PORTFOLIO COMMITTEE NO. 2 – HEALTH

Monday, 23 September 2019
Examination of proposed expenditure for the portfolio area

OPERATION AND MANAGEMENT OF THE NORTHERN BEACHES HOSPITAL

CORRECTED

The Committee met at 10:00 am

MEMBERS

The Hon. Greg Donnelly (Chair)
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Emma Hurst (Deputy Chair)
The Hon. Trevor Khan
The Hon. Natasha Maclaren-Jones
The Hon. Walt Secord

CORRECTIONS TO TRANSCRIPT OF COMMITTEE PROCEEDINGS

Corrections should be marked on a photocopy of the proof and forwarded to:

Budget Estimates secretariat
Room 812
Parliament House
Macquarie Street
SYDNEY NSW 2000

The CHAIR: Good morning everyone. Welcome to the second hearing of the inquiry of Portfolio Committee No. 2 into the operation and management of the Northern Beaches Hospital. The inquiry is examining matters such as the contract and arrangements establishing the hospital, the ongoing arrangements for its operation and maintenance, current standards of service provision and 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 on Mona Vale, Manly and Royal North Shore hospitals, and the merits of public-private partnership arrangements for the provision of health care.

Before I commence, I acknowledge the Gadigal people, who are the traditional custodians of the land upon which we are holding this hearing today, and I pay my respects to elders past and present of the Eora nation and extend that respect to other Aboriginal people present, who may be joining us later today or who may be with us on the internet. We will hear today from community representatives and local medical practitioners as well as the Australian Medical Association. Before we commence I would like to make some brief comments about the procedure for today's hearing.

This is a public hearing and we acknowledge the significant interest the community has in this inquiry, particularly those 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 make it difficult particularly for the witnesses to communicate with the Committee in answering questions put to them. Today's hearing is open to the public and is being broadcast live by 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 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 their evidence at the hearing, so I urge witnesses to be careful about any comments they may make to the media or to others after they complete their 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 these 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 the Committee's 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 Committee members through the Committee staff. To aid the audibility of this hearing, I remind Committee members and witnesses to speak into the microphones. The room is fitted with induction loops compatible with hearing-aid systems that have telecoil receivers. In addition, several seats have been reserved near the loudspeakers for persons in the public gallery who have hearing difficulties. Finally, would everyone please turn their mobile phones to silent for the duration of the hearing.

SUZANNE DALY, Newport General Practitioner, affirmed and examined

RICHARD WEST, Visiting Medical Surgeon, Royal Prince Alfred Hospital, Sydney, and President, Palm Beach and Whale Beach Association, sworn and examined

JONATHAN LESLIE KING, Historian, author and local resident, sworn and examined

The CHAIR: Thank you very much for coming along today and making yourselves available to provide testimony to the inquiry. You would be aware, but if you are not I will just confirm, that with respect to your submissions that have been made to this inquiry, they have been received, and thank you for that. The secretariat has processed them and they stand as submissions to this inquiry. With respect to Dr King, your submission is submission No. 195; with respect to Professor West, your submission is submission No. 111; and with respect to Dr Daly, your submission is submission No. 230. You can take it that all of those submissions have been read carefully by the Committee members who are here today and they will be seeking to ask you some questions in due course. We invite each of you to make an opening statement. I invite you to keep it, if you can, reasonably precise, which maximises the opportunity for questioning. I am not trying to pinch you too hard, but if you can keep it to the point that will enable the maximum time for questioning. We will start with Dr King.

Dr KING: Thank you, Chair. Inquiry members, please include in your report that I speak as a lay resident of the northern beaches where I have lived for 34 years. I have raised a family, produced the 1988 London to Sydney First Fleet re-enactment of the tall ships expedition, films and books. I stood for preselection for the Liberals, as a candidate for the Democrats and The Greens and I am campaigning now to get Mona Vale Hospital accident and emergency [A&E] back as it saved my life twice, like Rugby great Max Brown, and thousands of others. I am focusing on the terms of reference No. 1 (f), the impact of changes on Mona Vale, adding to my 24 July submission and earlier submissions to health Minister Hazzard and also CEO Willcox.

I am making five recommendations in two pages. Firstly, please report, inquiry members, that the 2005 upper House inquiry already recommended keeping Mona Vale with its A&E and land. We residents urge you to agree with your predecessors because our population has grown. I quote recommendation 7 from 2005:

> … Mona Vale Hospital be funded, staffed and equipped to provide an on-going effective 24-hour emergency department service.

Also, please report the contemporary supporting promises. In 2006, Liberal Party leader Brogden said, "Taking away intensive care for 60,000 people served by Mona Vale Hospital is an act of war on the Pittwater community by the State Government." He added, "Should there be a death … I will regard the blood of that person to be on government hands. Now accidents and emergencies [A&E] has been closed, please report that any pre-emptive demolition of Mona Vale buildings, perhaps happening as we speak, could be in contempt of this inquiry."

Second point, "Please report that we believe our democratic processes have failed us because our community wanted to keep the local hospital but the MPs ignored us; Government downgraded it and encouraged developers and private health companies to build a substitute and then took away our A&E so their new private Northern Beaches Hospital [NBH] would not have any competition—page 2. Also report how we campaigned for our hospital. Our recent survey reported 92 per cent wanted our hospital to stay; 23,000 signed petitions; 20 local Newport-based doctors signed statements warning of possible deaths; Parry Thomas's Save Mona Vale Hospital Committee of impressive professionals campaigned for years for the basic democratic right for a local hospital. Please report all of that passionate campaigning, so that it is not in vain." Third point, "Please report that a Northern Beaches Hospital is so far away from the people in Palm Beach that we could die before we arrive. Climate change is going to increase torrential rain and frequent flooding, closing our one-lane road over and over, compounding regular logjam traffic so it could be cheaper—and remember this—to renovate or build a new Mona Vale Hospital with A&E than flood-proofing Wakehurst Parkway."

Fourth point, "Mona Vale had and can still have again a first-class track record—if it ain't broke, don't fix it. Last year 182 lives were saved immediately and 4,833 were treated within 10 minutes—double the 2,322 that were treated in 10 minutes six years earlier. More people need more hospitals and more A&E—not less. The substandard urgent care centre replacing it does not even have 24-hour X-ray or CT scanning. Please support your 2005 inquiry predecessors. Demand the Government keeps the land—The Village Green—and stop planned demolition until the Government estimates the cost of renovating our structurally sound Mona Vale—like they did with Wagga Wagga—or building a new one, which will be needed by the 271,000 residents of the northern beaches now and the 309,000 expected by 2036. Our local paper, *The Manly Daily*, confirming that is a reality 2036 is only 17 years away."

"In conclusion, please report for us to the Parliament that we want traditional, Australian public hospitals, not Americanised, private, profit-driven hospitals, owned by foreign, tax-avoiding Brookfield. Ask the Government to reinstate Mona Vale with A&E and buy NBH—like it did with Port Macquarie—and operate it as a public hospital." Thank you.

The CHAIR: Thank you, Dr King. That was very clear and unequivocal.

Dr KING: Thank you, Chairman.

Professor WEST: Thank you very much for giving me the opportunity to address the inquiry. Chair Greg Donnelly, Deputy Chair Emma Hurst and members, ladies and gentlemen, I worked in the public and private hospital system in New South Wales for over 40 years, mainly as a general surgeon at the Royal Prince Alfred Hospital. I am very familiar with how the health service works at all levels. I was Censor-in-Chief of the Royal Australasian College of Surgeons for many years, responsible for all surgical training in Australia and New Zealand. I am also using my experience as a surveyor for the Australian Council on Healthcare Standards [ACHS], accrediting hospitals all over Australia. I was surprised to see that ACHS actually accredited the hospital to be opened—the Committee needs to get that report so they can see on what basis that decision was made, which was obviously, in retrospect, not correct. What are the main concerns of the residents of Pittwater? Most are covered by your inquiry: the lack of appropriate medical and surgical services at the Northern Beaches Hospital for public and private patients; the contract with Healthscope and the staffing; the downgrading of medical services at the Mona Vale Hospital site—for this to work the access to the Northern Beaches Hospital has to be improved by road and by public transport; and the lack of ambulance services and poor response times in Pittwater.

Those must be improved. There is evidence that the response time—we are in a great big area spread out with poor roads. There must be ambulances based in Avalon so that they can respond within a reasonable time. At the moment the ambulance station in Avalon, the ambulance drivers come and pick up their ambulances in the morning and go roving all round Sydney. Ambulances in emergencies can come from Brookvale, St Ives and all over the place. That is unacceptable. I want to highlight some of the clinical services as a clinician and I want to highlight three or four very important acute services, which are not fully available at the new Northern Beaches Hospital. That is a great disappointment to us. We expected with a level 5 hospital to have an upgrade of services. That has in fact not happened in these areas. Strokes—what is the action for strokes? Fast treatment, fast diagnosis by patients and their relatives and fast transfer to hospital. When you arrive at a hospital, a good stroke unit will have a stroke nurse who will treat you as you come in—they will quickly take a history and do the appropriate examinations, such as a CAT scan, an MRI. Those are available at the Northern Beaches Hospital. Strokes may be due to either a blocked artery in the brain or a haemorrhage. It is important to distinguish between what has occurred because if it is due to a blocked artery, it needs to be busted and you need to have thrombolysis.

It is very disappointing that thrombolysis cannot be administered at the level 5 hospital. If patients still have to go to the stroke unit at North Shore, this will only delay treatment more—the more rapidly the treatment is given, the better the outcome and the optimum is three hours. By the time they get to Northern Beaches, get investigated and transferred to North Shore, that time will probably have expired. It is important that that treatment is introduced. Cardiac services for infarcts cardiac disease: the Northern Beaches Hospital has a catheterization lab, which is able to do angiograms, find out where the blockages are, put in stents or dilate the arteries. They have this unit but I was surprised when the acting CEO at the last hearing said that they do not treat acute cardiac ischemia. Why? I have no idea. Those patients have to be transferred to Royal North Shore Hospital. That is unacceptable and once again prolongs treatment—the quicker you do an angiogram, the quicker you make a diagnosis and fix it, the better. Cardiovascular disease, including strokes and coronary heart disease, are two of three leading causes of death in Australia. There must be full facilities at the level 5 Northern Beaches Hospital to treat cardiovascular disease, in the interest of patient care.

Major trauma: Patients with major trauma are once again taken directly to the Royal North Shore Hospital. There is a golden hour for trauma treatment. The quicker the patients are treated, the better, and this has been very well documented. It has never been defined what is meant by major trauma. What guidelines do ambulance officers have to where they take patients with trauma? The unit must be upgraded to treat major trauma. Paediatric surgery is also very worrying for parents with children. There have been reports that children requiring an appendectomy for acute appendicitis or other minor surgical conditions, are being transferred to the Sydney and Westmead children's hospital. It appears they cannot be treated at the Northern Beaches Hospital. There is a suggestion that some private patients are, in fact, treated.

The CHAIR: Professor, I do not want to cut you off, but I am conscious of time. Are you reading from an opening statement? One option to consider is to incorporate the difference of what you have to say into *Hansard* to get it all captured. If not we can continue but that will reduce the time for questioning.

Professor WEST: I will continue and try to cut it down a little bit.

The CHAIR: I do not want you to cut out stuff that you do not want to cut out. Please continue.

Professor WEST: Sure. Children should not have to be transported all around Sydney to get an achievement. There was an operating theatre accessible by lift at the Northern Beaches Hospital. The hospital should be staffed to treat children. The guideline to role delineation of clinical services document at the department clearly states that a level 4 hospital should have surgeons and anaesthetists accredited to treat children. The contract clearly states that the patient can be admitted as either a public or private patient. Public patients will not be required to pay for their treatment. Patients will be prioritised according to their health needs and not whether they are public or private patients. There is evidence that patients are being prioritised. When they are private they can get extra services.

Once again the function, staffing and clinical service to be provided by a level 5 hospital is clearly stated in this document. Healthscope stated that they provide all level 5 services. The Committee must ensure that they produce evidence of what services they provide. People really have no idea what services are available at the Northern Beaches Hospital. Healthscope has stated that it has available some level 6 services such as cardiac and neurosurgery but these are only available to private patients. This is unacceptable. All services that are available must be available to both private and public cases. It seems to involve cardiac and neurosurgery. The contract clearly states that all patients should receive the same level of service.

The local health district should ensure that all patients receive the same level of services. It is well documented that there have been problems with the nursing staff and they should be commended on the excellent work they have done under difficult circumstances. The junior doctors, the report by the Health Education and Training Institute was very damning. Evidence given by the unions at the last hearing day indicated that these problems had not been addressed. They need to be addressed. The Mona Vale urgent care centre treats only minor injuries and illnesses such as minor burns, minor sports injuries, minor cuts, minor fractures and minor asthma. Patients with other conditions have been told to go to the Northern Beaches Hospital but they have to decide themselves where they go.

It is only a level 1 emergency department, equivalent to what is in a remote or rural hospital. It must be upgraded to a level 3 department. Dr King mentioned access. I have mentioned ambulance services that need to be upgraded so they can respond in time. The community of the northern beaches are concerned that they do not have a public hospital in the area administered by NSW Health. I have a private public model by Healthscope. The model has failed in the past and is failing again at the Northern Beaches Hospital. The local health area buys services from Healthscope. They seem to have little control over how these services are provided. Who is legally responsible for the patients at the Northern Beaches Hospital?

In every other public hospital NSW Health is responsible. Is Healthscope responsible or is the New South Wales department? If you have a problem who do you sue? I agree with Dr King that the New South Wales Government should take over the Northern Beaches Hospital. It should be upgraded to a tertiary level 6 referral hospital. The residents of Pittwater should not have to travel to North Shore to obtain these services. It is a $60 million hospital, 500-bed, state-of-the-art hospital with all the necessary facilities to function as a level 6 hospital. Thank you.

The CHAIR: Thank you, Professor. That was a detailed and helpful opening statement.

Dr DALY: Thank you for this inquiry and for inviting me today to give additional evidence. I am here as an advocate for thousands of my patients and also for the nearly 12,000 residents of the northern beaches who signed my petition back in 2012. They rightly foresaw then that the one hospital at Frenchs Forest would not meet their health needs and it does not and they want Mona Vale Hospital back. I have been and still am a general practitioner on the northern beaches for the last 40 years: Nine years in Dee Why; about 20 years in Avalon solo; and now 11 years in Newport. I have patients across the whole district from Palm Beach to Frenchs Forest. I also have patients working in the Frenchs Forest hospital and in the ambulance service.

Since the hospital opened at Frenchs Forest and Mona Vale was closed I have seen widespread confusion and distress. The situation as it now stands can only be described as a debacle. Soon after the hospital opened problems started to be reported, even in the press. "Just teething problems", said Mr Hazzard. A lawyer not a doctor. But the public rapidly lost faith in the quality of service at the new hospital and began bypassing it to go straight to the Royal North Shore or to the Sydney Adventist Hospital. How ironic is this? The hospital is located at Frenchs Forest rather than on the northern beaches, supposedly in order to take the pressure off the Royal North Shore Hospital. I believe it was more to be a Trojan horse for the over development of Frenchs Forest.

I would not accept teething problems in a jumbo jet, would you? The problems are due to poor planning and execution. However, they are not just teething problems because some problems as reported by staff to me are ongoing and systemic, largely due to this failed public private partnership which is a failed model. Profit is the main driver, not care. There is not enough staff and there is too much pressure on junior doctors and nursing staff. There was also confusion and distress with the urgent care centre at Mona Vale. I and my patients believe that urgent implies potentially life threatening and I would expect all necessary staff and equipment to be in an urgent care centre.

However, it took public demonstrations outside Mr Hazzard's office and Parliament House just to get basic services there such as x-rays and ultrasound. Even then he seemed surprised that things were needed. Just as Healthscope were surprised that there were very sick people going to the emergency at Frenchs Forest hospital. There is too much reliance on agency nurses who do their best but are just filling in and are often not familiar with equipment. I had a sick patient at the hospital comforting a junior nurse who was crying because she had not eaten all day and did not know where things were.

This hospital at Frenchs Forest is just too far away for people on the northern beaches—especially those living north of Narrabeen—because of flooding on the Wakehurst Parkway and now roadworks on Mona Vale Road. It takes too long for ambulances that are often coming from out of the area to reach the patient, let alone go to Frenchs Forest. This was highlighted just a few days ago when an ambulance took 35 minutes to reach a collapsed toddler at Bilgola Plateau near Newport, whose grandfather was doing CPR to keep her alive. The ambulance had to come from Balgowlah near Manly. Two other ambulances arrived too.

Thankfully, the child has survived; but had this been a drowning, probably not. This is just one of many incidents I have selected, and I will tender these in summary form to you. There are many beaches, swimming pools, surfers, rock fishermen et cetera on the peninsula and I am fearful of accidents in the coming months. The emergency department and hospital at Frenchs Forest are barely able to cope now, and the hospital is not even to full capacity; yet what is going to happen in the next few years as the population grows if nothing is done now?

In conclusion: First, more people need more hospitals not less; secondly, simply put, this is the wrong hospital in the wrong place at the wrong time; thirdly, the health department needs to take over management of the Frenchs Forest hospital now, making it a public hospital with clinicians allowed the right to treat private patients as well—this is the model working successfully all over the country; fourthly, the health department needs to rebuild a level 3 hospital on the Mona Vale site; and fifth, it needs to increase the number of ambulances and paramedics and have several based at the Mona Vale site now in order to give proper 24/7 cover. Ambulance officers do 12-hour shifts and are pressured and stressed. Sadly, more and more patients are refusing to go to Frenchs Forest, yet the ambulances were instructed to take all patients to Frenchs Forest. However, I have heard recently that ambulance officers are now instructed to take potential cardiac cases direct to Royal North Shore Hospital. This is an admission of the failure of the hospital at Frenchs Forest.

The CHAIR: Thank you, Dr Daly. I decided to allow you all to extend, effectively, your opening statements to put as much down on the record as you wish, because I understood you obviously had a lot to say. The consequence, though, is it has pinched the question time, but that is the quid pro quo. We will start with the questioning now.

The Hon. WALT SECORD: Thank you, doctors, for your evidence. I would like to move to some questions to Professor West. I understand from your evidence that you have more than 40 years' experience in the New South Wales public health system. I have to say I was deeply disturbed by your comments that at Northern Beaches Hospital, level 6 medical services were being offered to private patients rather than public patients. I would assume that you stand by your comments in January, where you spoke out about a two-tier system.

Professor WEST: I do not need to stand by my comments. It is clearly stated in 3.1 of Healthscope's submission that they have facilities beyond level 5 and these facilities—level 6 facilities—are only available to private patients. It seems to be cardiac surgery and neurosurgery.

The Hon. WALT SECORD: For lay people who are watching the proceedings and people who are looking at the evidence, what does that mean? You are going to have to simplify it. What does that mean, services that go to private patients but public patients do not get?

Professor WEST: It means services such as cardiac and surgeons of—I think they are developing a cardiac unit at the hospital, and these services would include surgery and changes of pacemakers and this sort of thing. They will not be available to public patients. In every hospital I worked in New South Wales, there is no question: All services available are available to both public and private patients.

The Hon. WALT SECORD: How do you feel when you, as a doctor with 40 years' experience, read or hear that? How do you feel about that?

Professor WEST: I think that is appalling. All through my career I looked after public and private patients. They were my responsibility and they got the same treatment.

The Hon. WALT SECORD: You did not look at them differently; you just treated them as a human being?

Professor WEST: I worked at Prince Alfred. It is a great hospital. We treated them as human beings. I was responsible and they all got the same treatment.

The Hon. WALT SECORD: What about the claim that stroke patients are being taken directly to Royal North Shore Hospital? What does that mean? You talked about something called the golden hour. I was shadow health Minister for five years so I know what the golden hour is, but the community does not. What happens if there is a delay in—

Professor WEST: The golden hour equates to trauma, not to strokes.

The Hon. WALT SECORD: I know that, but I am saying that you referred to time being of the essence.

Professor WEST: The whole modern treatment of strokes, I think you said, is the quicker the definitive treatment is given, the better the outcome. So by the time the ambulance comes and picks you up in, say, Pittwater and gets you to the hospital, we are probably talking about an hour. By the time you go into the hospital and you get all the investigations done, we are probably into two hours. Then if they have to transfer you to North Shore, that could take another—by the time you get an ambulance, that could take another two or three hours.

The Hon. WALT SECORD: You talked about three hours being—

Professor WEST: Three hours. Well, it is three hours, but the quicker the better. Three hours is the limit, but the quicker the better. If you dissolve the clots quicker, the outcome is better.

The Hon. WALT SECORD: What are doctors telling you up there? You must know doctors who work at the hospital. Are they accepting this? Are they frustrated by it? What are they telling you?

Professor WEST: I think they are frustrated. I think they are concerned about expressing their opinions because there may be problems from the administration if they express their opinions.

The Hon. WALT SECORD: Are they able to express their opinions internally?

Professor WEST: I think they have had various meetings and they are expressing their concerns internally, but I am not sure that their concerns are being addressed.

The Hon. WALT SECORD: I was rather startled by your statement about level 6 being available to private patients only. Are you confident that that is occurring?

Professor WEST: As I say, it was stated by Healthscope in 3.1 in their submission, so they admit that it is occurring.

The Hon. EMMA HURST: Professor West, you mentioned in your opening statement the issue of the movement of ambulances, particularly around Avalon. Dr Daly mentioned a situation where a toddler had to wait 35 minutes. Can you expand on that a bit further in regards to the waiting times for some of these ambulances and what the worst-case scenario would be?

Professor WEST: We are getting complaints from our members that people are waiting on the roadside for over 40 minutes for an ambulance to arrive. As Dr Daly said, they rarely come from Avalon. The Avalon ambulance station is not a 24-hour station. They can come from Balgowlah; they can come from St Ives. Because of the geography of the Northern Beaches, which is narrow with only one road, it is almost impossible for them to meet benchmark standards for ambulance arrival. The number of call-outs found has gone up by 20 per cent, they tell me, since the Northern Beaches Hospital opened. There does not seem to be an increase in the number of ambulance or paramedical, although we were told by the administrators that this has happened.

Dr DALY: It can only be described as a lottery. You can get an ambulance in 10 minutes or an hour and 10 minutes. As I highlight in one of my cases, which happened to a patient, an ambulance arrived but it was towards the end of their 12-hour shift. Of course, they are exhausted but they are under instructions to end a 12-hour shift. So they had to stay with the patient till another ambulance came, having established that the patient would have to go to hospital. So they then took another, I do not know, 20 minutes for a second ambulance to come so then the patient could be transported to the hospital. So there was an extra ambulance out of office. As I said in that case with the toddler, why did three ambulances end up there almost too late? There is something wrong with the system.

The Hon. EMMA HURST: Going back to Professor West, you note in your submission and you mentioned as well in your opening statement that the stroke unit cannot administer—

Professor WEST: Thrombolysis, yes. To put it simply, that is treatment to dissolve the clot. It is a clot-busting treatment.

The Hon. EMMA HURST: How often would a stroke patient require that?

Professor WEST: It is not all. It is about 20 per cent, I think, not all.

The Hon. EMMA HURST: About 20 per cent?

Professor WEST: But they should be able to differentiate which ones need it. The stroke guidelines of Australia say any hospital that gets over 70 strokes a year should have thrombolytic services. I have spoken to the stroke doctors at Royal North Shore Hospital. They are on the staff of the Northern Beaches Hospital. They should be able to set up a fully functioning stroke unit that will dissolve the clots. There is another way of doing it, which is doing embolectomies and taking clots out. That is only available at major hospitals. You would not expect them to do that. However, you would expect them to be able to do thrombolytic treatment for the best outcome.

The Hon. EMMA HURST: Do you know if Manly or Mona Vale had that treatment available?

Professor WEST: No, they did not. According to the stats they did not. But they were only a level 4 or level 3. A level 5 hospital—there are a lot of country hospitals that can give thrombolytic treatment and they have arrangements with a city hospital or major unit to give it. There is no reason why the same thing could not happen at the Northern Beaches Hospital.

The Hon. WALT SECORD: One quick question: What happens if you do not get the procedure? What is the impact on the patient?

Professor WEST: If you do not get the position and you have got a paralysis, the paralysis becomes complete. You have to dissolve the clot to get the blood through. If you can do that you have got a good chance of recovering.

Ms CATE FAEHRMANN: I want to explore that a bit further. What does it take to get this thrombosis—is that what it is? Did actually say that right?

Professor WEST: "Thrombo". Well let's say "clot-busting".

Ms CATE FAEHRMANN: Clot-busting!

The CHAIR: That sounds like a term a politician could use.

Professor WEST: It sounds like a—yes.

Ms CATE FAEHRMANN: I am trying to work out why it is not a level 5 hospital. What are the requirements in terms of staff? Is it this outrageously expensive machine? Why is it not offered?

Professor WEST: This document sets it all out very clearly: the guide to clinical—

Ms CATE FAEHRMANN: What is that document?

Professor WEST: I will table that.

The CHAIR: What is the title of that document, Professor?

Professor WEST: It is the *Guide to the Role Delineation of Clinical Services 2018*.

The CHAIR: Thank you. If you could table that it would be great.

Professor WEST: I will table that. It is an expansive document. It sets out the levels of service from 1 to 6. It sets out the staffing. It sets out what services should be available at all levels.

Ms CATE FAEHRMANN: Okay.

Professor WEST: They need physicians who can interpret the test results and give the treatment. It can be done by teleconferencing in country towns; I do not know why it cannot be done at the Northern Beaches Hospital.

Ms CATE FAEHRMANN: Right. Dr Daly, you mentioned in your testimony that ambulances are being instructed to take various patients to lower north shore. I missed what it was for—did you say cardiac arrests?

Dr DALY: Suspected cardiac cases. That is subject to interpretation, too. That is only just very recent. The ambulances were instructed to take all emergency cases to Northern Beaches first.

Ms CATE FAEHRMANN: Could you please tell the committee how you know that information?

Dr DALY: Which information?

Ms CATE FAEHRMANN: How do you know that ambulance drivers have been instructed to take cardiac patients to Royal North Shore Hospital first?

Dr DALY: This was told to me by two staff members at Frenchs Forest hospital and it was relayed to me by a patient who had called an ambulance just last week. It is only very recently that the instruction has changed from taking all emergency—unless they decided it was major trauma—all emergency calls were to take the patients to Frenchs Forest. Now it has changed to taking those who are not cardiac cases to Frenchs Forest.

Ms CATE FAEHRMANN: In your opinion, can that put the patient a greater risk, remaining in the ambulance for that extended period of time?

Dr DALY: Yes, it can. But then again, Frenchs Forest is not the best place for all cardiac cases. I allude to it in my cases here—there is great difficulty just getting an echocardiogram scan. This is necessary if you suspect anything other than a pending heart attack. All that the Frenchs Forest hospital has given us that that we did not have it Mona Vale is a catheter lab, but it is only there 9.00 to 4.00 Monday to Friday for public patients. Even private patients are on a waiting list for it. It does not provide state-of-the-art facilities for cardiac cases. Bear in mind that we have the highest over-55s in the State on the northern beaches, yet this hospital at Frenchs Forest is not providing cardiac and—we have heard from Professor West—adequate treatment of stroke and heart attack.

The Hon. WALT SECORD: Dr Daly, what would you do if you were in your surgery and you had a patient before you and you think, "This patient is having a stroke". What would you advise them to do, or what would you do? Would you send—

Dr DALY: What would I do with my family?

The Hon. WALT SECORD: Yes.

Dr DALY: Well, I would give them a bit of aspirin because you are not going to make a subdural haemorrhage worse—that is the haemorrhagic stroke—and you may save a life if it is a block stroke. Then I would request that an ambulance be called. In the past they would have gone much closer than now where we have this go straight to Royal North Shore Hospital.

The Hon. WALT SECORD: I will rephrase it. Would you take that patient to the Northern Beaches Hospital or would you go straight to Royal North Shore?

Dr DALY: I would direct the patient to go straight to Royal North Shore Hospital at the moment.

The Hon. WALT SECORD: Okay. Thank you.

Professor WEST: That is a terrible indictment of the facilities available at the Northern Beaches Hospital.

The Hon. WALT SECORD: Sorry, Professor West—could I ask you the very same question? What would you do, as a man with 40 years' experience as a surgeon? What would you do?

Professor WEST: At the moment I would send them to North Shore or one of the other major hospitals.

The Hon. WALT SECORD: How do you feel about that?

Professor WEST: I would send them to North Shore or one of the other major hospitals. That does not negate the problem that it is going to take longer. As I said repeatedly, there was no reason why they should not have a fully functioning stroke unit at the Northern Beaches Hospital. This is why I said the department of Health needs to take it over. It needs to monitor more carefully what is being done there. It is a 500-bed hospital that cost $600 million. It has all of the state-of-the-art equipment. It needs to be staffed properly so it can cope with all the common emergencies that are going to happen at the northern beaches in the quickest possible fashion.

The CHAIR: Just two quick ones, if I could just put these down? In terms of knowing what services—Professor West, this was in your opening statement I believe—about trying to establish with some precision the actual medical health services that are available out of, to use that phrase, out of the Northern Beaches Hospital. Other witnesses have expressed some frustration at not being able to get clarity and certainty. What are your thoughts about how one does get immediately, or is capable of getting immediately, some precise clarification over what are the health and medical services available out of this hospital?

Professor WEST: As I said, Northern Beaches says it is providing all level 5 services but it is not evident which level 5 services it is providing, whether it is providing for public or private patients—it needs to be asked to document carefully what services it is providing according to the guidelines of delineation. When you get that, you need to get someone to benchmark it against what is in the documentation that a level 5 hospital needs to provide. It needs to provide you with the evidence of what services it is providing and whether they are available for public and private patients universally. The main concern is that public patients are not getting the same treatment as private patients.

The CHAIR: Thank you all very much the three of you for coming along. It has been very important and valuable evidence—your submissions now augmented by your oral testimony. There may be some questions on notice arising from the honourable members reading *Hansard* tomorrow and preparing them and sending them to you. Would you be agreeable to receiving supplementary questions and having a look at being able to provide answers to those? The way it works is that we will have them drafted and prepared. The secretariat will liaise with you—this is arising from reading your testimony today—and then you will be provided with a 21-day period to turn around and bring back the answers to the committee.

Professor WEST: Sure.

The CHAIR: Thank you all very much—yes, Dr King?

Dr KING: Chairman Donnelly, can I table my short introductory speech as well?

The CHAIR: That would be great.

Dr KING: Can I tender it?

The CHAIR: Absolutely.

Dr KING: Thank you.

The CHAIR: Professor West, I did not mean to cut you off with yours—it was a very detailed one—but if there is any material on there that you feel you may not have been able to get to, that can be incorporated into the—

Professor WEST: Can I just say something in conclusion?

The CHAIR: Yes, please.

Professor WEST: This is a serious medical problem. It involves patient care.

The CHAIR: Yes.

Professor WEST: I hope this committee can come up with solutions. In the past it has been made a political football. I hope this committee can come up with medical solutions that will fix the problems of the healthcare services on the northern beaches. I wish you all the best in your endeavours.

The CHAIR: Thank you.

(The witnesses withdrew.)

CAROLINE ROGERS, local general practitioner, sworn and examined

ELANA ROSETH, local general practitioner, affirmed and examined

The CHAIR: We have received both of your submissions. They have been processed and now form part of the evidence to the inquiry. You may take those submissions as read. I invite you both, if you wish to do so, to make an opening statement. Try to keep it reasonably precise and tight, which maximises the opportunity for the questioning by the members on the matters that you raise in your submissions. I do not want to rush you but the more time that is taken in an opening statement reduces the time for the questioning.

Dr ROGERS: I am here because public health care matters to my patients. It is easy to assume because we are on the Northern Beaches and we have got big houses and fancy cars that patients can afford to pay a bit more for their health care and that does not matter. I am here today to tell you that is not the case, that every day I come across patients who are struggling to pay out-of-pocket costs for X-rays, for prescription medications, for specialist fees and that is affecting their health care. I have referred more patients to the Foodbank in the last six months than I did in the previous six years. The Northern Beaches Hospital is exacerbating this problem. Patients are frequently told that they have no option but to access care in the private system, that the public facility does not exist and they are paying for that. The ED avoidance programs, the outreach clinics, the discharge planning, that does not exist any more. Discharge summaries; these are written records of patients attending hospital, the investigations they have had done, the test results, the prescriptions that were supplied when they were discharged from the hospital, these either are not being written in a timely manner, or they are not being sent to or being received by the appropriate GP. This makes it very difficult for GPs to provide continuity of care to complex patients.

The Northern Beaches Hospital is full of committed and talented healthcare staff and they should be commended for the effort that they have put in in the last 12 months to prevent the effects of these changes from having too great an effect on individual patient care. But I hear from specialist colleagues the whole time that they are lacking junior hospital doctors on the ward to support them in the service. I hear from the nurses that they are having to cut back on nursing staff in the wards. I fear that we have created a system that is putting profits before patient care and my hope in attending this inquiry today is that we can work together to find a way of providing a public health service to the community of the Northern Beaches and, crucially, to ensure that our precious public health dollar is being wisely spent. Thank you.

The CHAIR: Thank you Dr Rogers, that is very precise and clear.

Dr ROSETH: Thank you for inviting me to appear before this inquiry. I am a GP who has worked in Dee Why on the Northern Beaches for 22 years. The purpose of my submission was to highlight aspects of the Northern Beaches Hospital that are relevant to general practice and GPs' ability to care for our patients. General practice is the frontline of Australia's healthcare system. GPs are the ones who look after patients before and after they go to hospital.

As a GP I have five major areas of concern regarding the Northern Beaches Hospital. The first is a lack of consultation and communication with general practice. We have had difficulty finding basic information on referral pathways, what specialists and services and clinics are available, and also issues that have been raised by GPs have not really been met with any meaningful response from the hospital.

My second concern relates to discharge summaries. Dr Rogers outlined this but it is a very important issue for us. When patients are admitted to hospital I rarely receive an electronic discharge summary and I hope later on to be able to explain to you in detail the effect that has on patient care. In addition, there are issues with the quality of the discharge summaries and that they are not compliant with the standards dictated by the Australian Digital Health Agency.

My third concern relates to an apparent lack of robust systems to minimise errors. In my written submission I gave an example of over 200 hard copy discharge summaries being sent incorrectly to our surgery. This was a breach of patient confidentiality and it makes me concerned that the processes for managing information are substandard.

My fourth concern is the loss of outpatient clinics, specifically the public outpatient neurology clinic, the bulk-billed cardiology clinic that was located at Mona Vale Hospital, and greatly reduced access to the public paediatric clinic. The loss of these clinics means that we now have to refer our patients to private specialists.

My fifth and most important concern is the disturbing amount of clinical errors and poor care my patients have received. There are a great many stories of positive outcomes delivered by dedicated staff working incredibly hard to improve things there; however, the number of reports of unsatisfactory incidents continues to be markedly higher than prior to the opening of this hospital. Thank you.

The Hon. WALT SECORD: Dr Rogers, from your evidence would you agree with the statement that they are pushing patients into the private system?

Dr ROGERS: I would agree with that statement. I have specific instances where patients have arrived in the emergency department with surgical conditions and have been sent home, told they have to make an appointment with a private specialist at the cost of $220. They phone up the specialist, they cannot get an appointment for four to six weeks. I phone the specialist, the specialist says, "I can get them in today." So they get admitted to the hospital and then the choice is you can either be operated on today in the private system or we have 17 patients on the public waiting list, so I cannot tell you when you will be operated on. This is someone who is in pain.

The Hon. WALT SECORD: They are telling people that when they are in the hospital?

Dr ROGERS: Correct.

The Hon. WALT SECORD: So they then go home, if they are a public patient?

Dr ROGERS: They could then go home, or they could wait, but they cannot guarantee when the surgery would be done.

The Hon. WALT SECORD: Does this happen very often?

Dr ROGERS: It has happened to more than one of my patients.

The Hon. WALT SECORD: Without breaking the confidence of the patients, what kind of procedures, or pain, or areas of medicine are we talking about?

Dr ROGERS: The one that springs to mind is a surgical condition.

The Hon. WALT SECORD: A surgical condition? And did that patient then go private, or did they have to delay their treatment?

Dr ROGERS: The patient chose to go private.

The Hon. WALT SECORD: Do you think it was a choice, or were they forced to go private?

Dr ROGERS: The patient was told several times that this particular operation was not available in the public sector.

The Hon. WALT SECORD: You also expressed concern about discharge summaries. To a lay person what are discharge summaries and why are they important?

Dr ROGERS: The discharge summary is written by the junior hospital doctor on discharge of a patient. It details the story of the patient's trip to hospital from the moment they come to the emergency department, what tests and investigations are done, what the results are, what the management of that patient is, what the plans are on discharge in terms of any change in medication, and any future care, any outpatient appointments.

The Hon. WALT SECORD: It helps you too.

Dr ROGERS: It is utterly critical. So many patients do not have the first idea what happens to them when they go into hospital, particularly the elderly patients. They will come and see their GP on discharge and say, "They told me to come and see you." That is the extent of the information you have. If you do not have a discharge summary from the hospital, you then are presented with different medications that they may have been started on. You have to try to make it up from there.

The Hon. WALT SECORD: What is happening at the Northern Beaches Hospital? Are they not providing them or—

Dr ROGERS: I think there are several blocks to the discharge summaries being created and sent to the general practitioner. I think there is an information technology [IT] challenge. The IT system is that they started with at the Northern Beaches Hospital were not compatible with the majority of general practitioners' IT systems and so the discharge summaries just were not being sent out. I think there is a second issue, which is that the system that they have at the Northern Beaches Hospital is that the patients have to opt in rather than opting out of having a discharge summary sent to their GP.

The Hon. WALT SECORD: Do you have to opt in?

Dr ROGERS: Patients have to opt in.

The Hon. WALT SECORD: How would an elderly patient know to do that?

Dr ROGERS: And even patients of mine who say, "I told them I wanted you to get this information." If I look at the discharge summary, it says "GP not specified".

Dr ROSETH: Can I interrupt, I do want to—

The Hon. WALT SECORD: Dr Roseth, you mentioned that you were incorrectly sent 200 discharge summaries.

Dr ROSETH: Yes, but can I talk a little bit about the opt-in issue? Is that all right?

The Hon. WALT SECORD: Yes, but I would like you to answer.

Dr ROSETH: I think it is such an important thing for us as GPs. There are lots of areas about this discharge summary. In the past, we were given electronic notification when patients were admitted and discharged. It was a notification when they had been admitted to discharged. Particularly for GPs who have elderly patients or, say, patients with dementia, that is really essential in tracking them. In addition, we were sent electronic discharge summaries when the patient was discharged so that before the patient came to you, you would know what had happened. Say, if there were a change of medications, it was my habit to already write that up. Now what happens is you rarely get a discharge summary when they are admitted. I do admit that the discharge summaries from Emergency have become much better and much more reliable but it is not that necessary to know if somebody has had a laceration and has been sutured. That is not that important. But if somebody has had a heart attack or a suicide attempt and ended up in intensive care, they are the sorts of patients I need to know about and that is the sort of information I am not getting.

The CHAIR: Sorry to interrupt, doctor, just to be perfectly clear, you set this up to explain it. You say they receive it. You say it used to be automatic. That was the point you are making.

Dr ROSETH: It was just electronically sent before I saw the patient so I knew about it.

The CHAIR: That was done as a matter of automatic transmission of the information.

Dr ROSETH: Yes.

The CHAIR: You are distinguishing that from the current position.

Dr ROSETH: Yes. Now, because it is not sent electronically, if you are lucky, the patient comes with a hard copy discharge summary. Often they have not been given one or they have forgotten or they say to me, "I thought you got one. I told the place to send it." We have got 15-minute consultations—if we are lucky, we have half an hour. You have to get the reception to get the faxed discharge summary sent. You just have not got time to gather that information in a 15-minute appointment. It is just impossible to continue patient care. That is the explanation why those discharge summaries are important.

In addition, the actual discharge summaries are not compliant with standards set by the Australian Digital Health Agency—you cannot copy and paste from the discharge summaries. Also, they are in a format where they will not be able to be uploaded to My Health Record. I have a GP colleague who is very involved in Digital Health and he saw them in November and pointed out the problem. Apparently, eHealth NSW has put them on notice, too. They said things would change; it is now 10 months after November and nothing has changed. We have talked about this GP opt-in box. The GP opt-in box is crazy. It means the sicker the patient, the less likely you would get the discharge summary because if you are unconscious, you are not going to tick your opt-in box.

The CHAIR: Sorry, just explain, what is this GP opt-in box that you were just referring to?

Dr ROSETH: We started asking the hospital what was going on with discharge summaries a few months after the hospital opened. The explanation of the hospital was, "A lot of you aren't getting discharge summaries because the patients are not ticking a GP opt-in box." It is patently absurd to have an opt-in box. No other hospital has—all of Healthscope's other private hospitals have the opt-in box. We had a meeting on 26 March for GPs. They told us the problem would be fixed in three weeks. Three months later the problem was not fixed. I had my practice manager ring them. I rang them in July. We kept getting the story that the problem of the opt-in box has not been fixed. In July, I was told the reason that was not fixed was that they had 43 hospitals in Australia and they would have to fix that form for all 43 hospitals. We keep being told, "It should not be difficult to fix" and we still do not reliably get electronic discharge summaries.

The Hon. NATASHA MACLAREN-JONES: I want to clarify. Currently do all other hospitals that you deal with provide the opt-in box and provide all discharge information?

Dr ROGERS: Maybe I can give you a very recent example. I had a patient discharged from one of the rehab beds at Mona Vale Hospital last week. The evening before she was discharged I received a phone call from the consultant who had been involved in her care. We spoke for 20 minutes. By midday the next day I had the electronic discharge on my computer. I can give you an example of a patient who was sent home to die from Northern Beaches Hospital two weeks ago. My colleague tried to phone the geriatrician involved. Nobody ever got back to her. We never received a discharge summary for that patient. She was being sent home. As a GP, when a patient is sent home to die, it is a significant resource because you are going to be doing a lot of home visits and a lot of care. We were never told by the hospital that this patient was coming home until the daughter came in with the discharge summary and said, "My mum's at home now." It is just not sufficient information for us and it is not allowing us to provide continuity of care. In terms of spending our public health dollar wisely, preventing hospital re-admissions is really key. If we do not have discharge summaries, we do not have discharge planning and we are not able to do that.

The Hon. NATASHA MACLAREN-JONES: To clarify, does every other hospital you deal with provide it?

Dr ROGERS: All of the NSW Health.

Dr ROSETH: I would also like to add to that. As GPs, we are used to private hospitals not providing us with discharge summaries. Often the discharge summaries from a private hospital is more of allied health—physios and occupational therapists [OTs] give us discharge summaries. But it is less critical because the sorts of clinical care that private hospitals give are completely different to the sorts of care that a public hospital should give. It is the heart attacks, the suicides and the long admissions that we need to discharge summary for. Actually, I am used to not getting discharge summaries from private hospitals but I am used to getting timely and accurate discharge summaries from public hospitals. We still do from North Shore.

Ms CATE FAEHRMANN: I have had a look at the transcript from the first hearing we had, where we had representatives from Northern Beaches Hospital and Healthscope here. My question is in relation to your earlier evidence about people being pressured into going into the private system. Dr Rogers your testimony was in relation to that particular patient you were referring to. I have the testimony that says that, "No, in fact—" I asked Mr Royle:

> We are 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?

It was referred to Mr Spillane, who, I think was the finance director for Northern Beaches Hospital. He said:

> 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 treated as a public or private patient on election to any public hospital in New South Wales.

He is basically saying that people are not pressured. What do you have to say about that evidence?

Dr ROGERS: I suppose there are three answers I could give to that. The first is that I hear from patients that that is not the case, that they are being pressured to go into the private system and that they are being told that the services that they require are not available in the public system. We have already heard this morning that there are particularly cardiothoracic and neurosurgical facilities that are only available to private patients. I think the third point that maybe has not come out is that on discharge from the public hospital, a lot of patients need to follow up with specialists in their rooms afterwards. We have very few public outpatient facilities available at the Northern Beaches Hospital. The vast majority of these patients who are being discharged are being discharged to the consultants' private rooms, for which they are going to be paying.

Ms CATE FAEHRMANN: Mr Spillane also said:

> We strictly adhere to NSW Health policy with respect to the election of private patient or public patient status on admission to a hospital.

Do you believe that is correct and they are strictly adhering to the Health policy?

Dr ROGERS: I can only tell you what patients have told me.

Ms CATE FAEHRMANN: Which you do not believe.

Dr ROGERS: That does not seem to be the case from what the patients are telling me.

The Hon. WALT SECORD: Dr Roseth, earlier in your oral evidence you talked about 200 discharge summaries being sent to your office.

Dr ROSETH: Upon one of our many requests for decent discharge summaries, after the practice manager rang a few days later we received by Australia Post, so in hard copy, 650 discharge summaries, most of which dated back months, up to eight months previous. They were absolutely useless to us. So a receptionist spent a couple of days scanning those discharge summaries into files. Over 200 of those discharge summaries were not meant for our practice, they were not meant for doctors in our practice. So that was a clear breach of patient privacy and it does lead me to wonder what other processes and protocols—there was clearly a mismanagement of protocols here.

The Hon. WALT SECORD: What did you do when you discovered that you had personal health information from 200 patients?

Dr ROSETH: I did not—I have actually asked the practice manager what we did with them. She said that they had put them aside. I know that when my submission was made public there was a fair bit of media response to that and that day a member of the hospital came and asked for those discharge summaries back.

The Hon. WALT SECORD: Were they embarrassed? Did a person just come in and say—

Dr ROSETH: I was not there. I was not at work that day.

The Hon. WALT SECORD: So it only occurred because it was put into the public arena?

Dr ROSETH: Yes.

The Hon. WALT SECORD: This was personal medical information.

Dr ROSETH: I did not see those discharge summaries but the practice manager and the receptionist that were scanning those discharge summaries confirmed that there were over 200 discharge summaries not meant for the doctors in our practice.

The Hon. WALT SECORD: If they are being so careless with personal medical records like that, how do you feel about the information that is contained in those reports? Would you trust the information and the material? Were they worthwhile reports?

Dr ROSETH: I did not look at those reports. All I can say is that that is another example that leads me to question the processes and protocols that are operating in that hospital.

The Hon. WES FANG: I just wanted to clarify something. When the practice manager discovered the 200 patient discharge summaries that were not for your practice, did they notify the hospital that there was a problem there?

Dr ROSETH: I do not believe she did.

The Hon. WES FANG: Do you know why she did not?

Dr ROSETH: I actually do not know. I asked her just before coming here because I was thinking, "What happened to those?" I think it did not happen very long before the media publicised that issue with the discharge summaries, so the hospital sent somebody to physically pick them up. I do not know why she did not ring them straightaway.

The Hon. WES FANG: I am just curious because I have had some involvement in medical practices and I know that if we had received 200 discharge summaries from a hospital that were not for us we certainly would have raised it with the hospital.

The Hon. WALT SECORD: You are blaming the wrong person there, Wes.

The CHAIR: Order!

The Hon. NATASHA MACLAREN-JONES: He is not blaming anyone.

The Hon. WALT SECORD: They got the files because of Health.

The Hon. NATASHA MACLAREN-JONES: Stop the performance.

The CHAIR: Order! The Hon. West Fang, you are entitled to continue your questioning. I think you are making some context so please continue.

The Hon. WES FANG: I was just curious to—

Dr ROSETH: Do you know what? I agree with you. I do not know why we did not ring. I really had no involvement in that at all except to find out that that is what had happened.

The Hon. WES FANG: I was just curious because it might have allowed Healthscope to have a look into the process a bit earlier than—

Dr ROSETH: It is one of the many examples though. I have got lots of examples of that where I have tried to engage with the hospital about processes that have not been satisfactory and they do not engage. In one instance, after many days I got called by a publicity officer who told me that she did not understand the clinical context of the problem I had raised. You feel like they have got no acknowledgement of our importance as a kind of integrated health system.

The Hon. WES FANG: I have a great deal of sympathy for the situation you found yourself in.

Dr ROSETH: I did talk to the woman who picked up the discharge summaries the following day and we had a discussion about what had happened.

Dr ROGERS: It has taken us 11 months to get one of my colleagues' names correctly as the GP for her discharge summaries and the only reason we managed to get that changed is because I have had communication in the past with the head of IT and eventually I sent an email to her. So someone else has been getting her discharge summaries for the last 11 months.

The Hon. WALT SECORD: Mr Chair, I just wanted to clarify something there. I understand the Government members were upset but I just wanted to make the point that it is not fair to blame the doctors—

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

The Hon. WALT SECORD: But I was going to say—

The CHAIR: A point of order has been taken.

The Hon. NATASHA MACLAREN-JONES: My point of order is that the Hon. Walt Secord knows that all members have a right to ask questions and is misleading in claiming that Government members are upset. Government members are asking questions as are the Opposition. We are all here to respect each other and ask questions.

The Hon. WES FANG: Point of order: The imputations that the Hon. Walt Secord has made about my line of questioning are wrong. They are wrong for a number of reasons. First, I was going to then lead onto another question. The question I was asking was that I noted when you were talking about the discharge summaries from the emergency department that they had improved. So there is obviously a level of engagement there with Healthscope and they are in some ways improving the services.

The CHAIR: You cannot re-prosecute the argument. I am chairing this meeting and I do not want to call people to order unnecessarily for interruption. I am trying to be fair and balanced in the way in which we are exchanging ideas, posing questions, receiving answers and the responses back. We know that our role is to ask questions, not to prosecute statements or make editorial comment. That is the way in which this rolls. Questioning is fine, but not editorialising or reflecting or anything like that. The Hon. Walt Secord?

The Hon. WALT SECORD: Dr Roseth and Dr Rogers, how do you feel when you discover that you have inadequate discharge reports? Do you feel that you can provide proper care for your patients?

Dr ROGERS: No, it is very frustrating, it is time-consuming and it often means that we are providing inadequate care.

Dr ROSETH: I would echo that. We always get there in the end. The discharge summary has not always been written—mostly you find it it is not efficient and correct patient care.

Dr ROGERS: I can give an example from last month where a patient was admitted for routine orthopaedic surgery and she had an unexpected cardiac event after the surgery. Eleven days later she came to see me. I phoned the hospital and it was confirmed that the discharge summary had not yet been written. I was sent a copy of the nursing notes, 11 pages of nursing notes, that I read through to try and make sense of what this unexpected cardiac event was that the patient had had that led her to be on all these drugs that she was not on before, but there was no discharge summary that had been written.

Dr ROSETH: I talked to a specialist last week who took leave from the hospital because she said to me she cannot work there anymore, she cannot do it anymore, and she said to tell you that the reason for the quality—because there is also an issue with the quality of the discharge summaries—she said there are just not enough junior medical staff and they are just not being properly supervised and supported.

The CHAIR: Can I just follow up, Dr Rogers? The example of the request by you and then the ultimate receipt of the nursing notes or the notes from the nurses, was that something almost asked out of desperation to obtain something from the hospital that you made that request?

Dr ROGERS: Absolutely. There is a fantastic lady—I will not say her name because I do not know what the rules are about that—

The CHAIR: No, please not the names.

Dr ROGERS: —but she is so helpful at the Northern Beaches Hospital, and whenever we do not have a discharge summary we send her a fax and she does her utmost to find some sort of discharge information for us because she knows how important it is. If there is a discharge summary that has not been sent out, which is often the case if the GP box has not been ticked or if it has been sent to the wrong general practitioner, she will forward it to us. In this case no discharge summary had been written and so she found the nursing notes and sent them to me instead, and I am very grateful; I was able to make some sense out of what happened to this elderly lady who really had no idea what had happened.

The CHAIR: I will finish on this. In terms of this brand-new hospital built for the price that it has been, sitting there in Frenchs Forest, to actually have to deal with discharge in the frame that you have described, it would have to be described as something that you would be surprised with. Would that be a fair comment?

Dr ROGERS: Extraordinary.

Ms CATE FAEHRMANN: So let us keep with this extraordinary situation of the discharge summaries. If you have received the 200 discharge summaries that were not for you, you were not their GP, that does suggest there are quite a few other GPs who are also receiving the situation in relation to discharge summaries. Can you confirm that this is not just isolated to your two practices?

Dr ROGERS: I think that is very fair. At the one and only meeting that GPs have been invited to at the Northern Beaches Hospital, which was on 26 March, there were a lot of comments made by general practitioners that they were not receiving discharge summaries and that the discharge summaries were not giving the detail particularly around medications that we required.

Ms CATE FAEHRMANN: I was trying to think before why would there not be discharge summaries provided. You have touched on that a little in terms of private hospitals do not normally do this. But of course this is a public-private hospital and there are a lot of public patients.

Dr ROGERS: I think the reasons are as Dr Elana Roseth said—

Ms CATE FAEHRMANN: The junior medical officers?

Dr ROGERS: The junior hospital doctors are not there. We have got the information technology [IT] challenges and the lack of staff. I hear stories from nursing staff that there are piles of notes waiting to have discharge summaries written on them sitting in the wards.

Dr ROSETH: Interestingly, often patients do have hard copies in my experience. So they often get discharged from hospital and get given a hard copy. It is just that we are not getting the electronic version so we have no idea what happened until a patient fronts our surgery. That is a different experience for us. It makes it much harder. I find it much easier to deal with a patient who has for example, had a heart attack, when I can say to them I know what has happened. Rather than just wading through this—

Dr ROGERS: It means you spend the first five minutes of your consultation reading the discharge summary rather than talking to the patient.

Dr ROSETH: If they have got the hard copy. So there is something going on there. It is hard for us to answer. It should be a simple problem to fix.

Ms CATE FAEHRMANN: Do you think they are cost-cutting already? It is a private hospital.

Dr ROSETH: No. It is more of an IT issue and the junior doctors.

Ms CATE FAEHRMANN: Why would not they put money into IT to ensure that discharges were provided to GPs electronically?

Dr ROSETH: They are not used to providing discharge summaries because they have been running different types of hospitals, I think.

Ms CATE FAEHRMANN: But it is not acceptable. One of you suggested in your testimony that the disturbing amount of risk with patients is still occurring. We heard from Healthscope that it was just all teething issues and everything has been sorted now. Are you sure that we should not give them a little bit more slack because they have just started up? Surely we can account for a few mistakes? But they have suggested they have tightened up. Have they not done that? This was the evidence we heard.

Dr ROSETH: The mistakes are ongoing. I have an example of a mistake that I read in a discharge summary yesterday. The mistakes are ongoing. I do not think they are at the level of the original opening but the amount and the seriousness of the mistakes that I have heard from there were, I would say, fairly severe.

Ms CATE FAEHRMANN: So it is not just teething problems now?

Dr ROSETH: The mistakes are ongoing. It is not just teething problems. There is some sort of systemic problem with the way patient care is delivered.

The Hon. WALT SECORD: Doctor, what was the mistake that you just alluded to?

Dr ROSETH: I have decided I would prefer not to give instances but I have got a whole list of mistakes that I would be happy to read to you.

The Hon. WALT SECORD: Can you do that?

Dr ROSETH: So over the year my patients have told me instances of misdiagnosis; test results that were lost; being billed for a test despite being a public patient; being billed for a test that had been mislabelled and therefore needed recollecting; not being given a meal or being given the wrong meal; not been given antibiotics on time; wounds not checked adequately resulting in serious infection; not being given adequate pain relief or sleeping tablets; not having their complaints of pain listened to adequately; being labelled not for resuscitation without consultation with a patient or family—

The Hon. WALT SECORD: What is that?

Dr ROSETH: I do not want to go into details because this is all hearsay and as a clinician I am trying to deal in verifiable and factual information. This was a patient whose father died at the hospital. He was for palliative care—I think that was before the time they actually had palliative care at the hospital because they did not have any palliative care for three months. The family was very upset because their father was labelled not for resuscitation but there had been no consultation with the family or with him. She was very distressed and has put a complaint into the NSW Health Care Complaints Commission about that. The list goes on: treatment by staff who were trying really hard but who were clearly overworked, harassed, unable to operate or find equipment, seemed inadequately trained or fairly junior; treatment by staff who seemed to have no orientation to the IT or ability to use the IT system; discharged either home or to a local rehabilitation hospital too early while still acutely sick; discharged without adequate follow-up and also not having complaints made via the website responded to. That is a list I have put together—one GP—over the course of one year. It is a long list.

The Hon. WALT SECORD: That is a very long list.

Dr ROSETH: All of that is reports—admittedly reports—from my patients. We just did not get this level of reports when—

The CHAIR: So these are reports to you as their GP either in the context of a treating doctor and the relationship between you and your patient, or in the case of the deceased I presume from another family member?

Dr ROSETH: Some of the reports are family members talking about the treatment of their family member and I cannot verify whether those reports are accurate or not.

The CHAIR: No. But they have spoken to you in those terms, describing what they say happened. That is their explanation.

Dr ROSETH: Yes.

The Hon. WALT SECORD: You said there was no palliative care for that three month period, so what would family members in that situation with elderly parents or people with terminal illnesses, what were they doing at the hospital?

Dr ROSETH: I do not know that I can speak to the details of that. The oncologists at the hospital were doing the palliative care. I do not want to talk about details. There is palliative care but it does not have adequate cover, I believe. But you would have to ask the oncologists and the hospital about those details.

The CHAIR: Can I invite you to just explore this palliative care a bit further? This is a brand new hospital and I think your testimony was that the provision of palliative care at the hospital, as far as you know now, still appears to be limited. Is that what your evidence is?

Dr ROSETH: Yes. But I do not know the details.

The CHAIR: That is fine.

Dr ROSETH: That is something for the specialists. An oncologist that has resigned has told me that.

The Hon. WALT SECORD: If you are in a situation and you have someone in your office who is clearly having a stroke, would you send them to the Northern Beaches Hospital, or would you get them directly to Royal North Shore? What would you do?

Dr ROGERS: As a doctor you would send your patient to the facility that was going to be able to adequately treat that condition. Given the choice between a facility that is able to offer thrombolysis and one that is not, you would choose the facility that is able to offer thrombolysis. For us that would be Royal North Shore.

Dr ROSETH: In the end we do not really have a choice. We call the ambulance and the ambulance takes them where they have been directed to take them.

The Hon. EMMA HURST: Dr Roseth, you say in your submission that as a GP that you really have to consider whether or not it is safe to even send people to the Northern Beaches Hospital and that you would not go there yourself if you got sick. Did you have the same concerns about Manly or Mona Vale Hospital?

Dr ROSETH: No.

The Hon. EMMA HURST: What do you think needs to be done urgently to improve the situation?

Dr ROSETH: To improve the situation, I think, the sort of targets I am talking about are very achievable. The situation overall from a GPs perspective would be that I would like acknowledgement and communication with general practice; I would like to receive accurate and timely discharge summaries and I would like to be confident that my local hospital is treating all my patients with the appropriate level of clinical care.

The Hon. EMMA HURST: Dr Rogers, do you feel confident to send your patients there and would you go there yourself?

Dr ROGERS: It very much depends what condition we are talking about. There are some conditions that are being very well treated at the Northern Beaches Hospital and there are some that I would prefer to use a different facility.

The Hon. EMMA HURST: Thank you. Also Dr Rogers, you mention in your submission the lack of public outpatient facilities available to patients being a problem and you have mentioned today about people being charged for pathology tests without realising it. Why do you think patients are being misled about the costs of these services?

Dr ROGERS: Informed financial consent is a big issue in health care. I do not think the Northern Beaches Hospital is alone in this. The difference is that patients thought they were going into a public health facility that had taken over from Mona Vale and Manly and it has turned out not to be the case. The issue of the outpatient clinics is especially pertinent because, while I have no argument with people choosing to pay to see private specialists, the choice there is absolutely key. And if we are not offering patients a choice, if we are saying, "The only way you can see a specialist is to pay and see them privately", then we are not providing a comprehensive public health system—and we have lost the public outpatient clinics that were Manly and Mona Vale Hospital and are no longer available through the Northern Beaches Hospital. I have had several meetings with the Northern Beaches Hospital and, to my knowledge, there is no plans for them to open any additional outpatient facilities there.

The Hon. EMMA HURST: Those sort of shock pathology bills were not happening at Mona Vale and Manly because—

Dr ROGERS: Because it was a public facility.

The Hon. EMMA HURST: Is it that transition to something that is a more private-based hospital?

Dr ROGERS: I think there was some errors made initially that public patients were given bills for pathology. My feeling is that has now been resolved if you are admitted as a public patient. I have not heard recently that patients have been coming out with bills for their pathology.

The CHAIR: Nonetheless though, we have the loss of—I am just looking at your useful submission about the loss of cardiology and neurology clinics.

Dr ROGERS: Correct.

The CHAIR: Are there any other clinics to your knowledge that are no longer available by virtue of the new hospital opening or that is the extent of it?

Dr ROGERS: We have very restricted access to the paediatric clinic now.

The CHAIR: Paediatric.

Dr ROGERS: I think there had been a hope, there had been aspiration that with this lovely new hospital opening that we would actually have an increase in public outpatient facilities. There certainly is the need for it on the Northern Beaches and that has not happened.

The CHAIR: Indeed, in your submission you said:

> We lacked outpatient services for the Northern Beaches in key areas eg gastroenterology, ophthalmology, orthopaedics.

And you nominate those three specifically.

Dr ROSETH: Can I just add—

The CHAIR: Please.

Dr ROSETH: You asked me a question about whether I had concerns about Manly or Mona Vale. As Caroline said, there are conditions that I would feel very safe sending my patients to the hospital or going there myself. I do not want it to sound like that. I just think we have all heard stories or reports of inadequate patient care with more severe or longer admissions.

The Hon. NATASHA MACLAREN-JONES: Could I just clarify on that, before the Northern Beaches Hospital was open were you confident that all the clinical needs of your patients could be met by Mona Vale and Manly or were they, at those stages, also needed to be referred on to other hospitals?

Dr ROSETH: There were lots of conditions that needed to be referred on. The situation for neurology and stroke patients is not new; the situation for cardiac patients is not new. We were hoping for a more comprehensive set of services for outpatients and we actually got less, that is the problem. The difference between having Manly and Mona Vale is really, from my point of view, is the reports of poor patient care.

The Hon. NATASHA MACLAREN-JONES: Getting your opinion on the actual location, we have heard the concerns you have about the services which is good to get on the record, but I am interested to know: Do you think that the current location of that hospital and the choice of it is servicing the people of the Northern Beaches area?

Dr ROGERS: It is an interesting question. There are lots of models of healthcare where it works really well having a hub and spoke model where you would have a hub where a lot of the inpatient facilities were, and then you could have public outpatient clinics in the community that were much easier accessible, particularly for the older patients. One of the problems with the public-private model is that we no longer really have anyone looking at the healthcare needs of our entire population and seeing how they can best be planned for and serviced. We have fragmented this. We have one person looking after the inpatient facilities and private facilities at the Northern Beaches site but we have not really got anyone looking at the rest of the population and seeing how best to provide for their healthcare needs.

Dr ROSETH: I work in Dee Why so it is less of an issue for us—just the physical proximity of the hospital—than it is for Mona Vale. I understand if I was an 85-year-old with a heart condition and I lived in Mona Vale, I would be concerned about the time it would take to get to the hospital.

The CHAIR: Or dare I say, further up?

Dr ROSETH: It is just not that impactful on my practice in Dee Why.

Dr ROGERS: Can I also add, another point that I made in my written submission was the effect on the mental health of staff members who have transitioned from Manly in Mona Vale to the Northern Beaches Hospital. I have, amongst my own patients, several staff members who, at the time were affected very adversely by the move. But I am particularly struck by one of my patients who, despite having worked at Manly Hospital as a respected member of staff for 20 years, was so traumatised by the move that she has not been able to be returned to work since and she is on WorkCover approved leave. Speaking with her rehabilitation coordinator, his comment was, "You are not the only one. It is a bit of a mess up there." I think the effect on individual people that this move has had should not be overlooked.

The CHAIR: Thank you very much. Thank you for your submissions in the first instance, your opening statements and your thoughtful answers to questions.

(The witnesses withdrew)

(Short adjournment)

DR FRED BETROS, Board Member, Honorary Treasurer and Former Hospital Practice Committee Chair of the Australian Medical Association NSW, before the Committee via teleconference, sworn and examined

MS FIONA DAVIES, Chief Executive Officer, Australian Medical Association NSW, affirmed and examined

FIONA DAVIES, Chief Executive Officer, Australian Medical Association NSW, sworn and examined

FRED BETROS, board member, Honorary Treasurer and former Hospital Practice Committee Chair of the Australian Medical Association NSW, before the Committee via teleconference, affirmed and examined

The CHAIR: I will invite one of you or either of you—I do not know whether you have an arrangement to make an opening statement. Then, if it is okay, we can commence with some questioning. Is that suitable, Doctor and Ms Davies?

Ms DAVIES: Yes, thank you.

The CHAIR: You will be making the opening statement?

Ms DAVIES: I will make the opening statement. To the Committee, I apologise on behalf of Dr Betros. He is operating today—not right as we speak.

The CHAIR: No, but I understand he has a busy list and there is a patient coming up relatively soon, so I will ensure we are on time, Doctor.

Dr BETROS: That is fine.

Ms DAVIES: We should have also mentioned that Dr Betros is the head of the Department of Surgery at Blacktown Hospital, in addition to his Australian Medical Association [AMA] roles.

The CHAIR: Thank you very much. That is very useful to know.

Ms DAVIES: AMA NSW has advocated for many years for the improvement of hospital and health services of the Northern Beaches. That included supporting the medical staff councils of Manly and Mona Vale hospital in their efforts to have a redeveloped hospital for the Northern Beaches area. We played an important role in facilitating discussions between doctors, Healthscope and NSW Health prior to the opening of the Northern Beaches Hospital. We presented concerns regarding rostering, cover, training and other clinical issues and we represented individual members who were visiting medical officers in the contract review process. From the outset AMA NSW cautiously accepted the decision to build the hospital using a public-private partnership arrangement. A history of successive government failures to provide appropriate infrastructure to the Northern Beaches had made it clear that this was a way to deliver an improved hospital service in the area. However, we felt for the public-private partnership to work the hospital needed to be built on an ideology that it was a public hospital being run by a private operator, rather than a private hospital that treated public patients.

Unfortunately, in the planning states and the initial stages of the operation of this hospital it was apparent that that was not the ideology that was being pursued. We were particularly concerned that management at the time of the opening and the lead-up to the operation of the hospital failed to recognise the need to adequately engage with clinical staff. This played a significant impact in the issues associated with the opening of the hospital. In particular, in the lead-up to the opening of the hospital many doctors were unable to confirm their contractual arrangements, were having to negotiate contractual arrangements on an individual basis, were having their terms and conditions reduced on an arbitrary basis. This played a very profound impact on the capacity of the hospital to open. AMA NSW also advocated on behalf of doctors in training, where there were significant issues in the early stages as they tried to establish an arrangement between the Northern Sydney Local Health District and Northern Beaches Hospital. There were issues and discussions that we participated in with regard to staffing and with regard to rostering that had a profound impact.

It is really important to note that in any hospital, public or private, where you disengage your medical staff you will have a significant impact on the opening of the hospital. There are many instances in public hospitals where the same thing has happened. Despite the operational and management challenges faced early on by Northern Beaches Hospital, we believe it is too soon to declare the project a failure. We have noted changes in senior management of Healthscope, which have made a significant difference in engagement with senior medical staff. We also acknowledge the significant efforts of the Minister for Health and Northern Sydney Local Health District in working to integrate Northern Beaches Hospital much more into the public hospital system network. We welcome the opportunity to appear before this Committee. We think this Committee has important work to do in evaluating what led to the issues, and we are open to answering questions and working through the process of evaluating how best to deliver the most comprehensive and high-quality health services on the Northern Beaches.

The CHAIR: Thank you, Ms Davies. I should have mentioned—forgive me for not doing this before you commenced—that the AMA NSW submission has been received and processed and stands as submission number 229 to this inquiry. All members have had an opportunity to read that. Thank you for the submission and now the opening statement. Are you comfortable that we now move to questions? I ask members to please specifically direct their questions to Ms Davies, who can see us because we are in the room. Dr Betros cannot, so if it is to be directed to him members ought say, "This question is to Dr Betros." We will start with the Hon. Emma Hurst.

The Hon. EMMA HURST: This is to either witness.

Ms DAVIES: If you are not certain, direct it to me and then I will certainly indicate that I think Dr Betros is better placed to answer.

The Hon. EMMA HURST: That would be fantastic, thank you. In the submission it was mentioned that one of the reasons that the Northern Beaches Hospital was needed was due to a concern about the growing population in the area. It is expected to grow a further 16 per cent by 2036. Do you think a single hospital is capable of meeting the needs of the growing population? Should consideration be given to keeping Mona Vale Hospital operational at a higher level to support the Northern Beaches Hospital, in your opinion?

Ms DAVIES: I can answer that, although Dr Betros may wish to add. That is not an issue the AMA has a position on. Our concern was very much the—I think it is fair to say—decrepit nature of the two hospitals that Frenchs Forest replaced. Beyond that the AMA does not have a position on that issue.

The Hon. EMMA HURST: Dr Betros, did you have anything that you wanted to add?

Dr BETROS: No, I would echo Ms Davies' statements exactly. We were primarily concerned with the wellbeing and the working conditions of the senior and junior medical staff. But I do acknowledge the conditions of the two previous hospitals prior to opening the Northern Beaches.

The Hon. EMMA HURST: In your submission you note that the opening of the Northern Beaches Hospital may have gone smoother if Manly and Mona Vale hospital had not closed at the same time and if there had been more of an overlap period with all three hospitals operating. Do you know what the justification was for a hard opening of the new hospital? Were you consulted at all on that?

Ms DAVIES: I will answer the first part and then I might throw to Dr Betros to explain why there might have been a better transitional approach. No, we were not consulted on the nature of the opening and we are not certain. In fairness to Northern Beaches, the transition across hospitals—Orange having been another case in point—is rarely easy, but we were not consulted. I will let Dr Betros comment further if he wishes.

Dr BETROS: Sure. Yes, I do have an additional comment to that. We did feel that a staged transfer of services from the existing hospitals to the Northern Beaches Hospital may have provided a safer environment. I know that Healthscope did have track record of doing similar things with The Hills Private Hospital when transitioning to Norwest Private Hospital, which I am a VMO at, and there is a clear staged process in the scale of services that were offered at the time to ensure that all the systems were running adequately and that there was not a capacity issue that was unforeseen. I feel that could have been a mechanism that could have been put in place, a staged transfer of services, which may have allowed early identification and management of the capacity issues we have seen once northern beaches opened its doors.

The Hon. EMMA HURST: Your submission also outlines some of the concerning behaviour of Healthscope in relation to contract negotiations. You say a number of craft groups of doctors were offered worse conditions compared to what they were originally promised and with limited time to review those conditions and negotiate changes, sometimes less than a day. For my benefit can you explain what a "craft group" is and why some groups were offered worse conditions?

Ms DAVIES: It is also known as a speciality, as in anaesthetics, surgery, different types of doctors. In the public hospital system there are staff specialists and there are visiting medical officers [VMOs]. Visiting medical officers are contractors. Many of the doctors at Manly and Mona Vale and then transitioning across to northern beaches were visiting medical officers. Under the State system while there are some slight modifications in the way you can be paid, there is a fee for service contract or a sessional contract. By and large it is consistent across whether you are a surgeon, an anaesthetist or an obstetrician. Although there were provisions whereby Healthscope could choose to negotiate their own arrangements we had expected that similar terms from the public hospital system would be offered.

We had also expected, and in fact had an authorisation in place from the ACCC, that we would be able to negotiate collectively for those visiting medical officers. We do that for visiting medical officers in public hospitals. That has enormous advantage for us but more importantly for the doctors in the hospital because you can imagine the scale of individual negotiations. In a private hospital where there is that very private hospital ethos it is an entirely individual process. I think unfortunately—I would acknowledge that this has completely and significantly changed—clearly previous management staff took a view that they would seek to negotiate with individual visiting medical officers and that process was left to the last minute.

In fact it was exactly this time last year because I remember most of it happened in the school holidays, which made it even more difficult. For some groups, particularly anaesthetists, there were reductions to their terms and conditions. You had very anxious very angry individuals whose time was being taken up with contractual negotiations at a time when what they needed to be doing and talking about was how are we going to run this hospital. I think that has been acknowledged by Healthscope. There has been a change to that approach but it was a very unfortunate situation.

The Hon. EMMA HURST: What sort of timeframes would you normally recommend?

Ms DAVIES: We had been seeking that for a couple of years and that should have been resolved. That certainly should have all been resolved, people should have had certainty about their appointments and contractual terms at least a year out. None of that should have been difficult. The sorts of changes that we hope will be addressed were quite minor things that just ended up really alienating and angering people. For instance, a visiting medical officer on a sessional contract will get superannuation. They removed that. In that sense you, as an individual, had to go and hope you were going to get looked after. It was a very confronting and unfortunate process.

The Hon. EMMA HURST: You say that there has been some genuine improvements in the way it has been managed and that is really good to hear. Do you think that medical staff are better off or worse off in terms of their conditions at northern beaches than they were at Manly or Mona Vale Hospital or nearby hospitals they were working at?

Ms DAVIES: For most I think there are some final contractual arrangements which we hope will revert but otherwise by and large they have been reverted to being consistent with the public hospital determination. My understanding is that we still have some minor issues we do still need to resolve for some speciality groups. We would encourage that in the longer term they continue to maintain the terms and conditions of the public hospital appointment for all staff because as I suspect they have discovered any small savings are completely lost when you disengage your medical staff.

The Hon. EMMA HURST: Actually, one of the recommendations in your submission was that there be a recognition by government that disengaging doctors will negatively impact on the delivery of high quality health care. Do you think there are doctors and medical staff that remain disengaged and disheartened by the approach taken by Healthscope in the lead up to the opening of Northern Beaches Hospital? Do you think that there is any particular impact on patient care from that?

Ms DAVIES: In the lead up to this hearing we put out a request to our members at northern beaches to ask them for their feedback. We got very little feedback. The sense we have is that I think they would like to get on with the business of providing high quality care. That is the sense. I am not suggesting that means that people are not still feeling disengaged by the process but very much the feedback we have now is "let us get on with our job". Dr Betros, do you have anything to add?

Dr BETROS: I do. Just to give some perspective in relation to impact of the way the contracts were handled. I know a significant number of visiting medical officers never actually signed contracts once they reviewed them and given the short turn around their concerns regarding the risks of taking on a position and a backwards step in their working conditions. There was a lot of uncertainty. An example I can give you is we met with the medical oncology and haematology craft group prior to contract deadlines for signing and it was a very short turnaround. I know that there were at least 10 specialists at that meeting. Only three of those are still now working. I know five signed up and two left based on the working conditions. We did see a significant impact to the senior medical workforce that commenced working there. I believe it was due to the uncertainty and the variability in the contracts and the way the contracts were offered to the senior doctors. They did not have certainty about what they were actually signing up for.

Ms CATE FAEHRMANN: We heard evidence at the first hearing a month or two ago that some of the junior medical officers were treating private patients even though their contract is with NSW Health to treat public patients. In your submission you reference this. You say that the New South Wales Government's contract with Healthscope stipulates junior doctors would care for public patients. However, in practice doctors in training were expected to undertake ward rounds with visiting medical officers for private patients and look after private patients in private wards. Is that happening as far as you are aware, is that still occurring?

Ms DAVIES: That was an issue at the commencement. It is not something that we have a hard philosophical opposition to. The concern at the time was the need for there to be clarity around how those relationships would work and how the staffing would work. Dr Betros, do you want to comment on private patients in public hospitals and the care there?

Ms CATE FAEHRMANN: That would be good, I have some questions about it.

Dr BETROS: Yes, sure. You happy for me to speak now?

Ms DAVIES: Yes.

Dr BETROS: Private patients in public hospitals is always a difficult area. Many doctors are misinformed and feel that there are grey areas in responsibilities of care. In terms of medico-legal cover, looking after a private patient in a public hospital most junior medical officers [JMOs] would be indemnified by the organisation under their cover if they are working for the organisation. The main concern we have with the junior doctors covering private patients at the hospital was that the staff numbers were based on the public hospital caseload. Our concern at a hospital practice committee level was focused on ensuring that there were not unsafe patient numbers for a relatively small number of junior medical officers. Once you go beyond a certain threshold there is only so much a single person can do in any given day and then you reach a point where you go beyond what we would consider safe working conditions for the patient and for the doctor.

That was our main concern, that junior medical officers—and we actually asked for numbers in terms of team make-up, staffing numbers, patient ratios from Healthscope prior to the opening of the hospital. We had been told via correspondence that there would be essentially plenty of doctors, but as we found out very quickly that was not the case. Our concerns regarding junior medical officer numbers were borne out as a reality, because these junior doctors were very quickly also being asked to help manage the private patients and our understanding was that those private patients were not the responsibility of the JMOs.

Ms CATE FAEHRMANN: Okay, so let me get this straight. I am assuming the JMOs do not get paid any extra money for caring for those private patients?

Dr BETROS: Correct.

Ms CATE FAEHRMANN: Does the Government get money from Healthscope for the JMOs who are caring for the private patients?

Dr BETROS: I am unaware of that.

Ms CATE FAEHRMANN: Essentially, is any record kept from the JMOs' perspective or the hospital's perspective in terms of how many hours the JMOs would treat private patients?

Dr BETROS: Again, I cannot answer that because I am unsure as to what mechanisms they have in place for keeping track of that.

Ms CATE FAEHRMANN: So the Northern Beaches Hospital has not put on enough private doctors to deal with private patient demand and therefore there is reliance on the JMOs, on the doctors being paid for from the public system to care for private patients as a result. Is that what is happening?

Ms DAVIES: This submission was based around the opening. I do not know that we would say that is an accurate statement going forward.

Ms CATE FAEHRMANN: Okay. We did hear from I believe it was the Paramedics Association at the last hearing that that was still occurring, according to their evidence.

Ms DAVIES: The information in our submission was very much focused on the time of opening. I think it is going to remain an ongoing issue as to what are the models of care that happen at Northern Beaches with that mix of public and private. If doctors in training are—if there are adequate numbers, they are appropriately resourced and they are getting training opportunities it may well be that there is a mix or a way in which that becomes appropriate. The comments in our submission were very focused on the particular concerns of the opening of the hospital.

Ms CATE FAEHRMANN: But it is important, if that becomes appropriate, that the taxpayer, if you like, or the Government is essentially reimbursed for the services provided to the private system, to Healthscope.

Ms DAVIES: There should be appropriate arrangements. Healthscope also to need to look at—and it is my understanding from discussions—they should certainly be employing, as many private hospitals do, appropriate private junior medical staff to also assist in that workload. I think there was an underestimation of the needs for the workforce levels at this hospital. There is no question of that.

Dr BETROS: I would echo that as well. It is the workforce demands that we had a major concern with at the time. Just for completeness, there are multiple examples of private patients in a public hospital setting where public hospital JMOs that are paid for by the Ministry of Health are looking after private patients in public hospitals every day. There is a precedent there that JMOs can look after private patients in a hospital setting—there is no problem with that. Our main concern was the workforce and the caseload demand upon the JMOs.

The CHAIR: Can I just ask this question, then? I understand the explanation just given about this—I would not call it a "concession"; probably the best word is "recognition"—of JMOs doing some "private work". However, surely we have this issue at heart here and that is that—and I am not saying I agree with what you have just said as a policy position—but having that happen in the context of a public hospital vis-à-vis having that happen in what is a for-profit hospital, which this is, surely one can see that it is almost, dare I say, playing with fire, that dynamic that operates in a for-profit operation vis-à-vis a public operation. Would you agree with that statement?

Ms DAVIES: The issue of the contractual nature between the parties and how it is funded is a matter for Government. Our concern is to protect the workforce. The funding decisions that this Government has made with Healthscope are a matter for the Government and Healthscope.

The CHAIR: But what if I said to you we have received evidence to this inquiry from a previous organisation having a number of members as JMOs who are saying they were being treated very poorly, in terms of a whole, across a whole scale of indicia you could use to measure the way in which the hospital was treating them—not just the long hours but in terms of being locked out of crib rooms and a whole range of things. I have to say, I think committee members were appalled to hear that evidence at that time. I would have thought the Australian Medical Association [AMA] would be shouting from the rooftops about that.

Ms DAVIES: You asked two different questions. The question of what payments should there be between the Government and Healthscope is not a matter for the AMA to determine.

The CHAIR: No, I did not ask that question of you.

Ms DAVIES: Yes, you did. But in terms of the—

The CHAIR: No. With respect, I did not ask you that question.

Ms DAVIES: I apologise. Your question as to—

The CHAIR: I was talking about the treatment of these JMOs, which some of us around the table share very closely with the previous witnesses who have spoken for and on behalf of them as pretty, pretty terrible—they had never seen this in public hospitals in New South Wales. I do not know if you are aware of their testimony, but they were very explicit: They had not seen this treatment of JMOs ever in New South Wales public hospitals. Pretty clear big statements by that organisation.

Ms DAVIES: We fully support the concerns about the treatment of doctors in training at Northern Beaches and the need for support for those doctors in training at Northern Beaches.

The Hon. WES FANG: I will declare that my wife is a member of the AMA—just upfront I will put that on the record. Thank you for coming today and presenting your evidence. Just a note for clarification: Do JMOs fall under the AMA or are they usually the Australian Salaried Medical Officers' Federation of NSW [ASMOF]?

Ms DAVIES: We have a shared relationship. We had an awareness of all of the same concerns. We escalated those concerns immediately as well. We participated in the immediate process that was established by the ministry, at our request, to urgently address the concerns. The ministry acted immediately on those concerns being raised. A working group was set up that required the general manager of Healthscope, the AMA and ASMOF, senior people within the ministry and Northern Sydney Local Health District. It was treated as incredibly serious, as it should have been.

The Hon. WES FANG: Excellent.

Ms DAVIES: Because it was a very serious situation.

The Hon. WES FANG: Thank you for that testimony. In your submission you say that Healthscope had failed to negotiate the contracts in good conscience. We have heard today some examples of that. Moving forward from now, are you seeing an improvement in the way in which Healthscope is engaging and an improvement in the engagement with doctors on their contractual obligations?

Ms DAVIES: Yes. I think the biggest problem we had was a philosophy with this hospital and we could see it in the planning stages. While I had a great regard for Minister Skinner as the former Minister for Health, I do think she drove that ethos that this was a private hospital that was going to see public patients. I think the advantage of the difficulties—this is a very small silver lining to a rather terrible process—is that we have seen a much better engagement between the ministry and Northern Sydney Local Health District and the management of Northern Beaches—the new general manager of Northern Beaches comes from a strong public hospital background—and fundamentally that is what we want to see. If this is to have a chance of succeeding, health is too complicated to establish standalone entities that do not link in with a network; the demands on our public hospitals and private hospitals are too complex to do that. We have seen that recognition that it needs to operate as part of the system and if it does not do that it will fail.

The Hon. WES FANG: Has the AMA conducted any staff surveys of the doctors at the hospital and have you seen an improvement in their satisfaction in the workplace?

Ms DAVIES: We run every year a survey of doctors in training across all public hospitals in New South Wales. I cannot disclose the results because they are not finalised but I was pleased to see that for Northern Beaches—they were not included last year because of the timing; the hospital was not open—but their results this year, I am pleased to say, were mid-level. We have run that now for three years; it is an incredibly important way of determining the views of doctors in training in New South Wales. It has been absolutely instrumental in changing behaviour, and that is critical to continuing to hear from doctors in training because for many people, I fully agree and I cannot say enough, that those early stages for doctors in training were a terrible experience that should not have been allowed to happen, but it has been good to see that, certainly from that Hospital Health Check survey that will be released in the next month or so that the results are mid-range.

The Hon. WES FANG: Is it fair to say that you think that there were teething problems certainly with contractual issues and staffing initially, but the trend to date over the last 12 months of operation has been one of an improvement?

Ms DAVIES: That is our understanding. That appears to be borne out in the results of the Hospital Health Check survey. That is not to say that this is not a hospital that continues to face plenty of challenges, as do all of our hospitals in New South Wales as they are dealing with an avalanche of demand.

The CHAIR: Dr Betros, are there any comments you would like to add to the comments of Ms Davies from the Hon. Wes Fang's question?

Dr BETROS: No, I have nothing additional to say. I agree with Ms Davies' statement.

The Hon. NATASHA MACLAREN-JONES: Just following on from the survey that you have done with your members, when would the results of that be available?

Ms DAVIES: In the next couple of weeks. I have somewhat given away some information, but that is okay.

The Hon. NATASHA MACLAREN-JONES: If the Committee could have access to that? In your submission, and you also refer to it in some of the evidence you have given today, you used the term "a hard transition opening "and that a staged opening would have been preferable. Could you outline ideally what you would have suggested rather than what has currently occurred, just to give lessons learnt?

Ms DAVIES: I will get Dr Betros to answer that one.

Dr BETROS: I can use an example of what we recommended. As Ms Davies mentioned earlier, I am head of the department of surgery at Blacktown and Mount Druitt hospitals and we have literally just opened our new theatre complex three weeks ago and transitioned our entire theatre activity into a new building, which was a massive undertaking, and that is just moving a theatre complex within an already set and purpose-built site. To do that we were engaged by the transition staff and the administrative staff and, at the advice of doctors, we recommended—and this is what I would have suggested for Northern Beaches Hospital as well—that I would only recommend that emergencies and urgent category elective services be done in the first weeks to months to enable the hospital to ensure that it was up and running adequately and not extend the resources to their fullest extent.

In terms of elective procedural work, you may be aware of the different types of categories—there is category 1, within 30 days; category 2, within 90 days; category 3, within 365 days. In terms of surgical intervention, I would not normally recommend that you do anything more than category 1 and urgent emergency work, especially in that first week of hospital opening, so that a feel could be had for what the services were capable of. That would have been something I considered to be a softer transition and we certainly got good evidence that that is we have done in other sectors of the public system previously.

The Hon. NATASHA MACLAREN-JONES: Do you think, looking back and reflecting on the challenges that you have identified then, that they are now adequately staffed, both doctors and also allied health, to meet the current needs?

Dr BETROS: I cannot personally comment on that from the information I have.

The Hon. NATASHA MACLAREN-JONES: That is fine. We have had witnesses say they would not send patients or would not send relatives to Northern Beaches but would go to other hospitals. Do you think that is a fair reflection on what services are available at the Northern Beaches Hospital?

Ms DAVIES: Dr Betros, do you want to—

Dr BETROS: Are you saying that the current situation is that people are saying they would not send relatives or friends to the hospital?

The Hon. NATASHA MACLAREN-JONES: Yes, that is correct.

Dr BETROS: Again, I cannot comment on the adequacy of the clinical care given at this present time. I can comment that the feedback we have received from our members, whether they be junior doctors or senior medical officers, is that the situation seems to have improved. We accept and acknowledge that there are still deficiencies and that that is the case in all areas of public service provision at the moment, and it is a subjective view. I find that a difficult statement to comment on because if you have spoken to enough people who work in the public sector, most experiences such as this are based on human interaction with human service provision and that is a huge variable and it is an individual and a subjective matter. So I would find that very difficult to comment on.

Ms DAVIES: I do know that some doctors working at the hospital now have found that quite a distressing reflection on them and the contribution that they have made to that hospital and that they continue to make. In fairness to everybody, sadly, this is probably the fourth or fifth sort of hospital-based inquiry that I have participated in and it is really important to note that comments like that do have an impact on the people who work at a hospital and who are doing their absolute best. I know they are not intended to reflect on those individuals, but they do. So we just want to recognise the extraordinary professionalism of the medical staff of the Northern Beaches Hospital and to acknowledge that we are all here to try and improve the system but we hope none of those comments reflect on people as individuals because I know that is how they feel.

The CHAIR: Having said that, Dr Betros, can I put this to you: We had witnesses earlier this morning—in fact, they were doctors who have practices in the northern beaches community—expressing direct concern because of this particular point. It is a very specific one and it has to do with the discharge summaries with respect to patients leaving the hospital, quite specifically, discharge summaries associated with patients not entering through accident and emergency. To the point, the position is that—this is their testimony— with respect to this hospital, which is a Healthscope-run hospital, it is an opt-in proposition—that is, the patient opts in with respect to the issuance of discharge summaries. The position with respect to the opt-in arrangement is that that is embedded in the Healthscope company's structure of running its hospitals, which are ostensibly private hospitals.

The doctors this morning were expressing and gave us some very detailed and, I thought, compelling evidence about problems that they have faced directly with respect to their patients that they treat, not actually having transmitted to them, as is generally the case in the rest of New South Wales with respect to the public hospitals, discharge summaries containing very important information that is taken up immediately by those doctors when they see those patients in their first visit after exiting from the hospital. I use this as this as a simple example. Discharge summaries are available only if you tick the opt-in box. The lack thereof is producing some serious difficulties for doctors treating patients on the northern beaches. That is a very telling point that was made by those doctors. They were expressing their concerns about how this is, in their view, having a potentially deleterious effect, if for no other reason than taking up five or so minutes of the time of their first appointment with the patient just to try to understand what the issues are associated with their patient coming out of hospital. What you have to say to that?

Dr BETROS: What you have said is concerning. Again, it is not an area of the hospital's operation that I am privy to. I have not had that feedback prior to this. What I can comment on, though, is that good medical communication between hospital and community medical services is essential. It is, what I would consider, a standard of care that is mandatory rather than opt-in. I am not aware that Healthscope has that as an opt-in-type service. That is something that I am unaware of, but if you ask me as to whether medical discharge summaries are considered mandatory, in my opinion, I would say they should be, yes. If that is true—if it is opt-in—I cannot comment as to the truth of that statement but if it is opt-in I would consider it should be mandatory.

The CHAIR: Finally, before I pass it to Ms Faehrmann, Mr Davies, have you had no complaints on any members of the AMA who operate on or around the northern beaches about issues associated with the failure to provide discharge summaries?

Ms DAVIES: I would acknowledge that concerns about GPs accessing discharge summaries are a bit of a widespread concern but—

The CHAIR: No, I am talking specifically with respect to—

Ms DAVIES: We have not had specific feedback on Northern Beaches.

The CHAIR: Have you surveyed your members on that particular point?

Ms DAVIES: No but we are certainly happy to follow up on that issue.

Ms CATE FAEHRMANN: Have you had any complaints regarding the recruitment process for senior medical practitioners at Northern Beaches Hospital? We have had a number of submissions and I have heard anecdotally about concerns in relation to the lack of transparency, I suppose, around that process.

Ms DAVIES: Yes, we did have complaints about that process. I think, again, it would have been preferable if they had followed public hospital processes for recruitment. They followed the Healthscope by-laws process and I think that left a lot of people feeling very unsettled by the experience. Yes, we did have complaints.

Ms CATE FAEHRMANN: Could you please explain the different between the public health process and the Healthscope by-laws?

Ms DAVIES: An appointment at a private hospital is a less complex process. The public hospital system requires an appointment panel with independents and others whereas under the Healthscope by-law process, it was a smaller number of people—largely the general manager and departmental members. We know some people found that it was a lack of information, a lack of timeliness of information and uncertainty about why appointment decisions were or were not made.

The Hon. EMMA HURST: In your submission, you said that you were cautious about supporting a public-private partnership [PPP] model for the hospital. Can you briefly detail what your concerns are with the PPP model?

Ms DAVIES: As I suspect you have had evidence, there is more evidence of failure than success in the public-private partnership model. However, there is the Joondalup model in Western Australia that has delivered health services. Our concern is that there are a number of examples of failure but the reason for our cautious support is that there were 750,000 admissions in our public hospitals last quarter and there were 750,000 admissions in our public hospitals in the quarter before. We are seeing the most staggering demand in our health system and we keep reporting on it. It is an absolute avalanche—"crisis" is an overused word. We cannot turn our backs on anything that may give us some answers—whether this is the right answer or not. The situation facing our hospital system is really significant. It is multifactorial but those levels of demand are just staggering. The reason for the cautious support—plus there was such a need for new infrastructure on the northern beaches. The situation that had been allowed there of those hospitals was unacceptable. Our cautious support is that it has not worked in many places but those were the factors that allowed us to consider that ruling out anything in this current environment is something we have to be cautious about because they are in unprecedented—our public hospital system outruns on levels of demand—year in, year out, quarter on quarter—that we have never seen before.

Ms CATE FAEHRMANN: Ms Davies, based on that evidence, though, they should not have, therefore, shut Mona Vale or Manly Hospital. Is that correct?

Ms DAVIES: That is not an issue we have a position on in terms of that but certainly we have to look at models of care and ways in which we are going to deliver health services to meet demand.

Ms CATE FAEHRMANN: You just said the extraordinary pressure. You said northern beaches needed new hospitals. They needed additional, did they not?

The Hon. WES FANG: I think you are drawing a bit of a long bow.

Ms CATE FAEHRMANN: No, I am just—

Ms DAVIES: It is not something we have got a position on.

Ms CATE FAEHRMANN: That is interesting.

The Hon. WES FANG: Given that the issues that were faced at the start are now continuing, is it possible that the perception of the hospital—that services are not as good as they should be—is affecting the staff and the members working at the Northern Beaches Hospital from whom you have had feedback?

Ms DAVIES: Inevitably, public scrutiny impacts on people's confidence. We saw this with the public hospitals that have also had to go through high-profile and public pressure. It means that where people question the service they get, there is a lot more pressure internally. It has a huge impact. Sadly, the opening of this hospital—the way in which that has happened—will have an impact and does have an impact. Publicity does tend to have that result.

The CHAIR: Ms Davies and Dr Betros, thank you both very much for making yourself available for today's hearing. There may be some questions that members may have, following the opportunity to read *Hansard* tomorrow or the next day. If you would be agreeable, our committee secretariat will liaise with you in terms of the preparation of the answers to those questions. Thank you both very much, particularly Dr Betros, for taking time out of your busy schedule.

Ms DAVIES: Thank you.

Dr BETROS: No problem. You are welcome. Thank you.

(The witnesses withdrew.)

(Luncheon adjournment)