Submission No 233

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

Name: Dr Jonathan Page

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Dear Madeleine,

I am pleased to have the opportunity to submit my concerns with the management of the NBH since the opening on Nov 1 2018.
I am happy for my name to be known. My major concerns are for less-than-ideal patient management.
These concerns have led to my considered resignation on Aug 24th 2019.
I have had no intention of retiring at this point, and had planned to work in a comprehensive capacity with my colleagues for many more years.
I am now seeing most of my NBH outpatients in my private rooms in Manly – all bulk-billed, but with less coordination with the NBH clinic in some cases.

I am 68 and have practised as a specialist medical oncologist for 36 years.
I worked at Manly Hospital for 36 years, with lesser periods at other public and many private hospitals over the years.
My focus has been on direct patient care (rather than predominant administration, teaching or research although clearly these activities demand some attention).
I choose to develop a close relationship with patients to support them emotionally through their treatment and beyond, being cognizant of important spiritual issues that often emerge.
I have also focussed on the public health system, preferring to minimise patient costs, to maximise patient contact (time and availability) and to treat all patients, whether public, private or DVA the same.
The oncology clinic at Manly Hospital (the Northern Beaches Cancer Service) has been a Privately-Referred Non-Inpatient, Medicare Funded clinic since 1995, ie bulk-billing all patients, with cancer treatments paid by the PBS rather that the hospital.

There have been well-documented rolling crises at the NBH since it opened. Communication with the executive and other administration has been poor with no sense that anyone understands our basic needs (or those of other hospital depts).
My final letter of resignation in April 2019 (intended to provide 4 months to obtain a replacement) led to no response until Dr Simon Woods emailed me in June to expedite the resignation, not to find solutions.
I will focus on the outstanding issues facing oncology (which of course may face other depts also).

1. We have had no systematic on-line communication (ie via the EMR, electronic medical record) with the LHD (public health system) ie the Cerner System=Powerchart (involving RNSH, MVH, Ryde Hosp, Hornsby Hosp, Greenwich , Neringah, plus Manly Hosp records, community services). We used this system every day and all day at MH, as did all medical, nursing, allied health and Admin. Thus we had ***no*** access to patient records from day 1 at the NBH, either our own patients or new patients, most of whom had visited MH or MVH previously. This was a critical deficiency in patient follow up. We would normally search back through the record in most patient visits, view past correspondence, view past pathology, view past x-rays and scans, and check contact with other services. Initially the MVH medical librarian was asked to go on-line (since MVH has such access), to find our patients, and to print 10-20 pages, not necessarily of value, then fax them to our clinic at NBH. This was unsatisfactory and burdensome to MVH. Our patients presenting to ED were often assessed with no available history. There are **many** examples of negative clinical consequences. Later 2 or 3 laptops were provided (for the entire NBH) by RNSH, connected to the "public EMR system". These may be out of order, unavailable as in use by other clinicians, locked away or just inconvenient for care for our in-patients in ward 6C (sixth floor). The planned full unification, the HIE (health information exchange) has not yet taken place.

2. The physical facilities in our dept are quite inadequate for a predominantly out-patient oncology service (now including haematology) three times the size of the MH clinic, with just a tiny room serving as an office for currently 5 oncologists and 5 haematologists! We have been using the general OPC which is remote from the clinic and does not have specialist reception and nursing staff. The waiting room and reception area are poorly designed. We need an experienced "practice manager" with an office, plus space for teaching, research and team meetings. These matters were discussed with DL well before opening (> 1 year) and with LM in the months before opening. I've heard that the out patient service and its budget are a source of contention between Healthscope and the LHD (Health Dept) – if so then many are suffering as a consequence.

3. We received ***no*** payment for our clinic work for the first 3 months and only then because I threatened to resign on Feb 1st. We were paid for Nov 2018 in Feb 2019. Promised payments for Dec 18 and Jan 19 did not occur (until later). Meetings with Finance along the way achieved little result. These payments remain delayed and erratic. The MH system of timely payment by Medicare is not yet occurring. Healthscope is paying. We spend many hours (unpaid) sorting out our services (Medicare item numbers) to enable payment but such payments remain un-itemised.

4. There have been unnecessary palliative care issues from day 1 (through poor planning) – initially no in-patient service (we oncologists provided this service, in addition to our oncology in-patient work). Again after a crisis meeting we obtained a bare minimum in-patient consultant service, which although excellent in quality, remains deficient in hours available – the balance provided still by oncology. This issue was also discussed before NBH opening. A comprehensive in-patient palliative care service is vital for such a large community (public)hospital, liaising with the community and the hospices.

5. We struggle without specialist oncology, haematology and palliative care registrars in such a large hospital. This would require accreditation and closer links with RNSH, both ideal arrangements anyway.

I am happy to discuss these and other issues if you feel this to be beneficial.

Best wishes,

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Medical Oncologist