health district. If you consider a hospital that only has public patients and you take away the private patients—this is the importance of what Kathryn was saying about the PPP—probably the important thing is that volume of patients coming through. Because we have private patients in addition to public patients, that increases the volume of patients in a particular service. That volume of patients brings with it the expertise from the nursing staff. Also, when we think about things like cancer surgeries and treatments such as Interventional Cardiology [IC] you need a volume of patients to make that service successful and sustainable. The surgeons, the nursing staff, the proceduralists—they have, if you like, their own KPIs about the number of cases that they have to do in a certain time period.

So I think one of the unique advantages of the PPP for the Northern Beaches community is that private patients have been able to have surgeries and procedures and treatments in Northern Beaches Hospital. That overall volume has lifted across the whole service, which has allowed accreditation of services. It's allowed the appropriate minimum volumes of certain types of surgery to be performed that allow us to be a cancer surgical centre or an interventional cardiology centre. That is something to consider—that if there aren't the private volumes of patients, some of those services may or may not be sustainable because of the volume of patients required to actually keep the skill set of nursing staff and proceduralists as well. That is one of the things that, even if you increase the funding, unless you have that private patient volume, it may not be possible to do.

TINO LA SPINA: That's without considering what happens to those—I mean, for the people of the Northern Beaches community that currently have private, and private for elective surgery, what's their option going forward? That's what Dr Schembri was talking about in terms of having to be working through that—and I sincerely hope they find a solution for that.

Ms JENNY LEONG: To take a different tack for a minute, it would be helpful to know how long all of you have worked for Healthscope for, in the context of this. I was curious.

PETER THOMAS: I arrived in Northern Beaches in December 2019, 12 months after the hospital opened. I've been there ever since. I commenced as the chief medical officer and then took over the role as the Chief Operating Officer.

TINO LA SPINA: I've been here since February this year.

KATHRYN BERRY: I've worked for Healthscope since April 2019, but I've been at Northern Beaches since July 2024.

Ms JENNY LEONG: To clarify, Mr La Spina, you talked about the fact that, on the one hand—and I think it was words to the effect of—profit isn't the primary focus of Healthscope, or you said that profit would never be put ahead of patient care. I want to have an understanding of the structure of Healthscope in the context of how these decisions are made. You said you've been in business for a long time and this is where it's at now. I can't understand, in this context—where we go back to the questions asked by Mr Barr in relation to the public-private partnership arrangements regarding decisions made around the digital systems that were in place—that the state was responsible for making a decision over what system would be used and that, potentially, there was a better option available but the state chose not to fund that. That is primarily a financial decision, then, that is made by Healthscope to go ahead with one version of that technology or another. That is a financial decision, surely?

TINO LA SPINA: Sure. You're just looking at the other side of the same coin. We had two parties coming together to determine the way public hospital services were going to be delivered moving forward. The bid was put forward on the basis of the Telstra system being put forward. The Government had the full knowledge of that. They had the option to go for a significantly more expensive system but, of course, in a PPP they're paying for that service so it would alter the bid that would go in for achieving that service. If you're saying to me—

Ms JENNY LEONG: But if Healthscope would never put dollars ahead of patient care, Healthscope could've decided that that was a better option to take.

TINO LA SPINA: I'm saying to you that, even at that point in time, the people of the day would've decided that system was okay and appropriate for the delivery of service, and making sure that it doesn't compromise safe patient care. I'd say that that has continued through to today, where no decisions are made where we're putting dollars ahead of patient care. In fact, all of the statistics and all of the KPIs that we've got associated with the hospitals would actually stand behind that fact. There's nothing that we can point to to say that somehow we've put profits ahead of patient care, which has created a public hospital system which is worse than the rest of its peers. It's better than its peers.

Ms JENNY LEONG: I take you at that point. You have said that no hospital is perfect, and I think we would all agree that tragedies can occur at every hospital.

TINO LA SPINA: And they do.

Ms JENNY LEONG: The big question here is who's ultimately accountable when those tragedies occur.

TINO LA SPINA: We're accountable. Absolutely, we're accountable. I take full accountability.

Ms JENNY LEONG: Mr La Spina, would you say that Healthscope is accountable for when those tragedies occur?

TINO LA SPINA: Absolutely.

Ms JENNY LEONG: What recourse is there to hold yourself to account? What level of experience do you have within the health system to know how best to make decisions that are then going to address those? How does that work in that context? I appreciate not all health ministers have experience as medical professionals or as health professionals. I'm not suggesting that that is a requirement. But at the point where Healthscope is then ultimately accountable for those serious incidents that occur—

TINO LA SPINA: My job is to put in place governance structures and oversight arrangements, and ensure that we've got the right people, the right training and the right expertise, to ensure that we run a safe facility. That's my background. I've come from an airline background before that. After that, I've worked with GenesisCare, who's the largest radio oncology provider in the country. I've worked with Boral, which has safety systems in place for its people. In terms of safety and a safety culture, I think you'll find no-one who speaks more highly for what the requirements for that moving forward are, and I will continue to push that. I am not a clinician. If you ever turn up to an operating theatre and I'm there holding a scalpel, you should not enter that room. That is not my expertise. But I am surrounded by people who have that expertise. My job is to make sure that we bring those resources together and ensure that we have the right governance structures in place. I think that we do that effectively.

In terms of the way forward, you'll know that right now we're in a process with receivers in place that are looking to potentially sell the hospitals. There's a separate dual-track process or alternative process that we're also pursuing, which is around becoming a not-for-profit organisation, which has got a lot of effort in the organisation. That is something that I'm quite passionate about and that our 18,000 people are quite passionate about as well—to become that not-for-profit organisation. That doesn't mean we will not be seeking to deliver a surplus. We will always seek to deliver a surplus because if there's waste in the health system and that money can go back into the health system, we should always be seeking to do that. I stand by our record and our people's records since I've been here and, frankly, from before I started.

Ms JENNY LEONG: In relation to the evidence that we heard previously about the KPIs and the various abatement regimes et cetera, and given your experience in business, Mr La Spina, I wonder, do you have views on whether there actually is a model that would improve the way that those KPIs are set and how you navigate the relationship and responsibility that you have to those that you're accountable for—i.e. those who are investing in a corporation and expecting a return versus the KPIs that are set by Health in relation to the delivery of quality health care?

TINO LA SPINA: My approach to this has been clear. I've been in situations and I've had learnings in my career as well where I've had financial KPIs, and was going after the financial KPIs first and found that, number one, they're not successful and that approach is not successful and, number two, it's not sustainable. I truly believe that if we set about being the best place for patient care and the best place for our people to work, dollars will look after themselves. As soon as we make that the centre of our focus, then that's when we're going to have issues. I'm saying to you here today that delivering exceptional patient care and delivering for our people are the first two priorities in the way that we approach the business.

With respect to a PPP and can a PPP be successful, like any partnership and like any marriage, any partnership can be successful. But guess what? It requires the goodwill and the trust and for both parties to want to make it work. As soon as you don't have that situation or you have an environment where both parties do not want it to work, or there's a lack of trust or a breakdown of that trust, then I'm going to say that there's going to be potential issues in that partnership, just like any marriage.

KATHRYN BERRY: I think today Professor Schembri made a comment that he welcomes Northern Beaches into his LHD. We're already in that LHD; we're already part of that LHD. We are clearly named in the Clinical Services Plan for the Northern Sydney LHD. For me, I think that is one of the biggest problems about the PPP. It's not accepted as being a suitable solution. I've spoken to Mr Regan about this before. I don't think the PPP, in essence of itself, is the issue. It is people's philosophical beliefs about a PPP. Again, with KPIs, I think there should be KPIs but they should be benchmarked to other hospitals within the LHD or within New South Wales.

That's not how it works. They're blunt instruments. The Audit Office noted this in their report. They say you have to reach the highest tier of every KPI, and every hospital in New South Wales does not meet that—and people don't call those hospital failures, because they're not failures either. For me, having been there since July last year, those would be a couple of the key things, I would think. We are part of the LHD; we are an intrinsic part of the LHD. Last month, we did more ambulance presentations than North Shore. If we're not part of the LHD, what are we?

TINO LA SPINA: Pointing to a project deed and saying that the project deed doesn't allow for whatever, I think, is not the right way to go. You cannot do a long-term public-private partnership and expect that there will be no changes. You need to go into it in the full knowledge that things may change and we may need to be flexible to ensure that we have the best thing for the total hospital system—and, therefore, by putting our patients first, create best patient outcomes. It just requires everyone to have that goodwill to want to make it work. I'm suggesting that, currently, that hasn't existed for the time that I've experienced.

Ms JENNY LEONG: I would also suggest that these are not new concerns that have come out. People were raising concerns about the concept of a public-private partnership, and the decisions to engage in this, before the hospital was established. It was very clear that the idea of outsourcing public health care to a private hospital entity was a cause for concern prior to this occurring and, indeed, prior to Healthscope being awarded the ability to deliver the hospital. Going back to looking at those discussions very early on, I think that is where, to your point, there were already concerns about the idea of the privatised delivery of public health care—and, indeed, of health care for the people of the Northern Beaches.

TINO LA SPINA: Yes, but I think that stopped short again of saying that the PPP is the reason for that. Yes, you can have concerns, but if all of those concerned parties are working with the best intent to deliver the best outcome, you can deliver that.

Ms JENNY LEONG: But they clearly aren't working with the best intent because they are delivering for people who are not the people of the Northern Beaches—that is, for those who are seeking to profit from Healthscope. That is the fundamental challenge with this. I appreciate the Chair spoke—

TINO LA SPINA: I fully reject that. If that were the case, then we wouldn't have the hospital achieving performance metrics that are superior to the rest of the public system. I fully reject that assertion.

Dr DAVID SALIBA: I have a couple of points. One of the things I want to ask about—Chair, stop me when required, please—is the management of business cases in PPP models. It's just something I thought about as you were presenting your evidence today. With respect to the system, the evidence you gave was that it went to government. Was there a business case that was produced to government with respect to the system, given that it was a large decision?

TINO LA SPINA: Is that a question for me, Dr Saliba?

Dr DAVID SALIBA: Yes, any one of you.

TINO LA SPINA: I've got no idea. As I said, I've been here since February. The inquiries that I made with respect to the eMR, because I know there has been a lot of conversation around the eMR, were similar to those that have been here. In other words, how did we get to that position, could the issues have been foreseeable at that time, and was there ever a discussion of an alternative option? All I've been told is that that was considered at that time. There were bilateral conversations with NSW Health. Everyone acknowledged that it was a more expensive system and therefore would require additional funding on top of what was agreed as part of the PPP.

Dr DAVID SALIBA: At that point, what I'm concerned about is that with this stuff—and I've noticed with government in general—we spend money and we do things and there needs to be a business case attached to

it. Alongside that business case, there would be a risk analysis attached to that as well. I know you know what I'm talking about here—risk mitigants, residual risk. In general terms, I'm trying to figure out whether or not, as part of the PPP model—and PPP models in general, because this is an inquiry about PPP in healthcare—whether or not business cases were used as part of decision-making.

TINO LA SPINA: Definitely, in Healthscope we use—

Dr DAVID SALIBA: You can take it on notice, by the way. I know you've made—

TINO LA SPINA: No, I know the way that we operate. Definitely in Healthscope, everything that requires capital expenditure requires a business case. That's just prudent financial management. Yes, of course, we need to make sure that scarce resources are allocated to where the greatest need is, and we continue to do that on an ongoing basis. With respect to the state and whether a business case was presented to the state, that's a matter for the state. I've got no idea whether there was one presented to the state.

Dr DAVID SALIBA: I'm trying to figure out the governance structure attached to this PPP model which enables the best decision-making to be made. It's a question for the Committee or whoever. I just want to know—on notice from you or on notice from Health to the Chair—whether or not business cases with risk management processes have been attached as part of decision-making with respect to acquisitions, or whether or not decisions have just been made verbally. That's the first thing I want to know. In terms of the system, I think the issue and the reason why there is a lot of angst about it is because—well, I haven't used the system. I'm not a user. I dare say, you probably haven't used the system in an operational capacity either.

But the staff that we spoke to before articulated that it could be better. The question is not whether or not it's good; it's whether or not it's the best system, especially if public hospitals use another system. My concern is about interoperability as well, given the fact that staff workforce transitions between the hospitals occur as part of your workforce strategy. I think that's why there's a bit of angst. On this point, too: As a statement, two systems versus one—the less complications the better. I'm sure you're aware of that.

TINO LA SPINA: Yes. I think to say that the imperative was to get the best system—I don't think that that's the approach. I think the approach is overall, when delivering to the objectives of the public-private partnership and delivering the outcomes that we deliver, what's the best way to get there? I think on any objective measure, yes, we've got there. Would someone do something differently if you went back in time? Perhaps. I can't really answer that question. But to suggest that the hospital is somewhat impaired as a result of the eMR, I think is going a step too far. It performs better than its public peers. I'm here to talk about the outcomes that we have. Yes, it may well be that it's because of the great work of the people that we've got that work at the hospitals, as opposed to the systems and the tools that they use, but it's all of that that comes together to provide the outcomes that we get.

Dr DAVID SALIBA: I hope you can understand—I understand you've made previous statements that it's empirically better than peer systems. We don't know that because we don't have the data to actually assess that. Is it possible to produce that?

TINO LA SPINA: Did you say that I said that the system that we use is better?

Dr DAVID SALIBA: You said "empirical evidence" previously.

TINO LA SPINA: No, empirical evidence suggests that our hospital's performance is better than other public hospitals. That's the Bureau of Health Information [BHI], an independent body, that collects the data. Out of 13 out of the 16 key performance indicators that NSW Health monitors for the performance of its public hospitals, we perform either at or better than our peers.

Ms JENNY LEONG: What is the problem then? Why all this scandal?

TINO LA SPINA: I don't know. You've asked me to appear here. I'm happy to appear here.

Dr DAVID SALIBA: Hang on. Let me continue my question, please. The system, from my recollection—I'll look over the transcripts, and I apologise if I've got this wrong. The system in itself—there were statements made. I'll get into that. I'll get back to you with questions on notice about that one point. Following on from that, in terms of the operational and financial challenges that you've mentioned as part of your opening statement, what were they exactly and how were they directly related to the PPP model?

KATHRYN BERRY: In terms of financial challenge, the biggest financial challenge we've had is volume. Yes, we have a discounted rate. I heard you talking earlier about a discounted rate. I get exactly what you're saying. Why would you ask someone to provide a service for a lesser dollar amount? On the back of that, we have had some top-up payments in relation to COVID. I think most hospitals got a top-up payment after

COVID due to the losses they had. For volume, we get given an amount of patients we can see in a year. If we exceed that volume, we don't get paid for it.

In the public system, that would mean that you would be given funding to pay for wages. That money, where we haven't been paid for volume, comes from Healthscope. Healthscope has paid that. To Tino's point, there has never been a question about paying for that. Of course we have to pay for our staff, our equipment and all those sorts of things. I've never been, in the time I've been there, rejected money for anything that I've asked for, but the volume discount is a significant issue for us.

TINO LA SPINA: Have you ever been asked to turn away volume that you know you're not going to get paid for?

KATHRYN BERRY: And we can't turn away patients from emergency.

TINO LA SPINA: No, have you ever been asked by anyone at Healthscope? Have I ever asked you to do that?

KATHRYN BERRY: No, absolutely not.

Dr DAVID SALIBA: As a qualification, I'm just trying to find out the structural flaws of the PPP model, not so much the scope.

KATHRYN BERRY: I think that's one of the structural flaws. Again, it's difficult, I understand, for the rest of the LHDs and the rest of NSW Health. You're allocated money to provide a service. When that money runs out—say, if you're given money for 10 patients and you get 20, you have to pay for that 20. For us, as an operator, it has been difficult because there's no-one to top up those funds. When we talk about financial issues, that's probably been one of the biggest ones and has been an issue in the past.

TINO LA SPINA: Which is a short-term saving. When the hospital goes back to the State, not only will it lose the discount or the efficiency and, potentially, the superior performance that Healthscope has been delivering under its stewardship, but those dollars will have to be paid.

The CHAIR: I suggest that if there are further questions, we put them in as supplementary questions. I note that Mr Regan has not asked a question. I wanted to give the final word to him.

Mr MICHAEL REGAN: Thank you, Chair. That was a good segue, Tino. Basically, reading the Auditor-General's report—and you just sort of confirmed it—Healthscope signed up to provide health care to the people of the Northern Beaches at a discount. The reality is that we've been getting cut-cost health care. The underlying assumption is that there are efficiencies that can be achieved, but something's got to give. From what I can tell, that cost is being borne by the staff and sometimes even the patients. I'm sure you don't agree with that, but I'm not going to put words in your mouth. If you don't agree with that, where are these efficiencies being achieved so that you can deliver the same health outcomes with less? Or has that not turned out to be the case, and that's why previously, unbeknownst to myself, in December and November 2023 you've tried to hand it back to the government?

KATHRYN BERRY: I don't think we do it for less. That money comes out of Healthscope's bank account, to be honest.

Mr MICHAEL REGAN: You just said you were delivering it for cheaper and more efficiently.

TINO LA SPINA: A cheaper cost to the state. It's coming to the state at a more efficient level. Peter, do you want to take that question?

PETER THOMAS: Yes. I think it's important to follow up and pull this together. Bear with me for a minute to give some examples. Essentially, what Kathryn was explaining is that we have a discounted price, and then we have a cap on our volume. We provide all of the services to the public patients within, effectively, a set budget, which is discounted price at volume. When we exceed that volume, the cost goes directly to Healthscope. In terms of how we pay for that, it's important to understand that a big part of any private hospital is its private elective surgery. That is where a private hospital makes its revenue to invest back in the business. It's that revenue that offsets the cost deficit.

I also wanted to talk about efficiencies and KPIs, and I think this is the important part. Earlier on in the hearing, some members asked the panel, how do we have efficiencies? One of the clear efficiencies we have is our operating theatre complex, which is incredibly efficient. I've worked for many years in the public sector to understand the efficiencies of that. I want to use that as an example, because it's the perfect example of how, across the whole hospital and out into the community, those efficiencies ripple across the health service and the

Northern Beaches. For example, because of that efficiency, when patients come in as emergency patients needing surgery, we're able to accommodate almost all of those patients within the first 24 hours.

Public and private patients who come as emergency patients will be pulled onto private operating lists, where the surgeons and anaesthetists will continue to operate a little bit longer and bring the efficiency of utilisation of the theatres. What that means is that the patients stay less time in the hospital. As I said, it is not uncommon for patients to wait two or three days on the public emergency list because of access and availability of theatres. What that also means is that those patients move through the hospital more quickly. That reduces the length of stay and creates bed access for the patients that present to the emergency department. The backflow of that is that then we can get patients off the ambulances more quickly and get the ambulances back into the community.

I think that's an example of an efficiency in the system because of the public-private partnership, where we have benefits in terms of flow of patients, and access to emergency surgery for public and private patients, that come from the efficiency. There are some savings to the system because of that and, more importantly, it has one of those key KPIs, which is transfer of care and getting patients off the ambulances so the ambulances can get back out into the community. All of that stems from a single point of efficiency. There are other examples of that. I think that's an important thing to understand when we talk about efficiencies in the system. Going back to the original question, which was about some of the structural problems, the first is the funding mechanism that we've talked about. The second is some of the KPIs that drive certain aspects of what we do, which make the system more efficient as well. But they can be contradictory to each other.

TINO LA SPINA: Mr Regan, I reject the assertion that the strive for that efficiency or the efficiency that the public-private partnership delivers in any way comes at the expense of the patient. There is no empirical data to suggest that there's a systemic issue with that. As I said before, we are not perfect. There are going to be instances where we fall short of the standards that we set ourselves, but we perform better than most of our peers on the accepted key performance metrics. I don't want to let it be said there that that's the case, because I don't believe it.

Dr DAVID SALIBA: On that, we spoke about the system being cheaper compared to the peer system and that decision being made, so that is an efficiency—

TINO LA SPINA: I am talking about outcomes to people that turn up to our facility, and I'm saying that the hospital itself—you're talking about inputs. I'm talking about results—outputs—and what we get for the people and for the community. For the people of the Northern Beaches community, what they get from that hospital is better than what is achieved at other peer hospitals. That is a fact.

Dr DAVID SALIBA: You're basing that on data, which I'll look at for the detail, but there have been reports to the Auditor-General and reports by your staff previously, so to say that the data alone explains the entire story is not fully correct.

TINO LA SPINA: These are the metrics that NSW Health actually assesses the performance of all its hospitals with. I can't use other data. It's the data that I'm using.

Dr DAVID SALIBA: That's the point of this inquiry—to actually speak to different people to find out what's going on. Just because you're relying on a dataset doesn't mean that's the totality of the evidence. I'll leave it at that.

The CHAIR: That's all we have time for, unless there are any other statements that the witnesses would like to make in closing.

KATHRYN BERRY: I'd just like to thank you for the opportunity today, but I also look forward, on Monday week, to the Committee coming to visit us at the Northern Beaches. Hopefully, that will be helpful in your review.

The CHAIR: Thank you very much for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to further questions?

KATHRYN BERRY: Yes.

PETER THOMAS: Yes.

The CHAIR: The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee. We kindly request that you return those answers within 14 days. That concludes the public hearing for the day. I thank all the witnesses who appeared before the Committee. I also

thank my fellow Committee members, Committee staff, Hansard staff and Department of Parliamentary Services for their help in the conduct of the hearing.

(The witnesses withdrew.)

The Committee adjourned at 17:05.