Submission No 200

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Organisation: NSW Nurses and Mid Wives' Association

Date Received: 26 July 2019

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NEW SOUTH WALES BRANCH

Submission by the New South Wales Nurses and Midwives' Association (in conjunction with the Australian Nursing and Midwifery Federation NSW Branch)

NSW Legislative Council, Portfolio Committee No 2

Inquiry into the operation and management of the Northern Beaches Hospital

26 July 2019

Our ref: EF/15/0009

The Hon Greg Donnelly MLC
Committee Chair
Legislative Council Portfolio Committee No 2

Attention: Director, Portfolio Committee No 2 - Health and Community Services

Email: PortfolioCommittee2@parliament.nsw.gov.au

Re: Inquiry into the operation and management of the Northern Beaches Hospital

The New South Wales Nurses and Midwives' Association, along with the Australian Nursing and Midwifery Federation NSW Branch ('Association') are the registered unions (in both the state and federal workplace jurisdiction) for all employees working in nursing and midwifery classifications and roles.

The Association provides both industrial and professional support and representation to some 66,000 members in NSW. This ranges, for example, from the provision of information about workplace rights, providing direct support to members (and representation if necessary) with employers or before industrial or professional courts and tribunals, assistance with appearances before other courts and jurisdictions, as well as negotiating and bargaining on behalf of members with their employers for awards and enterprise agreements.

The above has meant that the Association provides membership and therefore such services to nurses and midwives working in either the government or non-government sectors, state and federal. In other words, the Association is the relevant industrial organisation of employees for nurses and midwives whether they work in the NSW Health Service (government sector) or in the Northern Beaches Hospital (private sector).

Certainly the Association would welcome the opportunity to provide further evidence, in addition to that contained in our following submission, at any hearing the Committee undertakes. This submission is authorised by the Elected Officers of the Association.

JUDITH KIEJDA
Acting General Secretary, NSW Nurses and Midwives' Association
Acting Branch Secretary, Australian Nursing and Midwifery Federation NSW Branch

Executive Summary

The Association and its members opposed the privatisation of public health services on the Northern Beaches. Not through some absolutist opposition to private health services being available to the public and the privately insured in a complementary way, but one based that the provision of public health service remains a core responsibility of governments that should not be sublet or contracted out.

Unfortunately, the feedback from members and the experiences of the community since the end of October 2018 only reinforces the concerns expressed at the time.

The level of care and services currently being provided at the Northern Beaches Hospital (NBH) are generally seen as being less than that provided previously at Manly and Mona Vale Hospitals, both qualitatively in the view of members and statistically based on data available from the Bureau of Health Information.

Staffing was and remains a critical issue. A lack of staffing, poor skills mix, and a disproportionate reliance on casual and agency staff is causing significant issues, impacting on clinical care and the provision of a safe working environment for nurses and midwives.

This is sadly not surprising. In any privatised model, staffing levels and labour costs are all too often the first and most substantial target of cost savings and profit maximisation.

This runs counter to the rhetoric at the time the privatisation was announced, that promised much but can now be seen as hollow and unrealised promises. Assurances provided repeatedly by Healthscope regarding its readiness, and that it was fully staffed, equally proved empty and not reflecting the reality.

Much was also made that the new privatised hospital would be an integral part of the public health system in Northern Sydney, but the outcomes to date prove otherwise. Sadly, the Local Health District has been reduced to the 'purchaser' of public health episodes of care, rather than being directly responsible for the provision of such services. It has become a *bystander*, waving public monies at Healthscope in an attempt to manage and improve services. Whilst one of the so-called claimed benefits of privatisation is that it shifts (financial and operational) risk to a third party, current experiences again demonstrate that it is ultimately the patients and staff who carry the burden of that risk.

Certainly a number of actions and changes are needed urgently to bring about the necessary rectification desperately required.

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Format of this submission

The following submission by the New South Wales Nurses and Midwives' Association, along with the Australian Nursing and Midwifery Federation NSW Branch ('Association') draws upon a myriad of experiences leading up to the transfer of services and staff from Manly and Mona Vale Hospitals to Northern Beaches Hospital ('NBH') and the now near nine months since the opening of NBH.

More specifically, the Association notified members of the inquiry to be undertaken by Portfolio Committee No 2 of the NSW Legislative Council and encouraged feedback via a survey asking questions targeted primarily towards two of the terms of reference ('ToR') announced - namely (d) *"standards of service provision and care at the hospital"* and (e) *"staffing arrangements and staffing changes at the hospital"*.

The Association has assembled its feedback in this submission as per the most relevant ToR, albeit some feedback would sit comfortably within several. Accordingly, the Association has not sought to unnecessarily repeat or replicate feedback that straddle several ToR. Rather, it has concentrated on ensuring relevant information and feedback has at least been marshalled once in the submission.

Equally, a number of members gave experiences or examples that were similar in nature, and the Association has adopted the view of ensuring these views are expressed via the statistical feedback presented from the survey questions or by providing one such anecdote or example, with duplication of similar experiences resisted. Accordingly, it should not be assumed as a result that the narratives or examples provided are isolated.

Finally, the Association has taken the view to provide these experiences or commentary without identifying the member. In this way privacy has been preserved, and it encouraged the participation and receipt of feedback from members who were fearful of making public comments.

(a) the contract and other arrangements establishing the hospital

THE ESTABLISHMENT OF THE NORTHERN BEACHES HOSPITAL

The announcement and what was promised …

Without any prior warning, the then Minister for Health, the Hon Jillian Skinner MP, announced on 2 May 2013 [1] that an expression of interest process was to be established for *"… the private sector to design, construct, operate and maintain a world class hospital on Sydney's northern beaches."* [2]

The Minister further claimed that the private provider would use *"… leading digital technologies to deliver the highest quality care … the operator will … deliver public services and the hospital will remain part of the clinical network of the Northern Sydney Local Health District."* [3]

> *"I am excited our outstanding staff will have the opportunity to work in a fabulous new facility, which will in turn attract new staff of the highest calibre."*
>
> Minister for Health, the Hon Jillian Skinner MP, 2 May 2013

The new operator, was announced as being Healthscope on 29 October 2014, [4] following a *"rigorous evaluation process"*.[5]

> *"I have long had a dream about a state-of-the-art hospital which uses the latest technology and attracts the best clinicians to deliver care for the people of the Northern Beaches … This will mean exciting opportunities for the current, hardworking staff of both hospitals … Public and private patients will both be winners under this model … As part of the contract, Healthscope will be required to meet stringent Australian quality and safety healthcare standards."*
>
> Minister for Health, the Hon Jillian Skinner MP, 29 October 2014

The Northern Sydney Local Health District ('NSLHD') would enter into arrangements with Healthscope to ensure the delivery of public patient services for the first 20 years of the contract. [6]

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1 *"World class hospital for Northern Beaches",* Media Release, Jillian Skinner MP, Minister for Health, Minister for Medical Research, 2 May 2013.

2 Ibid.

3 Ibid.

4 *"Transforming NSW: Operator chosen to build and run new Northern Beaches Hospital",* Media Release, Jillian Skinner MP, Minister for Health, Minister for Medical Research, 29 October 2014.

5 Ibid.

6 Ibid.

Key deliverables promised
The Association, along with its members, staff in general, along with the community, have been largely reliant on the above type comments to ascertain the key goals or deliverables for the community. Reliance on voluminous and legalistic contractual material which is heavily redacted is not a recipe for readily accessible material.

It would also be fair to say that over the preceding four or so years prior to the NBH opening, the Association and its workplace representatives were involved in a considerable number of meetings, primarily with the NSLHD, and to a lesser degree the Ministry of Health ('Ministry'). These were predominately regarding workforce and employment issues for those staff who may elect to transfer to the NBH.

However, from the perspective of our members, it also involved a significant concern as to the services to be provided and the clinical profile of nursing and midwifery staff to provide such services, especially in speciality areas.

It would be fair to say that the Association and its members at Manly and Mona Vale Hospitals found the level of information and certainty provided to be inversely proportionate to the large number of meetings held.

Nonetheless, what was promised to the community and staff alike can be usefully captured and tabulated as follows.

TABLE 1

The new hospital would:	
i.	be a state-of-the-art, purpose built facility
ii.	provide greater capacity to the people of the Northern Beaches
iii.	provide greater complexity of services to the people of the Northern Beaches
iv.	utilise leading digital technologies to deliver the highest quality care
v.	be part of (or somehow incorporated within) the clinical network of the Northern Sydney Local Health District
vi.	be held accountable to the highest clinical standards
vii.	provide better public health services
viii.	provide better private health services
ix.	provide a better working environment for hospital staff
x.	have certainty regarding the employment conditions of transferring staff from Manly and Mona Vale Hospitals

The mechanisms for delivering these promises/arrangements
The primary vehicle for delivering and ensuring compliance with the goals and arrangements set out in Table 1 was the Project Deed ('Deed'). The Deed was entered into between Healthscope and the State of NSW and set out the terms and conditions of its establishment and subsequent operation.

The *episodes* of public health care to be 'purchased' by the NSLHD on behalf of the Northern Beaches community is subject to such terms. Other requirements within the Deed pertaining to transferring staff and any requisite obligations are embedded within the Deed as well, albeit these have been subject of public dialogue and communication.

However, as previously noted, visibility and access to the full terms contained in the Deed is not surprisingly limited to these direct parties. It was also clear that those persons not party to the Deed had no legal capacity to seek enforcement of its terms.

The Association, other public health unions, along with Unions NSW, held and raised significant reservations regarding a reliance upon the Deed, essentially a commercial contract, to somehow be a mechanism for the enforcement of, for example, certain promised workplace rights. These concerns were continually and repeatedly rebuffed. The basis of the refusal to entertain some 'additional' mechanism of enforcement can be usefully and pithily summarised in the following response received by unions:

"In the unlikely event that Healthscope does not comply with any commitment or obligation in the Project Deed, NSW Health can enforce that agreement on behalf of employees." [7]

This remains an unsatisfactory arrangement for those matters that, from an employment perspective, fall outside of the copied State awards and the reach of the Fair Work Commission (via provisions contained in the *Fair Work Act 2009* pertaining to award terms and conditions for employees who transfer from a state government employer to a private employer via a transfer of business).

This essentially leaves the Ministry to be the *industrial cop on the beat* on behalf of transferring employees and/or their unions in relation to certain employment commitments.

It is presumed that any mechanism to enforce clinical or other service delivery obligations upon Healthscope would similarly be totally reliant on the Ministry to pursue, albeit what those mechanisms are or the penalties involved remain unknown to the Association.

Effectiveness of these mechanisms

Ample opportunity would seem to have arisen from the first nine months of the NBH being operational to test the robustness and effectiveness of the Deed and the approach described above. It is unclear as to whether the Ministry has indeed pursued Healthscope in the manner intended under the Deed, presuming that the Deed contained actual mechanisms for ensuring the achievement of gaols as set out in Table 1.

[7] Contained in an Attachment to correspondence from the Hon Brad Hazzard MP, Minister for Health, to the secretary, Unions NSW, dated 18 August 2018.

For example, patient volume/capacity at the NBH were originally anticipated (promised) to achieve full 'ramp-up' within three to four years of opening. This was subsequently modified by Healthscope so that full capacity would not be achieved until four to five years. How will this 'business' decision impact on the delivery of public and private services? Is such a variation to patient volumes anticipated in the Deed?

In any event, a significant failing of the current arrangements (and privatising public health services in general) is that the NSLHD has been reduced to the 'purchaser' of public health episodes of care, rather than being directly responsible for the provision of such services. It has become a *bystander*, attempting to vicariously manage events rather than being directly responsible for them. Perversely, whilst one of the so-called claimed benefits of this approach is that divorces or shifts (financial and operational) risk to a third party (and away from the State), it only serves to magnify that risk and leaves it to be borne by the community and patients.

Certainly there can be no remaining illusion that the NBH is somehow an integral aspect of or part of the public health system, regardless of the rhetoric from the then Minister for Health when this arrangement was first announced. Healthscope to their credit has not shied away from what it is, *"… a private hospital treating public and private patients …"* [8]

The buck stops with Healthscope … literally.

There is a world of difference between the way that public and private hospitals operate, a view reinforced by subsequent member feedback in this submission.

From a staffing perspective at the NBH, in discussions leading up to its opening, it was clear that Healthscope largely determined the number and profile of staff it wished to employ and have available on its opening. The following example is emblematic of the differences in approach and emphasis between what was utilised at Manly and Mona Vale Hospitals as opposed to the NBH.

Clinical Support Officers

During discussions upon the proposed expression of interest process to be utilised for staff wishing to transfer from Manly and Mona Vale Hospitals, it became evident that Healthscope had chosen not to 'carry over' the position and role of Clinical Support Officers ('CSO'). The Association on behalf of members made known to Healthscope and the NSLHD that this was a retrograde step.

The Association put its concerns to the NSLHD at that time in the following terms:

"In the view of members, these roles are essential to assist in the good management of wards and part of the staffing architecture to ensure that NUMs [Nurse Unit Managers] *and senior clinicians in general are appropriately supported to ensure they are able to spend the maximum time on clinical activities/management.*

[8] Contained in a response from Healthscope to the Australian Salaried Medical Officers' Federation, circa 2016/17.

The role of CSO arose from a recognition that "… a real need exists in times of a national health workforce shortage for clinical support staff to be employed to undertake tasks for which they are suitably qualified so as to allow senior clinicians, in particular, to be freed up to attend to those components of patient care which require their other skills." [Extract from the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals, pp 19] It was found to be to the benefit of the patient, the relevant clinician, and the budgetary bottom line to have CSOs incorporated within the team based/staffing profile.

This was a key finding and recommendation of the Garling Report and should remain in any publicly funded hospital service. [9]

The Association also provided relevant extracts from the Garling Report to underpin its concerns regarding the impact arising from this erosion that would have a consequential impact upon clinical managers.

The response?

Essentially NSLHD and the Ministry could not in this instance 'require' Healthscope to maintain these positions, regardless of the weight and volume of evidence that led to their creation and continued use in the public health setting.

From the Association's view, this was a harbinger of the limitations that NSLHD and the Ministry would have over Healthscope and the public health services it procured.

[9] Correspondence from the Association to NSLHD, dated 2 November 2017.

(b) changes to the contract and other arrangements since the opening of the hospital

The Association and its members would have little ability to be aware of (or have access to in any event) changes to the contract, if this pertains to the Deed.

(c) ongoing arrangements for the operation and maintenance of the hospital

From an employment perspective, the ongoing arrangements for nursing and midwifery staff will be as follows: Healthscope and the NBH operate within the federal industrial relations jurisdiction. There is no dispute that NSW Award applicable to transferred staff from Manly and Mona Vale Hospitals, the *Public Health System Nurses' and Midwives' (State) Award* ('NSW Award'), follows such employees to the NBH and their employment by Healthscope as a ***copied State award*** - as per Part 6-3A of the *Fair Work Act 2009*.

This recognises that certain rights accrue to employees who transfer from a state government employer to a private employer via a transfer of business [as noted in ToR (a)].

In addition to the employment conditions set out in the now copied State award, additional commitments or guarantees on behalf of transferring Manly and Mona Vale Hospital employees were entered into by the NSW Government/Ministry with Healthscope, albeit most if not all of these were announced without any consultation with relevant staff.

Nonetheless, these included a two year employment guarantee period (if a permanent employee at the time of the transfer); maintenance of existing conditions during that period; and an undertaking that Healthscope cannot initiate the 'replacement' of the copied State award with a making of a federal enterprise agreement in relation to transferred staff for a period of two years.

These commitments did not extend as far as is known, to mandating the models of care or staffing skill mix to be utilised within the NBH. The only staffing arrangements that are likely to be mandated are those contained in the now copied State award. [10] [This will be further discussed in ToR (e)].

Those nurses and midwives employed directly by Healthscope (ie outside the transfer process involving Manly and Mona Vale Hospital staff) are employed under the terms and conditions of the *Healthscope Group - NSWNMA/ANMF - NSW Nurses and Midwives' - Enterprise Agreement 2015-2019* ('Federal EA').

The challenges of applying and utilising two differing sets of terms and conditions within a workplace is not without difficulty. It has at times required Healthscope and the Association to work collaboratively to reach outcomes that meld and yet comply with two industrial instruments covering the same cohort of nurses.

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[10] Clause 53, Staffing Arrangements, *Public Health System Nurses' and Midwives' (State) Award*. The intent of this provision is to establish reasonable workloads for nurses and midwives in certain designated wards and services across a number of public hospitals ie it does not exhaustively cover all areas or all public hospitals, despite attempts by the Association to vary and/or expand its scope. The clause utilises a methodology of Nursing Hours Per Patient Day ('NHPPD').

Of course a differing approach may have had Healthscope alternatively required to operate the NBH as an *"affiliated health organisation"* [11] (often referred to as Schedule 3 hospitals) - and not dissimilar to how St Vincent's Hospital Darlinghurst and others operate.

Whilst the non-government organisation is the employer of staff, it is more fully 'embedded' within the NSW Health Service and public hospital system. It also requires such providers to comply with and make available the same rates and conditions of employment for staff contained in NSW Awards, as well as complying with policy directives or other directions or policies issued by the Ministry. These are usually set out in a 'Conditions of Subsidy' arrangement with such providers (ie funding arrangements).

This would have been one way to truly ensure that the NBH remained *"… part of the clinical network of the Northern Sydney Local Health District."* [12]

Apart from keeping it in public hands in the first instance.

[11] *Health Services Act 1997*. The Act enables recognition of nominated non-profit, religious, charitable or other non-government organisations and institutions so they can be treated as part of the public health system where they control hospitals, health institutions, health services or health support services that significantly contribute to the operation of that system.

[12] As previously claimed by the former Minister for Health, *"World class hospital for Northern Beaches",* Media Release, Jillian Skinner MP, Minister for Health, Minister for Medical Research, 2 May 2013.

(d) standards of service provision and care at the hospital

The problems besetting the NBH on its opening are well documented and publicised. They continue to be the subject of regular media reporting and commentary. The Association does not for the purposes of this submission seek to replicate or dwell upon that reporting or some of the more notorious examples published in the media, other than to say that they have been confirmed by our members as being accurate.

However, it is an integral aspect and was a fundamental basis underpinning the new hospital that it would improve and enhance the services available to the community when compared to the then services available from Manly and Mona Vale Hospitals.

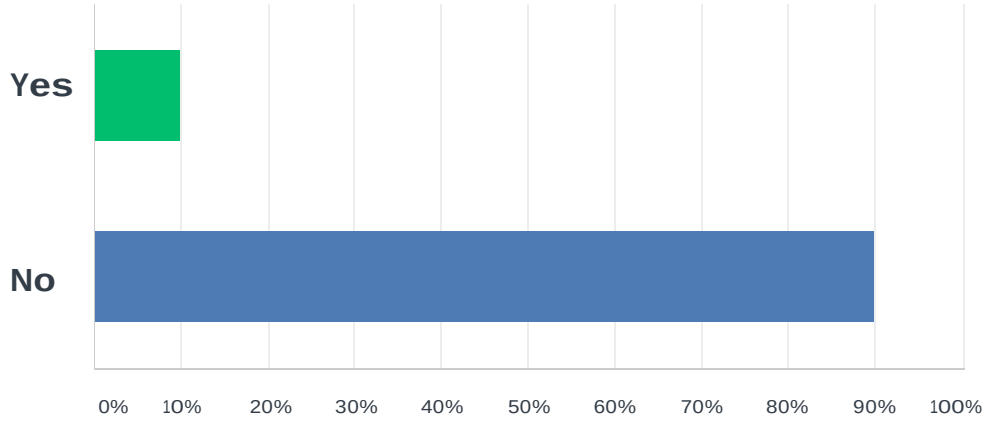
> *"I want the Northern Beaches Hospital to be a showcase to the world, attracting health professionals keen to see its high-tech facilities."*
>
> Minister for Health, the Hon Jillian Skinner MP, 29 October 2014

Sadly, this and other claims made then now seem all too hollow.

The Association asked the following questions of members working at the NBH regarding the standards of service provision and care:

TABLE 2

On <u>your commencement</u> at the NBH, was the hospital adequately prepared to provide acceptable levels of care and service to patients?



This is simply astonishing. Despite several years of preparation, and all the promises of not only an orderly transition and but indeed an improved span and scope of services, almost all members responding to this survey question indicated that the NBH was simply *not up to scratch* on commencement.

TABLE 3

If you found the NBH under-prepared on your commencement, what were the three biggest issues that prevented acceptable levels of care and service being provided to patients?

ISSUE	RESPONSE
Lack of equipment/medical-medication supplies	**98%**
Inadequate staffing (ie understaffed, poor skill mix, over reliance on agency/casual staff, lack of training for staff re the new hospital)	74%
No or inadequate policies and procedures in place	**44%**
IT system issues	16%

Perhaps not surprisingly, mindful of media commentary at the time, essentially all members responding to the survey listed lack of equipment and medical supplies as one of the three reasons for the NBH lack of preparedness on day one.

> *"Lack of basic stock ie IV fluids, syringes, delivery instruments …"*
>
> Association member responding to the survey

> *"Inadequate amounts of routinely used medication, IV antibiotics, fluids and stock to be able to prepare and administer these medications … inadequate amounts of regular ward stock such as pads …"*
>
> Association member responding to the survey

> *"… stock supplies inadequate, running out of basic supplies* [like] *10 ml syringes, normal saline IV bags …"*
>
> Association member responding to the survey

> *"… we ran out of IV cannula packs in emergency …"*
>
> Association member responding to the survey

> *"Massive lack of equipment … syringes, chest drains …"*
>
> Association member responding to the survey

"No basic equipment … no forceps in [the] *birthing unit …"*

Association member responding to the survey

"From the start of opening the hospital we were not given the triangular plastic pill counter … for four months we were counting drugs with our fingers … not being given pill cutters [so] *having to break medications with fingers or knife or scissors … no available blood sugar machines …"*

Association member responding to the survey

The next most common and pervading issue was staffing, or lack thereof, with three quarters of all respondents identifying this as one of the three issues leading to the dysfunction on opening.

"Staffing hugely understaffed, with poor skill mix further worsening things …"

Association member responding to the survey

"Lack of staff. Agency staff with no orientation and no access to EMR. Nurses being left with double to triple patient loads."

Association member responding to the survey

"Staffing with inexperienced agency nurses … sometimes 80% [of the] *shift was agency …"*

Association member responding to the survey

"Skill mix was non existent … Staff with little to no experience were expected to perform operations they had never seen …"

Association member responding to the survey

"The understaffing - the wards weren't open to its full potential … this made ED presentations hard to move to wards and led to bedblock in ED for a very long time …"

Association member responding to the survey

Almost half of all respondents indicated that IT system issues was one of the three issues impairing responsiveness and preparedness.

> *"Inadequate education on using computer systems …"*
>
> Association member responding to the survey

> *"EMR not working to electronically record patient notes."*
>
> Association member responding to the survey

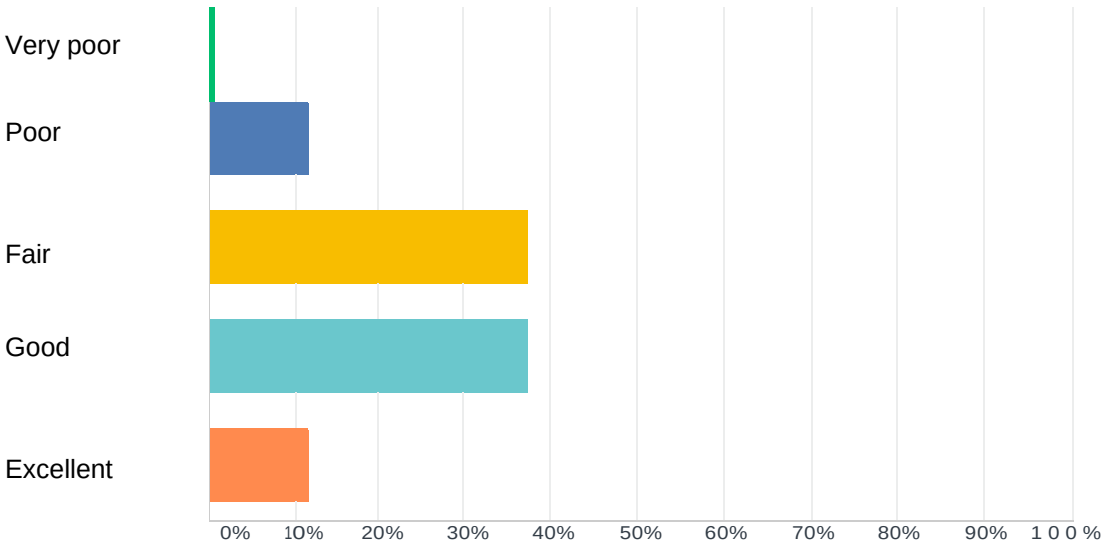
> *"No education with EMR system and no one to ask* [about] *ordering pathology, x-rays …"*
>
> Association member responding to the survey

> *"… no training in new IT system …"*
>
> Association member responding to the survey

Have things improved?

TABLE 4

How do you rate the levels of care and service <u>currently provided</u> to patients?



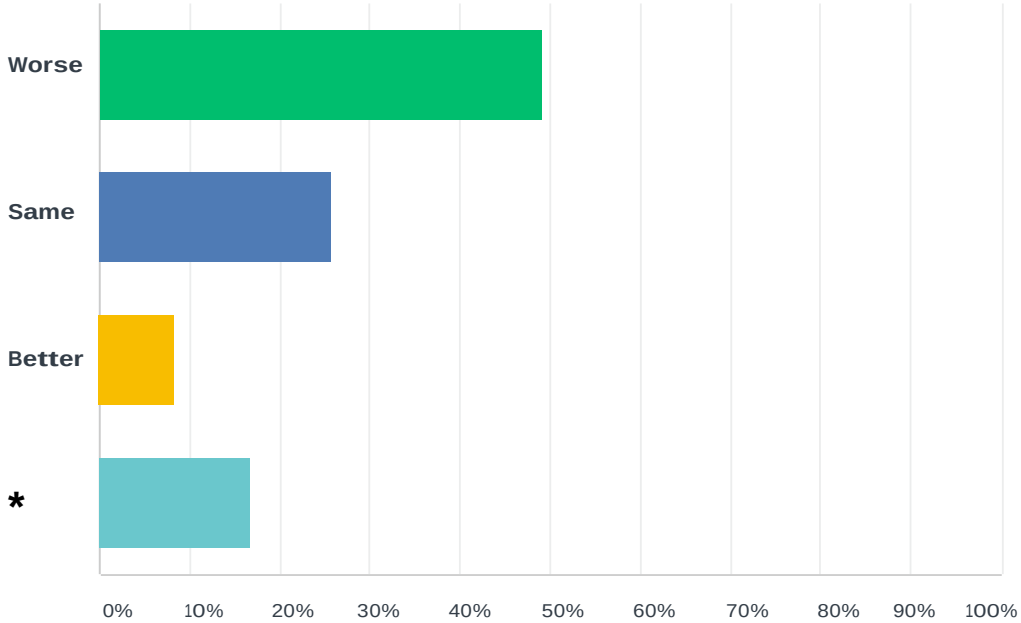
So progress has been made, but from the responses received from members, this can largely be attributable to the persistence and resilience of staff, who on a daily basis rise above endemic problems and issues to provide the best possible care, despite the continuation of a number of adverse conditions and challenges.

> *"…we'll keep working hard to ensure the best and safest possible care is provided to all our patients (private or public, it really doesn't matter to us and we'll treat everyone with equal respect and care). Without the nurses presence here, things could've been a lot worse …"*
>
> Association member responding to the survey

But is it comparable to what was previously available to the community?

TABLE 5

If you previously worked at Manly or Mona Vale Hospitals, how do you compare the current level of care and service provided to patients at NBH?



* Had not worked previously at Manly or Mona Vale Hospitals.

Based on this feedback much work still needs to be done to achieve parity with the level of care and services provided by Manly and Mona Vale Hospitals previously.

So what needs to change to achieve greater improvement at the NBH?

TABLE 6

What three things (if any) need to change to improve the levels of care and service <u>currently provided</u> to patients?

CHANGE NEEDED	RESPONSE
Improve staffing (ie more staff, improve skill mix, decrease reliance on agency/casual staff, increase number of experienced staff)	**100%**
Improve support/education/policies available	80%

Overwhelming, all feedback indicated the need to improve staffing to achieve better levels of care and service.

> *"Staffing increase with more experienced staff members …"*
>
> Association member responding to the survey

> *"… more qualified staff employed to work at NBH … less agency* [staff] *…"*
>
> Association member responding to the survey

> *"We are constantly faced with the threat of budget cuts to staffing … constantly forced to advocate for safe staffing levels …"*
>
> Association member responding to the survey

> *"Stop taking on more patients and/or opening up more shifts until we have adequate levels of appropriately trained staff …"*
>
> Association member responding to the survey

> *"Stop cancelling nurses for an afternoon shift because the ward seems quiet, then Emergency fills up and the afternoon nurses are run ragged as they are short a nurse and have lots of new admissions."*
>
> Association member responding to the survey

It is also clear that significant work also needs to occur in a range of supportive mechanisms in the hospital, including education, clear policies and the like.

"Improve electronic medical record – cumbersome and too much time wasted away from the patient."

Association member responding to the survey

"Provide more Nurse Educators … education on speciality areas [needed] *…"*

Association member responding to the survey

"Staff support!!! - (solid experienced leadership with greater staff focus - improved communication & collaboration from management - more flexibility & compromise with rostering - better ratios less admin/cleaning work – a New less disjointed user friendly computer system – space & support to take entitled breaks)… no training in new IT system …"

Association member responding to the survey

"Complete policies and procedures and compile them in one resource to enable finding them much more efficient!"

Association member responding to the survey

"… need to encourage Healthscope to get rid of the incompetent EMR that we currently have to use and get them to purchase the same program (FIRST NET) that NSW Health is using."

Association member responding to the survey

Other responses on the necessary solution(s) were more pointed.

"The unit needs to run like a public unit. It needs to be care based not budget driven."

Association member responding to the survey

"Private hospital feel, money-based, patients seem to be just a number. Quick turnover is expected. It get[s] *overwhelming and you feel like things can easily get missed."*

Association member responding to the survey

Or put more simply.

> *"… return this hospital back to public health …"*
>
> Association member responding to the survey

Emergency Department

Member feedback indicated significant and continuing issues within the Emergency Department ('ED') at the NBH. These are illustrated by the following examples of more specific comments and feedback - excluding those relating to staffing issues, which are dealt with in more detail under ToR (e).

> *"Actual Emergency dept set up is shit, ie you can't see the whole waiting room from triage, and it's still not fixed and it's dangerous."*
>
> Association member responding to the survey

> *"There is no drop off and pick up zone for ED, I had a lady … she was unable to park out the front* [with ill partner], *parked in the car park and then couldn't get* [them] *over to ED …"*
>
> Association member responding to the survey

> *"Only 168 beds fully open in the hospital to service a 55 bed ED - wait times for a bed unacceptable because of this."* [on opening]
>
> Association member responding to the survey

> *"… there's no treatment room in the ED paed area for cannula, nitrous suturing etc, poorly set up, there's not enough mental health rooms in ED ie able to lock the door …"*
>
> Association member responding to the survey

> *"…2 different computer systems which is another thing as well, you have to triage in one program but to put obs in or look at the patients notes, you need to go into another screen, it's time consuming and poorly set up."*
>
> Association member responding to the survey

"Fully operating ED with hardly any beds upstairs to offload to …"

Association member responding to the survey

"More than one registrar so they don't have to go between OT and ED, leaving patients waiting for hours in ED …"

Association member responding to the survey

"… hav[e] *firstnet* [NSW Health IT system], *instead of a shit program that won't allow triage obs and only 6 lines to* [record] *triage …"*

Association member responding to the survey

This feedback is also validated in the results thus far for ED performance at NBH.

TABLE 7 [13]

Emergency department performance		Manly Hospital Jan-Mar 2018	Mona Vale Hospital Jan-Mar 2018	NBH Jan-Mar 2019
Time to treatment by triage category				
T2: Emergency	**Median time to treatment**	**6m**	**7m**	**8m**
	90th percentile time to treatment	10m	11m	32m
	% started treatment on time	**91.7%**	**88.4%**	**58.5%**
T3: Urgent	Median time to treatment	12m	16m	28m
	90th percentile time to treatment	**33m**	**41m**	**1h 39m**
	% started treatment on time	88.1%	82.8%	53.4%
T4: Semi-urgent	**Median time to treatment**	**13m**	**15m**	**39m**
	90th percentile time to treatment	1h 01m	1h 19m	2h 00m
	% started treatment on time	**89.9%**	**85.2%**	**65.1%**
T5: Non-urgent	Median time to treatment	14m	16m	37m
	90th percentile time to treatment	**1h 20m**	**1h 40m**	**2h 01m**
	% started treatment on time	96%	94.9%	89.6%
Patients starting treatment on time %		**89.8%**	**85.8%**	**59.7%**
Median time to leave the ED		2h 31m	2h 36m	3h 22m
90th percentile time to leave the ED		**4h 37m**	**4h 51m**	**7h 00m**
Patients leaving the ED within four hours of presentation		87.1%	85.6%	72.3%

[13] This data has been extracted by the Association from relevant data for 2018 and 2019 contained in 'Healthcare Quarterly' produced by the Bureau of Health Information. Any accidental errors or omissions are those of the Association.

On almost every measure, the NBH has fallen short (at times significantly so) when compared to the exceptionally high standards previously achieved by Manly and Mona Vale Hospitals in ED performance.

And more

Mental Health and Maternity Services also received significant feedback regarding problems in delivering services (in addition to staffing concerns).

> *"On all of level 3 mental health there is not one wash basin for a nurse to wash* [their] *hands, on each ward on level 3 mental health the wash basin is in the office, or medication room, so if you are changing beds, doing dressings etc you cannot wash your hands anywhere outside any room on level 3 you have to go back into the office/medication room, I have and many other nurses put this into riskman online reporting but we all have been informed you won't be getting hand wash basins."*
>
> Association member responding to the survey

> *"… only just now they have supplied a torch for night staff …* [we] *have been using the torch on* [our] *mobile phone …"*
>
> Association member responding to the survey

> *"From the start of opening the hospital we were not given the triangular plastic pill counter … for four months we were counting drugs with our fingers … not being given pill cutters* [so] *having to break medications with fingers or knife or scissors … no available blood sugar machines …"* [Mental Health]
>
> Association member responding to the survey

> *"… whoever is doing this investigation to please have access to the RISKMAN reporting system so you can access all the incidents that have …"*
>
> Association member responding to the survey

> *"Mona Vale and Manly each had an O and G reg on weekends and nights, this was cut to one doctor to cover Birth Unit, Postnatal, Emergency and Antenatal resulting in lengthy delays in getting medical care for women …"*
>
> Association member responding to the survey

The uncertainty regarding Maternity Services extends to compliance with staffing arrangements in the copied State award for maternity (referred to as Birthrate Plus). This is designed to ensure that appropriate levels of care can be provided to birthing mothers and their babies.

As recently as June this year, in response to Association representations and concerns on behalf of midwifery members working at the NBH, Healthscope confirmed it was continuing to liaise with NSLHD and the Ministry to establish the best way it could achieve compliance with Birthrate Plus. [14]

It is hard to fathom or contemplate that this level of uncertainty or unpreparedness could be evident following years of preparation. Non-compliance with mandatory staffing obligations are hardly *teething problems* and it questions the vigilance and any probity checks undertaken by the NSLHD and Ministry to ensure that Healthscope was aware and fully understood the level of care required and staffing requirements to be met.

[14] Correspondence to the Association from Healthscope, dated 7 June 2019.

(e) staffing arrangements and staffing changes at the hospital

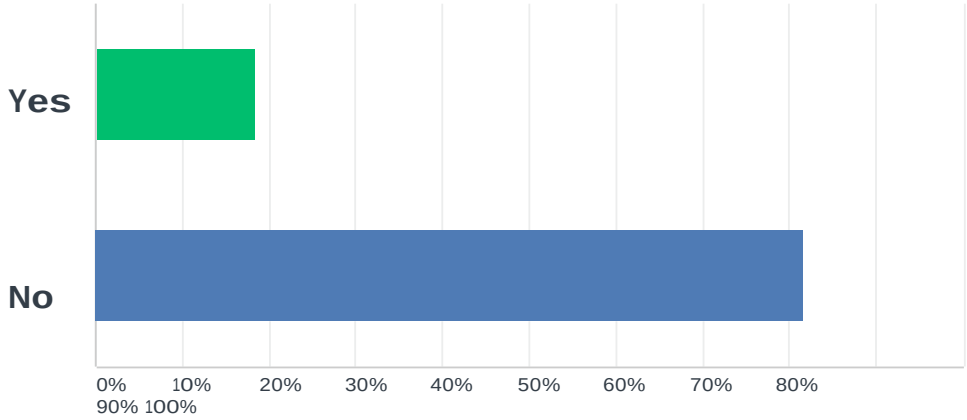
It would already be clear from previous responses that staffing was and remains an issue and a significant impediment to improve services.

This is diametrically opposite to the emphatic assurances made by Healthscope just prior to the NBH opening when it was reassuring the marketplace.

> *"Mr Ballantyne said 550 staff would be transferred from two nearby hospitals and **there was no shortage of staff in any unit** … "**There is no staff shortage** because if there were, we would not have reached this milestone.""* [15] [emphasis added]

TABLE 8

Were the staffing arrangements on <u>your commencement</u> at the NBH adequate to provide acceptable levels of care and service to patients?



This validates experiences identified in Table 3 and Table 6.

Members were then further asked to identify what the single most important impediment was for acceptable staffing arrangements at the commencement of the NBH.

[15] Comments attributed to the Chief Executive Officer of Healthscope in *"Healthscope says it has not lost investor support"*, Australian Financial Review, 24 October 2018.

TABLE 9

If not, what was the single biggest problem with the staffing arrangements?

ISSUE	RESPONSE
Not enough staff	**54%**
Over-reliance on agency/casual staff	20%
Poor skill mix	**16%**

Without replicating previous examples, the following feedback further crystallises how ill-prepared and potentially unsafe staffing was on the opening of the NBH.

"… nurse patient ratio unsafe level. In the Emergency Department it was very unsafe and unacceptable to the workload that was expected with the lack of staff and lack of medical supplies and to top it off, the ridiculous computer program that Healthscope decided to use.…"

Association member responding to the survey

"… they only staffed one emergency theatre (for the whole weekend) which in itself is outrageous when you've closed two hospitals that offered emergency services with a theatre each all weekend long. I believe all staff stayed and did hugely long and dangerous hours that weekend in order to get through the mountain of cases that needed to be done. This stress and dysfunction/mismanagement/poor communication from senior members has stayed with me ever since."

Association member responding to the survey

"At least half the staff in ED and a higher ratio on wards were agency nurses most of whom were new to the area they were working in.…"

Association member responding to the survey

"… inexperienced agency staff, 60-80% agency most shifts 1st 6mths…"

Association member responding to the survey

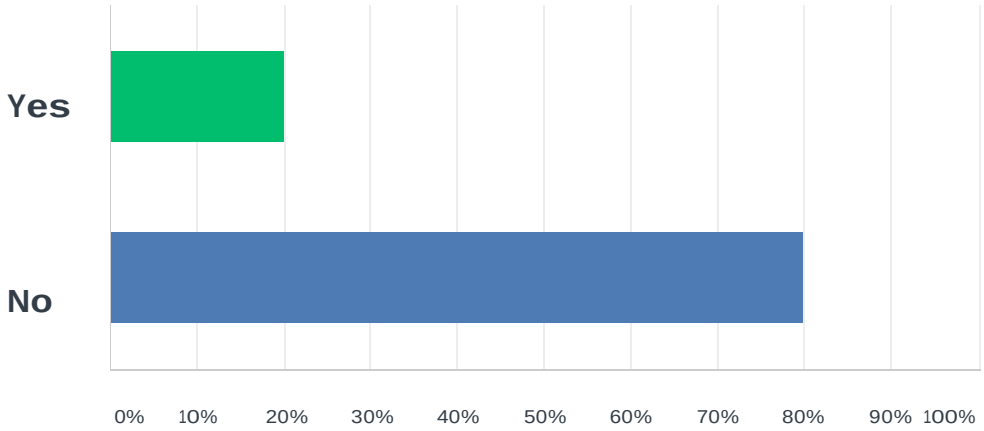
"… 50 bed ED fully functioning with only some wards opened upstairs."

Association member responding to the survey

And it wasn't only the safety of patients in question.

TABLE 10

On <u>your commencement</u> at the NBH, were staffing arrangements adequate to provide a safe place of work for nurses and midwives?



Inevitably, staffing arrangements that impacted or impaired service delivery to patients also created an unsafe place of work for nursing and midwifery staff.

The reasons offered by members are entirely consistent with results from Table 3, Table 6 and Table 9.

TABLE 11

If you answered no, what was the problem?

ISSUE	RESPONSE
Not enough staff	**60%**
Poor skill mix	20%

One or two additional comments complement those previously provided.

"It was a very unsafe environment The influx of patients that attended the ED was way over what was expected, staffing was inadequate. Staff were stressed, it was very unfair to expect staff to work under those conditions. It was appalling what we had to go through. Healthscope should NOT have opened up until ALL areas had sufficient staffing to meet the demands. Healthscope placed staff under great pressure and this is unacceptable."

Association member responding to the survey

"Often missed meal and toilet breaks due to work load."

Association member responding to the survey

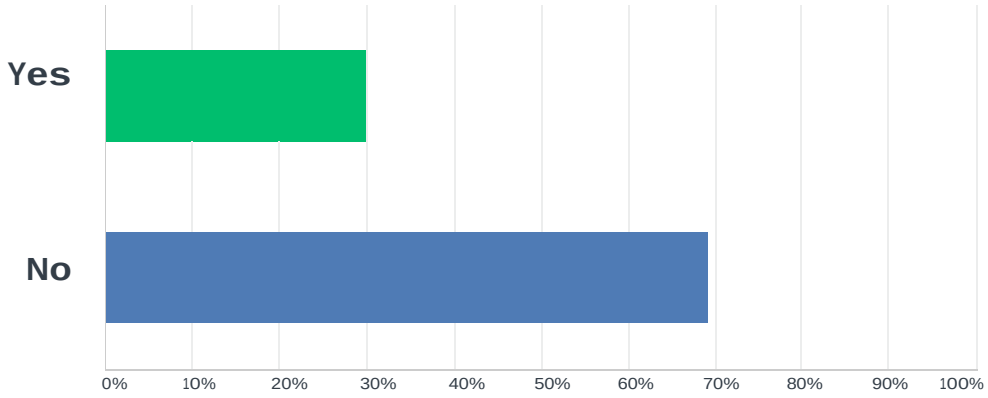
"… I would leave every shift deeply upset because of not having the stock, assistance and safe workload that I previously had to be able to provide the high standard of care I have provided my whole career … This job has taken an unmeasurable toll on every aspect of my life."

Association member responding to the survey

Have things improved?

TABLE 12

Are <u>current</u> staffing arrangements adequate to provide acceptable levels of care and service to patients?



This again only reiterates previous feedback regarding the criticality of getting staffing right.

TABLE 13

If you answered no, what needs to change?

WHAT'S NEEDED	RESPONSE
More staff	**70%**
Improve skill mix	20%

These additional comments complement those previously provided.

"Better ratios - less use of transient agency staff - more experienced staff having greater value - a patient free team leader on every shift to monitor and educate until more solid structure is established - less emphasis on minimising staff budget until basic processes are established sufficient Staff to support breaks and getting off on time."

Association member responding to the survey

"Having wards staffed with masses of agency nurses has not helped! Supporting the Nurses who have shown great dedication through this extremely tumultuous first 9 months will hopefully improve morale. Not "Taco day", but real support. Educators who are on the floor to relieve for breaks, to help Nurses understand the different specialties they are thrown into with no regard for the stress that involves."

Association member responding to the survey

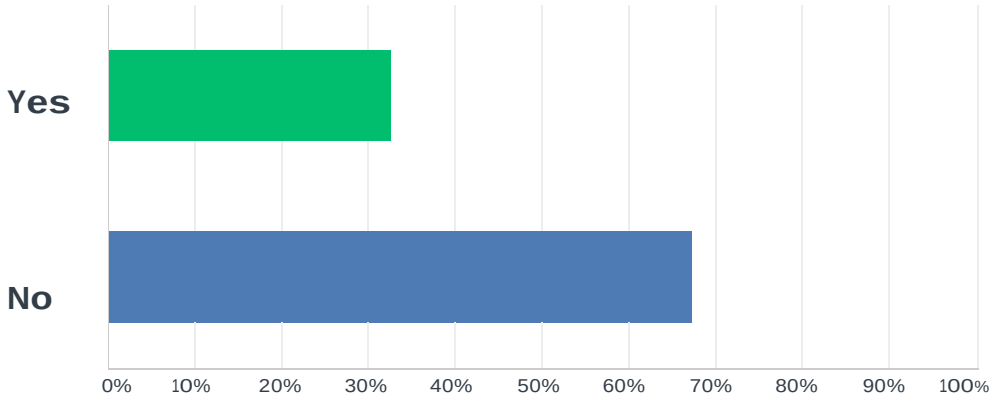
"… the best solution is to give this hospital back to NSW Health …"

Association member responding to the survey

And is the NBH any safer for staff?

TABLE 14

Are current staffing arrangements adequate to provide a safe place of work for nurses and midwives?



Not surprisingly, feedback reflected common themes.

"… get rid of Healthscope and get NSW Health to buy this facility back relying on agency staff to fill in the gaps is only a bandaid solution. It is unsafe because many times staff are inexperienced. For example in ED many time due to lack of staff an agency AIN will fill a gap. This is very unsafe as an AIN cannot do what an RN can in ED This causes the RN on shift having to increase their workload making it unsafe and very unfair…"

Association member responding to the survey

"More staff at the bedside to support favourable patient care with the level of documentation and clerical accountability required so that work can be completed on time - flexibility with 8 - 10 – 12 hour shift rostering to support fatigue levels & staff health - enough staff to cover for breaks."

Association member responding to the survey

"Better midwife to patient ratios."

Association member responding to the survey

"Improve nurse to patient ratios. 1:3 in Emergency and 1:4 on the ward. Increase number of nurses and employ more senior nurses."

Association member responding to the survey

Award versus federal agreement

As previously noted in ToR (c), from an employment perspective, nurses and midwives employed by Healthscope are under either:

(i) the copied State award (transferring nurses and midwives from Manly and Mona Vale Hospitals); or

(ii) the Federal EA (nurses and midwives employed directly be Healthscope).

Agency staff would alternatively be engaged and paid via contractual arrangements entered into by Healthscope and the agency involved.

The copied State award requires Healthscope to comply with staffing provisions for employees so covered (transferred nurses and midwives) - at least in certain prescribed areas of the hospital as set out in the copied State award. However, no staffing provision is contained within the Federal EA and therefore none is mandatorily applicable to those nurses and midwives.

This gives cause to a number of issues.

- Firstly, there are differing obligatory staffing arrangements dependent on how you were engaged by Healthscope (and what industrial instrument applies);

- The copied State award (and its staffing arrangements) would not apply to agency staff;

- Accordingly, as wards or services become increasingly staffed by Federal EA and/or agency staff, the impact of the staffing arrangements contained in the copied State award (which in certain areas seek to maintain a minimum nurse to patient ratio) lessens;

- With the effluxion of two years from opening, it will be open to Healthscope to seek to have the copied State award superseded by the Federal EA via processes under the *Fair Work Act 2009*, something 'permitted' by the Deed;

- The net consequence of this outcome would be the removal of any prescribed and obligatory staffing arrangements upon Healthscope; and

- In an environment whereby the lack of staffing has and remains the number one issue for nurses and midwives to facilitate a safe workplace that can deliver the best possible care, one is entitled to wonder what staffing arrangements may arise in an environment whereby Healthscope is unencumbered by any award based requirements.

The feedback received from members suggest that staffing is equated as a cost, and a cost that Healthscope is all too ready to trim back on.

Paradoxically this seems to be demonstrated based on member feedback in those parts of the NBH dedicated to patients with private health insurance, often staffed by nurses not covered by the copied State award. Whilst these patients would no doubt be expecting a superior level of service, it is these wards that are often operating with a staffing ratio of one nurse caring for up to eight plus patients (1:8+).

> *"I have been told, 1:8 … get used to it …"*
>
> Association member responding to the survey

Perversely, patients in the public health system who exercise the use of private health insurance would access as a minimum any prescribed staffing arrangement in the State award. For example, in a medical or surgical ward in metropolitan Sydney, they would be subject to a far better ratio of nurse to patient care.

Poor management or a business model?

It is clear a heavy reliance upon agency and casual staff is evident. In part this reflects that the NBH remains anything but fully staffed. This has its obvious difficulties. As member feedback details, agency staff are often thrown in the deep end, in areas or specialties that they are unfamiliar with, all of which creates greater stress and pressure on permanent, experienced nursing staff.

Having a *melting pot* approach to staffing, whereby there is no consistent nursing workforce familiar with the nuances of the services to be provided and the framework they operate within, is undesirable and ultimately unsafe.

No doubt it is increasingly difficult to attract and retain experienced nursing and midwifery staff to the NBH. But there is no point in blaming poor publicity. This is a failing that must be sheeted home to Healthscope, and ultimately also to the NSLHD and Ministry who entered this arrangement and are now paying the bill on behalf of the community for public health services rendered. It was they, along with then NSW Government decision makers, who promised that there was no staffing shortages.

Passing curious then that despite the confidence and the bravado exuded by the CEO of Healthscope in the marketplace and by others elsewhere, it was Healthscope who continually refused to provide any assurance to the Association and its members in relation to specific details on the staffing and clinical profile to be provided for wards and services. This information was persistently sought over several months, as exampled below:

"Firstly, the Association formally acknowledges receipt of this further information and confirms that it has been distributed to members at Manly and Mona Vale Hospitals ('Hospitals'). The Association is aware that the information has been actively reviewed and discussed by members, and has recently been subject of Association Branch meetings. The overwhelming consensus is that members working at the Hospitals would still seek to have provided, as part of the further tranche of information promised following the conclusion of Round 3, information that provides a breakdown of nursing classifications and FTEs that will be intended (based on assumptions regarding occupancy and demand) to be utilised in wards and services at NBH on its opening at end of October 2018." **16**

The concerns of members were obvious. They were suspicious that staffing levels and/or the skill profile of nursing and midwifery staff would be eroded and less than that provided at Manly and Mona Vale Hospitals. They were concerned that this would mean a lesser capacity to care and the potential for placing themselves in an unsafe workplace.

Healthscope refused to provide the detail as requested. NSLHD and the Ministry conceded they had no authority or capacity to compel Healthscope to do so.

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16 Extract from correspondence to both the CE of NSLHD (Ms Deborah Willcox) and CEO of the NBH (Ms Deborah Latta) from the Association, 5 June 2018.

One is left to speculate did Healthscope believe their own rhetoric. Did they know or realise the poor state of staffing that would be in evidence from day one? If not, why not? Did the NSLHD and Ministry harbour similar suspicions as that of our members?

What was or is going on here?

Unless, part of the business model determined to be utilised by Healthscope is to retain a significant reliance on agency and casual staff to enhance their 'flexibility' to change or cut shifts that would be more difficult with permanent staff. Member feedback has identified that Healthscope is not frightened to cut back on shifts if the (short-term) opportunity presents itself, regardless of the subsequent consequences if patient demand spikes.

This perhaps is the inevitable tension that arises in a privatised model of care.

Professional obligations

The matter of proper staffing levels (along with adequate education, training and supports) is critical to providing and enhancing safe clinical practice. Attempting to provide such care in an environment beset by shortages, also strikes at the heart on the obligations imposed upon registered health professionals, such as nurses and midwives.

A recent case [17] before the Victorian Civil and Administrative Tribunal grappled with a clinical error that occurred within an environment that was agreed was poor in general, and likely a contributing factor to the error. However, the conclusion drawn from this decision is that it is not enough for registered health professionals to make known their concerns and it is not an excuse for subsequent incompetent practice. The following extract is pertinent to the situation that nurses and midwives often confront:

"57 Poor working conditions do not excuse incompetence or dangerous practice.

58 Patients are entitled to assume that if they come through the doors of a hospital to give birth, they and their babies will receive safe and competent care.

59 And if midwives are unable to safely or competently care for patients because of conditions outside their control and have done all they can to bring the deficiencies to the attention of those responsible, they will need to make their own decision about whether they remain in that workplace. This case illustrates the risks not only to patients but also to professionals who work in such an environment.

[17] Nursing and Midwifery Board of Australia v Macrae (Review and Regulation) [2018] VCAT 1707

60 Dangerous conditions should be reported, documented and publicised. They should never be normalised …" [18]

The Tribunal would seem to be suggesting that despite the efforts of the registered health professional to make known the problems and have them rectified, it is a matter for them as to whether they 'choose' to remain in such a dysfunctional environment.

This latter aspect of this decision is concerning for any registered health professional who attempts in good faith to carry out their role in such an environment. If a genuine error or harm arises from the stress or strain of that environment, it will not necessarily mitigate the fact that their registration (and profession) may be placed in potential jeopardy.

No employer (public or private) should ever place a nurse or midwife in an untenable situation where they may compromise the level of care due to under resourcing and potentially lose their registration as a consequence.

The employer and provider of such services (in this case Healthscope) MUST be responsible and held accountable for providing the resources necessary to provide safe clinical care. And the NSLHD and Ministry should insist that this is the case.

[18] Ibid.

(f) the impact of the hospital on surrounding communities and health facilities, particularly Mona Vale Hospital, Manly Hospital and Royal North Shore Hospital

Mona Vale Hospital

On the initial announcement of the proposal to tender the construction and operation of the NBH, it was stated that whilst all acute services would be *stripped* from Mona Vale Hospital, the assessment and rehabilitation beds would remain, along with some form of Urgent Care Centre as a substitute for the Emergency Department. Reference was also made to the development of a master plan for the Mona Vale Hospital site.

Disappointingly for staff and the community, it was then not until June 2018 [19] (over four years later) that the services and staffing to remain at Mona Vale Hospital was more clearly articulated. This confirmed the retention of 56 beds, comprising assessment and rehabilitation services, community health centre, hydrotherapy pool, community palliative care, and a proposal to add an additional 20 beds for inpatient palliative care and geriatric evaluation and management.

It also confirmed that an Urgent Care Centre ('UCC') would be operational when Mona Vale Hospital acute services ceased from 31 October 2018. It was confirmed that the UCC would only be able to meet the needs of those with minor injury or minor illness (ailments similar to that which may have you attend your local GP), albeit some additional capacity has been introduced since opening, such as X-rays.

This would and has been a significant shift for the local community. An ED that previously averaged approximately 80 plus presentations per day (including a number of children), with approximately half of these presentations requiring some form of continued care and/or admission, to that of only having access to basic care or limited stabilisation prior to transfer to another hospital, is a seismic change.

Indeed the ongoing commitment to the UCC is also not locked in. The NSLHD made clear at that time that the *UCC "… will be 24/7 in the first 12 months with a plan to conduct an utilisation review to determine usage/demand."* [20]

This would be unfortunate for the community if even these limited services were further curtailed or had its hours of operation reduced. If anything, any review by NSLHD/Ministry should seriously contemplate whether further services may be needed to better complement those provided at NBH.

It is understood by the Association there would be no barrier to NSLHD expanding its range of public health services at Mona Vale Hospital. [21]

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19 Correspondence to the Association under the signature of the Chief Executive of the NSLHD dated 16 June 2018.

20 Ibid. Contained in a Consultation Paper attached to the Chief Executive correspondence.

21 Observation made during an address by the Hon Rob Stokes MP, then Minister for Education, at a 'Save Mona Vale Hospital' protest meeting, Pittwater RSL, 5 February 2019.

Manly Hospital

All services at Manly Hospital ceased with the opening of the NBH. Accordingly, the community is completely dependent on the NBH.

Royal North Shore Hospital

It is difficult for the Association to establish with any certainty what impact the closure of Manly and Mona Vale Hospitals and the opening of NBH has had on the services provided by Royal North Shore Hospital ('RNSH').

However, based on anecdotal feedback from members working at RNSH, there would appear to be an increased demand arising from those bypassing or refusing to be treated at the NBH. Indeed media reports [22] have suggested that local GPs were actively referring their patients to RNSH (rather than the NBH), at least in part to reduce out of pocket expenses for such patients that might be incurred at the NBH.

[22] *"GPs anger at patients out of pocket expenses",* Manly Daily, 10 April 2019

(g) the merits of public private partnership arrangements for the provision of health care

It will be no surprise to the Committee that the Association and its members have long taken a stance opposing the privatisation of public health services and assets. It vigorously campaigned against the decision to proceed with a privatised model for the NBH. Not because it is opposed to the provision of health services by NGO providers, the Association acknowledges and accepts that the private health system has long been a complementary part of the total health services provided to the community.

But the provision of public health services has long been and seen to be an integral responsibility of governments at both state and federal level. These are essential services that must remain in the hands of the community via their governments. As demonstrated time and time again, when governments have made decisions to contract out these essential services, they have largely failed in the Australian setting. The NBH appears, sadly to date, to validate those experiences.

The justification for privatising public health services generally rely upon the false assumption that such services can be commodified and dealt with as a financial equation - searching for supposed increased efficiency and effectiveness ie providing a service at a lower cost than would otherwise have been the case if these services had remained in public hands.

There are major flaws in this approach and view of the world. Firstly, the provision of health services cannot simply be reduced to, and tested on, achieving some notional lowest possible price for providing it. The ultimate test for such services are about their adequacy, the timeliness of their provision, and the quality of such services. It is a false economy to provide a (cheaper) episode of care first time round, and deal with the subsequent consequences for the patient when they need to be readmitted or have complications arising from such care or are left with a poor experience.

Further, if the privatisation leads to an alleged lower payment for episodes of public health care, a private provider will need to drive that service delivery at even a lower cost to achieve a profit ie it must reduce the cost of providing such care, and inevitably this results in poorer service delivery, a lack of timeliness and, all too predictably, a reduction in staffing (and labour costs). It is the latter reduction that only adds and fuels poorer performance and clinical outcomes.

This approach is already evident at the NBH, and is an everyday consequence that the Association and its members confront in the Aged Care (residential) setting for example, where despite the paucity of care available, staffing levels are often the first to feel the efficiency axe (often straight after accreditation is achieved).

The Australian experience with public hospitals clearly demonstrates as much. [23]

[23] The following summary of the experiences at Port Macquarie Hospital, La Trobe Hospital, and Robina Hospital is based on previous research undertaken by and for the Association.

Port Macquarie Base Hospital

This privatisation was initiated by the then NSW Government as part of its so-called reforms of the public sector. In December 1992, the Department of Health ('DoH') entered into a 20-year contract with Mayne Nickless for the construction and operation of the Port Macquarie Base Hospital ('PMBH').

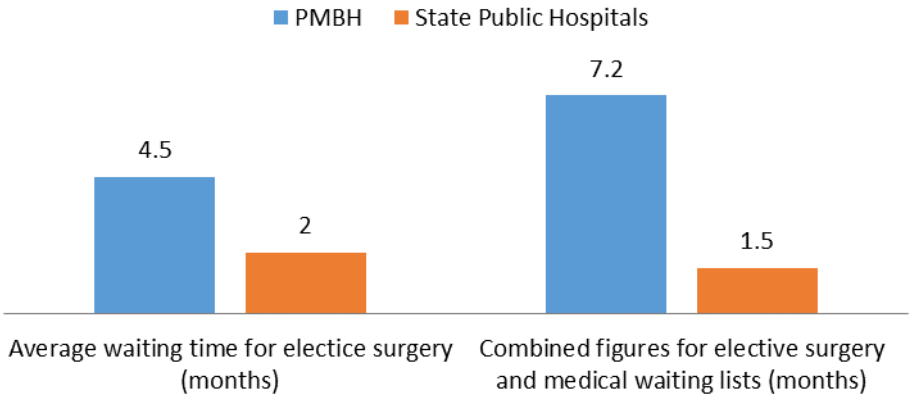
A subsidiary of Mayne Nickless, Health Care of Australia ('HCoA'), managed the hospital. The hospital was contracted to treat a mix of 80 per cent public and 20 per cent private patients. The PMBH commenced operations in November 1994.

Following ten years of operation, in October 2003 the Mayne Group proposed selling its entire Australian hospital portfolio, including the PMBH, to another private consortium. Consequently, the NSW Government commenced legal proceedings in April 2004 against the Mayne Group. On 31 January 2005, after 10 years of contracting public hospital services from Mayne Nickless, the NSW Government bought back the PMBH for $35 million, at which point the hospital reverted to public ownership.

While the most obvious outcome of the PMBH was contract failure, it is worthwhile to examine the performance of the PMBH on the criteria of quality of services and value for money (the said benefits of privatisation). A number of performance indicators for the PMBH had been set, which included elective surgery waiting times, and comparisons with peer hospitals. The privatisation quickly was seen as a gross failure on those parameters. [24]

TABLE 15

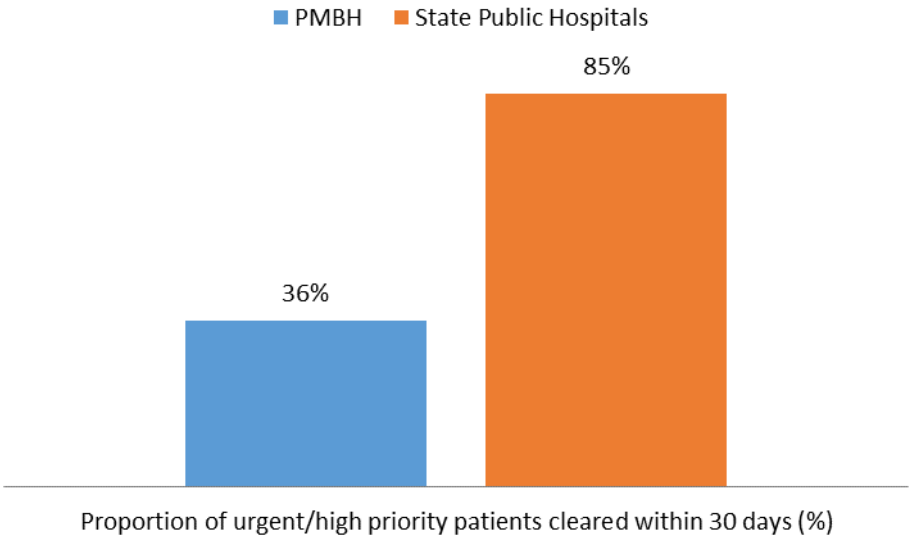
Performance Indicators of PMBH as of April 1998



[24] See for example *"Developing an analytical framework for analysing and assessing public-private partnerships: a hospital case study."* The Economic and Labour Relations Review, 19(2), 69-90, Chung, D.

TABLE 16

Performance Indicators of PMBH as of April 1998



The assumption that the privatisation would result in lower cost turned out to be false, despite the cost assessment being presented at its initiation with claims it would lead to significant cost savings. Rather, the PMBH cost the NSW Government 30% more to run than its public sector hospital comparators. Widely reported at the time and since, the exercise was labelled as being equivalent to the PMBH being *"…paid for twice over by the taxpayer …"* [25] following its collapse and return to public ownership.

La Trobe Regional Hospital

While the outcome of the PMBH was contract failure, it is not the only contact failure. La Trobe Regional Hospital was initiated in 1997 when the Victorian Government entered into a 20-year contract with Australian Hospital Care for the design, construction and operation of the La Trobe Regional Hospital. It commenced operations in October 1998. After 6 months of operation, Australian Health Care approached the Victorian Government for more funding following significant operating losses. The Government refused. In November 2001, the staff of Latrobe Regional Hospital transferred back into public employment and in 2002, the ownership of the hospital reverted back into public hands.

[25] For example, comments attributed to the then Premier, the Hon Morris Iemma MP, ABC Television, 2006.

Robina Hospital

The experience for Robina Hospital was almost identical to that of La Trobe Regional Hospital: the hospital operator, Sisters of Charity, approached the Queensland Government in the first six months of operation to alleviate operating losses and to seek more favourable contract provisions. The assumption that greater operating efficiencies would be achieved proved false. The Queensland Government did not assist and the operator continued to make operating losses. After just two years of operation, Robina Hospital reverted to public ownership.

Northern Beaches Hospital

As amply demonstrated in this submission and feedback from our members, significant issues are still plaguing the NBH. We will not seek to replicate these concerns here.

What is unclear is how the NSW Government, along with NSLHD and the Ministry, exert effective control over the episodes of public health care delivered by Healthscope at the NBH. As previously noted in this submission [ToR (a)], from observations and experiences to date, the Association believes:

"… that the NSLHD has been reduced to the 'purchaser' of public health episodes of care, rather than being directly responsible for the provision of such services. It has become a bystander, attempting to vicariously manage events rather than being directly responsible for them. Perversely, whilst one of the so-called claimed benefits of this approach is that divorces or shifts (financial and operational) risk to a third party (and away from the State), it only serves to magnify that risk and leaves it to be borne by the community and patients."

(h) any other related matter

The Association has never supported the decision of the NSW Government to privatise the public health services via the NBH for the community of the Northern Beaches. It has however, diligently and professionally participated in every forum, every consultation process, every meeting, along with providing copious feedback and suggestions regarding processes relating to employment and 'migration' of staff to ensure the best possible outcome for both patients and its members, the professions of nursing and midwifery.

Any success attributable to the NBH is a validation of the staff and the exceptional work being undertaken by nurses and midwives in the most trying of circumstances. Their story needs to be told and yet with each 'bad news story', it becomes harder to attract and retain experienced (in fact any) nursing and midwifery staff to work there at all, let alone permanently.

Based on the feedback received by the Association, and the experiences of our members along with the community, the report card for the NBH is less than glowing.

TABLE 17

Report card

The new hospital would:		Pass/Fail
i.	be a state-of-the-art, purpose built facility	Certainly new, but design faults are evident.
ii.	provide greater capacity to the people of the Northern Beaches	Fail. It appears to be providing a lesser level of service and performance than Manly and Mona Vale Hospitals.
iii.	provide greater complexity of services to the people of the Northern Beaches	Uncertain.
iv.	utilise leading digital technologies to deliver the highest quality care	Fail in relation to the IT platforms and EMR system being used.
v.	be part of (or somehow incorporated within) the clinical network of the Northern Sydney Local Health District	Based on experiences to date, fail.
vi.	be held accountable to the highest clinical standards	Experience suggests otherwise.
vii.	provide better public health services	Fail.
viii.	provide better private health services	Fail.
ix.	provide a better working environment for hospital staff	Fail.
x.	have certainty regarding the employment conditions of transferring staff from Manly and Mona Vale Hospitals	Pass, setting aside those guarantees fall well short of what staff sought.

What is needed?

Whilst the actions that may practically (and legally) be possible under the Deed between Healthscope and the NSW Government is likely to be limited, the following steps or actions are respectfully suggested by the Association to be strongly considered by the Committee as part of its Final Report and recommendations:

1. Resume public ownership of the NBH or at the very least have the NBH become an affiliated health organisation (Schedule 3 Hospital) so greater control can be exerted, and the NBH can truly be 'integrated' within the public health system of NSW.

2. Immediate intervention to review and increase permanent nursing and midwifery staffing levels.

3. Apply a hospital wide nurse/midwife to patient staffing ratio relevant to the speciality and service being delivered, which enables safe care to be provided and encourage the attraction and retention of staff, with these to remain in place indefinitely and certainly during the tenure of Healthscope.

4. As part of this intervention, ensure that appropriate skill mix levels are set for and included within staffing ratios that are relevant to the speciality and service being delivered.

5. Review the Emergency Department as to the number of beds that can be kept open safely and the number of permanent and experienced staff required.

6. Increase the numbers of Nurse/Midwife Educators and Clinical Nurse/Midwife Educators to provide necessary support and education.

7. Consider providing staff with access to HETI/NSW Health online education.

8. Increase additional support staff (and reintroduce Clinical Support Officers) to assist clinical managers (such as Nurse Unit Managers) to allow a greater emphasis on clinical leadership and oversight, and not administrative duties. Additional support is also required at ward level to allow nurses to cease undertaking unnecessary non-clinical duties, especially after hours and on weekends.

9. Urgently review IT platforms and electronic medical record systems and seek consistency with NSW Health.

10. Make known to the public what obligations and public health services are expected and required to be provided by Healthscope.

11. Reveal what KPIs are specifically established for Healthscope by the Project Deed and how these are tracked and make known the current report card.

12. Consider expanding services at Mona Vale Hospital and/or establish Mona Vale Hospital as a clinical centre of excellence for old age - geriatric care.

Survey Methodology

The Association established a series of questions to elicit feedback from members (with those outcomes tabulated and appearing in this submission).

Questions included providing specific answer options to select from and alternatively those that enabled free text responses so that members could further expand on their responses.

The survey (via email) was sent to 353 members. Of these, 250 members opened the email and survey, with 164 subsequently completing the survey.

Accordingly, this constitutes a 46% response rate, which from the experience and knowledge of the Association is an outstanding response rate for online surveys.

It is also of note that of those responding, some 60% did so within the first 24 hours of the survey being made available.

Submission feedback in general of course is also predicated upon the experiences of Association officers and members involved in this privatisation process, and the continued support and representation provided to members working at the NBH.