REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

INQUIRY INTO OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

At Macquarie Room, Parliament House, Sydney, on Monday 26 August 2019

CORRECTED

The Committee met at 10:00

PRESENT

The Hon. Greg Donnelly (Chair)

Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Emma Hurst (Deputy Chair)
The Hon. Natasha Maclaren-Jones
The Hon. Shayne Mallard
The Hon. Walt Secord

CORRECTED

The CHAIR: Welcome to this hearing of the inquiry into the operation and management of the Northern Beaches Hospital. The inquiry is examining matters such as the contract and arrangement establishing the hospital, the ongoing arrangements for its operation and maintenance, current standards of service provision, care and staffing arrangements, and changes at the hospital. Other matters that will be examined will be the impact of the hospital on the surrounding communities and health facilities—particularly at Mona Vale, Manly and Royal North Shore hospitals—and the merits of public-private partnership arrangements for the provision of health care in New South Wales. Before I commence I acknowledge the Gadigal people, who are the traditional custodians of this land, and I pay my respects to elders past and present of the Eora nation and extend that respect to other Aboriginals who may be present over the course of the day.

Today is the first of several hearings we plan to hold in this inquiry. Today we will hear from representatives of the New South Wales Government, Healthscope and the Northern Beaches Hospital. In the afternoon we will hear from key community groups such as Save Mona Vale Hospital Community Action Group, Friends of Mona Vale Hospital and Friends of Northern Beaches Maternity Services. We will also hear from representatives from the Australian Salaried Medical Officers Federation of NSW, the NSW Nurses and Midwives' Association and the Health Services Union. Before I commence I will make some brief comments about the procedures for today's hearing. This is a public hearing and we acknowledge the significant interest the community has in this inquiry—particularly those who live on the peninsula. I remind audience members that today is not an open forum for comment from the floor. Audience interruptions are not recorded in the transcript and make it difficult for witnesses to communicate with the Committee.

Today's hearing is open to the public and is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, while members of the media may film or record committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that you must take responsibility for what you publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of the evidence at the hearing, and so I urge witnesses to be careful about any comments you may make to the media or to others after you complete your evidence, as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation. The guidelines for the broadcast of proceedings are available from the committee secretariat.

There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days. I remind everyone here today that committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. I therefore request that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. Witnesses are advised that any messages should be delivered to the committee members through committee staff. To aid the audibility of this hearing, may I remind committee members and witnesses to speak into their microphones. The room is fitted with induction loops compatible with hearing aid systems that have telecoil receivers. In addition, several seats have been preserved near the loudspeakers for persons in the public gallery who may have hearing difficulties. Finally, could everyone please turn their mobile phones to silent for the duration of the hearing.

DEBORAH WILLCOX, Chief Executive, Northern Sydney Local Health District, affirmed and examined

NIGEL LYONS, Deputy Secretary, Health System Strategy and Planning, NSW Ministry of Health, sworn and examined

The CHAIR: That has got through the formalities. Thank you for your patience. The Committee has resolved that the way we wish to proceed is to invite both of you, if you wish to do so, to make a short opening statement. With respect to your submissions, the Government's submission has been received and is listed as submission number 224 to this inquiry. You can take that as read. You are both invited to make a short opening statement and then we will resolve to move into questioning and we will rotate the questions between the members of the Committee. Dr Lyons, would you like to make an opening statement?

Dr LYONS: Thank you. Let me begin by acknowledging the traditional owners of the land, the Gadigal people of the Eora nation. I also acknowledge elders past, present and emerging and pay my respects to First Nations people of New South Wales present today. I express my appreciation for the time taken by all involved in this inquiry to provide their expert opinions in both the submissions and the hearing process. I warmly welcome this opportunity to attend and to work with those involved so that we can continue to deliver health services that meet the needs of the northern beaches community.

I acknowledge the heartfelt and, in many cases, personal submissions to the inquiry from the individuals and local organisations from the northern beaches and acknowledge their passion for their local hospitals. I also take the opportunity to pay tribute to the committed professional staff who transitioned from Manly and Mona Vale hospitals to the Northern Beaches Hospital and who continue to provide exemplary care for the northern beaches community. Our frontline clinicians have demonstrated expertise and compassion and we should acknowledge their hard work, not only at the Northern Beaches Hospital but across our whole health system, which they support 24 hours a day, seven days a week.

It is important to remember that prior to the opening of the new hospital, the northern beaches community was serviced predominantly through Manly and Mona Vale hospitals, with complex tertiary services being provided at Royal North Shore Hospital. The infrastructure limitations of Manly and Mona Vale hospitals, with both smaller and ageing facilities, were unable to be reconfigured to provide contemporary models of care, including those specialty clinical services rightly expected by the community. In opening the new hospital, NSW Health successfully delivered the first major investment in public health infrastructure for the northern beaches community in decades, made possible through the public-private partnership. It allowed the consolidation of existing services and the addition of new, more complex services at the Frenchs Forest site, providing the critical mass at a location that could more adequately serve the population catchment areas.

Since the formal commencement of planning in 2014, NSW Health has taken a rigorous approach to ensure that the best outcomes were achieved under the contractual arrangements undertaken with the provider, Healthscope. We have had extensive and rigorous governance throughout the project, and I will just outline some of the governance now. The first is the project delivery board, which included representatives from NSW Treasury and NSW Health to provide executive oversight of all project milestones and advise on key strategic decisions surrounding the development, technical completion and operational readiness. There was also a project management office, which was established to appropriately report mechanisms for detailed work, which included contract management; workforce; facilities, incorporating Mona Vale and Manly hospitals; information management and technology; service planning and patient flow; and the operational readiness and transition.

In addition, there was a project coordination group that discussed and reviewed matters relating to the project works, including development, design, construction and commissioning issues, and preparation and compliance with project plans. Service planning and patient flow-stream was a critical group with senior clinicians from Northern Sydney Local Health District working closely with Healthscope to support the development of clinical services and define the integration of those services with existing local services. Clinicians and technical staff also gave significant time and effort to work on the information technology interface between the new hospital and other services in Northern Sydney Local Health District to enable the safe transfer of information between facilities to support patient care.

Throughout the concept, planning and delivery of the project, NSW Health has endeavoured to drive improved safety, quality and value in patient-centred care on the northern beaches. Our embedded business processes and frameworks monitor and improve the performance, and we are continuing to work with the provider to deliver those benefits. While we can be proud that our health services are amongst the best in the world, we acknowledge that more work can be done to meet the current and emerging needs of our communities. We

welcome the opportunity this inquiry provides to highlight where our efforts may be directed to enhance the care to patients and support the community of the northern beaches into the future. Thank you.

The CHAIR: Ms Willcox, would you care to make an opening statement?

Ms WILLCOX: I, too, would like to acknowledge the Gadigal people of the Eora Nation and pay my respects to elders past and present, and thank them for the care of the land on which we meet today. As the chief executive of Northern Sydney Local Health District, it is my role to manage the contract to purchase public patient services on behalf of NSW Health, and to ensure the private operator, Healthscope, of the Northern Beaches Hospital meets its obligations as set out in the project deed. In my role I do not have day-to-day management responsibility for the operations of the hospital in areas such as staffing, resources, planning or direct patient care. Northern Beaches Hospital has its own executive structure and is responsible for the day-to-day operations of the hospital.

The opening of the Northern Beaches Hospital was one part of a broader redevelopment project to enhance health services for the community of the northern beaches. It also included some new community health centres—at Brookvale, Mona Vale and Seaforth. It was a very, very large undertaking, and many years in the planning. As Dr Lyons indicated, the lion's share of healthcare services were provided to the community by Manly and Mona Vale hospitals, with very complex care provided at Royal North Shore Hospital. I will not re-cover the reasons for that, as it was covered by Dr Lyons. The transition of the healthcare services from Manly and Mona Vale hospitals was one of the largest the State has ever seen. Planning was meticulous to ensure we maintained high quality care to patients at Manly and Mona Vale and as we transitioned into the new hospital.

It was a major logistical exercise over two days at the end of October last year, where we safely transferred 105 patients and the acute services over to the Northern Beaches Hospital. Almost 700 staff transferred to the new hospital, taking with them their values and their commitment to providing care to their community. There was great excitement about providing the services in a brand-new hospital with state-of-the-art facilities. It is true that the health services that are currently available to the community are far greater than what was previously available to the residents of northern beaches. There is access to more complex care closer to home, including a state-of-the-art emergency department, an advanced intensive care unit and additional surgical services.

In the months leading to the opening, NSW Health worked closely with Healthscope to prepare for the opening of the hospital. The work plan was titled, "Operational Readiness". The operational readiness of the hospital was primarily the responsibility of Healthscope. However, it also involved substantial commitment from NSW Health over several months to support the preparations. As Dr Lyons outlined, a program management office was established with a series of work streams, responsible for areas such as workforce, clinical services, and information technology. There was a sharing of policies, protocols and procedures, models of care, service linkages and release of staff for many hours of training.

Under the project deed, Healthscope was responsible for demonstrating the completion of operational readiness to the reasonable satisfaction of the independent verifier. The independent verifier was jointly appointed by New South Wales and Healthscope in February 2015. The independent verifier was required to review Healthscope's operational readiness report to determine whether completion criteria set out in the project deed had been satisfied. This went to areas of staffing, equipment testing and interface with other services such as ambulance. The independent verifier met weekly with Healthscope and NSW Health from July 2018 to review progress and the status of the completion activities. After reviewing Healthscope's completion report, the independent verifier issued the operational readiness certificate on 23 October 2018.

In addition to being assessed by the independent verifier as being ready, there were also a large number of regulatory licensing and compliance bodies that needed to be satisfied in relation to a range of issues that involved on-site inspections, assessments of documents and certification and evidence of compliance, before the hospital could open. The final licence, covering all classes of services and treatment, was issued to Healthscope on 15 October as a precondition to operational readiness. The Northern Beaches Hospital was also fully accredited 10 days after its opening, with no recommendations, by the Australian Council of Healthcare Standards.

Under the project deed, Healthscope is required to deliver services to public patients at a standard expected of all New South Wales public hospitals. NSW Health and the district are responsible for ensuring that Healthscope meets its contractual obligations as set out under the deed and to monitor performance under a performance management framework. The governance group, the operational services group, oversees the performance of Healthscope and is co-chaired by Healthscope and NSW Health. Whilst a number of issues emerged following the opening of the hospital, I again point out that Healthscope was responsible for the operations of the hospital, and NSW Health acted swiftly to provide support and assistance.

It is also important to note that the commissioning of a new large hospital is a very complex process. As we would with any hospital, we maintain frequent and ongoing contact to assist the Northern Beaches Hospital executive and to provide advice and offer resources. Patient flow through the hospital was identified as an early issue, and we made sure that an experienced senior nurse manager was available to work on site with already very skilled emergency department staff to review and improve patient flow.

The CHAIR: Ms Willcox, I do not wish to cut you off but we have limited time for questioning. Do you have much of your statement left?

Ms WILLCOX: I might go to my closing remarks.

The CHAIR: You might like to table it, if you wish.

Ms WILLCOX: Thank you. I was just keen to point out the number of issues that have been ventilated and to cover off on some of the actions by NSW Health. I trust this summary has given some useful insight into the considerable effort by NSW Health in assisting Healthscope. This is a long-term partnership, and together we aim to deliver an enhanced range of services to our community. There are rigorous governance structures, processes and systems in place to ensure accountability and transparency by Healthscope in its operational responsibility, and by NSW Health in managing the contract. Ultimately, our collective aim is to provide the very best care to the community of the northern beaches. Finally, I, too, would like to thank the staff at Northern Beaches Hospital.

The CHAIR: We are going to rotate through the questions in this order: Opposition, cross bench and Government, equally divided. We will begin with the Opposition.

The Hon. WALT SECORD: Good morning. Thank you for attending. I will be asking questions today—previously I was the shadow Minister for Health—as the shadow Treasurer. But I still have experience and knowledge of the opening of the hospital. So that I can frame my questions appropriately and properly, Dr Lyons, what is your involvement with the Northern Beaches Hospital? That did not come out in your opening statement.

Dr LYONS: I was a member of the project delivery board—the group that had oversight of the governance of the work. I was a member of that board, which met on a monthly basis. It was chaired by the chair of Northern Sydney Local Health District and the chief executive of Health Infrastructure. I was a member of that group from the time of my appointment as deputy secretary in October of 2016 through until the time of operational completion. So when the hospital became operational, the involvement in that group was transferred to another deputy secretary role.

The Hon. WALT SECORD: Ms Willcox, I understand you have become newly-appointed CEO to the local health district. What was your involvement in the Northern Beaches Hospital?

Ms WILLCOX: I was appointed as chief executive of Northern Sydney Local Health District in November 2017. So my role was to work with both the Ministry and the Healthscope executive team to assist them with their planning and preparation toward operational readiness and, importantly, to work at Manly and Mona Vale hospitals with our staff, and manage what was an enormous transition of around 700 staff into the new hospital, and all the accompanying activities around the closure of Manly and the reconfiguration of Mona Vale.

The Hon. WALT SECORD: In your opening statement you said that one of your duties was ensuring that the hospital was meeting the obligations of its contract.

Ms WILLCOX: Yes.

The Hon. WALT SECORD: How does that occur?

Ms WILLCOX: That occurs across a number of fronts. Firstly, there is a very detailed governance arrangement whereby we meet frequently and regularly with Healthscope executives through the operational services group. Under the contract, the project deed there is also a performance framework, where Healthscope is required to report to us in terms of the clinical activities across a raft of safety and quality measures, performance and activity so that we can monitor performance.

The Hon. WALT SECORD: Does that occur once a month, once a week?

Ms WILLCOX: We are in day-to-day contact with the hospital, it would be fair to say, but we have formal meetings every fortnight and then there is a range of reporting measures that come monthly, six-monthly and annually.

The Hon. WALT SECORD: Do you feel that patient care has improved at the hospital under your watch since its 30 to 31 October opening?

Ms WILLCOX: Most definitely. The issues associated with opening have been well ventilated. The 700 staff that moved across are the staff of Manly and Mona Vale hospitals, who have provided exemplary care to their community, some for many years. They left those hospitals with that same set of clinical skills and those same values. Again, the issues that emerged surrounding supply and some staffing issues were well aired. We worked very quickly with Healthscope to assist them in those early days. It was in our mutual interest to make sure that we supported them and provided all the resources at our disposal to help them.

The Hon. WALT SECORD: So you are comfortable now that the hospital has improved since then?

Ms WILLCOX: I am.

The Hon. WALT SECORD: Have you read the other public submissions?

Ms WILLCOX: I have, yes.

The Hon. WALT SECORD: Would you be familiar with the Health Services Union's [HSU] submission?

Ms WILLCOX: I am, thank you.

The Hon. WALT SECORD: They portray, from staff working at the hospital, a clear two-tier system in the hospital. Is there are two-tier system in the hospital—preference and better care given to private patients, inferior care given to public patients?

Ms WILLCOX: No, it is not a "two-tier system". The new Northern Beaches Hospital is a private hospital independently operated by Healthscope. Yes, I am purchasing public activity. It is required to provide a standard of care at the same level as public patients currently receive in the health system. There is a raft of new services available to the community that were not previously available. The staff will be caring for those patients according to their clinical need, ascribing those same values that they ascribed when they were working at Manly and Mona Vale hospitals.

The Hon. WALT SECORD: What do you say to page 2 of the HSU submission? It says that staff are told to provide hot breakfasts to private patients and to give cold breakfasts to public patients. What do you say to that? That is page 2 of the HSU submission, from staff who actually deliver the meals to patients in the hospital. Does that occur?

Ms WILLCOX: I am not directly aware that that is the case. It is for Healthscope to operate the hospital and my job is to manage the contract. I am not aware of such stark differences.

The Hon. WALT SECORD: But would you be concerned that public patients are getting cold breakfasts? Staff there are being informed to give them cold breakfasts and give hot meals to private patients. Would that not concern you as a person funding that hospital?

Ms WILLCOX: I would be concerned if there were major differences between the public and private patients. However the—

The Hon. WALT SECORD: Well, submissions to us say that.

Ms WILLCOX: However, the care being provided and the nature of the services being provided now at the new hospital are much greater than those that were previously provided at Manly and Mona Vale. As I said, they are provided by the same staff who were caring for people at Manly and Mona Vale hospitals.

The Hon. WALT SECORD: What do you say to the suggestion that we have a "healthcare apartheid" on the Northern Beaches—better care for private patients, inferior care for public patients?

Dr LYONS: This hospital is a private hospital that is contracted to provide public services for the life of the contract. We have contracted this operator to provide public care at the same level as we would expect for any public hospital in New South Wales. We have very rigorous processes of assessing the performance of the operator. We have taken a position that, yes, there will be some issues with commissioning a new hospital— and those emerged, as we have heard. We worked very closely with the operator to make sure that those were addressed. The submissions that you have received raise a whole lot of issues. The question—

The Hon. WALT SECORD: These are people who work in the hospital.

Dr LYONS: I suppose the question for the inquiry is to test the veracity of those submissions and to come to a conclusion. From our position it is clearly about ensuring that the public services that are provided are of the highest quality and are delivered effectively at a level that is consistent with public hospitals across the rest of New South Wales.

The Hon. WALT SECORD: Let me take you to something that is not patient care, which is cleanliness in the hospital. Page 7 of their submission says that there was one mop and one bucket for every two wards and that it took them nine weeks to get mops for the hospital. Is that still correct?

Dr LYONS: I would respond by saying that from the perspective of NSW Health and Northern Sydney Local Health District these are not details that we would have knowledge of. They are operational issues and probably best put to people who are—

The Hon. WALT SECORD: But are you not funding this hospital?

Dr LYONS: We are contracting the hospital to provide services. The level of detail you are talking about around operational matters and what supplies are available is something that we would not have direct visibility of on a day-to-day basis.

The Hon. WALT SECORD: I was looking through the materials and it says that you get monthly service payments—page 9 of the NSW Treasury document from 2015 said that there will be monthly service payments. Does the New South Wales taxpayer provide monthly payments to Healthscope to provide care at that hospital?

Dr LYONS: Yes.

The Hon. WALT SECORD: After the problems occurred from the very beginning, did those payments continue?

Dr LYONS: Yes.

Ms WILLCOX: Yes. We were still purchasing public activity from Healthscope during those early months.

The Hon. WALT SECORD: So you paid them regardless of complaints and problems with care at the hospital? There was no reduction in payment; you just continued to pay them?

Dr LYONS: Can I just respond to that? Under the—

The Hon. WALT SECORD: Okay, take me, take me—

The CHAIR: Order! I think it is really important that the question be posed and allowed—

The Hon. WALT SECORD: Sorry.

The CHAIR: No, that's fine. Dr Lyons?

Dr LYONS: The first thing to say is that under the terms of the contract—this is a 20-year contract for public services. There are a whole lot of provisions in the contract around abatements that can be applied and changes to the contract that can be negotiated during the life of the agreement. The rate at which we contract services is annual, so there is an annual notice that dictates the amount of service to be provided. Then there is a series of performance indicators that monitor the level of performance that is required to be delivered. All those factors are taken into account for the payment to the operator. If there were any issues that needed to be escalated then there can be, under the contract, escalation of those issues to the point of step-in rights eventually, if required.

The Hon. WALT SECORD: Okay, well there—

Dr LYONS: We have taken a view that it is really important for the operation of this hospital to be a success for the patients who are receiving care there and for us to support the operator to make sure that they are getting services to the point where they need to be as swiftly as possible. It would not be in the best interests of the operator or the patients for us to proceed down that path of going to contractual issues straight up.

The Hon. WALT SECORD: But you are paying the bills for this.

Dr LYONS: We are. What we are saying is that this is over a 20-year period. It is important that we establish a relationship that is grounded on not just the contract but a relationship that is positive. The financing of the hospital is one component of it and we are very confident that we are getting good value out of the funding that we are providing to the operator for the provision of services. So it is—

The Hon. WALT SECORD: Okay, so what does Healthscope have—

The Hon. WES FANG: Point of order.

The Hon. WALT SECORD: Sorry, I am asking a follow-up question.

The CHAIR: A point of order has been taken.

The Hon. WES FANG: Point of order: The witness is trying to give a detailed answer to what is quite a detailed question by the Hon. Walt Secord. The witness needs to be given the opportunity to provide their answer in full before they are interrupted.

The CHAIR: Yes.

Dr LYONS: Could I just keep going? Because I think there is more to say on this issue around the funding. One of the benefits out of this arrangement, this contract for services with the operator was that for the life of the contract there has been agreement of the services provided at Northern Beaches Hospital will be at a discount rate to the State price. The State price is calculated through the cost of all public hospital services. We calculate the State price every year and that is the rate at which we fund all of our public hospitals. The operator is actually providing a benefit to the State, providing services that we will ensure are delivered at the level required under the contract. It will do that over the life of the agreement at a discount to the State price for the life of the agreement. That discount is a result of the economies of having a larger hospital, where two hospitals that were smaller and had fixed costs were brought together and by the fact it is actually able to have private services on the same campus. There are benefits to having the volume of patients being cared for and economies of scale.

The Hon. WALT SECORD: Back to my original question: What does Healthscope have to do to have the State Government take action or reduce funding to them? There is a carrot and a stick. What is your stick? Are you just going to continue to pay them for 20 years regardless of the provision of health care they are providing? Are you just going to continue to pay them but not check patient care?

Ms WILLCOX: Under the performance management framework that I described, there are also a suite of what we call abatement provisions set within the project deed.

The Hon. WALT SECORD: What does abatement mean?

Ms WILLCOX: Abatement means that there would be a reduction in the payment where certain things were not met. Those provisions have been applied in the previous months but I think, to Dr Lyons' point, the important thing here is that we want to build a strong and positive relationship with Healthscope. We have a community to jointly care for and it is our view that getting on together and working through the issues collaboratively—Yes, there were issues in those early months; largely, those matters have been resolved. Using the contract is really just of a—

The Hon. WALT SECORD: Was the hospital operation-ready? Was it ready to take patients safely when it opened its doors?

Ms WILLCOX: As I outlined in my opening remarks, the independent verifier gave a certificate of operational readiness based on a raft of considerations around staffing and equipment et cetera. We had done a very, very detailed plan to prepare for operational readiness and I think I have outlined some of that already. The matter for the operations of the hospital were simply that for Healthscope. Our job was to move the staff across and to have all of those things in place but ultimately the operations were for Healthscope.

Dr LYONS: Could I add? The independent verifier had a very extensive set of criteria that we established around assessing operational readiness. I make just one point: Having been involved in commissioning public hospitals and decommissioning public hospitals through my career, it is a very challenging process that requires extensive involvement of staff, processes and communication. All of those systems, processes and policies were established prior to the opening. Once you actually have the services up and operating, it revolves around how staff communicate, how the teams operate, how the system is that you had envisaged to work actually do when they are put into practice, how you respond to the challenges of providing patient care with a busy emergency department. They are very challenging situations and, of course, the day-to-day management then comes into play around how those are addressed.

The Hon. WALT SECORD: When the contract was initially released by Treasury in 2015 and through all the correspondence in public documents, it seemed to be a hospital of 488 beds. Why in your submission does it say it is now 423? Why does the hospital have 50 fewer beds than the original contract? Why is it a smaller facility? That is actually in your submission.

Ms WILLCOX: The current number of beds—When the hospital opened, they gradually ramped up their bed opening as the patient need was required through the emergency department and through planned surgery. I understand there are currently 350 beds open at the Northern Beaches Hospital as they progressively bring beds online and recruit staff and I believe there is an ability to get to 488. That would be opening at 423 with the, I guess, future-proofing capacity up to 488 beds if required.

The Hon. WALT SECORD: There are only 350 beds at the moment there but all the material that is going out says that it is a 488-bed facility and in your submission today it says 423. It is significant. It is actually much fewer beds than—

Dr LYONS: Could I clarify? The documentation I have here which talks about the project deed documentation says that the project deed provided for at least 423 beds with a minimum of 173 private-patient-designated beds with sufficient capacity to meet public patient demand. That is what was in the project deed.

The Hon. WALT SECORD: I want to take you quickly to the member of staff departures that have occurred in the major positions. In the public arena, there is confirmation of six senior positions: the chief executive, medical director, head of anaesthetics, second anaesthetist and director of nursing. Have there been any other major departures since then?

Ms WILLCOX: Not to my knowledge.

The Hon. EMMA HURST: Thank you both for coming today. A number of submissions on this inquiry have highlighted some serious concerns with the public-private partnership [PPP] model citing recent reports and other hospitals around New South Wales in Australia where the model has failed. In light of that evidence, was the Northern Beaches Hospital built as a PPP model rather than a public hospital? Why was that model chosen?

Dr LYONS: I think there are many examples of where the public sector is actually having services provided through either private operators or non-government operators. That exists right throughout the system at the moment including, for example, St Vincent's Hospital, which is actually a non-government organisation—a charitable organisation—providing public services under a slightly different arrangement. But we have many examples of other operators who are actually providing public services right across the State. We are having other examples of PPPs in existence across the State.

They are different types of arrangements for public-private partnerships, both at Calvary Mater Newcastle and Orange Hospital as examples. These models which are looked at on the basis of "How do we best procure an appropriate investment in capital and service to ensure that we can meet the needs of the local community?" That assessment is made from time to time as which is the best way to provide for the service to be made available as quickly as possible to benefit the community. That is an assessment and a judgement that is made. We have many of those examples, as I said. Many of those are continuing to operate quite successfully across the system at the moment.

The Hon. EMMA HURST: Why did you think that that particular model was better for this specific community?

Dr LYONS: I think that was a decision of Government around what was the best method of procurement. That option is available for any of the capital investments or projects that are available. However, I understand that after the Northern Beaches Hospital there was a decision made to not to proceed with a number of others that were actually announced to proceed afterwards. That was decision that was made by Government based on a number of factors, I suspect, including things like how they stacked up and how that related to the service provision for the local community.

The Hon. EMMA HURST: You mentioned the model for the St Vincent's Hospital. Was there any consideration for making the Northern Beaches Hospital an affiliated health organisation similar to that hospital?

Dr LYONS: I was not a part of the decision-making at that point but I think it was a decision made to go with the public-private partnership arrangement but there could have been charitable organisations like St Vincent's Health who could have responded to the public-private partnership arrangement. In fact, I think in the shortlist, there were other providers that were not-for-profits who expressed an interest in operating the hospital.

The Hon. EMMA HURST: In your submission you mention a long list of inspections and compliance checks that took place before the hospital opened. Why did not any of these checks identify some of the serious issue that came up when the hospital opened such as the lack of basic stock like intravenous [IV] fluids and syringes?

Ms WILLCOX: I think as Dr Lyons expressed, the commissioning of a new hospital is quite a complex arrangement. In this case where we are transitioning staff from other hospitals, new teams are coming together, there are new services and there is a new physical layout, there are a whole lot of those sorts of interactions that need to be settled as people come together to provide care to patients. Having an emergency department for the hospital meant that there were people coming through that they were needing to care for. So there was a whole lot of patient flow issues and those sorts of things that people had to respond to.

The licensing and accreditation processes are those that say, yes, the hospital is ready and that it is certified to do certain things. There are imaging checks, food authority, equipment checks, electricity, disaster management, fire and safety. There are some 30 or 40, even more, licences required and a private licence has to be provided upon the satisfaction of those and many other factors. Yes, all of those certifications were in place. Some of those issues emerged around the complexity of commissioning and working in a new environment with new teams.

Dr LYONS: Could I add? The independent verifier, in my recollection, actually had an audit of all of the supplies, the drugs and IV fluids. They were all in place at the time of opening. The issues that emerged subsequent to the opening were issues around the procurement processes and the supply chain, not that they were not there when the hospital opened. They certainly were there and they were independently verified.

The Hon. EMMA HURST: Just to go back to a question from the Hon. Walt Secord in regards to the number of beds. In one of our submissions, it is stated that there will only be 300 public beds, whereas there were 350 public beds when you consider Mona Vale and Manly hospitals combined. Do you dispute that number of public beds?

Ms WILLCOX: The split of beds at the new hospital is around 60-40, private to public. It is not easy to directly transfer, or translate, that the same number of beds at Manly and Mona Vale should go across because they are also to a mix of private and public patients as well. We are actually purchasing that public activity and as for the actual bed numbers, that really is a matter for the operations of Healthscope. Our obligations and our desires to ensure that public patients are receiving the types of care they require, are closer to home and that the performance of the hospital is at a level of other public hospitals in the State.

Dr LYONS: But could I just add, in addition to the issue around the services, there was an opportunity to actually enhance the services provided to the local community through the establishment of the Northern Beaches Hospital, by providing a level of specialty care that was above and beyond what was available at either Manly or Mona Vale. The benefits are not just around the number of beds available, it is about the range of services that are able to be delivered. It certainly has meant that people can receive many types of care closer to home than what they previously did because previously they would have had to have been transferred to North Shore hospital for that care. That can actually be provided at Northern Beaches now.

The Hon. EMMA HURST: Can you remind me what the number of public beds there are now in this hospital?

Ms WILLCOX: The matter for the actual bed numbers is really a matter for Healthscope so I cannot tell the Committee exactly what number of beds are currently there.

The Hon. WALT SECORD: You are paying the bills.

The Hon. WES FANG: Point of order—

Dr LYONS: Can I respond to that? We are contracting for a level of service and that level of service is dictated in the contract in the annual notice. It is saying, how many emergency department attendances are we paying for? How many admissions to hospital are we paying for? It is designating the level of activity that we want to see. How the operator provides that, is up to the operator. That might vary on a day today basis depending on what activity is going through the hospital. It is important to acknowledge that. That is the way that is the way all of healthcare is funded. When we purchase services from any public hospital in New South Wales now, we purchase through an arrangement where we actually purchase the service. You do not talk about we are buying a certain number of beds. We say we are actually purchasing a certain level of activity. That is the way we treat all of our public hospitals.

Ms CATE FAEHRMANN: So in the contract, the Project Deed, was Healthscope required to provide for public patients, services that they could have for free in Manly Hospital and Mona Vale Hospital? Did that Project Deed require Healthscope to provide those services for free for public patients at Northern Beaches Hospital?

Dr LYONS: The Project Deed was not constructed in that way. The Project Deed talked about what needed to be provided and dictated certain levels of service on the in-patient side, the emergency department side and the out-patient setting. Out-patient services, by recollection, there was a certain number of clinics that we agreed would be purchased under the arrangements. But there was a recognition that we were moving from one model of care to a different model of care.

Ms CATE FAEHRMANN: Is that so one model of care being free for public patients to a model of care where public patients have to pay more for services and more out-of-pocket costs? Are they the two models you are referring to?

Dr LYONS: No they are not. For public patients who are being treated and services that we are contracting the provider to provide, they are guaranteed to be with no out-of-pocket costs, so people can access that care as they would in any other public hospital.

Ms CATE FAEHRMANN: So we have been told in one of the submissions that patients previously, for example, they did not have to pay for pathology tests. They now have to pay for pathology tests at Northern Beaches Hospital.

Dr LYONS: Not if they are being treated as a public patient, they would not. So there would be no out-of-pocket costs for public patients.

Ms CATE FAEHRMANN: So that is what you are saying because submissions seem to say that differently.

Dr LYONS: For a public in-patient, there would be no costs for the patient.

Ms CATE FAEHRMANN: We have heard that there is no longer public neurology and cardiology clinics at Northern Beaches Hospital. Is that correct?

Ms WILLCOX: We do purchase out-patients services as part of the Project Deed with the Northern Beaches Hospital. There are similar specialty groups, in fact more at the new Northern Beaches Hospital than previously provided at Manly and Mona Vale.

Ms CATE FAEHRMANN: So does that include public neurology and cardiology clinics?

Ms WILLCOX: There are a raft of out-patient clinics. If the Committee can just bear with me briefly, it may be worthwhile, to understand the nature of those.

The CHAIR: I think that was a very specific question.

Ms CATE FAEHRMANN: Maybe even to take it on notice.

The CHAIR: If you are not sure just take it on notice. It was a very specific question.

Ms CATE FAEHRMANN: The Government is paying less are they for, I think you talked economies of scale earlier, for Northern Beaches Hospital compared to what the Government was paying for Manly Hospital and Mona Vale Hospital for the health services provided? Is that correct?

Dr LYONS: That is not what I said. Under the arrangement, there is a discount to the State price for the life of the agreement. The State price is calculated by looking at the cost of providing services across all of our public hospitals in New South Wales. That State price is reached by looking at those costs and looking at setting it around the average. There will be a range of services provided, some over that price and some under that price.

Ms CATE FAEHRMANN: Overall, has the Government saved money by closing Manly Hospital, by reducing services at Mona Vale and paying Northern Beaches Hospital? Overall, is the Government saving money?

Dr LYONS: So overall, if you look at a direct comparison between the money that was provided to Manly and Mona Vale under the previous arrangements, there is more being provided to Northern Beaches but it is for a different level of service. As we have indicated, it is not like for like. There are actually a range of services that Northern Beaches is now providing which neither of those hospitals were able to provide previously. It reflects an appropriate level of resourcing for the level of service provided, and benchmarked against what we set as the State price, it is at a discount rate. So it is not as simplistic as saying, is it costing more at Northern Beaches, or less than it did previously? It is a different level of service that is being provided as we have contracted at a different level of activity. If you do a comparison about the cost of Manly and Mona Vale and Northern Beaches at the time that Northern Beaches opened, it reflects an appropriate level.

Ms CATE FAEHRMANN: It is all well and good to talk about activity levels but I think with patients, and a lot of our submissions that we have received, some of which are confidential, it comes down to beds, it comes down to waiting times and to the services provided. We have heard from a range of people that that has been incredibly unsatisfactory. We have also heard that public hospital beds are less than combined for Manly and Mona Vale. That is correct and that is what the public in that part of Sydney are so concerned about.

Dr LYONS: I will come back to the point, which is looking at beds and counting beds, you need to look at the occupancy rates at both of those hospitals prior to the opening of Northern Beaches. You need to add the number of private patients actually cared for in those beds. You need to look at the length of stay of patients in those beds. You need to look at the complexity of the patients in those beds before you can make any direct comparison. It is really important we do not just look at bed numbers and say, it was this before and it is this now.

Ms CATE FAEHRMANN: A lot patients, a lot of people who have corresponded with members of this Committee are making comparisons, with respect Dr Lyons. They are saying that comparison does not stack up.

Dr LYONS: What I am saying is that there are other ways to look at it, which is that there are more services available now.

Ms CATE FAEHRMANN: I understand that.

Dr LYONS: They are much more complex services. There are a higher level of services now available.

Ms CATE FAEHRMANN: Friends of Northern Beaches Maternity Services has made a submission to this enquiry. It says the targets and thresholds for maternity services have been redacted in the public copy of the Project Deed. Why is that?

Ms WILLCOX: I would have to take that on notice, I am sorry. I am not aware.

Ms CATE FAEHRMANN: Would the Committee be able to get the targets and thresholds if it has been redacted from the public copy?

Dr LYONS: As Ms Willcox said, we will take that on notice.

Ms CATE FAEHRMANN: So in your submission, page 12, it says the hospital operator remains accountable to the local health District and Government pays the operator for the services they provide to public patients. In the case of Northern Beaches Hospital, total payments are subject to an annual cap. Talk me through what that annual cap means. Does that mean if there are too many public patients, the private operator cannot get the money to see more public patients if the demand is there? Is that what an annual cap means?

Dr LYONS: Like any public hospital, we are all on fixed budgets so we have a cap on the amount of resources we have available to provide in any of our public hospitals. The arrangement with the operator is no different to that. As you know in public health one of the challenges we all have is the fact that we have increasing demand and we have finite resources. The arrangements that are in place for this contract and the annual notice is no different to the arrangements we have for the operation of any public hospital in this State, which is that there is a finite budget, there is increasing demand and our services always look for ways that they can—

Ms CATE FAEHRMANN: And fewer beds.

Dr LYONS: Look, we have a very good health system by any comparison internationally. I think we need to acknowledge the hard work of staff in delivering really high-quality care right across our State.

Ms CATE FAEHRMANN: Of course, absolutely.

Dr LYONS: I think what we should acknowledge is that the arrangements that are in place for this contract are no different than what we have in place with other arrangements with the public hospitals.

The Hon. NATASHA MACLAREN-JONES: I am just following up on the question in relation to beds. You said before the Northern Beaches Hospital opened there were times when patients had to be transferred to the Royal North Shore Hospital for treatment. Is that correct?

Ms WILLCOX: That is correct. Manly and Mona Vale hospitals were what we call a lower role delineation than the new Northern Beaches Hospital. That means for certain complex or more specialised needs patients would go to the Royal North Shore Hospital, which is a tertiary quaternary service. Probably close to 20 per cent of ambulances would leave the Northern Beaches to take people to the Royal North Shore Hospital. We think that that figure has dropped to around 11 per cent, which means that people are able to have more complex care closer to home. Going to some of the points that our colleagues and the Committee have raised, there are MRI scanning and CT scanning. We are able to care for newborns at much younger gestational ages, around 32 weeks. There is a special care nursery. There are a number of new services that just were not available at Manly and Mona Vale hospitals.

The Hon. NATASHA MACLAREN-JONES: It also means that it will free up more beds at the Royal North Shore Hospital.

Ms WILLCOX: Yes, that is right.

The Hon. SHAYNE MALLARD: And services.

The Hon. NATASHA MACLAREN-JONES: And more services. Earlier reference was made to the Friends of Northern Beaches Maternity which has stated in their submission that consumers were not directly involved, or should have been more involved, in planning and design of the hospital. Can you outline the community engagement and stakeholder engagement in establishing and designing this hospital?

Ms WILLCOX: I was not around for the building of the new Northern Beaches Hospital, unfortunately, so I am unable to directly answer that.

The Hon. NATASHA MACLAREN-JONES: I am happy for you to take that on notice.

Ms WILLCOX: Yes. If that is okay with you, I would like to.

The Hon. NATASHA MACLAREN-JONES: That is fine. The other question I have is that the Save Mona Vale Hospital has said that they believe this hospital does not meet community needs moving forward. Could you outline, basically, your views in relation to their statements that this hospital is not designed for the future needs?

Ms WILLCOX: The new Northern Beaches Hospital obviously is a very modern state-of-the-art facility, which is one of the reasons why Manly and Mona Vale, with their ageing infrastructure, did not allow us to provide new models of care, et cetera. The new hospital is just that. Remembering, too, though we have a purpose-built new community health centre at Brookvale, which is around $50 million of investment that enables a whole range of community-based services—breast screening, early child care, mental health, podiatry, et cetera—right there at the B-line, and right there in the shopping centre for the community to access as well as refurbished community health centres both at Seaforth and at Mona Vale.

The Mona Vale campus too has been undergoing a transformation. For the first time on the Northern Beaches a 10-patient inpatient palliative care unit is under construction and also a 10-bed geriatric unit. These new inpatient units will be accompanied with the current rehabilitation and community health services already on campus as well as a helipad, a new ambulance station and an urgent care centre for when the community has minor illnesses. I think what we are seeing as part of this redevelopment is a package of services—a new modern hospital that is able to look after more acute and complex patients, a campus at Mona Vale to care for subacute needs of the community, and the ongoing referral patterns to the Royal North Shore remain for patients that are very, very unwell.

The Hon. NATASHA MACLAREN-JONES: Just to follow on from that, in relation to ambulance services, concerns have been raised that before with the Mona Vale Hospital it was a lot closer for people in that part of the area. Have ambulance services been changed to accommodate the new hospital in any way?

Ms WILLCOX: The ambulance service works to a matrix, but they are highly skilled paramedics in our Ambulance Service. Intensive care starts for patients from the moment they are picked up by the ambulance, whether it is at home, on the street or at work. The Ambulance Service has realigned its activities, obviously, to accommodate. There have been a lot of discussions and linkages with the new Northern Beaches and ambulances to make sure that that all works seamlessly. To date I am pleased to say that it is. The urgent care centre has seen people with more minor conditions. Obviously there is access to ambulance services if those patients need a transfer to the new Northern Beaches Hospital or to the Royal North Shore Hospital.

The Hon. NATASHA MACLAREN-JONES: The final question I have relates to policies and procedures. Again it has been claimed by the Friends of Northern Beaches Maternity that there are no policies or procedures in place for the hospital. I notice in your opening remarks, or it may have been the opening remarks of Dr Lyons, that you were involved in establishing policies and procedures. Where is that up to? How is that monitored?

Ms WILLCOX: We shared literally hundreds of policies and procedures and protocols and models of care in the lead-up to the opening of the hospital. The clinical staff at both Manly and Mona Vale and the clinical staff at the Royal North Shore Hospital were actively involved in preparing the service transition and the service linkages as we transitioned across. We were open and shared everything we had with Healthscope. It seemed to make perfect sense to move the policy straight across into the new hospital as opposed to starting from scratch. It also meant there was a level of familiarity for staff—that they were not needing to reacquaint themselves with new processes and protocols if they did not need to. All of that moved across as part of the operational readiness.

The Hon. WES FANG: You detailed in your previous answers that the complexity of the services provided at the Northern Beaches Hospital has increased over those provided at Mona Vale and Manly. Would you be able to outline some of those new services that are provided and what difference that makes to the combined care of patients in hospital?

Ms WILLCOX: Yes, certainly. As you outlined, there are a number of new services that were not previously available. Some of these include direct consultant care in areas of respiratory, neurology, renal and now haematology. There are electroencephalogram [EEG] services, which are for neurology patients. There is a fairly extensive age care network developed and there are some very specialised areas, such as cardiac catheterisation; CT scanning for children—low dose; onsite MRI scanning; as I mentioned previously, little ones

at 32 weeks gestation now are able to be cared for at the Northern Beaches whereas previously mums had to be at 36 weeks to be cared for; and there are also 14 special care nursery cots; there are 17 operating theatres; there is onsite and on-call interventional radiology.

There are a number of subspecialties, such as neurology that I have already mentioned; renal medicine and endovascular surgery; a highly skilled and specialised emergency department team as well as additional intensive care beds at a higher level than Manly and Mona Vale were able to provide. I have just some simple facts: 50 emergency bays compared to 30; 14 operating theatres compared to 5; 20 intensive care unit [ICU] beds compared to 13; and 40 maternity beds compared to 31. It just gives you a sense of the breadth and complexity able to now be provided.

The Hon. WES FANG: And the infrastructure that was existing at Manly and Mona Vale was not able to support the services that you are now able to provide at the Northern Beaches Hospital. Is that correct?

Ms WILLCOX: Yes. I think they were ageing infrastructure, without question, and certainly the provision of services across two sites does create some inefficiencies and I guess that reduces your ability to really network services effectively. So having a new facility to provide this meant there was a lot of input from clinical staff to design the layout and the fit-out to make sure that it was for contemporary practices.

Dr LYONS: I think the other benefit is actually leveraging those specialties that the private sector is able to bring in. The fact that there is a private hospital there as well as a public hospital means that is attractive to many of the clinicians to actually work there and provide services. That means that there are services available, specialties that are available, that were not available at either Manly or Mona Vale before.

The Hon. SHAYNE MALLARD: That is a good segue to my question, Dr Lyons, because you touched on what Ms Willcox said, which is that the public-private partnership [PPP] provided a greater volume of patients and therefore more services can be built around that. Do you want to give us some more detail about the advantages to the Northern Beaches community of the PPP model hospital that we built there?

Dr LYONS: I think the advantages are that we get a $600 million state-of-the-art building. We actually make a contribution to that which reflects the public contribution, for the public side of things, but we get a facility which is much larger than that.

The Hon. SHAYNE MALLARD: Which comes back to the State in 40 years in total.

Dr LYONS: Which after 40 years under the contract reverts.

The Hon. SHAYNE MALLARD: Twenty and then 20, yes.

Dr LYONS: For the public side there is 20 years of service and then those public services revert to the State. For the private hospital side of things it is 20 plus 20; so at the end of that 40 years that asset then reverts to the State. It is built on State land on a longer-term lease. The arrangements are that we get the benefits of that infrastructure over the life of the agreement and then subsequently. Not only that, we get the benefits of some of the other things that I talked about: Some of the services that were not previously available, the technology that was not previously available, the attraction of actually having the private sector on site as well, the benefits that will come from ultimately having a number of services including general practice services on the site and I am sure there will be the attraction of a range of other health providers on the site as a result of creating a precinct for service delivery.

I think it is also important to reflect that what the public-private partnership [PPP] arrangement allows us to do is to test whether we are providing public services at a level—if we bring another operator in sometimes there is a sense that the public side of things continues to operate in the same way. We might not be as efficient or effective. Maybe other providers can do things better than we can, or maybe they will bring new ideas in about how they can provide care, which is something that will challenge us to think about how we can continue to provide the best services on the public side as well right across the New South Wales public health system. We are really committed to that. We are very open to the fact that things are moving quickly, technology is changing, models of care are shifting and we need to make sure that we are able to provide contemporary care right across the State for all of our communities.

The Hon. SHAYNE MALLARD: I am just trying to think what a comparable challenge would be to commissioning a new hospital. I really cannot think of one—maybe an aircraft carrier—you know, to launch a new hospital has such complexity. Quite candidly—and it was welcome to me—the submission from Healthscope admits that there were problems at the beginning. They are upfront about that in their submission.

The Hon. WALT SECORD: You think so?

The Hon. SHAYNE MALLARD: I didn't interrupt you, by the way.

The Hon. WALT SECORD: That's fair enough.

The Hon. SHAYNE MALLARD: We acknowledge that there were problems at the beginning that were unforeseen and regrettable. Perhaps we would expect there would be some problems, like I say, with launching an aircraft carrier. But are you comfortable and confident now that those are behind us, and you have oversight of those services being provided and those problems are bedded in and fixed now?

Ms WILLCOX: Yes, I think it is fair to say we are confident. Obviously, a large, busy hospital is a complex business and there are high levels of complex human interaction. The issues that were ventilated very early on, as I said at the outset, we worked very closely and very promptly with Healthscope to provide any resource or assistance we possibly could. We have day-to-day, ongoing contact with the Healthscope executive team. We meet fortnightly. We have a very comprehensive performance reporting framework that obliges them to let us know how they are travelling in relation to emergency department [ED] performance, planned surgery, quality safety and a raft of indicators. It would be my view that they are working very hard, as are the staff, to provide a stellar service to the community of the Northern Beaches.

The Hon. SHAYNE MALLARD: You talked about abatement provisions, and I think you are touching on that there, in that they have been applied in previous months. So does that essentially mean that your audit has found that the service was not to standard at some point and you reduced a payment to them, is that what you are saying?

Ms WILLCOX: The data that is collected to monitor performance is Healthscope's data. They would then review their data each month to measure their performance and that information is then shared to us. They apply the abatements to themselves. We then review the performance data and the report that they provide to us and reconcile that data to assure ourselves that we are confident with that reporting. That is essentially the process.

The Hon. SHAYNE MALLARD: And that is done on a weekly basis?

Ms WILLCOX: A monthly basis.

The Hon. SHAYNE MALLARD: A monthly basis. Is that public?

Ms WILLCOX: Because they are a standalone private hospital, the performance reporting is their performance report, but the framework that is applied to them is all available on the project deed website.

Dr LYONS: Not only that, we publicly report on a quarterly basis the performance of all public hospitals across New South Wales. The Bureau of Health Information [BHI] has the responsibility for doing that independently. Northern Beaches Hospital has been included in the last quarterly report and will be included in future reports as well.

The Hon. SHAYNE MALLARD: I will just go over to Mona Vale. Correct me if I am wrong, Mona Vale has now changed over to geriatric services, am I right?

Ms WILLCOX: It currently has a rehabilitation service, some community based services and we are in the process of building the palliative care unit and the new 10-bed geriatric unit.

The Hon. SHAYNE MALLARD: All across the State there is demand for that. I am in the Blue Mountains and there is a lot of demand up there for palliative and geriatric care. That would be an additional service that has come to the Northern Beaches as a result of this redevelopment overall?

Ms WILLCOX: That is right. There would be public services run by the Mona Vale Hospital and by the Northern Sydney Local Health District. As I said at the outset, I think it will be the first time that the community of the Northern Beaches have had their own inpatient palliative care service.

The Hon. SHAYNE MALLARD: Where did they go before?

Ms WILLCOX: There are some private facilities, or they would have had to travel to other

places. **The Hon. SHAYNE MALLARD:** To other hospitals outside the area.

Ms WILLCOX: Yes.

The Hon. WALT SECORD: May I point out something that just occurred in the evidence? You referred to the BHI data. The evidence that you gave is not correct. The BHI data for earlier this year did not appear to involve the Northern Beaches Hospital. He gave evidence that was incorrect.

Dr LYONS: I said, "In the last report". Sorry.

The Hon. WALT SECORD: In the last report. You did not say that.

Dr LYONS: I did say that.

The Hon. WALT SECORD: I want the evidence to be correct.

The CHAIR: I am chairing this meeting. A point has been raised; it is a valid point, because there are issues that we have been dealing with here about the commissioning, the opening of the hospital and related matters and when information was published. For the record, can you please clarify exactly what you meant by your answer to that question?

Dr LYONS: So the last quarterly report of the BHI is what I meant. I am aware that there were issues about the data earlier on, so the Northern Beaches Hospital was not incorporated into the first of those quarterly reports this year. There is a commitment that they will be in the BHI reports in future.

The CHAIR: I have one question to Ms Willcox. Fifteen October last year was a significant date. You nominated it in your opening as a milestone date when the licensing and the accreditation were formalised or certified, I think. Can you help resolve this discrepancy for me? The hospital got its formal licensing and accreditation certified on 15 October. But it was not until eight days later on 23 October 2018 that the independent verifier issued his certificate with respect to the hospital. It seems to me that is placing the cart before the horse. You have licensing and accreditation endorsing the opening of the hospital, so it is ready to go, green lighting it, and yet there has not been an independent verification certificate issued by the certifier. How could that be so?

Ms WILLCOX: I think these are two separate things. So the private licensing authority looks at a raft of—

The CHAIR: I know that they are different things, but I am saying that one falls before the other.

Ms WILLCOX: The hospital would not have been able to open and operate without the independent verifier indicating it was operationally ready to go. The license was one component of a whole suite of things that needed to be in place for the IV to make their assessment that the hospital—

The CHAIR: Sorry, who?

Ms WILLCOX: The independent verifier, pardon me, to make their assessment that the hospital was, in fact, ready to be opened.

The CHAIR: I have a final question. You said in your opening statement, "To the reasonable satisfaction of the independent verifier". Can you please provide on notice the definition of "reasonable satisfaction"?

Ms WILLCOX: Yes, I can provide that.

The CHAIR: Thank you very much. We are very grateful to you for coming along.

(The witnesses withdrew.)

(Short adjournment)

RICHARD ROYLE, Interim Chief Executive Officer, Northern Beaches Hospital, sworn and examined

SIMON WOODS, Interim Director of Medical Services, Northern Beaches Hospital, sworn and examined

STEPHEN GAMEREN, State Manager—Hospitals, New South Wales & ACT, Healthscope, sworn and examined

ANDREW SPILLANE, Director of Finance, Northern Beaches Hospital, sworn and examined

The CHAIR: You will first have the opportunity to make an opening statement. Do you have a single opening statement or will you share it?

Mr ROYLE: You will be pleased to know there is only one.

The CHAIR: That is great news. Let us proceed.

Mr ROYLE: May I also pay our respects to members of the Gadigal people and to their elders past, present and emerging. Chair and committee members, on behalf of Healthscope I am grateful for the opportunity to appear before you, and we welcome the opportunity to contribute to this inquiry. I commenced as the interim CEO at Northern Beaches in early July this year, having worked for over 30 years as a public and private hospital CEO around Australia. I am joined by Dr Simon Woods, who is our interim medical director, and he has been at the hospital since December last year; by Mr Stephen Gameren, who is the State manager for New South Wales and the Australian Capital Territory [ACT] for Healthscope and was the interim manager and CEO at the Northern Beaches until I took over from him; and by Mr Andrew Spillane, who is the hospital's chief finance officer. He commenced in that role in November 2017.

Healthscope sees this inquiry as an important opportunity to inform and explain our perspective on the development and establishment of Northern Beaches Hospital, its operations and our aspiration to be a leading health facility serving the local community. This inquiry also provides an avenue for us to listen to and learn from the feedback and experiences of patients and other stakeholders as we continue to improve all facets of service and performance at the hospital. Healthscope is one of Australia's leading healthcare providers with a portfolio of 43 hospitals across the nation. We employ more than 18,000 people and around 17½ thousand medical practitioners are credentialed to work across our operations.

In 2014 we were entrusted with the responsibility of working with the New South Wales Government to develop and operate the new hospital as a flagship healthcare facility serving the local community. Opening a brand-new, full-service, greenfield hospital is a complex and difficult undertaking for any organisation. The fact that the problems encountered during the early days of the hospital's operations were more significant than should have been the case is a failure on the part of our company, and for that we apologise. Whilst acknowledging this, we also restate our commitment to ongoing improvement and high-quality patient outcomes. Over the past nine months, our team at Northern Beaches have directed all their efforts into putting things right, with a focus on continuous improvement.

This improvement has been clearly demonstrated by the feedback from patients we have cared for over this time and the clinical outcome data we have published on our website, in line with Healthscope's clinical governance framework. When compared with the most recent New South Wales Bureau of Health Information patient survey statistics on the rating of care in public hospitals, the hospital compares favourably and is 15 points above the New South Wales State average. By mid-July this year, over 80 per cent of patients rated the overall quality of treatment and care at the hospital as "very good", which is 11 per cent higher than in the first month of opening.

The period since the hospital opened demonstrates the resilience, pride and determination of our team to deliver high-quality care for the local community we serve. As a result, our patients are benefiting from access to a range of new and expanded services and a high standard of health care that will continue for decades to come. Finally, I would like to acknowledge the nurses, doctors, allied health and administrative staff of the hospital, who show their commitment each day to achieving excellence in the care of patients. I and my colleagues would be happy to answer your questions.

The CHAIR: Thank you, Mr Royle, for that clear and frank opening statement; it is appreciated very much. Thank you all for coming along this morning to provide us with the opportunity to ask some questions. Just to confirm, the Healthscope submission has been received by the Committee secretariat and it is noted as submission No. 119 to this inquiry. It is a very important document that we have been able to examine to prepare for questioning. I want to ensure that there is a proper amount of time for questioning so I suggest, with the

concurrence of Committee members, that we give this session one hour, which gives members 20 minutes of questioning each.

The Hon. WALT SECORD: Thank you, gentlemen, for attending today's inquiry. In the previous evidence, NSW Health talked about abatements. In the first months, in relation to your monthly payment from the New South Wales Government—the first month, the second month and the third month—did you in fact put any abatements, meaning that she should not receive the full payment for services rendered?

Mr ROYLE: Mr Gameren.

Mr Gameren: The system is the hospital provides data on a daily basis through to the Ministry of Health, so that information is being put into a data folder and we meet every fortnight to discuss it with the State and with the local health district [LHD], in particular. That will give our timings et cetera across a range of KPIs— approximately 80 within the contract. In that first month, which was really November—we opened on 31 October, so we say November is the first month—we did have abatements or KPI misses or penalties that were applied to the contract.

The Hon. WALT SECORD: Did you apply any penalties to yourself?

Mr GAMEREN: That happens through the contract, yes.

The Hon. WALT SECORD: You did? What were the penalties that you apply to yourself?

Mr GAMEREN: The key KPI was that patients spent over 24 hours in the emergency department. They were cared for in a bay and they had clinical care via a range of specialist clinicians; however, they were not moved into a ward bed or discharged within that time frame. It is important to know that we also have a short-stay unit within the emergency department.

The Hon. WALT SECORD: Do you have many patients who wait longer than 24 hours in the emergency department?

Mr GAMEREN: That happened in November. In November we had 17 incidences where patients stayed over 24 hours.

The Hon. WALT SECORD: What was the longest stay in the emergency department?

Mr GAMEREN: Shortly over 24 hours. Nobody stayed over—

The Hon. WALT SECORD: So 17 patients spent 24 hours in the emergency department?

Mr GAMEREN: Yes.

The Hon. WALT SECORD: Do you have a close relationship with the NSW Health?

Mr GAMEREN: Yes, we do.

The Hon. WALT SECORD: Do you talk to them regularly?

Mr GAMEREN: They have helped us through that early stage by providing support people on the site et cetera, looking at our processes and working with our clinical teams within the emergency department.

The Hon. WALT SECORD: Did you talk to NSW Health about the evidence that you are providing here today?

Mr GAMEREN: No.

The Hon. WALT SECORD: Can we go back to the opening of the hospital. Was the hospital ready to be opened when it was opened?

Mr GAMEREN: That is a matter for debate, obviously, but we think it was. We had had the independent verifier, the Australian Council of Healthcare Standards, and the Ministry of Health Regulation and Compliance Unit all certify the hospital that it was ready to go.

The Hon. WALT SECORD: Where would somebody get a copy of that report by the verifier? independent

Mr GAMEREN: I will take that on notice.

The Hon. WALT SECORD: Could you provide a copy of that report to the Committee, please?

Mr GAMEREN: I will take advice on that.

The Hon. WALT SECORD: Are you confident and happy with the current level of patient care that is provided to public patients at the hospital?

Mr GAMEREN: Yes, I am.

The Hon. WALT SECORD: What would you say to the submission from the Health Services Union [HSU] that says that staff on duty are told to give hot breakfasts to private patients and cold meals to public patients?

Mr GAMEREN: There is a standardised system and public patients can request hot breakfasts as well.

The Hon. WALT SECORD: Do people at the Northern Beaches Hospital who are public patients advise that they can ask for a hot breakfast?

Mr GAMEREN: All patients are reviewed by dieticians. It will depend on their diet—depend on the type of operation and treatment they have been receiving. So all of those things need to be reviewed but if it is appropriate and they request it, they can receive it.

The Hon. WALT SECORD: Back to the patient care: Are you familiar with something called sentinel events?

Mr GAMEREN: Yes.

The Hon. WALT SECORD: Actually, maybe I would like to ask the director of medical services about that. Are you familiar with sentinel events?

Dr WOODS: Yes, I am.

The Hon. WALT SECORD: Can you describe what a sentinel event is?

Dr WOODS: Sentinel events are clinical adverse events affecting patients, or they can also be near misses that have the potential to affect patients. They are defined slightly differently from State to State, but essentially they identify a range of events that all healthcare systems strive to never happen.

The Hon. WALT SECORD: They are unplanned deaths—unexpected deaths.

Dr WOODS: That is one type of sentinel event. It is certainly not every unexpected death, nor does every sentinel event relate to a death.

The Hon. WALT SECORD: How many sentinel events have occurred at the Northern Beaches Hospital?

Dr WOODS: The exact number I would have to take on notice, but I am aware of two which have been subjected to the full RCA—that is a root cause analysis. It is important to note that the final determination on whether something is a sentinel event occurs after the completion of a root cause analysis.

The Hon. WALT SECORD: But sentinel events are quite rare in the health and hospital system. You would probably have between 15 to 18 for the entire State. Is that correct?

Dr WOODS: There would be more than that.

The Hon. WALT SECORD: More than that?

Dr WOODS: Yes.

The Hon. WALT SECORD: The latest information from Health is that. But you had two sentinel events at the hospital. Tell me about procedures that occur at the Northern Beaches Hospital. For sheer volume for procedures that would occur on the premises of the hospital, what would be the largest area of procedures? For example, orthopaedics, deliveries?

Dr WOODS: It would be medical care: care of patients who do not require procedures or, if they do, often relatively minor procedures. So it is patients with medical conditions, whether they be chest infections, chest pain, delirium, stroke. As does any hospital that has a large emergency department, we have a large volume of, essentially, elderly complex patients, often with a number of comorbidities. By volume, that would be the largest group.

The Hon. WALT SECORD: I have been advised—correct me if I am wrong, but orthopaedics and that would be—if you were going to narrow it down to a pool of procedures, that orthopaedics would be one of those pools. Is that correct?

Dr WOODS: So if we are talking—

The Hon. WALT SECORD: Procedures.

Dr WOODS: —strictly about procedures that occur in an operating theatre environment, yes, orthopaedics.

The Hon. WALT SECORD: Is it correct that orthopaedics are—how do I say—quite lucrative for a private facility to do, compared to complex procedures? You can get a lot of people in and out and move through a lot of procedures quickly?

Dr WOODS: Could I clarify—you are asking about the profitability, in a private setting, of various specialty groups? Is that correct? Not the public side of it?

The Hon. WALT SECORD: I think you and I both know where I am going. I guess I will cut to the chase here. It has been put to me by doctors in the health and hospital system that you are doing things like orthopaedics because they are high volume and profitable, and sending more complex procedures to Royal North Shore Hospital.

Dr WOODS: I am sorry, Mr Secord. Could you just clarify—are we talking about the running of a private hospital or are you talking about the patients who seek care as public patients?

The Hon. WALT SECORD: I would say people seeking care as public patients.

Dr WOODS: So the vast majority of patients who present either as emergencies or electively with orthopaedic surgical requirements are managed at Northern Beaches Hospital. It is true that a small number of patients have presented to the emergency department with, for instance, complex pelvic fractures requiring internal fixation, and such procedures sit outside our role delineation. So a small number of such patients are transferred, but certainly far and away the majority are managed on site.

The Hon. WALT SECORD: In earlier evidence there was an exchange about the Bureau of Health Information's data, and the September to December data was unavailable for the Northern Beaches Hospital. I think they were described by the Bureau of Health Information as "challenges". Have you overcome those information technology challenges? And what were those challenges?

Dr WOODS: I think that you are most probably referring to some of the measures of time to be seen in the emergency department and time within the emergency department. It is true that there were challenges relating to the interface between the electronic medical record and the patient administration system. Doctors and nurses work within the EMR—the electronic medical record—but it is the patient administration system that actually tracks the clock, the time at which various events occur.

The Hon. WALT SECORD: But are you now able to track times, waits, procedures?

Dr WOODS: Yes, I am pleased to say we are.

The Hon. WALT SECORD: That must have been difficult for doctors and patients if you did not have an information technology system that was able to track this data.

Dr WOODS: I do not believe that it had any effect on clinical care. It did appear to reflect poorly on the productivity and efficiency in the emergency department. In order to clarify that, that is why the Bureau of Health Information [BHI] came and did a direct observational study to—

The Hon. WALT SECORD: Okay, but isn't productivity and efficiency euphemisms in an emergency department to mean patient care?

Mr ROYLE: No, sir. It is actually related to the administrative issues of how you actually measure it. It is not in relation to clinical care.

The Hon. WALT SECORD: Are there still problems at the hospital involving supervision of young doctors? I understand that there were reports from the Australian Salaried Medical Officers Federation [ASMOF] here, and the Australian Medical Association [AMA] also, of 110-hour work weeks for junior doctors. What are you doing in that area?

Dr WOODS: Yes, it is true that the workload on the doctors and nurses—both senior doctors and junior doctors—early on after the opening of the hospital was, for some specialties, excessive. The hospital recruited, both directly and with the aid of the local health district, additional junior medical officers and has also undertaken some expansion of the clinical teams, and that has been augmented by further junior medical officers. We are monitored in this area by a range of external agencies—HETI and the various colleges—who regularly come and inspect our training. I think it is common knowledge that the first inspection by HETI identified that the doctors and the system in general was under stress. It is also fair to say—

The CHAIR: Sorry to interrupt your response. Just for the purpose of Hansard, what is the acronym?

Dr WOODS: HETI is Health Education and Training Institute. It has direct responsibility for junior doctors in the first years of their training. Then, as they progress on to higher levels of training, they generally come under the jurisdiction of the various colleges, like the college of emergency medicine, obstetricians and gynaecologists, physicians, anaesthetists, orthopaedic association, college of surgeons, college of psychiatrists. All of those bodies at various times have come and inspected training programs and, I am pleased to say, have accredited all of the training positions.

The Hon. WALT SECORD: Are there any vacancies in the senior staffing positions in the hospital at the moment?

Dr WOODS: Not specifically. I would like to recruit a couple more dermatologists. That is actively underway. They are necessary to provide consultative services to inpatients. Above that, if anything the number of doctors requesting to be credentialed and to work at the hospital exceeds our capacity to provide them with positions.

The Hon. WALT SECORD: I just want to get this right. The CEO was Deborah Latta. She resigned; she departed. The Director of Medical Services, Dr Louise Messara resigned; left. He head of anaesthetics, Alistair Boyce left. A second senior anaesthetist left, and the director of nursing Moran Wasson left. Is that correct?

Dr WOODS: Yes, that is correct.

The Hon. WALT SECORD: What were the circumstances of the departure of Deborah Latta?

Mr GAMEREN: I appreciate that there has been a lot of media coverage on some of the high profile positions leaving the hospital but those matters are for those individuals' own employment circumstances. With respect to them and the privacy of those matters, I do not propose to talk about it in this public inquiry.

The Hon. WALT SECORD: Okay, I will move to another part, because the same answer could be applied to the other six positions. Have there been any amendments or variations to the contract between NSW Health and Healthscope since it was signed?

Mr ROYLE: No, there have not.

The Hon. WALT SECORD: There have not?

Mr ROYLE: Certainly not to my knowledge.

The Hon. WALT SECORD: Great. Can you explain to me how the monthly payments work involving NSW Health and Healthscope?

Mr SPILLANE: I can explain that for you, Mr Secord. Northern Beaches Hospital is funded on a basis that is almost identical in all respects to the way that all other New South Wales public hospitals are funded. It is an activity based funding formula which has been agreed nationally with the Commonwealth. Against that background, we submit an activity statement to the local health district that identifies the types, volume and acuity of patients that we have treated during the month based on the diagnosis related grouping code that is assigned to their care. On the basis of that a formula is applied to calculate a payment amount.

The Hon. WALT SECORD: We heard from previous evidence that the hospital now has 350 beds. Originally it was going to be 488. Was that a change in the contract or were the numbers—

Mr ROYLE: Can I just start to respond to that, and I will ask Mr Spillane to detail. First of all I agree with the previous commentary from the department around beds. However, there is always a focus around beds. The actual numbers, as I understand them, are as follows. There are currently 291 public acute beds available and, at times, used at Northern Beaches Hospital. There were 279 in Mona Vale and Manly public hospitals. The reason there were more than that is because there are a number of rehabilitation—called non-acute—beds which continue to be provided in different formats not part of the contract for Northern Beaches Hospital.

The Hon. WALT SECORD: So there are 12 more beds at the new hospital—

Mr ROYLE: And can I point out, please, that the whole issue of demand planning is very much related to what technology is doing and what the demand is for overnight beds.

The Hon. WALT SECORD: How do you define a bed? No, you may laugh, but is a bed a bed or is it—

Mr ROYLE: We laugh, sir, because that is a very common question of the health industry, I can assure you.

The Hon. WALT SECORD: Originally we were told 488. Then we were told 350. Now you are saying 291.

Mr ROYLE: Now, I am saying there are 291 public beds. Then there are also private beds.

The Hon. WALT SECORD: How many private beds are there?

Mr ROYLE: I believe 190-odd. I think it is a total of 488, sir.

The Hon. WALT SECORD: That does not add up to 488. That adds up to 391.

Mr ROYLE: No.

The Hon. WALT SECORD: 291 plus 100—

Mr ROYLE: No, 195.

The Hon. WALT SECORD: To go back to my question: Is a bed, a bed?

Mr ROYLE: Yes, it is. A bed is a bed.

The Hon. WALT SECORD: So, a chair is not a bed; a bed is a bed.

Mr ROYLE: I will let Mr Spillane answer the details.

The Hon. WALT SECORD: I am just checking.

Mr SPILLANE: I can give you a breakdown, Mr Secord.

The Hon. WALT SECORD: I would like a breakdown on how many beds there are at—

Mr SPILLANE: As per our licence issued by the NSW Health private licensing branch, we are licensed for 486 beds.

The Hon. WALT SECORD: Licensed.

Mr SPILLANE: Licensed. So, 439 are overnight beds, 41 are emergency department [ED] treatment spaces and six are paediatric short-stay beds. That means they are paediatric patients—young children. They cannot stay in a bed for any more than 24 hours. That adds up to 486 beds.

The Hon. WALT SECORD: So, if we go to the Northern Beaches Hospital today we will find that there are 486 beds with patients in those beds.

Mr SPILLANE: No, as of last night there are 363 patients in beds in the hospital—187 are public and 176 are private.

Ms CATE FAEHRMANN: Did the contract require the closure of acute services at both Mona Vale and Manly hospitals simultaneously with the opening of Northern Beaches Hospital? I am assuming that you are all very aware of the details of the contract.

Mr ROYLE: Yes, they did.

Ms CATE FAEHRMANN: I also asked the previous witnesses: Did the contract require Healthscope to provide the services that were available for free for public patients at Mona Vale and Manly hospitals for free at the Northern Beaches Hospital?

Dr WOODS: It was not expressed exactly in those terms. The contract with Healthscope required a range of outpatient services. Those outpatient services within the contract are being delivered.

Ms CATE FAEHRMANN: For free?

Dr WOODS: Correct. As the previous witnesses attested, some of the services that previously existed at Manly and Mona Vale remained at Mona Vale. They also enhanced services elsewhere within the local health district. Essentially, Healthscope has provided those services that it has been contracted to provide. I have read in the submissions that concern had arisen around a number of services which were thought by the local community to be publically funded outpatient services that previously existed.

Ms CATE FAEHRMANN: Yes.

Dr WOODS: In fact, what we have learnt is that there were some services which were provided on a bulk-billing, private, fee-for-service basis by independent doctors based at those hospitals to the community and to referring general practitioners. It looked like these were publically funded outpatient services. They were not, and they did not form part of the contract that we have been asked to fill.

Ms CATE FAEHRMANN: Just to get this straight. You have only now noticed that in the contract it was not every service that was provided at Manly and Mona Vale free—you have only now realised that some of those services are not in the contract for Northern Beaches Hospital to provide for free for public patients for those services.

Dr WOODS: I think it would be fair to say that that is more a question for the local health district, which has the overall holistic view of the health services in the district. As I said, we have delivered on those services which we have been contracted to provide.

Ms CATE FAEHRMANN: Services such as angiograms?

Dr WOODS: Yes.

Ms CATE FAEHRMANN: There are quite a few submissions in relation to cardio services particularly, which are no longer available for public patients for free. Is that correct?

Dr WOODS: I am aware that that is alluded to in the submissions but perhaps I could clarify. Northern Beaches Hospital has a cardiac catheter lab, where coronary angiograms are undertaken. That facility did not exist prior to Northern Beaches Hospital—

Ms CATE FAEHRMANN: Those services are available for private patients, I assume, at Northern Beaches Hospital?

Mr ROYLE: Private and some public.

Ms CATE FAEHRMANN: Define "some public"? Public patients who can pay for them?

Mr ROYLE: No, nothing to do with payment. As Ms Willcox alluded to before, there are decisions made by the ambulance based on the ambulance matrix. The ambulance has currently been directed not to bring patients who appear to be having a heart attack to Northern Beaches. That is not part of the service that we were asked to provide. Nonetheless, some patients do attend—either of their own volition or where it is not apparent initially to the ambulance that they have a cardiac syndrome. Under those circumstances they are provided with care, including coronary angiography, at no cost as part of the contracted services.

Ms CATE FAEHRMANN: That is extraordinary. There could be some patients living five or 10 kilometres away from the Northern Beaches Hospital, having a heart attack and unable to go to the Northern Beaches Hospital and have to go—where do they go?

Mr ROYLE: They go to where they went before, which is Royal North Shore—

Ms CATE FAEHRMANN: Manly? Mona Vale?

Mr ROYLE: No. Can I stress that Manly and Mona Vale could not care for those patients at all. They have always gone to Royal North Shore; some of them now come to Northern Beaches.

Ms CATE FAEHRMANN: I think we have received some submissions about patients being treated in emergency in Mona Vale for—

Mr ROYLE: Mona Vale has an acute-care centre, which is like a lower-tier emergency department. It does not have the capability of providing definitive treatment to patients with acute coronary syndromes— that is, heart attacks and the like. I think, to be clear, that those services were never available in the northern beaches area before. There is now a significant increase—

Ms CATE FAEHRMANN: It potentially would have been a good idea to have those services available, though, in the big new hospital that the Government was boasting about, surely?

Mr ROYLE: That continues to be a point of negotiation with the ministry.

Ms CATE FAEHRMANN: Okay. Back to the contract: What public health services does the contract require NSW Health to refrain from providing at Mona Vale, Manly and any other hospitals now or at any point during the next 40 years?

Mr ROYLE: I'm sorry, could you—

Ms CATE FAEHRMANN: So are there public health services that the contract specifically requires not to be provided?

Mr ROYLE: By Northern Beaches?

Ms CATE FAEHRMANN: Yes, by Northern Beaches.

Mr ROYLE: The way it is framed is not in terms of what is not to be provided; it is framed in terms of what is to be provided. In general terms that is in accordance with what is called a "level 5 hospital", which is part of the role delineation defined by NSW Health.

Ms CATE FAEHRMANN: For the private part of the hospital, a level 5?

Mr ROYLE: No. The public services are defined and documented in the clinical services delivery plan to a level 5 hospital level of complexity, whereas the previous two hospitals were at level 4. As has been alluded to before, that means that there is a range of additional services and also the ability to treat more complex patients.

Ms CATE FAEHRMANN: We hearing quite a bit from submissions made to this inquiry that patients are being pressured to go into the private system when they arrive at the emergency department. Is that correct?

Mr ROYLE: Mr Spillane?

Mr SPILLANE: No, that is not correct. Like every other public hospital in New South Wales we employ patient liaison officers in the emergency department. Their role is essentially a customer service function in accordance with Medicare principles—we all have the right to be either be treated as a public or private patient on election to any public hospital in New South Wales. Those patient liaison officers are there to inform patients of their choices and assist with the administration of their admission.

Ms CATE FAEHRMANN: Quite a few submissions are saying that the patients felt pressured to use their private health insurance. Are you saying here that no pressure has been placed on patients presenting to the emergency department to use their private health insurance if they are wanting to go public?

Mr SPILLANE: That is correct. We strictly adhere to NSW Health policy with respect to the election of private patient or public patient status on admission to a hospital.

Ms CATE FAEHRMANN: What services can a private patient at Northern Beaches Hospital expect to receive that a public patient cannot?

Mr ROYLE: Northern Beaches does have some capabilities above level 5. At the present time those services are cardiothoracic—that is, open-heart surgery—and neurosurgery. At the present time, as we have been contracted to provide those public services to the level 5 role delineation they are not within scope. Nonetheless, we have that capability and we have specialists providing those services.

Ms CATE FAEHRMANN: Did you ask or suggest to NSW Health that you could provide neurosurgery and cardiothoracic services for public patients? Did you put that to NSW Health?

Mr ROYLE: Are you referring to in the build-up to the development of the contract?

Ms CATE FAEHRMANN: At whatever stage.

Mr ROYLE: Mr Gameren?

Mr GAMEREN: NSW Health was aware that we were providing those services and it is on its licence.

Ms CATE FAEHRMANN: To private patients, when you say that, sorry?

Mr GAMEREN: Yes, they were aware we were planning to provide those services in time. You should note that they are complex services. We actually started cardiothoracic services after the hospital was opened. Those kinds—

Ms CATE FAEHRMANN: But NSW Health—

The CHAIR: Hang on.

Ms CATE FAEHRMANN: —just to finish on this, it was aware that you were providing neurosurgery and cardiothoracic surgery for private patients only, not public patients?

Mr GAMEREN: Sorry, could you repeat the question?

Ms CATE FAEHRMANN: NSW Health was aware that public patients would not be provided with those services. Were you requesting for those services to be provided to public patients at the new hospital?

Mr GAMEREN: I was not part of the project team that was putting those proposals to the Government or discussing those proposals at that time, which was probably 2014-15. However, the schedules under the deed allow for discussion of the provision of extra services at any time between the parties.

The Hon. EMMA HURST: Thank you all for coming today. Just to follow on from my colleague Ms Cate Faehrmann in regards to the claims and submissions from patients that they are being pressured into

using private health cover: In light of the submissions—and I understand that you do not feel, from the evidence that you gave, that that was happening—but given that submissions in this inquiry have suggested otherwise, do you have any plans to conduct any further investigations into those claims?

Mr SPILLANE: We take those claims all very seriously. We will review our literature that we provide patients to inform them of their rights under Medicare and also engage with our patient liaison officer teams to ensure that they are offering an information and customer-service function.

The Hon. EMMA HURST: Thank you. Sorry to return to the bed issue. You gave a really good breakdown of the 486 beds for the entire hospital. Could I get a breakdown specifically of the 291 public beds and how they are broken down?

Dr WOODS: Perhaps if I could assist you. As happens right across Australia, beds are not the basis on which contracts and agreements for provision of clinical services are based—

Mr ROYLE: Nor funding.

Dr WOODS: —or funded, it is based on the services. Now, to a certain extent, when you have an emergency department and when you have the normal seasonal fluctuations, there are ebbs and flows in the number of beds allocated to particular specialties. So, for instance, right at the moment, we have a significantly larger number of patients with respiratory conditions than we will anticipate having in February, but come December and January, we are going to have a lot of babies being born. Whilst we have general allocation of beds to mental health—

The Hon. SHAYNE MALLARD: Cold winter.

Dr WOODS: —I think it was Christmas—Whilst we have general broad areas of the maternity ward, the mental health wards, the coronary care unit, there is a lot of flex. Not to be evasive about this, but our job day to day is to provide the appropriate number and the appropriate beds to deal with the demand. We are purely driven by demand and clinical need rather than perhaps in the old days when you could say, "There is no bed in the orthopaedic ward so you'll have to wait in the emergency department". We will flex and there is a whole team responsible 24/7 for ensuring that the patients get an appropriate bed.

The Hon. EMMA HURST: Those 291 beds can be used for any purpose generally?

Dr WOODS: Within limits: Clearly you cannot use the special care nursery cot for any other purpose. There is some redundancy in the system. It is also important to recognise that there is not a clear distinction in our mind between—at least in most areas—the public and the private beds. Patients will, as we call it, surge from one area and into the other because we will put them where the care is—we will bring the care to the patient.

The Hon. EMMA HURST: What advantages do you think there are, if any, to this particular community of the public-private partnership model over a public hospital?

Mr ROYLE: Let me start by answering that question. As indicated from the ministry's attendance here earlier, one of the benefits for the taxpayer is that there is, in fact, a reduced payment that comes on a per-case basis as a result of the shared infrastructure in the public-private interface. That is a statement of fact. We believe that the services we are now offering—the expanded range of services and the ability we have to engage well with our medical community, which we are doing very strongly—demonstrate a very strong team engagement. I cannot say it does not occur in the public sector system, I am simply saying that we are demonstrating quite clearly that that is occurring now at the Northern Beaches Hospital.

Dr WOODS: If I could please add to that? One of the real strengths of this arrangement is the ability for specialist doctors to co-locate their practice. As an ex-surgeon who had appointments in both public and private, I experienced what many doctors do: constantly having to commute back-and-forth, which is wasted time and also a source of stress and anxiety if you are concerned about the patient at your public hospital whilst going to attend a patient at a private hospital. In addition to those economies of scale, there are great attractions for specialists to co-locate their practice: It is safer because those doctors spend more time on site and it leads to better engagement with those medical practitioners because it becomes very much their hospital. Coming into this from the outside, in December what I was absolutely struck by was the commitment of the specialists to this being their hospital and where they saw their future.

The Hon. EMMA HURST: In your submission, you referred to positive indicators to show that the hospital is doing well or improving. I am not sure if any of you have had a chance to review the submission that we received from the NSW Nurses and Midwives' Association. They included statistics around the waiting time for treatment in the Northern Beaches emergency department. I know we have talked a little bit about the 24-hour

wait. On table seven they indicate the waiting time and that a breakdown of the waiting time is higher and significantly worse compared to Manly and Mona Vale hospitals. Do you have a response to those figures?

Dr WOODS: Yes, I think that links in with the information I provided earlier about our information technology [IT] challenges early on. There is no doubt that the data, as reported, was uncomplimentary. It was a concern to us, naturally. Our staff were telling us that it was not a true representation of what they were seeing and that is why we sought independent verification with an on-site visit and time and motion observational studies from the Bureau of Health Information, which, prior to us being able to fix the IT system, confirmed that, in fact, our staff were right and that they were delivering timely care.

The Hon. EMMA HURST: It has also been suggested that a lack of permanent, full-time staff at Northern Beaches Hospital is part of a cost-saving strategy. Do you have a response to that?

Mr ROYLE: Yes, I do. Thank you very much. As it stands at the moment, we have nearly 1,800 staff at the hospital: 43 per cent of them full-time, 28 per cent are part-time and 29 per cent are casual. It is not uncommon for a public or a private hospital to staff casual because it will depend on the volume and the activity. Given that we have to pay additional premiums for casual rates that is not a cost saving efficiency measure; it is actually a measure to try to ensure that you get the appropriate levels of staffing with appropriate resourcing that is required for the demand at the time. We only currently have 34 full-time equivalent vacancies and we have recruited very strongly in recent times.

The Hon. EMMA HURST: Would you disagree that there are ongoing problems with the staffing levels at the hospital?

Mr ROYLE: I disagree with that statement.

Ms CATE FAEHRMANN: Could you provide the Committee with a breakdown of those positions. When you said full-time equivalent, I think you said 43 per cent. Is that correct?

Mr ROYLE: Correct.

Ms CATE FAEHRMANN: Would we be able to have a breakdown of each: what those full-time equivalent represent in terms of junior doctors, senior doctors, nurses and other staff?

Mr ROYLE: I cannot see an issue with that detail being provided.

Dr WOODS: I clarify, Ms Faehrmann, that the majority of the junior medical staff, whilst they are seconded to Northern Beaches Hospital, are actually directly employed by the local health district, as is common with many others so they do not actually fit within our human resources statistics.

Ms CATE FAEHRMANN: Is there a reason why in the project deed, I think, the targets in relation to maternity services have been redacted in the summary that is available for public viewing?

Mr ROYLE: I have no knowledge of that; I apologise. I would have to refer that to the ministry. I really do not know.

Ms CATE FAEHRMANN: So would it be the Minister who would have redacted it? Would you be able to—

Mr ROYLE: I am sorry, I have no idea on that.

The CHAIR: Just take it on notice.

Ms CATE FAEHRMANN: It is highly unusual, I believe.

The CHAIR: Mr Royle might take that on notice.

The Hon. NATASHA MACLAREN-JONES: Before I move to questions, I want to get more information about a question asked by my colleague the Hon. Walt Secord in relation to claims through some of the submissions that patients were being transferred to other hospitals. I note in your submission you say that under the project deed this cannot occur. I am interested to find out how that is monitored to ensure that patients are not being transferred inappropriately to other hospitals, as has been claimed?

Dr WOODS: It is possible and necessary to refer some patients who have conditions that sit outside our role delineation. They are complex requirements. For instance, with paediatric surgery, there is a metro-wide plan where children under the age of 12 go to centralised services. There are also issues around the management of trauma—we are not a major trauma centre, for instance. There are also some surgical conditions that sit outside a level 5 role delineation. Some of the really major surgical procedures like removal of a cancer of the oesophagus or a cancer of the pancreas are not currently within our role delineation. We have to distinguish between transfers

that are occurring as a planned, accepted matter of course, but on the other hand that we are not unnecessarily transferring patients and that it may be, in some ways, a reflection of our inability to provide those services. That is regularly and actively monitored. It is a regular agenda item with the local health district and we are very happy with the way that that process is going.

The Hon. NATASHA MACLAREN-JONES: You work with a number of other hospitals, not just in New South Wales, but across Australia. Is the model for the Northern Beaches Hospital similar to others, or is this a new model of care?

Mr GAMEREN: For Healthscope, it is a new model of care.

The Hon. NATASHA MACLAREN-JONES: I asked staff at the Department of Health about procedures and protocols when the hospital was opened and they said that a number of manuals were passed over. How much of that material has been implemented? Where is that up to now?

Mr GAMEREN: We had over 600 policies and procedures on opening. We appointed a project officer who has done nothing but work with policies and procedures. He is a senior educator. He has worked with all the department heads, the doctors in charge of the different specialty groups, as a form of control, and reviewed all of those. He has used the local health district policies or other policies that go through a committee and are ratified. They are all now in place. We have all policies and procedures in place at the hospital now.

The Hon. NATASHA MACLAREN-JONES: One of the submissions claims that Healthscope do not have the experience to provide maternity care. Do you have a view on that?

Mr GAMEREN: We provide a huge range of maternity services nationally. Something like 18 or 19 per cent of every baby born in Australia is born in a Healthscope hospital, so I would dispute that.

The Hon. SHAYNE MALLARD: It was 11,800 last financial year.

The Hon. NATASHA MACLAREN-JONES: So the care they provide and the experience in delivering maternity care at the Northern Beaches Hospital is similar to what you would provide anywhere else?

Mr GAMEREN: We do not provide public maternity services elsewhere in New South Wales but we birth babies at a range of different facilities across the country.

The Hon. NATASHA MACLAREN-JONES: Another issue that has been raised relates to community consultation in the lead-up to the design and building of the hospital. What engagement has been made with the community and with key stakeholders across the Northern Beaches—and also post the opening?

Mr GAMEREN: We have regular contact with a number of community groups now. I was not part of the project team that brought the hospital through to commissioning. However, we can provide that on notice. I am aware that hundreds of meetings occurred across the years prior to the hospital opening.

Mr ROYLE: In fairness, in almost every instance, we do that in conjunction with the Ministry.

The Hon. WES FANG: We have heard some commentary today about the junior doctors. In your submission you talk about the training positions offered in your hospital. Are there training positions that are now offered that were not previously offered at Mona Vale and Manly? You have said there have been a number of increases in those training positions since you opened, and the colleges who have visited. Can you expand a little bit on how the training is monitored? How it is being conducted and how happy are the colleges and trainees at the hospital?

Dr WOODS: Thank you. There is a range of advanced training positions which, I think, is what you are referring to. There is the pre-vocational training, which is overseen by the Health Education and Training Institute [HETI]—that is, doctors in their first couple of years of training. We have trainees in emergency medicine, obstetrics and gynaecology, psychiatry, anaesthesia, orthopaedics, general surgery and physician training. My understanding is that we had some trainees in all of those positions. I may be wrong but certainly we have seen an increase in the number of them across the board.

We have had visits from the relevant colleges, several of them on more than one occasion. As is typically the case with any new hospital, they grant provisional accreditation in the first instance and come back for a review at one year. So we have a number of those return visits coming up. Across the board, all of those trainees have some of our senior medical staff assigned to oversee their training. There are some extremely strong areas. I would single out psychiatry, mental health, for instance, where we now have approval from the college to have nine advanced trainees, which is a tremendous achievement. In fact, it has become one of the most sought after training positions in the State.

The Hon. WES FANG: Are there any training positions that were not previously offered at Manly and Mona Vale that you now offer?

Dr WOODS: I am not sure. I believe that there were representatives from each of those specialties but certainly not in the numbers.

Mr ROYLE: We could take that on notice and provide that detail.

The Hon. SHAYNE MALLARD: Thank you for being here today and thank you for your submission. I want to note on record your frank admission in your letter to the enquiry that there were some problems at the beginning. I note on page 5 of your submission that you outline Healthscope's experience. It is a serious health player in Australia with 43 hospitals, 12 co-located with public hospitals, 5,000 beds, 620,000 patients, and so forth. You are one of the leading health providers in Australia.

Mr ROYLE: That is correct.

The Hon. SHAYNE MALLARD: In New South Wales, you are involved with service provision in hospitals at Campbelltown, Hunter Valley, Nepean, Newcastle and Prince of Wales. This is not a new thing for you; maybe a different model. It is a very complex beast to launch a new hospital of this magnitude and complexity. I was likening it to an aircraft carrier. With your experience, as regrettable as those teething problems were, and the impact on people, could you have foreseen some of those problems? Were they unforeseen? I guess they were seen. Were you able to deal with those, in your experience?

Mr ROYLE: It is a very challenging situation to commission a quite complex hospital. There is no doubt that every effort was made to undertake that to the best of our ability. As I have indicated, we have apologised for the fact that we fell short. I apologise to the community of the Northern Beaches because we clearly fell short there. Hindsight is a wonderful thing. The reality is that I am led to believe that there was no actual clinical harm provided to anybody during that time. There were some challenges and that is a great recognition of the support and the assistance that all of our staff did during that time.

The Hon. WALT SECORD: What about the patient that fell off the gurney?

The Hon. NATASHA MACLAREN-JONES: Point of order—

The Hon. WALT SECORD: I disagree with that evidence.

The CHAIR: Well, you might. But Mr Royle is speaking. Please continue Mr Royle.

The Hon. SHAYNE MALLARD: Had you completed your answer?

Mr ROYLE: Yes, I had.

The Hon. SHAYNE MALLARD: So 1,800 staff. Have there been industrial disputes in the commissioning of this hospital?

Mr GAMEREN: Certainly around the senior doctors' contracts there was some discussion as we were opening the hospital. That is now being dealt with and managed cooperatively and constructively with all parties around the table.

The Hon. SHAYNE MALLARD: You probably do not want to go into the detail then since you have settled it harmoniously. Any problems with the nurses or anything like that?

Mr GAMEREN: No. We will be renegotiating, obviously, with the New South Wales nurses union upcoming enterprise bargaining agreement next year.

The Hon. SHAYNE MALLARD: That is coming up now, is it? There is a bit of talk around being admitted and being identified as a private healthcare person. I have had that experience at St Vincent's. When you are presented at hospital in an emergency that is the last thing on your mind. If you have got health insurance and you realise it covers the cost of that, that is a weight off the public purse, is it not?

Mr GAMEREN: That is correct.

The Hon. SHAYNE MALLARD: That is what they told me at St Vincent's when they put me in the private channel: if you have got it and you are entitled to this, so take some weight off the public purse.

Mr GAMEREN: That is correct.

The Hon. SHAYNE MALLARD: That is an advantage to the taxpayer.

Mr GAMEREN: That is correct.

The Hon. SHAYNE MALLARD: That is identified.

Mr GAMEREN: Yes.

The Hon. SHAYNE MALLARD: If the person willingly goes down that path; they have already got private health insurance and they are willing to go down that path?

Mr GAMEREN: That is correct, yes.

The Hon. SHAYNE MALLARD: I think that is something that should be noted. Specialists are co-locating. What types of specialists have co-located to this hospital? You were saying that the advantage was that they co-locate there.

Mr GAMEREN: Sure—a full range of paediatricians, orthopaedic surgeons, obstetricians, cardiologists. We can provide a full list of those co-located to the hospital but there is a significant range of doctors who have their own rooms based at the hospital.

The Hon. SHAYNE MALLARD: If you provide that on notice you might also provide on notice which ones are new services to the Northern Beaches that might not have been available from the other two hospitals.

Mr GAMEREN: Sure. Pleased to do that.

The Hon. SHAYNE MALLARD: That is one of the advantages of this new and larger hospital.

Mr GAMEREN: Absolutely.

The Hon. SHAYNE MALLARD: And the PPP model. You are getting those specialists there.

Mr GAMEREN: Yes, that is correct.

The Hon. SHAYNE MALLARD: Is there an advantage to young doctors? You mentioned the younger doctors are still government employees but they are seconded into your hospital. Obviously, an advantage to them would be working alongside specialists at this level.

Mr GAMEREN: Certainly I do not think that model was unique to Northern Beaches. That is really the model in Australia, working with seniors as mentors and going through different post-graduate levels, but certainly having those doctors onsite is an advantage because they can bring up to the rooms or ask queries and get hold of the senior doctors very quickly.

The Hon. NATASHA MACLAREN-JONES: I have got just one question. There has obviously been a lot of media around the opening of the hospital and public forums and things. I am interested in the level of engagement you have had with your staff, particularly up until now, and the impacts of a lot of that and some of that negative media—what impact that has had on the staff, and particularly on morale?

The Hon. WALT SECORD: What about the patients?

The CHAIR: Order!

Mr GAMEREN: I think it is a source of regret for us all that those first weeks of the hospital opening were difficult. I think the pressure really was most focused on the medical staff—the nurses, the doctors and allied health staff—in providing care, and on clinical staff. They rose to the occasion, and that is fantastic. We thank them and value them greatly. We have taken a range of different activities from thanking people from having barbecues outside to newsletters. We have staff forums that are open for anyone to come and talk about things that need to improve and try to engage at all levels—be visible in the hospital and, really, try our level best to engage with all levels of staff up and down the organisation from the senior doctors right through to the cleaning teams. That has been really a feature of what we have tried to do after that initial start.

I think that is a testament to everyone at the hospital that they have really rallied around. They are very proud of where they are now. They are very proud of the services that they are able to provide. It is a source of pride, as the executives of the hospital, to be able to lead those teams. They have done an extraordinary job and we are very proud of and very thankful to them. We look forward to continuing to invest in that community and to provide excellent health care.

The Hon. NATASHA MACLAREN-JONES: I think that is reflected in a lot of the submissions we have received as well—those that are congratulating the staff and the team there for everything that they are doing to provide quality health care to the people of the northern beaches. I think it is fair to pass that on to the staff in appreciation of everything that they are doing under some difficult circumstances.

Mr GAMEREN: Thank you. We will.

The Hon. NATASHA MACLAREN-JONES: I just wanted to get a bit more of an understanding in relation to the information technology [IT] services. It was raised in the Health Education and Training Institute [HETI] review but it was also raised by the NSW Nurses and Midwives' Association. Could you please outline the concerns that have been raised and if they have been addressed as per the submission that the nurses association raised?

Mr ROYLE: Certainly. Having implemented the first fully digital hospital in the country seven years ago, I do have some experience in the digital side. The IT system was implemented from day one and it was operating. It clearly was not up to the level of standard of expectations. The good news from our perspective is that the software people, in conjunction with our doctors, have been working very solidly over the last eight months for significant improvements. There have been eight software upgrades during that time and this close cooperation now between the doctors and the IT developers is fundamental to success of any digital health implementation. It has been clearly demonstrated from a number of past disasters around Australia that unless you engage closely with the doctors you will have some challenges. We are delighted to see that that is actually now occurring.

The Hon. WES FANG: In your submission you talk about—we are going back to beds again—the number of beds but you said there is room to extend to the future. Would you be able to expand in detail on some of the ways in which the hospital can be used in an expanded form into the future for future-proofing?

Mr GAMEREN: I am aware that when the hospital was designed there were lots of soft spaces built in for expansion of certain services to expand into the footprint of the site itself, so with either private or public beds—whatever is required—then capital could be sought to expand the hospital. That has been built in. I guess one of the advantages of building now and not trying to renovate, for want of a better word, an existing hospital or do a development onto an existing site. Those planned or softer areas for expansion were built into the plan so that approvals could be sought through the appropriate channels and the hospital expanded into the future.

The Hon. WES FANG: The hospital is really designed for future-proofing, I guess?

Mr GAMEREN: Yes. Yes, that is correct.

The Hon. SHAYNE MALLARD: In your letter to us you talk about continual learning in terms of the experience you have been through and the now contemporary patient feedback and clinical outcome data showing that you have turned the corner. Do you want to outline some of that information? It says it is on the public website, so how can people pick it up on the website?

Dr WOODS: Perhaps if I can lead off with this, it may also assist Mr Secord. The vast majority of our patients have good clinical outcomes and a positive experience and we have objective data to support that. Naturally, like any health service, from time to time we have people with adverse events or whose experience has not been as they would wish. I can say, both as a hospital administrator but also having spent many years as a clinician, that that always distresses us. I think what we have seen in health care over the last 20 years is a shift in mindset from the idea that complaints are inevitable and that adverse events are inevitable to a completely different mindset which constantly strives to get closer and closer to zero harm and to achieve not only good clinical outcomes but a good patient and family experience. That is why we track both of those.

The objective data that we have and that is published is that on both counts we are doing well. Our level of hospital-acquired complications—you know, first, do no harm—is lower than the State average. Our number of unplanned readmissions, unplanned returns to theatre, falls, unplanned admissions to ICU are lower than the State average and, after that difficult start, our patient satisfaction by two measures—the one that is done across the State, which is the general patient satisfaction level—is higher than the State average but we also monitor across Healthscope the metric of a net promoter score and that is now also strongly positive which tells us that our patients are firmly of the view on the whole that they would recommend this hospital to their friends and family.

The CHAIR: Thank you, gentlemen. Thank you for attending this morning and this afternoon. Some questions have been taken on notice. Our procedure is to have a 21-day turnaround time. The secretariat will liaise with you in regards to the ones taken on notice and, arising from members reading the *Hansard*, there may well be some supplementary questions. They will be packaged up and provided to you. Thank you again for attending and providing testimony to this inquiry.

(The witnesses withdrew.)

(Luncheon adjournment)

HELENA MOONEY, Co-founder, Friends of Northern Beaches Maternity Services, sworn and examined

PHILLIP WALKER, Honorary Secretary, Friends of Mona Vale Hospital, affirmed and examined

PARRY THOMAS, Chairman, Save Mona Vale Hospital Community Action Group, sworn and examined

The CHAIR: Welcome to the afternoon session of the very important Inquiry into the Operation and Management of the Northern Beaches Hospital. Before I get underway, can I make it clear that this is a public hearing and we acknowledge the significant interest the community has into this inquiry, particularly the community of the Northern Beaches. I remind audience members that today is not an open forum for comment from the floor. Audience interruptions are not recorded in the transcript, and they make it difficult for witnesses to communicate with the Committee and, in particular, to respond to questions directed to them. Thank you all for coming along this afternoon to this important inquiry. For the record, can I confirm that, with respect to your three organisations, we have received your submissions. I think you would be aware that they have been processed by the secretariat.

The Save Mona Vale Hospital Community Action Group Inc. is submission 121, the Friends of Mona Vale Hospital is submission 211 and Friends of Northern Beaches Maternity Services is submission number 170. They have been received by the secretariat, processed and they have been published. All Committee members have had them now for a little while. You can take it as read that, with respect to its content, all Committee members have read your submissions. I say that for this reason: shortly I will invite each of you to make an opening statement of a few minutes. There is no need to go through a lot of detail; it is in your submissions. That would just take up time. We would like, as soon as practicable, to move to the questioning. I do not want to crimp you with what you want to say in your opening statement but the content has been read and perhaps you could focus on some broader, salient points you wish to draw to our attention to get the questioning underway.

Mr THOMAS: Good afternoon, everyone. Thanks for having us here today. Firstly, I want to underwrite the credibility of the organisation that I represent. My organisation has been in place now for nearly 20 years. It has been active for a significant number of those years and, unquestionably, it represents the community, as you can see beside me here. This happens to be the latest petition that we have got—there are 11,000 names in that— calling for the reinstatement of a level 3 acute services hospital on the Mona Vale site. We have now had probably in excess of 50,000 signatures over the years of people petitioning for acute services at Mona Vale. I had planned on covering a number of issues; however, I have to say that, after listening to the Healthscope evidence, there are a number of things that have come out of that that I would like to see addressed as we go through questioning—things like the IT information.

The latest report I have is that it is still 10 days before—this comes from the IT organisation—patient records can be transferred to doctors or other hospitals. They talk about beds, and this thing about beds is something that is very significant. Let's not forget that this hospital was never about delivering effective hospital services to the Northern Beaches. This hospital was about taking pressure off Royal North Shore, and that is one of the reasons why it is in this location, and it is about privatisation of health. The significant thing about that is that we have fewer beds—whatever they say; they might have had that number of beds at the time of closure, or in recent times—than were operating in those two hospitals. We have significant increase in services and we have a vastly increased catchment. So, a lot more patients, a lot more services and a similar number of beds, let's say. That is not going to work.

In addition to that, the population statistics that were used for the planning of these hospitals—in fact, the 2036 projections are already what we have. Sydney Commission is talking about another 40,000 in our area. That is really important. When we talk about patient quality, I have to say to you that I have stopped going to my local pharmacist because I cannot get out. I walk into my local pharmacist and I get listed all of the issues that keep coming. Our organisation did not want to be part of this Healthscope situation. It is not something that we wanted, it is not something that we really wanted to get involved in, but because of our representation of the community we have become a conduit. So we are inundated with people talking to us about the issues. I get them every day. I never, ever got any of that about Mona Vale or Manly. We get them every day, and we still get them. I think that is really important.

There is a solution, and the solution is logical to me; that is, this concept of co-location works if you have a public hospital beside a private hospital. It does not and it has not worked when you try and amalgamate the two. A really interesting example: they talked about not pressuring patients to go private. Page 25 of the deed that they have says they will use their best endeavours to make these patients go private. That is significant, and the reason for that is obvious: they are trying to reduce the cost for delivering health. It is logical when you have this crazy model. Split it apart, do what they have done on the Sunshine Coast, reopen Mona Vale Hospital to an

effective acute services with an aged emphasis—and they talked about their biggest load through casualty is aged—and I think that solves the issues. We want this hospital, we need it to work and we depend on it. If you lived at Bondi and I told you that you had to go to the Northern Beaches Hospital for your health services, your reaction would be shock and laughter. That is what the people from Avalon North have to do. That is the distance and that is the time. It is unacceptable and it needs to be fixed.

The CHAIR: Mr Walker, I invite you to make an opening statement.

Mr WALKER: Driving past our new hospital, I noticed the exterior metal cladding and the exterior fire stairs. Images of the London Grenfell Tower fire came to mind, and images of New York's retrofitted external fire stairs on their old apartment buildings. So I did a Government Information (Public Access) Act [GIPAA] application for the fire engineer's report for the Northern Beaches Hospital and this submission is that GIPAA response from the Department of Health. It needs to be read in the order that it was created. The fire brigade response is to the plans—read that first. Then read the fire engineer's report, which addresses the fire brigade's concerns. Under the present planning process, the fire brigade does not get the opportunity to comment on the fire engineer's report.

The only information received on the cladding was the half page that has been provided, indicating there is both steel and aluminium cladding on the building, but with no indication of the flammability of the foam insulation used as backing for the metal cladding. In the London Grenfell Tower fire, those that used the internal fire stairs escaped safely. If the cladding on our new hospital burns—and I do not know if it will or won't—the occupants will have to use the external fire stairs, protected from external fires only by the wing walls on the stairs.

The fire brigade called for additional studies of these external fire stairs, but the fire engineer dismissed the fire brigade's concerns. I do not know if the external fire stairs are safe and I request this Committee to find out for us to reassure the public that this building is safe for its occupants, that it is a place of refuge in a time of crisis and not a ticking time bomb. In the disclaimer at the commencement of the fire engineer's report it is stated that they have only investigated fires from a single ignition point, that they have not studied fires started with accelerant or explosives and that catastrophic events and catastrophic fires are outside their study. I ask this Committee to allocate resources to resolve these fire issues at the Northern Beaches Hospital. It comes down to three basic questions: Is the cladding flammable? Are the external fire stairs safe? Is the scope of the fire engineer's report wide enough?

Mrs MOONEY: Thank you for inviting us today. Before we start, we want to make clear that our concerns are with Healthscope, NSW Health and Northern Sydney Local Health District and the management of the process, not at all with the staff who work in the hospital. We completely support them. It is really important that you understand that with maternity services, private maternity care is very different to public maternity care. Private maternity care is obstetrician led with a high intervention rate. Public maternity care is largely midwife led with low intervention rates. The fact that we are having a public maternity service being run by a private hospital is really concerning for us. Healthscope have one of the highest intervention rates in the State. Just to give you a context, there are studies showing that a first-time healthy mum has a 20 per cent increased risk of ending up with intervention purely by going into a private hospital.

Our issue is not about whether people choose private or public; it is having a private hospital running public services. One of our main concerns is that Healthscope has zero experience in running public maternity services. Evidence about the design of the birthing suites—the birthing suites design was signed off by NSW Health and it was not until previous colleagues of mine from our organisation pointed out that there were no facilities for water births in the birthing suites that then things got changed. There was an opportunity to create really amazing, beautiful birthing suites. There are 10 birthing suites and now only three of them have a birthing pool in which a woman can give birth. We have insisted that that is categorised purely for public patients, which they are currently saying it is. But we want to ensure that that is enshrined, so no private patients accidentally get in there and detract from the public suites.

There is currently also a lack of basic equipment, such as there are no births mats, which are normally used to facilitate a normal physiological birth. Another thing is there is a lack of oversight and input from the Northern Sydney Local Health District. We had a couple of meetings with them including with two acting CEOs and it was reiterated to us how little influence they have on the new hospital and the day-to-day runnings. They just had to implement it because it was a political decision, and we found it very concerning that a health body that is meant to be responsible for public services in their domain had minimal impact. Thank you for asking about the reduction of KPIs in the Healthscope contract. It really does appear that there is no accountability or oversight of the actual outcomes that are going to happen for women and their babies. Some things have been changed as service levels, which seems to be meaningless without any accountability.

That brings me onto the lack of meaningful consumer engagement, which has also been raised today—thank you. We were told that there were two maternity consumer representatives and we have repeatedly asked over the years who they were and what they said. Considering that we are the only maternity consumer group on the Northern Beaches, the fact that we were not officially engaged is concerning and the fact that we were not able to find out what was said is also concerning. Then we also find out that they were actually two members of staff, which again negates the representation or the consumer side of it. We would say that—

The CHAIR: Sorry, when you said "of staff", what do you mean by that?

Mrs MOONEY: We were told that they were two members of staff who happen to have given birth.

The CHAIR: Staff of the hospital?

Mrs MOONEY: Northern Sydney Local Health District told us that they were members of staff. I am not sure of which organisation. We are interested to hear that they are engaging with consumer representatives, but we would like to know who and exactly what that engagement is. There is a standard partnering with consumers and it has different levels of engagement. We know that meaningful engagement has the best outcomes. One of our big things is there is a continuity of care with a known midwife, which is known as midwifery group practice [MGP]. This has been proven to have better outcomes for women and their babies, but the main form of care is fragmented. For us, there is a real financial conflict of interest in having a private company running highly profitable maternity services. It is not in their financial interest to expand this proven popular public form of care with midwifery group practice. We feel that that is a huge area of concern.

I want to touch on staffing levels. We still feel that the number of midwives is inadequate, particularly for the MGP program. There is too much reliance on agency staff, and this impacts induction rates and levels of care that women receive. There is a loss of community services. Deborah Willcox referred to the community centres, but we were told that antenatal services were going to be provided in Brookvale and Mona Vale—their purpose-built community centres—but we have since found out that Healthscope do not want to pay rent in those public holdings, so there are no in-community antenatal services. Our recommendations are that public maternity should not be in the hands of a private company seeking to make profit from it. At the very least, there need to be very clear and transparent procedures for ensuring that corporate financial interests do not govern the provision of public health services.

Healthscope needs to be held accountable for its outcomes. The KPIs, whatever they are, whether they have been redacted or not, we need to know what they are and they need to be held accountable for them. The public birth statistics need to be made available for us all to see. We are not going to find out officially until the end of next year, which will be the 2019 mothers and babies report. That will mean that two years will have gone by without us knowing what actual outcomes are happening in that hospital. We also request a significant expansion in the public midwifery group practice program to at least the NSW Health targets of 35 per cent and that there should be a formation of a maternity steering committee to include representatives from my organisation to ensure transparency and that optimal maternity services are provided. If there cannot be a specific maternity one then at least we need to be included on the general consumer advisory committee.

The CHAIR: I think you got everything in in record time. Those were very comprehensive opening statements, thank you all.

The Hon. WALT SECORD: Mrs Mooney, could we start with your oral evidence. You are putting forward the case that there is much more intervention taking place, the proposition that there is more intervention involving births at the Northern Beaches Hospital than necessary. Is that correct?

Mrs MOONEY: We have heard anecdotally that that has been the case, but because we cannot get access, which we have requested, to the health statistics, we cannot tell. That is why we are requesting that the health statistics are released earlier than at the end of next year.

The Hon. WALT SECORD: But you are getting anecdotal reports from mothers?

Mrs MOONEY: From midwives, who officially are not allowed to talk to us on the pain of losing their jobs. But they do talk to us.

The Hon. WALT SECORD: Do you think that it would be part of the business model to funnel patients, mums and babies, into a situation where there are interventions into the birth?

Mrs MOONEY: You can still have intervention through the public system. Our concern is the management of it. It is a very different approach to births, and our concern is that the private obstetric model will transfer into the public system. The midwives have to work with public and private patients.

The Hon. WALT SECORD: But it would be more financially lucrative for Healthscope to have the model that you are expressing concern about?

Mrs MOONEY: I do not think they would change people once they had booked in. I think that they want to make it suitably attractive, which is why something like the midwifery group practice program is deliberately small. That is a very appealing public service, which has continuity of care and people often choose the obstetric model because they get continuity of care. If they keep the public model really small then it makes the private model much more attractive for mums.

The Hon. WALT SECORD: Do you have an idea of the number of babies who have been born at the hospital so far?

Mrs MOONEY: We do not have any official statistics, no.

The Hon. WALT SECORD: Mr Thomas, do you think, from the evidence provided to you by members of your organisation, that there is a two-tier system and a preference for private patients?

Mr THOMAS: Anecdotally, yes, that is the case. We talked about midwifery and we even have different colour doors to enter into the same area if you are private versus public. You get different food offerings. We have had a number of people, though, I must say—even who have gone in private—who have told us they have just had to get out. But yes, anecdotally—we do not have the numbers but anecdotally, yes, you are correct.

The Hon. WALT SECORD: What about the evidence this morning that there are fewer beds than originally promised—that there was a promise made to the community that there would be more beds and more staff at the new hospital, but when you put Mona Vale and Manly together you end up with just a slight increase?

Mr THOMAS: It is very slight. The Manly and Mona Vale websites quoted the numbers of beds. When you went back through there, the numbers of beds quoted on those websites actually comes out at more than were in the new hospital. They are right: You need to take the beds that still exist in Mona Vale—the non-acute beds in Mona Vale. Remember, all acute services have gone from Mona Vale. They have always had a rehab there so Ms Willcox was wrong on that. That has always been there for many, many years.

The palliative care—I chaired the community committee that I believe and our committee certainly believes was instrumental in getting the additional palliative care beds at Mona Vale Hospital, so I am on the ground in these things as well. If you take that out, yes, I would say that you could toss a coin as to there is a few more or a few less. But I made the point, and I make it again, that that would be fine—the vast majority of patients who went to Mona Vale or Manly hospitals were from the beaches catchment. Frenchs Forest is not the northern beaches. They will hate me for saying that. I do not mean that in any negative sense, but I mean distance-wise the people who went to Mona Vale and Manly were from the beaches strip.

You add the population, you add the catchment—I know of people who have come from Turramurra. Many come from St Ives. Many come from Chatswood. All these areas dramatically increase potential for patients through a catchment. That is fine if that is the goal, but add to that similar numbers of beds; there is an issue and there will unquestionably be an issue. Yes, there is a change in how we treat—people are not in beds as long. The aged are, by the way, and the aged are in longer. He did make the point that the vast majority seem to be aged. So I think there are big issues there.

The Hon. WALT SECORD: I have had submissions and some of the confidential submissions make reference to that more complex procedures are being sent to Royal North Shore Hospital and they are putting procedures through that are more lucrative for Healthscope, such as orthopaedics.

Mr THOMAS: Yes, I heard that evidence.

The Hon. WALT SECORD: You have heard that evidence? Does that ring true with what people are telling you?

Mr THOMAS: Again, this is anecdotal, obviously. Yes, that is some of the feedback we get. It is a combination of, yes, it is more lucrative, but it is also a combination of private hospitals can be really good—not all, but can be really good at dealing with scheduled procedures. That is what typically private hospitals are all about. You ring up, your surgeon or whoever it is books you in—the specialist books you in for a procedure, you go in and you get it done. Should be all fine.

Where they are coming a cropper is this whole patient feed via emergency, which is not something they have got any experience with at all. In fact, when a very senior executive of Northern Beaches Hospital says to a very senior clinician who works there that they cannot believe—this executive could not believe how many sick people go to public hospitals, that tells you something about where the headspace is when you are dealing with private versus public. The correct model is co-location side by side, not co-location integrated.

The Hon. WALT SECORD: What was the context of the conversation that you just relayed to us?

Mr THOMAS: I got it from the clinician, who was somewhat flummoxed about it. But it was in the time when they were being absolutely smashed by everyone initially trying to use the emergency department from all over this vastly increased catchment.

The Hon. WALT SECORD: What were they using the emergency department for?

Mr THOMAS: They were going to emergency. They had a need to use it.

The Hon. WALT SECORD: They were using the emergency department for emergencies?

Mr THOMAS: Absolutely.

The Hon. WALT SECORD: And doctors were surprised by that?

Mr THOMAS: It was not the doctors who were surprised by that. It was the senior administrative people in Healthscope—the hospital.

The Hon. WALT SECORD: Let me get this correct: The hospital executives who are running the hospital were surprised that people in emergency situations were going to the emergency department?

Mr THOMAS: Yes. The comment was they could not believe how many sick people went to public hospitals.

The Hon. WALT SECORD: They were surprised that sick people were coming to a hospital?

Mr THOMAS: Yes. That was this one person; I stress that.

The Hon. SHAYNE MALLARD: You said a doctor, I suggest.

Mr THOMAS: I cannot tell you it was a doctor.

The Hon. WALT SECORD: The people running the hospital were saying this?

The Hon. WES FANG: Anecdotally, though, I might add.

Mr THOMAS: I cannot tell you if that was a clinician. I do not know that.

The CHAIR: Order! The gentleman has the question.

Mr THOMAS: That information was not passed to me if that was a clinician or not. It was explained to me as a senior executive of the hospital.

The Hon. WALT SECORD: At the very beginning, the Premier and the health Minister said that these were just teething problems. Have the teething problems been overcome?

Mr THOMAS: No, and they are not teething; they are systemic. There are unquestionably some teething problems. Of course it is a terribly complex thing and I do not want to belittle how hard it is to make a hospital work and get it to run. I certainly do not want to do that, and obviously not everything that happens goes wrong. But we hear so much that it cannot be just still teething. It cannot be. It has to be systemic, and I think part of that is the culture of private health delivery built around scheduled procedures. Once your hospital fills up and you have no control over how many people turn up and need beds—you have no control over that. You get any sort of emergency, it could be full; you get a flu, which is what he is talking about now as respiratory problems. It is the flu. They are not geared to that. Private hospitals typically do not treat that. Private hospitals treat scheduled procedures.

The Hon. WALT SECORD: The evidence in response from your community group was the hospital— the health bureaucrats and Healthscope this morning maintained that the hospital received its certificate of readiness and it was ready to take patients. What did the community think there?

Mr THOMAS: It is not ready to take patients if the nurses go down to Mona Vale Hospital and raid the skip bins to get supplies that do not exist in the hospital. The answer is no, it was not ready to take patients. You just do not do that. And not have body bags and so you have got people lying in the morgue—no body bags. Could not put them in the drawers—the drawers were the wrong size. There is a range of things and they were not ready.

The Hon. WALT SECORD: You mentioned Mona Vale Hospital.

Mr THOMAS: That is my passion.

The Hon. WALT SECORD: I know that your community organisation was involved in getting the health Minister to commit to keeping an urgent care centre there. What is your response to it? They will not call it an emergency department.

Mr THOMAS: It is not an emergency department; it is a medical centre. Urgent care centres have a role. They are really useful centres. We need an emergency department. It is far enough away and access is a big enough problem.

The Hon. WALT SECORD: What is the distance between Northern Beaches and Mona Vale?

Mr THOMAS: From the hospital, I think it is about 15 kilometres, 14 or 15 kilometres. It is about 28 kilometres from once you get to Avalon type areas, and it is through the bends so it is difficult to access. And then you have got to add the offshore people and the offshore communities. In fact, the last discussion we had with the Minister—I would like to point out that on camera he made a categorical commitment that nothing would be demolished at Mona Vale. I would like you to be aware that while we are sitting around here today, they are demolishing Mona Vale Hospital. So there are big issues.

The Hon. WALT SECORD: Mr Walker, you have raised issues on cladding. The Government has assured us that there are no problems with government buildings. Why have you taken it upon yourself to raise this matter? Do you have concerns about this?

Mr WALKER: It is just I was driving past, saw the cladding and aware of the issues. I noticed that the Government has spent considerable amount of money just recently taking cladding off four hospitals in New South Wales. I have tried to find out the flammability of this cladding. The GIPAA that I did has not given us that answer. The responses that we received—it was received only after going to a NSW Civil and Administrative Tribunal [NCAT] review and two case conferences.

The Hon. WALT SECORD: There was this thing—your inquiry, your GIPA.

Mr WALKER: Yes. It is now government information rather than freedom of information. In the past we used to have too much freedom, I think, and too much information. So we changed it to government information—it seems to be owned by the Government and they do not want to release it. So all I got was the half page on the cladding. That is as much as I know.

The Hon. WALT SECORD: Mr Thomas, have things settled down with staffing? You understand that there were six high-level departures. Do you have anything to add on the shift of staffing?

Mr THOMAS: No, only that we still get reports that a lot of agency nurses are being used over-night in the hospital. One of the great weaknesses with agency nurses is that they do not build a relationship with the patient. They are not close to the patient; they do not understand the patient. They are not necessarily trained in the systems that are in that hospital—the IT systems or whatever else they are using. So agency nurses tend to be used when, "We're really inundated; we need to top our staff up," not as a general rule, "Use the agency nurses." The feedback I get is that there are still significant numbers of them.

The Hon. WALT SECORD: This morning we heard evidence from Healthscope that in the last quarter 17 patients waiting longer than 24 hours in the emergency department. What is your response to that?

Mr THOMAS: First of all, I am staggered. Seventeen people waiting 24 hours for an emergency procedure—I just find that incomprehensible, quite honestly. However, it goes a lot further because what none of the statistics will tell you in anything you get out of the system at the moment, is all of those people who arrive there and do not wait, who go home or go elsewhere. We have had quite a number of cases. One that particularly comes to mind is a patient who, after having a heart attack, was transported there. That is an issue, by the way— transport—because now that you have the hospital a long way away, the ambulances are just not there. The ambulances are gone out of the area. We have had people get ambulances from out west to come down and pick them up.

Anyway, a patient was taken to the hospital after they had a heart attack and then proceeded for the next day and a half or two days to try and figure out how to get out of there and was continually told they were helping her get out, because she wanted to go to the San [Sydney Adventist Hospital] because that is where her heart specialist was and she had a history of it. She had a second heart attack. Using agency nurses, drug treatments— volumes—were incorrect on the drips. When leaving she requested notes for the nurse to say—as it was given to me—"There you are," to the ambulance man. It was a bundle of scrunched up papers. There were no notes. They arrived at the San and the San said, "What is this?" They papers went in the bin and they had to start again. Our advice is that that sort of thing is still happening.

The Hon. WALT SECORD: Take me through that again. This person showed up to the emergency department with chest pains.

Mr THOMAS: Yes. She actually had a heart attack. Was taken by ambulance. This person had a heart attack very close to an ambulance station, but that did not help because the ambulance had to come from somewhere else. Was taken by ambulance to the Northern Beaches Hospital. Was admitted. Was put on particular sorts of drugs. The feedback we have is that they got the quantities wrong, not because of the prescription but because of the agency nurse that was dealing with it. Then the patient had a second heart attack that evening. She was continually trying to say, "I want to be transferred, I want to be transferred." She was told she was going to be transferred but eventually—they had people at the San standing by waiting to treat the person and they just did not come because the transfer did not occur until well and truly at the end of the day. They were then transferred but the notes were non-existent. So they effectively had to the start the whole treatment regime again once they got to the San.

The Hon. WALT SECORD: We have heard before about the lack of notes and the lack of—

Mr THOMAS: Information systems.

The Hon. WALT SECORD: But the Government and Healthscope say that that has been fixed now.

Mr THOMAS: I have spent 50 years in IT. It has not been fixed.

The Hon. WALT SECORD: What about the comments by the Auditor General in December 2018, where she expressed concern that there is a cloak of secrecy over the hospital and she was unable to investigate the dealings at the hospital?

Mr THOMAS: The whole information is what we believe a community should have—and has ready access to when you are dealing with a public hospital. Just because it is run privately, it is delivering a service to public patients. The public patients and the community have the right to the same information out of that service as they would have if they were going to a public hospital. I can get on line any time I like and find out role delineation information about exactly what services are available in what hospital at what level—level 3, level 1 or level 2; whatever it is. There is a mix of levels. When they talk about a level 5 hospital that does not mean that all the services are provided at level 5. Some might be 3 and some might be 4. What is worse is that we do not really even know the details. That sort of information that the community has a right to know is not available. I know that half the GPs in the community do not even know. So they struggle in terms of referring people.

The Hon. WALT SECORD: So what do GPs tell your organisation about the hospital, because several have spoken out?

Mr THOMAS: Yes, they have. It is quite interesting. When we first started fighting this battle, back in 2000, and then had an inquiry on Mona Vale Hospital here in 2005, it was quite difficult to engage the clinicians. The clinicians wanted the bright, new, shiny hospital. We were not against that principle. Today, many clinicians speak out. I had radiologists approach me at one event and start talking about the minimum you had to have at Mona Vale. We had 20 GPs sign to support, and we get phoned by GPs—more and more and more.

There was one GP in our area who got a petition herself of 11,000 signatures, not long ago, about it. There are a lot of GPs who are very worried about their patients. There are a lot of GPs who are advising their patients to go directly to Royal North Shore Hospital. Not only that; I know that a certain senior person of the Northern Sydney Local Health District is advising their family—that gets out into the school community—to go to Royal North Shore Hospital.

The Hon. EMMA HURST: Thank you all for coming this afternoon. Mr Thomas, I would like to continue on with some of the questions from the Hon. Walt Secord, particularly around the lack of transparency. You noted in your submission that there is a lot of confusion around the services that are being offered at the Northern Beaches Hospital that now incur fees, which were provided at no cost at Mona Vale Hospital—for example, pathology tests. Can you talk a bit more about this and how you think the situation could be improved?

Mr THOMAS: We get quite a bit of feedback from people who typically have had regular procedures at Mona Vale or Manly. Most of ours come from Mona Vale, of course, because that is our support catchment base, although I do get phone calls quite regularly from Manly people wishing we were also helping them. We get feedback, "I have had these procedures for years on a regular basis. They cost me nothing. I now go up there; I've got to pay for it." One gentleman had to have, I think, colonoscopies. He would schedule a colonoscopy regularly and now he has to wait for six months, where he used to have to book it for four weeks. These things keep arising. I saw the Healthscope answer to that question today, where they were saying that the clinicians were using a bulk-billing model. If that is the case—and I do not know if that is the case—then I suggest they get their

clinicians to do a bulk-billing on it. I do not think that the public patients should be out of pocket for services they were not out of pocket for in the public system.

The Hon. EMMA HURST: You also mentioned in your opening statement briefly about the location of the hospital. Can you talk us through some of the problems about the location of the hospital, including public transport issues and travel times to the hospital?

Mr THOMAS: The travel time increase is an interesting point. The ambulance union of paramedics talked about the travel times and the increase in travel times. The travel times have significantly increased for members of the community. One of the reasons that we were able to get area health to support with the inpatient palliative care beds—and not just the outpatient palliative care beds into Mona Vale—was because our palliative patients had to go to Greenwich or Neringah Hospital, which I think is out Turramurra way. You can imagine trying to travel there if you have elderly people or even young families with that happening.

Those travel times are just as critical for people trying to get to Northern Beaches Hospital. Now if you want to get to Northern Beaches Hospital you can get yourself to Mona Vale, and there is a bus schedule that goes up. I have forgotten the exact times. There is a schedule that goes up and back, but you have to get to Mona Vale. We have a Keoride system which you can book and it will take you to a place—maybe down to a bus stop. If you go by bus you effectively go to Dee Why and then up the hill. It is a very substantial amount of time to get there from Mona Vale north, quite frankly.

In terms of transport access the most direct route, which is Wakehurst Parkway, is a road that regularly floods and has bushfires. I have been there during those bushfires. I live just next to Wakehurst Parkway so I really do understand the implications of that. We had a time recently where every single access road—except, I think, maybe McCarrs Creek Road—was flooded. You literally could not get out of—you had flooding at Collaroy, you had flooding at Wakehurst Parkway, you had flooding of Mona Vale Road. You get flooding and bushfires. Access is a big issue. It is a particular issue to those who are aged and infirm, or have young children.

The Hon. EMMA HURST: You also cite in your submission that there is research showing a direct relationship between travel time to a hospital and health outcomes. Can you give us a bit more detail about that research?

Mr THOMAS: Yes, there has been a lot of research done on it. In fact, early on in the whole planning process I think that Northern Area Health—as they were called at that stage, not local district health—had a policy that it was going to be 20 kilometres or 30 minutes' travel time to get to the hospital because that is what the evidence was showing were the right numbers that you should go with. During the whole planning process that disappeared because the only site that actually met those criteria was Mona Vale, which is quite interesting. That disappeared off the criteria. But yes, the evidence that we have been able to research—again, I stress we are not experts in that area—indicates very strongly that outcomes are affected by distance and time. There can be some benefit in transporting patients with stroke, with heart attack, with a lot of those issues where you get a really high-end acute service—and we need that here.

Where it really tends to show up and give you some pretty poor outcomes is with things like severe anaphylaxis and drowning—two things that are endemic on the northern beaches. We have a very big tick problem. For example, I have a daughter who has developed a mammalian meat allergy because we have that as a problem with our ticks on the northern beaches. Basically if she eats red meat she can go into anaphylaxis and then we are in big trouble. Obviously we also have very significant numbers of pretty nice beaches and very large crowds that come there during the summer; therefore our drowning risk is increased. I think in the year preceding it being closed there were 147 or 148 people who arrived at Mona Vale's emergency requiring resuscitation immediately on arrival. I doubt they would have ever got up to the other hospital.

The Hon. EMMA HURST: You also said that the model developed and implemented by the Sunshine Coast hospital in Queensland is important to consider—

Mr THOMAS: Yes, I think it is.

The Hon. EMMA HURST: —in the way that it operates a network of public health services. Can you tell us a little bit more about this and the lessons that might hold for the Northern Beaches?

Mr THOMAS: I think it is a great model. In health, one of the things I have learned is nothing is perfect. It is an interesting model. They went with a PPP, but theirs was very different. They decided they needed a level 6 hospital, which is what this hospital should be—a trauma hospital, by the way; it should not be a level 5. In fact, we were told that nobody would have to leave the northern beaches. That is part of the commitment that was made to the community for health—wrong. What they did is instead of privatising anything they got a consortium to build and manage the building. They own it, built it and they maintain it. The public health system

runs a public hospital in that building. Then they co-located a private hospital next to it—a bit North Shore-ish in that sense, that you have a fully co-located private hospital. Good model.

The other thing, though, that they did—which I think was particularly interesting—was with a population not much greater than the catchment area of this hospital—which is around 300,000 and the Sunshine Coast is 340,000 but growing faster—they did not close any of their other hospitals. None. They had three other acute hospitals. One they scaled down to a Mona Vale style that they have got now. The other one, which is Nambour, they tweaked it, they redeveloped it and they moved it towards this age emphasis. The nice thing if you talk about age is that we have got the rehab on the site at Mona Vale. You have an ageing population that needs acute services. The evidence says that if the acute services are next to the aged support areas—the sub-acute services like palliative—you have much better outcomes from patients.

As soon as you try to transport them you have a problem. Obviously they would do things like orthopaedics and a range of other services which are very appropriate for aged patients, but because you have an acute services with the backing of theatres and a proper radiology department you can run a proper emergency department. You can run a proper level 3 emergency department, which means an awful lot of issues can be resolved before they even have to go to Northern Beaches.

The Hon. EMMA HURST: This is an open question for all three of you. A couple of you mentioned in your opening statements that there was a bit of concern about some of the evidence that we had this morning, that it was only covering one side and that there were some questions to be clarified with some of that evidence. Is there anything pressing that you feel we need to hear today?

Mrs MOONEY: In relation to what they said?

The Hon. EMMA HURST: Yes.

Mrs MOONEY: The fact that he was not sure about the redacted KPIs—I think that is something to really follow up, whether it is redacted or not. We need to know what those service-level agreements are. We need to understand that to have that level of transparency.

Mr THOMAS: I think one thing I would like this inquiry to do is to separate in their mind the old and the new. This should not be about a comparison as to what we used to have and what we have now. It is not about that. It is about what we have now and what we should have now. Comparing old and new, of course you would expect a brand-new level 5 hospital to provide more services and be better. Of course you would. Yes, it provides more services; whether it is better is debatable. However, what we are saying is that you need more. It is just not right. The model needs to be tweaked and changed in some way and you need additional acute services. The population demands alone will force that.

If they pull that Mona Vale Hospital down, which is in the process of happening—not the main building; they are working to get to that stage—then we will see privately leased space on that site, a very significant chunk of that site leased to private operators to build and operate "health-related services" is the terminology that has been given to me. There is a real chance if you do that with 99-year leases that you preclude the construction of another acute hospital on that site. Frankly, the building does not need to be pulled down: same design, same age, same builder as Port Kembla Hospital, which was fully renovated. Removed all the asbestos. I know someone who has been in the building who is capable to actually give me a valid assessment of the state of the building— aside from all the formal reports. There is nothing wrong with the building. It is very renovatable.

Ms CATE FAEHRMANN: Mrs Mooney, I am just hoping you could elaborate a little bit on why it is so important for those targets and thresholds in relation to midwife services provided to be in the project deed, for the public to know what the KPIs are. I think you alluded to it in your opening statement, in terms of knowing how much normal birth is—

Mrs MOONEY: Yes, because the Healthscope statistics—just in their Prince of Wales Hospital they have a normal birth rate of 33 per cent, whereas at Manly they had 52 per cent and at Mona Vale they had 56.8 per cent. There is a real significant difference in the outcomes for women. We need to know that Healthscope will be held accountable, but they need to provide good quality public services. We are having all this attention on them now so they are properly making an effort, but over time the culture might change towards what Healthscope normally operates in a private hospital. We want to ensure that public services are upheld and are what we had before.

Ms CATE FAEHRMANN: For example, you would think they should have targets that are similar to other public hospitals?

Mrs MOONEY: Yes. The thing is that if we do not have targets or KPIs then they might just go, "Oh, we just have this statistic" and then there is no comeback. There is no incentive to them to ensure that we reach

the targets or statistics that we had at other times in other public hospitals—particularly with the provision of the midwifery group practice. I am really concerned that currently we do not have as many midwives as they had at Mona Vale beforehand—or Manly beforehand, sorry. I do not know what they are doing about recruiting to get that back up.

Ms CATE FAEHRMANN: Thank you. I was hoping you could expand on this: On page 5 of your submission, you say:

> In all of our meetings with representatives of the NSLHD (including Acting CEOs) we were advised that Healthscope had an arrangement with NSW Health and that the NSLHD had limited, if any, control or input.

Mrs MOONEY: Yes. I met with Deborah Willcox when she was acting CEO and I raised the concerns that we have had and they said, "There's nothing that we could do because that is day-to-day running of the hospital and operations and we do not have any input in that". I have since raised that with Mr Brad Hazzard's post the hospital opening and he says, "Actually, they do have input", but I am not sure what that means and they certainly did not seem to have it whilst the hospital was being established.

Ms CATE FAEHRMANN: This is a general question for all of you. The transparency around the whole Northern Beaches Hospital is not great—

Mrs MOONEY: Less than ideal.

Ms CATE FAEHRMANN: —yes, less than ideal.

Mrs MOONEY: Yes, absolutely. I have been working on this for nearly five years; colleagues have been working on that for a year longer than me. We have had to push for every single meeting that we have ever had. We have had to ask every step of the way and we are very unhappy with the level of engagement that has been given with us.

Ms CATE FAEHRMANN: Mr Thomas, I think your submission referred to that.

Mr THOMAS: Yes, absolutely. We definitely believe that transparency is a fundamental issue. The community was led to believe that they would have product A and I think the end result is they certainly do not have the product that they were led to believe they were going to get. That is not just in terms of the quality of the product; it is in terms of what was going to be offered. I think there is a very significant lack of it. We are capable of researching and we struggled to find any information on what is actually available.

Mrs MOONEY: I also talk about the consultation process. They say, "We've met with 10,000 people". But telling people what is happening—Consultation is meant to be a two-way form of communication and that has not happened.

Ms CATE FAEHRMANN: I turn to the Mona Vale Urgent Care Centre. The submission of the Save Mona Vale Hospital Community Action Group says a little bit about this. Page 39 of the submission says that the Minister said that "the Urgent Care Centre would meet the requirements for a level 1 Emergency Department." I also understand that the community is being told that doctors at the Mona Vale Urgent Care Centre would be trained in emergency medicine. Has all of this happened? Is the Urgent Care Centre now a level 1 emergency department?

Mr THOMAS: Calling a cat a dog does not change what it actually is. The reality is that it is an urgent care centre, and for what an urgent care centre is supposed to be, it is an urgent care centre. I mentioned earlier about a radiologist who approached me—she raised things about the Urgent Care Centre—and said she has never seen anyone come to an emergency department or hospital with a headache who did not require a CT scan and never seen anyone who came to an emergency department with a stomach pain who do not require ultrasound.

At that point in time, there were no CT scans and no ultrasounds available so the Minister, to his credit, agreed that they should be put back there. That, I think, is the leverage, the attempt, to call it a level 1 emergency. If you read the College of Emergency Medicine definition of a level 1 emergency department, a level 1 emergency department is the basic of basics. If you read it, we do not believe it complies any way to that and it is specifically designed for remote areas—it is designed for out in the bush. Perhaps they do consider the northern part of northern beaches—

Ms CATE FAEHRMANN: Mona Vale.

Mr THOMAS: —a remote area but my belief is that people want their emergency department back. You cannot have a proper emergency department unless you have acute services supporting it; you cannot have it unless you have got theatres; you cannot have it unless you have got proper pharmacy and proper radiology. It just does not work. It is not an emergency department.

Ms CATE FAEHRMANN: Do the doctors and nurses currently employed at the Urgent Care Centre have specialist training in emergency medicine?

Mr THOMAS: Every doctor, as part of their training, gets training in emergency medicine. Are these doctors members of the College of Emergency Medicine, which is what one would normally define? My understanding is that the answer to that is no, they are not.

Ms CATE FAEHRMANN: Do you know why not?

Mr THOMAS: It is not necessary in an urgent care centre, is it? It is not an emergency department.

Ms CATE FAEHRMANN: The Minister claimed that the Urgent Care Centre would meet the requirements for a level 1 emergency department. Do you believe that is a true statement of the Minister?

Mr THOMAS: We think it is—No, we do not think that is accurate. It is close but it is not accurate. Be really careful, though: a Level 1 emergency department is, in the true sense of the word—

Ms CATE FAEHRMANN: Basic.

Mr THOMAS: —in a city, in a residential area, is not what is necessary.

Ms CATE FAEHRMANN: We were told by witnesses earlier today from Healthscope and Northern Beaches Hospital. I think I asked them a question about whether was it true that the private hospital was a level 5 hospital and, as of the community groups and residents were saying, the public part of Northern Beaches Hospital was, in fact, a level 3. They said, "No, that's not the case." I believe your submission does suggest that is the case. Would you like to talk to that?

Mr THOMAS: It suggests that some of the services are at that level. Whether that is a ramp-up level or not we do not know. We are continually told it is level 5. We get feedback from doctors and nurses who say a whole range of services is certainly nowhere near level 5. That was my point earlier about giving us a role delineation detail, which shows us what services is provided at what level. I think that is the key. It is easy to call a hospital a level 5 hospital but you do not have to provide all your services at level 5.

They are providing some service at level 6 to their private patients. Again, a part of the requirement is to make sure that they have either got equal or more services to private patients than public patients. The reason for that is if you are providing less services to the private patient than the public patient, all of those private patients, who you would not have to pay for under the public system, would all want to go public. There is this push continually to make sure that anyone who has got private health uses it in the hospital.

Ms CATE FAEHRMANN: I believe the contract states that the Government may buy back, or be offered a while back, the public part of the hospital in 20 years' time. What you think is very happening in 20 years' time? I say that it does say "may". What does that mean? It is very confusing.

Mr THOMAS: They have just done that at Mildura, have they not, where they have taken back their Ramsay-operated public-private hospital and that community are rejoicing and almost dancing in the streets, from the feedback I am getting. I do not how you can do it in that hospital. I think if you walk around that hospital, the design of the hospital integrates public and private. I know why they were trying to do that. It might have started like a good idea at the time but when you come and try to operate an integrated facility where you have got private and public literally next door to each other, sharing the same equipment, sharing the same theatres, sharing the same radiology department, how on earth do you separate out the private function for that? You cannot. I just do not know how you do it. That is why it needed to be a co-located private building. You still get the benefit of the co-locating your clinicians who love to be there. That is fine but I do not know how they are going to do it.

Ms CATE FAEHRMANN: May be they are not.

The Hon. SHAYNE MALLARD: Good afternoon. Thank you for coming to the inquiry. I might start with you, Mr Thomas. You touched on it a little bit when I walked in, I just want to establish your community credentials. Your organisation has a membership base?

Mr THOMAS: Yes, it does. It is a combination of membership and community, who attend the events we run and who, when we send an email out that we need to do a bit more printing or something, donate some money to us.

The Hon. SHAYNE MALLARD: So you have an annual general meeting and a constitution?

Mr THOMAS: Yes. We run an annual general meeting, we are an incorporated body.

The Hon. SHAYNE MALLARD: Do you have any political alignments?

Mr THOMAS: None at all.

The Hon. SHAYNE MALLARD: I have got information that Jared Turkington, who was the Labor candidate for Pittwater at the last election, is on your executive committee.

Mr THOMAS: No, he is not on our executive committee. He was actually a visitor to our committee. We approached a range of people and gave them the opportunity to participate from all sides of politics. We are not politically aligned. I am not involved, never have been involved, in a political party, and for your information, to clarify this again, the last time I was in this room it was the Liberal Party that had control of the meeting and the Labor party was in government. This is a community issue. It is nothing but a community issue. The community support it. You do not get 6,000 people turning up—

The Hon. SHAYNE MALLARD: I think you have answered the question.

The Hon. WALT SECORD: I want to hear more from Mr Thomas.

The CHAIR: Point of Order. I think it is appropriate that I make a declaration as well, regarding this matter you have just raised. In my capacity as duty MLC for the Opposition on the Northern Beaches, I have attended at least one event organised by Mr Parry Thomas' organisation. It was conducted before the State election. It was at the Pittwater RSL. Rob Stokes was in attendance and participated in an open forum—and was invited to do so. There may well have been other candidates, including the one that you mentioned also in attendance.

Mr THOMAS: They were.

The CHAIR: I think there might have also been a representative from the Greens.

The Hon. WALT SECORD: I should make a declaration then. In 2014 I also attended a meeting.

The CHAIR: We put that on the table. Let us move on.

Mr THOMAS: I am not offended by the question but I want you to understand I am being honest.

The Hon. SHAYNE MALLARD: Do you have associations with GetUp?

Mr THOMAS: No. Even if I did, what is the issue? The answer is absolutely no. Are you

The CHAIR: It is very important that the questioning be conducted in the appropriate fashion of question followed by answer. I know there is strong public feeling about this but I would ask you to reserve yourself, listen to the question, listen to the answer and not join in.

Mr THOMAS: I would like to clarify that. GetUp only deal with Federal issues.

The Hon. SHAYNE MALLARD: Is it not the case that you want Mona Vale Hospital acquired by the Federal Government?

Mr THOMAS: No.

The Hon. SHAYNE MALLARD: The Northern Beaches Hospital bought back by the Federal Government?

Mr THOMAS: No. The State Government runs hospitals, not the Federal Government.

The Hon. SHAYNE MALLARD: Not in Tasmania, my friend.

Mr THOMAS: That is true. We believe the public portion of the hospital should be in public ownership.

The Hon. SHAYNE MALLARD: I just want to come to some photographs that have come my way, of a rally in the park, next to the pre-poll, on the Saturday before the State election.

Mr THOMAS: Absolutely.

The Hon. SHAYNE MALLARD: You had posters attacking Liberal members of Parliament.

Mr THOMAS: We had a poster that said that we believe that if you want to get what you need in your community for your hospital, you have got to think seriously about where you put your vote.

The Hon. SHAYNE MALLARD: So I have got these photographs and I am happy to hand them around the table. Those posters on display are Labor Party corflutes reversed. We can see the Labor Party names on them. So you had Labor Party resources for this event?

Mr THOMAS: We had no Labor Party resources. Do you know why they are there? I will tell you why. Because we struggle for funds as all community groups do. They were second-hand previous election corflutes

that we were given by someone who happens to be a member of the Labor Party. There was no Labor Party support whatsoever. There was no support from any political party.

The Hon. SHAYNE MALLARD: Well there is support because you have got corflutes.

The Hon. NATASHA MACLAREN-JONES: So it is fair to say you are funded by the Labor Party.

The CHAIR: Hang on. I can see where you are wanting to take this. It is important that one person asks questions at a time.

The Hon. NATASHA MACLAREN-JONES: Sorry, I interrupted by asking whether or not you were being funded by the Labor Party.

Ms CATE FAEHRMANN: Point of Order. Witnesses do have the right to be heard with respect.

The CHAIR: Yes they do.

Ms CATE FAEHRMANN: We should not badger witnesses and, I think, some of that line of questioning towards the end was very much bordering on that.

The CHAIR: The way in which we conduct this is that we have a question followed by an answer. That is the way in which we do it. There is no pushing people. You will be presented with a question, you answer it and that is the way in which it goes.

The Hon. SHAYNE MALLARD: You are quite a community activist. You have fought against amalgamation of councils.

Mr THOMAS: Actually I have not fought against amalgamation.

The Hon. SHAYNE MALLARD: And you opposed the hospital originally?

Mr THOMAS: I was never involved in any community issues, because I had my own businesses and a family growing up, until I was approached to get involved with the hospital, in the year 2000. During that time I also took an interest in the Currawong situation because I happened to be a boating person on Pittwater and I believed that Currawong Beach should remain in public ownership. So I have supported the Currawong community and I have chaired their meetings of the Save Currawong Group. I have done that. The two major campaigns that I have been involved in are the Save Mona Vale Hospital committee and the Currawong committee.

The Hon. SHAYNE MALLARD: I will take you to your earlier comment where you said Mona Vale Hospital is your passion. Is that right?

Mr THOMAS: It is.

The Hon. SHAYNE MALLARD: You would like to see it reopened as a level 4 or 5 hospital?

Mr THOMAS: Let me make a point.

The Hon. SHAYNE MALLARD: No, answer the question.

The CHAIR: Excuse me. We have got to be civilised in the way in which we do this. The question followed by the answer.

The Hon. SHAYNE MALLARD: What is your passion then?

Mr THOMAS: I would like to make a point and it is part of answering your question. I happen to live in Elanora Heights and I am probably one of the least affected persons, on a day to day activity, with the new hospital on the hill. I am one of the least affected because I can get to it faster than most people. I am involved in it because I started my involvement when my wife worked in the hospital as a nurse back in the 1970s. She then became a nurse educator, she was training other nurses. I would drive up there and we would discuss the hospital, we had some of our children born there. I have become passionate about it because I was asked by the community to chair this committee and drive this committee. I have done it on and off, and I am back in the chair again now.

On the way in my wife was almost chastising me, saying you are really into this. I said, you cannot be half pregnant. If you are going to do something, you have got to do it properly and you have got to believe in it. I believe fundamentally that the delivery of hospital services on the Northern Beaches is substandard for the community. That is why I am supporting putting acute services back in Mona Vale. I am not supporting getting rid of the level 5 hospital. I think it should be level 6. But I am supporting, and I believe I have a right as a community member, getting the right services for my community.

The Hon. SHAYNE MALLARD: So the answer to the question is yes. You would like to see Mona Vale Hospital a level 5—

Mr THOMAS: No. We are not stupid, it was a level 4.

The Hon. SHAYNE MALLARD: Level 4. I am asking the question, now you have answered it.

The CHAIR: Order! I am being tested now—and not by the actual witness. The witness is entitled to be able to answer the question. Specifically, to clarify whether it is a level 5 or a level 4.

Mr THOMAS: We are more than happy to negotiate on the appropriate range of services put into Mona Vale Hospital. We have said that we would be happy with a level 3 because that would give us a level 3 emergency service, and with the level 5 in that proximity, that is an appropriate service mix.

The Hon. SHAYNE MALLARD: Thank you for the answer. So I put it to you, that the problem is there are not enough patients and there is not enough doctors—

Mr THOMAS: Rubbish.

The Hon. SHAYNE MALLARD: The question is not rubbish. I am putting it to you as a proposal. There are insufficient patients and not enough doctors to have two hospitals at that level in the northern beaches.

Mr THOMAS: Okay. Let me say, then, that perhaps you had better go and figure out why there are three or four hospitals on the Sunshine Coast with virtually the same number of people in the catchment. You are ignoring the catchment of the new hospital. You are ignoring the fact that it is not a northern beaches catchment. It is a catchment that extends to Chatswood, as far as St Ives, Pymble, Turramurra and Gordon. It is a very significant catchment in this hospital. There are enough patients. In fact, that is unquestionably not the problem. With the population strategy it is inevitable.

I have had the Hon. Rob Stokes, over a cup of coffee, say we both know it is inevitable that we are going to need another acute hospital on that site at some point in time, so it is unquestionable. Your issue about doctors and your issue about staff is a never-ending problem in the health system. And, yes, you are correct: There are shortages of staff everywhere we go. However, if we took the view that because we cannot get staff we will not have a hospital, then half the population would be dead.

The Hon. SHAYNE MALLARD: Thank you, Mr Thomas. To be fair, Mr Walker, would you like to respond to the questions around your organisation so it does not look like I am just targeting Mr Thomas with that question. We ask that question in many inquiries, by the way.

Mr THOMAS: Yes, sure.

The Hon. WALT SECORD: We do not ask people their political affiliations.

The Hon. SHAYNE MALLARD: Oh yes, we do.

The CHAIR: Order!

The Hon. WALT SECORD: I think he owes that witness an apology.

The CHAIR: Order!

The Hon. NATASHA MACLAREN-JONES: Point of order: The Hon. Walt Secord is wasting our time.

The CHAIR: With respect to Mr Walker, if you have a specific question—

The Hon. SHAYNE MALLARD: It is just a simple—

The CHAIR: You just cannot roll up all the other questions.

The Hon. SHAYNE MALLARD: No. It goes to the nature of his organisation.

The CHAIR: In fairness to the witness, if you have a specific question, put that to Mr Walker so that he understands precisely what he is answering.

The Hon. SHAYNE MALLARD: It is the same question. I will do the same for Mrs Mooney as well. Do you have a membership base? Is it democratic? Does it have a constitution? Do you have meetings?

Mr WALKER: No. It is informal, just friends—Friends of Mona Vale Hospital—which has taken an interest in this fire issue at the northern beaches. There are no formal meetings—nothing like that.

The Hon. SHAYNE MALLARD: Mrs Mooney?

Mrs MOONEY: We are a group of volunteers. It is informal but we represent about 1,100 people on Facebook and we are open to anybody coming to join us.

The Hon. SHAYNE MALLARD: I have about a thousand Facebook ones too. I might ask Mrs Mooney—

The CHAIR: Hold it. Could you just repeat what you just said?

The Hon. SHAYNE MALLARD: I said I have a thousand Facebook friends too.

Mrs MOONEY: But they are not friends. They are members of a specific group.

The CHAIR: Yes.

Ms CATE FAEHRMANN: Maybe you could ask about the Chair's—

The CHAIR: Order! I really think that is beneath an honourable member.

The Hon. SHAYNE MALLARD: I withdraw that. I did not realise that that would offend you.

The CHAIR: Thank you.

[*Interruption from gallery*]

The CHAIR: Please sit down. We are going to get through this.

The Hon. SHAYNE MALLARD: Mrs Mooney, would it be right to say you are philosophically opposed to PPPs?

Mrs MOONEY: I am opposed to private companies running public maternity services—companies who have no experience of running public maternity services. I would be okay if there are strict guidelines in place and that we felt that the public services were getting the attention that they needed.

The Hon. SHAYNE MALLARD: So you are not totally opposed to PPPs?

Mrs MOONEY: I am coming at it from purely a maternity point of view. I think there is a problem because there is a philosophical and actual difference in how private hospitals run maternity services to how public hospitals run maternity services.

The Hon. SHAYNE MALLARD: Thank you.

Mrs MOONEY: Can I just also say with our organisation we are affiliated to Maternity Choices Australia, which is a proper organisation with a constitution, an annual general meeting [AGM] and board members.

The CHAIR: Just to be clear, it is not a question of being proper and improper. You are completely proper. You may be informal but completely proper. Let us be very clear about that.

Mrs MOONEY: Okay.

The CHAIR: It is just that, obviously, some organisations have a formal structure, a constitution, et cetera, but you are entirely proper.

Ms CATE FAEHRMANN: Maybe the Government might ask some questions about the actual issues now.

The CHAIR: The Hon. Wes Fang?

The Hon. WES FANG: Thank you, Chair. Mr Thomas, I just want to take you back to some of your earlier evidence.

[*Interruption from gallery*]

The CHAIR: We will pull the microphones forward. Thank you. That is fine.

[*Interruption from gallery*]

The Hon. WES FANG: No.

The CHAIR: No. I have introduced him as the Hon. Wes Fang. Please continue, Wes.

The Hon. WES FANG: Mr Thomas, I would like to take you back to some of your earlier evidence when you spoke about the patients who had had a heart attack and was taken to the Northern Beaches Hospital. Some of your evidence was that the notes that were handed over were a crumpled piece of paper that was pulled out of a pocket and thrown to, I believe, the ambulance driver?

Mr THOMAS: I did not say "thrown".

The CHAIR: No. He did not say that.

Mr THOMAS: "Handed".

The Hon. WES FANG: I guess where I am leading to with this is: Is it your evidence that the staff at the San who took the patient proceeded to readminister medications and treatment with no thought to what was previously done at the Northern Beaches Hospital?

Mr THOMAS: The answer to that would be, obviously, no. I was not there.

The Hon. WES FANG: You said they went into the bin.

[*Interruption from gallery*]

The CHAIR: That was not his evidence. Please.

The Hon. WES FANG: It was. He said—

The CHAIR: The transcript will show that was not his evidence, that it was just thrown into the bin. Okay? We will check tomorrow.

Mr THOMAS: I do not mind if the evidence shows they did go into the bin, by the way, because what happened was—as it was relayed to me by the patient and I have a two-hour transcript on tape of this, which is currently being typed up—as it was relayed by the patient the staff at the San asked for the notes to be handed— this what was basically crumpled pieces of paper that literally were the nurse's own notes, and nurse's own notes that she had made during the process. They apparently read them. They looked at them and went, "Well, we can't do anything with this. We have to start again." That meant they had to take an approach that recognised, obviously, that the person had had some level of treatment at the Northern Beaches Hospital in terms of drugs and other things. They would have discussed this treatment with the patient, I assume: I am now second-guessing that staff, I stress. They certainly would not have just randomly started issuing drugs again. That is not how Health works.

The Hon. WES FANG: Are you aware if an incident information management system [IIMS] report was filed on this?

Mr THOMAS: I do not know. In fact, I would say no, it was not. I would also say that this would not even appear in Healthscope's records as any sort of problem, because why? Because they discharged her. They would treat her discharge normally, just like so many people that we hear who turn up and do not stay, or turn up and get poor treatment, go back to the local doctor who says, "How come they didn't treat you?" and then get another X-ray to find you have got three fractures in your foot. All of these sorts of things—

The Hon. WES FANG: Okay. Thank you. You are eating into my time. I guess what I am asking—

[*Interruption from gallery*]

The Hon. WES FANG: No, no, no. You can just all be quiet, thank you.

The CHAIR: Excuse me. You do not speak to the audience like that. You do not point your finger like that.

The Hon. WES FANG: The audience is required to sit—

The CHAIR: I am speaking to you, the Hon. Wes Fang. You do not do that. We are trying to conduct this properly and fairly and in an orderly fashion.

The Hon. WES FANG: And I am trying to question the witness.

The CHAIR: You do not point at the audience like that.

The Hon. WES FANG: Then the audience needs to understand—

The CHAIR: Do not talk back at me! Do not talk back at me! I have laid out how this is going to be done. How many times?

The Hon. WES FANG: And yet I am interrupted. Can I continue with my questioning, please?

The CHAIR: I can stand here as long as you like.

The Hon. WES FANG: I have a heap of questions. Mr Thomas has raised a very serious matter. I want to know if the San has actually put in an IIMS about this incident, whether the Northern Beaches Hospital has, and I want to know if you can please take on notice and reply.

Mr THOMAS: I do not know.

The Hon. NATASHA MACLAREN-JONES: Point of order: A member of the audience is filming. I would like you to remind about the use of mobile phones.

The CHAIR: There is no filming of these proceedings. Let us conduct this properly.

The Hon. WES FANG: Mr Thomas, can you please—

Mr THOMAS: The answer is "I do not know" to your question.

The Hon. WES FANG: Can you please provide on notice all details that you have of this incident, including the two-hour transcript which is being transcribed, I understand.

Mr THOMAS: I said I am not—I am going to—I have been given that information.

The Hon. WES FANG: You have raised a very serious incident here.

The CHAIR: Order!

Mr THOMAS: I could sit here and raise about 40.

The CHAIR: Order!

Mr THOMAS: I am sorry, Chairman.

The CHAIR: There is only one Chair in this meeting.

Mr THOMAS: I apologise.

The CHAIR: I thought I made this pretty clear from the outset. It has been a tough period for everyone, but talking across each other and talking at cross-purposes, putting shots across the bow, sarcasm and all the rest of it really is beneath us all. As honourable members, we know that we put questions, we have them answered, we do not try to talk over witnesses, we do not try to roll up four or five questions at once and say, "answer them or take them on notice". The Hon. Wes Fang knows better than that. You have been around for more than five minutes. You have been very disappointing in the last 20 minutes or so. I think we have effectively come to the end of the session. If there are questions on notice, they can be provided to the members of the respective organisations. Some supplementary questions may arise from reading the *Hansard*. What happens is that after reading *Hansard*, that may agitate some thinking about some supplementary questions.

Mr THOMAS: Sure.

The CHAIR: That will then be provided to the witnesses. Then you will have a 21-day period to turn around those questions and the secretariat will liaise with you. I am very sorry that I had to raise my voice.

Mr THOMAS: It is all right.

The CHAIR: I made it very clear at the start of the proceedings this afternoon. I specifically read that paragraph about the interruption from the audience. I did that very deliberately. My only regret is that I probably should have made it in capital letters and underlined it, perhaps, more than I did; but I thought that that message would have got across. This is a difficult thing. I do understand there are strong feelings in the community and there is a sense of people wanting to get their point made in the strongest possible terms. I understand that. But this is a parliamentary inquiry. It just cannot be reduced to a rabble. That was beneath us all, including, obviously, the witnesses and the members of the public. Thank you all very much.

Mr THOMAS: Can I ask a question, Chairman?

The CHAIR: You may.

Mr THOMAS: Just very briefly, I was asked a question about putting something on notice to provide information. I do not believe I am in a position to provide that information because of the privacy request of the person involved.

The CHAIR: On that matter, I think the best was to proceed is that there will be some liaising. Perhaps we will proceed this way: Tomorrow *Hansard* will show precisely what the question was. If that is not precisely the question the Hon. Wes Fang had, I am sure he will craft it into the question. That will be presented to yourself, Mr Thomas, then the secretariat will liaise with you with respect to what may be your concerns about that particular question, and there will be a discourse between yourself and the secretariat. If you put back the position which I think you are foreshadowing, that will then become a matter of discussion by this Committee. I am not foreshadowing it but if the Hon. Wes Fang presses his question, you put back a response, it will be a matter of discussion between the Committee and there will be an outcome determined on that. Thank you all very much.

(The witnesses withdrew.)

(Short adjournment)

TONY SARA, President, Australian Salaried Medical Officers Federation of NSW, affirmed and examined

ANTHONY JOSEPH, Senior Staff Specialist, Emergency Department and Director of Trauma, Royal North Shore Hospital, and NSW State Councillor, Australian Salaried Medical Officers Federation of NSW, sworn and examined

The CHAIR: With respect to your submission from your organisation, it has been received by the Committee secretariat, it has been processed and it stands as submission number 225 of this inquiry. Thank you very much. It is a very comprehensive submission. Thank you for that. I invite you to provide an opening statement of a few minutes. Take it as read that, with respect to the content of your submission, members of the Committee are familiar with it. Following your opening statement, we would like to move into a period of questioning in regard to your opening statement, the content of the submission and other matters.

Dr SARA: Thank you, Chair and Committee members. Thank you very much for accepting our submission and providing us the opportunity to address you today. The doctors' union, Australian Salaried Medical Officers Federation of NSW [ASMOF], has closely followed the progression of Northern Beaches Hospital. We have been outspoken on behalf of members who have transitioned to or have since been employed at the hospital. We have also been outspoken on behalf of our members who are employed at Royal North Shore and Mona Vale hospitals, such as Dr Joseph to my left, because the whole district is being impacted by what is happening at the Northern Beaches Hospital. Of course, we have also spoken out on behalf of patients, because our members are absolutely committed to providing safe, high-quality care to patients in even the most challenging circumstances.

It is almost unbelievable to us that for four years ASMOF and our members were kept entirely in the dark about what services would be provided at Northern Beaches Hospital and what working conditions would be offered. It is hard to fathom that a public hospital would be set up without the advice of senior doctors with decades of experience working at public hospitals. Our submission provides details of those claims. Doctors were not only kept in the dark when they did speak up or raise concerns, they were ignored, only to find that everything they had been warned about would come to fruition. Again, our submission has more details. Let's make no mistake, when the hospital opened disaster was only narrowly avoided. This was a very distressing time for our members, particularly the junior doctors, who bore the brunt of Healthscope's failure to establish the hospital properly— equipment, policies, processes and staffing. It was a nightmare.

Again, our submission has the details of that, as have our letters to the secretary, our letters to the Higher Education and Training Institute [HETI] as well as the HETI report. While we do not deny that major improvements have been made, nine months after opening the hospital is still understaffed, proper policies and systems are still not in place and patients are still falling through service gaps. Our submission refers to this. I am also happy to take questions about policies—policies and processes in hospitals is something that I do as part of my working life. Again, it is almost unbelievable the New South Wales Government was missing in action and let all this unfold on its watch. We brought this to its attention early but it is still, in our submission, not yet effectively managed. Again, it is almost unbelievable, because the events that led us here today were all entirely predictable and completely avoidable.

The public-private partnership [PPP] model is a fundamentally flawed model. It can never provide equivalent to safety and services for the same cost as a public hospital, as indicated by the Productivity Commission report of about 10 years ago, and a McKell Institute report of about the same time period. It is just not possible. The rationale for privatisation—that private operator will deliver better value for money for the Government—has been proven false time and time again. Our submission has those details. Another one of the public-private partnerships as of Friday last week reverted to the Government's control in Victoria. ABC News— we will provide the URL—announced that Mildura public hospital will be transferred back from a PPP to the Victorian Government. That is the last remaining PPP hospital in Victoria.

Thousands of community members voted for it to be brought back into public hands. The issue was not ideology, and the press piece makes that very clear. The issue was patient safety. As the Independent State member for Mildura, Ali Cupper, who had campaigned to return the hospital to public hands and was successful in that election by a handful of votes, stated to the ABC reporter, "It's going to be trying to serve shareholders and patients at the same time". It is just such a split conflict, it cannot work in our system.

What this means is that six out of eight triple-P models have failed outright in Australia—Port Macquarie, Robina, Modbury, Mildura, Latrobe and Northwest Regional and there were two remaining, Joondalup and Northern Beaches. In respect of Joondalup, in Western Australia, my colleagues in Western Australia advise that it failed under St John of God and subsequently was taken over by Ramsay Health Care. The senior and junior salaried doctors in Western Australia do not applaud it. It is not a hospital they liked to go to. It is unclear about

the standards of care. We did not do an enormous amount of research other than to say it is not a shining light. Will it fail in the near to medium term? Unclear. I think this hospital again is a timely reminder for the Committee that doctors and our communities can see through the spin. When we put the pursuit of profits before evidence-based health policy, we end up in a race to the bottom and staff and patients ultimately lose out.

We need major reform at Northern Beaches Hospital with proper oversight from the Government and the LHD and genuine integration into our public health system. We do not know what is going on inside the hospital, other than our members telling us. I met a number of our junior doctors less than two weeks after it opened, and one of them was in tears. Twenty junior doctors in a room in the hospital last year, and I have never felt such anguish in my life as a medical manager. Subsequently, about six weeks ago, I met with six of the staff specialists. Again, they are not happy—they are not happy with the care, they are not happy with the lack of policies and processes. They have done six clinical policies this calendar year.

Ms CATE FAEHRMANN: When was that?

Dr SARA: We met six weeks ago, with six staff specialists. The hospital listen to some of their concerns and action some, others have not been actioned. Six clinical policies that have been done is clearly unacceptable. I do not have authority to offer the policies from my employer, South Eastern Sydney Local Health District. I offered them all. The then chief executive, in October, said, "We don't want them". There are hundreds of such policies on the website from Prince of Wales and St George—clinical policies, in-between policies, some admin— I offered them all and it was declined outright. I was fairly disappointed to then learn from my colleague at the hospital six weeks ago they had done six in a year.

As I said, we need major reform at the hospital, proper oversight from the Government, policies and processes and we need integration into the public health system. Our submission goes into that in further detail. Patients are continuing to fall through the cracks due to the model that Healthscope is running with. But most importantly, we ask that the New South Wales Government ban the triple-P model once and for all. Six out of eight have failed in this country. Joondalup is in a grey zone. My suspicion is that Northern Beaches will fail in due course. It has been very poor to date. Will it be a failure long term? I do not think we can say, but six out of eight or seven out of eight, if we are going to look for evidence-based health policy in these, we have to give away the triple-P model once and for all. Hopefully we will then stop revisiting these same errors. They are ideological errors; they are not evidence-based. That is the main point of our submission.

The CHAIR: Dr Joseph, did you wish to add to what has been said by Dr Sara?

Dr JOSEPH: Yes, I might say a few words. Briefly, I think it is clear that privately owned for-profit public hospitals do not work. The only other example we have in New South Wales is Port Macquarie Hospital and that failed after 10 years. The Government knew this and still proceeded with this privately owned public hospital model. Incidentally, the Royal North Shore Hospital Medical Staff Council also questioned the wisdom of building a new 400-bed hospital at Frenchs Forest when there are always going to be transport infrastructure problems. We always advised that it would be better to build a new hospital on the site of Mona Vale Hospital. Healthscope were clearly not prepared to open as a public health facility at the end of October 2018, when they ran out of basic drugs and equipment and there were adverse clinical incidents, which are indicative of a hospital under stress. As a result, many patients and local GPs do not have any trust in the hospital. I have recently spoken to a patient, who did not trust the hospital and so she caught a taxi from Narrabeen to my hospital, bypassing the Northern Beaches.

NSW Health and Northern Sydney LHD clearly had no mechanism to ensure that the hospital was fit for purpose as a public hospital when it opened and for its integration into the Northern Sydney LHD. A couple of examples, the electronic medical record, the IT system were clearly not fit for purpose when the hospital opened. For some reason, Healthscope decided not to go with the Cerner IT system and went with their own Telstra IT system, which resulted in us initially relying on faxed discharge summaries when patients came from Northern Beaches to North Shore. They have fixed that problem to an extent now, where there is an interface with the Health Information Exchange [HIE], which I think will be clunky and will be subject to failure. But we do not know really how it is going to work. Currently, I think we will be able to see discharge summaries and get access to pathology and radiology.

North Shore clinicians were unable to find from Healthscope what models of care they would be offering when they opened and they seemed reluctant to collaborate with long-established clinical units at North Shore. I understand from talking to colleagues, who still work at Northern Beaches, there is still a large number of locum staff who are employed, particularly on the wards, so they are having problems maintaining a stable medical staff. Reading from the NSW Nurses and Midwives' Association submission, I understand there are still many agency nursing staff on the wards as well. Conditions and benefits of employment for senior medical staff seem slightly different to New South Wales hospitals, where there is a rigorous medical appointments committee process. This

process does not seem to be applying at the Northern Beaches; from my information, it seems to be a little ad hoc. I am not really sure of their ability to address adverse incidents, when these will be addressed in-house and will not be subject to the same rigorous scrutiny of an adverse incident, which occurs in one of the other New South Wales public hospitals.

In summary, I think that while Healthscope may be able to address some of the concerns that led to this inquiry, it will require a lot more transparent oversight by both the New South Wales Ministry of Health and the Northern Sydney LHD. Given the progress to date, that looks less likely to occur, while the models of care rely on one that is profit driven. A better outcome would be for the public component of the hospital to be reclassified as an affiliated healthcare organisation, such as Saint Vincent's, or the New South Wales Government just bite the bullet and buy it back now rather than in five to 10 years' time.

The CHAIR: Thank you for both of those opening statements.

The Hon. WALT SECORD: Dr Sara and Dr Joseph, thank you for your time today. Dr Sara, in your opening remarks you said that junior doctors bore the brunt of the problems at the hospital. In your submission you talk about incompatible gear, paediatric defibrillation pads not being fit for purpose, walkie-talkies being used to communicate, lack of vital drugs—in fact, no Panadol in the emergency department. Has the situation changed or improved at the hospital since then?

Dr SARA: Yes. We are advised by our members that large numbers of those problems have been resolved, so that they are no longer the significantly difficult issues they were in terms of risks to patients and risks to staff. But it took many months for that to occur. One example was that when the hospital opened, the warehouse in the basement was empty. They had decided to go for a just-in-time supply methodology. Within a couple of weeks they decided to start using that warehouse. If you are running a 400-bed public hospital, you cannot predict the demand. If you are running an elective surgical hospital, you know what is going to happen and therefore you can provide for it.

The Hon. WALT SECORD: What do you mean by "just in time"?

Dr SARA: Just in time is when you run out of a package of bandages or syringes then you order them from the supplier, whereas a big public hospital will have those things in the basement and intravenous [IV] fluid will maybe be in the pharmacy in the basement. What they built was a private hospital and it had the tenor and the operations of a private hospital, not the tenor and the operations of a public hospital. They have decided to put the warehouse in use and the drugs are now available. The issues the young doctors identified—the smaller ones in terms of the equipment and the resuscitation trolleys and the oxygen cylinders and the drugs on the wards—we are advised that they have been addressed. The issues that have still not been addressed are adequate staffing, the health IT system, as my colleague Dr Joseph said, and the policies and processes. Issues such as too many locums are yet to be addressed. They have done the basic stuff, but there is a lot more work to do.

The Hon. WALT SECORD: What does that do to a young trainee doctor? Do they second-guess themselves? How does that change their behaviour and how does that impact on patient care if they do not have access to the drugs or supplies that they are seeking?

Dr SARA: Then they have to go around the wards and look for it, or they may have to change the treatment that they had proposed or, in the case of some of the equipment, the nurses provide it if—you may remember the press last year. Nurses were bringing equipment in the boots of their cars from Manly and Mona Vale. So it puts an increased stress on the junior staff. It significantly increases the risks to patient safety because if you have not got the drug you want or the whatever, then you have to think about something else or you have to get it from somewhere else, or you have to send someone out to get it. So it is just frustrating, dangerous.

The Hon. WALT SECORD: You also mentioned about inadequate staffing.

Dr SARA: Yes.

The Hon. WALT SECORD: Are you referring to the situation that we are in today?

Dr SARA: Yes. There is not enough staff today. There are a number of locums still. A couple of weeks ago some of the surgical senior resident medical officers [SRMOs] were starting at five and six in the morning and a number of them were working till midnight. Now that has been resolved when it was brought to attention.

The Hon. WALT SECORD: What happens if someone does a shift from five to midnight? I guess what I am trying to say is what kind of care do patients get?

Dr SARA: After dinner time on that day you start to get the effects of stress and overwork and lack of sleep. If it goes on for too long, then the literature on overwork and being sleep-deprived is that it is the equivalent

of having a blood alcohol level of .05. You start to run the risks of increasing mistakes and increasing errors of judgement. It is not good for patients, it is not good for staff and it is not good for training as well.

The Hon. WALT SECORD: What are the junior doctors doing, then? Are they leaving the hospital or are they just copping it? What are they doing? What has been their human response?

Dr SARA: You just wear it. That has been the system since I was an intern in 1984. We have attempted to reverse some of those fairly deleterious effects on junior doctors. In the old days, you would do it for three to five years until you got through a training scheme. Today, with an increasing number of unaccredited registrars and graduates, some people will do it for years and years and years. It takes its toll on the young doctors in terms of suicide and in terms of mental and physical breakdowns, and it probably increases the risk to patients.

The Hon. WALT SECORD: In your submission, you are critical and you say that the hospital was set up as a business, rather than—developed a model based purely on a business perspective, rather than running a public hospital. Do you stand by that?

Dr SARA: Yes. An example was at the very beginning the elective surgical lists—and this has been in the newspaper and the press and various other submissions made this point. For the first couple of weeks, elective surgical lists would start on time at seven or eight o'clock and emergency patients from the night before were waiting until 10 or 11 o'clock in the morning because the elective lists, which is where the hospital makes its money, were given priority over emergency lists. The anaesthetists eventually said, "This is unsafe," because essentially the anaesthetists were the ones who were going to be in the gun if a patient died. They would be standing in front of her Honour the coroner, explaining why the patient died. That is why the anaesthetists said, "This has to stop," and that was within about the second or third week.

The Hon. WALT SECORD: So you are not surprised that we heard evidence this morning from the hospital itself that 17 patients in the last quarter waited longer than 24 hours in the emergency department?

Dr SARA: That is correct, and that is inadequate. That is not acceptable.

The Hon. WALT SECORD: I realise that. What did they do in response to that?

Dr SARA: Essentially, they agreed with the anaesthetists that they would give higher priority to emergency patients; they would cease some of the elective lists.

The Hon. WALT SECORD: So they were doing the elective because they got revenue from that?

Dr SARA: That is correct.

The Hon. WALT SECORD: They got higher revenue from doing that?

Dr SARA: That was prioritised for at least the first four or five weeks. I believe that that has changed; that is certainly the public position, that that priority has changed. So that is on the mend. I am not in the hospital— the colleagues do not say it is as big a problem as it was, so I suspect that that aspect of the culture has changed.

The Hon. WALT SECORD: What has been the long-term effect on the junior doctors? Do they come to you now? Do they speak out more?

Dr SARA: Yes, they still come to us. They still say, "These things are wrong; that's wrong." At the beginning of this year the young doctors said to our industrial staff, some of whom are seated behind me, "Everything's looking okay. It's the quiet period after Christmas. We don't think we want ASMOF to get deeply involved." Some weeks later they said, "We want to see you." So they had more meetings with our industrial staff. I think an interesting anecdote you may appreciate is that after a meeting with the young doctors—about 20 young doctors—our senior industrial officer had a meeting with one of the hospital executives.

He said, "I'm going to that meeting now. Who wants to come?" All 20 said, "We're going." So they all trooped into that executive's office. He was not a happy executive, I suspect, to have 20 young doctors come in and complain about too many locums, not enough staff, the various issues. They locked the sleeping-over rooms and locked the junior medical officers [JMOs] common room in the evening at nights. "We cannot possibly have junior doctors sleeping." But if you are starting at six o'clock in the morning and going through to midnight, it is reasonable to sleep overnight. To lock the common room is just unfair and inappropriate. It is just a nasty attitude.

The Hon. WALT SECORD: They locked the common room? What, so doctors could not sleep?

Dr SARA: So they could not go into the common room where the microwave was and the TV was and some lounges, so that on evening and night shifts they could not go in there to catch up, to read, to look at a computer and search the internet for information. So ASMOF made representations to the hospital and that was

reversed some weeks later. Another one that occurred in the last few weeks was they wanted doctors to tap on and off as a Bundy card system.

The Hon. WALT SECORD: A Bundy system for doctors?

Dr SARA: Yes.

The Hon. WALT SECORD: Does that occur anywhere in Australia?

Dr SARA: Nowhere.

The Hon. WALT SECORD: This is absolutely new.

Dr SARA: The young doctors clearly were not happy with that. Again they complained to ASMOF and we went to bat for them.

The Hon. WALT SECORD: They wanted young doctors to Bundy on and Bundy off?

Dr SARA: Yes. Again, it goes back to the attitude. Some staff of the hospital and the young doctors perceive that with Brookfield Partners now the owner, that the pursuit of profit and the minimisation of costs will get worse.

The Hon. WALT SECORD: It must be doing hell with the morale of these doctors.

Dr SARA: That is right. At the beginning of the year they did not want to know us, and then after a few weeks again they wanted us, their advocates, back engaged to assist them to say to management, "This is not fair. This is not proper. You need more staff. You need to stop having locums," whatever.

The Hon. WALT SECORD: Excuse my ignorance here, but you mentioned earlier in your evidence where you talked about six clinical plans you said that you had been involved in and you know of about 100. What are the six clinical plans? What are you referring to?

Dr SARA: The hospital developed six clinical policies this year.

The Hon. WALT SECORD: Explain that in layman's terms. What does that mean?

Dr SARA: It is a one- to five- to 10-page document that says "This is how we do this clinical thing." It might be how to insert a nasogastric tube, might be how to insert a central line, might be how to run adrenalin infusion, might be how to tap ascitic fluid in the abdomen—abdominal paracentesis—how to put in a chest tube.

The Hon. WALT SECORD: Is that common practice in any hospital?

Dr SARA: I went to the website for my hospital, Prince of Wales, and the letter A has got about 30. I went to the website for St George; same thing. So there will be hundreds and hundreds and hundreds of the clinical policies. When I was a boy—

The Hon. WALT SECORD: I will stop you there. So if you are a young doctor and you are told to do something and do not know what to do, you immediately go to this?

Dr SARA: You go to the website and you say, "Ah, this is how I do this. This is the best way to do this physical procedure. This is the best way to treat this symptom." Somebody has got hyperkalaemia; what is the best way to do it? So the website, with those policies and processes, gives you evidence-based—this is the best way to deal with this. When I was an intern, you made it up as you went along or you would have asked the nurses, you would have asked the boss. Over the last 25, 30 years, we have decided that is not good enough. The HETI processes for junior doctors is we have to have clinical policies and processes and procedures so that if the diagnosis is something, this is the best treatment; then there is a document that tells you how best to do that. As I say, I offered all the policies—I probably had no authority to offer them. My chief executive will not be happy, but I offered all of those for south-eastern Sydney to Deb Latta—to her face, because I have known Deb for 20 years.

The Hon. WALT SECORD: What did she say?

Dr SARA: She said, "I don't want them."

The Hon. WALT SECORD: What do you mean, she did not want them?

Dr SARA: She said, "We don't want them." That was in October.

The Hon. WALT SECORD: You mentioned HETI.

Dr SARA: Yes.

The Hon. WALT SECORD: Are all the accreditation needed at Northern Beaches Hospital in order at the moment?

Dr SARA: No, it is not.

The Hon. WALT SECORD: What is the outstanding accreditation? What is there a question mark over something?

Dr SARA: A broad range of recommendations were made in the last report. There will be a repeat survey in September.

The Hon. WALT SECORD: What areas of accreditation have question marks over them?

Dr SARA: Lack of policies, lack of processes, lack of term descriptions, lack of adequate rostering. There is a broad range; I would have to get our letter out. We wrote a long letter to HETI, saying—

The Hon. WALT SECORD: Can we have a copy of that letter?

Dr SARA: It is on our website, I think.

The Hon. WALT SECORD: I will get it.

Dr SARA: There is a repeat survey in September. For Healthscope to say, "We've got the tick," is not the case.

The Hon. WALT SECORD: I am mindful of my time. Staff departures—the CEO, director of medical services, nursing, anaesthetics. Are all the senior positions filled at the moment?

Dr SARA: I understand that there is an acting chief executive. I understand that there is an interim directly of medical services. I understand that there is a deputy director of medical services—a fellow at my college. I am a Fellow of the Royal Australasian College of Medical Administrators. They have a deputy DMS who is going to start in the near future. The director of nursing—I have no idea.

The Hon. WALT SECORD: You have given evidence that the hospital is doing elective procedures, and there were concerns about maternity services, where intervention procedures were taking place rather than midwifery. Have your members expressed concern to you about that, or that they are driving people towards elective and maternity services involving intervention?

Dr SARA: I recall that our submission talks about the fact that there is undue pressure on patients to use their private insurance. There is an increased level of care available to those with private insurance. Our submission talks about patients being forced into that and then having to pay large amounts of—

The Hon. WALT SECORD: Can I stop you? Did you just say "increased care if you are a private patient"?

Dr SARA: There are increased levels of care in terms of the procedures and the services available. It is a level 5 hospital for private patients, a level 4 for public, as I recall it.

The Hon. WALT SECORD: So for all these attacks on people saying that it not a two-tier system; it is a two-tier system.

Dr SARA: It is a two-tier system; that is the way it was designed.

The Hon. WALT SECORD: Yes. So all the denial of that this morning—that it is not a two-tier system—

Dr SARA: It was established as a two-tier hospital.

The Hon. WALT SECORD: I know it. I just wanted you to confirm it on the record.

Dr SARA: That is the way it is set up. That is the role delineation of it.

Ms CATE FAEHRMANN: Exactly where is that level 4, level 5 delineation? Where is that? I asked that question this morning.

Dr SARA: My recollection is that interventional cardiology, interventional neuro-radiology is level 5, not level 4. Intensive care is more level 5 for private than it is for public. Some public patients will be in it. It is around the neurosurgery, the interventional cardiology and intensive care. That is my recollection. If I had known that it was going to be an issue I would have read it up. That is my recollection only.

Ms CATE FAEHRMANN: Thank you. I will have a look at that. Your submission on page 26 talks about public-private interface, which I thought was very interesting indeed. You write that, particularly for junior medical officers [JMOs]:

> The demarcation between public and private patients is complex. Private patients are in public wards and public patients are in private wards, and JMOs can not simply skip patients in the same ward.

You say:

> Junior doctors continue to report that private patients are still primarily looked after by NSW Health employees, which is a breach of what is we can which is clearly outlined in Project Deed:
>
> '59.5.c.i: JMO Positions must be directly associated with the treatment of Public Patients'

That is rather alarming and concerning. Can you expand on that for the committee.

Dr SARA: I am certainly happy to. The original proposal was that there would be separate bedded areas for private patients and that there would be career medical officers who would be employed for the sole purpose of looking after the private patients. As I understand it, that model is no longer in operation. So the public and private patients are mixed. There is a small difficulty for junior doctors. Under the good Samaritan principle of duty of care, if someone is very unwell and needs something right now then they would be obligated as a professional responsibility to look after the private patients to save their lives.

We did seek clarification of that in terms of the Treasury Managed Fund [TMF] and there is written advice from Northern Sydney and the Secretary that they would be covered by the Treasury Managed Fund for those purposes. But that clarity between public and private patients—initially it was to be quite separate; it has now become very blurred. Our understanding is that the junior medical officers, even though they were not meant to be looking after private patients, they are now. Given they have TMF coverage I guess they are not personally at risk.

Ms CATE FAEHRMANN: TMF?

Dr SARA: Treasury Managed Fund. Health is a self insurer via the Treasury Managed Fund. It is a fund operated by the GIO on behalf of Health. So, in a sense, we self insure. The difficulty, though, still comes back to workload. If you have this quantum of private patients who were going to have a career medical officer looking after them—and the career medical officers are not there for the private patients in our rotated staff from Northern Sydney—they end up looking after those patients. So it is an increased quantum of work for them to do.

Ms CATE FAEHRMANN: So there could be a ward, and in that ward there are public patients and private patients. So your junior doctor should be, according to the project deed, walking past the private patients and just dealing with the public patients, but you are saying that many of them are feeling obliged—because of their duty of care—to see private patients if they need to be seen?

Dr SARA: I understand that it is now part of their duty. It has changed from the original model project deed so that it is now part of the responsibilities of their job.

Ms CATE FAEHRMANN: So doctors are paid for by NSW Health to treat the private patients at Northern Beaches Hospital.

Dr SARA: Yes. This is—

Ms CATE FAEHRMANN: Seriously?

Dr SARA: That is my understanding.

Ms CATE FAEHRMANN: Taxpayers' money.

Dr SARA: I am happy to be proven wrong, but essentially for an elective surgical patient, the VMO surgeon will do the surgery and then the post-operative care—for one- or three-to-five days—is by the junior doctors, it is my understanding. They are looking after the private patients as well, in their post-operative care state.

Ms CATE FAEHRMANN: Wow, that is really some type of public-private partnership model of care. They said it was a new model of care this morning. I did not realise that it entailed that. That is extraordinary. I wonder if we can get any more information. Did you say that it is now in the project deed?

Dr SARA: I do not believe it is but essentially that is the way it is done at the moment, I am advised.

Ms CATE FAEHRMANN: Wow. You also wrote in your submission:

> A significant issue that has recently emerged is the variation to senior doctors entitlement to superannuation.

Dr SARA: Yes.

Ms CATE FAEHRMANN: Could you please expand on that for the committee.

Dr SARA: The beginning of this was that in terms of the transfer of existing staff specialist employees at the hospital, the hospital elected to not offer the terms and conditions that the State offers. We ended up in the Industrial Relations Commission to try and prevent that happening. They then cherry-picked parts of the determination for rights of private practice. We had no choice but to accept, in a sense, because that was what was offered. Our submission says that we were given a few days to comment and the staff were given a few days to sign up. Subsequent to that, there are differences between the State legislation and the Federal legislation in respect of the superannuation guarantee payments.

I do not know the very fine details, but staff specialists earn about $300,000, which is above the limits for super, and there is this maximum cap. It used to be $50,000; it has dropped to $25,000. Because of these conflicts between the State and Federal legislation, Healthscope said, "We're not going to pay." I am in a defined benefit superannuation scheme [SASS]. My superannuation payments are as per the State Act. It is more than the amount that is deemed by the Federal Act to be okay, but I still make those payments and I pay a section 293 surcharge. So it has worked out to be reasonable for me and for SASS and for the State. Northern Beaches have decided to follow with their understanding of the letter of the law—and the two laws are in conflict.

So we have sought, at some significant cost, an opinion from a barrister who is an expert in taxation and superannuation law. We are yet to decide what we are going to do with that. I suspect that we will need to run an action. Will it be in the Federal Court or will it be in the State Supreme Court? I have no idea, but essentially it is this attitude of, "We're not going to take care of you. We want to treat you like private sector widget factory operators." That is not the way to nurture senior staff. It is not the way to engage senior doctors to do the best for their patients and the institution. It is yet another slap.

Ms CATE FAEHRMANN: Yes. I assume it was not what your doctors were expecting—

Dr SARA: Not at all.

Ms CATE FAEHRMANN: —when they transferred over.

Dr SARA: No.

The Hon. EMMA HURST: Thank you both for attending today. In your submission you were very critical of the public-private partnership model in general. We have heard from you both today that hospitals under this model have a poor track record and that they are constantly failing. I would like to hear from both of you why you think that specific model fails?

Dr SARA: I have got an MBA from the University of Sydney—very highly finance-based. The Productivity Commission report and the McKell Institute reports are sort of economics 101. For an equivalent level of services, staffing, whatever, the public sector can do it cheaper than the private sector. Essentially you have to add a profit margin. If you look at the earnings before income tax and amortisation you have to add 10, 15, 20 per cent. The taxman takes half, unless your assets are in the Cayman Islands and you are repatriating the profits—sorry, that was a—

The CHAIR: Moving right along.

Dr SARA: It is economics 101. You cannot provide a hospital for the same level of service and safety and the same quantity of experienced staff in the private sector for less money. It is just not possible.

Dr JOSEPH: Thank you. I would like to add to that. If you are running a private hospital which has to turn a profit for the shareholders then I do not think it is ethical to actually make a profit on the basis of the misfortune of public patients who actually end up in your hospital. Public patients are often unpredictable in the costs incurred in the treatment. If you have a private surgical hospital you know what your costs are going to be. You go in to get your hernia done, you are out of there in two minutes—or, you know, a couple of days. If you have pneumonia and you are older and you have heart failure than you might get a clot in your leg—the care is unpredictable and so are the costs.

I guess that if you are running a private hospital—that is ruling out the public patients—you are going to be looking at the bottom line. You will want to maximise your profits. The way that you do that is you cut your staff payments—that is the first thing—and you cut back on some of the equipment. We saw that when the hospital opened it was not actually adequately prepared because it did not actually have enough equipment to manage the acute patients who were coming in to the emergency department.

The Hon. EMMA HURST: Do you think there is a risk with this particular hospital that it will have to bought back or rescued in some way by the Government?

Dr SARA: The best predictor of future behaviour is past behaviour. A sage said that; I do not remember who it was. Six out of eight have failed outright. Port Macquarie, I think the then Premier or Minister for Health, Andrew Refshauge, made some comments, "We've paid twice for it" and the Auditor General I think said, "We have paid twice for this". If six out of eight have already failed and had to be bought back the likelihood is that Northern Beaches will fail.

Joondalup failed under St John of God—that is a not-for-profit Catholic healthcare organisation, which has got the best of intentions. They run some wonderful hospitals across Australia. It failed for them. Ramsays have bought it; it is not well applauded by senior doctors in Western Australia. I would think on the balance of probabilities that Northern Beaches will fail. Our public position is not to say it will fail, but I think it is likely to fail and we will need to buy it back as a community. My personal view—not the public position of the Australian Salaried Medical Officers Federation [ASMOF]—is that it is very likely to fail.

Dr JOSEPH: I agree. Again, if you are looking at the bottom line for your shareholders then you are going to deliver lesser quality of care. We saw that with Port Macquarie. The Government knew that when they embarked on this and still embarked on this flawed model. I think the problem is that Healthscope actually cannot manage a public hospital. I think a lot of the doctors and nurses in there are very good and very dedicated and it is only because of their dedication that the hospital has worked to date. But unless we see an integration of Northern Beaches with the Northern Sydney Local Health District it will not pass the test of time.

The Hon. EMMA HURST: Your submission highlights some of the serious problems with the hospital's electronic medical records system. Can you explain some of the problems that you have identified?

Dr SARA: There are three sets of issues and there are three sets of software. The patient administration system [PAS] records who was admitted, what their diagnosis was and who their relatives were and when they were discharged. The Telstra Health product is the electronic medical record [EMR]. I do not want to speak to badly of it because essentially it did work well and continues to work well at St Vincent's. However, there is no proper integration between the PAS and the EMR. The third piece of major software is the Cerner Health Information Exchange [Cerner HIE]. It was meant to go live in October last year. It is essentially a product that goes over the top of the Cerner PowerChart product used at Northern Sydney. It would allow read-only access by staff at Northern Beaches to see what the discharge summary was, to see what the pathology results were, to read some of the notes.

That was unsafe until about four weeks ago. Essentially the mapping of the fields meant that you could not look it up and actually see what you thought you saw. So eHealth NSW has been working furiously to get that up to speed. It went to pre-production couple of weeks ago. It is yet to be determined whether it will work properly or not. Clearly we hope that it does, because if you are at Northern Beaches and the patient has been to Manly, Mona Vale or North Shore you want to know the pathology results and their discharge summary. That is another issue with the health IT. We will come back to deLacy Telstra Health in a moment.

The last thing is that the pathology system is less than optimal and the pathology provider is less than optimal. That was made clear by the patient having the wrong side of their colon removed. In our submission we note that this private sector provider cannot do proper anatomical pathology reports—they still cannot get it right. They are still mislabelling specimens and that is what happened with that wrong colon. We have made representations to Healthscope on a number of occasions. It is essentially their problem. They have got a contract with ACL. Yes, you will say, "Dr Sara, you have got pathologists as members. You just have sour grapes that NSW Pathology was not successful." However, we know—

The CHAIR: Sorry: "ACL", for Hansard?

Dr SARA: ACL—I do not know. It is—

Dr JOSEPH: Australian Clinical Labs.

Dr SARA: Australian Clinical Laboratories. We know that the very big pathology vendors can do public-sector pathology. We certainly know that NSW Pathology can. It does on-the-spot tests, it does acute tests, it ships them out for lower-volume tests. The reports come back—you can trust the reports that come back. If you take six biopsies and you label them A to E then you expect to get a report back saying what each one of those was and you expect the report for that biopsy, that specimen to be listed against that. In your operation notes you will delineate what A to E were. That is what pathology providers are expected to do.

I think that it made it to the press that our junior doctors could not get a gram stain on a query septic hip in a child. They could not do it on site. They are set up for a private hospital where it is light and easy and

everything will be fine and those rigors, as Dr Joseph talked about, are very unwell public patients. They are just still not able to do that and the pathology lab clearly cannot do that. It is in our submission that as of only a few weeks ago the pathology laboratory is still unable to do what is required for a public hospital. Let's come back to Telstra Health. It is a product that has been in use in Western Australia and at St Vincent's. It has been reasonable. They incorporated a prescribing module in it that is fairly reasonable and fairly safe. However, it is perceived by our members as being more suited to office practice than public hospital practice.

Healthscope made a decision to choose that—I suspect on the basis of costs, because Cerner PowerChart is expensive. You pay for what you get. Could that reflect the profit motivation, that they chose a cheaper product? I suspect it does. I do not particularly want to go on the public record as bagging the Telstra Health product. It worked very well at St Vincent's. The young doctors were not happy for the first few months. It was not configured by Healthscope. They chose not to configure the product. They chose not to consult the doctors as to how this product should be configured; they just said, "Whatever you want to do is fine".

So the staff, at the beginning of the process of implementation, six months or nine months before the hospital went to live, chose not to engage the junior and senior doctors on how should this product be configured and, therefore, it did not work properly. As well, there was an issue with sizing. They did not have enough servers and enough computing power at the back end and so it did crash and it did go blank. Again, it goes back to inadequate preparation of the product and the computer capacity behind it. The Cerner Health Information Exchange [HIE], I guess, was probably preventable but these things take a lot of time and a lot of effort.

The Hon. NATASHA MACLAREN-JONES: I wanted to check: Your union membership is 5,000 members. Is that New South Wales?

Dr SARA: We have roughly 5,000 members, yes.

The Hon. NATASHA MACLAREN-JONES: Are they paid-up members of the association?

Dr SARA: That is correct, yes.

The Hon. NATASHA MACLAREN-JONES: How many of those are from the Northern Beaches Hospital or work in the Northern Beaches Hospital?

Dr SARA: The majority of staff specialists are members—those who transferred from Manly and Mona Vale to there. We also have some of the staff specialists who have been employed by Healthscope; they have also joined up. We are a sort of a bit of a hybrid. I am the president of the State union but I am also the president of the New South Wales branch of the federal union. We cover those staff who are rotated from Northern Sydney under the State award but we also cover those persons in the federal industrial relations jurisdiction who are staff specialists who are employed by the hospital directly.

A number of those staff have joined us up but they have joined the New South Wales branch of the federal union. In a year's time, we will be attempting to prosecute with the hospital a federal enterprise agreement, so we cover industrially the staff specialists who are there now but transferred because there is a two-year carriage. We cover those who have subsequently been appointed by Healthscope and we cover the junior doctors who are rotated there from Northern Sydney as the State union.

The Hon. NATASHA MACLAREN-JONES: I am happy for you to take this on notice but could you give a breakdown of the number of members who come from the Northern Beaches Hospital? I am just keen to know the number of doctors you are representing who are members of your union and those who may not be.

Dr SARA: My guesstimate from October-November is that we had about 26 members out of about 30.

The Hon. NATASHA MACLAREN-JONES: I am happy for you to take on notice if it is easier.

Dr SARA: I think 26 out of 30 of the Manly and Mona Vale doctors were members of ours. Some joined in the last few months before the transfer. They may have been a bit apprehensive but we cover three-quarters of the junior doctors rotating from Northern Sydney.

The Hon. NATASHA MACLAREN-JONES: I am happy for you to take that on notice just to get those exact numbers so we can look at how many are employed and are members. One of the terms of reference is looking at the impact of the Northern Beaches Hospital on the local area, including lower North Shore. Some of the evidence presented this morning is showing that from a community perspective, there has been an average of more services at Brookvale and Seaforth and so on. We also received evidence that said that there is been a drop of around 50 per cent of transfers that are no longer going to Royal North Shore Hospital because we have the Northern Beaches Hospital. I am interested in your views, particularly you, Dr Joseph, as you work at Royal North Shore Hospital. Surely that is a benefit for the community but also for being able to provide services at Royal North Shore Hospital.

Dr JOSEPH: Thank you. There is no doubt that our services have improved over the past couple of months but I think it is clear from talking to patients that there is a certain group of patients who do not have much confidence in the Northern Beaches Hospital. Also, if you look at the submissions from the patients and also from the local doctors, some of them do not have much confidence in Northern Beaches so they would bypass Northern Beaches to come to North Shore. I cannot give you the exact figure of the decrease in ambulance transfers but I know we still do receive—we are on trauma bypass to the Northern Beaches, so that comes to us anyway. Some of the stroke calls and the individual cardiology will still come to North Shore.

I think they are wrapping up the individual cardiology at Northern Beaches but they are not there yet. The thing for Northern Beaches, I think, is that they really do not have the confidence of the community for a lot of the population. I gave you the example of the older woman who got a taxi from Narrabeen. It cost her $100 to come to North Shore because she did not go to Northern Beaches because she had a bad experience there. I know one anecdote does not make a case but it is similar to the experience of the patient population.

The Hon. NATASHA MACLAREN-JONES: I think that is important because we are receiving a lot of submissions from patients and also from staff and they are coming through into the submissions supporting the hospital, the staff and reinforcing what has been done there. I am happy to ensure that you see of those positive stories as well so you are getting a bit of a balance. You have referred earlier to the HETI report. I am not sure if you are aware or have seen the Healthscope submission. I want to highlight a couple of things. They did admit in the hearing this morning that there were challenges at the start and apologised for that. They have been working on addressing those. Are you aware that there is now a career medical officer assigned to each acute inpatient floor overnight?

Dr SARA: I am not specifically aware of that, no.

The Hon. NATASHA MACLAREN-JONES: That is something that is happening. The other thing is that there is an interim deputy director of medical services appointed with direct responsibility for JMOs. That has been a permanent appointee from August. Are you aware of that?

Dr SARA: I think I suggested it. He is a fellow of my college. The advertisement appeared. He did ask me my thoughts about the appointment and I had a conversation with him but I do not think I should say his name because I am not too sure that it is public.

The CHAIR: No, there is no need to.

The Hon. NATASHA MACLAREN-JONES: No, there is no need. You said that was a suggestion of yours. Was it something that you suggested to Healthscope through consultation?

Dr SARA: I think in conversations we suggested that you need a proper Fellow of the Royal Australasian College of Medical Administrators [FRACMA] medical manager to properly run a public hospital. They are quite different to private hospitals: You have to satisfy more constraints and more requirements in terms of junior doctors early in the training, and there are much sicker patients. I did suggest that and so some months later they advertised and there are about to make an appointment.

The Hon. NATASHA MACLAREN-JONES: That is great. Healthscope said that they are then engaging with stakeholders and taking on advice so it is fantastic to see that. The other one that they said was the collaboration with the district to clarify roles better and also the role of JMOs and their teams. Are you aware of that? They mentioned this morning they have regular meetings—I think it was weekly.

Dr SARA: I think I did indicate that our senior industrial officer went to see their interim director of clinical services. Yes, we are aware that those processes are continuing and the consultation is continuing. It was certainly not the way it started out.

The Hon. NATASHA MACLAREN-JONES: They did apologise for that as well.

Dr SARA: But it took a long time for them to wake up to the fact that that is not the way you run a public hospital. Will they continue to strive for excellence in patient safety? We certainly hope so. In our submission we suggest that we would be happy to continue that process and dialogue. My sense is that with the new private equity partners, there are significant pressures and drivers to drive costs down, which means that potentially that will cause issues with driving staff harder and potentially raising questions with patient safety. We would be very happy to participate in those processes. We also said in our submission that we think that the Government, HETI and the Bureau of Health Information [BHI] need to drive quality very much harder in that hospital.

The Hon. NATASHA MACLAREN-JONES: That was a question I did ask of Healthscope this morning in relation to their policies and procedures and they said that there HAVE over 600 listed. I know you made reference to some hospitals having hundreds. Are you aware that they have over 600?

Dr SARA: The staff specialist I spoke to four to six weeks ago said they do not believe that to be the case.

The Hon. NATASHA MACLAREN-JONES: That is something this Committee can take on notice to ask Healthscope to clarify if you have evidence to see that is not correct.

Dr SARA: Healthscope made a media statement in January to say they had 246 policies. Our junior doctors and senior doctor members said they could not see them and that they did not know they were not there. Large numbers of such policies for private hospitals are likely to be around procurement; they are not likely to be around how to take care of sick persons. In January our members said they do not have the broad range of clinical policies, processes and procedures that you expect in public hospital for very sick patients. There has been no evidence presented to us or to our members that there are hundreds and hundreds of clinical policies. They just are not there. As I say, a staff specialist who is on their policy committee said to me four weeks ago said, "We've done six this year—that's it."

The Hon. NATASHA MACLAREN-JONES: The final question is, you referred to the Bundy system for doctors. You had concerns that they needed to clock-in and clock-out. Could you elaborate as to what the concerns were around that?

Dr SARA: The junior doctors were told that they would have to tap-on and tap-off when they came to work and when they left. That does not happen anywhere else. Given the hours that young doctors do, in terms of unrostered overtime, they are never going to be there for less time than they are paid for. The evidence is that they are there for hours and hours longer. The unrostered overtime is a major issue. We are having a dialogue, I use the word advisedly, with the Government about unrostered overtime. The policy directive that reflects unrostered overtime has been changed to increase the number of occasions when unrostered overtime can be claimed without reference to your supervisor. It is one of the biggest problems in health.

Given the workload, given the pressure on young doctors, they are never going to do less hours than they are paid for. They are going to be doing more. Senior Resident Medical Officers [RMOs] in surgery were starting at 5 a.m. and 6 a.m. and going until midnight a number of nights each week. They are getting paid for eight hours. It is just an absolute slap to say you will bundy on, you will bundy off. Now for career medical officers who may not be doing a great deal, and who are not our members, it may be required, it may be not, I do not know. But for junior doctors rotated from northern Sydney and for the staff specialists that I spoke to last week, they are doing significantly more hours than they are being paid for. It is just a nasty thing to do.

The Hon. NATASHA MACLAREN-JONES: As a former theatre nurse, I know how hard they work and all the staff.

Dr SARA: Thank you sister.

The Hon. NATASHA MACLAREN-JONES: Is it possible that the clocking-on and clocking-off is actually building up the evidence to show that they are doing the overtime, to ensure that they are getting paid their hours.

Dr SARA: It is possible but that is not the way it was presented to them. It was presented to them as a management prerogative, we are going to make you do this. And we are locking the sleeping rooms, and we have locked the common room.

The Hon. NATASHA MACLAREN-JONES: But it could be that they are gathering that information to ensure that they are not working overtime and not being paid for that, which is a good thing to monitor if that is the case.

Dr JOSEPH: Can I just say that does not happen in any other public hospital in New South Wales. Registrars just need their supervisors to sign it, and they will get paid. So that is a unique experience.

The Hon. SHAYNE MALLARD: I think the workplace is changing in terms of people having to log on, for security and analysis of data. I am in a totally different industry—hospitality—they do a lot of scanning like that to.

Ms CATE FAEHRMANN: We do it in Parliament.

The Hon. SHAYNE MALLARD: Dr Sara, in November 2018 there was a tweet which the ABC put out which was a quote from you. It says:

Correct me if I am wrong here, subsequently more recently you were asked by a television journalist whether the hospital is safe now and you said, words to the effect, I would rather not comment. Is that right?

Dr SARA: Yes, that is correct.

The Hon. SHAYNE MALLARD: We have heard the Hon. Walt Secord talk about the morale of doctors. As a representative of the doctors, do not think that undermines their morale at the hospital?

Dr SARA: It possibly does. The background, and my big picture sense, is that in November it was clearly unsafe. The Health Education and Training Institute [HETI] report makes that clear. The young doctors' concerns made that clear. The lack of equipment, no laryngoscopes on trolleys, drugs around the place, it was clearly not adequate.

The Hon. SHAYNE MALLARD: Dr Joseph said that—

The CHAIR: Excuse me—

Dr SARA: Can I finish? Subsequently we have continued to get concerns made to us by our members. I did not feel competent to say, it is safe. I did not feel competent to say, it is not safe. At that time, a month ago, was it equivalent to a public hospital. I suspect not. I did not perceive that I, as president of the union, should make a definitive statement that it was, or was not safe. If I said it was safe, and it was not then members would say how dare you, or the public would say how dare you. If I said it was not safe, my employers in health would say how dare you. I thought discretion was the better part of valour and that it was safer just to say I do not think I should comment.

The Hon. SHAYNE MALLARD: I put it to you that some of your members at that hospital were furious about the lack of support from you.

Dr SARA: Correct. I have an email from doctors in the emergency department. They are doing the very best they can, in spite of the information system issues, in terms of staffing, in terms of morale, in terms of effort in the emergency department, they are doing a really good job.

The CHAIR: Just hold it. Just be very clear. I think you may have misunderstood the question.

The Hon. WALT SECORD: You misunderstood his question.

The Hon. SHAYNE MALLARD: I thought he answered it.

The CHAIR: Point of Order. The question was, reflecting on the position of Dr Sara in terms of members of the hospital that were angry at yourself.

Dr SARA: Yes, that is correct. I had an email from emergency doctors. I responded and said, I believe that you are doing the best you possibly can. The issue is not so much the emergency department. The issue is behind the emergency department, in the wards of the hospital, with lack of staff, too many chief medical officers, too many locums and inadequate policies and processes. So you can draw a distinction between the emergency department and the rest of the hospital. I am very happy to say, that as far as I can see, the emergency department doctors, a number of whom are our members, are doing a great job and doing the best they can.

The CHAIR: Thank you gentlemen for coming along this afternoon and providing us all with an opportunity to ask you some questions to elucidate on what was a very useful submission made by your organisation. There are some questions which have been taken on notice. I suspect there may be some supplementary questions arising from today's transcript. We have a 21-day turnaround time in regard to responding to those supplementary questions or questions on notice. The secretary will liaise with you. Thank you very much for presenting this afternoon.

(The witnesses withdrew.)

BRENDAN ROBERTS, Acting divisional manager, public health, Health Services Union NSW, affirmed and examined

GERARD HAYES, Secretary, Health Services Union NSW, sworn and examined

KIERAN DALTON, Australian Nursing and Midwifery Federation Branch Organiser, Northern Beaches Hospital, affirmed and examined

DENNIS RAVLICH, Manager, Member Industrial Services Team, NSW Nurses and Midwives' Association, sworn and examined

BRETT HOLMES, General Secretary, NSW Nurses and Midwives' Association and Branch Secretary, Australian Nursing and Midwifery Federation NSW, affirmed and examined

The CHAIR: Your respective organisations' submissions have been received by the committee secretariat, have been duly processed and uploaded onto the inquiry's website. The NSW Nurses and Midwives' Association's submission is No. 200 and the Health Services Union is No. 108. If you are okay with this, what we would like to do is offer both organisations the opportunity to make an opening statement. Take it that the submissions are read so there is no need to go into the specificity of what the submissions contain, but some opening words and thoughts can be given. When that is done we will open up to questions across the political parties. We will begin with Mr Holmes.

Mr HOLMES: Thank you, Chair. On behalf of the NSW Nurses and Midwives' Association along with the Australian Nursing and Midwifery Federation, New South Wales Branch, we welcome the opportunity to provide evidence to the Committee today. The inquiry is timely, if not overdue. It occurs at a moment when we can reflect upon 10 months of activity of the privately operated Northern Beaches Hospital, which superseded two previously publicly operated facilities, namely Manly and Mona Vale hospitals. In New South Wales our membership includes nurses, enrolled nurses and assistants in nursing working in either the government or non-government health sector, State or Federal. Accordingly, there is nothing in the association's views that can be said to be coloured or prejudiced by issues of changing or lost union coverage or the like. We cover nurses wherever they work.

To be clear, the association and its members have, from the moment the announcement was made in May 2013 of a privately operated hospital for the northern beaches, expressed opposition and concern. We are not a newcomer to this debate, just jumping on the bandwagon arising from the reality that is opening. Our concerns were always based on previous poor experiences with privatisation in the public health space as well as the inevitable loss of control over public health services. The integrated and statewide strength of the public health system is only diminished by the creation of carve-outs or enclaves operated by third parties. As noted in our submission, one of the so-called claimed benefits of privatisation offered by bureaucrats and backers is that it shifts financial and operational risk to a third party, away from the New South Wales Government and the Ministry of Health. Current experiences only again demonstrate that it is ultimately the patients and staff and community who carry the burden of risk.

Disappointingly, as reflected in our submission and in many others, problems are being encountered that cannot be trivialised as teething problems or as those that could reasonably have been expected to arise when opening a new hospital. The extent and prevalence of the crisis on opening were profound, significant, and, to be frank, incomprehensible, even for those of us who may have expected the worst. It was diametrically opposite to all of the cast-iron assurances provided by Healthscope, the Ministry of Health, the Northern Sydney Local Health District and the New South Wales Government that all was well, the hospital had plentiful numbers of staff and that medical technology, described at the time as being akin to the wonders of a Disneyland, was about to be unleashed. How utterly wrong that was. Surely someone or some organisations must be held accountable for the fiasco following the hospital's opening—whether arising from sheer incompetence or the telling of brazen untruths prior to its opening: Or is it a dismal cocktail of both?

For example, it is impossible to accept that Healthscope or the local health district or the Ministry did not either know the real poor state of staffing that would be in evidence from day one or, at the very least, did not harbour strong suspicions of its failings. Unfortunately, from the experience of members as set out in our submission, these struggles and difficulties continue and remain in various ways 10 months after opening. It is a malaise permeating many aspects of the hospital's operating capacity. Ultimately that the hospital continues to provide services of any quality is largely a testament to its staff and their persistence and resilience along with their professional commitment to their patients triumphing over the considerable barriers they confront on a daily basis.

What may be practically and legally possible under the deed between Healthscope and the New South Wales Government is likely to be limited. The association and its members have respectfully suggested in our submission matters that could be considered by the Committee. This includes at its highest a return to public ownership to other very specific and targeted steps can go some way to assist in overcoming the current difficulties now and into the future for the benefit of patients and staff. Of course, we are happy to answer any questions that the Committee may have and assist in whatever reasonable way that may improve the current situation. Thank you.

The CHAIR: Thank you, Mr Holmes. Would any other witness from any other organisation like to add to that?

Mr HAYES: I will not go over some of the ground that my colleague has mentioned. The Health Services Union NSW [HSU] is not new to private-public partnerships, which is an underpinning problem, I think, for all governments of all persuasions. The HSU has been involved with the Port Macquarie matter back in the early-to-mid-nineties. We have also been involved with the Orange and Bathurst hospital privatisations. We have also been involved with the Royal North Shore privatisation, which, I would note, part of that has been brought back in under HealthShare. Consistently we see pressure put on the public system when there is a private partnership and a private competition for dollars to be engaged in that. We see that the Government has a real responsibility to care for the people of New South Wales in terms of their health. That is hard to do when it is actually competing against a profit-driven industry.

You will see in our submission at this point in time that we look at areas of cost-shifting. We look at areas where people are encouraged to go down a private path where there are limited resources in terms of not only human resources but also physical resources and assets as well. This limited resourcing only promotes further frustration of our members. One of the issues we see at the moment for a hospital that is barely 10 months old is morale within the membership is probably lower than in many hospitals that are decades old. We have also seen recently that basic things like information technology [IT] systems are incompatible, which is just unbelievable in this day and age. We welcome the opportunity to be here today and to make a constructive effort to have an improvement in the system.

The CHAIR: Thank you very much. Before we commence with questioning, which we will do in a moment, I preface that part of the session by saying it is very important we present the questions to the witnesses and allow them to answer, and that should be the back-and-forth exchange. If the witness does not hear the question, they can ask to have it repeated, but members will allow them to answer it before they ask the next question. I think that is the best way in which to proceed so that everyone can have a fair crack. We will begin with questions by the Hon. Walt Secord and then moved to the crossbench and then to the Government.

The Hon. WALT SECORD: Mr Hayes, you mentioned in your introductory remarks problems about the IT system being incompatible. Can you elaborate on that, and can you talk about how it affects your members and also how it affects patient care?

Mr HAYES: There are two issues that we have raised. One in our submission is that our members in medical records at Royal North Shore Hospital—while it would appear that Northern Beaches Hospital medical records are able to have access from Royal North Shore, the Royal North Shore Hospital cannot actually get information from the Northern Beaches, so there is a breakdown in that communication line. As we know, medical records is probably one of the most important facets.

The Hon. WALT SECORD: So how are they sharing information?

Mr HAYES: Our members are telling us that it becomes a very slow process. A lot of opportunity is lost by having to follow up by telephone calls and so forth. We found out only recently, as of today—this is not included in our submission—that in terms of pathology Northern Beaches Hospital is still using the Disk Operating System [DOS] system, which was utilised in the 1980s.

The Hon. WALT SECORD: DOS?

Mr HAYES: Yes. There is a blood bank function in the system. Our members are not clear on whether it is proved by the National Association of Testing Authorities [NATA]. The system is just not designed for a large hospital. These are people working in pathology; they are saying their tests and samples can be delayed due to the fact that these systems are so slow. The next step is that we have wardsmen waiting for results to be able to take back to the wards and they are indicating that there can be delays for those people as well. So it seems to be a bit of a slowdown of the system, clearly, because at this point in time it would appear that the IT function is not totally compatible, nor up to the standards of 2019.

The Hon. WALT SECORD: What kind of delays are you talking about?

Mr HAYES: Delays in terms of getting information on the tests. It goes to the point where test results provided insufficient data—example only. So it will give the date of the test, but it will not necessarily get the time of the test, and then you have to go into another part of the system to extract the time if that is what you want to do. Those small things all take minutes, which can build up to half an hour or so.

The Hon. WALT SECORD: Now, you also represent paramedics. What is the current state of play on patient transport? There was some denial that for life-threatening or major, complex issues paramedics were told to take them straight to Royal North Shore. Is that correct?

Mr HAYES: I do not know that paramedics have been told to take people directly to Royal North Shore. We have anecdotal information from paramedics but we have not included it in our submission because we do not have that firm that some paramedics are bypassing the hospital. As I said, we have not included it because we are not—

The Hon. WALT SECORD: So are they making personal judgements that they just think it is better for patient safety to go there?

Mr HAYES: Yes.

The Hon. WALT SECORD: And you trust that is a good thing to do? Because you are a paramedic.

Mr HAYES: Ex-paramedic. In regional areas it is not uncommon to bypass a hospital and go to a base hospital, or something along those lines, where the full range of services are there. That is not only a personal decision to make but paramedics do have the ability within the Ambulance Service of NSW to take such a course of action.

The Hon. WALT SECORD: In your submission some of your members said that it took nine weeks to get mops. There was one mop and one bucket for a ward. Also, staff were told to provide hot meals for breakfast to private patients and cold meals to public patients. Do you stand by this submission?

Mr HAYES: This is what has been reported to us from our members. In terms of the hot and cold meals, as I understand, when members who were working at either Mona Vale or Manly hospitals attended their orientation, that is what they were advised when they were doing their orientation. Bear in mind our members were highly confused as to how their rosters work, where they would be working and the orientation was relatively poor from what has been put forward to us.

When starting on the job there were limited resources. One would expect that not to be the case. But we do also note industrial staff indicated that throughout the build-up to the opening of the hospital, through negotiation with not only the health Ministry but also with Healthscope, that the information flow was poor at best. Indeed, I think the unions had to go to the Industrial Relations Commission on several occasions to try to extract information to be able to try to negotiate and also try to inform members of what their options were. Bear in mind people had to potentially make a choice whether they wanted to try to maintain a job or leave employment from the health sector.

The Hon. WALT SECORD: From your point of view and from your members' point of view, are there enough hospital workers to run the hospital safely?

Mr HAYES: I think it is clear the support staff that we currently represent, as well as our allied health professionals, are indicating that there is not enough staff. We understand that health generally is under pressure but here is a situation where you have a new hospital and one of our allied health professionals has indicated that they could not see 200 patients due to the fact—

The Hon. WALT SECORD: Say that again.

Mr HAYES: They could not see about 200 patients due to the fact that they just did not have enough staff to get through these lists. That is a concern. When allied health professionals, who are certainly there for the patients, find it frustrating to get to that point, it is a real concern. I just want to raise the issue that allied health professionals are about getting people out of hospital early and preventing them from coming back. So it is a major saving on the health system. To not be able to address that ability certainly is a concern for our members.

The Hon. WALT SECORD: Thank you. I notice that Mr Roberts was nodding at one point. Is there anything that you want to add?

Mr ROBERTS: Mr Hayes covered everything.

The Hon. WALT SECORD: Mr Holmes, in earlier evidence Healthscope mentioned that they will be renegotiating the award with the nurses. When will that occur?

Mr HOLMES: That is due in 2020. So there was a two-year period of retained conditions for those that transferred, but it just so happened that the Healthscope enterprise bargaining agreement [EBA] for New South Wales aligned with that same period of when the two years would expire. So the staff at Northern Beaches will be captured in the next round of bargaining with Healthscope.

Mr RAVLICH: Just for clarity I should add that is an agreement pertaining to nurses and midwives and it is a separate agreement.

The Hon. WALT SECORD: Mr Hayes, when is your agreement up?

Mr ROBERTS: We can take it on notice but my understanding is that it is around 2021. We can take it on notice and get back to you.

The Hon. WALT SECORD: Mr Holmes, earlier we also had evidence that the local community group representing mums supporting maternity services had concerns that patients and mums were funnelled towards intervention procedures. Can you elaborate on that, and what your members are telling us about that?

Mr HOLMES: My understanding from my midwife members is that they are concerned that the model of care has shifted from being a midwifery model of care to an obstetric model of care, which means that the obstetricians or the medical staff are making the decisions about things like discharges and the care. They also believe that they are seeing an increase in the caesarean rate and interventions. Obviously 10 months is a fairly short period but that is the—

The Hon. WALT SECORD: There have been a lot of births.

Mr HOLMES: —feeling of the midwives who are responding to us.

The Hon. WALT SECORD: Back to an issue that keeps coming up: Mr Hayes, when the hospital opened we had a bit of a debate about whether the hospital was ready when it was opened. What was the view of your members when the hospital opened in the last week of October, was it ready to be opened?

Mr HAYES: I think our members are of the view that it was rushed, and certainly our paramedic members were talking about access and egress being a difficult situation. For all intents and purposes it would appear that it could have been opened in a more timely fashion.

The Hon. WALT SECORD: Mr Holmes, do you and your members agree with Mr Hayes' members?

Mr HOLMES: From the preparation of the hospital, in terms of whether it was fully staffed, no. Did it have enough stock and equipment? No. Why would you open a hospital before you have equipment on the shelf and enough staff to safely operate once you open those doors? Everyone knows that—it happens in NSW Health and surely they were talking to Healthscope—if you open a new facility, there is a drag experience; that is, a lot more patients turn up to a new facility than were turning up to a previous facility. That has occurred at every opening of a new build of a hospital across New South Wales and there was no reason to think it would not happen at Northern Beaches.

The hospital was not prepared for that, a large ED operating but without the capacity or level to cope with the pressure that was there. Of course, there was a massive shortfall in the number of staff available. The IT systems have been mentioned and were not ready. People were not trained in those IT systems. The staff did what should be recognised as a magnificent job to get in there and help save lives. I am not sure that there has been enough recognition of that. It would have been like going into a disaster zone but having inadequate equipment, basic equipment and inadequate staff and unfortunately having to rely on agency staff to fill large numbers of shifts. We had situations where for many months there were more than 100 agency staff being employed per shift.

The Hon. WALT SECORD: What happens to patients? Is there a lack of knowledge?

Mr HOLMES: Yes, there is an inconsistency in where those staff might be allocated. We received reports from our members about the level of experience and expertise of those staff, the lack of orientation available to them. Even the permanent staff had difficulty with the new systems, and yet there could be as little as one, or even in some circumstances no, permanent staff on some wards for some shifts and it was all agency staff. There were those sorts of situations.

The Hon. WALT SECORD: How familiar would they be with the hospital?

Mr HOLMES: Completely unfamiliar. Even if you get a one-day orientation, that does not prepare you for everything that is going to come through the door. Where do you find things? What is the policy and procedure? There was a dearth of policies and procedures available as far as the staff was concerned. I note that Healthscope, the Ministry and Northern Sydney all say that there were plenty of policies available. I visited three or four months

after opening and when sitting down with staff they were still saying, "We don't know where those things are that they are talking about".

The Hon. WALT SECORD: Mr Hayes, I spoke to a wards person and they said that when the hospital opened there was actually a shortage of wheelchairs to move around patients. Has it improved? Is it now okay?

Mr HAYES: If you do not mind, I might defer to Mr Roberts, who might have a better idea of that.

Mr ROBERTS: Certainly that was our understanding, that early on there was a lack of wheelchairs and things like that. We reported on the opening day that admissions clerks were not sure where things were—there was a lack of signage and things like that. In terms of how it is now, my understanding from talking to members is that it is improving, but slowly. That is the challenge they were faced with. Obviously things are getting better, but in the early days there was a lack of signage, lack of equipment, lack of wheelchairs, as you say, yes.

The Hon. EMMA HURST: My first question to the Health Services Union is: In your submission you talk about the requirement that Healthscope imposed that required housekeeping and caring staff to have previous experience working at a five-star hotel. For the benefit of the Committee, can you explain why that would be problematic?

Mr HAYES: Both housekeeping and catering are part of the clinical function, so working in a five-star hotel, where you do not have things like vancomycin-resistant enterococci and staphylococcus [staph] as conditions that could actually kill somebody, in a hospital these things are really important. We see in areas of health that the catering people who are delivering food to particular patients now record on iPads what patients are consuming and what they are not. It goes some way to address things like malnutrition but also, from a saving point of view, saves NSW Health about 18 per cent in wastage. It is an integrated function, not just about making sure that the beds are rolled down at night and that people are very comfortable in a five-star hotel.

The Hon. EMMA HURST: Did the advertisement actually preclude experienced workers from other hospitals?

Mr ROBERTS: I can answer that one. Yes, people acting in managerial roles within cleaning and environmental services excluded them because, I understand, they needed a minimum of four or five years' experience and these people would not have had that. I know at least one of them has been transferred to Ryde Hospital and they were unable to apply for those jobs. If they did, they were unsuccessful.

The Hon. EMMA HURST: In your submission you also recommend a fully independent review of the current staffing requirements at this hospital. Can you expand on why this is required and why it is important for that review to be independent?

Mr HAYES: I think it is very important. We have seen already at Royal North Shore that the soft services, which were part of a public–private partnership [PPP], have been brought back in-house due to the fact that delivery was not there. We have seen in other areas where PPPs have been involved that there is great pressure on the function of the clinical facility, but also at the same time there are abatements in place. There is a real contract issue between the organisation and the Government. Having a review that is independent of all parties would mean that the body could review that the numbers are right, that there is a holistic approach to a patient's outcome that is inclusive of medical practitioners, of nurses, of allied health professionals and of people who are cleaners and who can prevent infection and so forth. It is such an important thing not only for a general hospital on a yearly basis but for this particular hospital given that the focus is currently on it.

The Hon. EMMA HURST: Your submission refers to a report saying that patients are being pressured into using their private health cover, rather than being admitted as public patients. Witnesses we heard from this morning denied this. Can you expand on your evidence to explain how this is happening?

Mr HAYES: I can only qualify that comment by indicating that our staff who interviewed members said that this was put to them, particularly by admin staff. I would probably suggest it is not something uncommon in a facility like this and, indeed, in places like Port Macquarie it was an active strategy.

The Hon. EMMA HURST: Moving to the NSW Nurses and Midwives' Association, you said in your submission that the poor staffing and management of the Northern Beaches Hospital could create a professional and legal risk for doctors and other health professionals. Can you expand on that specifically?

Mr HOLMES: In our submission, of course, we outline an example of where midwives have been severely criticised and subject to the Victorian tribunal as a result of their decision to continue to provide care despite everything else they had done in a particular circumstance. The conclusion you draw from that is that you can be still held accountable, no matter how much you have raised your concerns about the standard of care or the

quality of staffing, the number of staff and the skills of those you are working with. You are still held to account personally for whatever happens under your watch, despite the environment that you work in.

So our members reported that they went to work on the basis that they were concerned on every shift that their registration was at risk as a result of working in an environment where there were not enough staff to match the demands and needs of the patients and that they were working with people who did not have necessarily the skill level that was required to be looking after patients. So they considered themselves professionally liable for what was going on about them but powerless to make effective change.

They simply felt that they had to go to work and do the very best they could, but there were things that were beyond their capacity. That provided a highly stressful work environment every single day. They were reliant on many—as I said, over 100 agency staff per shift for many, many months and they are still reliant on those casual and agency staff. That provides a skill mix problem and those people are doing their very best but not necessarily having had the benefit of all the skills and experience that is needed in a level 5 hospital that professes to be providing the best possible level of care.

Ms CATE FAEHRMANN: Mr Holmes, in your submission to this inquiry—and I think we have just referred to it before—you mention moving from the State award to the Federal award, that some or many of your members working at the Northern Beaches Hospital will be needing to do that within a little over a year. Could you explain to the Committee—you also raise in your submission a number of concerns that you have with that for what that might mean for staffing arrangements at the Northern Beaches Hospital.

Mr HOLMES: Currently those staff who transferred from the public health system have entitlements to staffing arrangements, incorporated into the previous award and now the copied State award, that provided for a model of nursing hours per patient day for medical, surgical, rehab, palliative care and mental health and in midwifery for the birth rate plus staffing methodology. None of that is replicated in the Healthscope enterprise agreement. Despite campaigning and trying to negotiate that, so far there is only one or two private hospitals in New South Wales who have ever agreed to such a staffing methodology. Healthscope has certainly resisted.

So at the expiry of that agreement we will be concerned that the staffing methodology could change. As we have pointed out, there is a small irony is that people paying private health cover are being nursed in the private wards mostly staffed by non-public health staff and therefore their ratio—and the difference, just to explain in ratios, is one to eight. In the public wards it is one to four on the morning shift, one to five on the afternoon, one to seven at night. So there is the contrast of the different level of expectation that our members who have come from the public health system have around reasonable workloads, and that is not reflected in the private side of the facility.

Ms CATE FAEHRMANN: So if nursing staff go over to the Federal award at the end of 2020, patients at the Northern Beaches Hospital will see nurses less?

Mr HOLMES: That is right, if we are unable to convince the whole of Healthscope that they need to move to nursing ratios or a nursing staffing methodology that is equivalent to the public health system.

Ms CATE FAEHRMANN: How confident are you that you will be able to convince Healthscope to stick with the State award?

Mr HOLMES: As I said, there is only another two operators, Macquarie University Hospital and Lifehouse, who have ever agreed to a staffing methodology equivalent to ratios or to the public health system.

Ms CATE FAEHRMANN: So not too confident?

Mr HOLMES: No. We will fight very hard to do it.

Ms CATE FAEHRMANN: This is a question for the HSU. Thank you both for your submissions; they are very helpful. On page 2 you talk about the fact that the unions were asking Healthscope for the proposed models of care for staff, and that despite requests for discussions on service models, rosters, two weeks out from the transfer of staff and rosters there still were not prepared. Could you explain a little bit more about that and why that was such an issue for your staff?

Mr HAYES: It fundamentally goes to our assessment to advise members in relation to where the staffing levels or career prospects when they need to make a decision about where their future lies. It also goes clearly to the point of how difficult those lead-up negotiations were, that bearing in mind those discussions have been held over several years and, as I mentioned earlier, that to have to engage the independent umpire to try to get to a point of clarity, which is not unreasonable if it is a consultation in real terms, we have to go to that point. So to get to two weeks out and still not be any clearer and then not to have any answer at all, some of our members and

some of our officials have felt like we have been dragged along this trip for a while and it has just been dropped on us.

Ms CATE FAEHRMANN: Is that unprecedented, to not be provided models of care so close to a hospital opening when you have asked for it? Has that happened before?

Mr HAYES: In general terms, though, with health we generally bargain in good faith. In many parts of the private sector where we have membership, it is the same approach. So this is quite distant to what we would be expecting, fair and reasonable consultation and negotiation, bearing in mind, as I said, people are making lifetime decisions as to do they continue on. As Mr Holmes has just indicated, there could be great differences to their work patterns going forward. If we cannot be in a position to advise them, it makes it pretty difficult to make a good decision.

Ms CATE FAEHRMANN: Absolutely. On page 6 of your submission, there is a sentence or an example that is rather alarming. You say that the prevalence of pressure injuries in newly discharged Northern Beaches Hospital patients was also reported during interviews that I believe you may have had with your members, with allied health staff working in rehabilitation and therapy within the Northern District local—NDLHD. So an increase in pressure injuries as a result of—can you explain what is happening there?

Mr HAYES: If you can imagine that someone is bedridden for some time and then the patients need to be rolled to relieve the pressure on the particular area of their body. When people are working incredibly hard—and that is the collective health workforce—the ability to focus on these issues may slip from time to time. So as those being able to make sure that a patient has been rolled or a patient is not sustaining these types of pressure injuries is something that can only really occur when there is a lack of staff and the lack of ability for the staff to be able to make sure that all needs of a patient are being addressed, as opposed to trying to make do with what they currently have.

The Hon. NATASHA MACLAREN-JONES: I just want to clarify a question that was put by one of my colleagues to Mr Hayes in relation to ambulance transfers to other hospitals. We have received evidence earlier this morning that since the Northern Beaches Hospital has opened, there has been a reduction in the number of patients being transferred to Royal North Shore down to around 10 per cent, which is reflective of the fact that the Northern Beaches Hospital can now manage and deal with additional cases that they were not able to in the previous hospital.

I want to clarify your comments in relation to questions asked by the Hon. Walt Secord, where you said ambulance officers use their personal discretion at times. My understanding is that that is done when they arrive and assess the patient. In looking at the patient they would obviously look at the matrix first of all but, in the even that, having assessed the patient they feel that the local hospital—the hospital nearby—cannot accommodate, they will then transfer the patient to another hospital. For example, a major trauma to a child. Could you clarify, for the record, what you meant?

Mr HAYES: Yes. Again, that is why it is anecdotal and we have not put it in the submission. That would be in an emergency situation; it would not be a routine or lower-level situation.

The Hon. NATASHA MACLAREN-JONES: Thank you very much. I want to ask about the survey you have conducted. When was that done?

Mr ROBERTS: I will take it on notice, but it was done leading up to our submissions in the last few months. I will get back to you.

The Hon. NATASHA MACLAREN-JONES: Great. Thank you. That is all. I wanted to clarify that it was close.

Mr ROBERTS: I also want to add that only in the last month some of our team were up at Mona Vale and the northern beaches physically talking to people, as well.

The Hon. NATASHA MACLAREN-JONES: Perfect. If you do get additional information I would be grateful. Obviously our inquiry is going for a while so feel free to add that in. One of your recommendations was an audit of plant and supplies to determine and meet employee needs. What does that mean?

Mr HAYES: The fundamental thing, particularly when you have manual handling issues and those sorts of things, is to make sure you have the right equipment to prevent workers compensation matters and WHS issues. So I think if there is going to be a review of the hospital—not only from a human resource point of view—the assets of the building itself need to be addressed to ensure that ongoing issues, whether it is through understaffing or lack of equipment, are not going to produce injuries to workers.

The Hon. NATASHA MACLAREN-JONES: Are you aware if these reviews are being done now or you—

Mr HAYES: I am not aware of these reviews being done. Sometimes in many current hospitals, which have been in place for a long time we raise these issues, but it is very hard to get an independent review. We understand that hospitals are not cheap places to run, and that is where our concern is. When hospitals are not cheap to run sometimes savings need to be made. Unfortunately, sometimes they are made at the level of the workforce, and what the workforce needs in terms of assets and so forth.

The Hon. SHAYNE MALLARD: Thank you for your submissions with all the organisations. Mr Holmes, your members are also in the private sector, I think I heard you say at the opening. What percentage would that be—the public hospital system compared with the private sector. Is it just a small percentage?

Mr HOLMES: No, there are around 6,000 members in private hospitals across the State.

The Hon. SHAYNE MALLARD: As a percentage of your membership?

Mr HOLMES: Our total membership is 64,500.

The Hon. SHAYNE MALLARD: Thank you. It is about 10 per cent. Would it be right to say that your organisation is philosophically opposed to PPPs?

Mr HOLMES: Yes.

The Hon. SHAYNE MALLARD: Have you canvassed that issue with the members that are in the private health system?

Mr HOLMES: Yes. They are well aware of it, and they understand that our position is that we believe that there is a role for private health care and private hospitals. There is a separate role of the public health system and the provision of public health care.

The Hon. SHAYNE MALLARD: You would be aware that 29 per cent—nearly 30 cents in every dollar—of the State budget goes to our health system.

Mr HOLMES: Yes.

The Hon. SHAYNE MALLARD: Would you agree that it is incumbent upon government—no matter what flavour that government is—to try and get best outcomes for that money and keep it under control?

Mr HOLMES: Yes.

The Hon. SHAYNE MALLARD: Because it is exponentially growing.

Mr HOLMES: Yes, and it is incumbent on the Government to deliver the services that the people need to live in a healthy society.

The Hon. SHAYNE MALLARD: I want to touch on the staff arrangements for the transfer from the two hospitals to the Northern Beaches Hospital. Am I right to say that they got—was it one year or two?—entitlements protected but at any time in that period they could transfer back into a public hospital if they did not like the private hospital. Is that right?

Mr RAVLICH: If "transfer" means that they could return to the public health system with their entitlements and the like that is not correct. I think all unions were asking for a somewhat more beneficial way to manage the transition both ways—as an encouragement for people to go and at least try out Healthscope and then, if they were dissatisfied, that they could return. But the current situation is that essentially within the first 12 months after opening the hospital if a staff member wished to return to the public health system they would have to do so on merit. They would have to resign their employment with Healthscope. They would have all their entitlements paid out. The only concession during that 12 months is that if they paid back the full value of the transfer payment they received they would have their sick leave recognised. Beyond that 12 months—in other words, beyond the end of October this year—even that concession is wiped.

The Hon. SHAYNE MALLARD: I did not know that they got a transfer payment for coming across from the two hospitals.

Mr RAVLICH: We had argued that if you are a full-time employee and had been there it was a sliding scale depending on your length of service. But it was eight weeks pay, similar to what was done with Family and Community Services [FACS] nurses or FACS employees transferring as part of the NDIS system. But they would then be required, if they sought to exercise that in the first 12 months, to have paid that in total.

The Hon. SHAYNE MALLARD: Have many of your members transferred—even though it is on merit—back into the public hospital sector? Have they left the Northern Beaches Hospital?

Mr RAVLICH: There certainly has been a number. I could not tell you an exact figure.

The Hon. SHAYNE MALLARD: Can you take that on notice? Could you check that?

Mr RAVLICH: I will check but I am not entirely sure that our figure would be reflective of the true transitional movement of staff. We will do the best we can.

The Hon. SHAYNE MALLARD: I am trying to get some meat on the bones around this. Would it be fair to say that it is a small number? Guide us here.

Mr RAVLICH: It is probably a small number because in the whole process—it was five years in the making—a number of our members who have family or geographical commitments to that part of the State felt that it was a Hobson's choice, that they had no real choice, but that the Northern Beaches Hospital would be the best fit for them to manage their non-work-related life and activities. So for many of them the imperative of remaining there would continue to be the case regardless of the difficulties they may confront.

The Hon. SHAYNE MALLARD: Do either of the organisations have any engagement outside of New South Wales?

Mr HAYES: In terms of other health facilities?

The Hon. SHAYNE MALLARD: Other states?

Mr HAYES: We do in the Australian Capital Territory and in Queensland.

The Hon. SHAYNE MALLARD: I was going to ask about Joondalup hospital because we have had some comments from other witnesses today saying it is not in a good position but I have some feedback that the Labor Government in Perth is very happy with the way it is performing. Can you provide any insight on that?

Mr HAYES: I do not have any comment.

The Hon. SHAYNE MALLARD: I will leave that there. I am not right across the full detail on the Royal North Shore Hospital project that was mentioned in evidence. Correct me if I have this wrong. Essentially the building was constructed and the provision of that infrastructure was by the private sector but government employees are inside running it.

Mr HAYES: That is correct.

The Hon. SHAYNE MALLARD: That model of financing the infrastructure was under Labor. I guess there are services like cleaning and catering that are not your members, that are outsourced under that model.

Mr HAYES: No, in that model the employees are public health employees. Initially they were managed by an organisation known as ISS, which is part of the conglomerate, I am sure. Probably 18 months or two years ago, now, the Government took the decision to bring those services back in-house. That included cleaning, catering and a range of other services—what they call "soft services". It is now currently by HealthShare, which is part of the NSW Health.

The Hon. SHAYNE MALLARD: Is Spotless doing the—

Mr HAYES: Spotless are out at Orange and Bathurst hospitals.

The Hon. SHAYNE MALLARD: That model of private sector financing the infrastructure and providing the day-to-day infrastructure, not the medical start of it—would both groups support that model as a way of going forward in terms of this constrained financial environment?

Mr HAYES: From our perspective, how a hospital is built and financed is one matter for government. How it is run is seriously a matter for government. When we start to outsource our control of staff and patient outcomes to another party that may have a competing agenda—in the private sector that is not unusual—there becomes a conflict against that service that is to be provided to people of New South Wales who may not be the wealthiest people in the world and with an organisation who has to address its shareholders. I think that is a fair comment.

The Hon. SHAYNE MALLARD: I would be interested in your perspective, Mr Holmes.

Mr HOLMES: We share the same perspective, that the running of public health should be under the control of the public system. We see what happens when you have got two different lots of staff or even two different lots of management—frankly, it is not pretty. From our perspective it is not efficient or effective.

Of course, our members are delivering care but they are trying to do that with the support of Mr Hayes' members. If you have got split managements then you can get some unwelcome outcomes, decisions made by private companies that are not in the interests of the rest of the staff.

The Hon. SHAYNE MALLARD: It does sound less confronting for you than the Northern Beaches model. There are different types of models.

Mr HOLMES: Yes, there are. As Mr Hayes said, obviously private companies build hospitals. That is how it happens. It is then about who is operating it. In our opinion a public health service should be operated by the public system as a whole unit. Hospitals are complex organisations. If you add additional complexities like different management in the same hospital then you are sure to end up with poor outcomes where it does not mesh together and there are different philosophies about why they are there and what they are operating.

The Hon. SHAYNE MALLARD: I might not agree with that.

The Hon. WES FANG: There has been widespread acknowledgement today that there were some teething issues at the start. Have you found now that Healthscope is being more receptive to changes? Is the system improving at Northern Beaches Hospital?

Mr HAYES: I suppose I can only make an observation from our industrial staff who still find it to be an adversarial relationship, which is not one that we want to entertain. As you indicated, we understand that health takes up one-third of the State budget. It is in our interest and our members' interests to get the most out of things that we can. It is very hard to do that when you are working against a brick wall.

Mr RAVLICH: I think the survey results indicate that it is better than what it was in October. That is evidenced by the feedback we have received. Similar to what Mr Hayes said, we have always thought—Mr Dalton is often doing it on a day-to-day basis, but equally I was involved in a number of discussions with Healthscope trying to arrive at the best possible outcome that melded two differing staff covered by two differing arrangements to hopefully be not only to the benefit of the staff but the services that they provided. There is still much work to be done. I do not know if you want to add anything to that, Kieran?

Mr DALTON: There are still outstanding matters. Staff are disappointed that it is still short of what they were experiencing when employed with NSW Health. They would like things to move along a lot quicker in terms of improvements.

Mr RAVLICH: I guess as our submission says it seems a little tardy that 10 months down the track we are still trying to engage with Healthscope on some fairly basic applications of Birthrate Plus and the like. We had hoped and thought this would have been the subject of significant discussion leading up to the opening of the hospital to have a proper understanding of what they were required to have in place.

The CHAIR: That brings the testimony to a conclusion. On behalf of the committee I thank both organisations and their representatives here today. They were very good submissions and you provided ample opportunity for us to be able to ask you questions and elucidate those points. Thank you all very much.

(The witnesses withdrew.)

The Committee adjourned at 17.00.