General Purpose Standing Committee No. 2

Operation of Mona Vale Hospital

Ordered to be printed 26 May 2005

New South Wales Parliamentary Library cataloguing-in-publication data:

New South Wales. Parliament. Legislative Council. General Purpose Standing Committee No. 2
Operation of Mona Vale Hospital : [report] / General Purpose Standing Committee No. 2. [Sydney, N.S.W.] : The Committee, 2005. – xi, 200? p. ; 30 cm. (Report / General Purpose Standing Committee No. 2 ; no. 19, May 2005)

At head of title: Legislative Council.
Chair: Patricia Forsythe.
"Ordered to be printed 26 May 2005".
ISBN 0734764057

I. Mona Vale Hospital.
II. Hospital administration—New South Wales—Mona Vale.
III. Title.
IV. Forsythe, Patricia.
V. Series: New South Wales. Parliament. Legislative Council. General Purpose Standing Committee No. 2. Report ; no. 19.

DDC 362.11

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Terms of Reference

1. That General Purpose Standing Committee No. 2 inquire into and report on the operation of Mona Vale Hospital, and in particular:

   (a) the closure of the intensive care unit and the reasons behind its transfer to another hospital,

   (b) the level of funding given to Mona Vale Hospital compared to other hospitals in the area,

   (c) the level of community consultation in relation to changes proposed by NSW Health to the hospital, and

   (d) the reasons why the hospital has not been made a general hospital for the Northern Beaches area.

2. That the Committee report by 31 March 2005.[1]

These terms of reference were self-referred by the Committee

[1] On 21 March 2005 the Committee resolved that the reporting date for the inquiry be extended until Thursday 26 May 2005. On 22 March 2005 the Chair informed the House of this resolution of the Committee (Minutes of Proceedings No 95 page 1286).

Committee Membership

Hon Patricia Forsythe MLC	Liberal Party	*Chair*
Hon Tony Catanzariti MLC	Australian Labor Party	*Deputy Chair*
Hon Dr Arthur Chesterfield-Evans MLC	Australian Democrats	
Revd Hon Dr Gordon Moyes MLC	Christian Democratic Party	
Hon Melinda Pavey MLC	The Nationals	
Hon Christine Robertson MLC	Australian Labor Party	
Hon Amanda Fazio MLC[2]	Australian Labor Party	

[2] The Hon Amanda Fazio MLC substituted for the Hon Henry Tsang MLC for the duration of the inquiry.

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Chair's Foreword

The inquiry terms of reference required the Committee to examine the operation of Mona Vale Hospital, including the nature and effect of proposed and any future changes to the level of services it provides. This examination by necessity had to take place within the context of the overall planning for the reconfiguration of the delivery of health services for the entire Northern Beaches community.

This inquiry attracted 2,336 written submissions – a record response to a New South Wales Upper House inquiry. This response may have been due to the fact that the debate over the future role of Mona Vale Hospital has been the cause of significant community concern and action for some time, and the community was keenly interested in the proceedings of this inquiry. Many people raised concerns in their submissions. Often these concerns were caused by uncertainty and exacerbated by the divisive nature of the public debate on this issue.

This inquiry has sought to address all the issues that were raised in submissions and in evidence, at the least, by having the health authorities provide a formal response to these various concerns and suspicions of the community. One benefit of this inquiry has been the placement of relevant information, which may not have otherwise been made available, on the public record.

There are two impending decisions to be made by NSW Health and by the Minister that are of the utmost immediate concern to those who participated in this inquiry:

- Whether the current level 4 Intensive Care Unit at Mona Vale Hospital will be changed to a level 3 High Dependency Unit

- What will be the location for the new Northern Beaches Hospital.

This report considers the competing arguments that have been put forward with respect to these two questions. The report makes a number of recommendations designed to ensure that those decisions are made in an open and transparent manner and with full consideration of the impact they will have on the level of services able to be provided at Mona Vale Hospital.

It is clear that Mona Vale Hospital and Manly Hospital are supported by loyal and dedicated staff and have strong community support. Because of the decision to develop a new Northern Beaches Hospital on a more accessible site, Mona Vale Hospital may become the complementary secondary hospital.

I would like to thank all the individuals and organisations involved in the inquiry for the significant number of high quality submissions that the Committee received, and the valuable evidence that was provided to the Committee during its hearings. I would like to thank all the submission authors, particularly those who recounted personal details of being admitted to Mona Vale Hospital, often in life-threatening situations, and who wanted to note the exemplary attention they received from the hospital and its staff. I would also like to thank the officers from NSW Health and NSCCH for their cooperation with the Committee during this inquiry.

Thanks also to my fellow Committee Members and the Committee Secretariat for their work on this challenging inquiry.

Hon Patricia Forsythe MLC

Committee Chair

Summary of Recommendations

Recommendation 1 *Page 40*

That NSW Health immediately commence the physical upgrade of the Emergency Department at Mona Vale Hospital as suggested by the Greater Metropolitan Clinical Tasskforce interim proposal.

That Northern Sydney Central Coast Health recruit two additional staff specialists to the Mona Vale Emergency Department.

Recommendation 2 *Page 45*

That NSCCH provide a timetable and detail for the implementation of specific enhancements to patient and carer transport.

Recommendation 3 *Page 64*

That NSW Health publish information, when it becomes available, outlining the background services required to support particular levels of activity within hospitals.

Recommendation 4 *Page 69*

That NSW Health and NSCCH implement a modification of the GMCT proposal with an additional enhancement of ICU services so that Mona Vale Hospital ICU is maintained and operates as a level 4 Unit; Manly Hospital ICU becomes a level 5 Unit; with a single Northern Beaches Department of Critical Care.

Recommendation 5 *Page 104*

That the Value Management Study Process be broadened to include the evaluation and selection of a preferred site for the secondary complementary hospital as well as the preferred site for the new Northern Beaches Hospital.

Recommendation 6 *Page 106*

That once the Value Management Study evaluation report for the new Northern Beaches Hospital is available, NSCCH make public a full description of the basis for their decision on the preferred site including the score for each criterion for each of the six sites.

Recommendation 7 *Page 110*

That, whatever site is chosen for the new Northern Beaches Hospital, Mona Vale Hospital be funded, staffed and equipped to provide an on-going effective 24-hour emergency department service.

Recommendation 8 *Page 112*

That the new Northern Beaches Hospital include a helipad.

Recommendation 9 *Page 138*

That the Minister for Health publicly announce a commitment on the part of the NSW Government that all of the Mona Vale Hospital land will be retained and in the future will only be sold or used for health services.

Chapter 1 Introduction

This chapter provides an overview of the inquiry process. It also includes a short description of the Northern Beaches area. The chapter also briefly discusses a procedural issue which arose during the inquiry.

Terms of reference

1.1 The inquiry terms of reference were adopted on 8 December 2004, under the Committee's power to make a self-reference. They are reproduced on page iv of this report.

Submissions

1.2 The Committee called for submissions through advertisements in the *Sydney Morning Herald,* the *Manly Daily* and in other local newspapers in the Northern Beaches area. The Committee also wrote to individuals and organisations with a likely interest in the inquiry.

1.3 The Committee received a total of 2,336 submissions. This is the largest number of submissions ever received by a Legislative Council committee of inquiry. The Committee appreciates the effort and interest shown by so many individuals. The volume of submissions makes it impossible for the report to fully reflect the totality of community comment on this issue, but all submissions have been read, and have assisted the Committee.

1.4 Of the total of 2,336 submissions, 2,321 expressed a view that supported Mona Vale as the site for the new Northern Beaches hospital. Fifteen submissions supported a site other than Mona Vale.

1.5 It was notable that a substantial number of submissions came from former patients of Mona Vale Hospital. These patients spoke of their gratitude to the staff of the Hospital for their treatment and of the importance of the close proximity of the hospital to the success of their recovery or that of their family member. The following quotes are indicative of the many hundreds received:

> Our family has lived at Bilgola Plateau for approximately the last 25 years. During this time, Mona Vale hospital has been a marvellous local hospital for our family emergency situations… the doctors [in casualty] have always been marvellous.[3]
>
> My late husband spent his final weeks in the care of Mona Vale Hospital and due to the hospital's proximity to our home and the accessibility of the hospital to public transport I was able to visit him every day.[4]
>
> …the Hospital has played, and continues to play, an important part in the lives of the McGowan family; indeed its proximity was a factor in our choice of Bayview as a place to live all those years ago.[5]

3 Submission 660, Mr Ray Hawkins, pp1-2.

4 Submission 574, Mrs Winsome Forbes, p1.

> At 4 am in the morning, watching a little girl heave trying to get air is a shocking experience. We got to Mona Vale Hospital in 10 minutes and they gave her oxygen and Redipred, a drug to assist the opening of the air ways…Substance is far superior to form. Mona Vale may not look great, but it saved our little girl.[6]

1.6 A significant number of submissions also came from former and current medical staff of both Mona Vale and Manly Hospitals. There were also a number of community volunteers who had worked at the hospital assisting patients or with fundraising. An indication of the background of submission writers is presented in the table below, although this is likely to understate actual numbers as many submissions did not include any personal information:

Table 1.1: Background of submission writers (where identified)

	Former Patient	Current or former medical professional- Mona Vale Hospital	Current or former medical professional- Manly Hospital	Community Volunteer
Numbers of submissions	683	42	4	24

(Figures only refer to those public submissions where persons identified their connection with Mona Vale or other hospitals)

1.7 As with many inquiries some submission writers requested their submissions remain confidential. A number of individuals requested that either their submission or their name remain confidential. Many of these confidential submissions came from medical professionals currently working in the Northern Sydney Central Coast Health service. These are not included in the numbers above. All requests for confidentiality were agreed to by the Committee.

1.8 A list of all submissions is contained in Appendix 1.

Public hearings

1.9 The Committee held three public hearings involving 29 witnesses, including the Member for Pittwater, Mr John Brogden MP, and the Member for Manly, Mr David Barr MP. Hearings were held at Parliament House on 28 February, 8 March and 21 March 2005. A list of witnesses is provided in Appendix 2 and transcripts of public hearings can be found on the Committee's website www.parliament.nsw.gov.au/gpsc2.

5 Submission 597, Mr Michael McGowan, p1.

6 Submission 210 Mr and Mrs D & K Shields, p1.

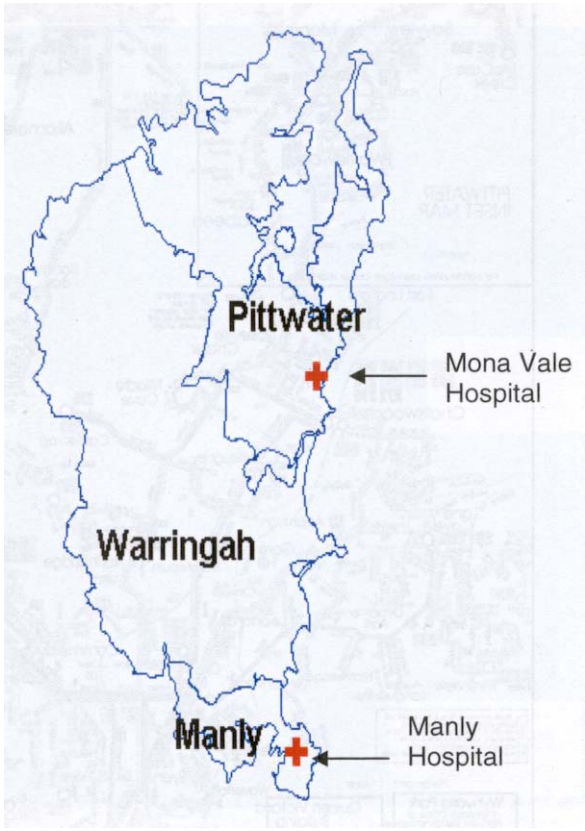
1.10 On 21 March 2005 the Committee also undertook a tour of the proposed sites for the new northern beaches hospital, arranged with the assistance of NSW Health for the benefit of those members unfamiliar with the geography of the northern beaches.

1.11 The Committee would like to thank all of the people who participated in the inquiry whether by making a submission, giving evidence or attending the public hearings.

The Northern Beaches area

1.12 The Northern Beaches consists of the three local government areas (LGAs) of Manly, Warringah and Pittwater and covers an area of 254.7km^2. The map below shows the LGAs within the Northern Beaches area.

Map 1: LGAs within the Northern Beaches area



Source: Submission 2230, Northern Sydney Central Coast Health, p11.

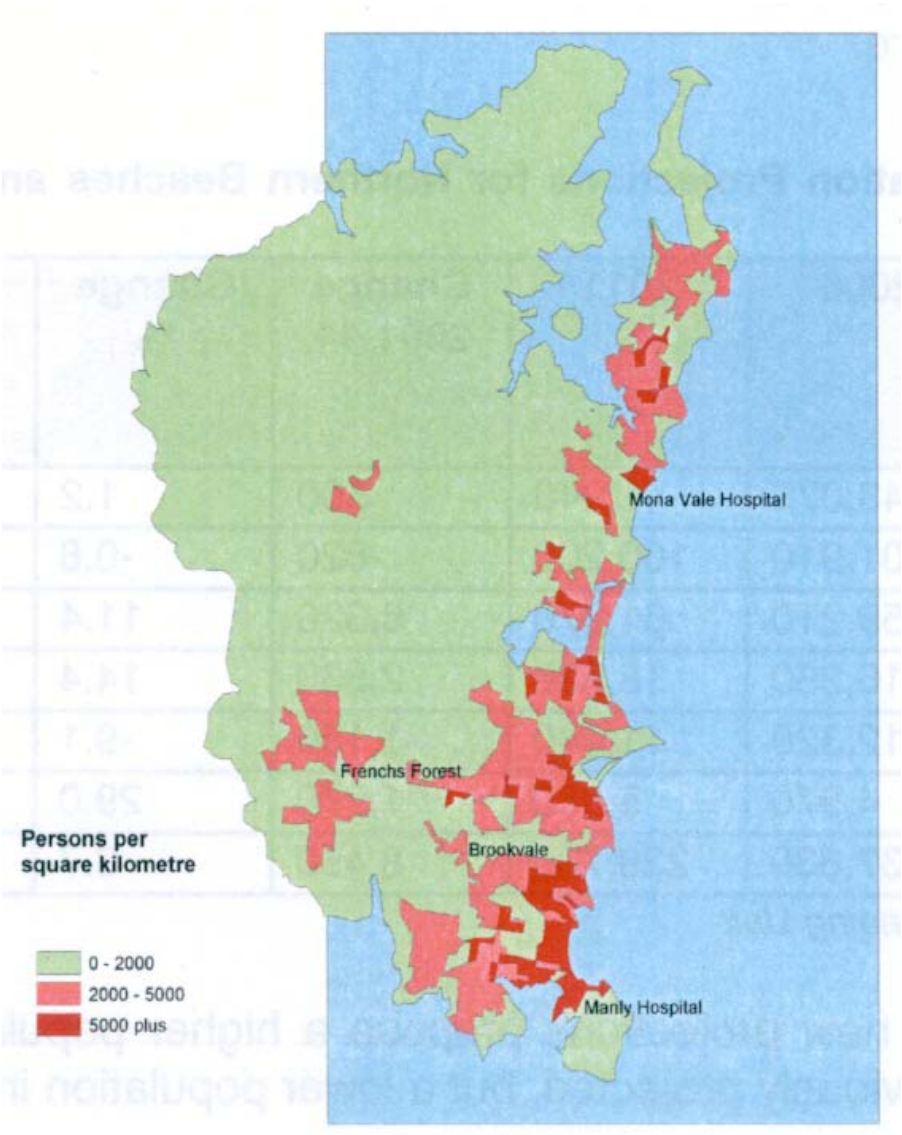
1.13 The Northern Beaches had a resident population (in 2001) of 231,280 people, distributed among the three LGAs as follows:

- Manly: 38,690

- Warringah 136,180
- Pittwater: 56,410.

1.14 The Northern Beaches has substantial areas of no or low population density, including the Ku-ring-gai and Garigal national parks. Higher population density is limited to small areas predominantly along the coast. The map below depicts the estimated population density for the Northern Beaches in the year 2011.

Map 2: Estimated population density, Northern Beaches, 2011



Source: Submission 2230, NSCCH, p14.

Procedural issue

1.15 During the inquiry a procedural issue arose as a result of a complaint by a witness to the inquiry. Ms Lynn Hopper, the Chairperson of BEACHES[7] wrote to the Committee Chair on 3 March 2005 alleging that immediately after the hearing on 28 February she was approached in an intimidatory manner by a member of the Committee, the Revd the Hon Gordon Moyes. A letter was also sent by Ms Alison McLaughlin, a staff member of the Member for Manly, Mr David Barr MP, who alleged that she had witnessed the incident.

1.16 Parliamentary committees in the Legislative Council follow Senate precedent in investigating complaints by witnesses regarding intimidation. Legislative Council committees tend to follow a process in which they consider the evidence received and determine whether the complaint is sufficiently serious that, if it were proven, it would constitute an attempt to interfere with the inquiry process. If the Committee determines there has been a potential contempt of the Committee, a special report is prepared and tabled in the House, for the House to consider a referral to the Privileges Committee.

1.17 Recognising the difficulty of a Committee investigating a complaint against one of its own members, the Committee when considering the matter on 8 March sought advice from the Clerk of the Parliaments. Following receipt of this advice Revd. Moyes tabled a written statement of his view of the incident at the Committee's meeting on 21 March. He also advised the Committee that he had decided that he would take no part in the Committee's deliberations on this matter.[8] The Committee resolved to defer consideration of this matter and to seek further advice from the Clerk of the Parliaments.

1.18 Following receipt of this further advice from the Clerk, dated 21 April 2005, the Committee subsequently considered the matter at its meeting on 19 May 2005. In accordance with his previous decision Revd. Moyes left the room during the Committee's deliberations on this matter. The Committee noted that while it was agreed that the incident had occurred the two parties involved had a different response to the same facts. The Committee resolved to take no further investigation or action other than to note that appearing before a Committee inquiry itself can be an intimidating and daunting experience for witnesses, and there was a need for all Committee Members to exercise caution and sensitivity in any dealings with witnesses. The Committee resolved to forward the advisings from the Clerk of the Parliaments to the Privileges Committee for information.

This report

1.19 The Committee adopted this report at a meeting on 19 May 2005. The minutes of this and other meetings held regarding the inquiry are presented in Appendix 6**.**

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7 "Better and Equitable Access to Community and Hospital Services", a community group set up with an aim of representing the interests of residents on the Southern end of the northern peninsula.

8 At the same meeting Revd. Moyes indicated that as Ms Hopper's letter had subsequently been published by the *Manly Daily* he would respond to the newspaper article by a personal explanation in the House. This explanation was made on Tuesday 22 March 2005 (Legislative Council, New South Wales, *Hansard* 22 March 2005).

Structure of the report

1.20 Chapter Two considers the funding given to Mona Vale compared to other hospitals. It looks at evidence of funding difficulties experienced at Mona Vale by patients and staff, arguments that Mona Vale is being deliberately under funded and the evidence from NSW Health to counter these concerns.

1.21 Chapter Three examines the reasons for the general trend in health planning to rationalise intensive care services and how they relate to the proposal to downgrade ICU services at Mona Vale Hospital.

1.22 Chapter Four examines the current Greater Metropolitan Clinical Taskforce (GMCT) interim proposal to upgrade Manly Hospital to a level 5 ICU and downgrade Mona Vale Hospital to a level 3 High Dependency Unit. It examines the community and clinician concern regarding the effect this proposal, if implemented, would have on the future of Mona Vale Hospital and the level of medical services it would be able to provide.

1.23 Chapter Five examines the long-running consultation process regarding the delivery of health services on the Northern Beaches up to the 18 March 2005 announcement of the current site selection process to determine the preferred location for the new Northern Beaches Hospital. It also examines the consultation that took place regarding the December 2004 GMCT interim proposal to rationalise intensive care services at Manly and Mona Vale Hospitals.

1.24 Chapter Six examines the current Value Management Study process that aims to determine the preferred site for the new Northern Beaches Hospital. The chapter also examines the arguments for and against both Mona Vale and the Civic Centre at Dee Why as viable options for the new hospital.

Chapter 2 Level of funding for Mona Vale Hospital

This chapter examines the level of funding provided to Mona Vale Hospital compared to other hospitals in the area. The Committee acknowledges that hospital funding is complex and that allocations are determined taking into account State-wide considerations through mechanisms such as the Resource Distribution Formula.

The interest of the Committee during this inquiry has been to examine whether the debate over the future of Mona Vale Hospital has had any influence on the funding provided to it in recent years. Based on the evidence received on this issue, the Committee has found that Mona Vale Hospital is experiencing funding shortages which have the potential to impact on the quality of health care delivered. However, the funding problem is not unique to Mona Vale, with other hospitals in the Northern Sydney Central Coast Health (NSCCH) service experiencing similar difficulties. It is clear that a resolution of the current impasse on a general hospital for the northern beaches will release much needed additional funding to the area as whole. It remains unclear whether this will lead to any improvement in funding specifically to Mona Vale Hospital.

Arguments that Mona Vale Hospital is under-funded

Under funding as a strategy

2.1 Many submission writers allege that NSCCH[9] has in recent years deliberately run down funding of Mona Vale Hospital. The argument made is that, as the new Northern Beaches Hospital is intended to be located elsewhere, funds which are urgently needed for upgrades are being withheld. The proponents of this view argue that the resulting deterioration of the condition and services within the Hospital then strengthen the case against locating the new general hospital at Mona Vale and then closing Mona Vale and selling the land.

2.2 This argument was put to the Committee by Pittwater Council:

> This data [1994/95 to 2003/04 funding provided by Northern Sydney Health] shows that a smaller percentage of funding has been spent at Mona Vale Hospital compared to other hospitals within Northern Sydney Area Health. This is despite the fact that Mona Vale Hospital had more hospital admissions and emergency attendances in 2002/03 than Ryde. Similarly Hornsby Hospital received double the amount of funding to what Mona Vale Hospital received, but did not have double the admissions and emergency attendances, in fact Hornsby only had around 5,000 more admissions and less emergency attendances than Mona Vale.[10]

2.3 The Council produced a table which explained their argument:

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9 NSCCH was created in January 2005 by the amalgamation of the former Northern Sydney Health Service with the Central Coast Area Health Authority. Mona Vale Hospital was previously part of the Northern Sydney Health Service.

10 Submission 1102, Pittwater Council, p13.

Table 2.1: Comparison between funding allocation and hospital admissions

	2002/03 Admissions	2002/03 Emergency attendances	2002/03 % of actual expenditure
Mona Vale	11,680	21,743	6.7 %
Ryde	10,835	21,003	7.6 %
Manly	12,937	17,247	9.4 %
Hornsby	16,964	21,204	13 %

Source: Submission 1102, Pittwater Council, p14
The Committee notes that this is raw data presented by Pittwater Council and recognises that these figures do not reflect levels of patient acuity.

2.4 The Council further argued that this was reflected in the experience of hospital staff:

> Staff at Mona Vale has reported that Mona Vale Hospital is so inadequately funded they have difficulty in purchasing materials to simply maintain the hospital and supply necessities to patients such as soap. Information received revealed that maintenance staff have had to purchase materials from a local hardware store in the past, but are now not able to because the accounts are not being paid. This lack of funding to maintain the hospital gives strength to Council's opinion that the hospital is being run down for its eventual closure.[11]

2.5 A variant of this argument was also put by the Save Mona Vale Hospital Committee in its submission:

> Due to inadequate funding at Mona Vale, there are many cases coming from hospital staff of breakdowns and failures not being attended to or repaired, not enough money to buy basics such as stationery, local businesses refusing to supply on credit and staff buying urgently needed supplies out of their own pockets. Possibly Northern Sydney Health is waiting for the complete collapse of the hospital infrastructure which could lead to the closure of this fine hospital.[12]

2.6 The view was also put by former Mayor Patricia Giles:

> It has now been proven that Mona Vale Hospital is the least funded hospital in the NSAHS. Mona Vale Hospital has also had less spent on it in Capital works than the other hospitals in the NSAHS…I say to Dr Christley, Mona Vale Hospital and the community rely on its services and we feel we have been shabbily treated and it is your responsibility, Dr Christley, to treat all areas of the NSAHS fairly and we believe this is not happening, when Mona Vale Hospital is being downgraded because of inadequate funding.[13]

2.7 The Save Mona Vale Hospital Committee further argued that the very active Hospital Auxiliary had successfully fundraised over $2 million for the purchase of equipment for the

11 Submission 1102, p14.

12 Submission 723, Save Mona Vale Hospital Committee, p28.

13 Submission 41, Clr Patricia Giles, pp14-15.

hospital, and that the level of dependence on this was causing embarrassment to the administration of the hospital.

2.8 In evidence to the Committee, senior health administrators have denied there is any strategy to under fund Mona Vale, and that, to the contrary, NSW Health is seeking to inject funds into the area as a whole. The sections below examine the evidence that Mona Vale is currently under funded, and the counter arguments and evidence from NSW Health.

Evidence of under funding

2.9 There is persuasive evidence that Mona Vale Hospital is experiencing recurring funding problems. In the first hearing the CEO of NSCCH, Dr Stephen Christley confirmed rumours that the hospital had difficulties paying for bottled water:

> Mr BAZIK: The area health service and local management had prior discussions about the feasibility of continuing with that type of water supply, and on review of that with our engineering staff, we have now put in place filtered water units in patient areas in lieu of the bottled water situation. We think that is the—
>
> The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did they remove that because you had not paid the bill?
>
> Mr BAZIK: As I have said, we certainly reviewed the way that we were dealing with our water supply and we believe that filtered water is a more economical way of dealing with that. Accordingly, Never Fail withdrew its bottled water. There have been issues in relation to orderly payments of bills and, in discussions with Never Fail, I understand from the area finance department that they decided to not continue with us in that regard.
>
> The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say that there have been discussions about the orderly payments of bills, is that a way of saying that you had not paid them?
>
> Mr BAZIK: I think in terms of what their expectations were with financial arrangements and payments of bills, they—
>
> Dr CHRISTLEY: There was a period over the Christmas where the area had a cash issue.
>
> The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Oh.
>
> Dr CHRISTLEY: No, no; just let me go on. There had been complex services, particularly those provided by North Shore which had grown significantly in recent times. We have had discussions with the department and received some additional cash, and that situation is now resolved.[14]

2.10 Nurses working at Mona Vale in a later hearing gave evidence of how the tightness of funding was impacting on staff and services provided:

[14] Evidence, 28 February 2005 pp22-23.

> Before the end of the last financial year we were just broke. I could not order paper. I was not allowed to order a ream of A4 paper so I could photocopy my stress test reports. I work one day a week in cardiac stress testing; my background is an officer of the Australian air force, retired, and coronary care sister. I went into stress testing because I wanted to see an avenue for cardiac rehab, which I do on a lower scale at the hospital. My reports are essential to get out to the referring doctors and for referring on to cardiologists. I was not allowed to order paper.[15]

2.11 The nurse unit manager for maternity services at Mona Vale gave evidence that a directive had recently required any requisition over $7 to be signed out by Mr Frank Bazik, the General Manager of Mona Vale and Manly Hospitals.[16] Manly Hospital was covered by the same directive. Although this was overturned when common sense prevailed, it appears to be symptomatic of hospitals where funding is so tight that it affects the way staff carry out their essential tasks:

> We were told that we had to go back and look at our goods and services, and look at our maximum and minimum levels to see if we could come up with some cost savings. We have gone from being just under $1 million over budget across Manly and Mona Vale, and over the last couple of weeks we have suddenly blown out to $3 million. So we need to go back and look at goods and services, and look at our staffing. Let us say Dennie is off sick today and I need to replace her. Do I need to replace her with someone for a full shift, or can I get away with a six-hour shift instead of an eight-hour shift, or maybe even a four-hour shift? Without compromising safety, you are staffing at the best options. I sat on the management committee a few years ago. When they looked at budgets, they looked at big picture stuff; they are not looking at particular bills and those kinds of things. They would go through the finance department through purchasing. Everything is done off campus; it is all centralised.[17]

2.12 In submissions to the inquiry it was the physical condition of Mona Vale Hospital that was cited as the most obvious sign of under funding. Examples of some comments made include:

> Air conditioning is urgently needed for the paediatric unit. My young son and I spent one night there in 34 degree heat. Windows cannot be opened because there is a risk of children falling from the windows, so no breeze or ventilation comes in. There is no air conditioning except in an isolation room. One child on oxygen with pneumonia, and little sick babies were suffering considerably with the heat. This is supposed to be a comfortable place for children to recover, not suffer further.[18]

> Our elderly mother recently required treatment at the accident and emergency centre at Mona Vale Hospital. The condition of the ward was virtually derelict with paint peeling off walls, dirty windows and antiquated equipment. Many procedures routine at other Sydney Hospitals… were not being followed due to lack of staff and equipment. For example, the portable x ray machine used was antiquated. Equally

15 Ms Debbie Carter, Secretary, Mona Vale Branch, Nurses Association, Evidence [in camera, subsequently published], 8 March 2005, p5.

16 Ms Karen Draddy, Nurse Unit Manager, Mona Vale Hospital, Evidence [in camera, subsequently published], 8 March 2005, p9.

17 Ms Draddy, Evidence [in camera, subsequently published], 8 March 2005, p9.

18 Submission 1041, Mr & Ms Treharne, p4.

> the beds are without accessories and non-adjustable, unlike the Striker beds available at St Vincents Hospital. This is in breach of OHS guidelines for staff and poses a danger to staff handling patients in beds and trolleys, and is detrimental to patient well-being and comfort.[19]

2.13 Nurses working at Mona Vale Hospital concurred with this view:

> Yes, not only in maternity but throughout the hospital. They are patch painting in different places, you can see in the roofs and those kinds of things. It is not just us, it is throughout the hospital. Some of the units look a little bit better than others, although we did have a nursery painted, I think three years ago, because the girls—if I stood still long enough they were going to raffle me off to fund raise at McDonald's or something—they fund raised and they had bought all their own big posters and the transfers and all the things to make the nursery look really good.[20]

2.14 Despite this when asked by the Committee whether Mona Vale received sufficient funds to operate and maintain services at both Mona Vale and Manly hospitals, the general manager of the hospitals replied: "I believe we have a fair share of the budget, yes I do".[21] This answer raises the question as to whether the Area as a whole receives a fair share of the State health budget.

Evidence of funding problems in other Northern Sydney hospitals

2.15 The rundown condition of basic facilities is not unique to Mona Vale: although the Committee received fewer submissions regarding Manly Hospital and other hospitals in the Northern Sydney region, there were a number of comments regarding the state of facilities, such as this example:

> The first time we needed to go to hospital we went to Royal North Shore Public Hospital because we thought it would be better for her as she was receiving treatment from the Private Hospital. We were made to wait in the waiting room with a terminally ill woman from approximately 3 am to 5 am. When a bed was available it was in the room that was used when psychiatric patients were brought in. There were blood spatters all over the walls with bits of the wall punched in. My husband and I swore we would never take my mother-in-law back there again. It did nothing to engender confidence in the public hospital system.[22]

2.16 BEACHES (Better & Equitable Access to Community Health and Hospital Services) was formed in 2001 by residents and workers in the southern end of the peninsula to support proposals for a single general hospital in the demographic centre of the Northern Beaches. The BEACHES submission presents arguments that Northern Sydney Health was the most under funded health service in the Sydney Metropolitan Area for the 12 years from 1989 to 2001. The 16% of Sydney residents who live in the Northern sector received 2.6% of capital

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19 Submission 392, Mr & Mrs & Ms Turner, p1.

20 Ms Draddy, Evidence [in camera, subsequently published], 8 March 2005, p5.

21 Mr Frank Bazik, General Manager, Northern Beaches Health Service, 28 February 2005, p22.

22 Submission 90, Mrs Jeanette Danser, p2.

funding.[23] This compares unfavourably with other areas, as they sought to demonstrate in the table below:

Table 2.2: Comparative Capital Funding Table NSW Budget 1989 - 2001

Area Health	$Million	% SYD $	% NSW $	% Pop'n Sydney
Central Sydney	368	12.0	7.6	9.9
South East Sydney	624	20.4	12.9	15.6
Wentworth	511	16.7	10.5	6.3
S W Sydney	474	15.5	9.8	15.3
Western Sydney	567	18.5	11.7	13.5
Hunter	190	6.2	3.9	10.9
Illawara	148	4.8	3.0	7.0
Central Coast	96	3.1	2.0	5.7
Northern Sydney	79	2.6	1.6	15.8
TOTAL	**3058**	**100.0**	**63.0**	**100.0**

Source: Submission 725, BEACHES, p4, derived from NSW Budget Papers

2.17 As with many parties in this inquiry, BEACHES supports the need for increased expenditure on the Northern Beaches. However, in its submission the group argues that the current inadequate funding is the result of diseconomies of scale in having both Manly and Mona Vale duplicating services to relatively small population catchments:

> BEACHES accepts that neither Mona Vale Hospital nor Manly Hospital as they are currently operating can be funded for all services when there is inconsistent local demand for them. It makes no sense to have under utilised and under staffed facilities operating at both hospitals when centralising would bring the benefit of greater public safety and optimum allocation of scarce resources. It is not a matter of Mona Vale versus the others; it is a matter of how you can have a hospital and community health system that satisfies the demands of patients across all of the Northern Beaches.[24]

Funding of Central Coast services

2.18 A side issue in many submissions to the inquiry is that Mona Vale is being under funded in comparison to hospitals in the Central Coast area, which is now part of the same area health budget. Significant capital expenditure is being committed by the State Government to redeveloping the Gosford and Wyong hospitals at their existing sites. An example of this argument was given in evidence by Pittwater Council:

23 Submission 725, BEACHES, p5.

24 Submission 725, p9.

> …We thought that the most compelling issue in regard to Central Coast Health was why is it acceptable for the Government to redevelop on existing hospital sites in the Central Coast area and to pour a large amount of government funding into redeveloping Gosford hospital, which is in a very similar situation to the northern beaches. When we look at these two maps we see that we are talking about not totally dissimilar geographic regions—long peninsulas, a major hospital in terms of the Central Coast being located in the south and with the bulk of the population in the north. To some extent the reverse is true on the northern beaches. Yet for some reason Northern Sydney Health and Central Coast Health are unwilling to consider Mona Vale as an option for a level five metropolitan hospital. Yet the same Northern Sydney Central Coast Health is pouring lots of taxpayers' dollars into upgrading Gosford hospital.[25]

2.19 NSW Health did not accept the comparison of the funding of the two areas as valid. The Central Coast has only been a part of the same area health service as Mona Vale since the beginning of 2005, so the decisions regarding capital allocation were made on the basis of state-wide planning rather than allocation within the one area. NSW Health indicated in the hearing on 21 March that future capital upgrades for the new general hospital for the northern beaches would not be coming from existing capital budgets for the area.[26]

2.20 The Committee believes there is ample evidence that Mona Vale is under funded both in terms of recurrent funds and capital expenditure on hospital infrastructure. There is also evidence that Manly is similarly in need of additional funding. It is not clear whether this is true of all hospitals in the Northern Sydney region. The argument that Mona Vale is under-funded in comparison to Ryde, Hornsby and other hospitals put forward by the Save Mona Vale Hospital Committee and Pittwater Council is able to be addressed by reference to NSW Health data.

Non spending of funds raised by volunteers

2.21 An allegation made during the inquiry is that the hospital administration has failed to spend money raised by volunteers for essential hospital equipment and services.[27]

2.22 It is apparent from submissions that Mona Vale Hospital has a large and dedicated group of volunteers that have served the hospital and its patient community both in time and in contributing money:

> I have served as a volunteer member of the Hospital Auxiliary for more than thirty years. I regard the Hospital as our most important service to the community and that it is worthy of support.[28]

> Over one hundred volunteers gathered at the Hospital Xmas party, coming from Hydrotherapy, Canteen and other supportive groups. Our work has been happy and

25 Mr Lindsay Godfrey, Manager Community & Library Services, Pittwater Council, Evidence 8 March 2005, p58.

26 Ms Robyn Kruk, Director General, NSW Health, Evidence 21 March 2005, p9.

27 Submission 723, Save Mona Vale Hospital Committee, p28.

28 Submission 635, Ms J Plumley, p2.

> rewarding. Unfortunately, over these years we have seen cut-backs in services and staff leading to low morale. Should all this free and willing service be thrown aside in the name of the state-of the art edifice now deemed so desirable?[29]

2.23 Volunteers assist in wards, the running of the kiosk and general fund-raising. In her submission to the inquiry the Federal Member for Mackellar, the Hon Bronwyn Bishop, MP provided details of a fundraising dinner in 2004 at which $87,516 was raised to buy hospital equipment for the hospital.[30]

2.24 In its submission to the inquiry the Save Mona Vale Hospital Committee advised that the Hospital Auxiliary has raised over $2 million for the purchase of specific equipment. It also notes the Auxiliary raised $241, 254.27, to be matched dollar for dollar by the government, to build a Palliative Care Hospice within the Mona Vale grounds. It notes that this promise has not been honoured and the money remains unspent.[31]

2.25 During the hearing on 21 March 2005 Dr Christley addressed concerns raised in some submissions that the hospital management was withholding expenditure on funds raised by volunteers:

> There may be a small balance in an account, but basically all the money raised has been spent. There was one recent occurrence when someone wanted to spend money on maintenance and the management's response was "No, we pay for maintenance. You pay for new equipment." There was some dialogue around that; I am not sure if that is the reason for your question. All the money raised is spent on equipment.[32]

2.26 Later in the hearing he confirmed that the exception to this was in relation to the Hospice:

> To answer the Chair's question, there is money in an account for a hospice—that is over $200,000. That has been the subject of discussion for a long period of time. There is no recurrent funding to staff a hospice. This is actually one of the opportunities I saw when I was talking before about the opportunities for a Commonwealth-State operation. I think we could actually get something exciting happening in that regard around hospice care, but we have, for a period of time, been trying to reconfigure services in other parts of the area to free up some recurrent funding to enable that to happen. We need the hospital debate to conclude so we know where we would build and how we would have the hospice. That has been a quite open discussion with those people who have raised the money. They know where we sit, so that money has actually sat in an account for some time. Because of the purpose it was raised for we have not been able to spend it yet, but we would intend to do so. There is also some money that is held by Hope Healthcare for a similar purpose, and we are hoping to aggregate the two sets of money and deliver that at the earliest point of time.[33]

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29 Submission 288, Mrs P Reeve, p1.

30 Submission 621, p2.

31 Submission 723, Save Mona Vale Hospital Committee, p26.

32 Dr Stephen Christley, CEO, NSCCH, Evidence 21 March 2005, p7.

33 Dr Christley, Evidence 21 March 2005, p27.

Conclusion

2.27 The Committee has received evidence of facilities at Mona Vale Hospital needing essential maintenance, and that both patients and staff perceive the hospital as lacking necessary funding. The section below examines the problems identified in the wider context of health funding.

Funding levels: the Northern Sydney Central Coast Health evidence

NSW Health funding framework[34]

2.28 Funding for NSW Health comes from a variety of State, federal and private sources. Health services are funded currently on a three-year basis, moving to four-year rolling budgets once the current amalgamations of 17 area health services to 8 is complete.

2.29 The main tool for ensuring a fair distribution of funds to area health services is the Resource Distribution Formula (RDF). This takes into account local population needs including age, sex, mortality and socio-economic factors. The Committee has not examined the RDF in this inquiry, but in the last Parliament this Committee while chaired by Dr Brian Pezzutti examined the RDF and in its two reports did not raise substantive criticisms of the formula as a mechanism to work towards equitable funding.[35]

2.30 Within the area health service, episode funding is used as a guide for the allocation of resources to their services, with specific policies for:

- acute patients (excluding Emergency and intensive care)
- intensive Care Unit (ICU) for designated level 5 or 6
- emergency departments
- rehabilitation, palliative care and non-acute services.

2.31 All of these models are said to be based on the average cost for the outputs for hospitals of a similar type, based upon data from around 80 hospitals in NSW. Activity weightings are also given based on predicted activity level of the periods of funding and for patient complexity.

Budgets for Northern Sydney Health: recurrent funding

2.32 The table below shows the budgets for hospitals within Northern Sydney Health comparing 2001 to 2005.

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34 Section below derived from Submission 2230, Northern Sydney Central Coast Health pp37-40.

35 General Purpose Standing Committee No. 2, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW: Discussion Paper* Report 13, March 2002, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW: Discussion Paper* Report 14, September 2002.

Table 2.3: Net cost of Service (NCOS) budgets for NSH facilities for 2001 and 2005

Hospital	NCOS Budget ('000) 2005	Share of Budget 2005 (%)	NCOS Budget ('000) 2001	Share of Budget 2001 (%)
Royal North Shore	262,920	38.3	195,431	37.7
Hornsby Ku-ring-gai	66,915	9.8	48,393	9.3
Manly	46,026	6.7	33,777	6.5
Ryde	38,165	5.6	31,637	6.1
Mona Vale	**34,414**	**5.0**	**26,054**	**5.0**
Macquarie	27,511	4.0	19,873	3.8
Area Mental Health	40,907	6.0	28,839	5.6
Affiliated organisations	32,730	4.8	25,604	4.9
Community and Extended Care	18,277	2.7	16,485	3.2
Population Health	7,400	1.1	936	0.2
Other	110,869	16.2	91,100	17.6
NSH Total	**686,135**	**100**	**518,125**	**100**

Source: Submission 2230, NSCCH p41.
The Committee notes that this is raw data presented by NSCCH and recognises that these figures do not reflect levels of patient acuity and the resultant funding weighting.

2.33 This table indicates that the Net Cost of Service budgets for Mona Vale increased from approximately $26.1 million in 2000/01 to $34.4 million in 2004/05, an increase of 32% over five years. The budget for Manly has increased from $33.8 to $46 million over the same period, a 36% increase. Overall, the budget for the northern beaches has increased 34% since 2000/01.

Mona Vale share of NSCCH budget

2.34 The submission from NSCCH indicates that the Northern Beaches represents 29.5% of the Northern Sydney Health population but receives 11.7% of the budget. Mona Vale receives 5% of the budget and Manly 6.7%. This would appear to support arguments that Mona Vale does not receive a fair share of funding. NSCCH argued that the discrepancy was due to the following factors:

- Complex services requiring high cost technology are generally provided from Royal North Shore Hospital to residents throughout the Area.
- High numbers of out-of area patients are treated at Ryde and Hornsby, and patient inflows come from across the state to Royal North Shore, and so this is reflected in the funding allocation. In contrast northern beaches hospitals are said to treat few patients from other parts of the Northern Sydney Health service or other areas.
- Many services such as mental health and community-based services are funded and managed area wide.
- Private hospital utilisation varies between sectors and this will also affect funding allocations.[36]

2.35 The Committee is not in a position to determine whether Mona Vale's share of net cost of services funding is fair compared to other hospitals within the area. The value of the inquiry process in this instance is in ensuring more financial data has been put on the public record by NSW Health and its distribution defended.

Budgets for NSCCH: capital funding

2.36 Some of the strongest criticisms in submissions was of the physical state of Mona Vale Hospital. Capital funds are used for the purchase of hospital equipment, buildings and other infrastructure. Recurrent capital is received by each area, for use at the discretion of the relevant manager. In the submission to the inquiry, NSCCH advised that over the past five years $10.2 million has been spent on maintaining and improving infrastructure. Listed projects include:

- purchase of the first CT scanner on the northern beaches
- establishment of two new x-ray rooms
- installation of a new paediatric assessment area in the Emergency Department
- upgrade of air conditioning of the operating suite
- relocation of drug and alcohol unit
- establishment of 24 hour security service
- fire and safety upgrades.[37]

2.37 While NSCCH provided to the Committee tables comparing capital budgets for other hospitals in the region, it did not provide an analysis of these tables. Rather than investigate this further the Committee sought more detailed information on the amounts spent on upgrades. This was provided, as a response to questions on notice, on 13 April 2005:

36 Submission 2230, Northern Sydney Central Coast Health, p41.

37 Submission 2230, pp42-43.

Table 2.4: Sample Mona Vale upgrade projects since 1998

2005	**Cost**
Funds allocated for Emergency department extensions	$400,000
Funds for building under Pathways Home Grant	$1,700,00
2004	**Cost**
Security monitoring system for Emergency Department	$50,000
New beds for Intensive Care Unit	$23,000
New orthopaedic beds	$23,000
Birthing bed for maternity	$24,000
Defibrillators for emergency department	$42,000
Cardiac monitoring units for emergency department	$170,000
Stress testing machine for cardiology	$30,000
Fire and safety upgrade	$103,000
2003	
Mobile X-ray machine	$65,000
X-ray Screening room for general x-rays	$100,000
Operating theatre equipment (gastroscopes etc)	$50,000
Early warning intercommunication system	$130,000
Establish new drug and alcohol unit	$80,000
Building works for 3 extra beds in emergency department	$100,000
2002	
Refurbish tutorial room	$40,000
New closed instrument cleaning system for day surgery	$60,000
New exhaust kitchen hoods	$40,000
Installation of paediatric assessment room in ED	$40,000
2001	
Upgrade helipad	$50,000
Fire compartmentation in nurses home	$80,000
Bed replacement/patient trolleys	$40,000
Maternity clinic	$25,000
Operating theatre equipment	$90,000

Replace thermal alarms and detectors	$50,000
Establish hospital in the home refurbishment	$20,000
Upgrade of emergency button system	$18,000
2000	
Procure CT scanner for Medical Imaging	$1,300,000
Upgrade CT room to meet standards	$88,000
Air conditioning of operating theatres	$500,000
Replacement of main electrical switchboard	$130,000
New X-ray room	$80,000
1999	
Shade cloth cover for playground	$10,000
Roof replacement community health building	$40,000
Emergency and exit lighting	$30,000
Medical gas outlets	$86,000
Free-set communication system	$40,000
Pharmacy refurbishment	$30,000
1998	
External signs	$20,000
Fire and safety initiatives	$100,000
Anaesthetic machines	$28,000
Air-conditioning replacement	$74,000
PABX installation	$46,000
Enlargement of nurses office station on level 3	$20,000

2.38 As with net services funding, the Committee welcomes the provision of more detailed information to assist in understanding the current debate, but cannot conclude that there is anything unique in the infrastructure shortfalls faced by Mona Vale over other hospitals in the area. Certainly many of the patients who have used Mona Vale's facilities in recent years praise the service they have received but are critical of the physical state of the buildings.

Conclusion

2.39 The Committee concludes that there is no persuasive evidence that Mona Vale Hospital is under funded in comparison to other hospitals. Both it and other hospitals serving Northern Beaches residents face funding difficulties, experienced by staff in terms of lack of resources and by patients who see wards and facilities in disrepair. However, there is no evidence of any

conspiracy specific to Mona Vale. Unfortunately the drawing out of the debate over a location of a general hospital has actually held back the inflow of new funding into the area. This is explored in the next section.

Additional funding for the Northern Beaches

Funding of interim proposals

2.40 The funding which NSW Health intends to provide to the Northern Beaches is in two stages. Firstly, for the interim period until the new general hospital is built, and secondly for the new general hospital. Several witnesses representing NSW Health were keen to emphasize that future proposals for the Northern Beaches represented a significant injection of new funding, not cutbacks to existing levels. This is true of the interim period as much as the future new hospital. This was put strongly by the Director General of NSW Health, Ms Robyn Kruk, in her evidence on 28 February:

> The configuration of these services will actually cost more money. This is not a rationalisation of services. All of the proposals that have been put forward actually speak of upgrading facilities. They speak of new services. This is not a rationalisation exercise...[38]

2.41 The Chair of the Greater Metropolitan Clinical Taskforce, Professor Kerry Goulston, explained this in evidence:

> It was interim because we concentrated not on where the new hospital should be but on the next five or six years until that hospital is built and patients start entering its doors. We were concerned about the safety of patients in the next five or six years. We were also concerned about the continued adversarial role between Manly and Mona Vale. So our proposal really stressed that a new hospital should not be called the new Manly hospital but be called the new Northern Beaches Hospital and that it should be planned by consumers and also by clinicians from both hospitals.
>
> They had to start networking here and now and they had to work in an integrated way between the two hospitals. Our proposal was not saving money; it was costing money. Roughly, what we suggested was about $1.5 million capital and about $1 million recurrent.[39]

2.42 Professor Goulston also indicated that the proposal included upgrading Mona Vale Emergency Department for $750,000 and employing more staff.[40] The provision of such funding has been delayed until the resolution of the interim division of services between Manly and Mona Vale. The discussion in the following chapters on intensive care shows how clinical issues such as this impact on funding requirements.

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38 Ms Kruk, Evidence 28 February 2005, p23.

39 Professor Kerry Goulston, Chair, Greater Metropolitan Clinical Taskforce, Evidence 8 March 2005, p16.

40 Professor Goulston, Evidence 8 March 2005, p23.

Funding for the new Northern Beaches Hospital

2.43 Ultimately the new Northern Beaches Hospital will represent a significant increase in funding for the area. While no firm figures are likely to be provided at present prior to site selection, an indication of future funding levels was provided during the hearing held on 21 March 2005:

> The Hon. MELINDA PAVEY: Earlier you said that any land purchase is a small fraction of the cost of development of a new level five hospital. Would that be around $200 million for a level five hospital?
>
> Dr CHRISTLEY: Probably a bit more than that.
>
> The Hon. MELINDA PAVEY: Between $200 million and $300 million?
>
> Dr CHRISTLEY: Of that order.
>
> The Hon. MELINDA PAVEY: It is reported that the Dee Why site is worth about $40 million. You are looking at 25 per cent of the cost of a new hospital being the land, is that right?
>
> Dr CHRISTLEY: Yes. If we translate that back to recurrent terms, our budget is over a billion dollars a year, and that is a relatively small expenditure to get the right result. The important thing in health planning terms is to look at the functionality and clinical benefits access of each of the options. We then translate that into a cost and make sure that in comparative terms the cost is factored in against other virtues of any particular health service configuration. That would be part of the value management study that we are now moving towards.[41]

2.44 The Director General of NSW Health in the same hearing made it clear that such funding would not be at the expense of other capital upgrades in the Northern Sydney area:

> Could I clarify that Dr Christley has a number of other capital works in his area. Probably the most significant is the upgrade of the Royal North Shore Hospital. There is no expectation that the capital upgrades are met from within his own area of health service.[42]

2.45 The concern of Mona Vale residents, however, is with the location of this new general hospital and the impact this will have on funding of Mona Vale Hospital if it is not the site. The Committee believes the community of the Northern Beaches is currently in a catch 22 situation. The continuing debate about the location of the general hospital and the future of Mona Vale means that much needed funding is held up from being spent on upgrading facilities. However, if the decision means facilities at Mona Vale Hospital are downgraded, the end result for current users at Mona Vale may be worse in some respects than under current funding levels. This is explored in later chapters of this report.

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41 Evidence 21 March 2005, p9.

42 Ms Kruk, NSW Health, Evidence 21 March 2005, p9.

Conclusion

2.46 The Committee believes that any funding issue is dependent on the interim and long term decisions made by NSW Health for hospitals in the Northern Beaches. The crux of the current problem is that two deeply divided communities have fought each other for years at the expense of the development of new health services in the area. While funding is impacting on both staff and patients at Mona Vale, the heat of the debate is about location and services. This is examined in the rest of the report.

Chapter 3 General trends in intensive care services

The Committee inquired into the reasons behind the Greater Metropolitan Clinical Taskforce (GMCT) interim proposal to change the current level 4 intensive care unit (ICU) at Mona Vale Hospital to a level 3 High Dependency Unit (HDU). During the course of the inquiry the Committee heard evidence that the proposal was made because there was an urgent need to rationalise intensive care services across the Northern Beaches.

The Committee also received substantial evidence that the move to rationalise intensive care services on the Northern Beaches is indicative of a trend that is occurring across the State and elsewhere in the world. This chapter examines the factors that are driving this trend and briefly touches upon how they relate to the current situation on the Northern Beaches. Chapter Four provides a more detailed examination of the impact the GMCT proposal.

Description of intensive care services[43]

3.1 An intensive care unit (ICU) is a specially staffed and equipped, separate and self-contained section of a hospital for the management of patients with life-threatening or potentially life-threatening conditions. An ICU provides facilities for the support of vital functions, and uses the specialist skills of medical, nursing and other staff in the management of these problems.

3.2 An ICU provides a service for patients with life-threatening illness, deteriorating clinical conditions, or for patients who are likely to deteriorate. These units also provide post-operative support following major surgery.

3.3 A high-dependency unit (HDU) is a critical care unit with less intensive resource levels able to provide a level of care for patients at low risk of serious morbidity, but with complex conditions that require intensive care expertise and a level of care that is not available at the general ward level. These units support surgical services and emergency departments, but only to the extent of overnight ventilation if required.

3.4 Intensive care units within a hospital receive the majority of their admissions from the hospital's Emergency Department (ED). Ideally ED staff also provide backup for acutely or critically ill patients in the hospital.

Functions performed

3.5 Functions performed by an ICU include the following:

- monitor patients' vital signs and symptoms closely
- provide intensive nursing care
- perform invasive monitoring – with catheters in arteries and veins close to and in the heart

[43] This section is drawn from submission 2230, Northern Sydney Central Coast Health (NSCCH) pp 25-26.

- perform sophisticated support for vital organs, such as the heart (eg. provision of adrenaline and other drugs), lungs (eg. non-invasive and mechanical ventilation), kidneys (eg. continuous haemodialyis), brain (management of airways and breathing with ventilation) and gut (eg. nasogastric or intravenous feeding)
- access to other specialists for advice and treatment, including surgeons, physicians and anaesthetists
- access to continuing medical education for all doctors and nurses.

Patient profile

3.6 Patients who require intensive care services come from:

- the emergency department
- theatres after emergency or elective surgery
- the wards, when there has been a deterioration in their clinical condition
- other hospitals, because they need more sophisticated treatment, or the intensive care unit of another hospital is full, or another hospital does not operate an ICU.

Current intensive care services on the Northern Beaches

3.7 Northern Sydney Central Coast Health (NSCCH) provided the following description of the ICU units at Manly Hospital and Mona Vale Hospital:

> **Manly Hospital** provides a role delineation level 4 ICU service, with some aspects at a higher level, and has eight intensive/coronary care beds. The unit is staffed to provide care for three ventilated patients and provide renal dialysis for one patient. Non-invasive ventilation is becoming more common. The unit has the capacity for prolonged intensive cardiac monitoring, mechanical ventilation and renal dialysis. Computed tomography, general and cardiac ultrasounds are available on site. Transoesophageal echocardiography is also available
>
> The unit is located on the ground level close to the operating theatre, emergency department and radiology.
>
> **Mona Vale Hospital** operates at role delineation level 4. It is funded to provide five intensive care/coronary care beds, two of which are staffed to care for patients who need ventilation. Non-invasive is becoming more common. Computed tomography, general and cardiac ultrasounds are available on site.
>
> The unit is located on level 3 of the main building, close to the operating theatre and the emergency department.[44]

3.8 NSCCH also provided the following comparative table regarding the resources and activity for the ICU and emergency department at both Manly Hospital and Mona Vale Hospital. During the inquiry a number of witnesses took issue with the ICU data provided by NSCCH and the interpretation that might be placed upon it. This issue is examined in Chapter 4.

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[44] Submission 2230, NSCCH, p26.

Table 3.1: Intensive care and emergency services on the northern beaches

	Manly	**Mona Vale**
Floor area (m^2)	375	304
Intensive care specialists	On site and available during working hours, 7 days a week	Morning ward round, then off site but available.
Resident medical ICU staff	Full complement of 4 RMOs provide 24hr cover with continuity of care	2 RMOs cover weekdays and evenings, variable cover weekends, ED senior covers at night
Advanced trainees	One FTE Registrar	Nil
Nursing staff	Staff familiar with CVVHDF, complex ventilation and invasive cardiac monitoring	Staff less familiar with CVVHDF, complex ventilation and invasive cardiac monitoring
Total funded bed numbers (ventilated)	8 (3)	5 (2)
Invasive therapy offered	CVVHDF, pulm. A Press. Monitoring, pulsion idex, continuous cardiac output monitoring, complex mechanical ventilation + arterial and CVP monitoring	Arterial and CVP monitoring
Medical retrieval team transfer patients into unit	Yes	Rarely
Emergency Department	3 staff specialists provide on-call service and backup for acutely ill patients in the hospital	Currently 1 staff specialist unable to provide adequate backup for critically ill patients in the hospital
ICU activity 2003/04:		
* total admissions (ICU+CCU)	502	452
*ICU admissions	359	270
* ventilated patients	79	63
Source of ICU admissions (2003/2004):		
*from ED (excludes CCU)	164	123
*from ward	66	49
*from another hospital	39	8
*elective surgery patients	51	53
*emergency surgery patients	39	37

Source: Submission 2230, NSCCH, p36.

Changes to the model of intensive care services delivery

3.9 The Committee was advised by numerous representatives from NSW Health and by other medical professionals of the increasing difficulty in maintaining smaller ICUs and as a corollary to that, the trend towards consolidating intensive care services.

3.10 The debate on changing the delivery of intensive care services is linked to that on determining more effective roles for the smaller metropolitan hospitals across the greater metropolitan area of Sydney. The Greater Metropolitan Clinical Taskforce (GMCT) was set up by the Minister for Health to work with the area health services and clinicians to facilitate these more effective roles and to enhance networking of clinical services to make best use of resources.[45]

3.11 The Chairman of the GMCT, Professor Kerry Goulston, told the Committee that the direction in which NSW Health is moving is in accord with reform and restructure that is occurring world-wide. In evidence Professor Goulston cited similar moves in Canada, Ireland and Scotland.[46] Professor Goulston cited reports from these countries that argue that a redesign of the health system was required and this in turn required a change in attitude and expectations on the part of the community, government and health care workers.

3.12 On a basic level the thrust of this redesign is to consolidate acute services at larger sized hospitals. This means that smaller metropolitan hospitals, where they continue to exist, would no longer attempt to provide as full a range of services as they have attempted to in the past.

3.13 At this stage the Committee notes that it did receive some submissions that questioned this underlying premise of NSW Health. Some of these submissions cited studies and trends that argue against acceptance of the premise for increased centralisation.[47] However, for practical purposes the debate on the consolidation of ICUs can be considered separately from the overall debate on metropolitan hospitals, as the problems being faced by ICUs exist in their own right.

3.14 Notwithstanding that smaller ICUs such as Manly and Mona Vale have operated well in the past, NSCCH advised there were three main factors driving the need for consolidation of these smaller units. These factors are:

- workforce shortage
- critical mass of clinicians
- increased standards of patient care.[48]

3.15 NSCCH suggested the following reasons for the medical workforce shortage in the public hospital system:

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45 Submission 2230, NSCCH, p33.

46 Professor Kerry Goulston, Chairman, Greater Metropolitan Clinical Taskforce (GMCT), Evidence, 8 March 2005, p15.

47 Submission 723, Save Mona Vale Hospital Committee, p 30; appendix 12; Submission 718, Macquarie Health Corporation.

48 Submission 2230, NSCCH, p33.

- Insufficient numbers of medical students are being trained throughout Australia.
- The feminisation of the medical workforce. For the first time there are more female than male medical students in Australian universities. Females in the medical workforce over their lifetime contribute significantly fewer hours to medical practice than their male counterparts.
- Lifestyle change. Many young doctors now opt for less demanding work roles than did previous generations.
- Private sector opportunities resulting in significant numbers of doctors now working outside the public hospital system.[49]

3.16 During the inquiry the Committee also heard that other contributing factors were the increase in clinical specialisation; the level of resources required to maintain smaller ICUs; and the difficulty in recruiting to smaller ICUs. The overriding factor however was patient safety. The Chief Executive Officer of NSCCH explained that this was his primary motive for seeking change:

> The whole contention now is that wherever you enter the system, wherever you are, you need to be in a place that can provide you with an equal standard of care and I think that is the fundamental about this debate. It is whether the intensive care units in the current configuration on the northern beaches are safe places for patients and whether they will remain safe places for patients into the future. Given that the intensivists have told us that they do not believe that is the case, I as a health service manager feel fairly motivated to see some change in the way we do business.[50]

3.17 The following sections briefly examine the often interlinked issues that have led to the move to consolidate ICUs.

Difficulty in attracting staff to smaller units

3.18 The Committee heard that the increasing desire on the part of younger doctors to achieve a better life and work balance by choosing to work only two or three days a week was not taken into account by central health planners. The only part of the medical workforce that is said to be increasing is the medical locum workforce.[51]

3.19 The Committee heard that Area Health Services were having problems in recruiting to smaller intensive care units. There were a number of reasons for this, depending on the individual unit, but a general reason was the unsociable and long hours associated with the intensive care specialty which are exacerbated when a unit does not have enough staff to provide a reasonable roster. This situation was described by the Director of Intensive Care Services, Northern Beaches Health Service:

> In the area of intensive care specialists it is a well-known specialty where there are unsociable and long hours. Many doctors are on call. The on-call for intensive care

49 Submission 2230, NSCCH, p33.

50 Dr Stephen Christely, CEO, NSCCH, Evidence, 21 March 2005, p21.

51 Professor Goulston, GMCT, Evidence, 8 March 2005, p15.

> specialists is fairly arduous in that they often have to turn up at 2 o'clock in the morning to help resuscitate somebody. From that point of view it makes it a little bit harder. I refer to the problems we are having in recruiting to smaller intensive care units.
>
> …Finally, when you have a critical mass of patients you might not have some other colleagues to help with the roster and the heavy workload. You cannot really attract junior doctors who want to work and train there. Again, there is a problem at Manly and Mona Vale. We then have to employ locums to help look after patients. Some of them are very good and dedicated but sometimes they are not so good or experienced. So you have very much a changing work force. That means that there is less continuity of care and the whole system does not work so well. On the northern beaches we are very lucky. There is a well-defined geographic area and there are two intensive care units. If we can put them together we will have a critical mass of doctors and patients, we can then attract intensive care specialists or junior doctors that might want to train in intensive care, and we can improve the level of skill throughout the hospital and provide other services to the hospital that we cannot currently provide. At the same time we can have a reasonable roster so we are not on-call every second week. I think all those factors make it far preferable to be able to work in an intensive care unit of a reasonable size.[52]

3.20 The Chairman of the Mona Vale Hospital Medical Staff Council related to the Committee that it was this very problem of a demanding roster on an under-staffed unit that he believed was the catalyst for the current proposal to amalgamate the two units:

> The consultation process probably started six months ago, when the two intensive care specialists who work at Mona Vale hospital were at one of our meetings, and at the end of the meeting put up that they were not happy to continue doing a one-in-two roster and were thinking of resigning if there was no additional help from a rostering point of view.[53]

3.21 Dr Jollow related how he and other members of the Medical Staff Council were upset and confused by this situation and the ensuing discussions over the following months. However, he understood the dissatisfaction of the intensivists with their rostered workload, and noted that it would be uncommon these days to find people who were prepared to be on call 24 hours a day, seven days a week:

> I think the problem revolves around the fact, like you say, that it is obviously incredibly difficult to find intensive care specialists who want to work in a hospital like this. … I can understand the intensive care specialists having concerns about them doing a one-in-two roster. I work a one-in-two roster between Manly and Mona Vale hospital, and it is obviously difficult running a one-in-two roster in the public system as well as looking after your own private patients, who are paying good money to be looked after by you, as well as having a commitment to your family. That is incredibly difficult. I understand their concerns.[54]

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52 Dr Paul Phipps, Director Intensive Care Services, Northern Beaches Health Service, Evidence, 28 February 2005, p10.

53 Dr David Jollow, Chairman, Mona Vale Hospital Medical Staff Council, Evidence, 28 February 2005, p68.

54 Dr Jollow, Mona Vale Medical Staff Council, Evidence, 28 February 2005, p69.

3.22 It would appear that the difficulty in attracting staff to smaller and often under-staffed ICUs is part of a vicious circle: under-staffed units are less likely to attract new staff and therefore find it harder to retain their existing staff. However, it is not only unreasonable rostering that makes it difficult to attract staff. The following section examines other factors that also have this effect.

Specialisation

3.23 The Committee heard that there has been a trend towards specialisation among the medical workforce. This trend has ramifications on a number of levels for the health system. This is particularly so with respect to the level of services that can be provided at small metropolitan hospitals and the resultant need to integrate and network some services between them.

3.24 Professor Kerry Goulston explained to the Committee how this issue is one of the factors in the need to redesign metropolitan hospital services:

> The driving force as far as we are concerned is work force, particularly the medical work force. No longer can a single district hospital be all things to its district community. The reason is because medicine has changed. We are now highly specialised in hospitals and we have to work towards networking and integrating. We have to keep the pressure on to improve transport between hospitals. We have tried to do that by special supplementary funding. So we aim to get the right patient to the right hospital at the right time.[55]

3.25 The measure of effectiveness of intensive care is based on quality criteria, output measures, and the clinical and technical requirements for role delineation.

3.26 This trend towards specialisation is also having an effect on the ability to recruit to smaller intensive care units. The Chairman of the Mona Vale Medical Staff Council acknowledged the need to have fully specialised and formally trained intensivists at the major hospitals, but he saw problems for the smaller hospitals:

> I would have to say in general that for people working in big teaching hospitals, having the most specialised intensive care training there is is very important. If you work at Royal North Shore or Royal Prince Alfred hospitals you need the best of the best. You need the people who are doing the job. In some respects we have been incredibly lucky at Mona Vale and Manly because our director of ICU works at Royal Prince Alfred as well. Therefore, he is bringing expertise to the northern beaches from another big teaching hospital in a different area health service. We are incredibly lucky from that point of view.[56]

3.27 Dr Jollow noted that the majority of intensive care specialists currently employed on the Northern Beaches do not have specialist intensive care qualifications, but have been performing effectively in that role for a long time. Dr Jollow believed that if these intensivists retired or scaled down their work it would be difficult to find replacements as it would be difficult to attract someone with incredibly specialised intensive care skills to a hospital like

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55 Professor Goulston, GMCT, Evidence, 8 March 2005, p15.

56 Dr Jollow, Evidence, 28 February 2005, p72.

Manly or Mona Vale.[57] Dr Jollow went on to state that he believed this problem has already manifested on the Northern Beaches:

> So I am sure there would be quite a few people around who might be a physician with a sub-specialist interest in respiratory medicine, or cardiology—someone who wants to help out in the intensive care unit, and under normal circumstances would be allowed to—but the Medical Staff Council gets the impression that those types of people are shunned away and are not offered work because there is this feeling that if you work in an intensive care department now you need to be an intensive care specialist; you need to have the special qualifications to say that you can look after this type of patient.
>
> That seems to be a change that has happened in the past very few years. People were very happy, patients were very happy, administration was very happy only a couple of years ago to have physicians with medical qualifications, who may not have intensive care specialist qualifications, to look after these patients, and they did so very, very successfully. The rule seems to have changed in the past couple of years, and I am not exactly sure why. The administration of the hospital still seems very happy with the majority of intensive care specialists on the northern beaches not having intensive care qualifications, as we speak. My understanding is that there is only one intensive care specialist on the northern beaches now who has full intensive care qualifications. So they are happy for the people who have been doing it for a while to continue doing it, but not necessarily with finding someone new who is just as experienced as the ones they have got already.[58]

3.28 Of the physicians who provide the intensive care services to the Northern Beaches only two have been formally trained and hold Intensive Care qualifications; they are the Director of Intensive Care Services, Dr Paul Phipps and Dr Stephen Nolan[59] who is contracted as Visiting Medical Officer (VMO) intensivist at Mona Vale Hospital on a ten per cent staff specialist position. Dr Nolan also works as a VMO intensivist at Manly Hospital on a locum basis.

3.29 Dr Nolan advised the Committee that the change in recruitment observed by Dr Jollow is supported by current thought and research:

> Intensive care is a highly specialised sub-speciality. Doctors who are trained or who have extensive experience in looking after these patients should only do the care of the critically ill. A rapidly growing body of evidence is emerging that shows survival is much improved if intensivists look after the critically ill patient. For that reason the majority of intensive care units in Australia are closed units. By that I mean the intensivist is the only person who makes decisions about patient management, independent of whether he or she comes from a medical ward, a surgical ward or an obstetrical ward.[60]

57 Dr Jollow, Mona Vale Medical Staff Council, Evidence, 28 February 2005, p72.

58 Dr Jollow, Evidence, 28 February 2005, p70.

59 Submission 1092, Dr Stephen Nolan, p2.

60 Dr Stephen Nolan, Intensiviist, Evidence, 8 March 2005, p41.

Economies of scale

3.30 The Co-chair of the New South Wales Intensive Care Clinical Implementation Group, Ms Kate Needham, advised that international literature shows the ideal size of an ICU is somewhere between ten to twelve intensive care patients. This size unit allows intensivist skill sets to be maintained. This also requires a robust infrastructure, including a senior registrar trainee, 24-hour registrar cover, qualified and competent registered nurses, and access to sub-speciality consultants and other services available 24 hours a day.[61]

3.31 The Director of Intensive Care Services, Northern Beaches, advised that the same level of resources are required to look after one or two ventilator patients as it does to look after ten or twelve:

> In most intensive care units, depending on the sort of size of the unit, the beds required to run a good unit are about 10 to 12. It is what is called a pod. So you need an intensive care specialist, an experienced junior doctor-registrar who can assess, recognise and initiate treatment of a very sick patient in intensive care, and you need well-trained nursing staff. You need that whether there is one or two beds or 10 or 12 beds.
>
> In relation to the amount of resources required, with similar resources you can look after more patients if you have the ventilator beds all in one place. So it makes sense from a point of view of economics as much as anything else, as well as training, education and research that can come from a bigger unit.[62]

3.32 Dr Phipps advised that the level of resources required currently exists on the Northern Beaches but they are spread across the two sites. If the proposal to consolidate the ICUs at one location went ahead Dr Phipps advised there was the possibility of gaining accreditation to train intensive care specialists of the future.

Critical mass of clinicians and patients

3.33 Throughout the inquiry the issue that was emphasised as the most significant factor in determining the viability of an ICU was that of critical mass of clinicians and patients. Small sized ICUs do not have a critical mass of patients and this is a primary factor in their not being able to attract a critical mass of clinicians. A critical mass of clinicians is essential for patient safety.

3.34 The Chairman of the GMCT conveyed the importance of what a critical mass of clinicians provides in terms of working conditions and job development:

> It means that you have enough specialists working in a particular area or department to allow a reasonable roster. Some doctors in metropolitan hospitals on the outskirts of Sydney are working a one-in-two or a one-in-three roster and they are cracking. They just cannot keep that up. We need time for them to do teaching because they have to do a lot of teaching, which is all honorary, unpaid teaching of young doctors

61 Ms Kate Needham, Co-chair, NSW Intensive Care Clinical Implementation Group, Evidence, 8 March 2005, p25.

62 Dr Phipps, Northern Beaches Health Service, Evidence, 28 February 2005, p10.

> and other people coming through. They have to supervise them, hopefully they do some research and hopefully they enjoy their work.[63]

3.35 Professor Goulston illustrated the importance of achieving a critical mass of clinicians by citing the example of a highly regarded Emergency Department (ED) specialist who left Mona Vale Hospital in 2004 to take up a position at Royal North Shore Hospital which had a critical mass of eight or nine ED specialists.[64]

3.36 The Committee heard evidence from Dr Stephen Nolan, a formally trained and qualified intensivist who works at both Mona Vale and Manly Hospitals. Dr Nolan, who is a resident of the Northern Beaches, also chooses to work at Blacktown Hospital in order to maintain his skills and knowledge:

> Blacktown ICU is one of the biggest and most technologically advanced level five hospitals in Australia and it is rapidly growing. I am willing to drive to Blacktown from home each day to work because it provides me with the number of critically ill patients that I need to maintain my intensive care skills. In addition, I have fellow intensivists who I can call upon to help me with the difficult management of patients and to help me with my ongoing skills maintenance. There are a number of trainees in intensive care at Blacktown and I am able to teach them in my role as supervisor of training in intensive care.[65]

3.37 Dr Phipps, the Director of Intensive Care Services for the Northern Beaches briefly outlined the training requirements for becoming an intensivist and described how a unit with a critical mass of clinicians and patients could apply for training accreditation. This assists in generating home-grown staff and also in attracting other staff who want a training role:

> It really depends on what specialty you have trained through. You can train through the emergency stream, if you like, or as a physician or anaesthetist. Once they have done some training, two core years of intensive care training have to be done in an accredited training unit. Neither Manly nor Mona Vale qualifies for accredited training. If we can pool our resources and get a critical mass of patients we might then be in a situation where, if we have an upgraded service, we can attract higher surgical services. We could certainly attract more work and we would have an increased numbers of patients. If that happened I believe we would then be in a position to apply for accreditation for registrar training and get ourselves an intensive care trainee, which I think would make a huge difference to our ability to attract further staff.[66]

3.38 The Co-chair of the NSW Intensive Care Clinical Implementation Group described how small sized ICUs do not provide the critical mass of patients that would expose nurses to the range of clinical complexities required to maintain their skills and professional development:

> Patients in intensive care require complete life support, and therefore must be nursed by nurses who are confident managing, interpreting and responding to a patient's condition rapidly. Small units, such as at Mona Vale, Mount Druitt, Ryde, Auburn and Fairfield, are unable to provide the volume of patients, that is, critical mass, to expose

63 Professor Goultson, GMCT, Evidence, 8 March 2005, p15.

64 Professor Goulston, Evidence, 8 March 2005, 18.

65 Dr Nolan, Intensivist, Evidence, 8 March 2005, p40.

66 Dr Phipps, Northern Beaches Health Service, Evidence, 28 February 2005, p11.

> nurses to the diversity of intensive care patients and treatments. Intensive care registered nurses must continually be exposed to new modalities of therapy, changing technologies and pharmacology to maintain their knowledge base and skill sets, to ensure they are capable of providing safe patient care. Even registered nurses who have post-graduate qualifications in intensive care nursing are unable to remain current unless they are continually exposed to the complexities of a constant throughput of critically ill patients, ongoing professional development opportunities and education.[67]

3.39 The Committee notes that the comments made by Ms Needham regarding the inability of Mona Vale ICU to provide the required volume of patients presumably equally apply to Manly ICU.

3.40 Ms Needham was asked whether registered nurses were being placed in positions of risk when working in small intensive care units that do not have appropriate infrastructure support. Ms Needham replied that they can be at risk in some cases. This risk would arise when a unit does not have its full complement of intensivist staff.

> It is really hard if you do not have that skilled junior medical work force to back it up. Whilst I might have had it 20 years ago, it is not there in the quantity or the quality as it was back then. As a registered nurse you often find, at 3 o'clock on a Sunday morning, that that does not institute a lot of ventilation in some of the smaller hospitals, and you are then charged with trying to ensure that that junior medical officer is up to speed or is directing the state of the management of a patient.
>
> Because of the skill sets issues and the quality issues, that is not always the case, and you often find that that registered nurse is probably more knowledgeable than some of the junior medical work force. From my perspective, intensive care nurses in big hospitals have always trained the junior medical work force to some degree or other. It is becoming more and more obvious in the smaller units that the nurses are the ones doing it, but they are not necessarily the nurses that are exposed to that degree of intensive care. So, yes, they are at risk in some cases.[68]

3.41 Intensive Care Units do as a matter of course have to deal with the decision to let people die. In New South Wales, 80 per cent of the people who die in intensive care units die when something is being withheld or withdrawn, when the goal is comfort and dignity and not cure.[69] The Committee heard that in these circumstances a critical mass of clinicians allows for consultation:

> This is something that intensivists deal with all the time. Again, this is a very burdensome activity and in a larger unit, where there is a group of people, it is very easy to get the guy in the next office and say, "Come and have a look at this with me. Tell me I'm doing the right thing." Being on your own, it is a very lonely position to be in.[70]

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67 Ms Needham, Evidence, 8 March 2005, p25.

68 Ms Needham, Evidence, 8 March 2005, p30.

69 Professor Malcolm Fisher, Chair, New South Wales Taskforce into Intensive Care, Evidence, 21 March 2005, p22.

70 Professor Fisher, Evidence, 21 March 2005, p22.

3.42 It is the Committee's view that while the issues of critical mass of patients and critical mass of clinicians are interrelated it is the issue of critical mass of clinicians that directly impacts on patient safety.

Redesigned intensive care services

3.43 As noted earlier the GMCT was charged with investigating the restructure of hospital services. The Chair of the GMCT advised that a redesign of intensive care services had occurred at Bulli and Shellharbour and at Mount Druitt and Blacktown.[71] The Committee was also advised that there was a proposal from the intensivists at Gosford Hospital to look after the intensive care patients at Wyong Hospital.[72]

3.44 The reorganisation of intensive care services at Mount Druitt and Blacktown Hospital was frequently cited as being particularly relevant to the situation at and the GMCT proposal for Manly and Mona Vale:

> The concept of a combined intensive care service across two sites is not new, and it is working in other areas. Blacktown-Mount Druitt is a good example. Blacktown has 250 beds and 27,000 emergency department presentations. Mount Druitt has roughly 160 beds and 25,000 emergency department presentations. They also experience similar medical coverage problems and safety issues that we are experiencing at Manly and Mona Vale. Mount Druitt has become a high-dependency unit, with patients being cared for by non-intensivists. Blacktown intensivists are available for clinical review and education, but not direct patient care.
>
> The Mount Druitt Emergency Department senior medical coverage has been increased to ensure expert assessment and management of emergency department patients. Blacktown Intensive Care Unit is responsible for keeping an intensive care bed for retrieval of patients from Mount Druitt. Medical staff is cross-credentialed so that they operate at both hospitals, and the nursing staff rotate. There are guidelines in place about who should be managed in the high-dependency unit and these hospitals have shown that it is possible to offer safe and high-quality intensive care services across two sites.[73]

3.45 While the aim was to create and benefit from a critical mass of clinicians and patients, it is interesting to note that the catalyst for downgrading the Mount Druitt unit to a high dependency unit was the loss of staff from that unit:

> The Blacktown-Mount Druitt situation was not dissimilar to the Manly-Mona Vale intensive care circumstances and had functioned as one intensive care unit over two campuses under the direction of one director of intensive care since May 2002, with intensivists covering both ICUs. In January 2004 the resignation of two intensivists resulted in Mount Druitt being unable to be supported as an intensive care unit. A decision was taken by the clinicians, together with the area health service, that Mount

71 Professor Goulston, Evidence, 8 March 2005, p16.

72 Professor Fisher, Evidence, 21 March 2005, p11.

73 Ms Lynette Hopper, Chair, Better and Equitable Access to Community and Hospital Services (BEACHES), Evidence, 28 February 2005, p79.

> Druitt would provide a high dependency service managing post-operative patients and medical patients requiring close observation and monitoring, but not ventilation.[74]

3.46 The Blacktown-Mount Druitt redesign was cited by various NSW Health representatives as a successful example of what has been proposed for Manly and Mona Vale. However, the Committee also heard argument that it was not a smooth transition and has not satisfied all of the clinicians involved. As can be reasonably expected those who are reportedly dissatisfied with this restructure are associated with Mount Druitt Hospital.[75] Staff at that hospital are currently in the same position as staff at Mona Vale Hospital will be if the ICU is downgraded.

Conclusion

3.47 The evidence from medical professionals during the inquiry consistently supported the validity of the factors outlined above as to the changes faced by intensive care services. They provided the rationale for the move to restructure intensive care services on the Northern Beaches. The Committee cannot comment on whether these factors are positive or negative, only that they are observations of what is occurring. The Committee's interest is the validity of the particular model that has been proposed to address these factors and redesign intensive care services at Manly and Mona Vale.

3.48 In the next chapter the Committee examines alternatives that have been proposed subsequent to the release of the GMCT interim proposal.

74 Ms Needham, Evidence, 8 March 2005, p26.

75 This issue is discussed further in Chapter 5.

Chapter 4 Proposed changes to intensive care services at Mona Vale Hospital

Currently, intensive care services for the Northern Beaches community is provided through two level 4 Intensive Care Units (ICUs) at Manly Hospital and Mona Vale Hospitals. The Committee heard comprehensive and compelling argument that this two small unit model is not sustainable in the long term. The Committee also heard that the Mona Vale intensive care unit will fall apart unless the two units are combined into a single service that supports both locations but shifts all the sickest patients to the one unit.[76]

This chapter examines the current Greater Metropolitan Clinical Taskforce (GMCT) interim proposal to upgrade Manly Hospital to a level 5 ICU and downgrade Mona Vale Hospital to a level 3 High Dependency Unit (HDU). It also examines the community and clinician concern regarding the effect this proposal, if implemented, would have on the future of Mona Vale Hospital and the level of services that it would be able to provide.

The GMCT interim proposal

4.1 The Greater Metropolitan Clinical Taskforce (GMCT) released the *GMCT Interim Proposal for Northern Beaches* in December 2004. This document is reproduced at Appendix 3. This was a plan to address the present arrangement of acute hospital services on the Northern Beaches in the interim until the opening of the new Northern Beaches Hospital. In summary the proposed interim changes were to create on the Northern Beaches a single:

- Department of Medicine.
- Department of Surgery.
- Department of Critical Care.
- Intensive Care Service.

4.2 Initially the GMCT had considered centralising Northern Beaches maternity services at Mona Vale Hospital with a new co-located Birthing Centre. However, it was decided that no change be implemented, but that maternity services continue to be reviewed locally to ensure high standards of care. The proposal document did state that maternity services should eventually be based at the new Northern Beaches Hospital.

4.3 The proposal to create a single Northern Beaches Intensive Care Service included the upgrade of the Manly ICU to a level 5 unit and to increase its number of ventilated beds from three to six – this included the transfer of the two ventilated beds from Mona Vale, and the creation of one additional ventilated bed for the area. As a corollary it proposed to downgrade Mona Vale ICU to a level 3 HDU and for that unit to have four to six non-ventilated beds. As Mona Vale

[76] Professor Malcolm Fisher, Chair, NSW Taskforce into Intensive Care, Evidence, 21 March 2005, p23.

is currently funded for five intensive care beds (including its two ventilated beds) this would result in either an increase or reduction of one in the total number of beds at the unit.

4.4 It is this particular element of the GMCT interim proposal that has attracted criticism and concern from some of the clinicians at Mona Vale Hospital and from the local community.

4.5 At the public hearing on 8 March 2005, the Chairman of the GMCT, Professor Kerry Goulston provided to the Committee a presentation on the GMCT. Professor Goultson commenced with the background to the creation of the GMCT:

> Briefly, in 2000 the Government set up the New South Wales Health Council chaired by John Menadue. He issued a report that was critical of the lack of transparency and clinician involvement in planning and policy making as well as implementation. As a result of that Minister Knowles set up the Greater Metropolitan Services Implementation Group, which I co-chaired. We were a group of 42 appointed by the Minister and we had 162 recommendations. We were then asked, as the Greater Metropolitan Transitional Taskforce, to implement those recommendations. Subsequent to that, Minister Iemma set up the GMCT and asked me to chair it. We have a group of 33 on that committee.[77]

4.6 Professor Goulston described the key principles and aims of the GMCT:

> We are there to try to promote clinician and consumer involvement in the planning and delivery of health services. Our key principles—and we have stuck to those all the time—are that things should be population based and not based around hospitals and fiefdoms. So we have tried to break down the fiefdoms between, say, Westmead and Prince Alfred, North Shore and St Vincents. We have tried to get clinicians to work together. We have involved clinicians right across the board in an inclusive fashion and we have got consumers on every single one of our committees. Our aim is to improve the care of patients and to make it safer and to promote fairer access for patients to get hospital services, and therefore better outcomes. We act in a transparent fashion. We have a web site, we put out email newsletters to everybody and our minutes are circulated.[78]

4.7 Professor Goulston advised that the GMCT put forward an interim proposal because it was concentrating on the issue of patient safety for the next five to six years. The GMCT deliberately did not focus on the question of where the new hospital should be located as it was also concerned about the continued adversarial role between Manly and Mona Vale. Professor Goulston concluded his presentation by providing details on what would be provided in terms of resources by the proposal:

> So our proposal really stressed that a new hospital should not be called the new Manly hospital but be called the new Northern Beaches Hospital and that it should be planned by consumers and also by clinicians from both hospitals.
>
> They had to start networking here and now and they had to work in an integrated way between the two hospitals. Our proposal was not saving money; it was costing money. Roughly, what we suggested was about $1.5 million capital and about $1 million

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77 Professor Kerry Goulston, Chair, Greater Metropolitan Clinical Taskforce (GMCT), Evidence, 8 March 2005, p14.

78 Professor Goultson, Evidence, 8 March 2005, p14.

> recurrent. We concentrated on the care of critically ill patients. We suggested that northern beaches clinicians should form a critical care department incorporating the intensive care unit [ICU] and the emergency department [ED] at both hospitals. There should be a level three high dependency unit [HDU] at Mona Vale and a level five unit at Manly. We suggested that the emergency department at Mona Vale was understaffed and that its facilities were under-resourced.[79]

4.8 Professor Goulston listed the other recommendations and suggestions made to the Minister and the Director-General which the GMCT believed would result in better resourcing and increased staff for patients who are critically ill, either in the Emergency Department (ED) or ICU at both hospitals:

- significant enlargement and increased staffing for the ED at Mona Vale
- improved transport for patients between the two hospital
- an outpatient fracture clinic at Mona Vale
- that the acute medical, surgical and orthopaedic rosters remain [originally the GMCT considered having just one roster to cover both hospitals but decided against that]
- new unit of cardiac rehabilitation be started at Mona Vale
- paediatrics to continue at Mona Vale
- upgrade of facilities of the Manly ICU
- a single critical care grouping in order to attract more intensivists and ED staff to the Northern Beaches
- a joint medical staff council for both hospitals
- each clinical department be called a Northern Beaches clinical department (rather than Mona Vale or Manly)
- all doctors be offered cross-appointments to both hospitals.[80]

4.9 The rest of this chapter will primarily concentrate on the proposal to combine the intensive care services and the other GMCT recommendations that closely relate to it.

Emergency Department upgrade

4.10 The ICU and the ED of a hospital are inextricably linked, as the ED is the greatest single source of admissions to an ICU. Perhaps in recognition of this the GMCT proposal included recommended improvements to the ED at Mona Vale Hospital and recruitment of more specialist staff. The Chairman of the GMCT outlined the reasons for this recommendation:

> Part of our proposal related to an upgrading of emergency services at Mona Vale. We think that is important. Their workspace is too small and cramped and they do not have enough bays. We got costs done of how that could be improved, that is, capital costs. I think that should be done quickly. I sympathise with the people working at the

[79] Professor Goulston, GMCT, Evidence, 8 March 2005, p16.

[80] Professor Goulston, GMCT, Evidence, 8 March 2005, p16.

> Mona Vale emergency department. They are working under a difficult situation at the moment. So far as staffing is concerned, until recently there was only one emergency specialist at Mona Vale. In a week that hospital would cover only 32 of its 160 hours a week. As I said before, a lot of that staffing was done by locums, who quite often were strangers to the hospital. That concerned us, as it did the ACHS accreditation team.[81]

4.11 Dr Stephen Nolan, an intensivist from Mona Vale Hospital emphasised the importance of the recommended improvements to Mona Vale Hospital ED within the overall GMCT interim proposal:

> You can have full-time emergency physicians for the majority of the day. This argument has been lost in the intensive care argument. Mona Vale has one emergency physician who provides 30 hours a week of consultant cover. Intensive care on the northern beaches is not in crisis; emergency is in crisis. The front door of the hospital at Mona Vale is in crisis, yet we are talking about intensive care, where I think we have been doing quite well.[82]

4.12 The urgent need to implement these recommendations was also emphasised by Professor Malcolm Fisher:

> It is absolutely vital that whatever is necessary to augment the emergency department is done. If it is possible to recruit sufficient specialists to the unit—which if it happens will be only temporary I believe, because the demand for jobs in the bigger hospitals will increase soon—then maybe specialists, at least in consultation, should be available to both hospitals.[83]

4.13 The Committee is concerned by the implication of Professor Fisher's belief that any action to provide adequate staffing to the Mona Vale ED is likely to be only temporary, given that this improvement is said to be absolutely necessary.

4.14 The Northern Sydney Central Coast Health (NSCCH) submission notes that Mona Vale Hospital ED is far busier than Manly ED; there are 22,301 presentations to Mona Vale and 16,567 to Manly,[84] which is partly due to Mona Vale having many more paediatric attendances. Despite this, Mona Vale ED currently has one staff specialist who is unable to provide adequate backup for critically ill patients in the hospital, while Manly ED has three staff specialists who provide an on-call service and backup for acutely ill patients in the hospital.

4.15 The Committee believes that the dire situation at Mona Vale ED demands immediate attention in its own right and should not be delayed while other elements of the GMCT interim proposal are considered.

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81 Professor Goulston, GMCT, Evidence, 8 March 2005, p17.

82 Dr Stephen Nolan, Intensivist, Evidence, 8 March 2005, p49.

83 Professor Fisher, NSW Taskforce into Intensive Care, Evidence, 21 March 2005, p7.

84 Submission 2230, Northern Sydney Central Coast Health (NSCCH), p35.

Recommendation 1

That NSW Health immediately commence the physical upgrade of the Emergency Department at Mona Vale Hospital as suggested by the Greater Metropolitan Clinical Tasskforce interim proposal.

That Northern Sydney Central Coast Health recruit two additional staff specialists to the Mona Vale Emergency Department.

How the proposed system would work

4.16 The GMCT interim proposal for the Northern Beaches released in December 2004 was a two-page document. It understandably provided limited detail on how the proposed single Northern Beaches Intensive Care service would in practice function. The proposal caused significant concern among the communities that rely on Mona Vale Hospital. These concerns relayed to the Committee via submissions and evidence primarily focussed on what many believed would be the impact on the hospital as a whole and also on the level of service that would be provided at the HDU.[85]

4.17 The Committee was concerned to ensure that more precise details on how the proposed system would work were placed in the public domain. The Committee sought these details initially in questions to relevant witnesses who appeared at the public hearings and then in written questions to NSW Health.

4.18 The Director of Intensive Care Services, Northern Beaches Health Service, provided a brief overview of how the new system would allow for the continuation of acute medical and surgical services at Mona Vale Hospital:

> The system really works because you have an integrated service. You have a northern beaches intensive care specialist, who is available on the phone to give advice. You maintain the acute service for patients who come through the emergency department, for instance, who may require surgery acutely. The system is activated and the people are notified that a patient is likely to need intensive care post-operatively. A decision is made—a combination of the anaesthetist, the surgeon and the intensive care specialist will make the decision where that patient should most appropriately be cared for. If it is believed that the patient is not too sick and the patient can be extubated post-operatively then they will be cared for at Mona Vale in the high-dependency unit. In that unit there will be a ward round from the northern beaches intensivist daily. So I believe that the GMCT proposal can provide the safe back-up of intensive care service to allow the continuation of acute medical and surgical services at Mona Vale. That is my belief.[86]

85 For example, see submission 1102, Pittwater Council, p9.

86 Dr Paul Phipps, Director, Intensive Care Services, Northern Beaches Health Service, Evidence, 28 February 2005, p12.

4.19 The Co-chair of the New South Wales Intensive Care Clinical Implementation Group referred to the arrangement in place between Blacktown and Mount Druitt Hospitals as being indicative of how the proposed system would work for the Northern Beaches:

> This arrangement has been in place for over 12 months and is working successfully. Protocols are in place for the rapid retrieval of patients requiring intensive care management from the high dependency unit and the emergency department at Mount Druitt, with intubated post-operative patients able to stay in the high dependency unit at Mount Druitt for up to four hours under the care of the anaesthetists, bearing in mind that anaesthetists are very capable and their core business is managing airways, and they are also capable of resuscitation. Then, hopefully, the patient is able to be extubated—that is, to take out their tube that is maintaining their airway—and if they cannot do that then they are transferred out to Blacktown ICU by the medical retrieval unit for further management as required.[87]

4.20 The Committee wrote to NSW Health, noting earlier advice that it was agreed that staff should be rostered between the two units where possible to maintain skills and consistent practice, and requesting details on how the roster would work and the level of cover at both hospitals for both doctors and nurses. The response from NSW Health is reproduced below:

> The GMCT proposal recommends a level 3 HDU at Mona Vale and a level 5 ICU at Manly.
>
> Under this proposal the staffing structure across the two units would include a senior medical staffing structure comprising of six part time intensivists (approximately 3.5 FTE) with each intensivist working 1 in 3 weeks and 1 in 4 to 1 in 8 weekends.
>
> The senior staffing structure would involve two of the six part-time intensivists working each week, including the Northern Beaches intensivist on-call and a second intensivist on duty. The on-call intensivist would provide an on-site service 7 days at the ICU site and a telephone consultative service at the HDU site, with the availability of further specialist backup where deemed appropriate. The second on duty intensivist would provide a daily ward round at the HDU site together with supervision, teaching and quality activities as necessary, then liaise with the on-call intensivist.
>
> On weekends, the intensivist on-call would perform a morning ward round at the HDU site as necessary. The second on-duty intensivist would provide back-up for the ICU consultant on call in case of illness or onerous night attendance.
>
> The junior medical staffing structure across the two units would ideally comprise two ICU registrars providing weekday and some overnight cover at ICU site. Full ICU resident medical cover would be provided. The ICU resident medical officers (RMOs) would rotate, 5 days or nights on and 5 days off. They will cover ICU days, ICU nights providing 24/7 cover and HDU 12/7 cover.
>
> Night HDU cover will be provided by the senior medical staff in the Mona Vale emergency department. The medical and surgical registrars will help supervise care of the HDU patients during the day.

[87] Ms Kate Needham, Co-chair, NSW Intensive Care Clinical Implementation Group, Evidence, 8 March 2005, p26.

> There will be a well developed medical emergency team at both sites. This will be supervised by the Northern Beaches Critical Care team and processes reviewed by the Resuscitation Committee.
>
> Nursing staffing across the two units would comprise the following:
> Northern Beaches Critical Care Nurse Manager
> Clinical Nurse Consultant across sites
> Nursing Unit Manager HDU
> Nursing Unit Manager ICU
> ICU nursing staff - 8 per shift
> HDU nursing staff - 2 to 3 per shift
> Two Clinical Nurse Educators – one designated at each site
> Nursing staff rotation between ICU and HDU is necessary
>
> The Service would require a ward clerk at each location. Secretarial services would be shared across the two sites. Allied health services including Physiotherapy, Speech pathology, a Dietician and the pain service are currently largely across the two sites.[88]

4.21 The Committee notes that the above staffing structure details are still a proposal only at this stage, as it is being considered by the Northern Beaches Implementation Group and will be further considered by the Area Health Service upon receiving their recommendations.

4.22 The Committee accepts the contention that the above proposed system, or any subsequent alternative designed by health professionals, could provide a safe environment for patients in the care of the ICU and HDU. As will be examined later the main concern with the proposal is regarding the indirect but potentially significant impact on the hospital with the HDU.

Transfer from HDU to ICU

4.23 The GMCT interim proposal for a single Northern Beaches Intensive Care service stated that patients requiring more than short-term ventilation will be transferred to Manly Hospital. Data indicates that one to two patients per week (50-70 patients per year) may require transfer.[89] Some critics of the proposal believed that any such transfers would be subject to inevitable delay and potentially fatal consequences.[90]

4.24 Professor Malcolm Fisher argued that these concerns are misplaced:

> It is said that patients will die during transport. I believe that is fallacious as well. One of the ways that intensive care, with Australia's unique geography, is able to survive is by having transport facilities equal to or better than virtually any other country in the world. It is extraordinarily unusual for people to die during transport. The people who may need transporting under the GM[C]T plan are generally the people who are not all that sick, who are patients who have surgery where they cannot be extubated and require ventilation. The Medical Retrieval Unit [MRU] has a great track record with moving critically ill patients, and these patients will be particularly easy to move. Indeed, in the Northern Sydney area we have set up a unique system which we call the

88 Correspondence, from Director General, NSW Health to Committee Chair, 13 April 2005, p6; and amended by supplementary advice received in correspondence of 26 April 2005.

89 *GMCT Interim Proposal for Northern Beaches* December 2004, Appendix 1, p2.

90 Submission 723, Save Mona Vale Hospital Committee, p9.

> automatic transport system where patients who have time-sensitive injuries which cannot be dealt with locally need to be transported they can be sent to North Shore without consultation. They just need to tell us that the patient is coming. This is to avoid the problems that occur with trying to organise beds which mean many phone calls. The rationale for this is that often those patients will be safer in the hands of the MRU or the paramedics than they will be particularly after hours in the emergency department.[91]

4.25 During the public hearing on 28 February 2005, the Chairman of the Mona Vale Medical Council raised his concerns regarding the effect on the resources of the hospital while a post operative patient is waiting for transfer to an ICU.[92] This concern was put to the Co-Chair of the NSW Intensive Care Clinical Implementation Group at the hearing on 8 March 2005 who was asked about the length of time it takes to pick up a patient who required intensive care from a smaller hospital:

> Medical retrieval is an excellent service. They are staffed by emergency and intensive care doctors who work in the units around Sydney. With this particular service plan that we are doing with intensive care, with regard to category 1 patients, from the time they get a call at the medical retrieval unit to the time they arrive at, for example, Auburn hospital, 80 per cent arrive within 60 minutes of that initial contact with the medical retrieval unit.[93]

4.26 Later in the inquiry Professor Malcolm Fisher in response to questions on this same issue provided information to the Committee on Adult Retrieval Team Response Times to Mona Vale Hospital for the period 2002 to 2004. Adult medical retrievals from Mona Vale Hospital are conducted almost exclusively by the Sydney Areomedical Retrieval Service located at Mascot. In the three year period there were 52 transfers, of which seven were high clinical urgency transfers; 23 medium clinical urgency transfers; and 22 low clinical emergency transfers. All of the high urgency transfers were conducted by helicopter; 38 of the medium and low urgency transfers were undertaken by road, and seven by helicopter.[94]

4.27 Data and analysis provided by the Director, Aeromedical and Medical Retrieval Services included:

- 100% of high urgency cases [7 out of 7] had a team at the patient within 60 minutes.
- 78% (18 out of 23) medium urgency cases had a team at the patient within 120 minutes and 100% of cases within 3 hours.
- 95% (21 out of 22) of low or no clinical urgency cases had a team at the patient within 3 hours.
- All high urgency cases were conducted in clinically appropriate timeframes.
- Medium urgency cases were conducted in clinically appropriate timeframes.

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91 Professor Fisher, NSW Taskforce into Intensive Care, Evidence, 21 March 2005, p6.

92 Dr David Jollow, Chair, Mona Vale Medical Staff Council, Evidence, 28 February 2005, p71.

93 Ms Needham, Evidence, 8 March 2005, p30.

94 Professor Fisher, Evidence, 21 March 2005, p19.

- There were no documented clinical incidents (death or clinical deterioration) with any of the patients transferred from Mona Vale Hospital by adult medical retrieval teams between 2002 and 2004.
- There were a total of 4 deaths in transit out of 2757 total inter-hospital transfers undertaken by the Sydney Areomedical Retrieval Service from 2002 to 2004.[95]

4.28 The Committee heard that on occasion the need to transfer a patient who requires one of the limited level three neonatal intensive care beds (eg. a pregnant woman at risk of delivering pre-term) can result in a quite lengthy process when such a bed has to be located outside of the NSCCH area.[96]

4.29 Notwithstanding the excellent service provided by the Medical Retrieval Team to the current Northern Beaches ICU structure, the GMCT interim proposal document stated that *Significant upgrading of transport between Manly and Mona Vale Hospitals for both patients and their carers would also be required as part of the proposal.*[97] In evidence Professor Goulston appeared to be less concerned with this requirement:

> We also suggested that there should be better transport for patients between the hospitals, although it is not bad.[98]

4.30 The Committee endeavoured to clarify what was entailed in the significant upgrading of transport for both patients and carers. To this end the Committee made a written request to NSW Health to provide details on what had been proposed. While NSW Health provided details on recent upgrading of patient transport which commenced in June 2004, it was less than forthcoming on what had been proposed as part of the GMCT proposal:

> Further enhancements to patient and carer transport were proposed in the December 2004 Greater Metropolitan Clinical Taskforce (GMCT) Interim Proposal for the Northern Beaches. These will be considered by Northern Sydney Central Coast Health as service planning on the Northern Beaches progresses.[99]

4.31 The Committee is disappointed with the response provided by NSW Health. The uncertainty whether upgrading of patient and carer transport will be implemented, when this was initially considered a requirement, can only raise doubt on the viability of the interim proposal.[100] The failure of NSW Health to provide details on what actually was proposed has only served to reinforce these doubts.

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95 Tabled Document No 10, Professor Malcolm Fisher, *Adult Retrieval Team Response Times to the Mona Vale Hospital:. 2002 to 2004,* 21 March 2005.

96 Professor John Morris, Professor of Obstetrics and Gynaecology, Royal North Shore Hospital, Evidence, 21 March 2005, p20.

97 *GMCT Interim Proposal for Northern Beaches,* December 2004, p1.

98 Professor Goulston, GMCT, Evidence, 8 March 2005, p16.

99 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p3.

100 This exact concern was raised in Submission 641, Dr and Mrs Hendy, p2.

4.32 The Committee accepts the view of the health professionals that gave evidence that patients' lives will not be placed at greater risk by being transferred from a HDU to an ICU, provided that any necessary upgrade of transport services is implemented.

4.33 However, it does believe that the average length of time likely to be taken to conduct these transfers will have an indirect effect on the resources of the hospital housing the HDU. This issue is examined further at paragraph 4.138.

Recommendation 2

That NSCCH provide a timetable and detail for the implementation of specific enhancements to patient and carer transport.

Why Manly and not Mona Vale

4.34 The Committee heard that part of the rationale for combining the Intensive Care Units at Manly and Mona Vale Hospitals was because currently both units were struggling. In both his submission and evidence Dr Stephen Nolan, an intensivist at both hospitals, described the current situation:

> At present we have two struggling units, both of which are too small to be viable in today's standards. Rosters for senior staff cannot be filled by existing clinicians. Nursing vacancies are high—at 30 per cent—and staff morale is low. Clinicians and nurses are being forced into a situation where they are working in an unsupported environment, where the safety of the patient is potentially compromised and where modern standards of care are not being met. Both our hospitals, to different degrees, suffer from these problems.[101]
>
> At present Mona Vale Intensive Care does not have a dedicated doctor between the hours of 11pm and 8am. At Manly a junior doctor dedicated to Intensive Care often does not have the clinical or technical skills necessary to safely manage an emergency situation. In my mind in 2005 this is not acceptable if the hospital continues to have ventilated or complex sick medical and surgical patients.[102]

4.35 The Committee notes that it was emphasised by Dr Nolan[103] and a number of witnesses and in many submissions that in this debate there was no criticism intended regarding the efforts of the staff at either ICU and rather that they should be praised for what they have achieved in the past. The Committee also endorses the comment made by Professor Malcolm Fisher in his opening statement of evidence where he paid great tribute to the nurses from Mona Vale Hospital in the intensive care unit.[104]

101 Dr Stephen Nolan, Intensivist, Evidence, 8 March 2005, p41.

102 Submission 1092, Dr Stephen Nolan, p3.

103 Dr Nolan, Evidence, 8 March 2005, p46.

104 Professor Fisher, NSW Taskforce into Intensive Care, Evidence, 21 March 2005, p5.

4.36 In his submission to the Inquiry Professor Fisher was primarily concerned with outlining the argument that the best intensive care service model for the peninsula is one level 5 intensive care unit and one high dependency unit jointly covered by a single pool of intensivists. Dr Fisher did not put forward argument for Manly over Mona Vale:

> There are arguments for and against which site is best for which. Manly has the better infrastructure and specialist cover and Mona Vale the best unit in terms of design. There my expertise ends and population and traffic factors become important.[105]

4.37 Professor Fisher elaborated further in evidence:

> I am less certain about the numbers of beds or where the site of the level five unit should be on the peninsula in the interim, before the new hospital is built. Some years ago I met with people from both ends of the peninsula, BEACHES and Save Mona Vale, and they could both give me a very compelling case for that unit being at their end. I certainly decided that at that time there was nothing I could do to solve the problem. Indeed, I do not believe anyone will ever get consensus on both the site of the hospital and the site of the level five unit. Someone will have to make a decision and wear the flak.
>
> The Mona Vale unit is the better building. Manly has the better infrastructure in terms of all the things that are needed to make a unit excellent. I guess I have a slight bias in terms of the patients who have been referred to North Shore over the years. I think I have seen more patients who have not been optimally managed from Mona Vale than I have from Manly. Again, that may be biased. I have worked at Manly and covered Manly when there have been no specialist staff there.[106]

4.38 In his submission to the inquiry Dr Stephen Nolan did not argue for one site over the other but noted that the location should be the responsibility of administration taking into account all the factors involved in service delivery.[107] However, during evidence Dr Nolan stated that at the start of the process he thought that Mona Vale would be the preferred site given the physical set-out of the intensive care unit, but that it became clear to him as a result of other issues that Manly was the better site. Dr Nolan stated that his agreement with the move of ICU services to Manly was conditional on the guarantee that a significant renovation of the Manly ICU was undertaken prior to the move.[108]

4.39 Critics of the selection of Manly Hospital as the location of the level 5 ICU point to the intended eventual closure of Manly Hospital and to the fact that Mona Vale Hospital is the better geographic location. They question why Mona Vale was not selected as the site for the level 5 ICU. As the proposed model includes the requirement for a significant renovation of the Manly ICU, critics, such as Pittwater Councilargue that this proposal represents a waste of money in the long term. [109]

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105 Submission 2238, Professor Malcom Fisher, p7.

106 Professor Fisher, Evidence, 21 March 2005, p11.

107 Submission 1092, Dr Stephen Nolan, p4.

108 Dr Nolan, Evidence, 8 March 2005, p41.

109 Mr Alex McTaggart, Councillor, Pittwater Council, Evidence, 8 March 2005, p60.

4.40 In response to the criticism of committing resources to Manly Hospital, NSW Health advised that neither Mona Vale ICU nor Manly ICU has sufficient space to accept all ventilated beds. The cost of refurbishing Manly has already been partly paid for by the NSW Health Department following the Greater Metropolitan Transition Taskforce (GMTT) report of 2002. The refurbishment needs to be carried out irrespective of the new hospital because the physical facilities will not support any intensive care service configuration (even level 3 HDU) for the 6+ years required to build a new hospital. Mona Vale ICU can be maintained for this period of time without further refurbishment if the ventilated beds are transferred to Manly.[110]

4.41 In its initial submission to the Inquiry NSCCH briefly stated that the decision was made on the basis that Manly is the larger and busier intensive care unit (thus minimising the need for transfer of ICU patients) with more resources and staff structure and therefore the better location for the level 5 Northern Beaches service.[111] This issue was examined in more detail during the public hearings of the inquiry.

4.42 The Deputy Director General of NSW Health argued that when considering this issue one needed to understand the four components that are required to comprise an effective ICU. Dr Matthews described these components as:

- the bricks and mortar
- a critical mass of trained workforce
- the ancillary services that support the ICU, such as other clinicians and the availability of 24 hour imaging and diagnostics
- a critical mass of patients who are required in order for staff to maintain their skills and to stop them gravitating towards larger systems.[112]

4.43 The Chairman of the GMCT told the Committee that the decision to opt for Manly over Mona Vale was made after due consideration and after consultation in particular with the emergency department and intensive care staff. Professor Goulston said that it was a difficult decision as it was not a case of one large and one small hospital but rather two level 4 hospitals. In the end the decision was eventually made on the basis of Manly having an additional ventilated bed, more intensivists and staff that were better trained and more conversant with sophisticated procedures.[113]

The differences between the two units

4.44 The Committee heard much debate on the stated differences between the two level 4 ICUs. In some cases the validity of these stated differences were contested by those who oppose the proposed move.

110 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p5.

111 Submission 2230, NSCCH, p35.

112 Dr Richard Matthews, Deputy Director General, NSW Health, Evidence, 28 February 2005, p11.

113 Professor Goulston, Evidence, 8 March 2005, pp16-17.

Clinical structure, infrastructure and expertise

4.45 There has been no argument that of the two units Manly currently benefits from the greater level of resources in terms of infrastructure and staffing. The Nurse Unit Manager (NUM) at Manly ICU argued that Manly already possessed the infrastructure and effectively operated as a level 5 ICU.[114] The Co-chair of the NSW Intensive Care Clinical Implementation Group noted that neither ICU currently had the infrastructure support requirements but that of the two, Manly was in a much better position to build up to a level 5 ICU.[115]

4.46 The Director of Intensive Care Services on the Northern Beaches told the Committee that the overriding issue was the need to improve the quality and safety of care for patients and to achieve that a critical mass of doctors and patients was required. Dr Phipps summarised the differences between the two units. In the end Dr Phipps noted that it was the existing clinical structure at Manly Hospital that made it the logical choice:

> Because of the staffing and resource structure at Manly, sicker patients are able to be looked after. There is more innovative cardiac monitoring, and the nursing staff are experienced in that the nursing staff are experienced in renal replacement therapy or dialysis, which cannot be done at Mona Vale. The staff are also generally more familiar with complex ventilation. There are 24-hour dedicated ICU resident staff doctors that work in the unit and are trained by the unit, which we do not have at Mona Vale. There is also a senior registrar at Manly, which we do not have at Mona Vale. There are a number of other things. We do not have a ward clerk at Mona Vale, we do not have secretarial services, and we do not have doctors' offices. All those other structural things are also in place at Manly.
>
> When you are looking at which hospital, the most important thing is that we have all the ventilated patients in one place for critical mass issues. Once you have made that decision, you then have to make the decision about whether they should be in Manly or Mona Vale. Because of the clinical structure at Manly, I think it makes sense for those ventilated beds to be placed there.[116]

4.47 Dr Phipps was at pains to emphasise that the decision needed to be viewed as an integration of ICU services and that the ICU beds needed to be viewed as a Northern Beaches resource and not as a Manly or Mona Vale resource. Dr Phipps noted that the proposal would mean an increase in traffic of patients transferred between the two hospitals (this would also be the case if Mona Vale had been selected as the level 5 ICU site). Dr Phipps acknowledged that this was not a long-term solution, but as an interim solution it was in his view the best way to manage the service.

4.48 The question of whether it is feasible to re-locate this better clinical structure to Mona Vale Hospital is examined later at paragraph 4.93.

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114 Ms Lynette Hopper, Chairperson, BEACHES, Evidence, 28 February 2005, p87.

115 Ms Needham, Evidence, 8 March 2005, p25.

116 Dr Phipps, Northern Beaches Health Service, Evidence, 28 February 2005, p8.

ICU Activity – admission figures

4.49 As noted previously in its submission NSCCH stated that two of the main reasons for deciding on Manly as the location for the level 5 ICU was that it was the larger and busier of the two units. In support of this NSCCH included the ICU activity data for both Manly and Mona Vale for 2003/2004. During the Inquiry the interpretation and indeed the validity of these figures were questioned by the Save Mona Vale Hospital Committee (SMVHC), Pittwater Council, and by the Convenor of the Surgeons and Anaesthetists of Mona Vale Hospital.

4.50 The SMVHC, Pittwater Council, and the Convenor of the Surgeons and Anaesthetists of Mona Vale Hospital all referred to ICU activity data for the period July 2002 to June 2004 for Manly, Mona Vale, Royal North Shore and Hornsby Hospitals.[117] NSW Health confirmed that this was official data compiled for the use of the Northern Sydney Area Intensive Care Network. NSW Health cautioned that this data is not meant for publication and requires expertise and familiarity with intensive care processes to interpret accurately and that the activity data of different hospitals cannot be directly compared without adjustment for case mix and patient acuity.[118]

4.51 The Committee notes that a direct comparison of the data for Manly and Mona Vale Hospitals was provided in the NSCCH submission without any notes regarding adjustment for case mix and patient acuity.

4.52 During the public hearing on 28 February 2005, representatives from the SMVHC drew the Committee's attention to what they believed to be the surprisingly high admission figures to Manly ICU when compared to other hospitals in the Area for the period 2002-2004. In their presentation to the Committee, the SMVHC raised the following points:

- Manly admitted more non-ventilated patients (635) than either Royal North Shore (599) or Hornsby (254), which are both larger hospitals.
- Manly had only slightly more ventilated patients (137) than Mona Vale (133) while noting that Manly had one more ventilated bed than did Mona Vale, and received considerably more patient transfers.

4.53 The SMVHC argued that this two-year data showed that Mona Vale Hospital generated more in-house ventilated patients than did Manly. The SMVHC also argued that the high admission figures for Manly must raise questions about its ICU admission policy.[119] However, the Committee does note that Mona Vale also had a higher non-ventilated admission number (479) than Hornsby.

4.54 During the course of the public hearings the Committee heard from a number of witnesses who focussed on different aspects of the ICU activity data. The NUM for Manly ICU advised that while Manly and Mona Vale have approximately the same amount of emergency department presentations (after discounting paediatric presentations to Mona Vale) Manly has

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117 Copies of this data was tabled by Mr Parry Thomas, Chair, SMVHC, 28 February 2005; and included in Submission 622a, Dr Stuart Boland, appendices 4 to 6.

118 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p3.

119 Mr Parry Thomas, Chair, SMVHC, Evidence, 28 February 2005, p50.

the higher admission to hospital rate. Ms Hopper highlighted the fact that Manly ICU is the busier unit and has almost triple the amount of ventilator days than Mona Vale – 523 days versus 185 days respectively for the last year.[120]

4.55 In contrast, Pittwater Council argued that the issue of patients being ventilated for more than 24 hours was a major consideration in the location decision as it will be these patients who will require transfer from the proposed HDU to the proposed level 5 ICU. Pittwater Council drew the Committee's attention to the fact that in 2002-2003 there were more patients at Mona Vale (37) that were ventilated for greater than 24 hours than at Manly (35).[121]

4.56 The Committee believes that focussing on and interpreting only one aspect of the data, as has been done by parties in favour of either site, cannot provide the basis for a useful conclusion. The Committee notes that an overall review of the figures shows that it appears most admission categories remained stable for Mona Vale while they fluctuated more markedly for Manly particularly with an increase in ventilation categories in the 2003-2004 period.

4.57 Professor Malcolm Fisher cautioned that too much emphasis should not be placed on ventilation statistics. These statistics are in part used for funding purposes. Professor Fisher advised that some patients who do not require ventilation may, in fact, be far more complex patients and require greater care and expense.[122]

4.58 Professor Fisher also commented on the debate during the inquiry on the respective Acute Physiology and Chronic Health Evaluation (APACHE) II data scores for the two hospitals:

> There has been information and data regarding length of ventilator stay, apache scores suggesting that there is something unusual going on in the Manly intensive care unit. APACHE scores are a most interesting tool that we use to measure severity of illness. We always find the smallest hospital has the best figures because, of course, their sickest patients are moved out and scored as leaving the unit alive. Also there are virtually always errors in smaller hospitals because they do not have the infrastructure to monitor the collection of this data. Indeed, the Mona Vale apache scores are artificially inflated.[123]

4.59 The Committee notes that neither the SMVHC nor Dr Boland referred to the comparative deaths in ICU figures for the two hospitals. On the basis of Dr Fisher's evidence, the comparison of APACHE II scores between Manly and Mona Vale Hospital may be pointless if the criticism of collection error and artificially inflated scores is apparently found in virtually all smaller hospitals.

4.60 Dr Stuart Boland, on behalf of the Surgeons and Anaesthetists of Mona Vale Hospital submitted a review of the NSH Intensive Care Services Activity Reports for the Northern Beaches (Manly and Mona Vale), Hornsby and Royal North Shore for the periods July 2002 to June 2004. In this critique Dr Boland ventured that the figures suggested that Manly hospital had a more generous admission policy to the ICU. He concluded that a review of these figures

120 Ms Hopper, BEACHES, Evidence, 28 February 2005, p79.

121 Mr Lindsay Godfrey, Manager, Community & Library Services, Pittwater Council, Evidence, 8 March 2005, p53.

122 Professor Fisher, NSW Taskforce into Intensive Care, Evidence, 21 March 2005, p23.

123 Professor Fisher, Evidence, 21 March 2005.

indicated that Mona Vale has a greater need for an ICU to provide ventilation support for its own patients while Manly processes more low acuity patients to its ICU/HDU.

4.61 As this issue, which requires some expertise to interpret, was discussed somewhat disjointedly in evidence, the Committee invited NSW Health to respond specifically to the critique of the ICU activity data presented by Dr Boland and to the comments made in evidence during the inquiry regarding the ICU admission policies at Manly and Mona Vale. The critique presented by Dr Boland, the response from NSW Health, and the ICU activity data for 2002-2004 are reproduced at Appendix 4.

4.62 In evidence Professor Goulston noted that Manly had more acutely ill patients going through its Emergency Department to intensive care. He commented that he could not offer any explanation as to why this was the case, but that this was what the figures showed.[124] According to the submission from NSCCH both Manly and Mona Vale Hospitals offer the same medical and surgical services with the exception that Mona Vale also has a paediatric unit.[125] While the Committee has been provided with the relevant figures and the assertion that Manly receives more and sicker patients than Mona Vale (and other hospitals), no one has presented any reason or argument as to why this might be the case.

4.63 The Committee believes that this is an issue that requires investigation by NSW Health. If it is the case that people in the Manly Hospital area are generally sicker then this should have an influence on the future of the Manly Hospital site. The Committee did receive a number of submissions that argued that general hospital services should continue at Manly Hospital.

4.64 The debate about whether Manly or Mona Vale is the busiest ICU or whether Manly or Mona Vale Hospital generates more patients that require ventilation support will remain unresolved for many of the involved parties. The Committee notes the arguments and facts that have been presented from both sides of the debate. The only conclusion of which Committee is certain is one that to some extent has been lost sight of in this debate: that both Manly and Mona Vale ICU are extremely busy units that have been providing a service to a demonstrable need.

Ability to attract staff

4.65 The NSCCH submission states that Mona Vale has traditionally had problems in attracting staff to its ICU unit.[126] Manly ICU on the other hand has been fortunate in that it has benefited from a shared professional interest of its three staff specialists who also work in thoracic medicine.[127] This has allowed Manly to avoid the problems that plague small ICUs in attracting new staff.

4.66 In 1997 negotiations with the intensivists at Manly Hospital was undertaken to implement a single intensive care roster to cover both Manly and Mona Vale Hospitals. The single roster commenced in November 1997 and concluded in June 2000, following a decision by those intensivists that they were no longer prepared to be on-call for two hospitals.

124 Professor Goulston,GMCT, Evidence, 8 March 2005, p19.

125 Submission 2230, NSCCH, p18.

126 Submission 2230, NSCCH, p30.

127 Dr Nolan, Evidence, 8 March 2005, p44.

4.67 The ideal number of specialists required to provide cover all year round for an active intensive care unit is 5.8 full-time equivalent positions which allows for reasonable after hours load and the ability to take leave. Mona Vale Hospital is funded to provide this level of coverage.[128]

4.68 Ideally, this arrangement is best provided by a team of specialists who are available to be rostered on site. However, for Mona Vale for the nominal 5.8 positions, 5.3 positions would be considered to be Visiting Medical Officers (VMOs) and the other 0.5 position would be the Northern Beaches Director of Intensive Care, also a VMO.

4.69 There are currently two permanent part-time Intensive Care specialists (VMOs) providing the on-call roster for the Mona Vale ICU. The Director provides limited clinical cover. The rest of the roster is covered by locum intensivists on an ad hoc basis.[129]

4.70 The NSCCH submission noted the significant shortage of intensive care specialists in Australia, and that despite advertising through national papers and the Medical Journal of Australia, no suitable applicants applied for the remaining vacant positions. NSCCH advised that the size of the ICU was a major issue for applicants who viewed caring for one or two ventilated patients not to be a productive use of their specialist time.[130]

4.71 The Committee received a number of submissions that alleged that the management of Manly and Mona Vale Hospitals has not vigorously sought to recruit additional specialists and in some cases have actively discouraged potential applicants from applying.[131]

4.72 The General Manager, Northern Beaches Health Service described the attempts to fill the intensive care consultant staff shortage at Mona Vale Hospital:

> In terms of intensive care specialists, in 2000 we advertised without success. In 2002 we advertised for two particular appointments, the current appointments. In 2004 we advertised through the *Medical Journal of Australia*, the *Sydney Morning Herald* and nationally through *The Australian*. We received only one application and that person was not credentialed, and I understand that Dr Phipps had six or seven telephone inquiries. As soon as the callers heard about the nature of the position, in terms of Mona Vale, the number of ventilated beds and the requirements, those particular inquiries ceased.[132]

4.73 The General Manager also commented on the situation at Manly ICU:

> Manly has had a traditionally good base of intensive care staffing. We have three staff specialists. These are intensivists appointed on a salaried basis who have provided a good culture, teaching and research area for that particular unit. Dr Phipps also helps in that regard. But, even with those staff, we still have to find locums on occasions to back-up the roster for Manly, as well.[133]

128 Submission 2230, NSCCH, p30.

129 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p7.

130 Submission 2230, NSCCH, p30.

131 Submission 605, Confidential, p12 (quoted with permission); Submission 723, SMVHC, p9.

132 Mr Frank Bazik, General Manager, Northern Beaches Health Service, Evidence, 28 February 2005, p21.

133 Mr Frank Bazik, General Manager, Northern Beaches Health, Evidence, 28 February 2005, p21.

4.74 There has been some conjecture that the positions at Manly ICU have been provided more attractive remuneration and conditions than has been offered for the ICU positions at Mona Vale Hospital.[134]In an attempt to clarify this issue the Committee wrote to NSW Health with regard to Mr Bazik's evidence relating to the advertising for intensive care specialist(s) in 2004 to be located at Mona Vale Hospital and asked:

- Was this round of advertising for one or more intensivist positions?
- Please provide the position description and remuneration that was offered for the position(s), and advise whether it/they were comparable in pay and conditions to the ICU positions at Manly.

4.75 In response NSW Health advised:

> The advertisement for the Intensive Care Unit at Mona Vale Hospital was entitled "VMO Intensivists". Depending on applicants' qualifications and availability, more than one person can be appointed against these advertisements. A position description for the Visiting Medical Officer (VMO) is attached (Attachment 2) for information.
>
> Remuneration was offered at sessional rates, consistent with the Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 1994. Pay and conditions for Visiting Medical Officers are set on a Statewide basis. Under these arrangements, Mona Vale is an election of choice hospital which allows the six major specialty groups (Surgery, Orthopaedics, Medicine, Obstetrics and Gynaecology, Paediatrics and Anaesthetics) to elect between sessional or fee for service arrangements.
>
> In respect of Manly Hospital ICU, three positions (last such appointment in 1997) are classified Staff Specialists and are considered salaried staff (as distinct from VMOs who are classified as contractors) and these positions are subject to the pay and conditions determined by the Staff Specialists (State) Award and the Salaried Senior Medical Practitioners Determination.
>
> Experience has shown little interest by medical staff in salaried staff positions at Mona Vale Hospital with only 3 appointments of such positions compared with over 50 VMO appointments.[135]

4.76 While the Committee acknowledges that Mona Vale Hospital has had little success in the past in securing appointments to salaried staff positions, it notes that this lack of success is guaranteed to continue if attempts are no longer made to recruit to these types of positions. There is perhaps little utility in contemplating whether there would have been any value in advertising the 2004 vacancies as an either/or VMO/salaried staff position opportunity. The crucial issue was that the vacancies were not filled.

4.77 The Committee accepted on a confidential basis a document from Dr Stuart Boland which he argued supported his view that health management had in the past entered negotiations with some of the intensivists at Manly Hospital regarding improvements to their working conditions via staffing enhancements for both the ICU and ED at Manly Hospital, new

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134 Mr John Brogden, MP, Member for Pittwater, Evidence, 28 February 2005, p29; Submission 622a, Surgeons & Anaesthetists, Mona Vale Hospital, p9.

135 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p6.

equipment, and attendance at conferences and overseas meetings.[136] The Committee does not know if any such agreement was made and enacted. The Committee is of the view that, as long as they accord with due and proper process, there is nothing wrong with any such arrangements being entered into. Indeed, given the difficulty in retaining staff particularly those who because of staff shortages work beyond their contract requirements, such arrangements could probably be encouraged. The only proviso is that such arrangements should not be selectively offered or applied so as to result in a disadvantage to any one unit through an inequitable allocation of resources.

4.78 The belief that interested applicants were discouraged from applying for the Mona Vale intensivist positions or that suitable applicants were not sought out has gained wide currency among the community and the critics of the Area health management. However, this belief, as reported to the Committee, is often based on second-hand information. [137] Similarly, those who have rebutted these claims have done so by general reference to third parties.

4.79 Professor Malcolm Fisher advised the Committee that he had spoken to a number of the persons who had made initial inquiries. Professor Fisher said that once the precise details of the activities of the units were explained to those doctors they did not wish to pursue the appointment. Professor Fisher further noted that over this same period Hornsby Hospital, which has a critical mass and a sound infrastructure, has had no problems with recruiting intensivists, while Mount Druitt and Auburn, which are similar to Mona Vale, have been unsuccessful in recruiting or retaining intensivists.[138]

Conclusion

4.80 The Committee acknowledges that those who have commented on this issue have appropriately chosen not to divulge the names of the applicants or interested parties involved. The Committee did not receive a submission from any of the doctors who either expressed an initial interest or applied for the advertised positions. Therefore, the Committee has no substantial evidence that confirms the contention that doctors have been discouraged from applying for the vacant intensivist positions at Mona Vale Hospital.

4.81 As has been noted previously, currently there are only two formally trained and qualified intensivists on the Northern Beaches. NSW Health advised that the proposed staffing structure for the proposed single Northern Beaches Intensive Care Service would include six part time intensivists. The Committee presumes on the basis of the evidence it has heard, that NSCCH would be seeking to fill any vacancies only with qualified and credentialed intensivists.

4.82 The success or failure of either ICU in attracting staff has been a factor in determining the best location for the proposed level 5 ICU. It has been argued that the proposed new Intensive Care Service would result in a critical mass of patients and clinicians. If this is the case, there should not be any anticipated difficulties in attracting staff regardless of whether the level 5 ICU was located at Manly or at Mona Vale.

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136 Submission 622a, Surgeons & Anaesthetists, Mona Vale Hospital, p9.

137 Dr Stuart Boland, Convenor, Surgeons & Anaesthetists, Mona Vale Hospital, Evidence, 28 February 2005, p61.

138 Professor Fisher, NSW Taskforce into Intensive Care, Evidence, 21 March 2005, p6.

Helicopter access

4.83 Mona Vale Hospital has a helipad with air access over the ocean. In the period 2002 to 2004 the helipad has been used on 14 occasions to retrieve and transfer adult medical patients. Manly Hospital does not have a helipad. The Committee heard that if the proposed level 5 ICU is linked to the State-wide register of ICU beds, then it is likely that transfers from other hospitals into the new ICU will occur, and that a functional helicopter access would be essential for this purpose.[139]

4.84 The Committee was advised that Manly ICU is already on the State ICU register and receives patients from all over New South Wales, and had successfully received patients for some years without the need for a helipad.[140] NSW Health advised that there are twelve hospitals in New South Wales with a similar role and service level to Manly that do not have helipads and that appropriate arrangements are in place to allow these hospitals to transfer patients by air if required.[141] A helipad at the Quarantine Station at North Head, the nearby Artillery School and the local oval have been used in the past as helicopter landing sites. In these instances a road ambulance was used to connect with Manly Hospital.[142]

4.85 In an ideal situation the location for a level 5 ICU would include a helipad on-site. Indeed all of the sites under consideration for the new Northern Beaches Hospital, which will ultimately house the Area's intensive care services, reportedly have the capacity to accommodate a helipad. While noting it is not an ideal situation, the Committee accepts that the position of NSW Health is that the lack of an on-site helipad is not an impediment to the location of a level 5 ICU.

Location

4.86 Much of opposition to the GMCT interim proposal is based on the comparatively poor geographic location of Manly Hospital. The GMCT decision has been characterised as a proposal to treat the sickest patients on the Peninsula on the worst possible geographic site.[143] Even those who acknowledge that the argument for the need to combine intensive care services is hard to flaw, cannot understand the decision to locate the main ICU at Manly.[144]

4.87 The GMCT Interim Proposal document included the comment [that with respect to improving intensive care services] "it is not the address that counts". However, the Committee is of the view that the intention of this comment was to emphasise that the primary concern of the GMCT was the need to create an expert team by combining the two ICUs. It is apparent that the relative merits of the two geographic locations did not influence the final decision of the GMCT. However, as noted previously, the Interim Proposal stated the significant upgrading of transport for patients and their carers would be required.

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139 Submission 2232, Dr David Jollow, p2.

140 Ms Hopper, BEACHES, Evidence, 28 February 2005, p79.

141 Correspondence, from Director General, NSW Health, to Committee Chair, 18 March 2005, p2.

142 Submission 2230a, NSCCH, p9.

143 Submission 622a, Surgeons & Anaesthetists Mona Vale Hospital, appendix 3, p3.

144 For example see Submission 2232, Dr Jollow, p1.

4.88 It has long been accepted by all that Manly Hospital is located on a poor site in terms of access for persons travelling to the hospital. In 2000 a review of the physical condition of Northern Sydney Health (NSH) facilities was prepared as part of the Area's Strategic Resources Plan (SRP). The SRP found that *access to Manly Hospital was inadequate with only one relatively minor road providing access and with major transport routes being some distance away.*[145] Manly Hospital was considered to be poorly sited in terms of providing access to its catchment population, this problem is only exacerbated when the catchment area for the proposed level 5 ICU would encompass the entire Northern Beaches area.

4.89 The Committee received evidence that it can be an extremely stressful experience for a person to visit or be with their partner, relative or friend who is an ICU patient. In many cases these visitors may need to travel to the hospital on consecutive days over an extended period. It can be expected that in many cases these visitors may be elderly or infirm themselves. The Committee believes that travel accessibility for visitors to an ICU is an incredibly important issue.

4.90 The Committee was somewhat surprised at the statement by the CEO of NSCCH that there was very little difference in most accessibility scores between Manly and Mona Vale hospitals, and that with respect to what is regarded as the best estimate, namely the tenth busiest time, Mona Vale is only marginally ahead of Manly Hospital.[146] The relevant figures drawn from the Northern Beaches Accessibility Study and to which Dr Christley was referring to are presented below:

Table 4.1: 2011 Auto 10th busiest peak hour: comparison Manly – Mona Vale Hospitals[147]

2011 Average AM peak	**Cumulative % of total Estimated Residential Population in the travel time band**	
Travel time band in minutes	Manly Hospital	Mona Vale Hospital
0-10	17%	13%
10-20	43%	31%
20-30	61%	89%
30-40	79%	100%
40-50	97%	
50-60	100%	

4.91 The above figures[148] refer to travel by car. The Northern Beaches Accessibility Study also provided estimated travel time by bus to the two Hospitals. As would be expected Mona Vale was more accessible than Manly.[149] Ease of access for visitors to an ICU is important.

145 Submission 2230, NSCCH, p53.

146 Dr Stephen Christley, CEO, NSCCH, Evidence 28 February 2005, p7.

147 Figures compiled from Submission 2230, NSCCH, Appendix 26, p7.

148 This table in full and the other travel accessibility tables from the *Northern Beaches Accessibility Study: Travel time analysis and mapping,* are included and discussed in Chapter 6.

149 Submission 2230, NSCCH, Appendix 26, p10.

4.92 Many supporters of Mona Vale Hospital who have argued that it should be the site for the new Northern Beaches Hospital refer to the calming and pleasant ambience of its coastal location and the intangible benefit this can provide to patients and visitors. Some submissions have argued that a hospital's ambience and environment is less important in these days where there is a trend to increasingly shorter stays in hospital.

Should Manly's ICU resources be relocated to Mona Vale?

4.93 NSW Health was asked whether the intensive care and clinical structure and resources present at Manly Hospital could be transferred to Mona Vale Hospital. Many submission writers have questioned why NSW Health would consider increasing the services at Manly ICU when the Committee has been told that, as an acute care hospital, it is going to close. They argued it was also hard to understand why money is being spent on the refurbishment of the ICU at Manly on the basis that Mona Vale Hospital was going to have an on-going role while Manly was not.

4.94 In evidence Dr Stephen Christley argued that it was not a matter of simple relocation and that if it were to occur there would be some loss in terms of the efficiency of a functioning team. Dr Christley did concede that the unit would be subject to relocation eventually, however, he argued that the disruptive effects of relocation should be minimised where possible:

> What I think Professor Fisher said and what every clinician has spoken about is the teamwork that is part of an intensive care service and a whole hospital. To use the words of another: it is not a bicycle; it is a frog. You cannot actually take it to pieces and try and reassemble it because it will not work when you try and reassemble it, so to pull apart a working intensive care service and try and reassemble it somewhere else as an interim measure makes no sense.
>
> …I could rephrase your question in human team terms: why create two separate disruptions in a five-year period when you could create one disruption to what is probably the more functional currently higher-level ICU service?[150]

4.95 Dr Christley's comments raised some concern with respect to how genuine NSCCH was in its statements that Mona Vale Hospital was one of the six potential sites for the new Northern Beaches Hospital and that the final selection had not already been pre-determined but would be dependent upon the findings of the Value Management Study that was announced on 18 March 2005. This issue is examined again in Chapter 6.

4.96 NSW Health were asked whether it was possible to relocate or transfer the ICU clinical structure and resources of Manly Hospital to Mona Vale Hospital and what would be required to achieve such a move. The Committee also sought to find out whether the GMCT or NSCCH had considered this option given that the Manly clinical structure and resources would eventually be subject to relocation to the new Northern Beaches Hospital.

4.97 NSW Health advised that the transfer of the Intensive Care resources from Manly to Mona Vale was considered by the GMCT but rejected because refurbishment of the Manly ICU will be required regardless of whether or not it was made the level 5 ICU; the greater number of

150 Dr Christley, Evidence, 21 March 2005, p25.

staff and resources that would need to be moved; and that some of the intensivist staff could not be transferred because of their other commitments.

4.98 Neither Mona Vale ICU nor Manly ICU has sufficient space to accept all ventilated beds. The cost of refurbishing Manly has already been partly paid for by the NSW Health Department following the GMTT report of 2002 and needs to be carried out irrespective of the new hospital because the physical facilities will not support any Intensive Care service configuration (even level 3) for the 6+ years required to build a new hospital. Mona Vale ICU can be maintained for this period of time without further refurbishment if the ventilated beds are transferred to Manly.

4.99 NSW Health advised the Committee that for Manly to accept the ventilated beds the following needs to be moved from Mona Vale to Manly:

- four nursing staff
- one ventilator.

4.100 For Mona Vale to accept the ventilated beds the following would need to be moved from Manly to Mona Vale:

- More than 10 nursing staff who have the ability to manage complex ventilation, continuous renal replacement therapy, invasive cardiac monitoring.
- Intensive Care Specialists. (Moving intensivists from Manly would be difficult because they provide a respiratory and TB clinic, bronchoscopy and respiratory consultative service for Manly hospital as well as supervising the advanced trainee in Respiratory Medicine. They hold 50% staff specialist positions and cannot increase their Intensive Care workload.)
- Senior registrar in Intensive Care and Respiratory Medicine. The Northern Beaches would lose the current senior registrar position (on secondment from RNSH).
- Four ICU resident medical staff.
- Secretarial services.
- Ward Clerk.
- Medical offices.
- Tutorial facilities.
- Medical student rotation from RNSH.
- Equipment such as PICCO, Dialysis machines, Heliox and advanced ventilators.[151]

Conclusion

4.101 The Committee agrees that there are compelling arguments for and against each site. However, the Committee believes that many of these arguments would become redundant if an agreed single intensive care service across both sites was implemented.

[151] Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p5.

4.102 The Committee heard that the ventilated intensive care beds (wherever they are located) will be a resource for all residents of the Northern Beaches and that the transfer protocols will ensure that patients at the hospital with the HDU will not be endangered or disadvantaged. The Committee also heard that the new service should have no problems in attracting new staff. The Director General of NSW Health advised the Committee that cost is not a barrier to resolving this issue and therefore refurbishment of both ICUs should not be a barrier to selection of Mona Vale.

4.103 The only differences between the two units that would not be addressed by the new system are geographic location and the existence or lack of a helipad. In isolation these factors are not sufficient reason to choose one site over another (although some would argue that location alone should be the determining factor). If it is at all possible to locate the new intensive care service at either location then it makes sense to locate it at the more centrally located and more accessible site.

4.104 However, as is discussed in the following sections, the Committee heard there were serious concerns regarding the effect that the proposed downgrade of Mona Vale ICU to a HDU would have on the hospital as a whole. While the following discussion focuses on Mona Vale, the Committee notes that these concerns would equally apply to Manly Hospital if it was to be selected as the site for the HDU.

The impact of a downgraded ICU on Mona Vale Hospital

4.105 The rationale for the GMCT interim proposal, that includes the downgrade of Mona Vale ICU to an HDU, is to provide an overall improved Intensive Care Service for the entire Northern Beaches. There is no argument that an improved level of service is required. Most participants in the Inquiry concede that the proposed model, while imperfect in itself, would achieve that result. However, it has been emphasised to the Committee that the overall impact of a downgraded ICU on Mona Vale Hospital as a whole is serious and cannot be ignored.

4.106 Many professionals associated with Mona Vale Hospital and the communities that rely upon the hospital believe that the downgrade of the ICU will be the catalyst to what will become an inevitable process of a diminishment and reduction of all services. At present the impact of the interim proposal, including the necessary delay in a final decision, has been to create uncertainty among staff and consumers. This in turn is causing problems with recruitment[152] and morale.[153]

4.107 In late December 2004 a number of services were suspended at Mona Vale Hospital, most notably maternity services. The reason for this decision by surgeons, obstetricians and anaesthetists was the fact that because of staff shortages, on-site intensive care services were not able to be provided. It has been argued that what occurred in December 2004 is indicative of the future for Mona Vale Hospital.

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152 Dr Phipps, Northern Beaches Health Service, Evidence, 28 February 2005, p23.

153 Ms Deborah Carter, Evidence [in camera subsequently published], 8 March 2005, p2; Ms Denise Hardie, Evidence [in camera subsequently published], 8 March 2005, p3.

Staff shortage at Mona Vale over Christmas 2004

4.108 During the period 22 to 26 December 2004 the normal intensivist staffing of Mona Vale Hospital was not able to be maintained. The hospital has only three part time intensivist VMOs to cover its ICU roster, the rest of the cover is provided by locums. The General Manager, Northern Beaches Health Service advised that it is perennially difficult to secure locum staff on an ad hoc basis, especially over festive periods such as Easter and Christmas. Despite offering to pay premium rates for anyone wishing to work he was unsuccessful in finding any locum staff for this five-day period over Christmas 2004.[154]

4.109 The General Manager and the Director of Intensive Care Services, Northern Beaches Health Service, approached staff from the anaesthetics department at Mona Vale and the intensivist staff specialists at Manly Hospital to help provide the normal level of cover during this period. However, these staff, who were already working in excess of their contractual obligations, were unable to assist.[155]

4.110 The Committee heard from Dr Stuart Boland that he had personally spoken to two intesivists who were prepared to offer their services to staff the ICU at Mona Vale Hospital for various periods over that time but that for various reasons were told their services were not required. Dr Boland conceded that this was probably understandable as the intensivists concerned may have only been able to offer intermittent cover.[156]

4.111 The Director of Intensive Care Services implemented a contingency plan which he believed ensured Mona Vale had a reasonably high level of cover for acute services. One of the Manly intensivists did a ward round at Mona Vale on Christmas Day and Boxing Day, and arrangements were put in place to expedite the transfer of any patient that required more than short-term ventilation.

4.112 Dr Stephen Nolan, one of the VMO intensivists at Mona Vale Hospital, described the contingency plan. Dr Nolan also provided his view on the concerns of the surgeons and anaesthetists regarding patient safety:

> My personal view on that is that people should never be asked to do something if they feel that a safe environment cannot be provided, that is my first statement. However, there are hospitals in Sydney that are able to provide the services that the Mona Vale surgeons and anaesthetists were not able to provide over that period. Dr Phipps, in liaison with the administration, and I was involved in those consultations, we thought we had provided a service that would enable safe practice to be occurring at Mona Vale Hospital. We had an intensivist who was going to do a round each day on the ICU patients. If that intensivist felt that a patient needed to go to higher level of care then Manly Hospital was going to accept the patient. So from an intensive care point of view we felt that the environment was safe, and from standards within Sydney there are other hospitals that do more operations than Mona Vale without intensive care that seem to be able to do that without any safety issues.[157]

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154 Mr Frank Bazik, General Manager, Northern Beaches Health Service, Evidence, 28 February 2005, p22.

155 Dr Phipps, Evidence, 28 February 2005, p22.

156 Dr Boland, Evidence, 28 February 2005, p65.

157 Dr Nolan, Evidence, 8 March 2005, p42.

4.113 It was the closure of maternity services that caused most disruption to patients. This closure attracted some media attention and no doubt has given cause for continued concern to the community and future prospective users of the service. This disruption was exacerbated by the fact that the maternity unit was given only one day's notice of the situation.

4.114 The Maternity Early Discharge Co-ordinator, Mona Vale Hospital explained that maternity services had to then contact all the patients that were likely to be due within the next 10 days and advise them that if they came into labour within the next few days not to come to Mona Vale. Potential patients were told that they should either go to Manly or, if they were a private patient, to contact their obstetrician to make other arrangements.[158]

4.115 Ms Hardie advised the Committee that fortunately it was a quiet period and only a few women, less than they expected, were affected. Ms Hardie noted that maternity bookings had decreased somewhat following this episode.

4.116 During the public hearing the CEO of NSCCH emphasised that it was important to note the ICU did not close and that alternative cover arrangements were put in place.[159] However, the Committee believes that despite these arrangements the effect was virtually the same. It did not matter that the unit was not closed, the fact that the level of service was considered to be sub-standard by the surgeons caused them to withdraw their services.

4.117 It is NSW Health's position that a hospital does not need an intensive care service to support a maternity service, and that such a requirement does not form part of their planning. Dr Christley advised that the only reason this issue arose was because of the decision by the Mona Vale clinicians to withdraw their services.[160]

4.118 The Chairman of the Mona Vale Medical Staff Council, who is an obstetrician, explained that the various reasons why Mona Vale obstetricians chose to withdraw their services during this period were several-fold. It was not a simple case of withdrawing services because there was no on-site intensive care cover. The primary reason was the absence of surgical backup. In this respect Dr Jollow agrees with Dr Christley. However, Dr Jollow was less sanguine about the contention that intensive care support is not necessary:

> Firstly, the general surgeons decided they were not going to cover the hospital, which makes it incredibly difficult for us. A fair number of patients present to the emergency department with abdominal pains and other things, and it is very difficult to know whether it is a general surgical or gynaecological problem. So, it is incredibly important to us to have surgeons' back-up and is incredibly important for the surgeons to have gynaecologists' back-up for these patients. They need someone they can ring at 3.00 o'clock in the morning and say, "We found something we did not expect, can you come in and help." That is the first thing. We would not be able to look after any gynaecological emergencies. That would be the main thing.
>
> The second thing is from an obstetric point of view. As much as people like to talk about being able to predict when there is going to be bad outcomes, you do not have

158 Ms Denise Hardie, Maternity Early Discharge Coordinator, Mona Vale Hospital, Evidence [in camera subsequently published], 8 March 2005, p2.

159 Dr Christley, Evidence, 28 February 2005, p22.

160 Dr Christley, Evidence, 21 March 2005, p18.

> to speak to many midwives or obstetricians to find that it is almost completely impossible to predict bad outcomes. Even though it would be very uncommon for an obstetric patient to end up in the intensive care unit at Mona Vale hospital, you never know when it is going to happen. You never know when a patient is going to start to bleed to death on the operating table after a caesarean section. I need to know I have a vascular surgeon behind me who can help me so this patient does not die. It is as simple as that.[161]

4.119 Dr Jollow also referred to the short notice given regarding the change in level of ICU cover. He believed that as people these days in Sydney actively choose where to have their babies and in making their choice they assess the type of medical cover and services provided, that it was not fair to accept patients who chose Mona Vale at a time when it had a fully functioning intensive care service.

4.120 Dr Jollow emphasised that the relationship between an intensive care service and a maternity service cannot be discussed in isolation. He conceded that from an obstetric point of view Mona Vale could probably cope with a HDU, though he believed this would not be ideal. The main issue is that obstetricians have to consider what the other speciality groups do and what surgical back-up is being provided.[162]

4.121 The provision of any health service at any location is dependent upon the availability and willingness of medical practitioners to provide that service. This is the ultimate determinant regardless of the Health Department's position. The Nursing Unit Manager of Maternity Services at Mona Vale Hospital spoke to her staff's uncertainty regarding the future of maternity services at Mona Vale:

> …the obstetricians we work with—Dr Kent is the director of the unit, and Dr Michael Kaye has been there for many, many years—have indicated to us that if the intensive care unit does not remain at Mona Vale, they will not be happy to continue obstetrics there. So it is very hard; on one side we are hearing one story and on the other side we have our senior clinicians saying they would not be happy to run an obstetrics unit without an intensive care back-up. We do not use intensive care very much, but when you need it you really need it. Maternal death is a really terrible thing, and I would hate to see it happen on my watch.[163]

4.122 The reported views of the obstetricians at Mona Vale Hospital are that they may discontinue their services either as a direct or an indirect result of the downgrading of the hospital's ICU. This possibly raises some question about the practical feasibility of the original intention to centralise maternity services at one location and intensive care services at the other. The Committee notes that the ultimate aim is to have both of these services centralised at the new Northern Beaches Hospital.

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161 Dr Jollow, Evidence, 28 February 2005, p73.

162 Dr Jollow, Evidence, 28 February 2005, p74.

163 Ms Karen Draddy, Nurse Unit Manager, Maternity Services, Mona Vale Hospital, Evidence [in camera subsequently published] 8 March 2005, p7.

The impact on level of services provided

4.123 The Convenor of the Surgeons and Anaesthetists of Mona Vale Hospital, Dr Stuart Boland told the Committee that the surgeons and anaesthetists do the scope of work that they do there now, both elective and surgical emergencies, on the basis of the knowledge that the intensive care unit is there. Conversely, if the ICU is downgraded to a HDU there is a scope of work that they will no longer be prepared to perform.[164]

4.124 The Committee heard that even though Mona Vale is a level four hospital, that surgeons performed level six surgery such as abdominal aortic aneurysms, repair of large vessels of the abdomen, carotid artery surgery, and liver and major pancreatic resections. The surgeons were able to perform this type of surgery for some time because, in part, of the support provided, over and above what was contractually required of them, by the Mona Vale intensive care specialists.[165] The Committee notes that NSW Health is concerned at the safety implications of this level of surgery being performed at a level four hospital. [166]

4.125 Notwithstanding the example of Campbelltown Hospital, which has a high dependency unit and still performs quite high level surgery, the surgeons and anaesthetists at Mona Vale are not comfortable operating in such an environment. They are also conscious of the potential medico-legal risk of working in a less than optimally supported environment and profess a lack of faith in the likelihood of individuals being supported by the Area Health authorities should situations, the circumstances of which are beyond their control, arise.[167]

4.126 In response to a question from the Committee Dr Boland advised that he also performed surgery at a number of private hospitals - one of which did not have an intensive care service. In each case Dr Boland advised that the scope and complexity of the work he performed depended on the intensive care service provided at the hospital.

4.127 Throughout the inquiry the Committee endeavoured to determine what surgical procedures would be precluded from being performed at Mona Vale Hospital if its intensive care operated as a level 3 HDU. In response to a written question from the Committee NSW Health stated:

> Compliance with the NSW Health role delineation guidelines requires that patients undergoing certain complex procedures or with particular comorbidities receive the procedures they require in a hospital with the appropriate level ICU. Preoperative screening would be used to ensure that elective surgery patients with potential comorbidities were referred to another hospital if required before surgery if indicated by their clinical condition.[168]

4.128 The Chair of the Surgical Services Taskforce, advised that more major surgery such as major vascular surgery and thoracic surgery should not be done without the back-up of a large intensive care unit. In his view a two-ventilated bed unit, which Mona Vale is at present, was

164 Dr Boland, Evidence, 28 February 2005, p62.

165 Dr Nolan, Evidence, 8 March 2005, p42.

166 Evidence, 21 March 2005, p11.

167 Dr Boland, Evidence, 28 February 2005, p64.

168 Correspondence, from Director General, NSW Health, to Committee Chair, 16 March 2005, p2.

not an appropriate place to do major surgery. Dr Cregan did believe that a HDU would enable a hospital to do between 80 to 90 per cent of surgery.[169]

4.129 The Committee was unable to obtain more specific information from NSW Health on what type or specific procedures would be precluded. It became clear during evidence from Professor Malcolm Fisher that this information apparently was, if not still, available at one time:

> There is a document of which I am aware that relates what surgical services you can safely provide in relation to critical mass and intensive care services. That is an old document now, and I believe it is being revised.[170]

4.130 The document referred to by Professor Fisher was the role delineation document of 2002, which outlines the background services required to support a particular level of activity within a hospital. The Committee was advised this document was deficient in that it did not adequately address the issue of staffing.[171]

Recommendation 3

That NSW Health publish information, when it becomes available, outlining the background services required to support particular levels of activity within hospitals.

4.131 Dr Stephen Nolan presented an analysis of Mona Vale ICU 2003-2004 admission figures from the hospital's operating theatres and suggested that if Mona Vale was to keep its current surgical load and profile then it could expect to be required to transfer 16 surgical patients to Manly per year for longer term ventilation.[172] It appears that Dr Nolan was suggesting that the surgeons and anaesthetists could maintain their current surgical profile if they were prepared to operate while knowing that on a certain number of occasions a patient would require immediate post-operative medical transfer. The Committee recognises that many doctors would not be comfortable with being part of a process that has a known distinct possibility of resulting in a lack of continuity of care.[173]

4.132 Indeed the Committee heard evidence that suggested with respect to any individual surgical procedure, in consideration of patient safety, when it is known or assessed that the patient will require post-operative ventilation that procedure should not be performed at a hospital that does not have the capacity to provide the required ventilation service. This decision will rest with either the surgeon or the anaesthetist collectively or separately.[174]

169 Dr Patrick Cregan, Chair, Surgical Services Taskforce, Evidence, 21 March 2005, p11.

170 Professor Fisher, Evidence, 21 March 2005, p12.

171 Dr Cregan, Evidence, 21 March 2005, p25.

172 Evidence, 8 March 2005, p43.

173 Correspondence, from Dr S Boland, to Committee Chair, 18 April 2005, p2.

174 Evidence, 8 March 2005, p28.

4.133 Professor Malcom Fisher indicated during his evidence that following the change in intensive care back-up at Mona Vale Hospital there should be a reorganisation of surgical activities and that the surgeons from Mona Vale should do their major cases in another hospital with safer facilities.[175]

4.134 The Convenor of the surgeons and anaesthetists of Mona Vale Hospital provided a statement giving an indication of the scope of work that would be affected by the downgrading of the hospital's ICU:

> Some procedures are done on the basis that an Intensive Care bed is available to meet their post operative needs. Cardia, Thoracic and Neurosurgery fits well into this category.
>
> For a busy General Metropolitan Hospital like Mona Vale, major vascular, oesophageal and liver and pancreatic surgery as well as complicated colorectal surgery would fit this category. Some head and neck surgery done at district hospitals would also fit into this area.
>
> On other occasions it is not the severity of the surgery but the age and general fitness of the patient that mandates an ICU bed being available for the patient's safe care even after relatively minor surgery. This is particularly applicable in a hospital like Mona Vale that serves so many elderly and infirm patients who live in nursing homes and other aged care facilities.[176]

4.135 It is unclear which surgical procedures currently being performed at Mona Vale will no longer be able to be performed if the ICU is downgraded. Aside from those specific procedures that will as a matter of policy no longer be considered, there will be individual cases where procedures will not be performed on the basis of preoperative screening of patients. The Committee believes the impact may be much more significant than what is currently predicted by NSW Health.

Impact on Registrar training

4.136 The downgrade of the hospital's ICU will have the direct result of reducing the level and number of surgical services able to be provided. A possible flow on effect is the loss of Registrar trainees. There is concern that any such loss will further damage the overall operation of the hospital.

4.137 The Committee was told that Registrar basic training and advanced training is generally attached to positions with exposure to a full range of clinical experience. It is argued that any reduction in the range of clinical services performed, as a result of the downgrading of the ICU, will mean that Mona Vale Hospital will no longer be able to provide the necessary experience and training opportunities with the inevitable outcome that the trainees will be withdrawn.[177]

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175 Professor Fisher, Evidence, 21 March 2005, p6.

176 Correspondence, from Dr Boland to Committee Chair, 18 April 2005, p1.

177 Dr Boland, Evidence, 28 February 2005, p66; Correspondence, from Dr Boland, to Committee Chair, 18 April 2005, p2.

The indirect impact on resources – tying up of anaesthetists

4.138 There is a concern among the medical staff at Mona Vale that the loss of intensive care staff will result, from time to time, in the inability of anaesthetists to respond to other emergencies within the hospital. The Chairman of the Medical Staff Council described a scenario of how this problem could unfold:

> However, as an obstetrician, the problem for me is that if a patient that Dr Boland, who was here previously, has operated on and they cannot extubate, they cannot take the tube out, and the patient has to go to the intensive care unit to be looked after properly, who is going to look after that patient? The responsibility falls on the anaesthetist who intubated the patient in the first place. They have to look after that patient.
>
> If that anaesthetist is responsible for that patient in the intensive care unit and I have a patient upstairs who needs a caesarean in 30 minutes—and that transfer to Manly hospital is going to take longer than 30 minutes, I can guarantee it—we are in a situation where a baby could die or a mother could die, all sorts of things could happen in the emergency department, and that is only one example. What a hospital like Mona Vale needs, for a case where the tube cannot be taken out, is someone who is taking responsibility for that patient. At the moment, the intensive care staff take the responsibility. An intensive care specialist is on call for that type of patient as well as for patients in the intensive care department already. If we lose an intensive care department at Mona Vale, even if it becomes a high-dependency unit where they cannot look after these ventilated patients, if a patient needs a transfer, while that patient needs the transfer the rest of hospital essentially closes down.
>
> …We lose the expertise of the anaesthetist, and if that is the only anaesthetist on call how can he help with the operation, with the other person in the emergency department or do my caesarean section, or how can he go to a cardiac arrest if someone has an arrest on the medical ward?[178]

4.139 Dr Jollow's concerns appear to be valid. The Committee heard evidence regarding the arrangement between Mount Druitt and Blacktown Hospitals, which has been in place for over twelve months. Representatives from NSW Health cited as a success this model whereby Mount Druitt now has a HDU and transfers patients requiring ventilation to Blacktown. Protocols are in place for the rapid retrieval of patients requiring intensive care management from the HDU and ED at Mount Druitt, with intubated post-operative patients able to stay in the HDU for up to four hours under the care of the anaesthetists.[179]

4.140 NSW Health acknowledge that there will be occasions when despite every best intention of the anaesthetist and preoperative screening, a patient will require post operative ventilation. NSW Health were at pains to emphasise that these situations will not result in that particular patient's safety being compromised, as the management of airways managing ventilation intraoperatively is the core business of anaesthetists. The Committee does not dispute this.

4.141 However, the Committee is concerned that it did not hear how the model addressed the loss of the anaesthetist to the wider hospital environment during such periods. Of particular

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178 Dr Jollow, Evidence, 28 February 2005, p71.

179 Ms Needham, Evidence, 8 March 2005, p26.

concern is the fact that it will be impossible to predict those instances when scarce anaesthetist resources will need to be redirected to cover the lack of on-site intensivist staff.

Conclusion

4.142 The Committee understands that the Northern Sydney Area Health had made a commitment to maintain services at their present levels at both Manly and Mona Vale Hospitals until such time as the new Northern Beaches Hospital was built. It is understandable that quality and patient safety issues would take precedence over any such commitment.

4.143 It has been generally agreed that intensive care services were unsustainable in their present form and that a solution was needed in a more immediate timeframe than the construction of a new hospital. However, it cannot be argued that only intensive care services will change as a result of the GMCT interim proposal.

4.144 If either Mona Vale or Manly Hospital has its current ICU downgraded to a HDU, there will be a significant effect on the level of service that the hospital would be able to provide.

4.145 The Committee notes that the Greater Metropolitan Clinical Taskforce Recommendations Implementation Group was established to consider implementation of the GMCT resolution or an agreed alternative that would provide the same level of sustainability for Intensive Care Services until such time as the new Northern Beaches Hospital is built. The alternatives are considered below.

Alternatives to the GMCT proposal

4.146 In recognition of the lack of a common view between the surgeons and anaesthetists of Mona Vale and the GMCT an implementation group was established to consider how to implement either the GMCT recommendations or an agreed alternative. Dr Stephen Christley advised the Committee at the public hearing on 21 March 2005 that all surgeons and relevant stakeholders have been invited to attend meetings of this group, and that it was working through from a clinical perspective what is the best way to deal with this interim proposal. Dr Christley further advised that to date no proposal as an alternative to the GMCT proposal had been advanced and considered sustainable, but that he was awaiting the outcome of that process.[180]

4.147 NSW Health subsequently advised the Committee that meetings of the GMCT Implementation Group were held during February and March 2005. [181] At the meeting on 23 March, two days after the evidence provided by Dr Christley, the group discussed the following four options for intensive care services:

- *Option 1*. Implement the GMCT proposal in its original format – Manly becomes a level 5 Unit and Mona Vale becomes a level 3 (HDU) Unit.
- *Option 2*. Implement the GMCT proposal, with an enhancement of ICU services at Mona Vale to be maintained and operate as a level 4 Unit.

180 Dr Christley, Evidence, 21 March 2005, p4.

181 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p7.

- *Option 3*. Implement the GMCT proposal, with enhanced on site intensivist cover at Mona Vale and agreement to transfer ventilated patients to the level 5 service at Manly.
- *Option 4*. Status quo – do not implement the GMCT proposal.

4.148 No proposal was put forward for locating the level 5 ICU at Mona Vale and the level 3 (HDU) at Manly. Members of the Implementation Group reportedly have expressed differing views about the four options. There was consensus that option 4 was not viable.

4.149 In correspondence dated 13 April 2005 NSW Health advised the Committee that the Implementation Group had held its final meeting and was currently finalising its final report.

4.150 Option 2 was forwarded following a meeting between representatives of management, intensivists and surgeons and anaesthetists from Mona Vale Hospital. NSW Health has reservations regarding option 2. Its concern is that the proposal is reliant on the ability to recruit and retain sufficient qualified senior and junior medical and nursing staff to a five bed unit of insufficient critical mass of patients to demonstrate and maintain staff expertise.[182] Professor Malcolm Fisher expressed similar reservations while giving evidence before the Committee.[183]

4.151 It appears to the Committee that these reservations are based on the premise that there would be two quite distinct and separate units, where staff would be permanently assigned to either one unit or the other. This premise appears to run contrary to the desired outcome of a single integrated Intensive Care Service. It also appears to run contrary to the advice from NSW Health on how the proposed level 5/level 3 HDU model would be staffed.

4.152 The Committee understands that the concern of the clinicians at Mona Vale is that the hospital should have the on-site capacity to deal with cases that require intensive care when they arise. This is so they can operate in a safe environment and that other clinical resources are not diverted to looking after these cases. Patients requiring longer term ventilation could be transferred to the level 5 Unit at Manly, keeping the ventilated beds at Mona Vale in reserve.

4.153 The Committee is of the view that there must be scope for examining whether the intensivist cover at both hospitals could be drawn from a single larger pool of staff, with all the intensivists and other staff rostered, on an equitable basis, to provide cover at the smaller, less busy ICU. Such an arrangement would be in accord with the 'one service – two campuses' view of how the system should be perceived.

4.154 The Committee noted the example of Dr Stephen Nolan, one of the current VMO intensivists at Mona Vale. In addition to his role at Mona Vale, Dr Nolan provided on call intensive care cover at Manly and, in order to work in a critical mass of clinicians and patients, also travelled to Blacktown Hospital to work in its ICU. Dr Nolan also works as a General Physician on call for both Mona Vale and Manly Hospitals.

182 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p8.

183 Professor Fisher, Evidence, 21 March 2005, p6.

4.155 It was suggested to the Committee that some suitably qualified or experienced clinicians might be attracted to providing cover at a less busy unit, as they may also have other interests besides intensive care, such as working as general physicians.[184]

4.156 At present both Manly and Mona Vale Hospitals are funded to provide full coverage for their respective ICUs. The Committee is not aware of the details of the required resources and staffing that were included as part of the proposal that formed option 2. The Committee believes that cost would and will not be an impediment to this option being implemented, given the comments of the Director General of NSW Health while giving evidence to the Committee.[185]

4.157 The Committee heard from representatives of NSW Health that they anticipated little difficulty in attracting new staff to a new level 5 ICU that had a critical mass of patients and a reasonable roster. The Committee also heard of the trend both overseas and in Australia of the increasing need for ICU beds and ICU Units to accommodate the ageing population.[186]

4.158 NSCCH is now at the commencement of creating the intensive care services team that will eventually be located in the new Northern Beaches Hospital. The Committee believes that in the interim it should be seeking to recruit enough staff to support Manly as a level 5 ICU Unit and Mona Vale as a level 4 ICU Unit.

Recommendation 4

That NSW Health and NSCCH implement a modification of the GMCT proposal with an additional enhancement of ICU services so that Mona Vale Hospital ICU is maintained and operates as a level 4 Unit; Manly Hospital ICU becomes a level 5 Unit; with a single Northern Beaches Department of Critical Care.

The impact of announcing the proposal to downgrade Mona Vale ICU on selecting the site for the new Northern Beaches Hospital

4.159 There is a strongly held belief among some sections of the Northern Beaches community that NSCCH has for some time shown a lack of support for Mona Vale Hospital. People believe that services and amenity at Mona Vale have deliberately been allowed to be run down in order to weaken any argument that it is a suitable site for the new Northern Beaches Hospital.

4.160 Many viewed the announcement of the GMCT Interim Proposal in December 2004, which favours Manly Hospital over Mona Vale with respect to the location of the level 5 ICU, as another example of this deliberate disfavour. This was particularly the case given the long anticipated decision on the site of the new hospital was believed to be close to being made.

184 Dr Jollow, Evidence, 28 February 2005, p70.

185 Ms Robyn Kruk, Director General, NSW Health, Evidence, 21 March 2005, p24.

186 Professor Fisher, Evidence, 21 March 2005, p22.

4.161 It was put to the Chairman of the GMCT that the decision regarding the downgrade of the Mona Vale ICU may have effectively pre-empted any decision-making about the site of the new level 5 hospital:

> No, definitely not. We made that very clear. We are concerned with the safety of patients and the quality of care given to them in the next six years; for example, upgrading Mona Vale emergency department for $750,000 and employing more staff. We have suggested more of our staff should be at Mona Vale. All those things will not affect the new hospital, wherever it is. We are talking about the next six years, and that is the urgent problem as far as I am concerned.[187]

4.162 While NSCCH have made it very clear that they do not currently consider Mona Vale to be the best available site, they have also maintained that a decision has not yet been made and that Mona Vale, as one of the final six potential sites, could still be nominated as the preferred site following the Value Management Study that was announced in April 2005.

4.163 However, during evidence when the CEO of NSCCH was asked for the reason why Mona Vale was not considered as the location of the level 5 ICU, Dr Christley replied that this would result in two disruptions to the intensive care team at Manly rather than one. This indicates that NSCCH does not expect Mona Vale to be selected as the site for the new level 5 hospital, and also implies that this view may have affected the decision making of the GMCT.

4.164 The Committee is willing to accept that the GMCT decision was made separate to any consideration of the site of the new hospital. However it can be argued that the announcement of the decision and the anticipated effect on the reduction of services that would occur as a result of the decision, has served to diminish any argument in favour of Mona Vale.

4.165 Similarly, the late decision by the Chairman of the GMCT not to proceed with the centralisation of maternity services at Mona Vale has also had this effect. It will also likely affect any consideration of what services will be provided at Mona Vale should it assume the unspecified role of the second, complementary hospital on the Northern Beaches.

4.166 It has been suggested that the announcement of the GMCT proposal should not have been made prior to the final decision of the site of the new hospital. The Committee acknowledges the view that the problems currently faced by intensive care services on the Northern Beaches required immediate attention. However, the need for subsequent further consultation and consideration has shown that the announcement may have been made prematurely.

The influence of majority clinician preferences on planning decisions

4.167 In their opening statement to the Committee, Pittwater Council argued that the debate about health services has been dominated by politics, power and influence. The Council believed that a group of clinicians based at Manly Hospital were being rewarded by NSCCH for their public support of the Area's position in the debate:

[187] Professor Goulston, Evidence, 8 March 2005, p23.

> It is about pandering to a small group of doctors and nurses at Manly, particularly when considering the issue of where a level five intensive care unit [ICU] should be placed.[188]

4.168 Dr Patrick Cregan, who chaired the Metropolitan Hospitals Group of the Greater Metropolitan Services Implementation Group, which became the Greater Metropolitan Transition Taskforce (GMTT), which was the father of the GMCT, took a similar view but believed claims of unreasonable self-interest should be directed elsewhere. Dr Cregan believed "a small group of people in a relatively privileged position" had failed to acknowledge that the GMCT was seeking to address generic problems which applied to all metropolitan hospitals and which were not just unique to Mona Vale.[189]

4.169 During evidence Dr Stephen Nolan, a VMO intensivist at Mona Vale Hospital who also provides 'as needed' cover to Manly and who resides at Palm Beach, articulated the overriding factor that should inform health planning:

> In my mind there are misconceptions from both the community group and clinicians on why Manly was chosen as the preferred site for the ICU. I support this decision, despite the fact that I need to travel further to work. Safety of, and quality of service to patients, is always far more important [than any] inconvenience it might bring to clinicians.[190]

4.170 Nevertheless, during the inquiry it became clear that any decision is ultimately reliant upon the consent of clinicians, regardless of whether opposing parties might argue it to be right or wrong. Any new model of health service delivery is doomed to fail if it cannot attract the required clinical staff.

4.171 The difficulty arises when there are opposing camps of clinicians that hold irreconcilable views on whether or not a proposed model does indeed improve safety and service to patients.

4.172 On a number of occasions during the public hearings it became clear that the factor that did play a significant role in deciding to locate the level 5 Unit at Manly was that Manly Hospital had more intensivist staff than Mona Vale:

> Mrs HUDSPITH**:**…There are differences because of the personalities and an example of this is the difference here with the two intensive care units, the greater mass of the personalities, the clinicians, are based at Manly; hence the service will go to Manly. If you have not got the clinicians, the service cannot be provided and that, to me, is quite simply what is happening with the Mona Vale end. You cannot get the doctors, therefore the service will just gravitate to where the staff are, and it is the same with any of the services.
>
> The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that not the antithesis of planning?

188 Mr Godfrey, Pittwater Council, Evidence, 8 March 2005, p51.

189 Dr Cregan, Evidence, 21 March 2005, p25.

190 Dr Nolan, Evidence, 8 March 2005, p41.

> Mrs HUDSPITH: That is right, but it is also a matter of personalities and people, where they choose to work.[191]

4.173 During the public hearing on 8 March 2005, the Co-chair of the NSW Intensive Care Implementation Group was asked when planning for the best location for an intensive care unit what other issues, apart from available clinicians, were measured. Ms Needham advised that while a whole range of issues are considered the one that cannot be escaped from is the need to have staff available – as this is what ensures patient safety:

> I guess you want to see what the demand is, where your patients are coming from, and what types of patients they are. As I said earlier, you need to understand the equipment you require. There are a lot of variables. But safety is the one key thing that we cannot escape from. It is about having on deck the people that know what they are doing. Whilst you are looking at a whole range of situations, safety, and the ability of the work force to look after those patients, is the key.[192]

4.174 The Chairman of the GMCT advised that the members of that Committee were there because they had a breadth of vision outside their own department, outside their own hospital, outside their own area. Professor Goulston advised that this was necessary as the GMCT was seeking to break down the fiefdoms that had been traditionally worked under for years:

> Our key principles – and we have stuck to these all the time – are that things should be population based and not based on hospitals and fiefdoms. So we have tried to break down the fiefdoms between say, Westmead and Prince Alfred, North Shore and St Vincents. We have tried to get clinicians to work together.[193]

4.175 The GMCT proposal may very well have been developed by experts with no affiliation with either Manly or Mona Vale Hospital, and without regard to any element of fiefdom and sense of rivalry that may exist between those two hospitals. However, it appears the decision on how the proposal should be implemented, that is where the level 5 unit should be located, did have to take into account, and was influenced by, that very situation:

> We talked to intensivists and they agreed that they would staff both hospitals. They agreed that they would provide cover at both hospitals. That was a big step forward. There is a history relating to and a lot of baggage between those two hospitals.[194]

4.176 Ms Deborah Carter, a registered nurse at Mona Vale, related how nurses at that hospital were informed of the agreement on the part of the intensivists. It appears the manner in which this was reported to staff at Mona Vale did little to dampen any sense of rivalry and of one group prevailing over another:

> The other thing I am feeling very passionate about is that when Dr Goulston did finally talk to the nursing staff last year, he said to us directly—I was with the group of intensive care nurses speaking with him—that the doctors from Manly intensive care

191 Evidence, 28 February 2005, p86.

192 Ms Needham, Evidence, 8 March 2005, p30.

193 Professor Goulston, Evidence, 8 March 2005, p14.

194 Professor Goulston, Evidence, 8 March 2005, p17.

> will come to our hospital to work if we are downgraded to a high-dependency unit. Prior to that they refused to work in our hospital at all.[195]

Conclusion

4.177 In many planning respects NSW Health is perennially dependent upon the availability and willingness of clinicians to provide services where they are needed. This is a problem for NSW Health with respect to health services throughout the State. The Committee concludes that with respect to the GMCT proposal to locate the level 5 ICU at Manly Hospital and the level 3 HDU at Mona Vale Hospital, this decision was influenced to a significant degree by the views of the Northern Beaches intensivists, the majority of whom were located at Manly Hospital, and by the difficulties in attracting intensivists to work at Mona Vale Hospital.

195 Ms Deborah Carter, Registered Nurse, Mona Vale Hospital, Evidence [in camera subsequently published], 8 March 2005, p7.

Chapter 5 Community consultation regarding proposed changes to health services on the Northern Beaches

This chapter examines the level of consultation that has taken place with respect to two issues. Firstly, the overall long-running consultation process regarding the delivery of health service on the Northern Beaches up to the 18 March 2005 announcement of the current Value Management Study (VMS) process to determine the preferred site for the new Northern Beaches Hospital. The VMS process itself is examined in chapter 6.

Secondly, examination is made of the consultation that took place regarding the December 2004 Greater Metropolitan Clinical Taskforce (GMCT) interim proposal to rationalise the intensive care services at Manly and Mona Vale Hospitals.

This chapter also discusses how the manner in which the consultation process and the overall debate on health services for the Northern Beaches has been handled has led to severe divisiveness between sections of the Northern Beaches community and among the medical community. This has resulted in an environment that has fostered actual and a perceived fear of intimidation.

Consultation on the reconfiguration of health services on the Northern Beaches

5.1 If measured solely in terms of volume, the level of community consultation in relation to the proposed changes to health services on the Northern Beaches is beyond compare:

> We have had more extensive community involvement than any other planning process you can point to in health in New South Wales, and probably the world.[196]

5.2 Such extensive consultation and planning has come at a price. If the consultation is measured in terms of results and community acceptance it does not appear that Northern Sydney Central Coast Health (NSCCH) has got value for money:

> The dollar value of the PFP was around $700,000. That includes all consultancies, of which a substantial amount was community consultation. There was then a further $200,000 allocated for site identification and there has been a further allocation, the precise detail of which escapes me at the moment.[197]

5.3 The consultation process commenced in 1999. To date, the consultation process has realised one firm result that has general community support: the two-hospital one network strategy for the Northern Beaches. This was announced by the then Minister for Health, the Hon Craig Knowles MP, in September 2002. Since that time consultation and planning has focussed on where these two hospitals should be located and what role each should have.

196 Dr Stephen Christley, CEO, Northern Sydney Central Coast Health (NSCCH), Evidence, 28 February 2005, p15.

197 Dr Christley, Evidence, 28 February 2005, p20.

5.4 The consultation process was the subject of much criticism during the inquiry. Pittwater Council and the Save Mona Vale Hospital Committee (SMVHC) both consider the consultation process to have been flawed and biased. The similar submissions from both of these organisations critique various elements of the different stages within the consultation process. The Committee also heard evidence from other participants in the consultation process who were critical of the approach taken by the SMVHC during the process.

5.5 The following sections briefly describe the different stages in the consultation process and some of the criticisms that have been raised by various participants. For the purposes of this report use is made of the definition of the various stages as contained within the submission from the NSCCH.

Community consultation regarding the Acute Care Services Framework (1999)

5.6 In 1999 Northern Sydney Health (NSH) embarked on the development of an Area Acute Services Framework, to determine how acute hospital services should be organised across the Area into the future. Consultation regarding this framework commenced with a meeting with peak consumer groups, on advice from the NSH Community Consultative Committee. A communication and consultation plan was guided by advice sought from this meeting. A range of consultation strategies was implemented throughout the development of this framework. The establishment of clinical advisory groups for clinical speciality areas was a key consultation strategy of the framework throughout 1999. Clinical advisory groups convened meetings with a number of consumer advocacy and support groups to assist in the development of recommendations for their specialty areas.[198]

Community consultation regarding the Strategic Resources Plan (2000)

5.7 In January 2000 NSH developed a Strategic Resources Plan (SRP), which incorporated the Acute Care Services Framework and identified recommended distribution of facilities across NSH until 2011. A consultation strategy was prepared in January 2000 to guide its development and strategies proposed were implemented throughout 2000. This consultation strategy was further enhanced later that year by the appointment of consultants, Gutteridge, Haskins and Davey (GHD) to design and implement consultation strategies responsive to community issues and needs. These strategies were implemented throughout the period November 2000 to February 2001 and included a random telephone survey, a representative Health Summit, and community newsletter and survey.[199]

5.8 During this stage of the consultation process NSH had determined that there were three major options for the delivery of future health services in the area:

- Option A: maintain the location of Manly and Mona Vale Hospitals and provide level 4 health services across both sites.
- Option B: concentrate acute level 4 heath care services at Mona Vale Hospital with community health and medical clinics available at the Manly Hospital site.

198 Submission 2230, NSCCH, p49.

199 Submission 2230, NSCCH, p49.

- Option C: build a new hospital in a central location to the population to provide level 5 hospital care with current hospital sites used for community health and medical clinics.[200]

5.9 The report prepared by GHD was included as Appendix 4 to the submission from NSCCH. That report describes the three strategies that comprised the consultation process:

> A random telephone survey, conducted by AC Neilson, of a sample of residents of the northern beaches to provide some base-line measures of information and attitudes at the beginning of the consultation process.
>
> A deliberative poll, called the Northern Beaches Health Summit aimed at exploring, in detail the complex health issues involved in the planning process with a representative sample of the northern beaches community.
>
> A community-wide information and feedback process aimed at involving all interested residents.
>
> More than 18,000 residents of the northern beaches participated in the consultation program. 503 people were involved in the telephone survey; 37 of these attended the Health Summit and more than 17,000 items of written feedback were provided by the wider community.[201]

5.10 The telephone survey took place in November 2000. It found that of those surveyed 71.5% preferred maintaining both existing hospitals, while 21.1% preferred building a single new acute care hospital in a central location. The SMVHC were critical of this survey, in particular they questioned why only two options (maintain both existing hospitals or build a single new hospital) were given for consideration to respondents.[202]

5.11 The Health Summit was held in February 2001. GHD report that by the end of this two-day process, 33 of the 37 people attending said that they would support having their acute care hospital services delivered from a single hospital in the future. Of these 6 preferred the site of the hospital to be at Mona Vale, while 27 preferred the hospital to be at a central location (4 people being undecided).

5.12 The SMVHC argued that the Health Summit process was flawed due to the small sample of participants and the manner in which information was presented:

> Only 37 people turned up to participate in the weekend long seminar (out of 60 invited). For such a small sample to have any meaning it must be randomly chosen. Only those who could afford the time to attend this weekend summit participated. The summit was conduced behind closed doors with observers and the press shut in another room with no contact allowed between them and participants.

200 Submission 2230, NSCCH, Appendix 4, p6.

201 Submission 2230, NSCCH, Appendix 4, pp6-7.

202 Submission 723, Save Mona Vale Hospital Committee (SMVHC), p21.

> The speakers, who were all health professionals, presented a lecture advocating NSH's preferred option of one hospital on a new site. Questions were limited and requests for additional information were ignored.[203]

5.13 Eighty-eight thousand copies of the community newsletter and survey were distributed in late January 2001. Of these 85,000 were distributed by Australia Post via a letter box drop with the remainder being sent out on request and distributed though local libraries. The deadline for feedback was 26 February 2001. GHD received 17,763 responses that were processed and analysed.[204] For the three LGAs of Manly, Warringah and Pittwater the return rates were 10.2%, 11.7% and 25.9% respectively.

5.14 The results of the survey question relating to which option for delivery of health services was preferred was:

- 18% favoured option A – Manly and Mona Vale be maintained.
- 56% favoured option B – concentrate health care services at Mona Vale.
- 24% favoured option C – build a new hospital in a central location.

5.15 There is general agreement from all sides in this current debate that this stage of community consultation did not yield truly representative data upon which decisions could be soundly based.

Community consultation regarding the Procurement Feasibility Plan (2001-2002)

5.16 Later in 2001, NSH was allocated funding to develop a procurement feasibility plan (PFP) for health services on the Northern Beaches. To ensure a transparent and comprehensive consultation strategy, NSH engaged another consultant, Manidis Roberts, which had considerable experience in community consultation processes for major public sector planning initiatives. This company facilitated two consultation workshops attended by clinicians, residents of the northern beaches nominated by the three local councils, consumer advocacy group representatives, and health services managers and planners.

5.17 A comprehensive consultation strategy followed, including the establishment of the Northern Beaches Community Consultative Health Planning Group (NBCCHPG) and a range of strategies for broader community participation. These included:

- Telephone surveys regarding health service options.
- Advertisements and calls for public submissions regarding health service options and criteria to assess them.
- NBCCHPG-led consultation forums and presentations to community groups.
- NBCCHPG-led public displays.

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203 Submission 723, SMVHC, pp22-23.

204 A further 332 items were received but were not processed for a range of reasons, see Submission 2230, NSCCH, Appendix 4, p33.

- NBCCHPG involvement in value management workshop and Options Workshop (this was held in September 2002 and involved the representatives from the Manly and Warringah LGAs in determining a preferred location for the new, redeveloped Manly Hospital).
- NBCCHPG membership on Northern Beaches Health Service PFP Steering Committee.[205]

5.18 Manidis Roberts prepared three reports that detailed the strategies and outcomes of the consultation process that occurred throughout the course of the PFP development from February to November 2002. These reports which are accessible from the NSH website are:

- *Northern Beaches Health Services Procurement Feasibility Plan: Phase 1 Community Involvement Report June 2002*
- *Community Attitudes Report on Health Services: Manly and Warringah Local Government Areas November 2002*
- *Community Attitudes Report on Health Services: Pittwater Local Government Area November 2002*.

5.19 NSCCH argue that the consultation process was ahead of contemporary practice for community participation in health service planning. NSCCH stated that the draft PFP recommendations had the written support of all three communities represented on the NBCCHPG. The draft PFP was submitted to NSW Health in November 2002. It recommended

- redevelopment of Manly Hospital in the Brookvale area
- upgrade of Mona Vale Hospital
- construction of new community health centres, including one co-located with the redeveloped Manly Hospital and one co-located with Mona Vale Hospital.[206]

5.20 Funding was subsequently allocated for the analysis of potential sites for the new Manly Hospital in the Brookvale area. This analysis occurred in 2003. Initially this process was looking at the site for the redeveloped Manly Hospital that would cater to the population of the Manly-Warringah residents.[207] In 2004 the Minister for Health announced that the Dee Why Civic Centre was the preferred site for the new Manly Hospital. Following that, more detailed analysis of the Civic Centre site was undertaken during 2004.

5.21 NSCCH advised that site analysis reports have been placed on the NSH website and information about the findings published in the local media. In their submission NSCCH noted that the Civic Centre site was still the subject of a conservation management plan and that other potential sites were being examined in the interim.[208]

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205 Submission 2230, NSCCH, p50.

206 Submission 2230, NSCCH, p50.

207 *Proposed new Manly Hospital site selection report – August 2004*, available from NSH website at http://www.nsh.nsw.gov.au/majplanning/northbeach/choosingsite.

208 Submission 2230, NSCCH, p50.

5.22 At the first public hearing of the inquiry on 28 February 2005 the CEO of NSCCH, Dr Stephen Christley summarised the outcomes of the consultation process to that date:

> Through extensive community consultation we gained agreement for three outcomes: to rebuild Manly hospital in a new location in the Brookvale area; to upgrade Mona Vale Hospital on its current site; and to build new community health facilities on the two hospital sites with the possibility of a third site [if that] is required.[209]

5.23 Later Dr Christley advised that Mona Vale Hospital was one of the six sites currently being considered for the location of the redeveloped Manly Hospital. The current consideration of these final six sites, and the community consultation and involvement that will form part of that process, is examined in Chapter 6.

5.24 At this hearing Dr Christley explained why there was a desire to move away from the description of a 'rebuilt Manly Hospital':

> The area health service's planning says that when the site of the new Manly Hospital is identified – and people are very keen that we call it the new "northern beaches hospital" because it will involve clinical staff from both Manly and Mona Vale in its operation – at that point in time the clinical services planning will take place to identify the services at the new Manly/northern beaches hospital and the existing but physically upgraded Mona Vale Hospital.[210]

5.25 These comments have caused some concern among supporters of Mona Vale Hospital. The first cause of concern is that despite NSCCH on the one hand stating that Mona Vale Hospital is on the list of six sites being considered as the location for the new Northern Beaches Hospital, it is at the same time indicating that future clinical services planning is predicated on Mona Vale not being selected. Supporters are also concerned that the decision to call the new hospital the Northern Beaches Hospital indicates that NSCCH is working towards a de facto one major hospital outcome with a much reduced clinical role for Mona Vale.

5.26 Both Pittwater Council and the SMVHC question the primary conclusion NSCCH has drawn from the consultation process, namely that the majority of the community supported the development of new Northern Beaches Hospital in the Brookvale area.

5.27 As part of the consultation process Manidis Roberts sent a newsletter to all Northern Beaches households (85,000) in August 2002. The newsletter requested feedback on community preference for one of three options:

- Metro South option: Manly Hospital re-built as a new metropolitan general hospital at Brookvale or Frenchs Forest; a new community hospital on the Mona Vale Hospital site; and a network of community health centres.
- Metro North option: A new metropolitan general hospital on the Mona Vale Hospital site; Manly Hospital re-built as a community hospital in the Manly-Warringah area; and a network of community hospital centres.

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209 Dr Christley, NSCCH, Evidence, 28 February 2005, p6.

210 Dr Christley, Evidence, 28 February 2005, p14.

- Metropolitan General Hospital option: A new metropolitan general hospital at Brookvale or Frenchs Forest or Mona Vale; and a network of community hospital centres. Effectively this was a one hospital option for the Northern Beaches.

5.28 The survey received 2,409 responses. Respondents overwhelmingly supported the option of a new metropolitan hospital on the Mona Vale site and Manly Hospital rebuilt as a new community hospital in the Manly Warringah area:

- 91% supported the Metro North option
- 6% supported the Metro South option
- 3% supported the Metropolitan General (One) Hospital option.

5.29 In response to claims that it was ignoring the views of the community NSCCH noted that while many of the consultation mechanisms were useful in providing insight into the breadth of opinion they were not reliable predictors of the proportion of people in the broader population who hold one opinion over another.[211]

5.30 In its supplementary submission NSCCH drew the Committee's attention to the results of market research that was carried out by the market research company Taverner Research. This research obtained responses from a representative and proportional sample from each of the three LGAs that comprise the Northern Beaches area. This presentation of the results of this research is examined in some detail in Chapter 6. That examination shows that these results should not be used to support a categorical claim that the majority of the Northern Beaches population support a new general hospital in the Brookvale-Frenchs Forest area.

5.31 As noted at paragraph 5.17 a major component of the consultation process was the involvement of the Northern Beaches Community Consultative Health Planning Group (NBCCHPG). This group was comprised of five representatives from each of the three LGAs that comprise the Northern Beaches.

5.32 The NBCCHPG commenced meeting in Feburary 2002. However, in July 2002 the five Pittwater representatives withdrew from the NBCCPHG. At that time the Pittwater delegates gave the following reasons for their withdrawal:

- In the only public consultative forum held, and in mail responses to NSH, the public has overwhelmingly spoken up for new hospital facilities at Mona Vale and the Manly hospital sites.
- Many of the community consultative delegates from Manly and Warringah council areas are not reflecting the publicly stated views of their constituency in favour of upgraded hospitals on existing sites. There were also concerns about possible conflicts of interest in some cases.
- The delegates were being denied essential information, particularly concerning potential alternative sites for new hospitals.

211 Submission 2230a, NSCCH, p4.

- The Pittwater delegates were also disappointed that the Chairperson of the Community Consultative Group had failed to direct delegates regarding their obligations to reflect the views of the community, not just their personal views.
- The importance of equity of access, and sense of community ownership and involvement in health management, along with retention of important community assets, must be given priority.
- There was insufficient opportunity or time to adequately explore major new concepts for health service delivery on the Northern Beaches, and that NSH planners were clearly opting for old fashioned, and unimaginative solutions, such as bulldoze and build somewhere else.[212]

5.33 The NBCCPHG continued its work without any representation from Pittwater LGA. This included the September 2002 workshop that decided upon Brookvale as the preferred area in which to locate the redeveloped Manly Hospital. The Committee notes that NSH wrote to Pittwater Council seeking its views on further representation in the continuing planning process.

5.34 At the public hearing on 8 March 2005 the Committee heard evidence from two Warringah and one Manly representative involved in the NBCCHPG. Their view of the process was completely at odds with those of the Pittwater representatives, who participated for only the first five of the nine month period in which the NBCCHPG was involved in the process:

> It has been a very fair process, really. Northern Sydney Health organised it and we elected a facilitator who led the process, led the meetings, and he took our advice. We had votes at every meeting we had. We often had fortnightly meetings, it was supposed to be monthly, and we did a huge consultation with the community in August and September in the lead-up to putting options to the options workshop in September. It was a fair, focused process. It was very big and everybody knew about it. It was in the papers, it was very thorough.[213]

5.35 The NBCCHPG representatives who gave evidence were critical of the behaviour of the Pittwater representatives:

> …I would say that they tried to dominate the meetings….They would take up about three quarters of the available time and the rest of the time was taken up by the other ten candidates…It was obvious that they wanted to get the other ten people onside to make sure we were all going to vote for the new hospital to be established at Mona Vale. But the representatives of Warringah and the representatives from Manly would not buy that. We thought it had to have a more central position on the peninsula.[214]
>
> I have never in my life seen any group so biased as the northern end, to the point where, as I think Paul mentioned, meetings became almost intolerable in terms of being able to get any worthwhile activity.[215]

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212 Media release, *Pittwater delegates withdraw from health consultative group,* 11 July 2002.

213 Ms Christina Heath, NBCCPHG representative, Evidence, 8 March 2005, p34.

214 Mr Paul Couvret, NBCCHPG representative, Evidence, 8 March 2005, p34.

215 Mr Carlo Bongarzoni, NBCCHPG representative, Evidence, 8 March 2005, p38.

5.36 Mr Carlo Bongarzoni believed that in the initial stages the representatives from Pittwater were more concerned with ensuring that hospital facilities were retained at Mona Vale but that as the process moved forward the Pittwater representatives began to focus on arguing for the central hospital to be located at Mona Vale.[216] Mr Bongarzoni indicated there appeared to be irreconcilable differences between the members of the NBCCHPG:

> Mr BONGARZONI: Very early on in the piece, and without the others knowing, I went to talk with members of the Save Mona Vale Hospital Committee to try to get them to see that we were really all on the same side and that if we worked together we could probably reach some sort of consensus that would try to match some of their requirements. I am afraid that I failed horribly and miserably and the process did not improve.
>
> The Hon. TONY CATANZARITI: Do you think that the other group would be in the much the same position?
>
> Mr BONGARZONI: I am sure that they would say we were in the pockets of the chair and the Northern Sydney Area Health Service. If you content analysed anything they put in the paper and anything they said, you would realise that they are a professional and dedicated action group that has only one point to make.[217]

5.37 The Committee heard that the involvement of the NBCCHPG representatives concluded with its input into deciding which area would be the best site for the redeveloped Manly Hospital and did not extend to the current six sites that are under consideration:

> The sites were beyond our brief. We got as close as saying that it was either at Brookvale or Frenchs Forest. That was as close as they came. The reason given every time was this was because it was very sensitive material and there were a lot of people thinking, "Well up goes the value of my real estate if they're going to build a hospital". They said negotiations were strictly confidential and we were not to be informed of where the actual site was. So we read about it in the papers.[218]

5.38 Both Pittwater Council and the SMVHC argue that the Northern Beaches community's dissatisfaction with the consultation process throughout its various stages can be gauged by the number of public rallies that have occurred and community petitions that have been organised.

5.39 On 18 February 2001 over 6,000 people attended a rally at Pittwater Rugby Park that was conducted by the SMVHC. Those present overwhelmingly called for the retention and upgrading of Mona Vale Hospital. In addition over 15,000 people signed a petition asking the State Government to retain and upgrade Mona Vale Hospital.[219]

5.40 Pittwater Council believe that these public displays of community preference have had a positive effect:

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216 Mr Bongarzoni, Evidence, 8 March 2005, p35.

217 Evidence, 8 March 2005, 38.

218 Mr Couvret, Evidence, 8 March 2005, p38.

219 Submission 1102, Pittwater Council, p18.

> Following the second phase of consultations the community was again extremely concerned that NSH and the State Government were still committed to a single centralised hospital strategy for the northern beaches. In response to this the SMVHC with the support of Pittwater Council organised a rally for late September at Brookvale Oval.
>
> One week prior to the rally the Health Minister announced the two-hospital strategy for the Northern Beaches. The SMVHC proceeded with the rally at Brookvale Oval on Sunday 22nd September. This was an enormous success. The rally of over 3000 people unanimously endorsed a resolution that Mona Vale and Manly Hospitals be maintained as upgraded Metropolitan Hospitals, that the land on which they are situated is kept as public land and that there be community participation in the planning process. The rally also called on the Minister to immediately make funding available to the Northern Beaches.
>
> In addition to the rally, over 20,000 people signed a petition supporting "One Network – Two Hospitals".[220]

5.41 In September 2004, in response to the announcement that the Dee Why Civic Centre was the preferred site for the new Manly Hospital, a rally was held at the site. Two thousand people attended the rally and called upon the Administrator of Warringah Council and the NSW Minister for Health to abandon any plans for building a new major hospital on the Dee Why Civic Centre site. The rally also called upon the NSW Minster for Health to abandon any plans to sell land at either Manly or Mona Vale Hospitals.[221]

5.42 In November 2004, 3,000 people attended a rally at Village Park, Mona Vale organised by the SMVHC. Speakers at the rally included members of the SMVHC, the Hon Bronwyn Bishop MP, Mr John Brogden MP, Dr Stuart Boland, Ms Karen Draddy (Nurse Unit Manager, Maternity Services at Mona Vale Hospital) and Dr Tom Wenkart CEO Macquarie Health Corporation. The rally overwhelmingly supported the motion presented by the SMVHC:

- Intensive Care Services must be maintained and upgraded at Mona Vale Hospital.
- That agreements with the State Government that Mona Vale Hospital be significantly upgraded must be honoured.
- That Mona Vale Hospital is the perfect site for the new General Hospital on the Northern Beaches.

5.43 Three days after the rally, a delegation of over 100 people from the rally took copies of the motion to Parliament House calling on the Premier and the Health Minister to support the views of the community.[222]

Conclusion

5.44 The Committee believes that the consultation process was extensive but cannot be judged a success. It also believes that it is likely that all parties involved can be fairly criticised to varying degrees for entering into the consultation with predetermined positions. There is little utility in

220 Submission 1102, Pittwater Council, p22.

221 Submission 1102, p22.

222 Submission 1102, p30.

trying to determine where blame should be apportioned for actions in the past, particularly when the primary issue is still to be resolved. The only value in focussing on the failures of the consultation process in the past lies in ensuring they are not repeated.

5.45 The current consultation and assessment process for the identification of the preferred site for the new Northern Beaches Hospital is examined in Chapter 6. In that chapter the Committee makes recommendations that it believes should ensure that this final process is one that is open and transparent.

Consultation regarding the GMCT interim proposal for intensive care services

5.46 The Director General of NSW Health, Ms Robyn Kruk, advised that the fact that the GMCT was comprised of a group of clinicians and community representatives meant that it provided a good independent form of advice to both herself and to the Minister. Ms Kruk noted that with respect to the Northern Beaches the group was asked specifically to work with clinicians and undertake wide-ranging consultations regarding the best clinical configuration of services on the Northern Beaches.[223]

5.47 The GMCT interim proposal document strongly presents its recommendations as the result of clinician and public involvement, consultation and consensus. The Committee received submissions and heard evidence from some clinicians and members of the public that were particularly scathing of the consultation process leading up to the release of the proposal. In particular representatives of clinicians from Mona Vale Hospital claim that their views were not reflected.

5.48 The Convenor, Combined Surgeons & Anaesthetists, Mona Vale Hospital, Dr Stuart Boland, cited as an example of the poor consultation process the announcement of a series meetings to consider implementation of the GMCT proposals. These were to be held on the basis of generalised agreement with the proposals, when Professor Goulston and NSCCH knew very well that the position of the Mona Vale surgeons and anaesthetists was that of total opposition to the proposal.[224] Dr Boland also criticised the composition of the membership of the GMCT, particularly the inclusion of Northern Sydney Area Health representatives.[225] Clearly the ability for clinicians to speak frankly has the potential to be compromised by the presence of Area Health Service management.

5.49 The CEO of NSCCH, Dr Stephen Christley who is a member of the GMCT, advised that while he was a member he took the decision not to attend any of the meetings the GMCT had with clinicians as he felt that it was important that such meetings be separate from administrative discussions.[226]

5.50 There are 34 members of the GMCT. In evidence, Dr Boland stated that he had spoken to some of the people on the committee who said that they had never been involved in any of

223 Ms Robyn Kruk, Director General, NSW Health, Evidence, 28 February 2005, p8.

224 Submission 622a, Surgeons & Anaesthetists, Mona Vale Hospital, appendices 2 and 3.

225 Dr Stuart Boland, Convenor, Surgeons & Anaesthetists, Mona Vale Hospital, Evidence, 28 February 2005, p60.

226 Dr Christley, NSCCH, Evidence, 21 March 2005, p10.

the decision-making processes; and this led him to presume that there was an inner sanctum of the committee who made the final decisions.[227]

5.51 Representatives of the SMVHC were also critical of the process employed by the GMCT. Despite their initial expectations they were disappointed with the process and the outcome:

> …to be honest, we actually expected more from the greater metropolitan clinical task force. Their web site certainly illustrates that they create the illusion they do it better. The principles, as stated by their web site: transparency—there is just no detail at all in this proposal. It is a two-page document with no evidence and certainly there has been no communication with the community on this and I know there has not been open and honest communication with the clinicians. Clinician and consumer involvement has just been very, very poor.[228]

5.52 The SMVHC were also disappointed that they were not invited to be part of the implementation group convened to consider among other things, implementation of the GMCT proposal or an agreed alternative that would provide the same level of sustainability for intensive care services. Their request to attend was declined. Two community members were included as part of the group, one of whom attended the initial meeting.[229]

5.53 It appears that, notwithstanding the consultation process, many clinicians had not received enough information at the time of the proposal's release. The Chairman of the Mona Vale Medical Staff Council noted that as more information came to hand some clinicians were able to better assess the proposal:

> Almost universally, the feeling has been that this was a downward step for the hospital and that this should not occur. However, at different times, depending on how much information we were given and how much information we sought about the proposal, different persons have felt differently about whether they have been positive for it or not. I would have to say that the vast majority of senior medical staff at Mona Vale hospital are completely against the move. …At some points in time a small minority of the medical staff have thought that the proposals were reasonable, but the vast majority of people seem to think that the proposal as it stands is not reasonable and is untenable.[230]

5.54 The submission from the GMCT includes a list of the consultation meetings held by the GMCT with respect to Manly and Mona Vale Hospitals. Thirty-one consultative meetings are listed. The first meeting was held on October 8 2004 and the last on 15 December 2004. Nineteen of those meeting included participation by individual or groups of clinicians from Manly and/or Mona Vale Hospitals.

5.55 The GMCT proposal undoubtedly has the support of the intensivists from both hospitals. During the public hearing on 8 March 2005, Professor Goulston was questioned about the

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227 Dr Boland, Evidence, 28 February 2005, p61.

228 Mr Parry Thomas, Chaiman, Save Mona Vale Hospital Committee (SMVHC), Evidence, 28 February 2005, p50.

229 Mr Harvey Rose, Deputy Chair, SMVHC, Evidence, 28 February 2005, p55.

230 Dr David Jollow, Chairman, Mona Vale Hospital Medical Staff Council, Evidence, 28 February 2005, p68.

level of consultation with other clinicians from Mona Vale Hospital. Professor Goulston stated that the GMCT had had meetings with the medical staff councils of both hospitals and that both councils supported the proposal.[231] However, the Chairman of the Medical Staff Council, Mona Vale Hospital told the Committee that no such endorsement was ever given.[232]

5.56 In response to further questions regarding claims that only those clinicians in agreement with the proposal were consulted, Professor Goulston referred to a joint meeting of the Medical Staff Councils of both Hospitals that was held at Harbord Diggers Club on 11 November 2004. Professor Goultson advised that all clinicians from both hospitals were advised, but that the general surgeons from Mona Vale chose not to attend.[233]

5.57 This particular meeting was the only time a formal meeting of both medical staff councils was convened. The Committee received a confidential submission from a local physician who advised he received notice of this meeting by fax less than 24 hours prior to its commencement, notwithstanding that venue arrangements for the meeting had apparently been made ten days earlier.[234] The Convenor of the Mona Vale Surgeons & Anaesthetists in a letter to Professor Goulston noted that the meeting was poorly attended and that the views of that group that had previously been expressed were not presented at that meeting.[235]

5.58 The Committee was also presented with the view that the consultation process was hampered by a deliberate unwillingness on the part of some clinicians to engage in the process in a collaborative manner:

> Their [some doctors'] participation in some of the processes to discuss this has not been full. They have stated to me that they deliberately stay away from some of the GMCT processes so that they can come back later and conduct the sort of debate that I suggest spells out something about the strength they felt in their position.[236]

5.59 The Committee believes these claims of non-involvement by some clinicians in the internal consultations suggest a lack of faith by those clinicians in the GMCT process.

Consultation within Mona Vale Hospital

5.60 Dr Stephen Nolan advised the Committee that he first raised intensivists' concerns regarding the safety of critically ill patients under the current ICU structure with the Mona Vale Medical Staff Council after he had written a letter to the Director of Intensive Care, Dr Paul Phipps on June 12 2004. Dr Nolan advised that the surgeons tended not to turn up to the medical staff councils.[237]

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231 Professor Kerry Goulston, Chair, Greater Metropolitan Clinical Taskforce (GMCT) Evidence, 8 March 2005, p22.

232 Dr Jollow, Evidence, 28 February 2005, p76.

233 Professor Goulston, Evidence, 8 March 2005, p23.

234 Confidential Submission 605, p16 (cited with permission).

235 Submission 622a, appendix 3, p3.

236 Dr Christley, NSCCH, Evidence, 21 March 2005, p10.

237 Dr Stephen Nolan, Intensivist, Mona Vale Hospital, Evidence, 8 March 2005, p45.

5.61 The Chairman of the Mona Vale Hospital Medical Staff Council described how at the end of one of the medical staff council meetings the two intensive care specialists who work at Mona Vale Hospital advised that they were not happy to continue doing a one-in-two roster and were thinking of resigning if there was no additional help from a rostering point of view. Dr Jollow advised that this caused some upset at the meeting as those present had not been aware that there was a problem.[238]

5.62 Dr Jollow went on to describe that the issue was extensively discussed, often heatedly, at subsequent medical staff council meetings. Dr Jollow praised the intensive care specialists who came to these meetings to explain their view on the situation and various proposals put forward by them to recruit new intensivists and to look at sharing services with Manly Hospital.

5.63 Dr Jollow stated that he understood and sympathised with the concerns of the intensivists about working a one-in-two roster. However, the Medical Staff Council was concerned about the overall impact on the hospital if the only resolution of that problem was the downgrading of the ICU.

Decision to reverse consolidation of maternity services at Mona Vale Hospital

5.64 Critics of the GMCT consultation process note the very late notice given regarding the decision to abandon the proposal to centralise maternity services at Mona Vale Hospital, and argue that this is indicative of the overall poor consultation process. It has been claimed that this was the only proposal to attract clinician support at the two hospitals. However, the Committee is mindful that it did not have the opportunity to hear from the relevant staff at Manly Hospital whether the proposed move had their universal support.

5.65 The Chairman of the Mona Vale Hospital Medical Staff Council related to the Committee the circumstances surrounding him being notified that the proposed move of maternity services would not be taking place:

> I do not know why the reversal was made. As chair of the Medical Staff Council at Mona Vale, I was intimately involved in the GMCT discussions with Kerry Goulston and also Jonathan Page from Manly hospital, and the understanding most of the time had been that Kerry Goulston's proposals would revolve around intensive care moving to Manly and maternity moving to Mona Vale. The day before the final submission was made public, Kerry Goulston gave me a telephone call and said that he had pulled the maternity move off, and he did not give me a reason for it, and I have not been able to find out a reason since.[239]

5.66 Similarly, the Nurse Unit Manager of Maternity Services at Mona Vale Hospital related how the night prior to the GMCT proposal being made public she had attended a GMCT consultation meeting at which Professor Goulston was present. At the end of that meeting she was still of the understanding that maternity would be coming to Mona Vale. In the afternoon

238 Dr Jollow, Evidence, 28 February 2005, p68.

239 Dr Jollow, Evidence, 28 February 2005, p68.

of the next day she was advised by a colleague that he had heard the move was not taking place – which was confirmed by the NUM at Manly who had been advised that morning.[240]

5.67 The Committee heard that the sudden abandonment of the merger caused frustration and affected morale in the maternity unit at Mona Vale Hospital, particularly as only two weeks earlier they had been advised by Professor Goulston that the merger was definite and that they had six months to put procedures and protocols in place to give effect to the merger.[241]

5.68 Professor Goulston argued that it was necessary to withdraw the maternity proposal in order to focus on the issue of safety of critically ill patients:

> That was my decision. I guess, when I looked at the proposal, it was about safety. If you read the two-page document again, you will see the front page is all about safety and concern about safety. I still feel, and have made it clear, that there is a good case for having maternity at one hospital rather than two, and Mona Vale is the obvious choice because of paediatrics and other things that are there. However, I felt so strongly about the safety of critically ill patients that I thought it would muddy the waters if I put that in the proposal, which we finished in mid December. It has not changed the GMCT's position, and we will continue pushing the area health service, the department and the Minister to do something about maternity. The immediate issue is the care of critically ill patients.[242]

5.69 It is regrettable that the GMCT Chairman did not come to this conclusion earlier on in the consultation process. The timing of the decision and the manner in which it was disseminated has become another rallying point for those who are critical of the overall process.

5.70 As previously noted, it is proposed that maternity services should be based at the new Northern Beaches Hospital. While the issue of maternity services have been put aside for the moment NSCCH is of the view that at a point in time within the next five years the current configuration of services will not be sustainable.

Conclusion

5.71 Whatever the criticisms of the past process, there is still the opportunity for the opposing parties to engage in useful and effective consultation. Chapter Four discussed the implementation group convened to consider the GMCT proposal or an agreed alternative that would provide the same level of sustainability for intensive care services on the Northern Beaches.

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240 Ms Karen Draddy, Nurse Unit Manager, Maternity Services, Mona Vale Hospital, Evidence [in camera subsequently published], 8 March 2005, p2.

241 Ms Denise Hardie, Maternity Early Discharge Program Co-ordinator, Mona Vale Hospital, Evidence [in camera subsequently published], 8 March 2005, p3.

242 Professor Goultson, Evidence, 8 March 2005, p23.

The divisive result of the consultation processes

5.72 An unfortunate feature of the consultation process and current debate on changes to health services on the Northern Beaches has been the creation of diametrically opposed factions among both the general and the medical communities. What has been even more unfortunate is that the way the consultation process and overall debate on this issue has been handled has led to divisiveness between these factions. This has in turn resulted in an environment that has fostered marked ill will, harassment and intimidation.

Animosity and division among the community

5.73 The long running consultation process has given rise to the formation of a number of organisations each of whose stated aim is to give voice to and lobby on behalf of the views of their local community. It is perhaps indicative of this debate that these organisations are either strongly opposed to or strongly aligned with the direction taken by NSCCH. During the inquiry the Committee heard evidence from two of these organisations: the Save Mona Vale Hospital Committee (SMVHC) and Better & Equitable Access to Community and Hospital Services (BEACHES).

5.74 In their submission the SMVHC advise that their group was formed in late 2000 as a direct result of the community's grave concerns over the continued downgrading of services, the total lack of any capital improvement, the lack of basic maintenance, the concern of the staff and real community fears that all these issues were part of a plan to close Mona Vale Hospital.[243]

5.75 In their submission BEACHES advise that it was formed in 2001 to support a major upgrade of hospital services on the Northern Beaches, and in particular a new Metropolitan Acute Services General Hospital at its demographic centre.[244] During evidence the Chairperson of BEACHES indicated that part of the reason for its creation was to provide a counter voice to that of the SMVHC:

> BEACHES…was formed in 2001, as we felt there was no lobby group representing the 80 percent of the northern beaches population living south of Mona Vale.[245]

5.76 However, the Committee also received a submission from the unregistered voluntary organisation Community Expressions (Save Manly Hospital Campaign). Community Expressions are primarily concerned with the preservation and adequate funding of Manly Hospital but are also involved in two other closely related campaigns: the preservation and adequate funding of Mona Vale Hospital; and the preservation and adequate funding of the Cremorne Community Mental Health Clinic. The submission from Community Expressions argues that the many thousands of residents who have signed petitions supporting the retention of Manly and Mona Vale Hospitals, should be held in contrast with the public agitation by a handful of people in favour of the Dee Why site.[246]

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243 Submission 723, SMVHC, p6.

244 Submission 725, BEACHES, p1.

245 Ms Lynette Hopper, Chair, BEACHES, Evidence, 28 February 2005, p77.

246 Submission 2235, Community Expressions, p2.

5.77 The Committee heard that there is cooperation between those community organisations that have allied aims. The Deputy Chair of the SMVHC advised that other groups had contributed to his committee's funding:

> It is predominantly the Pittwater area that we would get most of our donations from, but there are also groups in the centre and the south that support us and have contributed to our funding. The Save Our Civic Centre Group, headed by Keith Amos, the Save Manly Hospital Group, headed by Michael Darby, have worked with us in collecting funds. But predominantly it comes from the community. I point out that our rallies have not just been in Pittwater. We went to Brookvale Oval, which is even further south than Dee Why, to hold one of our biggest rallies.[247]

5.78 It was apparent during the inquiry that the SMVHC and BEACHES viewed each other as rivals in the debate on the best site for the new Northern Beaches Hospital. While it is healthy in any debate for two opposing views to be championed the Committee is concerned that rather than concentrating on presenting their own case these groups were, to varying degrees, focussing on each other.

5.79 In his presentation to the Committee the Deputy Chair of the SMVHC outlined the credentials that he believed entitled the SMVHC to claim that it was truly representative and had the overwhelming support of its community. Mr Rose contended that this was not the case with all community groups that were making submissions to the inquiry:

> It is simply wrong for groups with limited membership who meet very occasionally to claim they are really representative of their community and that they have community representative status.[248]

5.80 During the public hearing on 28 February 2005 the Chairperson of BEACHES (Ms Hopper) again indicated that she believed it was BEACHES role to provide a counter argument to that presented by the SMVHC:

> CHAIR**:** When I read the submission from BEACHES what struck me was the animosity between the Save Mona Vale Hospital community and your community. Why do you not consider you both have a right to present a position without needing to make it all relative to the other committee? Why is it all in reference to the other committee?
>
> Ms HOPPER**:** I think we do have a right to present a view, and the reason that we were formed originally is to provide another view for the southern end of the population. It is important that we have that.[249]

5.81 All the organisations that have and continue to contribute to this public debate have been created because of a perceived need for a vehicle by which the views of their community may be given voice. This perceived need has arisen at different times throughout this process despite the attempts by NSCCH to engage the entire community in inclusive and meaningful consultation.

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247 Mr Rose, SMVHC, Evidence, 28 February 2005, p52.

248 Mr Rose, SMVHC, Evidence, 28 February 2005, p46.

249 Evidence, 28 February 2005, p83.

Animosity and division arising from the proposal to change ICU services

5.82 The debate regarding the proposal to rationalise intensive care services certainly saw the creation of animosity and division within the medical community on the Northern Beaches. It appears that in this case the potential for this to occur could have been anticipated. The submission from the Surgeons & Anaesthetists, Mona Vale Hospital includes minutes of a 28 August 2004 meeting at which the surgeons and anaesthetists were first advised of the threat to intensive care services at the hospital. The minutes include the following comment:

> The meeting noted the 'Area promise' to keep both Manly and Mona Vale Hospitals functioning at their present levels until the long promised new Hospital is built. Doubtless the reason for this decision was to provide certainty and to prevent a destabilising brawl between competing interests across the peninsula.[250]

5.83 Despite any acknowledgement of the potential for disharmony, the manner in which the consultation occurred appears to have only contributed to this situation. The Committee heard evidence from a registered nurse from Mona Vale Hospital who saw a parallel between what was happening at Mona Vale and Manly Hospitals and what had occurred previously at Blacktown and Mount Druitt Hospitals:

> The same thing has happened there to what is happening between Manly and Mona Vale. Instead of the two hospitals uniting and being happy, we have been made to fight tooth and nail against each other. It has become a divide and conquer scenario. I hate that. At the second last Nurses Association meeting I said we have to get together as nurses for the betterment of everybody on the Northern Sydney Area Health Service. We have been made to absolutely fight against each other the whole time; it has been engineered. The same thing happened at Blacktown and Mount Druitt hospitals, with Mount Druitt becoming the underdog.[251]

5.84 Ms Carter also believed that the manner in which consultation was conducted only served to foster a sense of division:

> Getting back to Professor Goulston, he only listens to the clinicians he wants to hear from. When Dr Peter Lawrence went to speak at a previous meeting with the task force he was just talked down dramatically. They stacked the meeting with Blacktown hospital doctors, of which Dr Nolan is one. We are just getting sick of it.[252]

5.85 Contributing to what would have been a difficult process to manage in any circumstances was the apparent existence of ill will between some of the clinicians from the two hospitals. The Committee heard that this was taking its toll on the morale of the nursing staff:

> They are frustrated. They are sick of the bad blood between some of the clinicians. Basically, the nurses just want to look after patients; they do not want to get caught up

250 Submission 622a, Surgeons & Anaesthetists, Mona Vale Hospital, Attachment 1.

251 Ms Deborah Carter, Registered nurse, Mona Vale Hospital, Evidence [in camera subsequently published], 8 March 2005, p6.

252 Ms Carter, Evidence [in camera subsequently published], 8 March 2005, p6.

> in the politics. They go to work to do their job, and this is distracting them from patient care.[253]

5.86 The fact that it was known that some ill will between the two hospitals already existed should have alerted those handling the consultation to the need to ensure that there was no appearance of one faction being favoured over another. The Chairman of the GMCT advised that the development of the proposal for the interim changes to intensive care services had to overcome past difficulties in the relationship between the two hospitals:

> We talked to intensivists and they agreed that they would staff both hospitals. They agreed that they would provide cover at both hospitals. That was a big step forward. There is a history relating to and a lot of baggage between those two hospitals.[254]

5.87 However, this big step was dependent upon the ICU at Mona Vale being downgraded to a HDU. It is unfortunate that the GMCT proposal was dependent upon a concession being made to the group of intensivist clinicians primarily based at Manly Hospital that was viewed as being detrimental to the operation of Mona Vale Hospital.

5.88 Throughout the inquiry, witnesses who supported the GMCT interim proposal were concerned that the proposal should be viewed as an upgrading of intensive care services for the Northern Beaches, and not in terms of two competing communities.[255] However, the GMCT and NSCCH have been unable to manage this difficult process so as to avoid the creation of a sense of winners and losers.

Intimidation

5.89 During evidence and in submissions there were allusions to fear and intimidation relating to the position that health professionals took with respect to the matters that were the subject of this inquiry, particularly the question of the proposed reconfiguration of intensive care services. There were two types of intimidation about which claims were made. Firstly, there were claims that NSW Health and NSCCH had created or allowed to persist a culture whereby health care professionals felt intimidated to speak out against the Area health's agenda. Secondly, there were references to some health care employees directly intimidating other employees.

5.90 Pittwater Council argued that the staff at Mona Vale Hospital were prevented from openly entering into the current debate free from fear of reprisal:

> It is about an area health service executive that allows nurses at Manly to speak out publicly and join pseudo-community groups to support their claims, whilst at the same time creating a culture of fear and intimidation amongst staff at Mona Vale Hospital should they speak out against the area health service agenda.[256]

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253 Ms Kate Needham, Co-chair, NSW Intensive Care Clinical Implementation Group, Evidence, 8 March 2005, p31.

254 Professor Goulston, Evidence, 8 March 2005, p17.

255 Dr Nolan, Evidence, 8 March 2005, p47.

256 Mr Lindsay Godfrey, Manager, Community & Library Services, Pittwater Council, Evidence, 8 March 2005, p51.

5.91 On the 8 March 2005 the Committee heard evidence from three nurses from Mona Vale Hospital. This evidence was taken in camera; that is the Committee heard the evidence from these nurses in private without the media and members of the public being present. At the conclusion of this evidence the Committee resolved, with the concurrence of the nurses involved, to publish the evidence and their names.

5.92 The Committee notes that Ms Draddy, Ms Hardie and Ms Carter requested that they be allowed to give their evidence in private because they did not wish to feel intimidated by speaking in front of the press and the public. There was no suggestion that they were concerned that they would suffer as a result of giving evidence before the Committee.

5.93 The Committee received a number of submissions from medical professionals who currently hold appointments within NSCCH. A number of those authors who expressed criticism of either the direction being taken by NSCCH or of the condition of Mona Vale Hospital requested that their submission remain confidential to the Committee.

5.94 One such confidential submission argued that this was due to fear among medical staff that any public comments that were critical of the Area administration would be viewed unfavourably:

> I have come across the idea – supported to some extent by special arrangements – that medical staff who support the line of moving Manly from its existing site and running down Mona Vale will be smiled upon by the administration, and that those who don't will be frowned upon at re-appointment time. In keeping with this, I have been told that the only doctors who are putting in submissions opposing the changes, are the "old guys" who are not seeking re-appointment at the end of the quinquennium.[257]

5.95 The Committee notes that a number of medical professionals requested that their submissions remain confidential. While it very well might be the case that some medical staff did believe that a public submission could jeopardise their career, the Committee did not receive any evidence to support the contention that staff have or would be penalised for publicly criticising the health administration with respect to the subject matter of this inquiry. The Committee further notes that any inquiry participant who does experience any harassment has the recourse of reporting that to the Committee.

5.96 The public debate on the future of health services on the Northern Beaches has divided the local community to some extent. Many individual community members also requested that their submission remain confidential as they preferred that their views remain private.

5.97 However, the Committee did hear that when a number of doctors at Mona Vale Hospital withdrew their services over the 2004 Christmas period, because of the staff shortage within the ICU, that those doctors who were rostered on over that period received threatening letters from Area management. The Convenor, Surgeons & Anaesthetists, Mona Vale Hospital argued that this was an attempt by management to change a safety issue into an industrial dispute and that is only served to increase the mistrust of management's willingness to address the concerns of the staff regarding the Goulston proposal:[258]

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257 Confidential Submission 605, p 17 (quoted with permission).

258 Submission 622a, Surgeons & Anaesthetists, Mona Vale Hospital, p6.

> They were threatened because over the Christmas period, and with only three days notice, the area health service announced that it could not provide an intensive care service. They said unanimously, as it turned out, except for one group, that they could not provide services under those circumstances. The people who were rostered on over that period received threatening letters.[259]

5.98 The Committee is concerned at any suggestion that the Northern Beaches Health Service management would seek to coerce doctors into working within an environment that those doctors consider to be unsafe.

5.99 During the hearing on 8 March 2005, Dr Stephen Nolan, a VMO intensivist at Mona Vale Hospital, was asked whether he had been subject to harassment or intimidation from other medical professionals as a result of expressing his views:

> Unfortunately, the answer to that question is yes. When I met with the Minister last year with the group that Dr Boland was talking about in his submission—with the anaesthetists, with the intensive care specialists, obstetricians, orthopaedic surgeons—immediately after that meeting I received a very threatening phone call from a person who was at that meeting suggesting that this individual was going to impede my career. It is suggested that he thought I was selling out Mona Vale and he was going to make sure that everyone knew about that. Those sorts of things have continued, unfortunately. I have received further phone calls from that individual about various things.[260]

5.100 Dr Nolan also advised the Committee that an intensive care colleague of his at Mona Vale had also suffered similar things after that person had made his views about the Intensive Care Unit known.[261]

5.101 It is unfortunate that again this type of behaviour could apparently have been anticipated by the health authorities. Ms Kate Needham, was asked whether she or any other of the intensive care specialists faced any backlash or harassment from the staff at Mount Druitt Hospital following the decision to downgrade that hospital's ICU:

> Certainly we all did. I was not told directly by a surgeon, but it was sent to me via a line that was going to get to me that my career would be destroyed. One of the intensivists, who was actually the director of both Blacktown and Mount Druitt, and who worked very, very hard, had a lot of abuse hurled at him. He had abuse on his answering machine when he was not at home but his wife was at home with her four little children.[262]

5.102 The Committee heard that while the medical profession is a very small world, the intensive care specialty is even smaller across Australia. It was put to the Committee that the animosity and ill will that had attended the downgrading of the ICU at Mount Druitt Hospital and the proposal to do the same at Mona Vale had and would affect the ability to attract intensivist staff to those hospitals:

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259 Dr Boland, Evidence, 28 February 2005, p63.

260 Dr Nolan, Evidence, 8 March 2005, p44.

261 Dr Nolan, Evidence, 8 March 2005, p45.

262 Ms Needham, Evidence, 8 March 2005, p29.

> Some of us know that medicine is a very small world. Intensive care is even smaller across Australia; everyone, if they do not know each other individually, knows of each other. At one stage where we had these two resignations across Blacktown and Mount Druitt intensive care service, we did advertise. We advertised across Australia, and we received three applications. One of those applicants withdrew when they contacted somebody in Sydney to find out what was happening at Blacktown and Mount Druitt. From my perspective, we lost a potential candidate. That was really unfortunate, because when they were queried by the medical director it was said that they would not be touched with a barge pole because of the animosity present.[263]

> Another factor has become important recently. The intensive care community is a small and close knit one. The attitudes expressed about Intensive Care and some bullying tactics by Mona Vale surgeons I strongly believe have prejudiced any chance of attracting staff to Mona Vale.[264]

5.103 During the hearing on 8 March 2005, Dr Nolan advised the Committee that he would be prepared to outline the harassment to which he had been subjected and to name the individual involved, if he could do so on an in camera basis. The Committee did not pursue that matter but it did advise Dr Nolan that if he did suffer any threats or harassment as a result of his giving evidence before the Committee that he was urged to contact the Committee as such behaviour would amount to contempt of the Parliament.[265]

Conclusion

5.104 The consultation process employed did little to address the climate of fear and anxiety that had developed in the community. The Committee believes that it is something that NSW Health needs to address proactively rather than see the difficulties experienced at Mount Druitt and Blacktown and then at Manly and Mona Vale continue to occur in the future.

Politicisation of the NSCCH

5.105 The NSCCH and most particularly its CEO Dr Stephen Christley has become the source of considerable antagonism and mistrust from those who do not agree with the direction the Area Health Service is taking. The Committee believes the fault for this in many ways lies in the absence of political will on the part of successive Health Ministers to intervene to bring the community debate to a satisfactory conclusion.

5.106 The Director General of NSW Health, Ms Robyn Kruk, expressed concern at the way staff of the NSCCH and a number of clinicians were criticised and their reputations and motives questioned during the continuing community debate:[266]

> As I indicated in my opening statement, there has been a whole range of assertions made about what have been the preferences or otherwise of the Chief Executive of the Area Health Service in relation to the siting of the hospital. It is very difficult for

263 Ms Needham, Evidence, 8 March 2005, p29

264 Submission 2238, Professor Malcolm Fisher, p7.

265 Evidence, 8 March 2005, p49.

266 Ms Kruk, NSW Health, Evidence, 28 February 2005, p5.

> Dr Christley to say, " I believe this is the one and only solution". He has been charged with the task to put forward a series of options, both in relation to bricks and mortar and site and clinical service configurations. It is not ultimately his call. I have had members of Parliament personally say to me that Dr Christley has an agenda.
>
> That is not the case; he has a statutory responsibility and would be negligent in his responsibility if he did not consider a full range of options and the various feasibility studies that have previously taken place. It is his responsibility to provide advice to the government of the day on what he believes, on technical, community, and health grounds to be the best configuration.[267]

5.107 Dr Christley explained similar concerns:

> One of the things that has really disturbed me in this debate is the number of times Dr Christley has been quoted as saying X, Y or Z by other people, by third parties. While I have not chosen to get into a dialogue about what I have said, the reality is that had I chosen to do so, a vast amount of what has been reported in the public domain as my comment or my views are not things I have said.[268]

5.108 However, in his evidence the Member for Pittwater, Mr John Brogden MP, argued that staff of NSW Health had inevitably been drawn into the debate as a result of the lack of involvement of successive Health Ministers:

> I noted Dr Christley's and Ms Kruk's concern about the use and misuse of their names and reputations in this process. If the Minister and his successive Ministers had fronted the community, Dr Christley and Ms Kruk would not have to be doing their dirty work for them. What is annoying about this process is the lack of involvement, over a long period, of successive ministers in this long-term solution. It is for that reason that Dr Christley has had to engage himself in part of a political process because of the Minister's refusal to do so. I believe it has been grossly unfair on members of the public service to require them to do the Government's dirty work time and again.[269]

5.109 During the public hearing on 28 February 2005 in response to a question on whether his statements could be taken to clearly indicate where the new Northern Beaches Hospital would be located, Dr Christley emphasised that it was the role of the NSCCH to provide advice, not to make decisions:

> No, that is a decision for government. The area health service's advice is that the new hospital to replace Manly hospital be located in the travel centre of the northern beaches, and that is defined in our work as being somewhere between Brookvale, Dee Why and Frenchs Forest.[270]

5.110 However, no decisions have yet been made and in what has been this long interim it has been Dr Christley who has made public comment on what the likely outcome of that advice will be:

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267 Ms Kruk, Evidence, 28 February 2005, p19.

268 Dr Christley, NSCCH, Evidence, 28 February 2005, p19.

269 Mr J Brogden MP, Member for Pittwater, Evidence, 28 February 2005, p30.

270 Dr Christley, Evidence, 28 February 2005, p14.

> …I am on the record as stating that, given the transport demographics and all of the analysis that we have done, the site of the major acute hospital is most likely to be the new Manly hospital.[271]

Conclusion

5.111 This inquiry demonstrated how the problem has unfolded. At the commencement of the inquiry *The Manly Daily* ran a full page photograph of Dr Christley, followed by a double page open letter from him explaining the rationale behind the decision relating to intensive care services.[272] The Committee believes that this position would have been better put by the Minister. This situation can lead to public servants being forced into a position of exceeding their role and commenting on political rather than policy matters. The Committee believes that the Minister needs to take a more active role in the debate relating to health services on the Northern Beaches.

271 Dr Christley, Evidence, 28 February 2005, p14.

272 *Health chief's letter to you, The Manly Daily,* February 26 2005, pp29-31.

Chapter 6 The future role for Mona Vale Hospital

The entire community of the Northern Beaches is united in its desire for a first-class health service that can provide excellent primary and emergency care, a greater range of services and that meets local needs, particularly that of an ageing population. There is also general agreement that this improved health service should be delivered via a two-hospital model, with one being the major acute services hospital and one providing a complementary role and range of services.[273]

The future role for Mona Vale Hospital will be either that of the new major acute services hospital, or that of the second complementary hospital. While there is a relatively clear understanding of what a new acute services hospital would be, the level of services that will be provided from the complementary hospital is unknown at this stage. The fear expressed by many local residents is that if Mona Vale Hospital becomes the complementary hospital it will be the first step towards its eventual closure.

The final six sites currently under assessment for selection as the new Northern Beaches Hospital did not become known until just prior to the final public hearing conducted by the Committee. The Mona Vale Hospital site is one of those six sites.

This chapter examines the assessment process that is to be undertaken prior to a decision being finally made on the location of the new hospital. It also examines the arguments for and against the Mona Vale site, and to a lesser extent the Civic Centre at Dee Why, which were put before the Committee in submissions and evidence. On review of the evidence the Committee finds that there is no reason why Mona Vale would not be a viable choice as the new Northern Beaches Hospital.

The Committee notes that on 11 November 2004 the four State MPs for the Northern Beaches area released a "Statement of Understanding" that outlined their agreed position with respect to the future hospital service needs for the area.[274]

The final site selection process

6.1 The announcement of the final stage of the long-running evaluation and selection process for the new Northern Beaches hospital was made just prior to the final public hearing of the Inquiry. Despite all the consultation, evaluation and assessment that had previously occurred the announcement included some elements that surprised people who had been closely following this issue.

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273 The Committee acknowledges a number of submissions have questioned the validity of the underlying premise that the current two 'metropolitan' hospital model must be abandoned and the majority of services be concentrated in the one acute hospital.

274 A copy of the "Statement of Understanding" was included in submission 1102, Pittwater Council, Appendix 1, p23.

Announcement of the six potential sites

6.2 At the first public hearing of the Inquiry on 28 February 2005 the CEO of Northern Sydney Central Coast Health (NSCCH) announced that there were six potential sites for the new Northern Beaches Hospital. Dr Christley announced that one of those sites was Mona Vale Hospital. He also indicated that, as expected, the Civic Centre at Dee Why was also one of the sites, however, the other four sites were not divulged during the hearing.

6.3 The fact that the Mona Vale Hospital site was still under consideration came as a surprise to many participants in the public debate on the location of the new hospital. Dr Christley explained how the Minister for Health gave direction for this final selection process:

> We have been through a series of exercises in looking at sites for a new northern beaches hospital. We have been asked by the Minister to go back and review what we have done to make sure that we had tried to overcome any obstacle there was to any particular site, so there was no way we could be perceived to have been identifying a site, working through how we overcame its difficulties, without having given the same rigour to every other site.
>
> The most recent document looks at six sites. It includes Mona Vale hospital, which has been a concern of a number of people. The criteria we have used are outlined in our submission. A set of criteria was agreed in consultation with the community, and it includes issues such as access, buildability and capacity for sustainable services. We have used those, we have done various rankings and various sensitivities around that, and presented some recommendations.
>
> In essence, there are a number of sites where one could build a hospital. I think it is fair to say that the area's recommendation at this point—and I would not mind if it was not what came out at the end—is that Dee Why is the most suitable site. However, there are other options, and they will be evaluated by others as we go through the process.[275]

6.4 The Deputy Chair of the Save Mona Vale Hospital Committee (SMVHC) told the Committee that despite being involved in and closely monitoring this issue they were not aware, until Dr Christley's statement, that Mona Vale was still being considered as a potential site. Mr Rose was of the opinion that Mona Vale was included in this final process solely for the purpose of examining the perceived negatives of the site in order to justify its non-selection.[276] The Committee believes that this is a valid part of the selection process as long as it is applied equally rigorously to all sites under consideration.

6.5 The Committee welcomes the intervention of the Minister in directing NSCCH to review its previous assessments. The Committee understands how the announcement would have come as a surprise to many. At the time of the public hearing the most recent public information on

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275 Dr Stephen Christley,CEO, Northern Sydney Central Coast Health (NSCCH) Evidence, 28 February 2005, p8.

276 Mr Harvey Rose, Deputy Chair, Save Mona Vale Hospital Committee (SMVHC), Evidence, 28 February 2005, p52.

the Northern Sydney Health website[277] regarding choosing the best site for the new hospital advised that four sites were under consideration. These sites were the Civic Centre at Dee Why, Brookvale Bus Depot, Manly Council Depot and Brookvale TAFE.

6.6 The full list of the final six sites under consideration became known on 18 March 2005. On this date NSCCH provided information to the Committee on the six sites including a copy of a document entitled *Northern Beaches Health Service – Site Selection*. This three-page document listed the six potential sites and provided a brief amount of site description and information. The document also listed the criteria that would be used to assess the sites, and described the process by which the final assessment would be made. A copy of this document is attached at Appendix 5.

6.7 At the same time this information was provided to the Committee, NSCCH also provided it to the relevant councils and to *The Manly Daily*. An article based on this information appeared in *The Manly Daily* on 19 March.[278] This article advised that NSCCH was seeking public feedback on this issue. The site selection document was not placed on the NSH website until 8 April 2005.

6.8 The six sites are:

- **Dee Why**: part of Council Civic Centre and some adjacent private land.
- **Brookvale Bus Depot:** limited amount of STA Bus Depot land plus some industrial land.
- **Frenchs Forest:** NSW Housing site expanded east to include Bantry Bay Rd houses, land to Wakehurst Parkway.
- **Brookvale Greenfield:** northern corner of Warringah public golf course.
- **Beacon Hill:** vacant NSW Education site (Landcom proposals).
- **Mona Vale:** Mona Vale Hospital site.

6.9 It is fair to say that, apart from NSW Health and NSCCH, the inclusion of the Warringah Golf Course site surprised all people associated with this issue. Warringah Golf Club was first advised on NSCCH's interest in the golf course land late on 18 March 2005. Similarly, residents in Bantry Bay Road, Frenchs Forest were first advised on that date that their homes were now included in an expanded Frenchs Forest site.[279]

The assessment criteria

6.10 As early as the public hearing on 28 February 2005 NSCCH advised the Committee that there were a number of criteria that would be used to evaluate the six sites and that these criteria had been allocated various rankings. The *Northern Beaches Health Service – Site Selection* document

277 *Proposed new Manly Hospital site selection report – August 2004;* and *New Manly Hospital – January 2004,* located on NSH website under Major Planning Projects/Northern Beaches Planning/Choosing the best site.

278 *New Brookvale site on short list,* The Manly Daily, 19 March 2005.

279 *Suddenly it's a hospital site,* The Manly Daily, 24 March 2005.

that was provided to the Committee, and subsequently placed on the NSCCH website, lists the ten criteria that will be used to assess the sites. That document does not indicate the various weightings that apply to each criterion.

6.11 The Committee requested NSW Health to provide the relative weightings that applied to each criterion. NSW Health advised that a weighting had been allocated to each criterion and that these weightings might be changed by the consultative group selected to assess the sites:

> In order to arrive at a short list of six sites and a preference within these selected for further review, NSCCH allocated a weighting to be applied to the criteria adopted. It is normal practice that the Value Management Study (VMS) group will review the criteria and allocate rankings/weightings.[280]

6.12 For the preliminary analysis leading to the site identifications and investigations, the following weightings applied:

Table 6.1: Assessment criteria and weightings

Criterion	Weight
Ease of community access by public transport	6
Travel time by car to emergency services < 30 minutes	15
Traffic access and impacts	7
Development constraints (flexibility, expansion)	5
Planning and approvals (community acceptance)	10
Environment and heritage issues	10
Operational efficiency and productivity gain potential	10
Ensures viable services in the long-term	15
Private partnership opportunities	10
Total development cost (acquisition and construction)	12
Total	100

6.13 The Committee believes that if new weighting is given to the assessment criteria then this information should be made public. This will be important to ensure transparency and to engender public trust in the process.

The assessment and selection process

6.14 The *Northern Beaches Health Service Site Selection* document outlined the two steps that will be undertaken in the process. They are:

[280] Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p10.

- The involvement of community and health professionals in a Value Management Study (VMS) to advise which of the sites is the preferred site for the new Northern Beaches Hospital.
- Once the first step is decided health professionals and community representatives will get together to decide how health services will be networked across the two hospitals [the new Northern Beaches Hospital and the second, complementary hospital] for the benefit of Northern Beaches residents.

6.15 The Committee wrote to NSW Health requesting advice on the number of community and health professionals that would be involved in the VMS and on what basis they would be selected. The Committee was also interested to learn if the representatives involved in step 1 of the process would also be the group involved in the decisions on how services should be networked. NSW Health advised:

> During the previous round of consultation in 2002, NSCCH (then NSH) invited the three local Councils to select five community representatives for participation in the Value Management Study (VMS) and other processes. A similar approach will be taken during this round of consultation and VMS.
>
> A range of senior health professionals will be invited to participate in the VMS. Representatives will be invited with representation across professional groups.
>
> A rigorous consultation process will apply during service configuration planning [step 2], with a substantial committee structure to ensure that staff from all services and the community have the opportunity to provide input to the planning process. It is envisaged that a Steering Committee will be formed to oversee the process.[281]

Involving the wider community in the process

6.16 The Committee acknowledges that it would be impractical to attempt to engage meaningfully the entire Northern Beaches population with a view to determining the community's preference for the site for the new hospital. The Committee believes that the final decision must be made by a representative group as proposed by NSW Health.

6.17 The *Northern Beaches Health Service Site Selection* document invited feedback from the community about the proposed sites. This document, placed on the NSH website on the 8 April 2005, is very brief and does not include any site maps.

6.18 NSW Health advised that it plans to keep the wider community informed on the selection process by posting on the Area Health Service website site identification and investigation reports once complete (excluding commercial in confidence aspects). It will alert the community to that initiative through appropriate media, such as *The Manly Daily*. NSW Health also plans for exhibits that will provide details and explanations of the evaluations relating to each of the six sites to be placed in centres frequented by the local community such as Council offices and/or shopping centres.[282]

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281 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p11.

282 Correspondence, from Director General NSW Health, to Committee Chair, 13 April 2005, p10.

6.19 NSW Health also advised that NSCCH will formally respond to all written feedback received. The feedback will be summarised in terms of site preferences and issues raised. NSW Health advised that this information will be considered by it and the Area Health Service in recommending a final site to the Government.

6.20 The Committee notes that, based on the answer provided on 13 April 2005, this information apparently will not be provided to the VMS group for their information. The Committee believes that NSCCH may have erred in not setting a deadline for the provision of community feedback, which would have allowed for a plan to summarise this information in time for presentation to the VMS group. As it stands, it is unclear how NSW Health will use this information, if at all, relative to the outcome of the VMS process.

The impact of the location of the preferred site on the networking of services

6.21 Throughout the inquiry members of the Committee sought to ascertain what level and mix of services would be provided from the second, complementary hospital. NSCCH advised that they could not provide a response to this question as it would depend on what the clinicians and the community determine is the best service mix between the two hospitals. During the public hearing on 21 March 2005, Dr Christley emphasised that the level of services to be offered at both the new hospital and the complementary hospital would be determined as part of the process and that it was incorrect at this stage to apply the level 5 description to the new hospital:

> When the new site is identified there will be service planning across the two sites. There has been no description of level of either site at this stage made in advance of the planning process.
>
> …the language of level three and level five has been a description of the interim proposal [relating to intensive care]. The hospitals will be complementary and the nature of services provided at each hospital has not yet been determined. That has always been explicit, we have always said that we would determine the services when the sites are identified.[283]

6.22 Dr Christley also advised that in the case of some services the question of whether they could be provided from the secondary hospital would depend on the distance between it and the site of the new major hospital.[284] Notwithstanding that is one of the six proposed sites for the new Northern Beaches hospital, representatives from NSW Health and NSCCH repeatedly made comments that made it clear that they expected Mona Vale would not be selected and would therefore become the secondary hospital in the two-hospital model.[285]

6.23 The Committee requested NSW Health to confirm whether their planning allowed for the scenario of Mona Vale being selected as the site for the new Northern Beaches Hospital and, subsequent to that, a complementary hospital being developed in the south of the Northern Beaches. NSW Health advised:

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283 Dr Christley, NSCCH, Evidence, 21 March 2005, p8.

284 Evidence, 21 March 2005, pp14-15.

285 See Evidence, 28 February 2005, p14; p18; 21 March 2005, p4; p9; p26.

> The PFP did not favour the selection of Mona Vale Hospital as the major acute hospital on the Northern Beaches. However, the VMS will enable a re-examination of Mona Vale and the other sites.[286]

6.24 The Committee takes the NSW Health response to mean that the VMS process is capable of evaluating and selecting a site for the secondary, complementary hospital. The Committee believes that, if NSW Health and NSCCH are being honest with the Northern Beaches community, then there is an inherent flaw of omission in the VMS process as outlined in the site selection document. There must be an acknowledged provision for the VMS to also evaluate and select a site for the secondary, complementary hospital.

6.25 The Committee acknowledges that if Mona Vale was selected as the major hospital, the best site for the secondary hospital might not necessarily be one of other five sites. In this instance other sites, perhaps such as Manly Hospital, would need to be re-examined.

Recommendation 5

That the Value Management Study Process be broadened to include the evaluation and selection of a preferred site for the secondary complementary hospital as well as the preferred site for the new Northern Beaches Hospital.

6.26 If Mona Vale is not selected as the major hospital it will become the secondary, complementary hospital. The Committee was concerned that the VMS process as outlined would see the representative group making a decision on a preferred site without making any reference or giving any consideration to the implications it would have for the range of services to be offered from the secondary hospital.

6.27 The Committee requested NSW Health to advise whether each site being considered as part of the VMS process would also be considered in terms of the likely mix of services that would be offered at the complementary hospital, as a result of that site being selected. NSW Health advised:

> At the VMS information will be provided on the catchment of each of the proposed sites, based on travel times and under a number of scenarios. The final configuration of other services will be determined from subsequent community and clinician consultation.[287]

6.28 It is apparent that certain services that might be provided at the complementary hospital would be ruled out as a matter of course depending on the distance between it and the major hospital. During evidence Dr Christley gave the indicative example of a midwife-led maternity service being able to be offered from a smaller (secondary) hospital if it was close enough to a major hospital to enable emergency transfer of patients within a safe timeframe.[288] The Committee also presumes that NSCCH would already have a general idea of how services

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286 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p12.

287 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p12.

288 Dr Christley, NSCCH, Evidence, 21 March 2005, p15.

might be networked between the two hospitals particularly if its stated favoured option of Dee Why as the major hospital and Mona Vale as the secondary hospital did eventuate.

6.29 The Committee believes that NSCCH should have a concept of which services would need to be located at the major hospital and those services which may need to be duplicated in order to ensure safe and equitable access for the entire community to essential services. The Committee presumes that consideration of the evaluation criteria of operational efficiency and viable services in the long-term would require reference to the relationship between the major and secondary hospitals.

6.30 The response from NSW Health indicated that the VMS group will be provided with a number of scenarios relating to access to certain essential services. NSW Health also advised that the second step in the process would determine the configuration of 'other' services. It is not clear what percentage those 'other' services would comprise of the overall services to be networked. Though it was described as such the VMS process is clearly not a distinct two-step process.

Making an open and transparent decision

6.31 It is fair to say that all participants in this issue wish to see a final decision made so that the overall improvement to health services on the Northern Beaches can at last be put in train. The Director General of NSW Health acknowledged that it is not an area in which they expect consensus.[289] The Committee agrees that whatever final decision is made there will be some individuals or communities that will be disappointed.

6.32 The CEO of NSCCH advised the Committee that it was his intention that the VMS process be undertaken and completed swiftly.[290]

6.33 The Committee notes the repeated comments from representatives from NSW Health and NSCCH that referred to Mona Vale as the secondary complementary hospital despite the fact that they were at the same time advising that the final decision was still to be made. Suspicion that the final site selection process has a predetermined outcome would not have been allayed by the following comment from the Administrator of Warringah Council:

> The fact that there are six sites on a list, of course, does not mean that they think that six sites are suitable.[291]

6.34 The Committee notes the comment of the Member for Manly, Mr David Barr MP, who, though a staunch opponent of Mona Vale as the site for the new Northern Beaches Hospital, argued that it should be considered as part of this final selection process:

> I think Mona Vale always should have been one of the sites that it looked at because it has to be able to be said clearly, "We have looked at sites X, Y and Z and we think site Z is the appropriate one."[292]

289 Ms Robyn Kruk, Director General, NSW Health, Evidence, 28 February 2005, p9.

290 Dr Christley, NSCCH, Evidence, 21 March 2005, p26.

291 Mr Richard Persson, Administrator, Warringah Council, Evidence, 8 March 2005, p4.

292 Mr David Barr, MP, Member for Manly, Evidence, 28 February 2005, p44.

6.35 The Committee agrees that once the final decision has been made the reasons for the selection of the preferred site must be presented in full and made public. However, that alone would not provide sufficient information to the Northern Beaches community given the current level of anxiety. A full description of the comparative evaluation of each site and the information on which the evaluation was based must be provided.

Recommendation 6

That once the Value Management Study evaluation report for the new Northern Beaches Hospital is available, NSCCH make public a full description of the basis for their decision on the preferred site including the score for each criterion for each of the six sites.

6.36 As mentioned in the introductory chapter, 2321 of the submissions received by the Committee argued support for Mona Vale as the best site for the new Northern Beaches Hospital. Fifteen submissions either supported a specific alternative site or argued that Mona Vale was not an appropriate site.

6.37 Many of the pro Mona Vale submissions also argued two other main points:

- the need to retain and upgrade Manly Hospital
- that the Civic Centre site at Dee Why was not a suitable option.

6.38 Overwhelmingly, the majority of submissions focussed on the Mona Vale site and to a much lesser extent the site at Dee Why. During the public hearings it was the merits of these two sites that were the subject of evidence and examination.

The arguments for and against the Mona Vale Hospital site

6.39 The major rallying point of this current debate is whether Mona Vale should be the site for the new Northern Beaches Hospital. It has attracted extremely strong support from the surrounding community, who have put forward a number of arguments why they consider it to be the 'perfect hospital site'. These include:

- no delay in commencement of construction
- ample land
- central geographic location
- ease of access by road and public transport
- helicopter access
- healing and peaceful environment
- cost-effectiveness of the site
- provision of greater choice for residents in the north
- community support and acceptance.

6.40 Equally, NSW Health has argued there are a number of reasons why it is in fact not the perfect site. In particular NSW Health and NSCCH have focussed on two main issues:

- remoteness from the population centre of the northern beaches
- poor travel accessibility.

6.41 The following sections briefly examine each of the various arguments put forward during the inquiry.

No delay in commencement of construction

6.42 The Mona Vale Hospital site has support from local residents and it has been argued that there would be no opposition to development on the site. Community acceptance with respect to planning and approvals is one of the criteria that will be used in the assessment of the six final sites under consideration. Also, as the NSW Government owns the site there would be no delay associated with land purchase or acquisition.

6.43 NSW Health stated that it takes two to three years to plan, design and document a major hospital, prior to the commencement of any construction. It further argued that any land purchase and rezoning that might be required for the selected site would be completed within 18 months and therefore would not delay the construction stage nor the completion date.

Ample land

6.44 Of all the six potential sites Mona Vale provides the largest parcel of land for development. The Mona Vale land site is 8.8 hectares in total, although 1.5 hectares of that total currently forms part of the adjoining Mona Vale Golf Course. The size of the other five sites are:

- Dee Why – 3.1 hectares
- Warringah Golf Course – 5.5 hectares
- Brookvale Bus Depot – 3.1 hectares
- Beacon Hill High School – 4.5 hectares
- Frenchs Forest – 6.3 hectares.[293]

6.45 It has been argued that the Mona Vale 8.8 hectares provides a necessary capacity for growth and flexibility to satisfy the changing health needs of a diverse community for the foreseeable future.[294] The Deputy Chair of the SMVHC argued that throughout his involvement in the consultation process he was led to believe that at least 4.5 hectares was required to construct a new acute services hospital.[295] This figure and the figure of 4 hectares were listed in the procurement feasibility plan (PFP) for health services on the Northern Beaches. However,

293 Mr Michael Roxburgh, A/Director, Capital Procurement, NSCCH, Evidence, 21 March 2005, p13.

294 Sumbission 723, Save Mona Vale Hospital Committee, p11.

295 Mr Rose, SMVHC, Evidence, 28 February 2005, p49.

NSW Health representatives advised during this inquiry that while it would not be ideal as little as 2.4 hectares would be sufficient.[296]

6.46 It was also pointed out that the land site sizes for some of the sites, such as Warringah Golf Course and Frenchs Forest include areas set aside for vegetation preservation and other constraints such as water flows and buffer zones.[297]

6.47 Some critics have argued that Mona Vale is the only site that is large enough to accommodate the co-location of a private hospital and community health services. However, the feasibility plans for all six sites do include provision for these services.[298]

6.48 The Committee believes that Mona Vale is an excellent site in terms of available land; a point acknowledged by the CEO of NSCCH.[299] When the six sites are being assessed it will be vital to ensure that public amenity is not compromised in exchange for selecting a site that is constrained by limited size.

Central geographic location

6.49 Mona Vale is situated in line with the geographic centre of the Northern Beaches. It is also close to the relatively isolated communities on Scotland Island and on the western foreshores of Pittwater. Additionally, during the summer season from October to March, the population on the coastal fringe, where Mona Vale is situated, is increased by seasonal holiday-makers and weekend and day visitors.[300]

296 Mr Roxburgh, NSCCH, Evidence, 21 March 2005, p14.

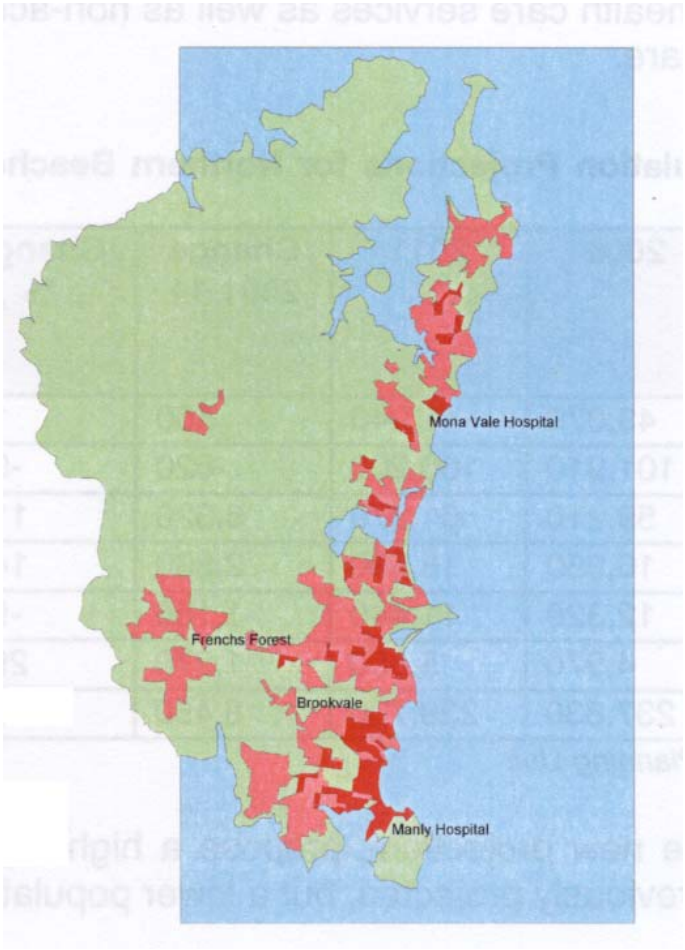
297 In the case of the Frenchs Forest site, 2.5 hectares is set aside for bush retention.

298 Dr Christley, NSCCH, Evidence, 21 March 2005, p13.

299 Dr Christley, Evidence, 28 February 2005, p18.

300 Submission 723, SMVHC, p12.

Map 3: Northern Beaches



Source: Submission 2230, NSCCH, p14.

6.50 During the inquiry there was some debate as to whether NSCCH had originally identified but subsequently dropped a criterion of a maximum travelling distance/time of 20km/30 minutes by private car.[301] Mona Vale is the only site that would meet a 20-kilometre distance criterion.

6.51 For the current six sites the relevant criterion is *Travel time by car to emergency services <30 minutes*. While this criterion currently has equal highest weighting, according to NSW Health this criterion will be used to assess but not to preclude sites from selection:

> Travel time by private car being less than 30 minutes is a criterion which can be applied to each potential hospital site as an indicator of emergency access. The use of this criterion does not imply that all patients should be able to reach the hospital in 30 minutes, but rather that this can be used to gauge the relative benefits of each site against the others.
>
> The measure is derived from the recommended criteria of the NSW Government Action Plan for Health, which states:

301 Evidence, 21 March p15.

Metropolitan [emergency] services should be planned using the following parameters. These parameters should be considered together – not individually in isolation:

throughput – 20,000 emergency department cases per year (minimum)

travelling distance/time – 20km/30 mins by private car (maximum)

population base – 1:200,000 (minimum)

equity factors (including transport, social factors, geography).[302]

6.52 With respect to the residents of Scotland Island and the western foreshores, NSW Health advise that they were included in the studies used to determine the travel accessibility times and the population centre of the Northern Beaches. Figures indicate that demand for emergency services by these residents represents about half of one per cent of the Northern Beaches emergency workload. NSW Health stated that these communities relate to their local hospitals in the same way that residents of Brooklyn relate to Hornsby Ku-ring-gai Hospital and residents of Bundeena relate to Sutherland Hospital.[303]

6.53 The Committee received 683 submissions from individuals who were former patients at Mona Vale Hospital, many of these described instances when they or members of their family were involved in medical emergencies and received treatment at Mona Vale Hospital ED. Many of these people, who live in the northern half of the Northern Beaches, believed that their survival was due to the proximity of the hospital. The Committee acknowledges these concerns expressed in many submissions but notes that wherever the new hospital is located there will be people who will be disappointed that it is not located closer to their residence.

6.54 Any concern regarding the safety implications of not strictly applying this 30-minute travel time criterion when selecting the site for the new hospital would be partly offset if the second, complementary hospital also had a functional emergency department. NSCCH propose that the services that will ultimately be offered from the complementary hospital need to be determined after the site for the major hospital is selected.

6.55 In Chapter 4 the Committee recommends that NSW Health immediately commence the physical upgrade of the Emergency Department at Mona Vale as suggested in the GMCT interim proposal, and that staffing of that department be enhanced. If Mona Vale is selected as the secondary hospital NSW Health must ensure that residents in the north of the peninsula are provided with the long-term means to access adequate emergency services in a safe and reasonable timeframe.

Recommendation 7

That, whatever site is chosen for the new Northern Beaches Hospital, Mona Vale Hospital be funded, staffed and equipped to provide an on-going effective 24-hour emergency department service.

302 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p11.

303 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p11.

Ease of access by road and public transport

6.56 Mona Vale Hospital is located just off the six-lane Pittwater Road. It is also close to the major routes of Mona Vale Road and the Wakehurst Parkway, both of which connect to Pittwater Road. A major bus service between Palm Beach and the City operates on Pittwater Road with stops located a short walk from the Hospital entrance. There is also a regular bus service from Manly to Mona Vale that stops directly outside the hospital.

6.57 The hospital is not located within a congested commercial zone, being about one kilometre from the village of Mona Vale. While this can be seen as a positive, NSW Health view distance from a commercial zone as a negative factor.[304] It appears that the benefits of being located in or near a commercial zone, such as easy access for patients and visitors to commercial amenities, incurs the cost of having to deal with, and contributing to, traffic congestion in the area.

6.58 NSW Health point out that the hospital has a single road access.[305] The hospital is bounded by ocean headland reserve and the Golf Course on two of its sides. Multiple road and pedestrian access points is seen as an advantage for any potential site.

Helicopter access

6.59 The Committee assumes that the new Northern Beaches Hospital would require a helipad to receive and transfer patients by helicopter. Mona Vale Hospital has an operating helipad with air access over the ocean. As the site is not surrounded by residential or commercial properties, the operation of helicopter transfers would result in relatively minor disturbance to local residents compared to other potential sites.

6.60 The Committee notes that at hospitals that do not have helipads appropriate arrangements are put in place to allow these hospitals to transfer patients by air if required. Typically this involves the air transport landing at the closest available location and being met by an ambulance, which then transfers the patient to the hospital.

6.61 In its supplementary submission to the inquiry NSCCH advised that all of the six sites under consideration for the new Northern Beaches Hospital have the capacity to accommodate a helipad.[306] The Committee notes that on the same date that NSCCH made its supplementary submission the Director General of NSW Health provided written advice on the same issue:

> The Northern Sydney and Central Coast Area Health Service has been advised by an expert helicopter service consultant that all of the sites currently under consideration are capable of accommodating a helicopter service or helipad.[307]

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304 *Northern Beaches Health Service Site Selection*, accessed from http://www.nsh.nsw.gov.au/majplanning/northbeach/releases, p3

305 *Northern Beaches Health Service – Site Selection,* p3.

306 Submission 2230a, NSCCH, p9.

307 Correspondence, from Director General, NSW Health, to Committee Chair, 16 March 2005, p2. *Note:* the Committee was not provided information on what is meant by a helicopter service as opposed to a helipad.

6.62 Therefore the Committee makes the following recommendation, even though it anticipates it fully accords with the planning and intention of NSCCH and NSW Health.

Recommendation 8

That the new Northern Beaches Hospital include a helipad.

Healing and peaceful environment

6.63 Mona Vale Hospital is located in a pleasant environment. Located very close to the ocean, it shares two of its boundaries with a golf course and a headland reserve. The upper floors of the hospital provide ocean views. Supporters of the site note that it provides an ideal environment for healing, recovery and recuperation. The Committee received many submissions from former patients of Mona Vale Hospital praising the comfort and assistance this ambience provided them.[308]

6.64 While this ambience can be argued as a reason why Mona Vale should be selected as the site for the new Northern Beaches Hospital, it could also be argued that it is a reason why it should become the secondary hospital.

6.65 It has been argued that a hospital's ambience and environment is less important considering the trend to increasingly shorter stays in hospital for surgical procedures. However, it was suggested that a role for the secondary hospital should be one of rehabilitation where families and friends can come and visit patients.[309] If this did become the agreed role of the secondary hospital then a site with a pleasant recuperative environment would be ideal.

6.66 For young children, and their parents, visits to hospital are often very stressful times, and a pleasant environment can serve to lessen this. One submission author, whose daughter suffers a chronic illness and is admitted to Mona Vale ED on a fairly regular basis, recounted the benefit of the Mona Vale site:

> As [my daughter] is intellectually disabled, hospital is indeed a very frightening and upsetting experience for her, she and we find great comfort in being able to see the ocean from the Paediatrics ward and she knows she is close to home.[310]

6.67 Whichever site is ultimately selected it is expected that the design for the new hospital will seek to make the hospital grounds and environment as welcoming and peaceful as possible.

308 Submission 228, Mrs Shirley Cooper, p1.

309 Dr Stephen Nolan, Intensivist, Evidence, 8 March 2005, p49.

310 Submission 388, Ms S Nicholson, p1.

Cost-effective

6.68 Those in favour of Mona Vale as the location for the new Northern Beaches Hospital argue that the fact that there is no cost associated with land purchase, as there is with some of the other sites, should influence the final decision. NSW Health officials are of the view that land acquisition cost, even if of the magnitude of $40M, is not an impediment if it means achieving the best result.[311]

6.69 The CEO of NSCCH argued that Mona Vale could easily be one of the more expensive options as there would be a need to put additional services at Royal North Shore for outflows of patients from the southern portions of the Northern Beaches.[312] This concern of NSCCH is examined in more detail later.

6.70 Notwithstanding NSCCH's view that land acquisition cost is not an impediment, the criterion of total development cost (acquisition and construction) was given the third highest weighting during the preliminary analysis leading to the selection of the six sites. It is not clear from the information publicly released by NSCCH whether this criterion will also include any potential indirect costs.

6.71 The SMVHC believe that, if Mona Vale Hospital was selected, new buildings could be erected while existing care programs were continued with minimal disruptions.[313] This contention was never tested or addressed by NSW Health during the inquiry, so the Committee is not able to confirm whether this is a practical option.

Provides greater choice in north of the peninsula

6.72 In the Northern Beaches area there are no private hospitals north of Dee Why. Currently for residents in the north of the peninsula the nearest public hospital, apart from Mona Vale and Manly, is Hornsby, which, because of the geography of the peninsula, requires some travel time to reach.

6.73 It has been argued that Mona Vale should be the new Northern Beaches Hospital to account for this lack of choice, and because residents in the south do have a choice of other hospitals to attend including Royal North Shore.[314] However, the issue of patients in the south of the Northern Beaches choosing to attend Royal North Shore is one of the reasons that NSW Health and NSCCH do not favour locating the new hospital at Mona Vale.

Community support and acceptance

6.74 There are two elements to community support and acceptance of the site for the new Northern Beaches Hospital. Firstly, there must be support, as far as practicable, from the overall Northern Beaches community for the general area in which the Hospital is to be sited.

311 Dr Christley, NSCCH, Evidence, 21 March 2005, p9.

312 Dr Christley, NSCCH, Evidence, 21 March 2005, p3.

313 Submission 723, SMVHC, p11.

314 Submission 2232, Dr David Jollow, p3.

Secondly, there must be support and acceptance, particularly from the immediate local community, for the specific site and proposed development.

6.75 The support for the Mona Vale site from the immediate local community is unquestioned. Support for the other nominated sites and proposed development has not yet been fully tested.[315] This should be addressed during the Value Management Study (VMS) process when all six sites are assessed.

6.76 The question of which general area has the greatest Northern Beaches community support was the subject of the long-running, multi-phased community consultation process. This process was examined in Chapter 5, including the opposing arguments regarding the validity and interpretation of the various survey results. In summary, it was argued that some of the survey results did not give a true indication of community preferences as they reflected the number of responses received which were disproportionally from residents of the north.

6.77 The Committee heard that of all the consultation strategies the most scientifically rigorous was the Taverner Research telephone survey, which was conducted in September 2002 by a market research company and which reached a randomly selected 1,168 residents across the Northern Beaches, with a representative proportion from each LGA.[316]

6.78 The research surveyed 282 residents from Pittwater LGA, 886 residents from Warringah LGA, and 203 residents from Manly LGA. This represented 0.5 per cent of LGA residents aged 16 years and over. In its supplementary submission NSCCH highlighted the following results:

> Among Manly LGA residents (17% of Northern Beaches population), a clear preference for Brookvale (50% of respondents) as the location for the new general hospital.
>
> Among Warringah LGA residents (58% of the Northern Beaches population), a clear preference for either Frenchs Forest (35%) or Brookvale (30%) as the location for the new general hospital.
>
> Among Pittwater LGA residents (25% of Northern Beaches population), a clear preference for Mona Vale (82%) as the location for the new general hospital.[317]

6.79 These figures have led some to argue that only residents of Pittwater favour Mona Vale and that Warringah and Manly LGA residents favour alternative locations. It might also have led to the view put to the Committee by the Member for Manly that it is not acceptable to the majority of people on the Northern Beaches that Mona Vale be the new centralised hospital.[318]

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315 It was suggested to the Committee that local opposition to some of the other sites could realistically be expected, see Evidence, 28 February 2005, p65.

316 Dr Christley, Evidence, 21 March 2005, p3.

317 Submission 2230a, NSCCH, pp4-5.

318 Mr David Barr, MP, Member for Manly, Evidence, 28 February 2005, p39.

6.80 The survey asked residents to nominate their preference for the location of the new general hospital, they were given the options of Mona Vale, Brookvale, Frenchs Forest or other (which respondents could specify). The full results of these surveys are shown below:[319]

Table 6.2: Preferred location for new general hospital by residents in Manly and Warringah

Preferred location	Manly LGA	Warringah LGA	Total
Mona Vale	7%	24%	21%
Brookvale	50%	30%	35%
Frenchs Forest	19%	35%	32%
Manly	15%	3%	6%
Keep existing locations	4%	3%	3%
Other	2%	2%	2%
Don't know/care	2%	2%	2%
Total	100%	100%	100%

Source: Submission 2230, NSCCH, Appendix 9, p4.

Table 6.3: Preferred location for a new general hospital by residents from Pittwater

Preferred location	Pittwater residents
Mona Vale	82%
Brookvale	8%
Frenchs Forest	5%
Keep existing locations	1%
Other	1%
Don't know/care	2%
Total	100%

Source: Submission 2230, NSCCH, Appendix 10, p3.

6.81 The Committee notes that the purpose of the survey was to inform NSCCH of the overall Northern Beaches community attitude to the most preferred location. If the results from all three LGAs are combined it shows that of all the sites Mona Vale had the highest individual level of community support:

319 These results are reproduced from two reports, namely: *Community Attitudes Report on Health Services: Manly and Warringah Local Government Areas, November 2002*,p4; and *Community Attitudes Report on Health Services: Pittwater Local Government Area, November 2002*,p3. These reports were included as appendices 9 and 10 respectively in Submission 2230.

Table 6.4: Preferred location for a new general hospital by Northern Beaches residents

Preferred location	Mona Vale	Brookvale	Frenchs Forest
Pittwater LGA	82%	8%	5%
Manly LGA	7%	50%	19%
Warringah LGA	24%	30%	35%
Total all LGAs	**35%**	**28%**	**25%**

6.82 The Committee finds that is incorrect to argue that support for Mona Vale as the site of the new Northern Beaches hospital does not exist outside Pittwater LGA. The Committee notes that some participants in the debate have combined the results for Brookvale and Frenchs Forest to argue that a majority (52%) of residents prefer the new hospital to be located in the Brookvale-Frenchs Forest *area*.[320] While it is easy to understand why some might draw this conclusion, it is not technically valid.

6.83 At the public hearing on 21 March 2005, the CEO of NSCCH focussed less on the survey results and chose to explain where community support sat within the decision making process:

> Among other questions, the survey asked people if they wanted one or two hospitals, and if two, which one they wanted to be the major acute hospital. This was a random survey, and could not be affected by large numbers of people filing in form letters. It showed that people wanted two hospitals, but wanted the closest one to them to be the major one-not surprising. Clearly, resolution of this question requires more than a vote by residents. It needs also to be informed by what is clinically feasible, what can be staffed and which decision will result in the best outcome for everyone.[321]

6.84 The Committee shares the view that while community support and preference should be gauged and is important, it is only one of a number of factors that must be considered.

Population centre

6.85 NSW Health, NSCCH and others who believe that Mona Vale is not an appropriate site for the new Northern Beaches Hospital base their argument on two basic premises. These are Mona Vale's relative location to the population centre of the Northern Beaches, and how accessible it is for the entire Northern Beaches community in terms of travel time relative to other potential sites. There is an obvious inter-relationship between these two factors.

6.86 NSCCH advised that central to their argument for not considering Mona Vale to be an appropriate site was the fact that 80% of the Northern Beaches population lives to the south of Mona Vale [Hospital].[322] NSCCH believe that this ratio is unlikely to change substantially in the future. NSCCH did note that with the commitment to retain Mona Vale Hospital there

320 See Evidence, 8 March 2005, pp35-36.

321 Dr Christley, NSCCH, Evidence, 21 March 2005, p4.

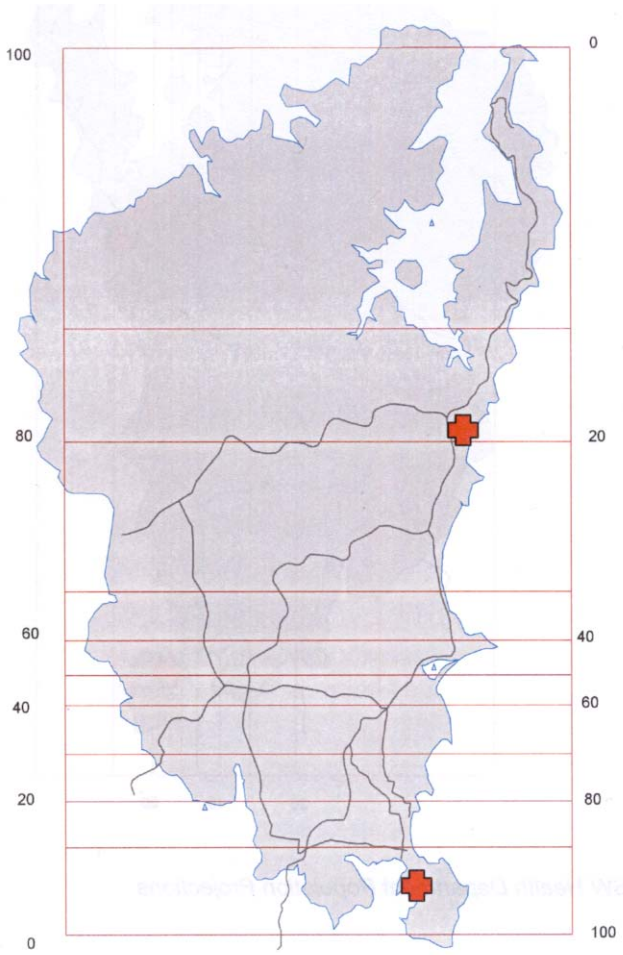
322 Dr Christley, NSCCH, Evidence, 28 February 2005, p6.

would be the opportunity to respond to any very long-term (100 years) changes in demography.

6.87 NSCCH provided the following breakdown of north-south population distribution of the Northern Beaches:[323]

- 20 per cent of the population lives south of Queenscliff
- 40 per cent of the population lives south of Dee Why
- 60 per cent of the population lives south of Collaroy
- 80 per dent of the population lives south of Mona Vale Hospital.

Map 4: Cumulative percentage of population (Northings) Northern Beaches 2011



Source: Submission 2230, NSCCH, p15.

6.88 The figure of 80% has become a catchcry of those who argue against Mona Vale as an appropriate site. The Committee notes that comments such as those by the Director General

323 Submission 2230, NSCCH, p15.

of NSW Health[324] which implied that 80% of the population would consider Mona Vale to be a bad choice, need to acknowledge:

- that many residents to the south of the hospital are in close proximity to it
- 24% of Warringah residents and 7% of Manly residents surveyed in the Taverner research nominated Mona Vale as their preferred site.

6.89 As part of its planning Northern Sydney Health in August 2000 enlisted the help of experts in geographic mapping to identify the population centre of the Northern Beaches – that is the point from which the whole population was most equally distributed. The *Northern Beaches Accessibility Study* prepared by Associate Professor Mike Poulsen found that the geographic centre for the Northern Beaches population was in Cromer, close to the intersection of Carcoola Avenue and Dorothy Street. This point lies level, on an east-west axis, with Collaroy Basin.

6.90 Northern Sydney Health's Procurement Feasibility Plan (PFP)[325] was based on Department of Infrastructure, Planning and Natural Resources (DIPNR) population projections to the year 2011.

6.91 In December 2004 DIPNR released New South Wales Statistical Local Area Population Projections for 2001 to 2031. These figures showed the following population change projected for each LGA:

Table 6.5: DIPNR population projections 2001-2031

Year	Warringah	Pittwater	Manly	Northern Beaches Total
2001	136,180	56,410	38,690	231,280
2006	138,120	60,010	39,700	237,830
2011	137,980	60,570	41,180	239,730
2016	135,480	61,370	42,230	239,080
2021	135,550	65,000	43,380	243,930
2026	135,280	71,170	44,530	250,980
2031	134,870	76,870	45,500	257,240
Change 2001-31	**-1.0%**	**+ 36.3%**	**+17.3%**	**+11.2%**

6.92 A comparison between the projected figures for 2011 and 2031 show a decrease of 1,310 for Warringah, an increase of 20,460 for Pittwater and an increase of 6,830 for Manly. This results in a net increase of 15,090 people for Pittwater. The figures also show that Pittwater LGA would grow to approximately 30% of the predicted Northern Beaches population in 2031.

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324 Ms Kruk, NSW Health, Evidence, 21 March 2005, p27.

325 The PFP was commenced in July 2001 and the draft completed in November 2002.

6.93 During the inquiry representatives from Pittwater Council and from the Save Mona Vale Hospital Committee noted that the new Northern Beaches Hospital would not be completed until 2011 and that therefore the figures on which NSCCH had based their planning were no longer valid. The SMVHC implied that NSCCH may have deliberately ignored the 2031 projections as it did not suit their agenda,[326] while Pittwater Council argued that the figures allowed the reasonable assumption that the geographic population centre would move north. They argued that any assessment of potential sites, particularly in terms of accessibility, should be based on the 2031 figures.[327]

6.94 Pittwater Council noted that the DIPNR data also showed that between 2001 and 2031 the number of older people aged 65+ will increase by 7,560 in Pittwater, 7,970 in Warringah and 1,830 in Manly.[328]

6.95 The Committee notes that the planning and studies conducted by NSW Health commenced prior to the release of the 2031 projections by DIPNR. Notwithstanding that they did not refer to these projections in their submission to the inquiry, NSCCH advised that they did take the latest figures into account:

> Our planning horizon is 2011. We did adjust our figures. At the end of the day the advice that we got on all the future projections is that the demographic centre of Cromer moves matters of hundreds of metres, rather than anything more significant.[329]

6.96 The Poulsen report which identified the geographic population centre found that the general trend in the changes observed in the geographic centres over time is that they are advancing approximately 20 metres east each five years and 40 metres north.[330] In 2002 Associate Professor Poulen was asked to provide data on the effect on the weighted population centre of large increases in population on the Northern Beaches. Professor Poulsen's study demonstrated that an increase of 10,000 people in the Warriewood Valley without other population growth in the rest of the Northern Beaches would move the geographic population centre 250 metres towards Mona Vale from Cromer.[331] As indicated at earlier the DIPNR projections predict a net increase of 15,000 people in Pittwater LGA.

6.97 Population projections are based on assumptions, including information provided by Councils, which may not come to fruition.[332] NSCCH noted that the margin for error when using long-term population projections for decision making increases with the longer projection timeframe. It drew attention to the following advice to users of population projections provided on the DIPNR website:

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326 Mr Rose, SMVHC, Evidence, 28 February 2005, p48.

327 Mr Lindsay Godfrey, Manager, Community & Library Services, Pittwater Council, Evidence, 8 March 2005, p53.

328 Submission 1102, Pitwater Council, p28.

329 Dr Christley, NSCCH, Evidence, 28 February 2005, p19.

330 *Northern Beaches Accessibility Study*, p6.

331 Submission 2230a, NSCCH, p6.

332 This issue, with respect to forecast housing development at Ingleside within Pittwater LGA, was examined in evidence, see Evidence, 8 March 2005, pp60-61.

> These population projections should not be regarded as predictions, forecasts or targets, but are projected using particular assumptions. These assumptions have been developed to assess change in different components of population change. Changes in social policy, behaviour or economics can have a significant effect on the direction of policy change in the future. Consequently, it is not certain that these assumptions will hold for the projections period. For this reason DIPNR intends to update these population projections regularly, taking into account the latest available data.[333]

6.98 According to NSCCH, population projections have a bearing on health planning in two main ways. The first is to determine the current and future distribution of the population. The second is to identify the likely future activity volumes of each of the hospitals.[334] With respect to the first the conclusion that may be drawn is that the geographic population centre is currently north of Dee Why and will continue to move north-east over time.

6.99 In terms of the second component – activity volumes, NSCCH advise:

> It is important to note that clinical trends do not allow reliable projections beyond a 10-15 hear horizon. Changes are likely to occur in relation to, for example, day only procedures, home based care, remote monitoring and new therapies which will render projections of bed numbers very uncertain over longer time periods. Activity projections take into account changes in age cohorts, previous admission rates and clinical opinion. A revised version of the Department's [DIPNR's] APPI projection tool will be used in the next stage of service planning to update medium term projections. At the design stage flexibility in physical facility use will be an important component to allow for future changes in service provision.[335]

6.100 The Committee believes that if updated population projections are assessed as part of the Value Management Study and any decisions on how health services will be networked across the Northern Beaches, it will be incumbent upon NSCCH to make public the data used and the reasoning for any decisions based upon that data.

Do hospitals have to be located as close as possible to population centres?

6.101 The example of the John Hunter Hospital in the Hunter Region suggests that proximity to population centres is not always a primary criterion for selecting the location for a major hospital.

6.102 During the inquiry it was suggested that NSCCH were merely using population distribution as a convenient reason to discount Mona Vale as a potential site. Pittwater Council drew attention to the case of Gosford Hospital which is being redeveloped and upgraded on its existing site despite the fact that according to 2031 population projections 65% of the population will live to the north of Gosford Hospital, and implied there was inconsistency from NSCCH in its stated need to locate major hospitals near population centres.[336]

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333 Cited in Submission 2230a, NSCCH, p5.

334 Submission 2230a, NSCCH, p6.

335 Submission 2230a, NSCCH, p6.

336 Mr Godfrey, Pittwater Council, Evidence, 8 March 2005, p53.

6.103 In order to address any concerns that may be held among the community and to reduce the risk of uninformed inferences being drawn, the Committee requested NSW Health to provide comment on this comparison:

> The bulk of the Central Coast population does not live in the north. The majority of the Central Coast population lives in the south, in the Gosford Hospital catchment. The redevelopment of Wyong and Gosford Hospital has been undertaken on current and future service requirements. Both acute hospitals on the Central Coast are well located relative to their catchment populations.
>
> Planing for health services on the Northern Beaches has been carried out according to approved Health Department procedures, and has taken into account the views and needs of the community and clinicians. Northern Sydney and Central Coast areas were separate organisations when Northern Beaches planning commenced, and government funding allocations to the Gosford and Wyong Hospital redevelopments were determined prior to amalgamation and prior to the period when there was a shared CEO.[337]

6.104 While not specifically stated in the response from NSW Health, there are a number of criteria that would need to be assessed in the decision of location for any hospital, and these criteria or other factors (eg. access to rail transport) that might come into play will vary from one area to another. The Committee does not see any utility in pursuing this issue, particularly as many of the submissions it received from individual community members were voicing personal concern that in the end they will have to travel longer to access hospital service. The Committee shares the view of the CEO of NSCCH that poor decisions of the past should not be used as precedents for decisions of the future:

> We are trying to put the hospital in a location that evidence tells us it should be, not trying to say, "Well, we will put it there" and try to justify the reasons why it might work, because I think that has been shown not to work on many occasions before.[338]

Conclusion

6.105 Ultimately the overall population centre is only relevant in terms of it being one of the primary factors that will determine the overall travel accessibility of any potential site. It is not how close a potential patient (or visitor) resides near a hospital that is important but how long it takes that patient to get to the front door of that hospital. Travel accessibility is therefore a crucial issue.

Travel accessibility

6.106 It became clear during the inquiry that the major criterion for selection of the site of the new Northern Beaches Hospital was travel accessibility; that is the site that can provide the maximum access to the maximum number of people.[339] This point was emphasised during the

337 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p12.

338 Dr Christley, NSCCH, Evidence, 21 March 2005, p26.

339 Dr Richard Mathews, Deputy Director General, NSW Health, Evidence, 28 February 2005, p16.

public hearings on a number of occasions.[340] Those who emphasised this point argued that it was this criterion that discounted Mona Vale Hospital as a viable choice for the new hospital. During the inquiry the Committee was advised that travel accessibility was one of the two highest ranked criteria to be used in evaluating sites for the new Northern Beaches Hospital.

6.107 Dr Christley explained that the new Northern Beaches Hospital would be built at the travel centre for the northern beaches or as close to that as it can be. The travel centre is the point where travel times for all potential users were minimised. NSCCH have defined the travel centre as being somewhere between Brookvale, Dee Why and Frenchs Forest. As Mona Vale Hospital does not fall within this defined area, NSCCH believe it is best suited to fill the role of the secondary complementary hospital.

6.108 NSCCH came to this definition of the travel centre following the findings of three separate but related independent studies that it commissioned.[341] In August 2000 Northern Sydney Health engaged Associate Professor Mike Poulsen from Macquarie Universtiy to undertake a travel accessibility study – titled the *Northern Beaches Accessibility Study.*[342] Dr Poulsen concluded that the most accessible locations by road on the Northern Beaches were the intersections along Warringah Road (running from Forest Way in the west to where Warringah Road intersects with Pittwater Road), and the central section of Pittwater Road (running from the intersection with Condamine Street in the south to the intersection with Hay Street in the north). Professor Poulsen identified the most accessible location to be the intersection of Warringah Road and Pittwater Road, which lies at the divide between Dee Why and Brookvale.

6.109 In response to criticism of the study from some sections of the community, NSH in mid 2002 engaged Professor John Black, Professor Emeritus of Transport Engineering at the University of NSW, to critically appraise the study. In addition, Professor Black met with members of the Northern Beaches Community Consultative Health Planning Group (NBCCHPG) to discuss community concerns and reviewed community views articulated in the media.

6.110 Professor Black concluded that the report was "a worthy document of investigation at a very preliminary stage in the ongoing planning process" and should be retained on the Northern Sydney Health website. He did support community criticism regarding aspects of the input data, and supported the community's view that public transport access should have been considered.

6.111 Professor Black proposed that an additional accessibility study be undertaken by another consultant to address the identified shortcomings of the earlier study. Professor Black developed the terms of reference for this subsequent study in consultation with the NBCCHPG, and briefed the consultants, Computing in Transportation (CiT). The study by CiT entitled *Northern Beaches Accessibility Study: Travel Time Analysis and Mapping* was completed in October 2002. This study is also available on the NSH website.

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340 Ms Kruk, NSW Health, Evidence, 28 February 2005, p9: Dr Christley, NSCCH, Evidence, 28 February 2005, p14; p17; Evidence, 21 March 2005, p3; Ms Hopper, BEACHES, Evidence, 28 February 2005, p78.

341 Paragraphs 6.109 to 6.111 are drawn from Submission 2230a, NSCCH, pp6-7.

342 This report is available from the Northern Sydney Health website.

6.112 The SMVHC noted that Professor Black in his comments on the Poulsen study stated that the presentation of the findings in the Northern Beaches Accessibility Study does not bring out clearly the distributional consequences (the winners and losers in travel time access) of different options and combination of options. The SMVHC believe that this fact is again displayed but not addressed in the later study:

> The CiT study clearly shows the vast differences (inequities)in travel time between the averages and maximums. Coupled with this is the disproportionate increase in travel times from the northern end of the peninsular when compared with southern end.[343]

6.113 The SMVHC were also critical that at no time has any analysis been done on actual travel times. All studies only used theoretical computer modelling with no actual journeys taken.

6.114 In its supplementary submission and during evidence NSCCH drew the Committee's attention to the following conclusion from the CiT study:

> [The tables show that] the Brookvale sites are easily the most accessible of all the hospital sites, especially from the perspective of the study area residential population within the 10 minute travel time band. More people can reach this site is a shorter travel time than the other sites both now and in the future years 2011 and 2021 during the AM and PM time periods.[344]

6.115 The relevant tables from the *Northern Beaches Accessibility Study* are reproduced below:

Table 6.6: 2001 Auto Average AM peak hour

2001 Average AM peak	**Cumulative % of total Estimated Residential Population in travel time band**				
Travel time band in minutes	Brookvale sites	Frenchs Forest site	Manly Hospital	Mona Vale Hospital	RNS Hospital
0-10	40%	14%	18%	13%	
10-20	63%	72%	45%	40%	
20-30	85%	77%	63%	94%	4%
30-40	97%	97%	85%	96%	43%
40-50	100%	100%	97%	100%	66%
50-60			100%		81%
60-70					93%
70-80					100%

343 Submission 723, SMVHC, p17.

344 Dr Christley, NSCCH, Evidence, 21 March 2005, p3; and Submission 2230, NSCCH, Appendix 26, p8.

Table 6.7: 2001 Auto average PM peak hour

2001 Average PM peak	**Cumulative % of total Estimated Residential Population in travel time bands**				
Travel time bands in minutes	Brookvale sites	Frenchs Forest site	Manly Hospital	Mona Vale Hospital	RNS Hospital
0-10	30%	11%	18%	16%	
10-20	67%	69%	47%	29%	18%
20-30	89%	87%	69%	52%	76%
30-40	100%	100%	85%	95%	85%
40-50			100%	100%	100%

Table 6.8: 2011 Auto 10th busiest peak hour

2011 Average AM peak	**Cumulative % of total Estimated Residential Population in travel time bands**				
Travel time band in minutes	Brookvale sites	Frenchs Forest site	Manly Hospital	Mona Vale Hospital	RNS Hospital
0-10	37%	13%	17%	13%	
10-20	61%	63%	43%	31%	
20-30	79%	76%	61%	89%	8%
30-40	97%	91%	79%	100%	43%
40-50	100%	100%	97%		68%
50-60			100%		78%
60-70					91%
70-80					100%

Table 6.9: 2011 Auto 15th busiest hour

2011 Average PM peak	**Cumulative % of total Estimated Residential Population in travel time band**				
Travel time band in minutes	Brookvale sites	Frenchs Forest site	Manly Hospital	Mona Vale Hospital	RNS Hospital
0-10	29%	11%	17%	16%	
10-20	61%	66%	46%	24%	10%
20-30	87%	86%	61%	44%	66%
30-40	100%	100%	87%	70%	85%
40-50			100%	95%	100%
50-60				100%	

Table 6.10: 2021 Auto Saturday peak hour

2021 Average AM peak	**Cumulative % of total Estimated Residential Population in travel time band**				
Travel time band in minutes	Brookvale sites	Frenchs Forest site	Manly Hospital	Mona Vale Hospital	RNS Hospital
0-10	30%	10%	16%	17%	
10-20	57%	52%	36%	39%	
20-30	67%	68%	57%	89%	
30-40	87%	81%	67%	97%	15%
40-50	97%	97%	85%	100%	40%
50-60	100%	100%	97%		52%
60-70			100%		68%
70-80					78%
80-90					94%
>90					100%

Table 6.11: 2021 Auto Sunday peak hour

2021 Average PM peak	**Cumulative % of total Estimated Residential Population in travel time band**				
Travel time band in minutes	Brookvale sites	Frenchs Forest site	Manly Hospital	Mona Vale Hospital	RNS Hospital
0-10	24%	8%	16%	16%	
10-20	51%	47%	41%	27%	10%
20-30	81%	78%	54%	32%	56%
30-40	97%	97%	81%	55%	73%
40-50	100%	100%	97%	74%	97%
50-60			100%	95%	100%
60-70				100%	

6.116 The CiT report states that "Brookvale sites" refer to more than one possible site within the Brookvale area, and that for the analysis undertaken, only one representative point was used.[345]

6.117 The CEO of NSCCH advised the Committee that of the data presented in the tables the one regarded as the best estimate was the tenth busiest time.[346] Dr Christley also advised that of the criteria that was being used to evaluate the potential new hospital sites there were two that ranked highest and one of those was travel accessibility.[347] The relevant criterion is: *Travel time by private car to emergency services < 30 minutes.*

6.118 The Committee notes that NSCCH has focussed on the relative scores in the zero to ten-minute time band. None of the sites analysed achieve accessibility for a meaningful percentage of the total estimated residential population within this time band. It is not until the 20 to 30 minute time band that significant percentages are achieved by any of the sites.

6.119 The evaluation criteria being used for selection of the new hospital is 'travel time to emergency services within 30 minutes', and the stated aim is to determine the maximum access for the maximum number of people. The Committee therefore believes that the 20 to 30 minute time band would give a better indication of maximum travel accessibility. As noted previously NSCCH have advised that this criterion does not imply that all potential patients should be able to reach the hospital in 30 minutes, but the criterion will be used to gauge the relative benefits of each site against the others.

6.120 In the 20 to 30 minute time band Mona Vale scores much better with respect to the other sites. In this time band Mona Vale has the best accessibility score on three occasions, and the

345 *Northern Beaches Accessibility Study: Travel time analysis and mapping*, Computing in Transportation, October 2002, p1.

346 Dr Christley, Evidence, 28 February 2005, p7.

347 Dr Christley, Evidence, 28 February 2005, p14.

worst on three occasions. Mona Vale achieves the best score within this time band on the 10th busiest analysis – which the CEO of NSCCH described as the best overall estimate. However, the Committee does note that Dr Christley was also of the view that most people attend a hospital in the afternoon or early evening when the traffic is heading out from the centre of Sydney so it is more difficult for them to go north rather than south.[348] In the Auto Average PM peak analysis Mona Vale achieves the lowest score in the 20 to 30 minute timeframe.

6.121 The Committee believes that Mona Vale Hospital should not be discounted as a potential site for the new Northern Beaches Hospital, as it has been suggested it should, on the basis of the travel accessibility studies to date. This is particularly the case as the area of greatest forecast future population growth is in the Pittwater LGA.

The need to travel through traffic congestion points

6.122 During discussion on travel accessibility, the issues of the heavy traffic congestion in Dee Why and the potential for major single lane access roads such as Mona Vale Road and the Wakehurst Parkway to become impassable due to accidents or flooding were raised on a number of occasions. It was suggested during the inquiry that the requirement for residents from certain areas to travel through these points should be a reason for ruling out some of the potential sites.[349] Some participants in the inquiry seized upon these comments and pointed out that any concerns about the need to travel through congestion points can only be assessed validly from the perspective of all residents that would need to travel through them.

6.123 While traffic congestion and the likelihood of potential road closures are valid concerns, which must be addressed when evaluating the potential sites for the new hospitals, they can not be used as argument for one potential site over another if each site is located on either side of the congestion point.

6.124 A primary point made to the inquiry was that Pittwater Road at Dee Why is currently a point of heavy traffic congestion. Many people are concerned that if the new Northern Beaches Hospital is located at the Civic Centre site, then it would be inevitable that the congestion would increase to the point of being intolerable for local residents and making immediate access to the hospital difficult for patients and visitors alike.

Selecting Mona Vale would increase the burden on Royal North Shore Hospital

6.125 Throughout the public hearings the Committee heard the concern of NSW Health and NSCCH that if the new Northern Beaches Hospital was located at Mona Vale then there would be an inevitable outflow of patients from the south of the Northern Beaches to Royal North Shore (RNS).[350] The consequences of this would be, it was argued, a loss of the critical mass of patients required to maintain services at the new hospital.[351] If such an outflow of patients did occur this would incur a greater financial cost as additional services would need to

348 Dr Christley, Evidence, 21 March 2005, p26.

349 These concerns and similar arguments were raised in a number of submissions to the inquiry.

350 Ms Kruk,NSW Health, Evidence, 28 February 2005, p16.

351 Dr Christley, Evidence, 28 February 2005, p2.

be placed at RNS.[352] Because RNS is a level 6 hospital it incurs a greater cost to increase patient capacity than would be incurred at a level-5 facility.[353]

6.126 The Committee also heard that RNS currently has the largest number of no-bed days of any teaching hospital in New South Wales, despite having reduced the number of out-of-area transfers.[354] A consistent increase in presentations to RNS would therefore be a significant concern. However, the Committee is not persuaded by the arguments of NSW Health and NSCCH that the predicted outflow of patients to RNS would definitely occur if Mona Vale were selected as the site for the new hospital.

6.127 On a number of occasions the example of what occurred when the paediatric unit was closed at Manly in January 2000 was cited to the Committee as a clear indication of what would occur if Mona Vale were selected. When the unit at Manly closed, paediatric patients flowed to North Shore as well as to Mona Vale, and the numbers at Mona Vale did not increase significantly enough to be used as a justification for any centralising of services there. It was argued that exactly the same result would happen if Mona Vale became the new general hospital.[355]

6.128 The Committee is of the view that this example is not analogous. During the public hearings when this issue was examined it was argued on a number of occasions that people will choose to travel further if they believe they will receive a better service.[356] Professor Kerry Goulston described it as:

> …there still is that indefinable thing that people go to a hospital that they think is the best place.[357]

6.129 When the paediatric unit closed at Manly two paediatric nurses from Manly were transferred to Mona Vale; these nurses filling existing nursing vacancies in that unit. The unit also received an additional RMO, which did finally allow 24-hour cover for the unit.

6.130 The Committee also heard that the Mona Vale maternity unit has been losing some of its patients to RNS since the opening of the new maternity unit at that hospital. People from the Mona Vale area are choosing to travel an additional 40 minutes in order to receive their service in a new unit. The change at RNS was comprised of a new building and incorporation of a birthing unit.[358]

6.131 The Committee believes that the above example illustrates that the concern about outflow of patients to RNS if Mona Vale was made the new hospital could equally apply to any of the

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352 Dr Christley, Evidence, 21 March 2005, p3.

353 Dr Christley, Evidence, 21 March 2005, p16.

354 Professor Fisher, Evidence, 21 March 2005, p7.

355 Dr Christley, Evidence, 28 February 2005, p6; Ms Hopper, BEACHES, Evidence, 28 February 2005, p86.

356 Ms Hopper, BEACHES, Evidence, 28 February 2005, p85.

357 Professor Goulston, GMCT, Evidence, 8 March 2005, p23.

358 Ms Denise Hardie, Maternity Early Discharge Program Co-ordinator, Mona Vale Hospital, Evidence [in camera subsequently published], 8 March 2005, p3 & p7.

other sites if the new Northern Beaches hospital does not provide an attractive alternative to RNS.

6.132 If Mona Vale did become the new Northern Beaches Hospital and people in the south of the catchment area did consider that they would make a choice between it and RNS then it is reasonable to assume they would factor in the relative accessibility of the two sites. It is agreed that RNS does not offer quick accessibility to Northern Beaches residents:

> Access to [Royal] North Shore is not good. Travel studies show the length of time it can take to get to North Shore in various peak times and others. It is not a particularly accessible hospital.[359]

6.133 During the public hearing on 21 March 2005 it was put to the CEO of NSCCH that if Mona Vale, or Frenchs Forest, became the site for the new Northern Beaches Hospital there was a real potential that it would attract patients from outside its designated catchment, and this could ameliorate any concerns regarding critical mass of patients. Communities, such as St Ives, with easy access to Mona Vale Road might find either of these two sites more attractive than their current options.

6.134 The CEO of NSCCH conceded that this was a possibility and that hospital catchment boundaries do not in reality reflect where patients choose to go.[360] Despite this acknowledgement, traditional health planning is based on the local catchment population and does not take into account any assumptions regarding likely potential inflows of patients from outside a designated catchment area.

6.135 It appeared to the Committee that NSW Health's concerns regarding the potential outflow of patients to RNS did not take into account the agreed two-hospital model where the second hospital would *provide a complementary but no less important range of services.*[361] If Mona Vale was selected as the major hospital it would be reasonable to presume that the complementary hospital would be located in the southern end of the area. If a new complementary hospital provided a reasonable level of services it could be expected that it would address some of the concerns about outflow of patients to RNS.

6.136 The Committee wrote to NSW Health requesting whether they could confirm that their planning allowed for the scenario of Mona Vale being selected as the site for the new Northern Beaches Hospital and, subsequent to that, a complementary hospital being developed in the south of the Northern Beaches. NSW Health responded that the PFP did not favour the selection of Mona Vale Hospital as the major acute hospital on the Northern Beaches. However, NSW Health noted that the VMS will enable a re-examination of Mona Vale and other sites.[362]

6.137 The Committee also specifically asked NSW Health to comment on the proposition that if Mona Vale was selected as the site for the new Northern Beaches Hospital and a

359 Dr Christley, NSCCH, Evidence, 21 March 2005, p16.

360 Dr Christley, Evidence, 21 March 2005, p26.

361 Dr Christley, Evidence 21 March 2005, p2.

362 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p12.

complementary hospital was developed to the south that this would account for the concern about people in the south seeking treatment at RNS. NSW Health responded:

> If the major hospital is not located in the centre of the population catchment for the northern beaches, patients may flow to the nearest major facility. In the case where Mona Vale Hospital was to be the 'major' hospital, it is likely that a higher than current portion of residents that live south of Pittwater LGA would choose Royal North Shore over Mona Vale Hospital. Locating the major hospital at Mona Vale is unlikely to reduce flows to Royal North Shore.
>
> Accessibility factors, such as travel times, traffic conditions and times of the day where patients may present to hospitals will be examined further in determining the final mix of services as part of the VMS and subsequent clinical and community planning.[363]

6.138 The Committee finds that the responses from NSW Health indicate that there has been no forward planning or allowance for the complementary hospital being located at any location other than Mona Vale. The Committee strongly believes that hypothetical concerns about *likely* outflows of patients to RNS that *may* occur if Mona Vale was selected as the major hospital should play no part in the VMS assessment process.

Conclusion

6.139 On review of the evidence the Committee finds that there is no reason why Mona Vale would not be a viable choice as the new Northern Beaches Hospital. However, the Committee is not in a position to be able to state that Mona Vale is best possible site for the new Northern Beaches Hospital, nor would it choose to do so. That decision must be determined by the current VMS process, provided that it is conducted in an open, fair and transparent manner.

The arguments for and against the Dee Why Civic Centre site

6.140 On the 6 April 2004 the NSW Health Minister announced the Warringah Council Civic Centre as the preferred relocation site for the new Manly Hospital. During the Inquiry NSCCH, while acknowledging that the ultimate decision would rest with the participants in the VMS process, clearly indicated that it believed that the Dee Why Civic Centre was the most suitable site for the new Northern Beaches Hospital.[364] The question of the suitability of the Civic Centre site drew a response from many people who made a submission to the Inquiry. For many of these people the Civic Centre site has become almost as emotive an issue as has the Mona Vale site.

6.141 Despite the fact that there were and are other sites under consideration many submission authors saw the issue of the location of the new Northern Beaches Hospital in terms of a comparison of the merits of the Civic Centre and Mona Vale. This is understandable as the announcement of the final six sites under consideration occurred well after the call for and closing date for submissions, and up to that point NSCCH had stated in its public documents that the Civic Centre was the preferred site.

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363 Correspondence, from Director General, NSW Health, to Committee Chair, 13 April 2005, p12.

364 Dr Christley, NSCCH, Evidence, 28 February 2005, p8.

6.142 Many people who made a submission that primarily outlined their support for Mona Vale Hospital or another site also included criticisms of the Civic Centre site. These centred on the issues of traffic congestion at Dee Why, the small size and sloping nature of the site and heritage issues. The following quotes are indicative of the comments made:

> I work in Dee Why and catch the bus from the corner opposite the proposed location. One only has to stand there every day to see how dangerous this junction is in normal conditions. There is a long hill and there is an enormous amount of traffic already using this busy junction. Imagine if emergency ambulances and helicopter flights are added into this equation – the chaos and accidents that will ensue. The site is sloping and the buildings already there were purpose built for the area. The cost of purchasing these and relocating/rebuilding these facilities elsewhere would be a complete waste of public money when there is a site more than suitable already in existence at Mona Vale.[365]

> How anyone could expect a General Hospital to be built on Dee Why on a site that is one quarter the size of Mona Vale is beyond belief. Unless of course the government want a high-rise hospital in which case that is even sillier because where are the roads to feed the place? Owing to terrible planning Dee Why is already chock-a-block.[366]

> The Dee Why site seems a bad joke. It is sloping, small in comparison [to Frenchs Forest site], on different levels and dark at the back. Many trees would need to be cut down, buildings demolished, roads around it are narrow at the side and back and congested at the front. The Council Chambers which won a Sulman Prize and built for a purpose should be heritage listed – it shouldn't be demolished or built around.[367]

6.143 Pittwater Council argue that since the announcement of the Civic Centre as the preferred site community opposition has grown. This opposition was publicly expressed in a rally at the Civic Centre on 18 September 2004, which was attended by almost 2000 people. Pittwater Council list the following objections to the Civic Centre site:

- potential loss of significant heritage buildings/precinct
- traffic congestion
- loss of civic open space
- residential amenity conflict with future helicopter medical transport
- limited site space available, which would require any proposal to be 'squeezed' onto the site.[368]

6.144 The submission from the NSCCH states that the Civic Centre site became the preferred site following an analysis of potential sites that was undertaken following completion of the PFP in November 2002:

365 Submission 442, Ms N McFee, p2.

366 Submission 412, Mrs G Llyod, p1.

367 Submission 453, Mrs D Carely, p3.

368 Submission 1102, Pittwater Council, p32.

> Funding was subsequently allocated for analysis of potential sites for the new Manly Hospital in the Brookvale area. Following this analysis in 2003 and the announcement by the Minister for Health in 2004, regarding the preferred site for the new Manly Hospital, more detailed analysis of the Warringah Council site was undertaken during 2004. Site analysis reports have been placed on the NSH website, and information about the findings published in the local media. The Warringah Council site is still to be the subject of a conservation management plan. Other potential sites are being examined in the interim.[369]

6.145 During the public hearings members of the Committee did raise specific aspects of the Civic Centre with representatives from NSW Health or NSCCH. While NSW Health and NSSCH were willing to respond to any specific concerns regarding the site they did not take the opportunity to offer any argument as to why they considered the Civic Centre to be the most appropriate site. They did state and emphasise on a number of occasions that it was vital that the new hospital be located in the travel centre of the northern beaches, which NSCCH defined as being between Brookvale, Dee Why and Frenchs Forest.

6.146 The Committee is aware that there are many critics of the circumstances by which the Civic Centre came to be considered as a potential site. It was suggested to the Committee that the initial approach by the Government-appointed Administrator of Warringah Council to NSCCH was part of a sanctioned deal by which Warringah Council could clear its debt.[370]

6.147 Prior to briefly examining the arguments for and against the Dee Why site that were raised during the inquiry, it is important to include an overview of the circumstances leading to the Civic Centre becoming a potential site.

6.148 Mr Dick Persson advised the Committee that early on in his period as Administrator of Warringah Council he was visited by a group of doctors. It was the view of this group that the issue of the new hospital had stalled and they were concerned that the previous Minister's commitment to build a new hospital on the northern beaches might be lost. A couple of months later Mr Persson met with Dr Christley. At that time Council was supporting a new hospital at either Frenchs Forest or the Brookvale Bus Depot.

6.149 Mr Persson advised that during his discussion with Dr Christley it quickly became apparent that the issue had stalled and, Mr Persson told the Committee, NSCCH was not positive about either of the two sites:[371]

> I asked if they had ever considered the Civic Centre site in Dee Why. I made it clear that if they wished to proceed further with evaluating this option there would need to be a public statement before any discussions were held with council. I felt it essential that any such discussions would be very open and the public aware.

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369 Submission 2230, NSCCH, p50

370 Mr Harvey Rose, SMVHC, Evidence 28 February 2005, p53; It was also suggested in Submission 2235, Community Expressions (Save Manly Hospital Campaign), p2, "that it was difficult to escape the conclusion that the real reason for the sacking of Warringah Council was to permit the appointment of an Administrator who would do the bidding of the NSW Government in respect of the Warringah Council site."

371 It may have been the discussion at this meeting which led Mr Persson to state to the Committee his belief that not all of the final six sites would be subject to serious consideration during the VMS process as quoted at paragraph 6.33.

> Subsequent to this meeting I contacted the Minister, the Hon. Morris Iemma. I wanted to make sure he was committed to building a new hospital in the area before I invested a lot of time and effort. The Minister gave me that assurance, so I allowed the process to continue. I can assure this Committee that there was no State Government agenda here. The only agenda running was, and still is, a sincere attempt on my behalf to get a decision and a commitment of funds from the State Government before other priorities overtake us. I cannot think of a single more important thing to achieve for the residents of Warringah Council than a new state-of-the-art general hospital.[372]

6.150 Mr Persson refuted the assertion that Warringah Council had a financial problem or that it carried a significant debt. Mr Persson noted that while given its circumstances Warringah was generally unlikely to have an operating surplus it had negligible debt. He advised that the sale of the Civic Centre land would provide some available capital for spending on other community projects.

6.151 Mr Persson was aware that many residents believed that the selection of Dee Why as the new Northern Beaches hospital would inevitably mean the closure of Mona Vale Hospital. He felt that uncertainty and distrust was so deeply established about this point that rational debate was almost impossible and that the resulting community division stood in the way of any consensus being achieved.[373] In an attempt to address that concern Mr Persson advised NSH that if it wished to proceed with the Dee Why site, Warringah Council would make it a contractual condition of any sale that NSW Health make a definite commitment of capital funds for an upgrade of the buildings and infrastructure at Mona Vale Hospital for the same time period as construction of the new hospital.

6.152 Mr Persson also advised the Committee that he was aware that there might be a concern among Warringah ratepayers that significant Council assets were being sold, and possibly being sold cheaply, in order to resolve an issue for a government department. To address this he has established a transparent process to ensure that all parts of any commercial transaction are open to the public and that the Council receives a good price for its assets.[374]

6.153 The following sections briefly examine some of the concerns regarding the Civic Centre site that were raised during the inquiry. It should be noted that some factors that are relevant to the Dee Why site were also examined in the section on arguments for and against the Mona Vale site.

Community acceptance

6.154 The Civic Centre site has never been the specific subject of any form of community survey regarding community acceptance or preferences. The Administrator of Warringah Council was asked for his view on the general response of the ratepayers of Warringah to the proposal to have a central hospital located in their area:

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372 Mr Persson, Warringah Council, Evidence, 8 March 2005, p3.

373 Submission 2231, Warringah Council, p5.

374 Mr Persson, Evidence, 8 March 2005, p7.

> I would have to say that initially it was quite positive. As campaigns have proceeded, I would have to say that there is a significant level of opposition to a hospital in Dee Why, primarily around the view that the area is congested and traffic will be made more difficult and more complex.[375]

6.155 The Deputy Chairperson of the SMVHC argued that there is significant local opposition to the proposal. This was evidenced by the rally held in September 2004 reported in *The Manly Daily* as having approximately 2,000 people in attendance. Mr Rose was assured that this was the largest rally ever to have been held in Warringah:

> Again, a rally was held that Dee Why mainly organised by the Save Our Civic Centre Group. We were involved as well as a group from Manly. Everyone got together. This called on the Minister for Health to abandon any plans for building a new major hospital in the Dee Why Civic Centre area.[376]

6.156 While acknowledging that this was a significant demonstration, Mr Persson believed the figure of 2,000 attendees to be an exaggeration. Mr Persson supported the right of people to protest and ensured assistance was provided in terms of sound equipment and overnight site protection. Mr Persson argued that the large number of people in attendance were mostly as a result of the 'efficient and well-oiled machine of the Save Mona Vale Hospital group'.

6.157 The relevant criterion to be used in the VMS process for evaluating potential sites is *Planning and approvals (community acceptance)*. The Committee notes that the submission from Warringah Council included a copy of the Administrator's Minute of the Council meeting on 23 November 2004 which, in part, stated:

> If NHS accepts the ultimatum about the future [funding] of Mona Vale [a condition of any sale of the Civic Centre site] the next step will involve NHS releasing a further report that will provide the community with more detailed information about design detail, traffic impacts and a timetable for community consultation.[377]

6.158 The Committee believes there is an urgent need to first fully inform the local community of the details and impact of the proposed development and secondly to assess that community's level of acceptance.

Heritage issues

6.159 There are two aspects to this issue. Many people were alarmed when the Civic Centre was first announced as the preferred site as they believed many important heritage items would be lost if a new hospital was developed on the site. These issues have substantially been resolved, although there are some who still believe that any adjoining development would diminish the overall heritage value and visual aspect of the site. However, the result of the resolution of this issue has substantially reduced the amount of Warringah Council land that is now available to 2.6 hectares.

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375 Mr Persson, Warringah Council, Evidence, 8 March 2005, p9.

376 Mr Rose, SMVHC, Evidence, 28 February 2005, p48.

377 Submission 2231, Warringah Council, p6.

6.160 Mr Persson described the effects of the anticipated heritage listings on the land now available for development:

> If a hospital was to be built on the Dee Why site with that constraint or that factor to be taken into consideration, it would not be built on the Civic Centre, or the library, or the land in between, or the fairly large car park that many of you would know as you drive through Dee Why heading north, the one on your left behind the big row of Norfolk pines. That would all remain unchanged. I believe the health department's ideas now focus on the Salvation Army site at the rear of the council, the private land at the rear of the council, the major public car park behind and to the side of the council and going through some council land down to Kingsway.[378]

6.161 Any proposal for development of a hospital on the site would have to include replacement of the currently available public car parking spaces that would be lost.

Site condition

6.162 The amount of available Council land at Dee Why is 2.6 hectares, the total size of the site being considered is 3.1 hectares. Of the six sites being considered this is equal smallest in size. However as discussed at paragraph 6.46 NSW Health advise that a site of this size is sufficient for the development of a new major hospital.

6.163 The *Northern Beaches Health Service Site Selection* document in its brief description of the Dee Why site notes that it is a sloping site with some limits on expansion or reconfiguration. Opponents of the Civic Centre site criticise the sloping land and argue that it will provide poor pedestrian access. This is currently a problem for people wishing to access Council facilities:

> I do not believe it is very good in terms of access [for] people. It is up quite a steep hill. We have a lot of elderly residents who mention that, with regard to accessing the library and the council service offices.[379]

6.164 However, Mr Persson was confident that any design concept for a new hospital would provide adequate pedestrian access:

> So far as people walking up from the bus to the Civic Centre is concerned, I know that any design concept would not have them accessing the hospital through the same trek up the hill. I think that picking a site for a hospital is obviously a complex mix of factors. As I mentioned before, I was Director-General of Queensland Health and oversaw a major rebuilding of the Queensland hospital program throughout 1994-95. From my own personal point of view the thing I am most concerned about is that the people who are not able to drive a car, do not have a car or cannot learn to drive one have access to the public hospital. It is not just for the fancy surgery, it is for a whole range of services that people access a hospital.[380]

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378 Mr Persson, Warringah Council, Evidence, 8 March 2005, p4.

379 Mr Persson, Evidence, 8 March 2005, p9.

380 Mr Persson, Evidence, 8 March 2005, p11.

6.165 The *Northern Beaches Health Service – Site Selection* document stated that the sloping site would enable multiple ground level access points to the hospital. This is presented as a positive for the site. However, the document does not indicate how people without access to a car would reach these multiple access points without being required to travel up the slope.

6.166 One of the evaluation criteria for the VMS process is ease of community access by public transport. The Committee believes the evaluation of the Dee Why site will need to pay close attention to the issue of pedestrian access particularly if public transport access terminates at the bottom of the sloping site.

Traffic congestion

6.167 The traffic congestion in Dee Why was the most frequently cited criticism of the proposal to develop the new hospital within the town centre. From the perspective of Warringah Council it was one of the four key factors affecting consideration of the site.[381] The Committee heard that the previous two councils rezoned Dee Why very generously to property owners, which resulted in a significant development of new medium-density housing. This has caused understandable concern about additional major development among residents.

6.168 The Committee heard that Warringah Council's early assessment of the traffic impact was the likely extension of the afternoon peak period, currently running from between 4pm to 5:30 or 6pm, from 3pm to that same time period. This would be largely due to the afternoon nursing shift changeover.[382] Mr Persson believed that in terms of increased congestion this would not be 'a straw that would break the camel's back'. However, he did believe that it could provide Council with some leverage with the State Government to bring about some traffic management measures that it has not been successful with in past negotiations with the Roads and Traffic Authority.[383]

6.169 Mr Persson told the Committee that if there was to be any development consent from Warringah Council the Council would first have to be satisfied that the traffic measures were adequate. The Committee heard that negotiation and interaction between Council and NSCCH regarding the potential traffic impacts has been ongoing:

> We have had a traffic study undertaken, in conjunction with the Dee Why town centre master plan, which established the existing traffic flows and also the expected flows from the development of the town centre. We have passed that on to Northern Sydney health to use in its examination of traffic issues. A preliminary report has been produced by a traffic consultant commissioned by Northern Sydney Central Coast Health. We have been provided with that information and have gone back to them with a series of questions. It is in somewhat of a state of flux of the moment.[384]

381 Submission 2231, Warringah Council, p3.

382 Mr Persson, Warringah Council, Evidence, 8 March 2005, p9

383 Mr Persson, Evidence, 8 March 2005, p10.

384 Mr Stephen Blackadder, General Manager, Warringah Council, Evidence, 8 March 2005, p11

6.170 The Committee is not aware if NSCCH is conducting similar studies with respect of the other five sites under consideration. If the VMS process is to allow a valid comparative evaluation of sites it must work from an equal base of site-specific information.

Conclusion

6.171 The Committee reiterates its earlier statement that the recommendation for the site of the new Northern Beaches Hospital must be based on the evaluation of the current VMS process.

The future of the Mona Vale Hospital land

6.172 There is a concern among many Northern Beaches residents that the Mona Vale Hospital is not being considered as the site for the new level 5 hospital because the NSW Government wishes to realise a significant profit from the sale of its land. Many submissions referred to the fact that the land was originally owned by the Salvation Army. It was clear that many people were uncertain as to who currently owned the land and whether there were any caveats on its use. Many inquiry participants believed that the land was bequeathed to the Government on the understanding that it could only be used for the site of a hospital or other community health purposes.

6.173 NSW Health advised that the land was resumed in 1955 and that the Salvation Army was paid the sum of 34,162 pounds 9 shillings and 9 pence including interest in 1959. The amount was determined by the Valuer General at the time as representing market value for the land.[385] Therefore there are no caveats on the land, and no impediments to the sale of the land by the Government if it so desired. According to valuations undertaken by the State Valuation Office in June 2004, and the NSCCH accounting records at 28 February 2005 the Mona Vale Hospital land has been valued at $25M.[386]

6.174 NSW Health and NSCCH are well aware of this concern among sections of the community that the Government wishes to sell the land, and how this has affected all facets of the community debate on the future of the hospital. In many cases any decision made by the Health authorities that directly or indirectly affects Mona Vale Hospital is linked back to this belief that the Government has an unstated motive to eventually close the hospital and sell the land.

6.175 NSW Health welcomed this inquiry as an opportunity to place very clearly on the public record that the NSW Government is committed to the retention of Mona Vale Hospital.[387] NSW Health emphasised that the current Minister for Health, the Hon. Morris Iemma, MP, and his predecessor, the Hon Craig Knowles, MP, had both made public statements that the Government was committed to retaining Mona Vale Hospital.[388]

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385 Submission 2230a, Northern Sydney Central Coast Health, p7.

386 Correspondence, from Director General, NSW Health, to Committee Chair, 18 March 2005, p3.

387 Ms Kruk, NSW Health, Evidence, 28 February 2005, p5.

388 General Purpose Standing Committee No 2, Evidence (Inquiry into Budget Estimates 2003-2004), 14 September 2004, The Hon. M. Iemma, Minister for Health, pp9-10; Hon Craig Knowles, Legislative Assembly, *Hansard*, 1 May 2003, p208.

6.176 It is clear that Mona Vale Hospital will not be closed. However it is not clear to what extent its role and level of available services will change as this is dependent upon the final selection of the site for the new level 5 hospital.[389]

6.177 While the Government has made a commitment to retain a hospital on the Mona Vale site it has not made a commitment that it will retain all of the 8.8 hectares of land. Even if Mona Vale was selected as the site for the new Northern Beaches Hospital it would be very likely that some portion of the 8.8 hectares would be available for consideration of sale; if Mona Vale does assume a complementary role an even greater portion of the land would be available.

6.178 During the inquiry NSW Health were asked whether it was proposed that the cost of the development of the new Northern Beaches Hospital would be in part funded by the sale of existing land. NSW Health advised that the selection of any of the current six sites was not predicated on the sale of any particular site. However it also advised that asset sales may or may not be part of the ultimate decision and that it was generally government policy that where assets are surplus to requirements that they be considered for sale. NSW Health did indicate that any surplus land could and should be considered for complementary health purposes such as aged accommodation.[390]

6.179 Vacant land that is suitable for development is a scarce commodity on the Northern Beaches. For this reason it is perhaps best to view such a resource in terms of whether it might be a future requirement, rather than in terms of whether it is surplus to the requirements of the present. If the Government was to sell part of the Mona Vale Hospital land this would serve to confirm the suspicion of many that the fate of the hospital was primarily determined on the basis of financial rather than community health considerations.

6.180 The Committee believes that the Northern Beaches community would be justifiably outraged if part of the Mona Vale Hospital land was sold for commercial development. This is true given the comments from NSW Health that the cost of any land purchase, such as the reputed $40M price of land at Dee Why, is a relatively small expenditure in terms of NSW Health's overall budget. However, the Committee also believes that if the land was sold or used for health service purposes then this would be acceptable to the community.

Recommendation 9

That the Minister for Health publicly announce a commitment on the part of the NSW Government that all of the Mona Vale Hospital land will be retained and in the future will only be sold or used for health services.

389 Ms Kruk, NSW Health, Evidence, 28 February 2005, p13.

390 Evidence, 21 March 2005, p9.

Appendix 1 Submissions

The Committee called for submissions through advertising in the Sydney Morning Herald and in local papers for the Northern Beaches region in early December 2004, and by writing to relevant individuals and organisations. The committee received a total of 2336 submissions.

1	Miss Kerry Euers
2	Miss Erica Goodsir
3	Mrs P.M. Kinninment
4	Mrs M De Jong
5	Mr and Mrs B and M Priday
6	MS Thelma Alexander
7	Mr and Mrs David and Libby Ingall
8	Mr Ron Davies
9	Mr Bruce Kercher
10	Mrs Rhonda Wright
11	Mrs Gwen Lawrence
12	Mr Edwin Clare
13	Mr Max Steel
14	Mrs Betty Empsall
15	Mr and Mrs Craig Savage
16	Mrs May Conder
17	Mrs Anita Kite
18	Mr and Mrs Derek Stanning
19	Mr Dave Kennedy
20	Confidential
21	Mrs Alicia Ryan
22	Mr Alard Campbell
23	Mr W Murray
24	Mr and Mrs G and L Roberts
25	Ms Erica Goodsir
26	Confidential
27	Mrs Daphne Hollis
28	Mr and Mrs R and L Woodward
29	Mr Bruce Borthwick
30	Mr Graham Spong
31	Mr T Remington
32	Ms Catherine Whiddon
33	Ms Mia Dalby-Ball
34	Ms Pam Dunkley
35	Ms Carolann Stakenburg
36	Ms Linda Cahill
37	Mr Len Riordan – Partially Confidential
38	Ms G Flakelar
39	Mrs C Kelly
40	Ms Iris Hardie
41	Cllr Patricia Giles – Partially Confidential
42	Ms Bethany Shaw
43	Name withheld
44	Mr Norman Bedford
45	Ms Joyce Smith
46	Mr K Curran
47	Mr & Mrs G and O Vanda
48	Mr H Mills
49	Mrs Leone Trim
50	Mr and Mrs Alan and Sharyn Robinson
51	Mrs Thelma Kelly
52	Mrs Jan Tully
53	Ms Shirley Phelps
54	Ms Barbara Brown
55	Ms Marcia Horan
56	Mrs Colleen Uren
57	Ms Barbara Matterson
58	Ms Julia Blenkhorn
59	Ms Margaret Reyes
60	Mrs Julie Dunn
61	Ms Rachel Pearce
62	Mrs Linda Venn
63	Mr and Mrs Dorothy and Leslie Kamaker
64	Ms Mary Paget-Cooke
65	Mr Hermann Gfeller
66	Mr Graeme Keats
67	Mr and Mrs Gillian and Stephen Richmond
68	Mr Richard Watkins
69	Mr and Mrs Eric & Tessa Felton
70	Ms Iris Pierce
71	Mr Warren French
72	Mr Gerald Laurance
73	Ms Claire Loh
74	Mr and Mrs Edwin and Susan Barnard
75	Mr R.A. Fishburn
76	Mr and Mrs LT & EJ McCotter
77	Mr A.M. Morison
78	Mr Robert Anderson
79	Mr Francis Hawdon OAM JP
80	Mr Nelson Sinclair

81	Mrs Loretta Barnard
82	Mr Robert Farr
83	Ms Veronica Rando
84	Mr and Mrs R.N. & S.M. Haverfield
85	Mr Dudley Skelly
86	Ms Anne Bell
87	Mrs Dianne Peck
88	Mr and Mrs K & R Allsop
89	Ms H.C. Malone
90	Mrs Jeanette Danser
91	Mr and Mrs George and Shelagh Champion OAM
92	Mr J Dunbar
93	Ms Jeanette Sylvester
94	Mr and Mrs R & J Stiebel
95	Mr John Loh
96	Ms Natasha Porteous
97	Ms Judy Marcure
98	Ms Valerie Trevelyan
99	Ms Angela Chellas
100	Mr and Mrs R & M Taylor
101	Mr and Mrs R & D Salisbury
102	Mr Adam Johnston
103	Dr Stafford Loader
104	Ms Regina Miller
105	Ms Gail Borthwick
106	Ms Carolyn Dowling
107	Ms Yvonne Barnes
108	Mr & Mrs Andrew and Linda Hellmich
109	Ms Ilona Hellmich
110	Mr Simon Hellmich
111	Ms Jodie Morris
112	Ms Mary Barnes
113	Mr Peter Tommerup
114	Mrs Deborah Fisk
115	Mr Peter Hodgkinson
116	Ms Pamela Rose
117	Mrs Claire Robertson
118	Mr and Mrs Peter and Georgia Deretic
119	Mr Warren Armitage
120	Ms Maree Winspear
121	Confidential
122	Confidential
123	Mr John Golden
124	Mr Ron Davies
125	Mr Jim Revitt
126	Ms Pamela Harvey
127	Mr and Mrs Bill and Janet Hay
128	Mr Artur Hellmich
129	Mr Steven Hellmich
130	Mrs Nola Halcrow
131	Mr David Hellmich
132	Mrs Janet Hunter
133	Mrs C Stapleton
134	Mr and Mrs Terry and Christina McDowell
135	Ms T Westall
136	Mr Trevor Dunbar
137	Mr and Mrs Brian and Cicely Clarke
138	Ms Jacqueline Robertson
139	Mr Bill Ryder
140	Ms Nina Matthewson
141	Ms Patricia Stewart
142	Ms Hazel Kelly
143	Mrs Bromwyn Davie
144	Mrs Denise Swallow
145	Ms Isobel Bennett
146	Mr and Mrs H & N Bacon
147	Mr and Mrs F & D Johnson
148	Mr and Mrs G & J Smith
149	Mrs Shirley Ensor
150	Mrs Mary Farrell
151	Mr Peter Richardson
152	Mr R Perrich
153	Ms Sara Taylor
154	Confidential
155	Ms Edna Fairley
156	Mr Bob Saunders
157	Mr and Mrs J &S Gorman
158	Mr & Mrs S & S Anderson
159	Mr Roy Jones
160	Mr George Ramsay
161	Mr & Mrs William and Diane Parker
162	Mr Colin Hardie
163	Ms Vivian Mare
164	Mr Lance Hopkins
165	Ms Trina Moyes
166	Mr and Mrs Fred and Ann Gunner
167	Ms Frances Smith
168	Ms Anna Cunningham
169	Ms Nola Macdonald
170	Ms Alison Annesley
171	Mr Jack Godfrey
172	Ms Trish Hyndman
173	Ms Norma Couper
174	Ms Marlene Smith
175	Mr James Somerville

176	Ms I Capel
177	Ms Margaret Primrose
178	Ms Holly Smith
179	Mr and Mrs Alan and Ann Jolly
180	Mrs Tracey Walters
181	Mr and Mrs H and M Kirk
182	Ms Patricia Shires
183	Mr and Mrs Jan & Brian Coates
184	Mr Robert Kelly
185	Mr Michael Cleary
186	Ms Pam Kinninment
187	Captain T.E. Harris
188	Ms Verl Lawrence
189	Ms Patricia Lovell
190	Ms Belinda Driver
191	Ms Sheridan Hudson
192	Ms Cassandra Mitchell
193	Ms Jo Hume
194	Ms Alison Berner
195	Confidential
196	Mr Greg Hawes
197	Mr and Mrs James and Maureen Pearce
198	Ms Anne Warell
199	Mr Paul Narmer
200	Mr B Marris
201	Ms K Austin
202	Ms Noelie Newton
203	Mrs Marjorie English
204	Ms Barbara Couston Cliff
205	Confidential
206	Dr D.I.A. Fraser
207	Mrs Betty Langford
208	Mr and Mrs George and Fiammetta Morello
209	Mr and Mrs l & L Rothwell
210	Mr and Mrs D & K Shields
211	Mr and Mrs J & T Fairbanks
212	Mr and Mrs P & J O'Mara
213	Mrs Eileen Bernett
214	Mrs Ida Anderson
215	Ms Shirley Moore
216	Mrs Wendy Morrow
217	Mrs S Poole
218	Confidential
219	Ms Renee Jackson
220	Ms Enid Gill
221	Mr and Mrs P & M Perrett
222	Mrs Imelda Vince
223	Mrs P Becker
224	Mr Edwin Reynolds
225	Mr David Thomas
226	Mr and Mrs A & B Marks
227	Mr and Mrs D & F Collins
228	Mrs Shirley Cooper
229	Mr Roger Russell
230	Mr John Hunter
231	Mr Brian Pearson
232	Mrs Cecelia Pearson
233	Mr and Mrs O & C Glover
234	Mr William Ashton
235	Dr John Ivering
236	Ms Yvette Nastas
237	Mr E Neel
238	Ms Elisabeth Holgersson
239	Ms T M Knapman
240	Confidential
241	Ms Wendy Miles
242	Ms Susan Colvin
243	Mr George Dibdin
244	Mr John Borrow
245	Mr Matthew Watt
246	Ms Alison Holland
247	Mr John Read
248	Ms Daniel Simpson
249	Ms Kim Shaw
250	Ms Martina Kammerl
251	Mr John Swainston
252	Ms Janice Bertram
253	Ms Grace King
254	Ms Tracey McCall
255	Mr Colin Woodley
256	Ms Suzanne Tonkin
257	Mr and Mrs Stuart and Michelle Dunbar
258	Mr Antony Fabbro
259	Mr and Mrs S and L Wasinski
260	Ms Jennifer Dixon
261	Ms Elizabeth Seaman
262	Ms Linda Reay
263	Mr and Mrs B and J Carroll
264	Mr Andrew Tiede
265	Mr Geoff Lintzer
266	Ms Alice Reynhout
267	Confidential
268	Ms Cherie Tilley
269	Confidential
270	Confidential

271	Ms Joan Kay
272	Mr Stephen Clark
273	Mr Kevin Buckley
274	Mrs Jan Carroll
275	Mrs Florence Bell
276	Mrs Indu Mehts
277	Mrs V Wuehr
278	Mr & Mrs John & Helen Ayliffe
279	Mrs Valda Barnes
280	Mr D McMurray
281	Miss Georgia Cunneen
282	Mrs Audrey Foster
283	Mr & Mrs Thomas & Pauline Howells
284	Mr F.W. Spencer
285	Mr & Mrs P & M Curtis
286	Miss Ashlee Cunneen
287	Mr Alan Cunneen
288	Mrs Patricia Reeve
289	Mr John Russell-Wood
290	Ms Kaye Dexter
291	Ms Alison Carr
292	Mrs Enid Pate
293	Mrs Rachel Symons
294	Mr & Mrs RJ & JI Forbes
295	Mr David Williams
296	Mrs Jean Osborne
297	Mrs Elizabeth Bliss
298	Mrs Maureen Stuart
299	Mr K Stuart
300	Mr Alex Glauerdt
301	Mr Robert Thomas Dunn
302	Mr Eric Gumley
303	Confidential
304	Mrs Genevieve Allen
305	Confidential
306	Mr Phil Diacono
307	Mr Paul Wilson
308	Ms Jennifer Fisher
309	Mr Ros Duesbury
310	Mr & Mrs Dennis & Andrea Casper
311	Mr & Mrs Tom & Jay English
312	Mr George Phelps
313	Mr JR Philip
314	Name withheld
315	Mrs Ruth Pursehouse
316	Mrs M Martin
317	Mr & Mrs P & B Osborne
318	Mrs Jenny Hill
319	Mrs Betty Kopetko
320	Mr & Mrs Pat Bennett
321	Mrs Helen Williamson
322	Mr & Mrs Allen & Patricia Edmonds
323	Mr Bill Willcox
324	Mr Rik Deaton
325	Mr Neville Watkins
326	Mrs Jean Broadhurst
327	Mr & Mrs Richard & Irene Green
328	Mr Bryce Ross-Jones
329	Mrs Cherie Tilley
330	Mrs Patricia McKenzie
331	Mr Michael Yates
332	Ms Angela Petith
333	Mrs Margaret Hayes
334	Mrs V A Woodward
335	Mrs Beth McLean
336	Mr Richard Jess
337	Mrs Helen Rosenkranz
338	Mr Bernard Cox
339	Mr JW Newham
340	Confidential
341	Mr & Mrs Paul & Meryn Kay
342	Mrs A Risk
343	Mrs E Jeans
344	Mr & Mrs B & J Griffiths
345	Mr D F Castle
346	Mr P.L. Ferrero
347	Name withheld
348	Mr & Mrs Simon & Anna Kramer-Higgins
349	Mrs K Drury
350	Mrs Margaret Halgren
351	Mrs Joan Rae
352	Mrs N Beuz
353	Mrs B Duncan
354	Mr & Mrs J Fudge
355	Mrs Margaret Strachan
356	Mr Ronald Dunphy
357	Mr Carlo Bongarzoni
358	Mr & Mrs Ian & Carmen Sablatnig
359	Mrs Wendy Starkie
360	Mrs Sandra Skelly
361	Mr Edward Holburn
362	Mrs Nola Clark
363	Mr David Skidmore
364	Mr Frank Saunderson
365	Mr & Mrs Maurice & Pamela Gunter
366	Mrs Laurie Seaman

367	Mr & Mrs Mal & Linda Cheese
368	Mr Peter Hyde
369	Mr Colin Pocklington
370	Mr & Mrs Darren & Nicole Maddock
371	Mr Mark Buizen
372	Confidential
373	Mr & Mrs Brian & Kathleen Challen
374	Mrs Kathleen Jenkins
375	Mrs C Guzman
376	Mrs Sandra O'Keefe
377	Mr Robert Whittaker
378	Mrs Anita Kite
379	Mrs Laura Deeby
380	Mrs Jenny Heming
381	Mr David Hammond
382	Ms Claudette Moffatt
383	Mrs Rebecca Hammond
384	Mr Ian Holmes
385	Mrs Elizabeth Denham
386	Confidential
387	Mr & Mrs Ronald & Susanne Davies
388	Ms Sally Nicholson
389	Mr Stephen Charlesworth
390	Mrs Shirley Kalf
391	Mrs V Steward
392	Mr & Mrs Michael & Fiona Turner
393	Confidential
394	Ms Carolyn Hely
395	Ms Felicity Davis
396	Ms Susan Stephens
397	Mr & Mrs Barry & Joan Watts
398	Mr Walter J. Murphy
399	Mr & Mrs Malcolm & Meredith Jansen
400	Mr David Gleen
401	Mr & Mrs R & S Murdock
402	Mr & Mrs John & Daphne Mobbs
403	Mr & Mrs Richard & Pamela Links
404	Ms Marian Cunneen
405	Mrs Margaret Niall
406	Ms Eleoura Spasic
407	Mr Ron Pate
408	Mr A.R. Hill
409	Mr S J Payne
410	Mr Brian Greig
411	Mrs Beverley Wilson
412	Mrs Georgina E Lloyd
413	Mr & Mrs M.C. & L.G. Touw
414	Mr & Mrs David & Linda Batchelor
415	Mrs S Boon
416	Mr & Mrs C.G. & C.F. Esterman
417	Mr & Mrs David & Libby Ingall
418	Confidential
419	Mrs D.W. Williams
420	Mr E.W. Brown
421	Mrs Kathleen West
422	Mr Norman Poppleton
423	Ms M Hertslet
424	Mrs Eileen Blackall
425	Mr & Mrs Jack & Elaine Levy
426	Mr Phillip Eckford
427	Mrs J Mills
428	Mrs Veronica Thomas
429	Ms Terrie Harper
430	Mr & Mrs Julie & David Simpson
431	Mrs Norma Watt
432	Ms H Airns
433	Ms Dianne Cook
434	Mr W.L. Thomas
435	Ms Heather McCallum
436	Ms Elsie Nicholson
437	Mr & Mrs Ken & Marie Muir
438	Ms Margaret Parsons
439	Mr & Mrs Michael & Helen Meares
440	Mrs V Cunningham
441	Mrs E.M. Glover
442	Ms Nora McFee
443	Mrs Sue Chessbrough
444	Mr & Mrs John & Jan Delohery
445	Mr Walter Drain
446	Mr & Mrs Ken & Irene Harris
447	Mrs Grace Pate
448	Ms Patricia Leslie
449	Ms Genevieve Allen
450	Name withheld
451	Rev Ken Gilmore
452	Mr & Mrs T & M Roberts
453	Mrs D Carely
454	Ms Gillian Waterhouse
455	Mr Gregory R Ross
456	Mr & Mrs Nick & Christine Durrant
457	Name withheld
458	Mr Andrew Edwards
459	Mr Colin Thompson
460	Mr Syd Russell
461	Ms Joanne Marshall
462	Mr David Heather

463	Ms Tara-Jane Thornton
464	Mr Henry Lo
465	Ms Joan Young
466	Name withheld
467	Ms Madeleine A Gilmour
468	Ms Suzie Erdbrink
469	Mr Bill Stanley
470	Mr & Mrs John & Elizabeth Barraclough
471	Ms Dianna Locke
472	Mr D.A. Williams
473	Mr & Mrs Robert & Catherine Chidgey
474	Mr James Fairley
475	Mr & Mrs John & June Gormley
476	Mrs Babs Spring
477	Mr & Mrs Laurie & Sue Bombardiere
478	Ms Ingrid Brand
479	Mr & Mrs Geoffrey & Adrienne Yates
480	Mr & Mrs Bill & Alvia Buckle
481	Mr Laurel McLaren
482	Mr Eric Rogers
483	Ms Judith Hutchings
484	Mr C.K. Brown
485	Mr James Hill
486	Mr Ric Hubbard
487	Mr & Mrs David & Lynette Millett
488	Mr & Mrs David & Kerryn Odell
489	Mr Robyn Eather
490	Mr Michael Asbridge
491	Confidential
492	Ms Elizabeth Henderson
493	Mr John Cregan
494	Ms Judith Burer
495	Mr Steve Jordan
496	Cllr Lynne Czinner
497	Mr Peter Burgess
498	Mr Bahram Boutorabi
499	Mr Ramtin Shams
500	Mr Mei Chua
501	Mr Neela Sarkar
502	Mrs Robin Hill
503	Mr Dilys Graham
504	Ms Sandra Young
505	Ms Mary Fisher
506	Mr Corry Dancaster
507	Ms Anne Sherwood
508	Mr Rod Stephens
509	Mr & Mrs John & Pat Mumford
510	Mr Colin Peek
511	Ms W.B. Matterson
512	Mr Simon Walker
513	Mr Len Hall
514	Ms Wendy Gleeson
515	Mr & Mrs Peter & Allison Bosley
516	Mrs Maureen Chambers
517	Mr & Mrs Alan & Doreen Walter
518	Confidential
519	Mr & Mrs Bruce & Kerrie O'Hagan
520	Mr Bobbie Winger
521	Mr & Mrs Norman & Pamela Smith
522	Ms Dora Booth
523	Mr & Mrs John & Barbara Seaton
524	Ms Sally Johnston
525	Mr Andrew Timmis
526	Mr Richard J. McIntyre
527	Mr Ross Alexander
528	Ms Lindy Hubbard
529	Mr & Mrs John & Lynette Illingsworth
530	Mr & Mrs Ray & Dorothy Barnes
531	Mr R Mesker
532	Ms K Burton
533	Ms Kim Sharpe
534	Ms Gwen Allen
535	Mr Eric Pearse
536	Ms Edna Fairley
537	Mr & Mrs Garth & Jennifer Wilson
538	Mr & Mrs Ken & Carole Jones
539	Mrs Jann Kennedy
540	Ms Marita Macrae
541	Ms Elizabeth Capel
542	Mr & Mrs G.T. Stokes
543	Mr & Mrs Anthony & Jan Rathbone
544	Mrs M.A. Baxter
545	Mr & Mrs S & K Bartlett
546	Mrs Yvonne Purll
547	Mr & Mrs C.A. & M.B. Bartlett
548	Mrs Justine Lay
549	Ms Janet Petterson
550	Ms Frances Kasch
551	Mr Bill Sinclair
552	Mr John Patterson
553	Ms Mary M. Charlesworth
554	Ms Olga Byron
555	Dr & Mrs Keith & Judy Amos
556	Ms T Bennett
557	Mr R.J. Baxter
558	Mr V Mullins

559	Ms Sandy Tall
560	Mr Peter Shears
561	Mr Peter L Kellaway
562	Mr Richard Womack
563	Ms Bridgid McLean
564	Mr Craig Woodroff
565	Mr & Mrs Max & Norma Watt
566	Mr & Mrs P & R Squire
567	Mrs Betty Bell
568	Mr & Mrs Bill & Bernice Yates
569	Ms Eileen Gordon
570	Ms Janice Russell
571	Mrs N Grunseit
572	Ms Maureen Adshead
573	Ms Pam Phelan
574	Mr Winsome M Forbes
575	Ms Lisa Ess
576	Mr John Goosen
577	Mrs N Willsher
578	Mr Ian Wradrowski
579	Mr & Mrs N & J Johnson
580	Mr & Mrs R & J Veale
581	Mr & Mrs H & N Kranenburg
582	Mr Rodney Forbes
583	Ms Ann D. Owens
584	Mr Michael Moss
585	Confidential
586	Mrs Molly Adams
587	Mrs J Hanly
588	Mrs Patricia Farrow
589	Mrs Joyce Low
590	Mr John Cobb
591	Mr John Stephen
592	Mr John A. Reed
593	Dr J.B. Roche
594	Mr & Mrs K Curtis
595	Ms Rachel Symons
596	Mr Simon Abel
597	Mr Michael McGowan
598	Mr & Mrs Everton
599	Ms Yvonne Farrawell
600	Mrs Elizabeth Balparry
601	Mr & Mrs G Livingston
602	Mr & Mrs K Edsien
603	Mr Robert Kasch
604	Ms J Bayley
605	Confidential
606	Mrs June Malakou
607	Mr Peter Haes
608	Ms Welma Laierick
609	Ms Marguerite M. Morgan
610	Mr George Bennett
611	Fr William Tyer
612	Mr M Robinson
613	Ms Margaret De Low
614	Mr John W Jenkins
615	Ms Connie Fierravanti-Wells
616	Confidential
617	Ms Nancy Page
618	Mr Ian Major
619	Mrs B Menier
620	Mr John D Seilley
620a	Mr John D Seilley
620b	Mr John D Seilley
621	The Hon Bronwyn Bishop
622	Confidential
622a	Dr Stuart Boland (Surgeons & Anaesthetists, Mona Vale Hospital)
623	Ms Heather Ga
624	Confidential
625	Ms Tess A Ewan
626	Mr Peter Castle
627	Ms Jennie MacKenzie
628	Ms Susan Ross
629	Mr A Graham
630	Mr Luke Carter
631	Mrs June Gillian
632	Mr & Mrs John & Evelyn Douglas
633	Confidential
634	Ms Caressa Crouch
635	Ms Joan Plumley
636	Mr Martin Kemp
637	Ms P Hunstead
638	Ms Lynette O'Neill
639	Mrs A McGuinness
640	Mrs Mary Newlinds
641	Dr & Mrs Ian & Deborah Hendy
642	Mr Stephen Mitchall
643	Mr George Shirling
644	Mr & Mrs Kevin & Jeni Connolly
645	Mr & Mrs JF Delohery
646	Mr Gary D Wilson
647	Mr Alan Stansfield
648	Ms Katharina Standen
649	Mrs Elizabeth Cullen
650	Mr Mina Yavari

651	Mr Mike Grinham
652	Ms Robyn Strevens
653	Mr & Mrs Ray & Kay White
654	Ms Marion van den Driesschen
655	Mr John Barnes
656	Ms Marketa Vacek
657	Ms Vicki Martin
658	Mr W N Croasdale
659	Mr & Mrs David & Joan Pitt
660	Mr Ray Hawkins
661	Ms Sue Richards
662	Mr & Mrs Tim & Cathie Cahill
663	Ms Katy Dixon
664	Mr & Mrs Brian & Rita Cox
665	Mr & Mrs Lewis & Patricia Morrell
666	Mr & Mrs M Kitching
667	Mr Mark Norris
668	Ms Mari-Louise Kelly
669	Ms Jan Buckingham
670	Ms Gillian Unwin
671	Mr Gay McCorby
672	Ms Roslyn Black
673	Mr Karl Mullin
674	Mr & Mrs Geoff & Helen Mulcahy
675	Mr Peter Newman
676	Mr Peter Phelps
677	Mrs Elizabeth Chambers
678	Ms Sue Martin
679	Mr Jan Pothof
680	Mr Malcolm Malone
681	Mr & Mrs Bob & Lindie Rogers
682	Mr & Mrs Michael & Amanda Warby
683	Mr & Mrs Simon & Anna Kramer-Higgins
684	Mr & Mrs Larry & Alison Turmure
685	Mr & Mrs Christian & Tracey Trinder
686	Mr Greg Doyle
687	Ms Maree Nutt
688	Mrs Cathy Doyle
689	Mrs Brigitte Mills
690	Mr Stephen Wells
691	Mr & Mrs Colin & Syl Hughesdon
692	Ms Vanita Ogden
693	Ms Amanda Roche-Brown
694	Ms Ellen Ash
695	Ms Nicole Freeman
696	Ms Narelle Deeney
697	Mr M Richmond
698	Confidential
699	Ms Sharon Esterman
700	Mr Davyd Wergs
701	Dr Alison Jane Rawling
702	Mr A J McTaggart
703	Mr & Mrs Anthony & Narelle Mutton
704	Ms Glynda Hurley
705	Professor Kerry Goulston (GMCT)
706	Ms Ann McIntyre
707	Ms Kate Needham
708	Mr & Mrs D.G. & L.J. Peacocke
709	Ms Joan O'Johnson
710	Mrs Patricia Vandenhout
711	Mr H Lawson
712	Mr Allan J Hicks
713	Mrs Pamela Quintin
714	Mr Peter Foster-Bunch
715	Mr B Stain
716	Mrs Barbara Andersory
717	Mrs A Byrne
718	Mr Peter Mangles
719	Confidential
720	Dr Paul Phipps
721	Mrs J Baker
722	Ms Elizabeth Stoner
723	Mr Parry Thomas (SMVHC)
724	Mrs Mary Gartner
725	Dr Graham Robards (BEACHES)
726	Mr Peter Randazzo
727	Ms Nancy Carrington
728	Mr P Pringle
729	Ms Enid Pringle
730	Ms Mary Burke
731	Ms Helen Dawson
732	Ms Mae Rae
733	Ms Kim Latham
734	Ms Elizabeth Minwick
735	Ms Vera Jones
736	Mr Josh Sassen
737	Mr Tate Williams
738	Ms Leanne Procopis
739	Ms Emma Couch
740	Mrs H M Criss
741	Mrs E J Radford
742	Ms Margaret Davis
743	Ms Sue Riley
744	Mrs R Holmes
745	Ms Julie Connell
746	Ms Linda Moss

747	Mr Reg Duncan
748	Mr David Inglis
749	Mrs Parr Ahrens
750	Ms Ruth Gunn
751	Mr S Randall
752	Mr Trevor Gay
753	Mr John Oswald
754	Ms Penny Destasi
755	Mr Paul Destasi
756	Ms Tanya Winner
757	Mr Iroh Skinner
758	Mr N Woodworth
759	Ms Pamela Campbell
760	Mr Clifford Lord
761	Mr P Turton
762	Mr Ben Sutton
763	Ms Linda Pedersen
764	Ms Mary Davidson
765	Mr L Lowry
766	Ms Beryl Ford
767	Mrs Nancy Riley
768	Mr Robert Young
769	Ms Narelle Carroll
770	Mr Peter Minichini
771	Mrs Giuseppina Minichini
772	Ms Hilary Rowell
773	Mr Ray Kaufmann
774	Mrs D Booth
775	Ms Claudia Aubort
776	Ms Allison Peterson
777	Mr Paul Dwyer
778	Ms Jan Prior
779	Ms Rebecca Tringham
780	Mr & Mrs Wendy & Dave Thomas
781	Mr Simon Belford
782	Mr Lee Elsley
783	Mr Trevor EDWARDS
784	Ms Christine Meyers
785	Mrs Liz Watson
786	Mr L Ucogt
787	Ms Sharen Foster
788	Mr Jack Carpenter
789	Mr Steve McCabe
790	Mr Charles O'Shea
791	Mrs A Collins
792	Ms Helen Webster
793	Ms Edwina Parkin
794	Mr Nick Simonetti
795	Ms Emma Vonk
796	Ms June Sutcliffe
797	Mr David Giles
798	Mr Rocco Scamarcia
799	Ms Sue Crawford
800	Ms Shirley Ford
801	Mr & Mrs Eric & Joan Bruce
802	Ms Louise Lynas
803	Mrs G D White
804	Mr George Fairburn
805	Confidential
806	Mr & Mrs Arthur & Joy Hartshorne
807	Mrs Fogwell
808	Mr Barry Paterson
809	Mrs Pam Brown
810	Ms Diana Baker
811	Ms E Morgan
812	Ms Jean Legar
813	Mrs Kim Gobbe
814	Mr Derrick Peers
815	Ms Margaret Peers
816	Mrs Pam West
817	Mr & Mrs Rodgers
818	Mr Colin Williams
819	Mr & Mrs Neil & Beverley Anderson
820	Mrs Jean Calcraft
821	Ms June Ireland
822	Ms Mundie Macfarlane
823	Mrs L Reglin
824	Mr Robert Reglin
825	Mr Peter Spring
826	Ms Catrina Hodges
827	Ms Adelina Cimino
828	Mr/Mrs D Lyall
829	Ms Ann Reeve
830	Ms Kylie Ferguson
831	Mrs H Lyall
832	Mr/Ms Virgina Cleary
833	Ms Alice Cleary
834	Ms Renae Leopold
835	Mr/Ms J Bridgman
836	Mrs Joan Leonard
837	Mr Jeremy Toolin
838	Mr Malcolm Toolin
839	Mrs M Bridgmay
840	Mr Norman Mowbray
841	Mr & Mrs J Cameron
842	Ms Maureen Bishop

843	Mr P A Keen
844	Ms A Atkins
845	Mr Bob Zavodna
846	Mrs C Cave
847	Mr Gareth Morgon
848	Ms Phyllis Moore
849	Mr Howard Friend
850	Ms Beverly Slocombe
851	Mr Arthur E Murphy
852	Ms Dragana Lalic
853	Ms Bianca Barnwell
854	Mrs M Carpenter
855	Mr & Mrs Laurie
856	Ms Lauren Phipps
857	Mr & Mrs B Taylor
858	Mrs Barbara Colen
860	Mr D Cavanagh
861	Mrs Rita Di Bello
862	Mr John DeAngeli
863	Mr E W Brown
864	Ms Megan McCrostie
865	Ms Tracy Newlands
866	Ms Lynne Burgess
867	Ms Navelle Turvey
868	Mr Richard Martin
869	Ms Ruby Burgess
870	Mrs Linda Halligan
871	Ms Ingrid Ambrosius
872	Ms Audrey Ward
873	Ms Barbara Champion
874	Mr & Mrs M & T Calcagno
875	Ms G M Welch
876	Mr Keith Dooley
877	Name withheld
878	Mr Jason Murphy
879	Mr B Kilgour
880	Mr J A Beresford
881	Ms Joan Gates
882	Mr Don Gates
883	Ms Victoria Van Brugge
884	Ms Lorrie Morgan
885	Mrs R Erdely
886	Ms Rosemary Garrity
887	Mrs S Stanek
888	Mrs Julia Beckley
889	Mrs Verelle Williams
890	Mr & Mrs John & Betty Rice
891	Mrs Robin Newman
892	Mr & Mrs D & A Mitchell
893	Ms Brigitte Rowland
894	Mr J Wheaton
895	Mr J Elliott
896	Ms Kate Hush
897	Ms Karen Hawes
898	Ms Anne Flitcroft
899	Mr Ted Calanruccio
900	Mr Mark Lennon
901	Ms Diane Day
902	Mr R White
903	Mrs L White
904	Ms Penny Walton
905	Ms Monique Stidwill
906	Ms Lisa Stain
907	Mrs Julie Norris
908	Ms Judith Martin
909	Mr Lawrence Gardner
910	Ms Hilda Potter
911	Ms Sherene Burgmann
912	Ms Louise Manton
913	Mrs Beryl Gardner
914	Ms Dianne Watts
915	Ms Collette Searl
916	Mr Geoff Searl
917	Mrs F Linton
918	Mr H Hodgkinson
919	Ms P Henry
920	Mr S E Hardy
921	Mrs M Hardy
922	Mrs Pauline Brown
923	Ms Rosemary Robertson
924	Ms Kay Sutton
925	Ms Vikki Tanswell
926	Ms Jan Blake
927	Ms Krystine Combs
928	Mr Phillip Tubb
929	Mr M Combs
930	Mr H Williams
931	Mr Herbert Brownlee
932	Ms Katie Somerville
933	Mr W Williams
934	Ms Jean Wellings
935	Mr Chris Grout
936	Mrs B Carne
937	Ms Beryl Williamson
938	Ms Pamela Sauer
939	Ms Cherie Ireland

940	Ms Diane Birdsall
940	Ms Diane Ellicott
941	Mr M Wicox
942	Ms Tina Henry
943	Mr W Koch
944	Mr Jim Hutchings
945	Ms Patricia Koch
946	Ms E Nero
947	Ms Margaret Wright
948	Col J P Death
949	Mr A Kelly
950	Mr M Wester
951	Ms C Westen
952	Mr H Bald
953	Ms Margaret Francis
954	Mr Matt Rice
955	Ms Pamela Drurey
956	Ms Rosemary Richie
957	Mr Gordon Trimble
958	Mr Rex Steickey
959	Ms Samantha Rice
960	Ms Sigrid Baldi
961	Ms Emily Gazal
962	Ms Ann Harriman
963	Ms Margaret Shepheard
964	Mr W Thomas
965	Ms Ira Kaurinovie
966	Mr L Newell
967	Mr & Mrs Bourell
968	Ms Lorna Aitchinson
969	Mr Nigel Rowland
970	Ms Eunice Owenden
971	Ms Monica Gribble
972	Mr Peter Lambert
973	Ms Kathleen Walton
974	Ms Jean Liebert
975	Ms Mary Fenner
976	Ms Olive Carpenter
977	Mrs K Lockheart
978	Mr Ken Fawkner
979	Ms I Kisky
980	Ms Beverly Sinclair
981	Mr Ken Sinclair
982	Ms Astrid Fawkner
983	Ms Gweneth Woodbury
984	Ms Betty Forbes
985	Ms Mary Dominello
986	Mrs B Monty
987	Ms Judith Trumper
988	Ms Heather Dolan
989	Ms Lynette Smith
990	Mr Barrry Trumper
991	Ms Kim Maaka
992	Ms Cherie Adlard
993	Ms Judith Beggs
994	Ms Colette Lambert
995	Mr B Wood
996	Mr & Mrs S & B Dobrich
997	Mr W S Beale
998	Mrs W S Beale
999	Mrs D Brownlie
1000	Mr W Rodgers
1001	Ms R Warren
1002	Mr Robert Johnson
1003	Ms Elizabeth Davies
1004	Ms Sonja Navakas
1005	Mrs Eila Cox
1006	Mr H Fraser
1007	Mr Terry Ryan
1008	Mr Michael Clinen
1009	Mr J Fredrick
1010	Ms Margaret Cox
1011	Mr J Brusey
1012	Mr Tony Cullen
1013	Mr Kenneth Hughes
1014	Mrs Lynette Sue
1015	Mr A Golden
1016	Ms Lynne Dennis
1017	Mr David Mason
1018	Ms Elizabeth Bennett
1019	Mr and Mrs Dalton
1020	Mr & Mrs Bernotas
1021	Mr Frank Adshead
1022	Mrs Lynette Hess
1023	Mr & Mrs Morgans
1024	Mr Wes Harder
1025	Mr William Tyer
1026	Ms Helen Turrall
1027	Mr Anthony Sergas
1028	Mr Don Morgan
1029	Confidential
1030	Mr Adam Carter
1031	Mrs Maureen Hillier
1032	Name withheld
1033	Mr Harold Booth
1034	Ms Nicki Kranenburg

1035	Ms Jeanette Buckley
1036	Mr & Mrs Kasch
1037	Mr P Bayldon
1038	Mr & Mrs Stewart
1039	Mr & Mrs Muires
1040	Ms Alina Bead
1041	Mr & Mrs Treharne
1042	Mr & Mrs Barraclough
1043	Mr E Mullin
1044	Mrs Marie Digby
1045	Mr & Mrs Noone
1046	Ms Lynne Gumbleton
1047	Ms Olive Taylor
1048	Mr Brian Gaukrodger
1049	Ms Julie Brackenreg
1050	Ms Linda Conroy
1051	Ms Marie Conroy
1052	Ms Anne Hinds
1053	Mr Jeff Skebe
1054	Mr Frank Adshead
1055	Mr David Reynolds
1056	Mr M Watson
1057	Mr & Mrs AJ Durst
1058	Ms Marjorie Simpson
1059	Ms Herminie Swainston
1060	Mr Brian McKevitt
1061	Mrs Joan Webster
1062	Mr Stephen Dearnley
1063	Ms Barbara McCarthy
1064	Ms Jean Spiers
1065	Ms Ella Familo
1066	Ms Hylda Lane
1067	Ms Valda McLerie
1068	Mrs H Day
1069	Mr Wilfred Conroy
1070	Mrs Dorothy Watson
1071	Ms Barbara Smith
1072	Mr & Mrs Oakley
1073	Ms Marilyn Guion
1074	Mr & Mrs Beck
1075	Mrs E Adams
1076	Mrs W Baird
1077	Ms Denise McTaggart
1078	Mr Alex McTaggart
1079	Confidential
1080	Mr John Halcrow
1081	Mr C Adams
1082	Ms Allison Peterson
1083	Mrs Judith Frejer
1084	Ms Jan Golden
1085	Ms Margaret Gould
1086	Mr & Mrs Mayne
1087	Mr Phillip Thompson
1088	Mr D P Evans
1089	Mrs Dorothy Olson
1090	Ms Marjorie Kay
1091	Mr & Mrs Croften
1092	Dr Stephen Nolan
1093	Mr & Mrs Horten
1094	Ms Annette Lanham
1095	Confidential
1096	Ms Danijela Spadina
1097	Mr & Mrs M Martin
1098	Ms Eleanor Hawke
1099	Mr Tim Mussared
1100	Mr Carl Gonsalves
1101	Ms Imelda Mason
1102	Cr Lynne Czinner (Pittwater Council)
1103	Mrs Gabrielle Hogan
1104	Ms Patricia Boydell
1105	Mr P Ribbon
1106	Mr P J Donaldson
1107	Mrs B J Donaldson
1108	Mr Agostino Sergas
1109	Mrs Helen Sergas
1110	Mr Julio Moretto
1111	Mr John F Rose
1112	Ms Patricia Rose
1113	Ms Nancy Vukobratovich
1114	Mr & Mrs J Mathison
1115	Ms Mary Martin
1116	Mr & Mrs N Pasalich
1117	Ms Kerry Wright
1118	Ms Ruth Holdsworth
1119	Ms Carole Spring
1120	Ms Julie Holdswoth
1121	Mr & Mrs Robert & Janet Constable
1122	Ms Louise Canney
1123	Ms Maureen Coggio
1124	Ms Jodi Mason
1125	Ms Janine Wolfgramm
1126	Ms Tessa Inglis
1127	Mrs Gwen Henry
1128	Ms Jess Joils
1129	Ms Barbara Elwin
1130	Mr David Fealy

1131	Ms Margaret Lawson
1132	Mr Steve Fealy
1133	Mr E A Casey
1134	Ms Maria MacFanlane
1135	Ms Carolyn Fealy
1136	Ms Betty Wallace
1137	Ms Jane Fealy
1138	Mr William Fealy
1139	Ms Tammy Jackett
1140	Ms D S Wallace
1141	Mrs J Kitson
1142	Ms Barb Byrne
1143	Ms Sally Angus
1144	Ms Tiffany Barber
1145	Ms Michelle Smith
1146	Mr M Bennett
1147	Ms Donna Rushton
1148	Ms Vanessa Cox
1149	Ms Brigitte Donnan
1150	Dr Lorna Hollis
1151	Mr Christian Van Der Plaat
1152	Ms Shirley P Wright
1153	Ms Lisa Watkins
1154	Ms Denise Wilson
1155	Ms Robyne Fleuer
1156	Ms Robyn Mowatt
1157	Ms Olive Vehelite
1158	Mrs E Cuthbertson
1159	Ms Audrey Douglas
1160	Mrs B Moon
1161	Ms Jennifer McLean
1162	Mr David Phipps
1163	Mr J Potts
1164	Ms Margaret Kolarik
1165	Ms Dorothy Healey
1166	Ms Nancy Oakley
1167	Ms Norma Moss
1168	Ms Laurel Hocking
1169	Ms Kylie Slater
1170	Mr B Robinson
1171	Ms Margaret Friend
1172	Mr R Robinson
1173	Ms Maria Dwola
1174	Mr B R Gubbay
1175	Mrs D Olson
1176	Ms Vicki Diggins
1177	Ms Carolyn Salvog
1178	Ms T Keen
1179	Ms Alison Hammell
1180	Mr Robert Albers
1181	Ms Linda Myles
1182	Ms Merriel Coxhill
1183	Ms Sheryn Woon
1184	Mr B Harman
1185	Mr G Simmons
1186	Ms Kate Cleary
1187	Ms Samantha Du-Ross
1188	Ms Emma Norris
1189	Ms Rosanne Harvey
1190	Ms Leanne Easterby
1191	Mr Frank Winter
1192	Mr D Hyde
1193	Ms Linda Weynton
1194	Ms Doreen Crapp
1195	Ms Kaye Samus
1196	Ms G Klein
1197	Ms Halina Royle
1198	Ms Leah Davids
1199	Ms Matilda Finnegan
1200	Ms Jaime McCabe
1201	Mr J Hopton
1202	Ms Carolyn Hawkes
1203	Mr Daniel Solvyns
1204	Mr Nicky Matthews
1205	Ms Karen Ferrier
1206	Mrs Hastlieren
1207	Ms Allison Copo
1208	Mr William Robbie
1209	Ms Patricia Wallington
1210	Mr S Van Dyke
1211	Mr Lee Coates
1212	Mr Damian Walczak
1213	Mrs J I Williams
1214	Mr P Dousset
1215	Mrs Joan Dousset
1216	Mrs B Harrison
1217	Mr Darren May
1218	Ms Joanne Vertel
1219	Ms Lorraine Maitland
1220	Mrs June Buckylen
1221	Ms Gillian Wilson
1222	Mr & Mrs G Kibble
1223	Mr Geoff Wilson
1224	Ms Zoe Ferrier
1225	Mr Alan Calcraft
1226	Mr Lionel Kools

1227	Ms Francesca Glass
1228	Mrs Sylvia Winterbottom
1229	Miss Madelene Matthews
1230	Ms Chloe Hazelwood
1231	Ms Sheree Seymour
1232	Ms Patricia Eleftherion
1233	Mrs Betty Liesen
1234	Mr S Leech
1235	Ms Margaret Ridley
1236	Ms Margaret Le Clere
1237	Mr Andrew Knight
1238	Ms Kelly Tremain
1239	Mr Paul Abbott
1240	Ms Ellen Clendining
1241	Ms Janine Christensen
1242	Mr Chris Senior
1243	Ms Shirley Ensor
1244	Mr E Christie
1245	Mrs M Loughan
1246	Mr Jason Cladming
1247	Mr M Seymour
1248	Ms Annette Hardwich
1249	Ms Susan Logan
1250	Mr W Klassey
1251	Ms Louise Yarker
1252	Ms Ayleen Assim
1253	Mr T Morris
1254	Ms Lucy Morris
1255	Ms Katie Morris
1256	Ms Margaret Edwards
1257	Ms Valerie Keirle
1258	Mr Jerome Gallo
1259	Ms Norina Dragovic
1260	Ms Robyn Lee
1261	Ms Carolyn Nerrie
1262	Ms Kimberley Brennan
1263	Ms Allyson Lenaghan
1264	Ms Draga Vrcek
1265	Ms Nanette Law
1266	Ms Kerry Spence
1267	Mr & Mrs J & M Garrard
1268	Ms Sandra Ferro
1269	Mrs M Kerslake
1270	Ms Daisy & Donald Sauer
1271	Mr Chris Bean
1272	Ms Lara King
1273	Ms Emily King
1274	Ms Liz McLoughlin
1275	Ms Zoe King
1276	Ms Carlie Maitland
1277	Ms Karen Stevenson
1278	Ms Gai Domanski
1279	Mr Jack Tutty
1280	Mr Burt Dekeyzer
1281	Ms Carmel Parker
1282	Ms Margaret Hannagan
1283	Mr J Ranken
1284	Ms Donna McKinnon
1285	Ms Conny Harris
1286	Ms Valmai Turner
1287	Ms Sandra McKirdy
1288	Mr Frank Harrison
1289	Mr Adrian Van Druton
1290	Mr Graem Colello
1291	Mr Terry Kirkpatrick
1292	Mr Alan Wheaton
1293	Ms Kerry Mornie
1294	Mr M Gleeson
1295	Mr & Mrs Brian & Courteney Prenner
1296	Ms Barbara Keaton
1297	Ms Tenelle Coddington
1298	Ms Viviene Stewart
1299	Ms Kim Plowes
1300	Ms Sue Bolton
1301	Mrs Jean Burton
1302	Ms Queenie Brickwell
1303	Mr J Rutherford
1304	Ms Mavis Sharp
1305	Mr David Jenkins
1306	Mr W J Hutton
1307	Mr Peter Adams
1308	Mr Bob Dunbar
1309	Mr Gary Harris
1310	Ms Wendy Bellamy
1311	Ms Carmel Molloy
1312	Ms Susie Boyle
1313	Mr Peter Boersya
1314	Ms Joy Martin
1315	Mr Peter Burgess
1316	Ms Libby James
1317	Mr R Dunnes
1318	Mr Josh Williams
1319	Ms Robyn Burgess
1320	Mr & Mrs Rob & Jeni Perriot
1321	Mr Stuart Burnley
1322	Mr George Pagacs

1323	Mr S P Hurley
1324	Ms Amy White
1325	Mr R H Bury
1326	Mr David Watson
1327	Ms Jacinta Vanderpuije
1328	Mr Daniel Batup
1329	Ms Vlasra Novak
1330	Ms Yvonne Read
1331	PMr P J Juneford
1332	Mr Adrian Smit
1333	Mr Bob Radridge
1334	Mr John Holman
1335	Mrs C Follett
1336	Mr E F Fraya
1337	Mr Hirsche Evans
1338	Mr Wilfred Kelvin
1339	Ms Jules Brunier
1340	Ms Astrid Simpson
1341	Ms Joanne Tulan
1342	Ms Maxine Bruncer
1343	Mr timothy Matchett
1344	Ms Yvonne Lee
1345	Ms Sue R
1346	Mr Jimmy Koi
1347	Mr A Gunner
1348	Ms Melissa Mitchell
1349	Ms Christine Rutherford
1350	Mr Jim Ritchie
1351	Mr G D Tidmarsh
1352	Ms Rose-Mary Wong
1353	Mr Richard Hazard
1354	Ms Cherie Ireland
1355	Mr S Antosiewicz
1356	Mr Phillip Elliott
1357	Mr Dan Bidwell
1358	Ms Sue Arey
1359	Ms Michelle Thomas
1360	Mrs D Martin
1361	Ms Julie Papalia
1362	Mr B North
1363	Mr Barry Broadway
1364	Mrs Eileen Broadway
1365	Ms Gwen Forno
1366	Ms Barbara Glover
1367	Ms Jean Acreman
1368	Ms Cheryl Halliday
1369	Mr D K Robertson
1370	Ms Colleen Glover
1371	Ms Jeanine Rees
1372	Ms Lara Robertson
1373	Mr Todd Halliday
1374	Ms Kristine Shaw
1375	Ms Karen Munro
1376	Mr J P Ferguson
1377	Ms Margaret Clements
1378	Mr Robert McGowan
1379	Mr J Walsh
1380	Ms Debra Copeland
1381	Ms Pearl Bigalow
1382	Mr John Copeland
1383	Mr Joan Plumley
1384	Ms Sue Balkin
1385	Ms Ruth Wilcox
1386	Mrs A Monk
1387	Mr & Mrs Carmen & Vince Kelly
1388	Ms Amy Moseley
1389	Ms Tracey Paterson
1390	Mr E Ruse
1391	Ms Diane McConaghy
1392	Mr Michael Egan
1393	Mr Alan Peters
1394	Ms Anne Carlow
1395	Mr Terry Purves
1396	Ms Katherine Hatton
1397	Mr John Graham
1398	Mr G M Scott
1399	Ms Lorraine Whitehead
1400	Mr Carson Dunn
1401	Ms Dorothy Gowan
1402	Mr Jack McGowan
1403	Ms Carolyn O'Regan
1404	Ms Ilana O'Regan
1405	Ms Carmel Salerno
1406	Ms Neela Sarker
1407	Ms Kai-Lani Riley
1408	Mr Carter Flanigan
1409	Mrs L M Langley
1410	Ms Leanne Sutherland
1411	Mrs Dorothy Schrier
1412	Ms Constance M Putsey
1413	Mr David Caldwell
1414	Ms Edith Caldwell
1415	Miss A Caldwell
1416	Ms Deborah Keenan
1417	Ms M Schwartz
1418	Ms Cedar Watt

1419	Ms Mrudula Govind
1420	Ms Geri Wilson-Matenga
1421	Miss J Kulhay
1422	Mrs C Slavin
1423	Ms Linda Calvert
1424	Mr G Irwin
1425	Mr R Gillard
1426	Mr G Rudder
1427	Ms Tammy Rudder
1428	Mr B Thornly
1429	Ms Rosie Hughes
1430	Mrs Lesley O'Rourke
1431	Dr J R Angel
1432	Mrs H Peters
1433	Ms Carole Evans
1434	Ms Anne Delawey
1435	Ms Shaunna Roberts
1436	Mr & Mrs Laurrie & Fay Myers
1437	Ms Christina Stewart
1438	Ms Susan Miller
1439	Mrs M Gendle
1440	Mrs Maree Bensley
1441	Ms Fran Davies
1442	Ms Joan Tait
1443	Ms Kerry Downes
1444	Ms Sue Mitchell
1445	Mr Darrell Fay
1446	Ms Deirdre King
1447	Mr David Hanley
1448	Mr S Vick
1449	Ms Margaret Walsh
1450	Ms Jean Sutherland
1451	Mr B Delangre
1452	Ms Susan Belford
1453	Mrs H Bracher
1454	Mr Brian Crisp
1455	Ms Beryl Perrott
1456	Ms Kelly Emerson
1457	Ms Mair Lang
1458	Mr & Mrs George & Sandra Ogden
1459	Mrs V Uicich
1460	Mr Jake Matthews
1461	Ms Emma Matthews
1462	Mr Frank Matthews
1463	D Latham
1464	Ms Linda Frost
1465	Ms Rebecca Sheerin
1466	Ms Joan White
1467	Ms Martina Watson
1468	Mr John Waddington
1469	Ms Dianne Waddington
1470	Ms Patricia Diamantis
1471	Mr Alexander Woods
1472	C Bushnell
1473	Ms Caroline Frith
1474	Ms Leanne Woods
1475	Kerry Ottawell
1476	Ms Lorraine Hogan
1477	Ms Lynette Wellens
1478	Mr Jack Hogan
1479	Ardy Sudarso
1480	Ms Julie Harris
1481	Ms Joy Williams
1482	Ms Belinda Wilcox
1483	Mr Gordon Simmonds
1484	Ms Lucy Williams
1485	Mrs R Loudan
1486	M G Selby
1487	Mr Graham Downs
1488	J Selby
1489	Ms Carole Steer
1490	Ms Lynne Doyle
1491	Mr Jim Delaney
1492	Mr Jack Steer
1493	Billie Kamekawa
1494	Mrs Kathy Hines
1495	Ms Kath Bokford
1496	Ms Lauren Simpson
1497	Ms Alva Warland
1498	Ms Sandra Summergreene
1499	Mrs D Green
1500	Mrs E McPherson
1501	W L Marcroft
1502	Mr Alan Nogan
1503	Mr Alex Robertson
1504	Mr Geoff Callender
1505	Mr Jamie Groodger
1506	Mr J Sanossian
1507	Ms Maria Sanossian
1508	Ms Andrea Smith
1509	Ms Claire Chudgey
1510	Mr David Chudgey
1511	Mr Matthew Chudgey
1512	Mrs C Gravolin
1513	Mr Simon Tuma
1514	Ms Charmaine Beckett

1515	Mr Paul Williams
1516	Ms Maria Wilkinson
1517	Miss Kelly Jones
1518	Ms Julie Jones
1519	Ms Sarah McColm
1520	Chris McColm
1521	Ms Janice McColm
1522	Mr Paul Hickling
1523	Ms Sarah and Anthony Ball
1524	Ms Janette Dormer
1525	Mr Belinda Koch
1526	K Piscioneri
1527	Mr Warren Welsh
1528	R Koopman
1529	Mr Scott Fitcherald
1530	Mr Aaron Johnson
1531	Mr Robert Engelander
1532	Ms Erin Doyle
1533	Ms Bronwyn Leopold
1534	Mr Kurt Leopold
1535	Mr Joel Goodwin
1536	Ms Kandice Johnston
1537	L J Raillon
1538	Ms Jeny Daly
1539	E D West
1540	Mr Daniel Miegel
1541	L H Wizer
1542	Ms Melanie Miegel
1543	Ms Victoria Mackay
1544	Ms Carla Sexton
1545	Ms Sharon Porter
1546	Doune Sexton
1547	Mr Richard Lagden
1548	J Crawford
1549	Ms Karen Dickings
1550	Mrs L Fisher
1551	Mr David Hegarty
1552	Ms Jane Miles
1553	Ms Cassie Verzendaal
1554	Mr John Leeder
1555	Ms Rosemary Leeder
1556	Ms Elizabeth Hunt
1557	Mr Ray Beyant
1558	Ms Lorna Porter
1559	Ms Sarah Engelander
1560	Sam Chaseberry
1561	Ms Doreen Euers
1562	Mr Mark Fox
1563	Ms Jennifer Fox
1564	Mrs Sue Naylor
1565	Ms Tammy Van Der Linden
1566	D Clarie
1567	Ms Jodie Cohen
1568	Mr Simon Cohen
1569	Ms Marissa Cooper
1570	Mr Damian Cooper
1571	G Knight
1572	Ms Heather Ryman
1573	Yukari Stuart
1574	Chris Stuart
1575	Gillian Wares
1576	Mrs and Mr Jenny and Dave Simpheidonfer
1577	Anka Spadina
1578	Ms Carolyn Kinsela
1579	Ms June Johnson
1580	Mr Robert Lloyd
1581	Ms Pat Lloyd
1582	Ms Iris Collings
1583	Ms Jenni Cragg
1584	Ms Wendy Hayfield
1585	Ms Jane Matthews
1586	Ms Tanya Lee Davies
1587	Ms Jennifer Hamilton
1588	Tudor Robertson
1589	Ms lynne Davies
1590	Ms Samantha Osborne
1591	Ms Bronwyn Bishop
1592	Mr Michael Osborne
1593	Mr Carl Hubbard
1594	Mr Lewis Hubbard
1595	Ms Dianne Loneon
1596	Sam Nizeti
1597	C Pastor
1598	Ms Jean A Walter
1599	K Hendry
1600	D Hendry
1601	Ms Heather Johnston
1602	Ms Amanda Hurley
1603	Ms Heather Shaw
1604	Ms Marilyn Plaskitt
1605	A Pastor
1606	Mr G C Yorke
1607	Ms Catherine Weir
1608	Ms Patricia Maguire
1609	Ms Ruth Jackson
1610	Mr Wayne McPherson

1611	Mr Russell Bradfield
1612	Mr Dick Maguire
1613	Mr Max Clark
1614	Mr Bern McCrohon
1615	S Versace
1616	Ms Daphne Evans
1617	R Brand
1618	W Fletcher
1619	Mr Graham Sloper
1620	Ms Celia Kelly
1621	Ms Barbara Jones
1622	Mr Geoff Johnston
1623	Mr D MacDonald
1624	Ms Kristen Beck
1625	Mr Rowan Mason
1626	Ms Margaret Lambert
1627	Mr David Kennedy
1628	Ms Carol Russo
1629	Mr Terry Russo
1630	Mr Fortunato Mercuri
1631	Ms Eliana Mercuri
1632	Ms Geogina Russell
1633	Ms Joy Stokes
1634	Mrs Victoria Retford
1635	Mr Tom Stokes
1636	Mr Julius Moretto
1637	Ms Janette Scanlon
1638	Mr Matthew Corfe
1639	C Bayfield
1640	R A Hatfield
1641	M Hatfield
1642	Mr Joshua Real
1643	Mrs Angela Jones
1644	Mr Colin Peter Jones
1645	Ms Susan W van Den Bosch
1646	Mr and Mrs Ian and Vicki Foley
1647	Mr Steve Dench
1648	Mr Michael Garrod
1649	Ms Sasha Gallagher
1650	Ms Fiona Granville
1651	Mrs Angela Read
1652	Mr Michael Ennis
1653	Ms Peggy Molden
1654	Ms Betty Wright
1655	Ron and Judy Coffey
1656	Ms Jillian Phillips
1657	Ms Lisa Llewellyn
1658	Ms Kate Ryce
1659	Mr Tim Bradley
1660	C Cooper
1661	Mr Ross Cox
1662	Mr Christopher Fairweather
1663	Jagoda Prica
1664	C Fairweather
1665	Natalie Castellan
1666	Ms Shirley Turner
1667	Conor Gallagher
1668	Mr Michael Gallagher
1669	Professor Rosemary Johnston
1670	Ms Mary Napier
1671	Mr David Brock
1672	Ms Ellie Wheeler
1673	Ms Rachel Wheeler
1674	Ms Melissa Napier
1675	Mrs Jan Kahn
1676	Mr M Kahn
1677	Mrs and Mr J Wheen
1678	Ms Rosie Carroll
1679	S Jordan
1680	Mr Jonathan Wells
1681	Chris Sweeney
1682	Mr Simon Ware
1683	Ms Fiona McCallum
1684	Mr Phil Burrows
1685	L Tremayne
1686	Ms Kathryn Burrows
1687	Mr Jason Burrows
1688	Ms Gillian Burrows
1689	Ms Michelle Buhler
1690	Mr Tim Cuming
1691	Mr Colin King
1692	Ms M King
1693	Ms Joan McClelland
1694	Eilish Sheerin
1695	Mr John Sheerin
1696	K Berge
1697	Ms Myriam Marchand
1698	R Woodward
1699	Mr Glenn Woodward
1700	Kerrie Vickerman
1701	Wanlee Tasakoo
1702	Ms Clarice Prior
1703	S Cobham
1704	L Waller
1705	Larelle Snelling
1706	Ms Dorothy Bold

1707	Mr Brett Cohen
1708	Mr Doug Lukson
1709	Ms Marie Svenoy
1710	Ms Eve Kiernan
1711	R W Squire
1712	Ms Patricia Squire
1713	Mr Adam Kiernan
1714	Ms Judy Longworth
1715	Ms Jean Dusting
1716	Ms Elizabeth Desmond
1717	Ms Cheryl Wunsch
1718	Ms Julie-anne O'Donoghue
1719	Ms Michelle Hawkett
1720	Mr John Walsh
1721	Mr Bill Woods
1722	Mr David McPhee
1723	Ms Clare Goetze
1724	Mr Derek Roal
1725	Ms Lynne Real
1726	Ms Janet Sioman
1727	M W Pilz
1728	Mrs R Vade
1729	Ms Charlotte Gregoire
1730	Ms Susan Sparke
1731	Ms Marie Gregoire
1732	Ms Claire Hogan
1733	Ms Laura Hogan
1734	Ms Audrey Playford
1735	Ms Elizabeth Gibbs
1736	Mr Kevin Gibbs
1737	H F White
1738	Ms Mary Kitchen
1739	Ms Rosemary Spence
1740	Mr Sean Thomas
1741	Ms Betty Grimes
1742	Mr Joseph Viskovich
1743	Ms Chris Arnold
1744	Ms E Cadogan
1745	Ms M Geur
1746	Ms Maryanne Maras
1747	Ms Rene Lasser
1748	Ms Mary Nicholson
1749	Ms Lili Walsh
1750	Ms Thelma Le Sueur
1751	Ms Anne Surland
1752	Mrs and Mrs Jeanette and Ken Lue
1753	Ms Beryl Clarke
1754	Ms Penelope Drake
1755	Ms Sheridan Hudson
1756	Ms Deborah Hennessy
1757	Ms Elena Konstantinidou
1758	Mr Tony Fleet
1759	Ms Lana Turner
1760	Ms Danielle Allen
1761	Ms Evelyn Beackman
1762	Mr Ron Farr
1763	Ms Angela Martinez
1764	Ms Kerrie Hoare
1765	Ms Jessica Ashley
1766	Ms Katherine Ashley
1767	Ms A Herlihy
1768	Ms Judy Wentworth-Ping
1769	Ms Kerrie Lombardo
1770	Ms Kjell Jawerth
1771	Ms Margaret Jawerth
1772	Ms S Blouny
1773	Ms Debra Searle
1774	Mr Brad Noel
1775	Mr Stephen J Noel
1776	Ms Sally Fenton
1777	Mrs Chimene Powell
1778	Ms Sicin Zanze
1779	Ms Karen Walkden
1780	Ms Maxine Gilligan
1781	Mr Roland Hough
1782	Ms Amanda Mossel
1783	Mr Wayne Terry
1784	Mr Mark Fitzpatrick
1785	Ms Lainie McPherson
1786	Ms Trudy Schweppe
1787	Mr Ivor Davies
1788	Ms Julie Miller
1789	K Martin
1790	Ms Indigo Meakins
1791	Ms Jenny Geary
1792	Ms Jacqui Walton
1793	Ms Joan Parfitt
1794	Ms Ann Browne
1795	Mr Sam Crispin
1796	Ms Marcia Crispin
1797	L Stevens
1798	Ms Jean Trotter
1799	Ms Carol Saw
1800	Mrs Joanne Bryde
1801	Mr Mark Norris
1802	Ms Mia Galo

1803	Ms Kylie Adams
1804	Ms Vesna Stankovic
1805	Mr Phil Mithieux
1806	Mr Ross Browne
1807	Ms Sharon Marks
1808	Ms Jean Wood
1809	Mr John Clark
1810	Ms Melinda Dhillon
1811	Ms Helen Robinson
1812	Martyn George
1813	Mr Kurt Hilguist
1814	Mrs Inga Hilquist
1815	Maree Black
1816	D Drummond
1817	John Camilleri
1818	Brooke Andrew
1819	John Freeman
1820	Clare Mitchell
1821	Valda Watts
1822	Justine Durvea
1823	Louise Jonnson
1824	Laura Pearce
1825	Inge Ther
1826	Mrs Kiri Hubner
1827	Mr Jamie Hubner
1828	Juliet Potter
1829	Lesley Harper
1830	Mr T Paul
1831	Mrs Julia Paul
1832	Elizabeth Branett
1833	Mr Michael Fairbrass
1834	Mrs Nicole Fairbrass
1835	Mrs W A Johnston
1836	Mrs Miranda Farr
1837	Mrs Helen Farr
1838	Mrs Annette Minter
1839	Mr Hawerth
1840	Mrs Margaret McClaron
1841	Mrs C Houlds
1842	Mrs Barbara Nielsen
1843	J R Copley
1844	Ms Emma Cameron
1845	Ms Michelle Rae
1846	H.R Louwen
1847	Mr Richard Taber
1848	Ms Alison Cullen
1849	PA Cullen
1850	Ms Alexandra Cullen
1851	Mrs Judy Cullen
1852	Ms Samantha Livingston
1853	Mr Patrick Sware
1854	Ms Vera Dobrich
1855	Milica Dobrich
1856	Lazar Dobrich
1857	Ms Elle Schippers
1858	Mr David Hutton
1859	Ms Marianne Bennett
1860	Ms Janice Blake
1861	Ms Rosemary Nichols
1862	Ms Carol Desser
1863	Ms Patricia Cree
1864	Ms Debbie Rose
1865	P J Johnston
1866	Ms Vlatka Peric
1867	Ms Robyn Duffy
1868	Mr Reg Taylor
1869	Mr Alan Stevens
1870	Mrs J Stevens
1871	Mish Coates
1872	Ms Lisa Gilmour
1873	Ms Angela Miles
1874	S. H Creed
1875	Ms Heather Watson
1876	Mr Rob Satcliffe
1877	Mr Garry Hughes
1878	Ms Claire Garnham
1879	W Benz
1880	Ms Danielle Crotty
1881	Mr Christopher Crotty
1882	Mr John Kempster
1883	Mr & Mrs Jeff & Lynne Scranage
1884	Mr David Grout
1885	Ms Julie Whitaker
1886	Mr Ben Jankalns
1887	Ms Jane Blinkhorne
1888	Ms Tracey Reid
1889	Ms Evonne Gerges
1890	Mr Sean Gazzard
1891	Ms Margaret Richardson
1892	Mr Rob Pedersen
1893	Mr Lynne Pinlayson
1894	Mr Linley Beck
1895	Mr Ian Giles
1896	Ms Julie Bennett
1897	Ms Shelley Moore
1898	Mr Dave Handley

1899	Ms Donna Handley
1900	Ms Harley Frazer
1901	Ms Kylie Boss
1902	Mr Rodney Boss
1903	Ms Lindsay Frazer
1904	Ms Tatava Porter
1905	Mr Howard Sycamore
1906	Mr Jeff Anderson
1907	Ms Pepper Sharrad
1908	Ms M Herbert
1909	Ms Pam Kempster
1910	Mr Marko Skoric
1911	Ms Roslyn Scott
1912	Ms Catherine Lee
1913	Mr Peter Davies
1914	Ms Sonia Timnis
1915	Ms Judy Bennetts
1916	Mrs Kathleen Taylor
1917	Mr Darryl Nete
1918	Mr Marko Lemmetty
1919	Ms Irene Green
1920	P Rogers
1921	Ms Betty Gilbey
1922	Ms Bev Gilbey
1923	Ms Michelle Johnston
1924	Mr Craig Sweccinc
1925	Mr George Broadfoot
1926	Mr Neil MacGowan
1927	Mrs Kerry Schott
1928	Mr Alton Paul-Ultiera
1929	R F Komoll
1930	Ms Pauline Rose
1931	Mr John Williams
1932	Ms Robyn Brownlow
1933	Ms Carmen Riegg
1934	I Gededikin
1935	Ms Jaclyn Dikin
1936	P Peard
1937	Mr John Warburtin
1938	Ms Pamela Gates
1939	Ms Barbara Rowntree
1940	Mrs Katherine McLachlan
1941	Ms Cathy Moore
1942	Mr Phil Lamb
1943	Mr Tony Balkin
1944	Ms Carolanne Gano
1945	Mr and Mrs Alice and Malcom Lehamann
1946	Ms Mira Marov
1947	Mr Justin Newbold
1948	Mr Nick Williams
1949	Mr Shane Clugston
1950	Mr Damian Devine
1951	Ms Nerona Hautley
1952	Ms Kathren Walker
1953	Mr David Gantman
1954	Ms Joy Wyton
1955	Ms Glenda Gantman
1956	Mr Greg Rowntree
1957	Ms Alannah Skinner
1958	Mr Brian Blake
1959	Ms Olivia Berry
1960	Mr Peter Winny
1961	Ms Sally Barry
1962	K McDonald
1963	Mr Paul Godfrey
1964	Ms Christina Morris
1965	Ms Elaine Clark-Smith
1966	Mr Aaron Rawson
1967	MS Bronwyn Hartcher
1968	Mrs Betty Dykes
1969	Ms Margaret Fisher
1970	Ms Phoebe Rose
1971	Mrs Kelly Rose
1972	D Cruickshank
1973	Ms Helen Jones
1974	Ms Nicky Wragg
1975	Mr Aaron Wragg
1976	Ms Gemma Rawson
1977	W Roberts
1978	Ms Susan Sykes
1979	Mr Mark Sykes
1980	Mr Richard McIntyre
1981	Ms Lina Salanitro
1982	Mr Steven Moore
1983	Ms Dorothra Stokes
1984	Mr Richard Lewis
1985	Mr Glen Taber
1986	Ms Nina Sokolov
1987	Chhuyeng Gyaltsen
1988	Mrs Lyn Taber
1989	Ms Katrina Pearce
1990	Ms Kim Mulkeen
1991	Mr Kevin Coyle
1992	Ms Sandra Tutt
1993	Ms Jesse Makins
1994	Ms Robbie Meakins

1995	Ms Tina Aikman
1996	Mr Stuart McEvoy
1997	Ms Felicity McEvoy
1998	K Brownlow
1999	Ms Charmaine Caldwell
2000	Mrs P Hayden
2001	Mr Allan Rodgers
2002	Mr Barry William
2003	Ms Heather Brooks
2004	F.J Roberts
2005	J Arnott
2006	D Milburn
2007	L Seeney
2008	Mr and Mrs Sanja & Anasha Rostamians
2009	Ms Kim Sharpe
2010	Ms Carolyn Zietsch
2011	Mr James Salatnam
2012	Mr Craig Wyton
2013	Mr Keith Wyton
2014	Chris Wyton
2015	Ms Fay Filrese
2016	Ms Leonie Haygarth
2017	Ms Areen Green
2018	Ms Leigh Skinner
2019	Ms Maria Ledieir
2020	R.G. Finlayson
2021	P. Finlayson
2022	Ms Barbara Latham
2023	Mr Robert Young
2024	Ms Lesley Roberts
2025	Mr Michael Rosic
2026	Mr Claudio Marcolong
2027	Ms Katrina Young
2028	Ms Annette Castaing
2029	M.A. Hodges
2030	Ms Susan Taylor
2031	B.T. McNamara
2032	M McNamara
2033	Ms Roslyn Coyle
2034	Ms Trudy Stackhouse
2035	Ms Barbara Davies
2036	Ms Mary Christofis
2037	Ms Margaret Partridge
2038	Lepa Spadina
2039	Padovan Lalic
2040	Kellie Jones
2041	Ms Kristen Noehr
2042	Ms Martine Cohnen
2043	Ms Debbie Hendley
2044	Mr Fabian Cohnen
2045	Mr Geoff Hendley
2046	Mr Shane Clements
2047	Ms Julia de Berg
2048	Mr Jon Russell
2049	Mr Ron Titley
2050	Ms Jane Broadbere
2051	Ms Stella Roberts
2052	Ms Kathryn Cole
2053	Mr J Peric
2054	Ms Sally Claremont
2055	Ms Sue Murray
2056	V Vanden Brock
2057	Mr Richard Lewis
2058	Mr Glen Taber
2059	Mrs L M Evans
2060	Ms Salina Sinah
2061	Ms Amanda Selby
2062	Ms Larissa Raheb
2063	Ms Phyllis S Lang
2064	B Maladay
2065	Ms Catherine Andreo-Tuma
2066	Mr and Mrs Geoffrey E Smith
2067	Ms Barbara Robinson
2068	Ms Mary Mahdi
2069	Mr Ala Mahdi
2070	Ms Jacqueline West
2071	Ms Janet Kydd
2072	Mrs Rose Sutos
2073	Ms Katrina Pearce
2074	Ms Kim Mulkeen
2075	Ms Anne Nicholson
2076	B D Green
2077	Ms A M Green
2078	Ms Amanda Simpson
2079	Mr Marc Spence
2080	Mrs S Robertson
2081	Ms June Smith
2082	Ms Mary Roseworne
2083	Mr Eddie Elelman
2084	Mr Robert Frayne
2085	Mr Clifford Taylor
2086	Mr Andrew Thor
2087	Mr Stuart Thor
2088	Ms Bec Richardson
2089	Ms Sharon Foster
2090	Ms Annette Brown

2091	Ms Maddie Brown
2092	Ms Francesca Cunningham-Gruber
2093	Ms Louise Gruber
2094	Mr Mark Hammond
2095	Mr Nigel Leck
2096	Ms Christine Duff
2097	Mr Robert Hunter
2098	R Callaghan
2099	Ms Rosemary Cunnan
2100	A S Edmonds
2101	Mr Jack Bjerre
2102	R and M Smith
2103	S and G Higgs
2104	Ms Stacey Parkes
2105	Ms Melissa Lees
2106	Ms Susan Johnson
2107	Ms Bianca Lowe
2108	Ms Karen Lowe
2109	Ms Megan Brown
2110	Ms Corrine Cunningham
2111	Mr Michael L Smith
2112	Mr Robert Gibson
2113	Ms Solange Gibson
2114	Mr Michael Cunningham
2115	Ms Susan Smith
2116	Mr Jeffrey Feulices
2117	M Casey
2118	Ms Margaret Harper
2119	Charina Warne
2120	Nada Witkamp
2121	Mrs B McDonald
2122	Mr Ian Young
2123	Ms Judith Bryan-Morton
2124	Mr Andrew McLeod
2125	Annette and Aaron Rawson
2126	Mr Ray Pickard
2127	Ms Marie Cookson
2128	Ms Tina Hansen
2129	Mr Ray Edwards
2130	Stephen Witte
2131	Mr Ross Clements
2132	Mr John Marre
2133	Mr Geoffrey P Butt
2134	Mr Bryan Price
2135	Mr Ken Lindsay
2136	Mr John Purnell
2137	Mr Mark Silberberg
2138	Mr T R MacKenzie
2139	Mrs Helen Ireland
2140	Ms Megan Donald
2141	Ms Karen Heyman
2142	Mrs K Bell
2143	Mrs J E Inns
2144	Mr B Inns
2145	Ms Narelle Beard
2146	Ms Vicki Woodward
2147	Mr Jeremy Fenton
2148	Ms Bianca Howard
2149	Mr Keith Platt
2150	Ms Lyn Christie
2151	Ms Teneil Van Dyke
2152	Ms Elaine Boyd
2153	Mrs D Van Dyck
2154	Ms Lindy Graham
2155	Mr Darren McNamara
2156	Ms Carolyn Noble
2157	Ms Carly Bonnor
2158	Ms Dorothy Curtis
2159	Ms Pam Curtis
2160	Mr Sharon Godden
2161	Mr Tosca Edwards
2162	Mr Christian Petersen
2163	Mrs Margaret Barrack
2164	Ms Jane Petersen
2165	Ms Emily Petersen
2166	Ms Cassie Williams
2167	Ms Anne Williams
2168	Mr Anthony Stevenson
2169	Ms Cheryl Stevenson
2170	Ms Pam Morio
2171	Mr George E Wood
2172	Mr Joshua James
2173	Mr John Stokes
2174	Mrs B MacKenlay
2175	Mrs Marilyn Pua
2176	Ms Pat Copey
2177	Mr Bob Barrack
2178	Ms Prue Partridge
2179	Ms Sally Penendick
2180	Mr Andrew Timmis
2181	Mr Brett Menzies
2182	Fernanda Menzies
2183	Ms Heather Beyleveldt
2184	Ms Sally Davies
2185	Ms Cleon Savage
2186	F de Beer

2187	Ms Barb Davoren
2188	B Follett
2189	Ms Lerisa Rosic
2190	Mr Ross Fleet
2191	Ms Karen Astley
2192	Ms Fiona Hinchcliffe
2193	Mr John Vujasinovic
2194	Ms Dama Vujasinovic
2195	Ms Dolcie Berkley
2196	Ms Danielle Felton
2197	Ms Karen McKay
2198	Ms P Edmonds
2199	J Hunt
2200	Ms Ann Van Haren
2201	Ms Claire Ashley
2202	Ms Lynda Santich
2203	M Barrack
2204	Ms Margaret Barrack
2205	Ms Mary Ryland
2206	Ms Ella Santich
2207	J F G Walker
2208	Mr Hugh Smart
2209	Mr Paul Droock
2210	B Wrigley
2211	Tatjana and Gordana Zuklic
2212	Ms Katharine Laman
2213	Mr David Mostrov
2214	H V Creed
2215	Gisela Behrendt
2216	C Kabi
2217	R Bruce
2218	C Williams
2219	K Metcalfe
2220	Stig Widholm
2221	F and E Robertson
2222	Ms Phillipa Carlya
2223	Ms Mary Farr
2224	Ms Jean and Eric Middlemost
2225	Mr Richard Tapscott
2226	Ms Carole Coventry
2227	Mr Stephen Coventry
2228	Dr Peter Brennan
2229	Mr David Walsh
2230	Dr Stephen Christley (NSCCH)
2230a	Dr Stephen Christley (NSCCH)
2231	Ms Lea Rosser (Warringah Council)
2232	Dr David Jollow
2233	Mr Philip Gough
2234	Confidential
2235	Mr Michael Darby
2236	Confidential
2237	Dr Paul Phipps
2238	Professor Malcolm Fisher
2239	Mr Cameron Amos
2240	Ms Bronwyn Amos
2241	Ms Heather Anderson
2242	Mr James Barrie
2243	Mr Patrick Barrie
2244	Ms Kaye Brindle
2245	Mr John Bruce
2246	Mrs Fiona Calabrese
2247	Mrs Rosalind Butler
2248	Miss Belinda Carter
2249	Mrs Michelle Carter
2250	Mr Art Cartwright
2251	Dr Geoffrey Chang
2252	Mr Lyndon Clark
2253	Mrs Marie Colbron Conroy
2254	Mr John Cooke
2255	Mrs Mouse Cooke
2256	Mrs Jennifer Cover
2257	Mr Peter Cox
2258	Ms Linda Coyle
2259	Mr Ross Dalgleish
2260	Mrs Narelle Deeney
2261	Mr Shane Douglas
2262	Mrs Felicity Douglas
2263	Mrs Judith Douglass
2264	Mrs Margaret Theresa Dunbar
2265	Mr R. Simon Dunn
2266	Mr Marc Eady
2267	Mrs Marie Edwards
2268	Mrs Lea Fogden
2269	Mrs Bobbie Fox
2270	Mr Richard Andrew Gliddon
2271	Mrs Bronwyn Gliddon
2272	Mrs Robyne Glover
2273	Mrs Hilary Graham
2274	Mr Mark Gundersen
2275	Dr Conny Harris
2276	Ms Klara Hollestelle-Watson
2277	Mrs Cornelia Hollestelle
2278	Ms Helen Howes
2279	Mr Deon Hubner
2280	Mrs Allison Hurley
2281	Ms Renee Jackson

2282	Mr Paul Kelly
2283	Ms Susan Kelly
2284	Ms Lisa Kelshaw
2285	Mrs Rowena Kempton
2286	Mrs Nicole Koerner
2287	Mrs Sue Langbecker
2288	Ms Kellie Langbecker
2289	Mrs Kylie Llewellyn
2290	Confidential
2291	Mrs Susan Lowrie
2292	Ms Janene Luff
2293	Mr Glenn Luff
2294	Confidential
2295	Mr Frank Maiuolo
2296	Mr Steve Matthews
2297	Mr Phillip Mayne
2298	Mrs Margaret McGlone
2299	Mr Ian McKenzie
2300	Mr Ross McPherson
2301	Mr Geoffrey Mulcahy
2302	Ms Patricia Munn
2303	Mr Clive Napthali
2304	Mrs Sandra Napthali
2305	Ms Nada Novakov
2306	Mr Alan Perman
2307	Mrs Waveney Perman
2308	Ms Nadine Phipps
2309	Mr Dragan Radulovic
2310	Ms Trina Minter
2311	Mr Chris Rath
2312	Mrs June Robson
2313	Mr Peter Roger
2314	Mr Steven Sherwood
2315	Miss Patricia Silk
2316	Mrs Penelope Soegaard
2317	Mrs Miriam Stevens
2318	Mrs Dorothy Tinker
2319	Mr Tony Vandenhurk
2320	Ms Helen Walker
2321	Mr Steven Wassell
2322	Dr Pieter Watson
2323	Mr Willem Watson
2324	Mrs Philippa Waugh
2325	Mr Kyle Wilkinson
2326	Mrs Megan Willcox
2327	Mrs Amber Woodroff
2328	Mr Richard O'Neill
2329	Ms Iris Hardie
2330	Mr Colin Hardie
2331	Mr Alan Jepps
2332	Ms Hylda Lane
2333	Ms Shar Jones
2334	Ms Carolyn Tyrer
2335	Ms Jacqui Davies
2336	Mrs Shirley Borthwick

Appendix 2 Witnesses/Site visit

A total of three public hearings were conducted at Parliament House involving 30 witnesses. A list of witnesses is provided below and transcripts of the hearings are on the Committee's website at www.parliament.nsw.gov.au. The Committee also conducted a driving tour of the Northern Beaches area which included the six sites under consideration as the location for the new Northern Beaches Hospital.

Witnesses

Date	Name	Position and Organisation
Monday 28 February 2005	Ms Robyn Kruk	Director General, NSW Health
	Dr Stephen Christley	Chief Executive, Northern Sydney Central Coast Health (NSCCH)
	Dr Richard Matthews	Deputy Director General, NSW Health
	Mr Frank Bazik	General Manager, Northern Beaches Health Service (NBHS)
	Dr Paul Phipps	Director, Intensive Care Services, NBHS
	Mr John Brogden, MP	Member for Pittwater
	Mr David Barr, MP	Member for Manly
	Mr Parry Thomas	Chair, Save Mona Vale Hospital Committee (SMVHC)
	Mr Harvey Rose	Deputy Chair, SMVHC
	Dr Stuart Boland	Convenor, Surgeons & Anaesthetists, Mona Vale Hospital
	Dr David Jollow	Chairman, Mona Vale Hospital Medical Staff Council
	Ms Lynette Hopper	Chair, Better & Equitable Access to Community & Hospital Services (BEACHES)
	Ms Sandy Hudspith	Member, BEACHES
Tuesday 8 March 2005	Mr Stephen Blackadder	General Manager, Warringah Council
	Mr Richard Persson	Administrator, Warringah Council
	Professor Kerry Goulston	Chairman, Greater Metropolitan Clinical Taskforce (GMCT)
	Ms Kate Needham	Co-Chair, NSW Intensive Care Clinical Implementation Group
	Ms Tina Heath	Community representative, Northern Beaches Community Consultative Health Planning Group (NBCCHPG)

Date	Name	Position and Organisation
	Mr Paul Couvret	Community representative, NBCCHPG
Tuesday 8 March 2005	Mr Carlo Bongarzoni	Community representative, NBCCHPG
(continued)	Dr Stephen Nolan	Intensivist, Mona Vale Hospital
	Ms Karen Draddy	Nurse Unit Manager, Maternity Services Mona Vale Hospital
	Ms Deborah Carter	Registered Nurse, Mona Vale Hospital
	Ms Denise Hardie	Maternity Early Discharge Program Coordinator, Mona Vale Hospital
	Mr Alex McTaggart	Councillor, Pittwater Council
	Mr Lindsay Godfrey	Manager, Community and Library Services, Pittwater Council
Monday 21 March 2005	Ms Robyn Kruk	Director-General, NSW Health
	Dr Stephen Christley	Chief Executive, NSCCHS
	Mr Michael Roxburgh	Acting Director, Capital Procurement, NSCCH
	Professor Malcolm Fisher	Chair, NSW Taskforce into Intensive Care
	Dr Patrick Cregan	Chair, Surgical Services Taskforce
	Professor Jonathan Morris	Professor of Obstetrics and Gynaecology, Royal North Shore Hospital

Site visit

Date	Location
Monday 21 March 2005	
The Committee conducted a driving tour of the Northern Beaches area, including the six sites under consideration for the location of the new Northern Beaches Hospital. The Committee was accompanied by Mr Stuart Muirhead, Program Director Service, Atkinson Capital Insight Pty Ltd	• Manly Hospital • Mona Vale Hospital • Frenchs Forest, Warringah Road & Wakehurst Parkway • Beacon Hill, Tristram Road • Brookvale Bus Depot, Pittwater Road • Dee Why Civic Centre, Fisher Road and the Kingsway • Warringah Public Golf Course, Condamine Street & Pittwater Road

Appendix 3 Greater Metropolitan Clinical Taskforce Interim Proposal for Northern Beaches

Attachment 2

GMCT Interim Proposal for Northern Beaches* December 2004

"Clustering acute care services in regional hubs leads to improved retention of health care staff, better access to quality services for patients and better patient outcomes." ***(The Picture of Health; British Columbia, Canada 2002)***

"Redesign of the delivery of services is in our view inevitable." ***(Securing the New Medical Workforce; Scotland, 2003).***

Senior clinicians (doctors, nurses and allied health) on the Northern Beaches agree that the present arrangement of acute hospital services is not sustainable. Following consultation with those clinicians GMCT is proposing change under the condition that this is an interim solution only and that the Minister commits to building the new Northern Beaches Hospital and expedites the announcement of the site and building timetable. GMCT proposes that clinicians from both hospitals, together with community members be authorised to implement this proposal and to develop plans for the new hospital.

To find the best solution, we've asked the people doing the job
In talking to clinicians at Manly and Mona Vale hospitals it became clear that in Intensive Care and Emergency Medicine it has been difficult to maintain medical staffing 24 hours a day, 7 days a week. This is not just a Northern Beaches problem. To provide complex health services safely and efficiently a critical mass of clinicians and a critical mass of patients are needed. Around the world, medical workforce shortages are affecting the provision of hospital care for patients and it is certain that this situation will get worse over the next few years.

A shortage of skilled doctors is driving this change
The shortage of skilled nurses has been widely publicised. Australia is now facing problems in staffing acute medical positions in public hospitals. Shortages threaten the provision of safe and effective hospital care for patients.

Why are there not enough doctors?
- Not enough medical students are being trained in Australia. Recognising this, the Commonwealth Government has increased medical student places by over 400. It will however, be 10 years before these students graduate as specialists or general practitioners.
- Workplace culture has changed, with young doctors now demanding a better work/life balance resulting in fewer available work hours.
- The growth in private hospitals provides many more jobs for doctors and nurses outside the public system.

Where to from here?
The GMCT proposes an interim plan to take us through to the opening of the new Northern Beaches Hospital. It is not cost-cutting, nor a political exercise, indeed it would involve substantial capital and recurrent funding. Significant upgrading of transport between Manly and Mona Vale hospitals for both patients and their carers would also be required as part of the proposal.

No longer can metropolitan (district) hospitals expect to offer every service for every patient. To assure high quality patient care we are working towards integrating clinical services - combining forces across the two Northern Beaches hospitals. Through better service co-ordination across the Area and by adopting innovative solutions, Northern Beaches patients can access the full range of public health care services they need.

If patients are sick enough to need intensive care, they need the most expert team. It is not the address that counts. By combining specialist clinical resources across the two hospitals a better service will be possible for all Northern Beaches residents. Staff recruitment and retention will improve and junior staff will receive the guidance, supervision and training they need to acquire strong clinical skills. This will help to assure better patient care into the future.

*** The Greater Metropolitan Clinical Taskforce was established by the Minister for Health to promote clinician (doctors, nurses and allied health professionals) and public involvement in health policy planning and delivery. The GMCT works with clinicians and patients to improve clinical services and to advise on appropriate roles for the smaller hospitals.**
Contact us: gmct@doh.health.nsw.gov.au

A team approach is necessary for the best possible care of patients. To maintain clinical expertise and to provide adequate training, specialised health services need a certain volume of patients and an adequate supply of clinicians. If there are not enough doctors to cover the shifts 24 hours a day 7 days a week, the workload becomes unmanageable. Staff members leave and are difficult to replace. It is also important for senior staff to have sufficient time to provide on-the-job training.

That's why we are proposing to boost acute services across both Northern Beaches hospitals.

GMCT's Proposed Interim Changes

The proposal is for acute specialists to work as a team to manage patients at both sites through new Northern Beaches clinical departments of Medicine, Surgery, Women's and Children's Health, Critical Care, Aged Care and Rehabilitation - with a single Northern Beaches Medical Staff Council. Cross-appointments would be offered to all doctors at both hospitals.

A single Northern Beaches Department of Medicine is proposed

- The acute medical roster at both hospitals to be maintained
- Aged Care and Rehabilitation services to be maintained at both hospitals
- Cardiac Rehabilitation to be introduced at the Mona Vale site
- The Stroke Unit to continue at the Manly site.

A single Northern Beaches Department of Surgery is proposed

- The acute surgical and orthopaedic roster to be maintained at both sites
- A new outpatient clinic to treat patients with fractures to be established at the Mona Vale site
- Under a local initiative an additional orthopaedic surgeon is being recruited for 2005 to meet increased demand (especially in paediatrics).

A single Northern Beaches Department of Critical Care is proposed - incorporating Emergency Department (ED) and Intensive Care Unit (ICU) services from both sites.

- Northern Sydney Health Emergency specialists would rotate across both sites with recruitment of additional medical staff to increase the number of specialists at Mona Vale.
- The Emergency Department at Mona Vale to be significantly upgraded.
- Manly Hospital has recently opened a state-of-the-art Emergency Medical Unit to supplement its ED services.
- These initiatives would help to reduce Access Block.

A single Northern Beaches Intensive Care service is proposed. Specialist staff will provide services at both hospitals. Manly and Mona Vale hospitals currently each operate a Level 4 Intensive Care Unit.

- The proposal seeks to upgrade to Level 5 the unit based at Manly and to increase from 5 to 6, the total number of ventilated beds, thus providing a higher level ICU service for all patients needing life-support
- At Mona Vale a Level 3 ICU(High Dependency Unit) with 4 – 6 non-ventilated beds is proposed
- A new position of Critical Care Nurse Co-ordinator to be established
- Additional after-hours medical cover at Mona Vale is proposed, with video links between the two IC units
- Patients requiring more than short-term ventilation will be transferred to Manly Hospital. Data indicates that one to two patients per week (50 – 70 patients per year) may require transfer.

Maternity Services should be based at the new Northern Beaches Hospital when built

The GMCT initially considered centralising Northern Beaches maternity services at Mona Vale Hospital with a new co-located Birthing Centre. After listening to the clinicians and to the community, the GMCT– proposes that maternity services continue to be reviewed locally to ensure ongoing high standards of care, but no change be implemented at this stage. When the new Northern Beaches Hospital is built, maternity services should be based there to provide a critical mass of maternity clinicians and patients and support obstetric training. Community based ante- and post-natal services would continue.

The GMCT aims to make the best use of clinical resources to provide top quality patient care in our public hospitals. It is working with clinicians and managers in Area Health Services across greater Sydney to help plan for the future. This interim proposal would address the current staffing concerns in the Northern Beaches and help to provide a smooth transition into the new hospital. An ongoing process of development and review of clinical services will continue on the Northern Beaches over the next 12 months.

Appendix 4 Intensive Care Services Activity Reports

This appendix contains:

- The Intensive Care Services Activity Reports for the period July 2002 to June 2004 for Manly, Mona Vale, Hornsby and Royal North Shore Hospitals.
- The relevant section from Submission 622a, Surgeons & Anaesthetists, Mona Vale Hospital, which reviews and compares these figures. This review concludes that the figures seem to indicate that Mona Vale has a greater need for an ICU to provide ventilation support for its own patients while Manly processes more low acuity patients admitted to its ICU/HDU.
- The response from NSW Health to both the assessment and conclusions contained within Submission 622a and to comments made in evidence during the inquiry regarding the ICU admission policies at Manly and Mona Vale hospitals.

NSH Intensive Care Services – Northern Beaches Activity Report **July 2002 – June 2004**

	Manly						Mona Vale					
	2002/03			2003/04			2002/03			2003/04		
	ICU/HDU	CCU	Total	ICU/HDU	CCU	Total	ICU/HDU	CCU	Total	ICU/HDU	CCU	Total
Total admissions	412	181	593	360	147	506	279	226	545	270	182	452
ICU bed days	1606			2057			1367			1163		
Length of stay (mean)	3.9			5.7			4.9			4.3		
Admit from: OT – emergency	81			39			30			37		
Admit from OT – elective	49			51			39			53		
Emergency Dept	167			165			150			123		
Other floor	94			66			52			49		
Other Hospital	18			39			8			8		
Ventilated patients	58			79			70			63		
% admissions ventilated	14			22			25			23		
Ventilated > 24hrs	35			56			37			34		
Ventilated > 1 week	17			26			6			9		
Ventilation days (mean)	8.26			6.62			4.34			2.93		
Total ventilated days/hrs	479/11496			523/12552			168/4032			185/4440		
CPAP/Bipap	53			54			29			32		
CVVHD	10			7			0			0		
APACHE Score (mean)	14.8			16.1			19.6			18.6		
Readmit within 72hrs				5						1		
Deaths in ICU	32			47			33			31		

Data Source: ICU data base

NSH Intensive Care Services – RNSH Activity Report **July 2002 – June 2004**

Royal North Shore Hospital								
	2002/03				2003/04			
	General	Neuro	Cardiac	Total	General	Neuro	Cardiac	Total
Total admissions	767	397	554	1718	708	462	597	1767
ICU bed days	3912	2580	2271		3859	2613	1760	
Length of stay (mean)	5.1	6.5	4.1		5.5	5.7	2.9	
Admit from: OT – emergency	140	74	28		117	94	21	
Admit from OT – elective	119	153	517		141	184	559	
Emergency Dept	195	68	7		171	70	1	
Other floor	174	29	2		178	46	13	
Other Hospital	131	70	0		94	68	3	
Ventilated patients	454	144	546		422	168	557	
% admissions ventilated	59	36	98.5		60	36	93	
Ventilated > 24hrs	241	91	70		252	101	68	
Ventilated > 1 week	69	39	12		82	45	11	
Ventilation days (mean)	4.1	8.46	1		5.23	6.19	1.15	
Total ventilated days/hrs	1861/44664	1218/29232	546/13107		2209/53016	1040/24960	664/15936	
CPAP/Bipap	95	7	23		109	9	17	
CVVHD	29	0	1		40	0	3	
APACHE Score (mean)					17	11	13	
Readmit within 72hrs					10	2	1	
Deaths in ICU	89	27	7	123	85	28	11	124

Data Source: ICU data base

NSH Intensive Care Services – Hornsby Activity Report **July 2002 – June 2004**

	Hornsby					
	2002/03			2003/04		
	ICU/HDU	CCU	Total	ICU/HDU	CCU	Total
Total admissions	268	104	372	341	15	356
ICU bed days	1822			1836		
Length of stay (mean)	6.8			5.4		
Admit from: OT – emergency	36			38		
Admit from OT – elective	37			47		
Emergency Dept	76			89		
Other floor	47			73		
Other Hospital	70			94		
Ventilated patients	156			199		
% admissions ventilated						
Ventilated > 24hrs	113			122		
Ventilated > 1 week	28			31		
Ventilation days (mean)	7.04			4.8		
Total ventilated days/hrs	1098/26352			955/22920		
CPAP/Bipap	36			49		
CVVHD	15			10		
APACHE Score (mean)				20.5		
Readmit within 72hrs				2		
Deaths in ICU	44			41		

Data Source: ICU data base

Relevant sections from Submission 622a, Surgeons and Anaesthetists, Mona Vale Hospital

NSH INTENSIVE CARE SERVICES ACTIVITY REPORT

33 Surgeons and Anaesthetists have, for the first time, seen the NSH Intensive Care Services Activity Reports for the Northern Beaches, Hornsby and Royal North Shore for the periods July-June 2002/2003 and 2003/2004.
Attachment 4,5 and 6

34 The report raises as many questions as it answers however it seems obvious that the Manly ICU has a different admission policy and a different treatment culture to the other ICU'S.

Admission Policy

35 The Emergency Department is the main source of admissions to ICU/HDU. Hornsby receives about 27,000 presentations to its Emergency Department, Mona Vale about 23,000 and Manly 17,000.

TOTAL ADMISSIONS

36 Manly ICU/HDU reported 772 admissions, 27% more than Hornsby and 41% more than Mona Vale

37 The report reveals that the disparity is mainly accounted for by Admission of increased numbers of non-ventilated patients, of low APACHE Score.

NON-VENTILATED PATIENT ADMISSIONS

38 Over the 2 years Manly ICU/HDU admitted 635 patients who were not ventilated, RNSH 599, Mona Vale 416 and Hornsby 254.

39 The figures strongly imply that the patients at Manly Hospital have a lower (Severity of Illness grading as measured by APACHE Score and implied by Length of Stay numbers) as those at the other 3 hospitals

40 The figures do not provide an explanation for Manly having so many non-ventilated patients, with low APACHE Scores in its ICU/HDU. The most likely reason for this massive disparity in the figures appears to be due to an idiosyncratic admission policy. It seems likely that the other hospitals look after similar patients in the normal ward environment.
The effect is to create a statistical anomaly of the Manly ICU/HDU activity levels relative to Mona Vale and the other hospitals.

Treatment Culture

41 Analysis of the figures relating to Ventilated Patients raises the possibility of a different (more interventionalist) treatment culture in the Manly ICU/HDU.

VENTILATED PATIENTS

42 In the absence of any offsetting factors, virtually all parameters relating to ventilated patients point to an interventionist treatment culture for patients requiring ventilation.
Ventilation days (mean) at Manly Hospital of 7.31 is about double the 3.67 at Mona Vale and considerably more than both Hornsby and Royal North Shore (all with higher APACHE Scores)
Similarly, Manly along with Hornsby has the highest proportion of patients (about 66%) ventilated> 24 hours
However with 47.3% of ventilated patients ventilated for >1week finds Manly alone at one end of the spectrum. The other three Hospitals lie in the range 21%-31%.
These figures provide the reason for Manly ICU reporting 1002 Ventilated days against Mona Vale's 489 even though they only treated 4 more patients (137 to 133).

INTENSIVE CARE ACTIVITY

43 Intensive Care Activity as measured by **ICU bed days** shows Manly ICU/HDU (3663 days) to be busier than the ICU at the much bigger Hornsby Hospital (3658 days) and Mona Vale (2530 days) even though Manly Emergency Department has the least attendances.

44 The increased ICU/HDU Activity reported at Manly Hospital seems to reflect an Admissions policy that allows admission of vastly increased numbers of low acuity, non-ventilated patients to ICU/HDU when compared to the other Units.

45 Also the effects of an interventionist treatment culture for the ventilated patients appear to significantly increase the ICU bed days.
The infrastructure to handle this enhanced activity in turn enables acceptance of transfers from other hospitals not so well staffed.

INTENSIVE CARE AND HIGH DEPENDENCY NEED

46 Manly ICU ventilated 137 patients over the two years to June 2004 while Mona Vale ventilated 133, however these figures include transfers from other hospitals. When the 57 hospital transfers to the Manly ICU and the16 to Mona Vale ICU are excluded **it is almost certain that Mona Vale generates a significantly greater number of its own patients requiring ventilation support**. This is not surprising given Mona Vale has a significantly larger Emergency Department load.

47 The figures seem to indicate that Mona Vale has a greater need for an ICU to provide ventilation support for its own patients while Manly processes more low acuity patients admitted to ICU/HDU. The Goulston proposals seem not to take these issues into account nor do the proposals address the other issues (including safety) documented earlier.

Response from NSW Health

Question 2: ICU Activity Data

The data referred to in Dr Boland's submission was provided to him by the Nursing Unit Manager of Mona Vale Intensive Care, and is compiled for the use of the Northern Sydney Area Intensive Care Network. It provides information on the activity of each of the intensive care units in the Northern Sydney Area. The data is not meant for publication and requires expertise and familiarity with intensive care processes to interpret accurately. The activity data of different hospitals cannot be directly compared without adjustment for case mix and patient acuity.

The accuracy of the data depends on the particular parameter collected. Patient numbers are more accurately recorded than ventilator hours, and in the smaller units the data can be skewed by small numbers of very long stay patients. The data may also be less reliable in the smaller units that serve a number of functions not traditionally offered in larger units, such as after hours recovery service, central line insertion service, elective cardioversion or recovery of paediatric elective surgical cases.

Review of the data provided in this table reveals an error in the mean ventilator days for Mona Vale in 2002/03. The correct figure should be a mean of 2.39 days, not 4.34 days as reported. The remainder of the table correlates with the reports generated from the ICU database.

The 2003/2004 data reviewed by the GMCT was the most up-to-date, complete and reliable. Previous years' data are less reliable, as they were affected by a change in data collection protocols. The data over the past four years shows a similar trend of greater numbers of admissions and ventilated patients at Manly.

Question 3: ICU Admission Policies

All patients admitted to intensive care at Manly and Mona Vale are referred by a hospital specialist such as the emergency department consultant, general medical consultant, surgical consultant or anaesthetist. The specialist team refer the patients because they consider them to require intensive care admission. The intensive care team then assess the patient and a decision for admission is made on the basis of clinical need. Many of the physicians and anaesthetists work at both hospitals and as a result there is a consistency of referral to Intensive Care across hospital sites. The fact that all but one of the six Northern Beaches intensive care specialists work at Manly ICU means that there is also a consistency of ICU admission across hospital sites.

NSW Health Response (continued)

There are minor differences in the admission policy between the two hospitals that would not affect patient numbers. Manly admits patients under the care of the intensive care physician of the day. Mona Vale admits patients under the shared care of the attending physician or surgeon and the intensive care physician. As with all other policies and protocols, the policy will be reviewed on a regular basis.

In contrast to the larger hospitals, the two Northern Beaches hospitals admit patients to the Intensive Care Units as high dependency admissions. Smaller hospitals such as Manly and Mona Vale do not have the capacity to provide specialist wards with specialist trained nursing and medical staff (for example, specialist respiratory or cardiology wards or specialist surgical wards such as vascular or colorectal wards). The HDU therefore provides a higher level of nursing and medical care and has an important role to play in the small metropolitan hospital.

The greater numbers of patients passing through the Intensive Care Unit at Manly compared with Mona Vale is due to the greater number of adult admissions to the hospital in general. In 2003/04 there were 3,993 adult admissions at Manly compared to 3,728 at Mona Vale. In addition, the triage category of adult patients presenting to Manly emergency department demonstrates that they are of a higher acuity than at Mona Vale. During 2003/04, 2,388 Manly patients presented with a triage category of 1, 2 or 3, this is compared to 2,071 patients presenting at Mona Vale.

In regard to ventilated patients, Manly Intensive Care has traditionally been managed by respiratory physician intensivists who have developed an expertise in non-invasive ventilation (face-mask ventilation or 'CPAP/BiPAP'). Research has shown that non-invasive is superior to invasive ventilation (patients sedated and intubated) for certain types of respiratory failure. The total number of ventilated patients at Manly is therefore even greater if these patients are included in the figures. During 2003/04, 133 patients at Manly were ventilated via invasive and non-invasive ventilation compared to 95 patients at Mona Vale.

Unlike Manly ICU, Mona Vale is unable to support patients with multi-organ failure and transfers its sickest patients. The length of time patients are ventilated is therefore expected to be shorter than at Manly.

In regard to the acuity of patients, both Dr Stuart Boland and Mr Parry Thomas presented APACHE II data to the Inquiry. This data provides a measure of acuity by scoring the most unstable physiological parameters recorded over the first 24 hours of admission to ICU. It is clear that patients admitted to a level 4 unit that accepts high dependency patients (for example Mona Vale) are of a lower acuity than those admitted to a level 6 unit such as the General Intensive Care Unit at Royal North Shore Hospital that accepts the sickest patients from the Area and does not have any high dependency beds. However, the recorded APACHE II values at Mona Vale (18.6) are higher than those at Royal North Shore General Unit (17). This is clearly incongruous but well recognised and may be explained by the older age of the patients at Mona Vale and by the fact that if a patient is admitted to ICU at Mona Vale and deteriorates overnight, they will record a high APACHE II score. Patients with multi-organ failure are then transferred out of the unit at Mona Vale and their subsequent death will not be recorded as occurring in Mona Vale hospital. An appearance that Mona Vale ICU accepts high acuity patients with low death rates is therefore false.

In contrast, the Manly Hospital ICU provides multiple organ support, has more complete medical cover and therefore does not transfer patients out of the unit. The APACHE II scores and death rates are therefore more realistic.

Appendix 5 Northern Beaches Health Service – Site Selection Document

Northern Beaches Health Service - Site Selection Release

Over the past five years, Northern Sydney Central Coast Health (NSCCH) has been working with local communities and health professionals to improve how we deliver health care to the residents of the Northern Beaches.

We now have a clear and compelling vision of a single health service that includes community health services and two hospital campuses – the existing Mona Vale Hospital and a new Northern Beaches Hospital to replace Manly Hospital.

NSCCH remains committed to retaining Mona Vale Hospital in its present location. Six potential sites for the new Northern Beaches Hospital are described below.

Hospital-based health services will be networked across the two sites to ensure every Northern Beaches resident receives the best and most appropriate health care.

NSCCH objectives for the Northern Beaches Health Service:

- Minimal need to travel outside the Northern Beaches for non-tertiary services
- Minimised travel time between services and improved integration of services
- Convenient access to community health services
- Co-location of hospital and community health services
- Buildings designed to support modern health care delivery
- Better capacity to attract and retain quality staff
- Enhanced efficiency in both acute and community health service delivery
- Improved safety for patients, staff and visitors

In the early stages many different sites for a new Northern Beaches Hospital were identified and assessed. Most had significant drawbacks or obstacles that made them inappropriate for further, and more expensive, investigation.

Now we have six potential sites.

Dee Why	part of Council Civic Centre and some adjacent private land
Brookvale Bus Depot	limited amount of STA Bus Depot land plus some industrial land
Frenchs Forest	NSW Housing site expanded east to include Bantry Bay Rd houses, land to Wakehurst Pkwy
Brookvale Greenfield*	northern corner of Warringah public golf course

Beacon Hill	Vacant NSW Education site (Landcom proposals)
Mona Vale	Mona Vale Hospital site

The Dee Why location has emerged as the preferred site but it is important we have external input into priorities.

Here are the criteria used to assess the sites:

1. ensures viable services in the long term
2. travel time by private car to emergency services is less than 30 mins
3. total development cost
4. planning and approvals (community acceptance)
5. environment and heritage issues
6. operational efficiency and the potential to gain productivity
7. partnership opportunities
8. traffic access and impacts
9. ease of community access by public transport
10. development constraints (How flexible is the site?)

Site descriptions and information

Dee Why
The Dee Why site is close to public transport, the town centre and other community facilities. The ground conditions are good. It is a sloping site with some limits on expansion or reconfiguration. The slope enables multiple ground level access points to the hospital. There is some traffic congestion and the need to acquire private property.

Brookvale Bus Depot
This site proposes to use a small section of the bus depot and a larger number of adjacent industrial properties. It is on a main road and has alternative access. It is a compact site with a northerly aspect close to public transport. It's close to Warringah Mall and the main traffic route. It is an industrial zone and might have some contaminated ground. Ground conditions are difficult and require expensive foundations and construction. Expansion and reconfiguration is likely to be limited and it will be necessary to acquire a significant amount of private property.

Frenchs Forest
The Frenchs Forest site has access to good road infrastructure and a woodland buffer zone. It's an undulating site with good ground conditions and an attractive setting. The site is level. A proposed hospital would require the use 1.5 hectares of protected forest and there are concerns about bushfire protection and poor public visibility. The hospital would be adjacent to a public school and there is no integration with a commercial zone. There is limited public transport and the potential problem of more traffic at an already busy

intersection. Expansion would require displacement of more forest area. This site is currently earmarked for housing.

Brookvale Greenfield*
This site occupies a northern parcel of Warringah Golf Course. It is close to public transport and road infrastructure. It is adjacent to Warringah Mall and other community facilities. There are opportunities for expansion and good access to a flat site. It is an easily identifiable site in a landmark position. The present golf course would require some redesign. Foundations would be expensive and there is an existing lease.
* A 'Greenfield' site is one which has no structures that require demolition prior to redevelopment.

Beacon Hill
The Beacon Hill High School site is open, requires minimal clearing and is readily available. Ground conditions are good. Access is by a single, congested road. The residential location may not easily support future health developments. Private property will need to be acquired and the steep site will require terracing. It is adjacent to a primary school and there will be some loss of green space. Residential housing proposals exist.

Mona Vale
A review of the Mona Vale Hospital site showed good ground conditions and amenity with the potential for expansion. There are no heritage issues and land acquisition is not required. However, the site is not close to the main population catchment and has single road access. There are potential environmental issues and loss of some green space. The site is distant from a commercial zone.

The way forward

There are two important steps.

1. **Within the next two months NSCCH will involve community and health professionals in a Value Management Study (VMS) to advise which, of the sites listed above, is the preferred site for the new Northern Beaches Hospital.**
2. **Once this is decided health professionals and community representatives will get together to decide how health services will be networked across the two hospitals for the benefit of Northern Beaches residents.**

We welcome your feedback about the proposed sites. Please write to:

Northern Beaches Health Service Proposal
Northern Sydney Central Coast Health
c/- Executive Unit, Level 5
Royal North Shore Hospital
ST LEONARDS NSW 2065

Appendix 6 Minutes of proceedings

Minutes No 34
Wednesday 8 December 2004
Room 1108, Parliament House at 6.40pm

1. Members Present
Mrs Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Ms Jan Burnswoods (Tsang)
Ms Melinda Pavey
Ms Christine Robertson
Dr Arthur Chesterfield-Evans
Revd Gordon Moyes

2. Substitutions
The Chair noted the written advice from the Government Whip that Ms Burnswoods would be substituting for Mr Tsang.

3. Confirmation of Minutes
Resolved on the motion of Mr Catanzariti: That Minutes No. 33 be adopted.

4. Correspondence
The Committee noted the following items of correspondence, that had been circulated previously:

- Letter, dated 7 December 2004 and signed by Revd Moyes, Dr Chesterfield-Evans and Ms Forsythe, to the Committee Director requesting a meeting of the Committee to consider an inquiry regarding changes by NSW Health affecting Mona Vale hospital.

- Letter, dated 7 December 2004 and signed by Ms Forsythe, Ms Pavey and Revd Moyes, to the Committee Director requesting a meeting of the Committee to consider an inquiry regarding the NSW Ambulance Service including the aero Medical Retrieval Unit.

- Letter, dated 7 December 2004 and signed by Dr Chesterfield-Evans, Ms Pavey, Revd Moyes and Ms Forsythe, to the Committee Director requesting a meeting of the Committee to consider an inquiry regarding the ATLAS program for young adults and school leavers with disability.

The Chair distributed copies of suggested minor drafting amendments, prepared by the Clerk-Assistant Committees, to the wording of the three proposed terms of reference.

Inquiry into the operation of Mona Vale Hospital
The Committee considered the suggested amendments to the proposed terms of reference that had been circulated previously.

The Committee considered the initiation of the self-reference.

Revd Moyes moved: That the Committee adopt the following terms of reference:
1. That General Purpose Standing Committee No. 2 inquire into and report on the operation of Mona Vale Hospital, and in particular:
   (a) the closure of the intensive care unit and the reasons behind its transfer to another hospital,

(b) the level of funding given to Mona Vale Hospital compared to other hospitals in the area,
(c) the level of community consultation in relation to changes proposed by NSW Health to the hospital, and
(d) the reasons why the hospital has not been made the general hospital for the Northern Beaches area.

2. That the Committee report by 31 March 2005.

Ms Robertson moved: That the question be amended by omitting all the words after "That the Committee" and inserting instead "give notice to the representatives of NSW Health scheduled to appear before the Committee at its next Budget Estimates hearing of questions regarding the proposed changes to Mona Vale Hospital; and that after reviewing the responses provided by NSW Health the Committee then consider the question of initiating an inquiry into the operation of Mona Vale Hospital.

Question - That the amendment of Ms Robertson be agreed to – put.

The Committee divided.

Ayes: Ms Burnswoods, Mr Catanzariti, Ms Robertson.
Noes: Dr Chesterfield-Evans, Ms Pavey, Revd Moyes, Ms Forsythe.

Amendment negatived.

Original question put.

The Committee divided.

Ayes: Dr Chesterfield-Evans, Ms Pavey, Revd Moyes, Ms Forsythe.
Noes: Ms Burnswoods, Mr Catanzaritie, Ms Roberston.

Question resolved in the affirmative.

Resolved on motion of Ms Pavey: That the secretariat, on behalf of the Chair, be authorised to place advertisements calling for submissions in the Sydney Morning Herald and in local papers for the Northern Beaches region.

Resolved on motion of Ms Pavey: That Thursday 31 January 2005 be the closing date for submissions.

Resolved on motion of Revd Moyes: That the Committee secretariat write to the Department of Health, local councils, the Save the Mona Vale Hospital group and local medical groups, to advise them of, and invite submission to, the inquiry.

The Chair indicated that the Committee would need to convene a further deliberative meeting in mid-February 2005 to consider the submissions received and the conduct of the public hearings, and the secretariat would contact Members as to their availability for a deliberative and for two public hearings to be held in late February – early March.

5. …

6. Adjournment

The Committee adjourned at 7.55pm until 9.15am on Monday 20 December 2004 (Budget Estimates).

Steven Reynolds
Clerk to the Committee

Minutes No 35
Monday 20 December 2004
Jubilee Room, Parliament House at 9.30am

1. Members Present
Ms Patricia Forsythe (*Chair*)
Mr Tony Catanzariti (*Deputy Chair)*
Dr Arthur Chesterfield-Evans
Revd Dr Gordon Moyes
Ms Melinda Pavey
Mr John Ryan (Pavey – from 2pm)
Ms Amanda Fazio (Robertson)
Mr Henry Tsang

2. Substitute arrangements
The Chair advised that Ms Fazio would be representing Ms Robertson for the purposes of this meeting, and that Mr Ryan would be substituting for Ms Pavey from 2pm onwards.

3. …

4. Deliberative meeting
…

Confirmation of Minutes
Resolved on motion of Dr Moyes: That Minutes 34 be confirmed.

Correspondence received
The Chair noted the following item of correspondence received:

- E-mail, sent on 14 December 2004, from Committee Director to Members regarding the drafting error in the terms of reference for the inquiry into the operation of Mona Vale Hospital.

Inquiry into operation of Mona Vale Hospital
The Committee considered a drafting error in point (d) of the terms of reference adopted by the Committee at its meeting on 8 December.

The Chair asked if there was any objection to point (d) of the terms of reference being amended by omitting the word "the" and inserting instead the word "a" immediately before the word general, so that the terms of reference for the inquiry would read:

1.That General Purpose Standing Committee No. 2 inquire into and report on the operation of Mona Vale Hospital, and in particular:
(a) the closure of the intensive care unit and the reasons behind its transfer to another hospital,
(b) the level of funding given to Mona Vale Hospital compared to other hospitals in the area,
(c) the level of community consultation in relation to changes proposed by NSW Health to the hospital, and
(d) the reasons why the hospital has not been made a general hospital for the Northern Beaches area.
2. That the committee report by 31 March 2005.

No objection taken.
…

5. Deliberative meeting

…

6. Adjournment

The Committee adjourned at 4.25pm until 9.30am, Wednesday 23 February 2005.

Tanya Bosch
Clerk to the Committee

Minutes No 36
Wednesday 23 February 2005
Room 1108, Parliament House at 9:32am

1. Members Present

Mrs Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Ms Henry Tsang
Ms Kayee Griffin (Robertson)
Ms Melinda Pavey
Revd Dr Gordon Moyes
Dr Arthur Chesterfield-Evans

2. Substitutions

The Chair noted the written advice from the Government Whip that Ms Griffin would be substituting for Ms Robertson at this meeting.

3. Confirmation of Minutes

Resolved on the motion of Mr Catanzariti: That the Committee adopt Minutes No. 35.

4. Papers tabled by Committee Clerk

The Committee Clerk tabled the following documents:

- Letter, dated 22 February 2005 from the Director General, NSW Health to the Committee Director advising of the NSW Health departmental officers who would appear as witnesses at the public hearing on 28 February 2005.
- Submission No. 3233.

5. Correspondence

The Committee noted the following items of correspondence:

Sent:

- Letter dated 20 December 2004 from Committee Chair to General Manager, Manly Council advising of inquiry and inviting submission.
- Letter dated 20 December 2004 from Committee Chair to General Manager, Pittwater Council advising of inquiry and inviting submission.
- Letter dated 20 December 2004 from Committee Chair to General Manager, Warringah Council advising of inquiry and inviting submission.
- Letter dated 20 December 2004 from Committee Chair to Convenor, Surgeons & Anaesthetists, Mona Vale Hospital advising of inquiry and inviting submission.
- Letter dated 20 December 2004 from Committee Chair to Chairperson, Save Mona Hospital Committee advising of inquiry and inviting submission.

- Letter dated 20 December 2004 from Committee Chair to Chairperson, Medical Staff Council, Mona Vale Hospital advising of inquiry and inviting submission.
- Letter dated 20 December 2004 from Committee Chair to Minister for Health advising of inquiry and inviting submission from NSW Health.
- Letter dated 23 December 2004 from Committee Director to Administration Manager, Cumberland Newspaper Group, regarding advertisement appearing in *the Manly Daily* of 18 December regarding Parliamentary Inquiry into Mona Vale Hospital (copy circulated to Members on 23 December).
- Letter dated 1 February 2005 from Committee Director to Manager, Community and Library Services, Pittwater Council regarding receipt of 860 individual short submissions that accompanied the submission from Council.
- Letter dated 17 February 2005 from Principal Council Officer to Chairman, Mona Vale Hospital Medical Staff Council regarding his appearance as a witness before the Committee on 28 February 2005.
- Letter dated 17 February 2005 from Principal Council Officer to Chairman, Save Mona Vale Hospital Committee regarding the appearance of representatives of that organisation as witnesses before the Committee on 28 February 2005.
- Letter dated 17 February 2005 from Principal Council Officer to convenor, BEACHES regarding the appearance of representatives of that organisation as witnesses before the Committee on 28 February 2005.
- Letter dated 17 February 2005 from Committee Director to Director General NSW Health inviting representatives of the Department to appear as witnesses before the Committee on 28 February 2005.
- Letter dated 17 February 2005 from Committee Director to Minister for Health enclosing copy of correspondence sent to Director General, NSW Health.
- Letter dated 17 February 2005 from Committee Director to the Member for Manly inviting him to appear as a witness before the Committee on 28 February 2005.
- Letter dated 17 February 2005 from Committee Director to the Member for Pittwater inviting him to appear as a witness before the Committee on 28 February 2005.
- Letter dated 21 February 2005 to the author of Submission No 622 regarding the author's appearance as a witness before the Committee on 28 February 2005.

Received

- Letter received 28 January 2004 from Independent Member for Manly to Committee Director enclosing a copy of an Agreement of Understanding between the four Northern Beaches State Members concerning hospital services, and requesting invitation to appear as a witness before the Committee.
- Letter received 7 February 2005 from Ms Patricia Giles, Councillor, Pittwater Council, to Committee Director requesting invitation for herself and Mr Allan Hicks and Mr Edward Clare to appear as witnesses before the Committee.
- Letter, received 9 February 2005 from Dr J B Roche enclosing an article from *Pittwater Life* concerning population growth projections to 2031 for Northern Beaches local government areas.
- Letter, received 11 February from Manager, Community & Library Services, Pittwater Council to Committee Secretariat requesting that the Committee invite Cr Alex McTaggart and the Manger, Community & Library Services to appear as witnesses before the Committee.
- Letter received 18 February from Mr and Mrs John and Helen Ayliffe requesting that the Committee invite them to appear as witnesses before the Committee.
- Letter received 21 February 2005 from Mr Robert T Dunn requesting advice on the procedure for securing an invitation to appear as a witness before the Committee.
- Letter received 22 February 2005 from the Director General NSW Health to Committee Director advising of the names of the NSW Health staff who would appear alongside the Director General as witnesses before the Committee at the public hearing on 28 February 2005.

6. Inquiry into the operation of Mona Vale Hospital

Publication of submissions

The Committee considered submission Nos 37 and 41 with respect to sections of those submissions containing adverse mentions of third parties.

Resolved on the motion of Dr Chesterfield-Evans: That the Committee publish submission No 37 with the exception of the fourth and fifth sentences of the second paragraph and the second sentence of the seventh paragraph, which shall remain confidential to the Committee.

Resolved on the motion of Dr Chesterfield Evans: That the Committee publish submission No 41 with the exception of the first two paragraphs of page six; the first two paragraphs of page eight; and the sentence commencing with the words "According [sic] the nurses he…", which shall remain confidential to the Committee.

The Committee Clerk advised that many submissions refer to the belief that a group of doctors opposed to the Mona Vale Hospital site as a potential site for a new general hospital would derive a financial benefit from a new general hospital being located in Dee Why or Frenchs Forest.

The Committee noted that a number of authors of submissions to the Inquiry had requested that their name and address remain confidential to the Committee.

Resolved on the motion of Mr Tsang: That the Committee publish submissions Nos 43; 314; 347; 450; 457; 466; 633; 877; 1032, with the exception of the name and address of the authors of those submissions which shall remain confidential to the Committee.

The Committee noted that a number of authors of submission to the Inquiry had requested that their submission remain confidential to the Committee.

Resolved on the motion of Ms Pavey: That the Committee publish all submissions up to and including submission No 2233 with the exception of submission Nos: 20; 26; 122; 154; 195; 205; 218; 240; 269; 303; 305; 340; 386; 393; 418; 491; 518; 585; 605; 616; 622; 633; 698; 719; 805; 1029; 1079; 1095.

The Committee Clerk note that submission 719 and the adverse mentions in submissions 37 and 41 are contained in the CD Rom distributed to members.

Placing submissions on inquiry website

The Committee noted the impracticality of placing all submissions received on the committee website. The Committee noted its anticipation that there would be requests from inquiry stakeholders for access to certain key submissions including the submissions of those appearing as witnesses before the Committee.

Resolved on the motion of Mr Catanzariti: That it be left in the hands of the Committee Secretariat to place on the inquiry website all or part of key public submissions, including public submissions by those persons or organisations appearing as witnesses before the Committee; and that the inquiry website include an acknowledgement of the number of submissions received and of the reasons for placing only selected submissions on the website.

Public hearings of 28 February 2005 and 8 March 2005

Revd Dr Moyes tabled a document nominating a number of individuals to be invited to appear as witnesses before the Committee, and indicating the possible preference of some of those nominated to appear in camera.

Resolved on the motion of Revd Dr Moyes: That at the public hearing on 28 February 2005 the Committee would hear the evidence of the author of submission 622 in camera.

The Chair advised Members that any nominations for witnesses for the public hearing on 8 March 2005 could be directed to the Committee Clerk.

Meeting between Committee Secretariat and representatives of NSW Health

The Committee Clerk advised the Committee of a meeting, arranged on the initiative of the secretariat, held on the 18 February 2005 at the offices of NSW Health, the purpose of which was to raise the issue of protection of NSW Health and Northern Sydney Central Coast Health employees who appear as witnesses before or make submissions to the inquiry.

7. **…**

8. **…**

9. **Adjournment**

The Committee adjourned at 10:15am until 9.15am on Monday 28 February 2005 in the Jubilee Room, Parliament House (Inquiry into operation of Mona Vale Hospital).

Steven Reynolds
Clerk to the Committee

Minutes No 37
Monday 28 February 2005
Jubilee Room, Parliament House at 9:25am

1. **Members Present**

Mrs Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Ms Amanda Fazio (Ms Henry Tsang)
Ms Christine Robertson
Ms Melinda Pavey
Revd Dr Gordon Moyes
Dr Arthur Chesterfield-Evans

2. **Substitutions**

The Chair noted the written advice from the Government Whip that Ms Fazio would be substituting for Mr Tsang at this hearing.

3. Inquiry into the operation of Mona Vale Hospital

Public Hearing

Witnesses, the public and the media were admitted.

The Chair made a brief opening statement.

The following witnesses representing NSW Health were sworn and examined:

- Ms Robyn Kruk, Director General, NSW Health
- Dr Richard Matthews, Deputy Director General, NSW Health
- Dr Stephen Christley, Chief Executive, Northern Sydney Central Coast Health
- Mr Frank Bazik, General Manager, Northern Beaches Health
- Dr Paul Phipps, Director, Intensive Care Services, Northern Beaches Health

The Chair indicated that the Committee might at a later stage resolve to provide written questions to NSW Health.

Evidence concluded and the witnesses withdrew.

Mr John Brogden MP, Member for Pittwater was examined.

Evidence concluded and the witness withdrew.

Mr David Barr MP, Member for Manly was examined.

Evidence concluded and the witness withdrew.

The public and the media withdrew.

4. Deliberative meeting

The Committee deliberated at 12:45pm.

4.1 Confirmation of minutes

Resolved on the motion of Mr Catanzariti: That the Committee adopt Minutes No. 36.

4.2 Correspondence

The Committee noted the following items of correspondence:

Sent

- Letter dated 24 February 2005 to the author of submission No. 37 advising of the Committee's resolution to publish the submission with the exception of certain sections that shall remain confidential to the Committee.
- Letter dated 24 February 2005 to the author of submission No. 41 advising of the Committee's resolution to publish the submission with the exception of certain section that shall remain confidential to the Committee.

Received

- Letter received 24 February 2005 from the Chief Executive, Northern Sydney Central Coast Health to Committee Director correcting an error in that organisation's submission (No. 2230).

4.3 Resolution to hear evidence of witness in public

The Committee noted the misunderstanding as to Dr Boland's original intention and that he had not requested to appear in camera.

Resolved on the motion of Ms Robertson: That the Committee hear in public the evidence of Dr Stuart Boland, Convenor, Surgeons & Anaesthetists, Mona Vale Hospital.

4.4 Publication of supplementary submission

Resolved on the motion of Ms Robertson: That the Committee publish supplementary submission No. 622 with the exception of appendix 7 and appendix 8 of that submission which shall remain confidential to the Committee.

4.5 Adjournment

The Committee adjourned at 12:55pm until 2:00pm (continuation of the public hearing).

5. Inquiry into the operation of Mona Vale Hospital
Public hearing (continued)

Witnesses, the public and the media were admitted.

Mr Parry Thomas, Chairman, Save Mona Vale Hospital Committee and Mr Harvey Rose, Deputy Chair, Save Mona Vale Hospital Committee were sworn and examined.

Mr Thomas tendered the following documents:
A hard copy of his opening statement to the Committee.
A copy of correspondence including attachments dated 14 February 2005 from the Save Mona Vale Hospital Committee to the Minister for Health regarding the GMCT Interim Proposal for the Northern Beaches.
A copy of Northern Sydney Health Intensive Care Services Activity Reports for the years 2002/2003 and 2003/2004 for Royal North Shore, Hornsby, Manly and Mona Vale hospitals.

Mr Thomas tendered a copy of correspondence dated August 2003 regarding intensive care services at Manly Hospital, which he requested remain confidential to the Committee.

Evidence concluded and the witnesses withdrew.

Dr Stuart Boland, Convenor, Surgeons & Anaesthetists, Mona Vale Hospital, was sworn and examined.

Dr Boland tendered a summary signed by two of the three parties involved in a December 2004 conversation, which he requested remain confidential to the Committee.

Evidence concluded and the witness withdrew;

Dr David Jollow, Chairman, Mona Vale Hospital Medical Staff Council was sworn and examined.

Evidence concluded and the witness withdrew.

Ms Lynette Hopper, Chairperson, Better & Equitable Access to Community and Hospital Services (BEACHES), and Ms Sandra Hudspith, representative BEACHES were sworn and examined.

Ms Hudspith tendered a brochure produced by Northern Sydney Health entitled *Better health services on the northern beaches are one step closer.*

Evidence concluded and the witnesses withdrew.

The public, the witnesses and the media withdrew.

The Committee deliberated.
Resolved on motion of Ms Pavey: That the Committee publish the documents tendered to and accepted by the Committee during the public hearing, with the exception of those for which confidentiality was requested, or which the Committee determined should remain confidential.

Resolved on motion of Dr Chesterfield-Evans: That Members be given the opportunity to provide written questions to NSW Health for which a response will be requested within 14 days, and that Members provide their questions to the secretariat by 5:00pm Wednesday 2 March 2005.

Resolved on motion of Dr Chesterfield-Evans: That representatives of NSW Health be invited to appear as witnesses before the Committee at a public hearing to be held on 21 March 2005.

Resolved on motion of Ms Pavey: That Members provide the secretariat, by 5:00pm Wednesday 2 March 2005, with the names and contact details of potential witnesses for the remaining public hearings.

6. Adjournment

The Committee adjourned at 5.09 pm until 9.30am on Tuesday 8 March 2005 in the Jubilee Room, Parliament House (Inquiry into operation of Mona Vale Hospital public hearing).

John Young
Clerk to the Committee

Minutes No 38
Tuesday 8 March 2005
Jubilee Room, Parliament House at 9:30am

1. Members Present

Mrs Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Ms Amanda Fazio (Ms Henry Tsang)
Ms Christine Robertson
Ms Melinda Pavey
Revd Dr Gordon Moyes
Dr Arthur Chesterfield-Evans

2. Substitutions

The Chair noted the written advice from the Government Whip that Ms Fazio would be substituting for Mr Tsang for the duration of the inquiry.

3. Inquiry into the operation of Mona Vale Hospital

Public Hearing

Witnesses, the public and the media were admitted.

The Chair made a brief opening statement.

Mr Dick Persson, Administrator, Warringah Council, and Mr Stephen Blackadder, General Manager, Warringah Council were sworn and examined.
Evidence concluded and the witnesses withdrew.

Professor Kerry Goulston, Chairman, Greater Metropolitan Clinical Taskforce (GMCT) was sworn and examined.

Professor Goulston tendered a hard copy of a slide presentation explaining the role and actions of the Greater Metropolitan Clinical Taskforce.

Evidence concluded and the witness withdrew.

Ms Kate Needham, Nursing Co-Chair, NSW Intensive Care Implementation Group was sworn and examined.

Ms Needham tendered copies of nine photographs relating to technology historically and currently employed in intensive care units.

Evidence concluded and the witness withdrew.

Ms Tina Health, Warringah Council community representative on the Northern Beaches Community Consultation Health Planning Group (NBCCHPG); Mr Paul Couvret, Warringah Council community representative, NBCCHPG; and Mr Carlo Bongarzoni, Manly Council community representative, NBCCHPG, were sworn and examined.

Evidence concluded and the witnesses withdrew.

The public and the media withdrew.

The Committee deliberated.

Resolved on motion of Ms Fazio: That the Committee hear evidence in camera from the witnesses scheduled to appear before the Committee from 2:45pm.

The Committee adjourned at 12:35pm for the lunch break until the re-commencement of the public hearing at 2:00pm

Witnesses, the pubic and the media were admitted.

Dr Stephen Nolan, Intensivist, Mona Vale and Manly Hospital, was sworn and examined.

The Chair made a statement regarding the protection provided to witnesses against any intimidation arising from the evidence they have given to the Committee.

Evidence concluded and the witness withdrew.

The public and the media withdrew.

The Committee proceeded to take in camera evidence, as per its resolution of earlier in the day.

Ms Denise Hardie, Registered midwife, Co-ordinator, Maternity Early Discharge Program, Mona Vale Hospital; Ms Deborah Carter, Registered Nurse, Secretary Mona Vale Branch, NSW Nurses Association; and Ms Karen Draddy, Registered Nurse, Nurse Unit Manager, Maternity Services Mona Vale Hospital, Vice-President, Mona Vale Branch, NSW Nurses Association were sworn and examined.

[Persons present other than the Committee: Mr Steven Reynolds, Mr John Young, Ms Glenda Baker, Mr Michael Jarratt and Hansard reporters]

The Chair confirmed with the witnesses that they had no objection to their evidence being published.

Resolved on motion of Dr Chesterfield-Evans: That in accordance with Standing Order 223 the evidence provided by Ms Hardie, Ms Carter and Ms Draddy be published.

The Chair made a statement regarding the protection provided to witnesses against any intimidation arising from the evidence they have given to the Committee.

The in camera evidence concluded and the witnesses withdrew.

Witnesses, the public and media were re-admitted.

Mr Alex McTaggart, Councillor, Pittwater Council; and Mr Lindsay Godfrey, Manager, Community & Library Services, Pittwater Council were sworn and examined.

Cr McTaggart tendered a document entitled *Great Lies and Myths of the Hospital Debate on the Northern Beaches.*

Evidence concluded and the witnesses withdrew.

The public hearing concluded and the public and the media withdrew.

4. Deliberative meeting

4.1 Confirmation of minutes

Resolved on motion of Ms Pavey: That the Committee adopt Minutes No. 37.

42 Publication of tendered documents

Resolved on motion of Ms Robertson: That the Committee publish the documents tendered to and accepted by the Committee during the public hearing.

4.3 Correspondence

The Committee noted the following items of correspondence:

Sent

- Letter dated 3 March 2005 from Chair to Director General NSW Health inviting nominated departmental officers to appear as witnesses at a public hearing on 21 March 2005; requesting responses to written questions on notice; and requesting details regarding location of sites under consideration as location of new northern beaches general hospital.
- Letter dated 3 March 2005 from Committee Chair to Minister for Health enclosing copy of correspondence sent to Director General NSW Health.
- Letter dated 2 March 2005 to Dr Stephen Nolan regarding his appearance as a witness before the Committee on 8 March 2005.
- Letter dated 2 March 2005 to Manager, Community & Library Services, Pittwater Council regarding the appearance of representatives of that organisation as witnesses before the Committee on 8 March 2005.
- Letter dated 2 March 2005 to Ms Kate Needham regarding her appearance as a witness before the Committee on 8 March 2005.
- Letter dated 2 March 2005 to Professor Kerry Goulston, Chair, GMCT, regarding his appearance before the Committee on 8 March 2005.
- Letter dated 2 March 2005 to General Manager, Warringah Council regarding the appearance of representatives of that organisation as witnesses before the Committee on 8 March 2005.

Received

- Letter dated 3 March 2005 from Ms Alison McLaughlin to Committee Chair regarding an incident she witnessed that occurred following the conclusion of the public hearing on 28 February 2005 and which involved a Member of the Committee and a person who had earlier appeared as a witness before the Committee.
- E-mail received 3 March 2005 from Mr Peter Phelps of Whale Beach requesting the Committee invite him to appear as a witness before the Committee.
- E-mail received 3 March 2005 from Ms Patricia Giles, requesting the Committee consider inviting her to appear as a witness before the Committee.

The Chair tabled a letter received 8 March 2005 from Ms Lyn Hopper to the Committee Chair detailing Ms Hopper's complaint regarding the behaviour of a Member of the Committee following the conclusion of the public hearing on 28 February 2005 during which Ms Hopper had earlier appeared as a witness.

The Committee deliberated.

Resolved on motion of Ms Fazio: That the Committee refer the correspondence received from Ms Alison McLaughlin and from Ms Lyn Hopper to the Clerk of the Parliaments and seek the advice of the Clerk on what courses of action are open to the Committee.

Resolved on motion of Ms Robertson: That the Committee write to Ms McLaughlin and Ms Hopper and advise them that the Committee is examining the issue raised in their correspondence.

4.4 Site visit 21 March 2005

The Committee noted that the Secretariat was finalising arrangements for the conduct of an informal tour, for the benefit of interested Members, of the Northern Beaches area including the location of the six sites currently under consideration as the location of the new level 5 Hospital.

4.5 …

Notice of motion to rescind resolution

Dr Chesterfield-Evans gave notice that at the next meeting of the Committee he would move a motion to rescind the resolution of the Committee on 12 December 2004: That the Committee conclude its public examination of the proposed expenditure for the portfolio area of Health.

5. Adjournment

The Committee adjourned at 5.15 pm until 9.00am on Monday 21 March (site visit).

John Young
Clerk to the Committee

Minutes No 39
Monday 21 March 2005
Parliament House at 9:30am

1. Members Present

Mrs Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Ms Amanda Fazio (Mr Henry Tsang)

2. Apologies

Ms Christine Robertson
Ms Melinda Pavey

Revd Dr Gordon Moyes
Dr Arthur Chesterfield-Evans

3. Inquiry into the operation of Mona Vale Hospital

Site Visit – Northern Beaches area including potential sites for new Northern Beaches Hospital
The visit was conceived on the initiation of Hon Tony Catanzariti, who as one of the Committee's country members was unfamiliar with the Northern Beaches area, and wished to be provided with an informal tour so that he could more easily place some of the issues raised during the inquiry within a geographical context. Some members advised that they were familiar with the area and did not require a tour. Subsequently it was considered beneficial to make use of this time to incorporate a visit to the sites currently under consideration as the location of the new Northern Beaches hospital. The Committee was accompanied by Mr Stuart Muirhead, Program Director Service, Atkinson Capital Insight Pty Ltd. Copies of information given to members during the driving tour were later distributed to the other Committee members.

The Committee drove to the following locations:

- Manly Hospital
- Mona Vale Hospital (site)
- Frenchs Forest, Warringah Road and Wakehurst Parkway (site)
- Beacon Hill, Tristram Road (site)
- Brookvale Bus Depot, Pittwater Road, (site)
- Dee Why Civic Centre, Fisher Road and the Kingswary (site)
- Warringah Public Golf Course, Brookvale, Condamine Street and Pittwater Road (site).

4. Adjournment
The Committee adjourned at 12:30pm until 2.00pm at the Jubilee Room, Parliament House (public hearing).

John Young
Clerk to the Committee

Minutes No 40
Monday 21 March 2005
Jubilee Room, Parliament House at 2:05m

1. Members Present
Mrs Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Ms Amanda Fazio (Mr Henry Tsang)
Ms Christine Robertson
Ms Melinda Pavey
Revd Dr Gordon Moyes
Dr Arthur Chesterfield-Evans

2. Substitutions
The Chair noted advice from the Government Whip that Ms Fazio would also be substituting for Mr Tsang at this meeting with respect to the Inquiry into Budget Estimates 2004-2005 and the Inquiry into Post School Disability Services.

The Chair noted advice from the Opposition Whip that at subsequent meetings regarding the Post School Disability Services inquiry Mr Ryan would substitute for Ms Pavey.

3. Inquiry into the operation of Mona Vale Hospital

Public Hearing

Witnesses, the public and the media were admitted.

The Chair made a brief opening statement.

The following witnesses representing NSW Health were sworn and examined:

Ms Robyn Kruk, Director General, NSW Health
Dr Stephen Christley, Chief Executive, Northern Sydney Central Coast Health
Professor Malcom Fisher, co-chair, NSW Taskforce on Intensive Care
Mr Michael Roxburgh, Acting Director, Capital Procurement, NSW Health
Dr Patrick Cregan, Chair, surgical services taskforce
Professor Jonathan Morris, Director, Newborn Network, RNSH.

Professor Fisher tendered a document regarding Adult Retrieval Team Response Times to the Mona Vale Hospital 2002-2004.

The Chair indicated that the Committee might at a later stage resolve to provide written questions to NSW Health.

Evidence concluded and the witnesses withdrew.

Deliberative
Resolved, on the motion of Mr Catanzariti: That the Committee publish the document accepted by the Committee during the public hearing.

Resolved, on the motion of Ms Fazio: That Committee members be given until close of business on Wednesday 23 March to submit further questions, and that NSW Health be provided 14 days to respond with answers.

Resolved, on the motion of Ms Pavey: That the Committee resolve to publish the additional submissions received by the Committee up to 21 March 2005, with the exception of those that the Committee has resolved should remain confidential, in full or part, to the Committee.

Resolved, on the motion of Ms Robertson: That the reporting date be extended until 26 May 2005.

Confirmation of Minutes
Resolved on motion of Ms Fazio: That the Committee adopt Minutes No. 38.

Correspondence

The Committee noted the following correspondence

Sent:

- Letter dated 7 March 2005 to Chair Save Mona Vale Hospital Committee containing question taken on notice at the public hearing on 28 February 2005.

- Letter dated 10 March 2005 from Chair to Ms Alison McLaughlin responding to Ms Mclaughlin's correspondence of 3 March 2005 in relation to an incident involving a witness at the conclusion of the public hearing on 28 February 2005.
- Letter dated 10 March 2005 from Chair to Ms Lyn Hopper responding to Ms Hopper's correspondence of 1 March 2005 in relation to an incident involving at the conclusion of the public hearing on 28 February.
- Letter dated 10 March 2005 to Pittwater Council containing questions taken on notice during the public hearing on 8 March 2005.
- Letter dated 10 March 2005 to Ms Kate Needham containing question taken on notice at the public hearing on 8 March 2005.
- Letter dated 15 March 2005 from Principal Council Officer to Director General, NSW Health advising of change of location of public hearing on 21 March 2005.

Received:

- Letter dated 9 March from Ms Sandra Hudspith commenting on the manner of questioning at the public hearing held on 28 March 2005 containing documentation relating to travel times to various hospital locations from Seaforth.
- Letter dated 11 March 2005 from Mr Richard Bryce, Editor of Manly Daily to Committee Chair requesting permission for a reporter and photographer to accompany the committee on their tour of the proposed hospital sites.
- Letter dated 16 March 2005 from Director General, NSW Health confirming the attendance of departmental witnesses at the public hearing on 21 March 2005.
- Letter dated 16 March 2005 from Director General, NSW Health containing responses to written questions on notice concerning the operation of Mona Vale Hospital.
- E-mail, dated 18 March from Ms Patricia Giles, Councillor, Pittwater Council concerning statements made during and after the public hearing on 28 February 2005.
- Memorandum from the Clerk of the Parliaments to the Committee Chair regarding the process required following receipt of a complaint from a witness regarding intimidation by a Committee member.
- Letter, dated 18 March 2005 from Parliament & Cabinet Unit, NSW Health containing information concerning the Northern Beaches Health Service Site Selection Release.

…

Consideration of witness complaint

The Committee considered the advice from the Clerk, which had been previously circulated.

Revd. Dr Moyes tabled a letter providing his account of the events described in the correspondence by Ms Hopper and Ms Mc Laughlin. He informed the Committee that he would make a personal explanation to the House in response to the article which had appeared in the Manly Daily regarding Ms Hopper's letter.

Revd. Moyes indicated that following the tabling of his letter he intended to take no further role in the investigation or deliberations of the Committee on this issue of the alleged intimidation.

The Committee deliberated.

Resolved, on motion of Ms Fazio: That the Committee defer further consideration of the matter and seek further advice from the Clerk on the following issues:

(a) whether the committee has the option to refer the matter to the House for consideration for reference to the Privileges Committee
(b) is it appropriate for the committee to consider the matter of a special report when the member, about which the complaint has been made, is a member of that committee
(c) in the abscence of a direct precedent, whether the Privileges Committee should recommend an appropriate process to the House for adoption
(d) the issue of denial of natural justice in allowing a procedure in which the member about whom the complaint has been made can participate in the consideration of and adjudication of the matter

(e) the perception that allowing the committee to determine the matter could be construed as a cover up, which would reflect in a negative way on the Committee system and the Legislative Council

…

4. Adjournment

The Committee adjourned at 5.15 pm *sine die*.

Steven Reynolds
Clerk to the Committee

Minutes 46
Thursday 19 May 2005
Room 1108, Parliament House at 9.36am

1. Members Present

Mrs Patricia Forsythe (Chair)
Mr Tony Catanzariti (Deputy Chair)
Dr Arthur Chesterfield-Evan
Ms Amanda Fazio
Rev Dr Gordon Moyes
Ms Melinda Pavey
Ms Christine Robertson
Ms Kayee Griffin (Catanzariti after 1.30pm)

2. Substitutions

The Chair noted written advice from the Government Whip that Ms Griffin would substitute for Mr Catanzariti from 1.30pm onwards.

3. Confirmation of Minutes

Resolved, on motion of Mr Catanzariti: That Minutes 39 be confirmed.

Inquiry into the operation of Mona Vale Hospital

4. Correspondence

The Committee noted the following items of correspondence:

Received

- Letter, dated 13 April 2005, from Director General NSW Health to Committee Chair containing responses to questions taken on notice at the public hearing on 21 March 2005 and to additional written questions submitted by the Committee via correspondence dated 24 March 2005 (previously circulated).
- Letter, dated 18 April 2005, from Dr Stuart Boland, Convenor, Surgeons & Anaesthetists, Mona Vale Hospital, to Committee Chair providing clarification on areas of Submission 622a and on Dr Boland's subsequent appearance before the Committee on 28 February 2005 (previously circulated).
- Letter, dated 22 April 2005, from A/Manager, Parliament & Cabinet Unit, NSW Health, to Committee secretariat providing clarification in relation to information contained within correspondence from NSW Health dated 13 April 2005 (previously circulated).

5. Complaint by witness

Revd Moyes left the room.

The Chair referred to the two advisings received from the Clerk of the Parliaments on this matter.

The Committee deliberated.
Resolved, on motion of Mr Catanzariti: That:

- There is agreement of the facts by both the complainant and Revd. Moyes, but a difference in the response o both to those facts.
- That the Committee does not intend to conduct further investigation or action, except to note that it is an obligation of all Committee members to deal with witnesses sensitively and to exercise caution in dealings with witnesses.
- That the Committee forward the advisings received on this issue to the Privileges Committee for their information.

Revd. Moyes returned to the room.

6. Publication of confidential submission

Resolved, on motion of Ms Pavey: That submission 605 remain confidential to the Committee with the exception of: the last three paragraphs of page 12 and the first paragraph of page 13; the second paragraph of page 16; and the last paragraph of page 17.

7. Consideration of Chair's draft report

The Chair tabled her draft report, which having been previously circulated, was taken as being read.

The Committee agreed to consider the Chair's draft report page by page.

Chapter One considered.

Resolved, on motion of Ms Fazio: That the second sentence in paragraph 1.5 be amended by omitting the word "passionately".

Resolved, on motion of Ms Fazio: That the first sentence in paragraph 1.9 be amended by omitting the words "local members" and inserting instead "Member".

Resolved, on motion of Ms Fazio: That the first sentence in paragraph 1.16 be amended by inserting the words "tend to" immediately before the word "follow".

Resolved, on motion of Ms Robertson: That the Committee Secretariat draft a sentence, to be inserted at the end of paragraph 1.17, indicating that the Committee sought further advice from the Clerk of the Parliaments prior to considering the procedural issue; and that the draft sentence be circulated to Members prior to the tabling of the report.

The Chair advised that the Committee Secretariat would prepare a draft paragraph, to be inserted immediately after paragraph 1.17, indicating the outcome of the Committee's deliberations on the procedural issue; and that the draft paragraph would be circulated to Members prior to the tabling of the report.

Resolved, on motion of Ms Fazio: That the last sentence of paragraph 1.22 be amended to read as follows:
It examines the community and clinician concerns regarding the effect this proposal, if implemented, would have on the future of Mona Vale Hospital and the level of medical services it would be able to provide.

Resolved, on motion of Ms Pavey: That Chapter One, as amended, be adopted.

Chapter Two considered.

Ms Fazio moved: That paragraphs 2.5 and 2.6 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Dr Chesterfield-Evans, Ms Forsthye

Question resolved in the negative.

Resolved, on motion of Ms Robertson: That the following sentence be inserted immediately below Table 2.1:
The Committee notes that is raw data provided by Pittwater Council and recognises that these figures do not reflect levels of patient acuity.

Ms Fazio moved: That paragraph 2.9 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Dr Chesterfield-Evans, Ms Forsthye

Question resolved in the negative.

Resolved on motion of Ms Fazio: That the first sentence of paragraph 2.16 be amended by omitting the words "the Member for Manly David Barr MP and other" appearing immediately before the word "residents".

Dr Chesterfield-Evans left the room

Resolved, on motion of Ms Robertson: That the last sentence of paragraph 2.20 be amended by omitting the word "only" appearing before the word "able".

Resolved, on motion of Ms Robertson: That the following sentence be inserted immediately below Table 2.3:
The Committee notes that this is raw data provided by NSCCH and recognises that these figures do not reflect levels of patient acuity and the resultant funding weighting.

Ms Fazio moved: That the first sentence of paragraph 2.39 be amended by omitting the word "persuasive".

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Ms Forsythe.

There being an equality of votes, Ms Forsythe used her casting vote as Chair to vote for the Noes.

Question resolved in the negative, (on the casting vote of the Chair.)

Dr Chesterfield-Evans returned to the room.

Ms Fazio moved: That paragraph 2.39 be amended by omitting the second last sentence.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative.

Resolved, on motion of Ms Pavey: That the second sentence of paragraph 2.46 be amended by omitting the words "overall funding to the area" and inserting instead "the development of new health services in the area".

Resolved, on motion of Dr Chesterfield-Evans: That Chapter Two, as amended, be adopted.

Chapter Three considered.

Resolved, on motion of Ms Fazio: That the first sentence of the first introductory paragraph be amended by omitting the word "downgrade" and inserting instead "change".

Resolved, on motion of Ms Robertson: That consideration of the insertion of a new paragraph to be inserted after paragraph 3.24 be held over until a later time in the deliberative.

Resolved, on motion of Ms Robertson: That paragraph 3.29 of the Chair's draft report be omitted.

Resolved, on motion of Ms Robertson: That paragraph 3.34 be amended by omitting the words "endeavoured to convey" and inserting instead "conveyed".

Resolved, on motion of Ms Robertson: That paragraph 3.47 be amended by omitting the word "concern" and inserting instead "interest".

Resolved, on motion of Ms Fazio: That the first sentence of paragraph 3.48 be omitted.

Resolved, on motion of Revd. Moyes: That Chapter Three, as amended, and with the exception of the item held over for consideration at a later stage in the deliberative, be adopted.

Chapter Four considered.

Resolved, on motion of Ms Fazio: That paragraph 4.4 be amended by omitting the word "many" and inserting instead "some".

Resolved, on motion of Revd. Moyes: That Recommendation One be amended by omitting the words "immediately commence recruitment for a minimum of" and inserting instead "recruit".

Resolved, on motion of Ms Robertson: That the last sentence in paragraph 4.22 be amended by omitting the words "that is left" appearing after the word "hospital".

Ms Fazio moved: That paragraph 4.31 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative.

Resolved, on motion of Ms Fazio: That paragraph 4.32 be amended by omitting the words "willing to accept" and insert instead "accepts".

Resolved, on motion of Dr Chesterfield-Evans: That the first sentence in paragraph 4.39 be amended by omitting the words "geographically sited location of the two sites" and inserting instead "geographic location".

Ms Fazio moved: That paragraph 4.52 and 4.53 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative.

Resolved, on motion of Ms Robertson: That the last sentence of paragraph 4.59 be amended by omitting the word " that" appearing after the words "inflated scores" and omitting the words "also applies to Manly Hospital" appearing after the words "smaller hospitals".

Resolved, on motion of Ms Robertson: That the first sentence in paragraph 4.82 be amended by omitting the words "Ultimately the history of success or failure of either ICU in attracting staff should not be" and inserting instead "The success or failure of either ICU in attracting staff has been".

Ms Fazio moved: That the last sentence in paragraph 4.87 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti, Revd. Moyes
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the affirmative.

Ms Fazio moved: That paragraph 4.89 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative.

Resolved, on motion of Ms Robertson: That paragraph 4.89 be amended by inserting the following words at the beginning of the paragraph "The Committee received evidence that".

Ms Fazio moved: That the first sentence of paragraph 4.90 be amended by omitting the words "was somewhat surprised" and inserting instead "noted".

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative.

Resolved, on motion of Ms Fazio: That the last sentence of paragraph 4.91 be amended by omitting the word "incredibly" appearing before the word "important".

Resolved, on motion of Ms Fazio: That the last sentence of paragraph 4.92 be omitted.

Resolved, on motion of Ms Fazio: That the second sentence of paragraph 4.102 be amended by omitting the word "blood and that staffing should no longer be an issue" and inserting instead "staff".

Resolved, on motion of Ms Fazio: That the first sentence of paragraph 4.129 be amended by omitting the words "was disappointed that it".

Resolved, on the motion of Ms Fazio: That the last sentence of paragraph 4.131 be amended by omitting the words "The Committee doubts most doctors would be comfortable with" and inserting instead "The Committee recognises that many doctors would not be comfortable with".

Resolved, on the motion of Ms Fazio: That last sentence in paragraph 4.135 be amended by omitting the word "will" and inserting instead "may".

Resolved, on motion of Ms Fazio: That the first sentence in paragraph 4.140 be amended by omitting the word "screening" and inserting instead "ventilation".

Ms Robertson moved: That paragraph 4.144 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Revd Moyes, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative.

Resolved, on motion of Dr Chesterfield-Evans: That paragraph 4.144 be amended by omitting the word "either" and inserting instead "the" and by omitting the words "to their communities" from the first sentence; and by omitting the second sentence.

Resolved, on motion of Ms Robertson: That the Committee hold over consideration of paragraph 4.145 until a later stage of the deliberative.

Ms Pavey left the room.

Ms Fazio moved: That paragraph 4.159 and Recommendation 4 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Dr Chesterfield-Evans, Revd Moyes, Ms Forsythe

Question resolved in the negative on the casting vote of the Chair.

At 12.30pm the Committee took a short adjournment. Revd. Moyes advised that he would be absent from the remainder of the deliberative.

At 1.00pm the Committee resumed consideration of the Chair's draft report.

Resolved, on motion of Ms Fazio: That the first sentence of paragraph 4.160 be amended by omitting the word "many" and instead inserting "some".

Resolved, on motion of Ms Fazio: That the second sentence of paragraph 4.165 be amended by omitting the words "it cannot be denied" and inserting instead "it can be argued".

Resolved, on motion of Ms Fazio: That the last sentence of paragraph 4.167 be amended by omitting the words "was indeed made before the appropriate time" and inserting instead "may have been made prematurely".

Resolved, on motion of Ms Robertson: That the last sentence of paragraph 4.172 be omitted.

Resolved, on the motion of Ms Fazio, that the last sentence of paragraph 4.178 be amended by inserting the following words at the end of the sentence "and by the difficulties in attracting intensivists to work at Mona Vale Hospital."

Resolved, on motion of Ms Fazio: That Chapter Four, as amended, with the exception of the item held over for consideration at a later stage, be adopted.

Chapter Five considered.

Ms Fazio moved: That the third introductory paragraph be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe
Question resolved in the negative, on the casting vote of the Chair.

Ms Fazio moved: That paragraph 5.2 be omitted and the quote be moved to paragraph 5.3.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Resolved, on motion of Ms Fazio: That the second sentence of paragraph 5.4 be amended by omitting the word "respective" and inserting instead "similar".

Ms Fazio moved: That paragraph 5.12 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Ms Fazio moved: That paragraph 5.26 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Resolved, on motion of Ms Fazio: That the second sentence of paragraph 5.34 be amended by inserting at the end of the sentence the words "who participated for only five of the nine months in which the NBCCHPG was involved in the process":

Ms Fazio moved: That paragraphs 5.38 to 5.43 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Ms Fazio moved: That paragraph 5.44 be amended by omitting the words "cannot be judged a success" and inserting instead "was extensive" and by omitting the last two sentences.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Mr Catanzariti
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Resolved, on motion of Dr Chesterfield-Evans: That the first sentence of paragraph 5.44 be amended by inserting the words "was extensive but" before the word "cannot".

Mr Catanzariti left the room and was substituted by Ms Griffin.

Ms Fazio moved: That paragraph 5.46 to 5.111 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Resolved, on motion of Dr Chesterfield-Evans: That paragraph 5.104 be amended by omitting the first sentence and by omitting, in the second sentence, the words "this likelihood" and inserting instead "the climate of fear and animosity that had developed in the community".

Ms Robertson moved: That the last sentence in paragraph 5.105 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Resolved on motion of Ms Pavey: That paragraph 5.111 be amended so as to read from the second sentence:

At the commencement of the inquiry The Manly Daily ran a full page photograph of Dr Christley, followed by a double page open letter from him explaining the rationale behind the decision relating to intensive care services. The Committee believes this situation would have been better put by the Minister. This situation can lead to public servants being forced into a position of exceeding their role and commenting on political rather than policy matters. The Committee believes that the Minister needs to take a more active role in the debate relating to health services on the Northern Beaches.

Question put.

Committee divided.

Ayes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Noes: Ms Fazio, Ms Robertson, Ms Griffin

Question resolved in the affirmative, on the casting vote of the Chair.

Resolved, on motion of Ms Pavey: That Chapter Five, as amended, be adopted.

Chapter Six considered.

Ms Fazio moved: That the last sentence of the fourth introductory paragraph be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Resolved, on motion of Ms Fazio: That the Committee Secretariat draft a new introductory paragraph, to be inserted at the end of the introduction, acknowledging the Statement of Understanding signed by the four State MPs for the Northern Beaches area; and that the draft paragraph be circulated to Members prior to the tabling of the report:

Resolved, on motion of Ms Fazio: That paragraph 6.16 be amended by omitting the last two sentences.

Ms Fazio moved: That paragraph 6.17 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Resolved, on motion of Dr Chesterfield-Evans: That the second sentence of paragraph 6.17 be omitted.

Ms Fazio moved: That the paragraph 6.20 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.
Resolved, on motion of Ms Griffin: That paragraph 6.20 be amended by omitting the words "is disappointed" and inserting instead the word "notes".

Resolved, on motion of Ms Robertson: That Recommendation Five be amended by omitting the words "if Mona Vale is selected as the site for the new Northern Beaches Hospital" and inserting instead "as well as the preferred site for the new Northern Beaches Hospital".

Resolved, on motion of Ms Fazio: That paragraph 6.29 be omitted.

Resolved, on motion of Dr Chesterfield-Evans: That paragraph 6.32 and Recommendation Six of the Chair's draft report be omitted.

Resolved, on motion of Ms Fazio: That the last sentence of paragraph 6.33 be omitted.

Resolved, on motion of Ms Fazio: That the last sentence of paragraph 6.34 be omitted.

Resolved on motion of Ms Pavey: That paragraph 6.35 be amended by omitting the words "This is particularly the case given" and inserting instead "The Committee notes".

Resolved, on motion of Ms Fazio: That Recommendation Seven be amended by omitting the words "VMS identifies the preferred site for the new Northern Beaches Hospital, NSCCH make public a full description of the basis for that decision" and inserting instead "Value Management Study evaluation report for the new Northern Beaches Hospital is available, NSCCH make public a full description of the basis for their decision on the preferred site"

Ms Fazio moved: That the second and third sentences from paragraph 6.47 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Ms Fazio moved: That the paragraph 6.50 be omitted.

Question put.

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair.

Resolved, on motion of Ms Fazio: That Recommendation Eight be amended by omitting the words "for 2011 and beyond".

Resolved, on motion of Ms Robertson: That Recommendation Nine be amended by omitting the words "an operational" and inserting instead "a".

Resolved, on motion of Ms Fazio: That paragraph 6.68 be omitted.
Ms Fazio moved: That paragraph 6.69 be omitted.

Question put.

Motion lost on the voices.

Resolved on motion of Ms Fazio: That the third sentence of paragraph 6.77 be amended by omitting the words "from the overall community and particularly" and inserting instead "particularly from".

Ms Fazio moved: That paragraphs 6.79 to 6.87 be omitted.

Question put

Committee divided.

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative on the casing vote of the Chair

Resolved, on motion of Ms Fazio: That paragraph 6.87 be amended by omitting the last two sentences.

Ms Fazio moved: That paragraph 6.91 be omitted.

Question put.

Committee divided

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair

Resolved, on motion of Ms Fazio: That paragraph 6.92 be omitted.

Resolved, on motion of Ms Fazio: That paragraph 6.94 be amended by omitting the words "The above results and".

Ms Fazio moved: That paragraphs 6.97 and 6.98 be omitted.

Question put.

Committee divided

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair

Ms Fazio moved: That paragraphs 6.106 to 6.108 be omitted.

Question put.

Committee divided
Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair

Ms Fazio moved: That the second sentence of paragraph 6.116 the quote following and paragraph 6.117 be omitted.

Question put.

Committee divided

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair

Resolved on motion of Ms Pavey: That paragraph 6.122 be amended by omitting the words "is somewhat surprised" and inserting instead the word "notes".

Ms Fazio moved: That paragraph 6.123 be amended by omitting the second and third sentences.

Question put.

Committee divided

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsthe

Question resolved in the negative, on the casting vote of the Chair

Ms Fazio moved: That paragraph 6.130 be amended by omitting the final sentence.

Question put.

Committee divided

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair

Resolved on motion of Ms Fazio: That paragraph 6.133 by amended by omitting the words "there was no corresponding upgrade of the paediatric unit facilities at Mona Vale" appearing after the word "Manly" and by omitting the last sentence of the paragraph.

Ms Fazio moved: That paragraph 6.142 be omitted.

Question put.

Committee divided

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe
Question resolved in the negative, on the casting vote of the Chair

Ms Fazio moved: That paragraphs 6.144 to 6.176 be omitted.

Question put.

Committee divided

Ayes: Ms Fazio, Ms Robertson, Ms Griffin
Noes: Ms Pavey, Dr Chesterfield-Evans, Ms Forsythe

Question resolved in the negative, on the casting vote of the Chair

Resolved, on motion of Ms Fazio: That paragraph 6.175 be omitted.

Resolved, on motion of Ms Fazio: That paragraph 6.176 be amended by omitting the words "determined by the current VMS process, provided that it is conducted in an open, fair and transparent manner" and inserting instead "based on the evaluation of the current VMS process".

Resolved, on motion of Ms Fazio: That the first sentence of paragraph 6.177 be amended by omitting the words "widespread suspicion" and inserting instead the word "concern".

Resolved, on motion of Ms Fazio: That the first sentence of paragraph 6.179 be amended by omitting the words "widespread suspicion" and inserting instead the word "concern".

Resolved, on motion of Ms Fazio: That paragraph 6.186 be omitted.

Resolved, on motion of Ms Pavey: That Chapter Six, as amended, be adopted.
The Committee considered the items held over from the earlier consideration of Chapters Three and Four.

Resolved, on motion of Ms Robertson: That the following new paragraph be inserted before paragraph 3.25:
The measure of effectiveness of intensive care is based on quality criteria, output measures, and the clinical and technical requirements for role delineation.

Resolved, on motion of Ms Fazio: That paragraph 4.145 be omitted.

Resolved, on motion of Ms Pavey: That the report, as amended, be adopted by the Committee and signed by the Chair.

Resolved, on motion of Ms Pavey: That the Committee secretariat be authorised to make any grammatical or typographical changes to the report prior to tabling of the report.

Resolved, on motion of Ms Pavey: That the report, with accompanying documents, be tabled in the House in accordance with Standing Order 230.

Dr Chesterfield-Evans left the room.

The Chair tabled her draft Chair's Foreword for consideration of the Committee.

The Committee deliberated.

Resolved, on motion of Ms Fazio: That the second paragraph be amended by omitting the words "and mistrust of the health planning process" appearing after the word "uncertainty".

Resolved, on motion of Ms Fazio: That the first bullet point under the fourth paragraph be amended by omitting the word "downgraded" and inserting instead "changed".

Resolved, on motion of Ms Fazio: That the sixth paragraph be amended by omitting the words "Because of the decision to redevelop Manly Hospital on a more accessible site the conclusion one draws is that to find the resources to redevelop Manly Hospital, Mona Vale Hospital may pay the price by being downgraded." and inserting instead "Because of the decision to develop a new Northern Beaches Hospital on a more accessible site, Mona Vale Hospital may become the complementary, secondary hospital."

The Chair advised Members that if they wished to append a dissenting statement to the report that any such statement was to be delivered to the secretariat by 10am Tuesday 24 May 2005.

8. Adjournment

The Committee adjourned at 4.05pm until 9.30am on 31 May 2005

Steven Reynolds
Clerk to the Committee

Appendix 7 Dissenting statements

DISSENTING REPORT – AMANDA FAZIO

Introduction

The NSW Department of Health since 1999 has been conducting studies into the reconfiguration of health services on the Northern Beaches. More recently in the planning process it was identified that health services on the Northern Beaches had not been able to keep pace with modern models of service delivery and that the existing facilities at Manly Hospital had, in general, reached the limit of their useful lives. It was also found that the facilities at Mona Vale Hospital needed to be upgraded and reconfigured.

During the Inquiry, Northern Sydney Central Coast Area Health Service (NSCCAHS) never swerved from their commitment to providing improved health services on the Northern Beaches that would deliver safe and modern heath care to the local community and that the process to do would be open and transparent.

A Value Management Study (VMS) undertaken in July 2002 supported an option with one hospital as a metropolitan hospital (level 5) and one as a community hospital. It was determined that a new Northern Beaches Hospital be developed, which in effect would be a redevelopment of Manly Hospital, on a new site.

Since this announcement the residents from the northern part of the Northern Beaches have conducted an extensive campaign, funded and supported by Pittwater Council, to have the metropolitan hospital developed on the site of the existing Mona Vale Hospital.

During the course of the Inquiry on 12 March 2005*, The Manly Daily* reported on the Save Mona Vale Hospital Action Group as follows:

> *"Cashed-up, well organised and well connected, with local doctors and Liberal and Christian Democrat politicians on side, the group has steam rolled any opposition to its parochial interests. While the State Government believes it makes more sense to consolidate health services into one major hospital, it has agreed to retain Mona Vale Hospital in a secondary role to a new facility, which will replace overly tired Manly Hospital.*
>
> *The Mona Vale community group has stomped all options for a new hospital at a demographically central location such as Dee Why.* ***But for people outside of the Mona Vale community, the frustration of waiting six years for a new hospital has become heartbreaking."***

It is notable that all of the local State Members of Parliament (the Members for Davidson, Manly, Pittwater and Wakehurst) on 11 November 2004 jointly signed a letter supporting the development of a new centrally located Northern Beaches Hospital.

The Government members of the committee feel it is important to also note that while a range of views and expert opinion representing the needs of residents of the southern end of the northern beaches was received during the Inquiry, this is not adequately reflected in the final report. The State Government has a responsibility to provide health services to all residents of the northern beaches in ways advised by expert clinicians and senior public servants, not to provide health services in configurations suggested by vocal minority interest groups.

Comments on Recommendations and Conclusions

Conclusion 2.39
This conclusion, which claims that Mona Vale Hospital has been under funded, is not supported as NSCCAHS presented evidence of funding for Mona Vale and Manly Hospitals and also funding of hospitals of similar size and function, such as Ryde and Hornsby, which showed that this was not the case. Financial program and funding for all North Sydney Health facilities for the 2000/01 and 2004/05 financial years was included in the NSCCAHS submission.

Hon Amanda Fazio MLC

DISSENTING REPORT – CHRISTINE ROBERTSON AND TONY CATANZARITI

Comments on Recommendations and Conclusions

Conclusion 3.47
The Committee simply does not have the specialised knowledge base or experience to make a recommendation on the best planning model for intensive care services on the Northern Beaches or anywhere else.
"At present we have two struggling units, both of which are too small to be viable by today's standards," Dr Stephen Nolan (Intensivist) in evidence on 8 March 2005.

Conclusions 4.80, 4.81 & 4.82
These conclusions clearly ignore the expert advice provided to the Inquiry that Mona Vale Hospital is not the appropriate location for the proposed level 5 Intensive Care Unit (ICU) and would not be able to attract the necessary critical mass of clinicians or patients.

Conclusion 4.144
This conclusion ignores the evidence the ICU services proposed would offer a higher level of care on the Northern Beaches.

Recommendation 4
This recommendation is opposed due to the compelling evidence before the Inquiry that a level 4 ICU is not achievable at Mona Vale. A commitment has been given by
NSCCAHS that the highest possible level of ICU services at Mona Vale Hospital will be offered until the new hospital is built. The evidence of Dr Phipps on 28 February is very strong in this regard.

Paragraph 5.4
While a scant reference is made to the fact that the submissions of Pittwater Council and the Save Mona Vale Hospital Action Group are "similar", in evidence given by Mr Godfrey, an employee of Pittwater Council on 8 March, he admitted that the Council hosted the Action Group's website and that he has provided administrative support to the Action Group for the last four and one half years of between 10 to 20 hours per week. This evidence raises the question of the honesty of the campaign to save Mona Vale Hospital.

Paragraph 5.32
The damaging and disruptive role of the Pittwater representatives on the Northern Beaches Community Consultative Health Planning Group (NBCCHPG) is whitewashed in this paragraph. The evidence from other representatives from the Planning Group (refer to transcript of 8 March 2005) indicated that they strongly believed the consultation process to have been very fair.

Mr Bongarzoni stated, *"I have never in my life seen any group so biased as the northern end, to the point where, as I think Paul mentioned, meetings became almost intolerable in terms of being able to get any worthwhile activity".* (Transcript 8 March page 38)

Conclusion 5.44
This evidence before the Inquiry is to the contrary. The NSCCAHS has put forward proposals and changed its position over time in response to community and clinician feedback and this is not refected in this conclusion.

Paragraphs 5.46 to 5.111

These paragraphs are not supported, as they do not accurately reflect the consultation process, which was undertaken, and in part comment on matters such as the "Divisive result of the consultation process" that are not within the Inquiry's Terms of Reference.

Conclusion 5.104
This conclusion is incorrect because the process was led by the Greater Metropolitan Clinical Taskforce (GMCT) not NSCCAHS. NSW Health approached GMCT to review the proposed reconfiguration in order to try to broker a solution to the problem.

Paragraph 5.105
The paragraph plainly and simply demonstrates the politically driven nature of this Inquiry and ignores evidence to the contrary placed before the Inquiry. It also demonstrates an old fashioned and inaccurate understanding of the role of senior bureaucrats.

This is grossly inaccurate because every time a potential site has been announced there has been a huge outcry from sections of the Northern Beaches community. The political will of the current and former Health Ministers is demonstrated by the provision in State Budgets over the years of funds to continue the planning process for the new Northern Beaches Hospital. On 12 March 2005, in *The Manly Daily,* the NSW Health Minister Morris Iemma MP was reported as stating, *"The real disappointment is that we want to invest $200 million in giving the northern beaches a better health service and action groups are fighting against every possible location".*

Conclusion 5.111
This is inaccurate. Stephen Christley responded to an invitation by *The Manly Daily* to explain the current situation regarding the reconfiguration of health services on the Northern Beaches as public awareness had been heightened by the commencement of this Inquiry. Mr Christley has briefed all interested members of parliament and has acted without partiality at all times. If the Minister were to take an active public role while this Inquiry was taking place and the VMS process on the six potential sites is underway, it would be inappropriate. This conclusion infers otherwise and is regrettable.

Paragraphs 6.65 & 6.66
These paragraphs dwell on the "special ambience" of Mona Vale Hospital, which is not appropriate when the potential special ambience of the other sites is not considered.

Paragraph 6.93
This paragraph demonstrates the biased approached of the Pittwater lobbyists and should have been deleted as it adds no value to the report.

Paragraphs 6.102, 6.103 & 6.104

This information is not borne out by the evidence given by NSCCAHS and reflects the views of Pittwater Council.

Paragraph 6.119
The Committee does not have the expertise to make statements regarding the most appropriate time bands to be used in this or any other transport study.

Paragraph 6.126
The Committee does not have the expertise or alternate evidence to allow it to dismiss the expert evidence of both NSW Health and NSCCAHS in regard to this critical health planning issue.

Paragraphs 6.140 to 6.171
This section of the report, which "analyses" the potential Dee Why site is clearly outside the Terms of Reference for the Inquiry and should not have been included. Any comparison of proposed sites for the new Northern Beaches Hospital, if it were to be entertained, for the sake of balance should have considered all other sites.

Hon Christine Robertson MLC Hon Tony Catanzariti MLC