Submission No 2230

INQUIRY INTO MONA VALE HOSPITAL

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Date Received: 11/02/2005

Subject:

Summary

Submission to the Legislative Council General Purpose Standing Committee No. 2

Inquiry into Mona Vale Hospital

Northern Sydney
Central Coast Health

better health: caring for our communities

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1 EXECUTIVE SUMMARY

Northern Sydney Central Coast Health (NSCCH) has an unswerving commitment to the provision of safe, modern health care to the people and communities of the Northern Beaches.

To ensure the delivery of health services on the Northern Beaches keeps pace with modern models of care and international trends in health service delivery, studies into the reconfiguration of health services have been in progress since 1999.

Doctors, nurses, allied health professionals, health planners, health service managers and community representatives continue to contribute to this planning process, drawing on their professional expertise and experience.

The provision of **intensive care** on the Northern Beaches is one of the important issues to be addressed by this inquiry. Intensive care beds are a Statewide resource and NSCCH has an obligation to provide safe, effective intensive care within its hospitals.

Mona Vale Hospital has five intensive care beds (including coronary care and high dependency beds) and Manly Hospital has eight. Experts in intensive care now agree that units of this size can't provide the clinical workload to provide staff with the opportunity to maintain their skills. Maintenance of small units can lead to a decline in the quality of patient care, poor staff retention and an increase in the transfer of critically ill patients.

For this reason, small rural units are being linked to tertiary centres and the metropolitan hospitals are networking and integrating their intensive care units to ensure high standards of care.

Mona Vale Hospital has had a longstanding difficulty staffing its intensive care unit and the shortage of intensive care and emergency specialists at the hospital was a significant issue during a recent accreditation survey by the Australian Council of Healthcare Standards. These difficulties will continue unless action is taken.

The Greater Metropolitan Clinical Taskforce have put forward a proposal to transfer the two ventilated intensive care beds from Mona Vale to Manly Hospital and retain a high dependency unit at Mona Vale Hospital, as part of a single Northern Beaches intensive care service servicing both hospitals. The most obvious benefits of the proposed changes to patients of both hospitals are better access to higher level critical care services and the ability of larger integrated units to attract, train and retain skilled staff who wish to use their ability and experience at the highest level. Further consultation will occur before a decision is made by the Area Health Service.

This submission addresses the **funding of Mona Vale Hospital.** Mona Vale Hospital receives a fair share of the Northern Sydney Health budget. Funding of hospitals and health services is complex. A large proportion of Northern Beaches residents receives health services from outside the local Area either in other NSH hospitals or in the private sector. Many complex and high cost technology services for Northern Beaches residents are provided only at Royal North Shore Hospital, and the funds for some clinical services are managed at an Area level. Analysis of budget allocations needs to take account of these factors and of the roles of individual services. Funding

allocated to maintain and improve health infrastructure has steadily improved over the last five years.

Consulting our communities about health care provision has always been part of NSH planning. The opinions, experiences and suggestions of interested citizens on the Northern Beaches have been taken into account when NSCCH developed the Acute Care Services Framework, the Strategic Resources Plan, the Northern Beaches Procurement Feasibility Plan (PFP) and in the planning of Intensive Care and Maternity Services.

Community consultation is a valuable part of the planning and implementation of health services and has been a feature of this Area Health Service for many years. In planning for new services, the views of the community need to be weighed up against the expert advice provided by experienced clinicians and health planners.

The future **role and mix of services** for the Northern Beaches hospitals was determined after extensive community consultation. The preferred option proposed in November 2002 and in place today calls for:

- The redevelopment of Manly Hospital in the Brookvale area. This decision was based on population and travel studies which show, unambiguously, that the Cromer area is the centre of population for the Northern Beaches and Brookvale has the best private and public transport access of the major options considered.
- The upgrade of Mona Vale Hospital.
- Construction of new community health centres - one co-located with the redeveloped Manly Hospital and one with Mona Vale Hospital.

The final decision of Government on the location of the Northern Beaches Hospital will have regard to the planning undertaken by NSCCH, the community consultation, and the availability of a suitable site that best meets the following criteria:

- Fairer access
  - ensures equitable travel accessibility
  - allows maximum 30 minutes travel to health services
  - community health located close to civic facilities, e.g. shopping centres
  - requires minimal travel out of area for health services
  - reduces barriers to access
- Quality health care
  - attract and retain appropriate staff
- Better value
  - provides consumer value for money
  - allows reconfiguration of facilities.

The end result of comprehensive community consultation and expert planning will be safe, modern health services delivery by expert staff working in state-of-the-art facilities.

NSCCH is confident that the long-awaited new Northern Beaches Hospital, an upgraded Mona Vale Hospital and their respective community health centres will meet and exceed community expectations.

2 INTRODUCTION

2.1 TERMS OF REFERENCE OF INQUIRY

General Purpose Standing Committee No. 2 is to inquire into, and report by 31 March 2005, on the operation of Mona Vale Hospital, and in particular:

a) the closure of the intensive care unit and the reasons behind its transfer
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 the 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.

Mona Vale Hospital is managed by Northern Sydney Central Coast Health (NSCCH) through the Northern Beaches Health Services and, with Manly Hospital, provides local networked hospital and community health services on the Northern Beaches.

Studies into the reconfiguration of health services on the Northern Beaches have been in progress since 1999, although it should be noted that joint planning across Manly and Mona Vale hospitals had been underway since 1986, beginning with the then Manly-Warringah Area Health Service. Early in the more recent 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. Additionally, it was found 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, while not as old as those at Manly, needed to be upgraded and reconfigured.

NSH is committed to providing improved health services on the Northern Beaches that will deliver safe and modern health care to the local community. This submission sets out the steps Northern Sydney Health has taken to achieve this, provides background information that sets the context, and responds specifically to each of the terms of reference.

There are a few implications made within the wording of the terms of reference that require clarification:

- The Term of Reference (a) implies that closure of the intensive care unit has occurred, or at least a decision to close it has been made. This has not occurred. This issue is discussed in section 5 of this report.
- The Term of Reference (c) implies that NSW Health Department has proposed changes to Mona Vale Hospital. This is not correct. Northern Sydney Central Coast Health (NSCCH) has submitted its preferred option for health services on the Northern Beaches to the NSW Health Department. The detail of the draft Procurement Feasibility Plan (PFP) is currently being finalised through discussion between the NSW Health Department and NSCCH. More detailed clinical services planning will be the subject of the next stage of planning once the PFP has been finalised and the site for the proposed redeveloped Northern Beaches Hospital has been confirmed. This issue is discussed in section 7 of the submission.
- The Term of Reference (d) implies that it has been decided that Mona Vale Hospital will not be made a general hospital. Firstly, it is important to note that the term "general hospital" has no particular meaning. A value management study[1] (July 2002) (see Appendix 1) supported an option with one hospital as a

metropolitan hospital, and one as a community hospital. In this context, the metropolitan hospital was proposed to have a critical mass large enough to support high-level expertise in emergency, intensive care, mental health, diagnostic imaging, obstetrics, paediatrics, dental and a wide range of medical and surgical specialties. In the preparation of this submission, it has been assumed that the local community understanding of the term "general hospital" refers to a previous broad service mix such as that described above. Secondly, the PFP describes the service mix of the two hospitals, but does not use the term 'metropolitan general hospital'. As indicated above, more detailed clinical services planning will be the subject of the next stage of planning once the PFP has been finalised and the site for the proposed redeveloped Northern Beaches Hospital has been confirmed. These issues are discussed in section 8 of this submission.

2.2 GLOSSARY

2.2.1 Definitions

Acute care	Acute care is care in which the clinical intent or treatment goal is to manage labour (obstetrics), cure illness, or provide definitive treatment of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care), reduce the severity of an illness or injury, protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function, and/or perform diagnostic or therapeutic procedures.
Aged care	Aged care services are provided for that group of people whose care needs are compounded by conditions associated with ageing including chronic illness, functional limitations, and physical and mental frailty. Services provide required functional and social support to people aged 75 years and older.
Ambulatory care	Care that does not require an overnight hospital admission. Care can be provided in a variety of settings - including hospital, outpatient and emergency departments, community health centres, ambulatory care centres, the patient's home, the patient's workplace or general practitioner or specialist rooms.
Average length of stay (ALOS)	The total number of bed days divided by the total number of separations within a given time period, generally over a financial year. The calculation can include or exclude same-day patients.
Budget	A plan expressed in quantitative, usually monetary, terms covering a specified period of time, usually one year.
Budget holding	Budget holding policy enables those Areas with significant acute patient outflows to other Areas, to implement flow reversal strategies, and in anticipation of successful flow reversal, claim that portion of the other Areas' budgets to support the service to those patients.
Casemix	Casemix is a method of describing the different types of patients treated by a health system, recognising that patients require different levels of resources.

Casemix complexity (CMI)	Casemix complexity (CMI) is a measure of acute patient complexity. It is calculated as $CMI = \frac{\text{Cost weighted separations}}{\text{separations}}$
Catchment population	A group of persons within a defined geographic boundary who would normally be expected to attend a given hospital or health service.
Community health services	A range of community based prevention, early intervention, assessment, treatment and rehabilitation services designed to improve or maintain the health of the community.
Cost weights	Cost weights describe the cost and complexity of patients within particular Diagnostic Related Groups (DRGs), as compared to the average for all episodes within the scope of the classification.
Cost weighted separations	Acute separations weighted for casemix.
Critical Care	Services that are provided to patients suffering potentially life-threatening illnesses or injury, and whose treatment is time-critical. The clinical settings in which these services are routinely delivered include pre-hospital care, emergency departments, intensive care units, retrieval and trauma services.
Episode funding	Output based funding approach to be used by Area health services to guide them in allocating resources to their services. There are specific policies for: ▪ Acute inpatients (excluding ED and ICU) ▪ ICU for designated level 5 or 6 units ▪ Emergency Departments (ED) ▪ Rehabilitation, palliative care and non-acute care services.
Episode of care	A phase of treatment during which the patient receives a particular type of care (e.g., acute, rehabilitation, etc.). When that type of care is concluded, the episode of care is ended and the patient undergoes either a type change separation to a different type of care or a formal separation, such as the patient leaves the hospital.
Expenditure	The cost of goods or services funded by budget appropriation. Expenditure typically refers to either: ▪ Operating Expenditure – expenses incurred in the ongoing delivery of all aspects of healthcare e.g., salaries or medical consumables ▪ Capital Expenditure – expenses incurred in the acquisition, replacement or modernisation of the organisation's physical assets e.g., purchase of medical equipment or a building refurbishment.
Facility	A complex of buildings, structures, roads and associated equipment which represents a single management unit for financial, operational, maintenance or other purposes.
High-dependency unit	A discrete unit within the hospital, able to supply critical care expertise at less intensive resource levels, providing a level of care that falls between the general ward level and the intensive care unit.

Incidence	The number of newly identified cases of disease for a population for a stated time period.
Inpatient	A patient admitted to a hospital for treatment either overnight or on a day-only basis.
Intensive care unit (ICU)	An intensive care unit (ICU) is a specially staffed and equipped, separate and self-contained section of the hospital for the management of patients with life-threatening or potentially life-threatening conditions. It provides facilities for the support of vital functions, and utilises the skills of medical, nursing and other staff with expertise in the management of these problems.
Intensivists	Medical specialists in intensive care.
Local government area (LGA)	A division of New South Wales into administrative units with responsibilities as set out in the Local Government Act.
Non-inpatient	A patient who does not undergo a hospital's formal admission process and receives services as an emergency department patient, an outpatient, or at locations other than the hospital campus e.g., community/outreach services.
Palliative care	Care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure.
Procurement Feasibility Plan (PFP)	The first stage within the process of facility planning which assesses options within the context of an Area's asset strategic plan, and includes feasibility investigations, resource and layout planning, value management studies and economic appraisal.
Resource Distribution Formula (RDF)	A population health needs-based formula used by NSW Health to allocate budgets to Area health services.
Rehabilitation	The process that brings about the highest level of recovery following loss of function and ability from any cause. It can involve the development of physical compensatory mechanisms and psychological adjustment by medical, social, educational and vocational services.
Role delineation	The role delineation of a service indicates the complexity of clinical activity undertaken by that service. A service can be described from level zero to six. Each level describes support services, staff profiles, minimum safety standards and other requirements to ensure that clinical services are provided safely and are appropriately supported.
Separation	A formal or statistical discharge of a patient from inpatient care within a hospital.

2.2.2 Abbreviations

The following abbreviations are used within this document.

ABS	Australian Bureau of Statistics
AHS	Area Health Service
BEACHES	Better Equitable Access for Community Health & Emergency Services
C/CWT	Cost per cost weighted separation
CWTS	Cost weighted separation(s)
DOH	Department of Health (NSW)
DRG	Diagnostic Related Group
ED	Emergency Department
GHD	Gutteridge, Haskins and Davey (consultancy)
GMCT	Greater Metropolitan Clinical Taskforce (from 2004)
GMTT	Greater Metropolitan Transition Taskforce
GP	General practitioner
HDU	High dependency unit
HK	Hornsby Ku-ring-gai
ICU	Intensive care unit
LGA	Local government area
LNS	Lower Northern Sydney
MV	Mechanical ventilation
MVH	Mona Vale Hospital
NB	Northern Beaches
NBCCHPG	Northern Beaches Community Consultative Health Planning Group
NCOS	Net cost of service
NSCCH	Northern Sydney Central Coast Health
NSH	Northern Sydney Health
PDP	Project Definition Plan
PFP	Procurement Feasibility Plan
RDF	Resource Distribution Formula
RMO	Resident medical officer
RNS(H)	Royal North Shore (Hospital)
SRP	Strategic Resources Plan
TOR	Term(s) of Reference
VMO	Visiting medical officer

2.3 SCOPE OF THE SUBMISSION

This submission responds to the Terms of Reference of the Inquiry in the following way:

- The context for the operation of Mona Vale Hospital is provided through an examination of the population and geography of the Northern Beaches, an overview of NSH services, and an outline of health services currently provided on the Northern Beaches, including those of Mona Vale Hospital.
- A timetable of major events in health services planning on the Northern Beaches is provided to assist the Committee in understanding the sequence of events referred to in this submission.
- The recent proposal by the Greater Metropolitan Clinical Taskforce regarding intensive care services on the Northern Beaches is discussed, with information on the background to the issue, the consultative and planning steps taken in response, and the findings.
- An overview of the NSW Health Funding Framework is provided. Mona Vale Hospital funding (capital and recurrent) and Northern Beaches Health Service's expenditure on Northern Beaches residents is discussed. Funding comparisons with other hospitals are made.
- Community consultation in relation to health services planning on the Northern Beaches is discussed. This covers the period from 1999 to the end of 2004.
- The planning and consultation processes that led to, and the reasons for, the proposed role and mix of services of hospitals on the Northern Beaches is addressed.

It should be noted that while Northern Sydney and Central Coast Area Health Services were amalgamated on 1 January 2005, Northern Sydney Area Health Service was the relevant organisational entity for most of the decisions referred to in this document, and is referred to accordingly.

3 CONTEXT

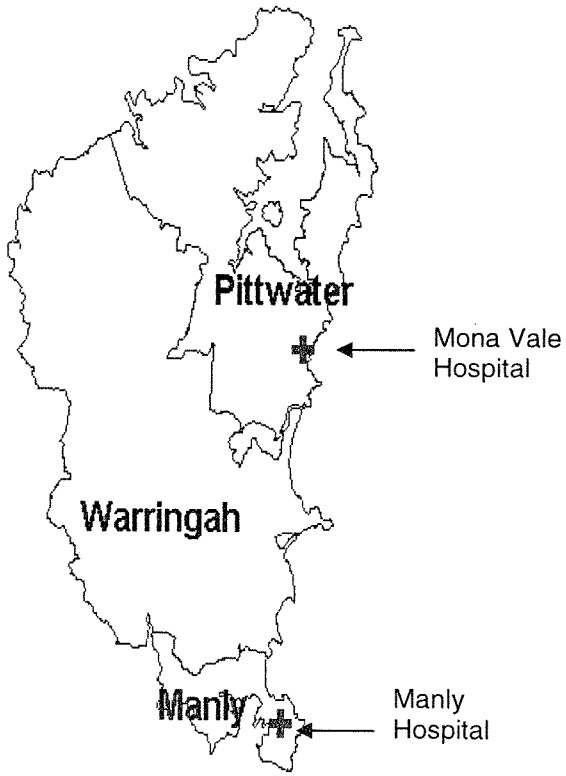
Mona Vale Hospital is one of two public hospitals that provide local networked services to the Northern Beaches population. Below is an overview of the geography and population of the Northern Beaches.

3.1 NORTHERN BEACHES GEOGRAPHY

3.1.1 Area

The Northern Beaches consists of the three local government areas (LGAs) of Manly, Warringah and Pittwater and covers an area of 254.7 km². The map below shows the LGAs within the Northern Beaches area.

Figure 3.1 LGAs within the Northern Beaches area



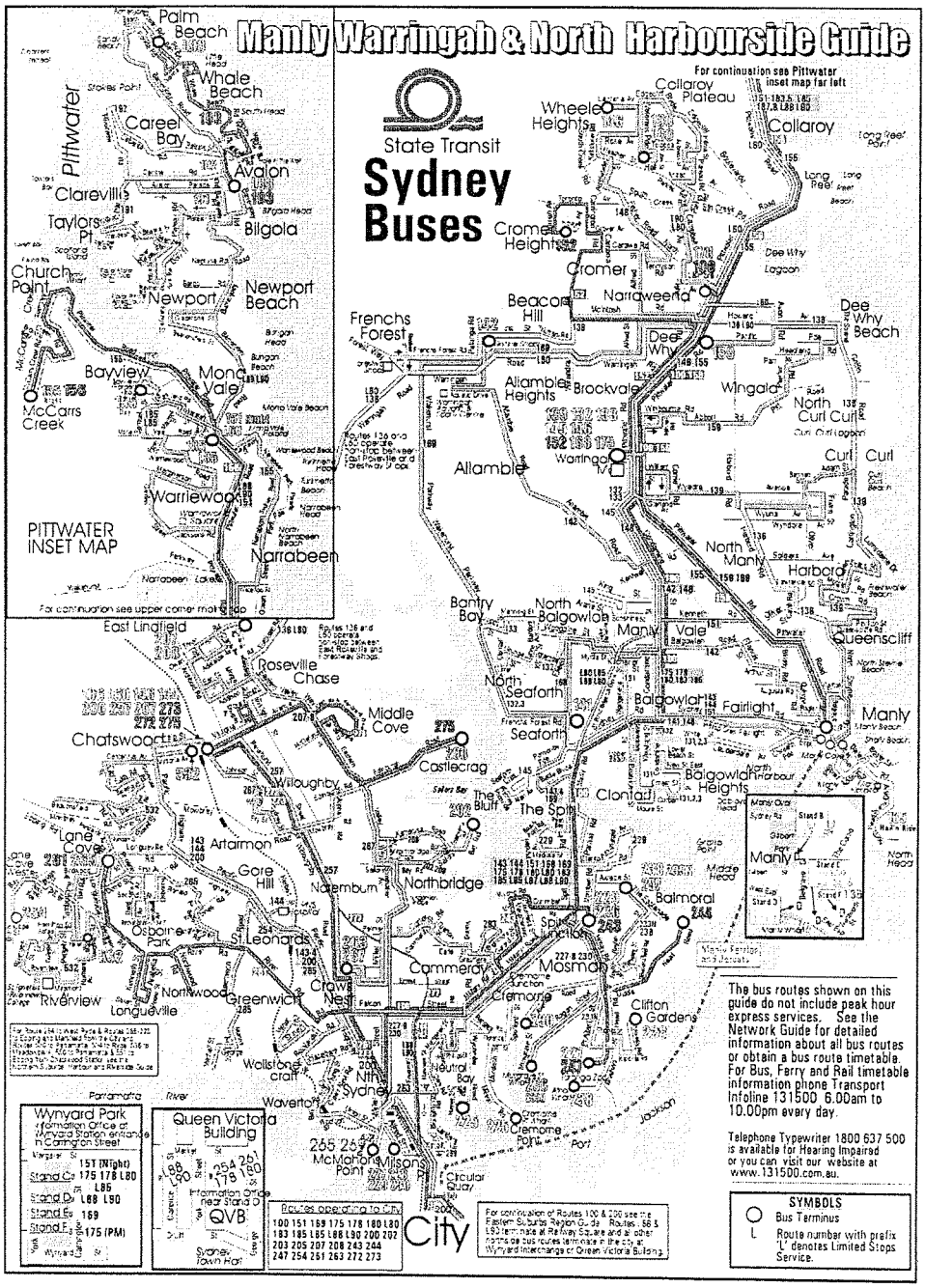
3.1.2 Transport

The major roads on the Northern Beaches include Condamine Street, Pittwater Road, Barrenjoey Road, the Wakehurst Parkway, Warringah Road, Forest Way, Sydney Road and Mona Vale Road.

The area has an extensive public transport bus service that operates in, out of and around the Northern Beaches. The major bus transport centre is located at Brookvale (opposite Warringah Mall) and connects the bus services from the southern and northern ends of the peninsula. Buses on the Northern Beaches serve two purposes. The first is to transport people to places such as work, school, hospital, and shopping. The second is to connect people with ferries, trains and other buses as part of the public transport network. The map below shows the extensive bus network that operates on the Northern Beaches.

The Northern Beaches is also accessible by ferry and jetcat services that operate from Manly Wharf to Circular Quay.

Figure 3.2 Northern Beaches transport services



3.2 NORTHERN BEACHES CATCHMENT POPULATION

3.2.1 Current and projected resident population

The Northern Beaches had a resident population (in 2001) of 231,280 people (Department of Infrastructure, Planning and Natural Resources (DIPNR) projections), which represents 21.4 per cent of the resident population of the Northern Sydney Central Coast Area and 3.5 per cent of the NSW population. The Area projects an increase in population overall, with the population in each LGA increasing within the Northern Beaches sector. The paediatric age group, of 0-14 years, is projected to have a slight increase up to 2006, but then to gradually decline to 2016. Preliminary population projections indicate that the Area should continue to plan for an increasing overall population.

Population projections released by DIPNR since completion of the draft PFP indicate that its projections slightly overestimated the 2011 Northern Beaches population by about 1,000 residents. The new projections are higher for the 0-14 and 15-44 year age groups, and lower for all other age groups. Table 3.1 examines the estimated resident population (ERP) for the Northern Beaches 2001 to 2011 by age range and shows how it compares to that outlined in the draft PFP.

The following trends have been identified for the Northern Beaches population:

- Between 2001 and 2011, the population is expected to grow by 3.7 percent from 231,280 to 239,730 people, compared to the state growth of 9 per cent.
- Between 2001 and 2011, the number of men and women aged 45 to 64 years will increase by 11.4 per cent, the number of men and women aged 65 to 74 years will increase by 14.4 per cent and the 85 years and over age group will increase by 29.0 per cent.
- The greatest proportional growth in population will be among people aged in the 85 years and over group. This age group is expected to make increasing demands on acute health care services as well as non-acute services, community and nursing home care.

Table 3.1 DIPNR Population Projections for Northern Beaches and comparison with draft PFP[1]

Age Group	2001	2006	2011	Change 2001-11	Change %	Draft PFP Proj. 2011	Change from draft PFP (%)
0-14	41,440	43,070	41,940	500	1.2	41,350	1.4
15-44	101,020	101,910	100,200	-820	-0.8	99,670	0.5
45-64	55,650	59,210	61,970	6,320	11.4	62,680	-1.1
65-74	16,200	16,350	18,530	2,330	14.4	19,500	-5.2
75-84	12,590	12,320	11,440	-1,150	-9.1	11,680	-2.1
85+	4,380	4,970	5,650	1,270	29.0	5,840	-3.4
Total	231,280	237,830	239,730	8,450	3.7	240,720	-0.4

Source – Health Services Planning Unit

Examined by LGA, the new projections propose a higher population in Manly and Warringah than was previously projected, but a lower population in Pittwater.

[1] Department of Infrastructure Planning and Natural Resources (DIPNR) projections (December 2004)

3.2.2 Population projections by LGA

A steady population growth is expected in Manly and Warringah LGAs of 6.4 per cent and 1.3 per cent respectively, while the population of Pittwater is expected to grow by 7.4 per cent over the next decade to 2011. In 2011 the population of Manly and Warringah LGAs will constitute 74.7 per cent of the Northern Beaches population.

The following table identifies the population growth by local government area.

Table 3.2 DIPNR Population Projections by LGA

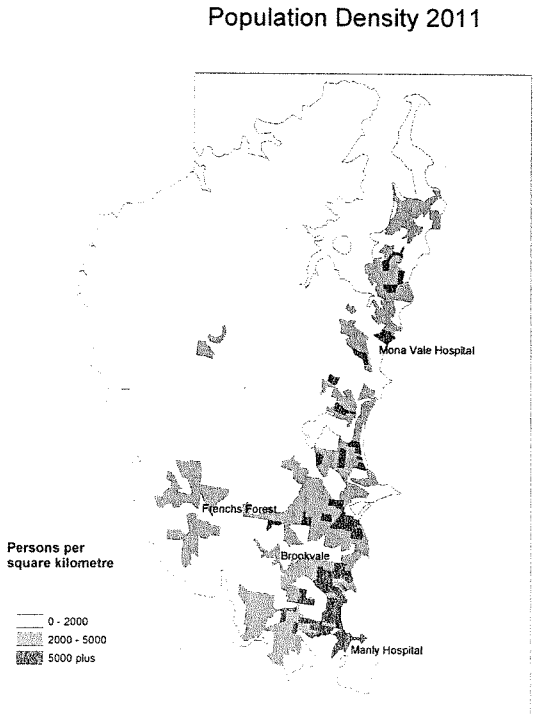
LGA	2001	2006	2011	2011-2001	Change (%)	Draft PFP 2011	Diff from Draft PFP (%)
Manly	38,690	39,700	41,180	2,490	6.4	39,760	3.4
Warringah	136,180	138,120	137,980	1,800	1.3	137,340	0.5
Pittwater	56,410	60,010	60,570	4,160	7.4	63,620	-5.0
NB Total	231,280	237,830	239,730	8,450	3.7	240,720	-0.4

Source – Department of Infrastructure, Planning and Natural Resources

3.2.3 Population Density

The map below shows that the Northern Beaches has substantial areas of no or low population density areas, including the Ku-ring-gai and Garigal national parks, with higher population density limited to small areas - particularly in the southern end of the Northern Beaches, including Collaroy, Dee Why, Frenchs Forest, Brookvale, Queenscliff, Manly and Balgowlah.

Figure 3.3 Estimated Population Density, Northern Beaches, 2011



Source - NSW Health Department Population Projections

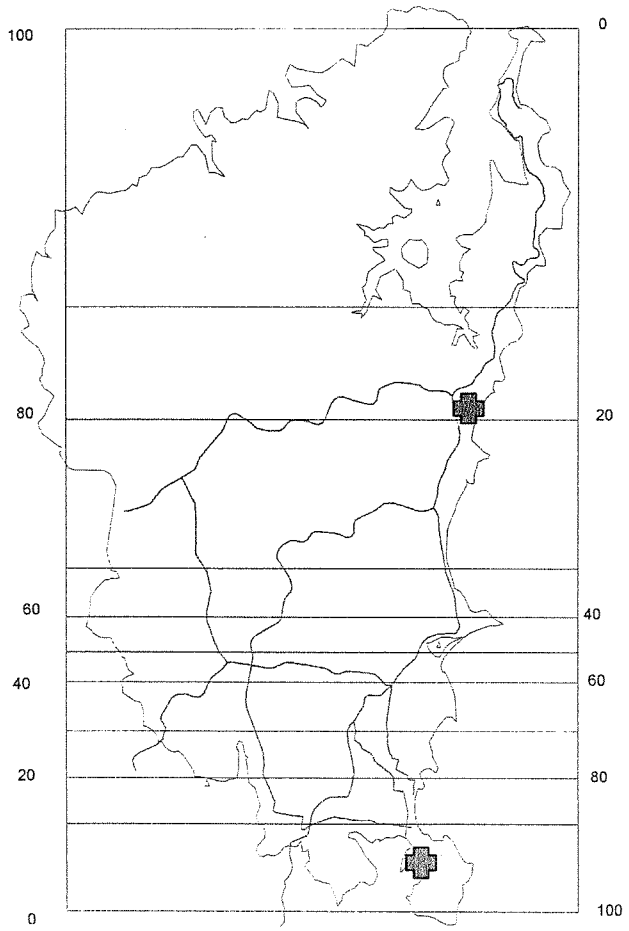
3.2.4 Population

Figure 3.4 and Figure 3.5 below show where the residents of Northern Beaches live in terms of cumulative percentage.

Figure 3.4: North-South population distribution of the Northern Beaches:

- 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 cent of the population lives south of Mona Vale Hospital

Figure 3.4 Cumulative Percentage of Population, (Northings) Northern Beaches, 2011

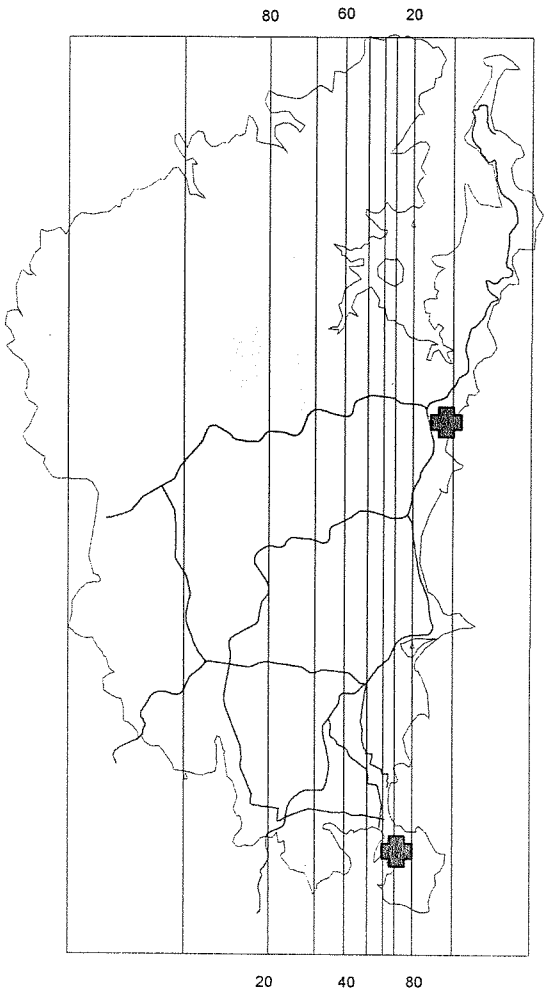


Source - NSW Health Department Population Projections

Figure 3.5: East-West population distribution of the Northern Beaches:

- 20 per cent of the population lives east of Dee Why Beach
- 40 per cent of the population[2] lives east of Dee Why
- 60 per cent of the population lives east of Brookvale
- 80 per cent of the population lives east of Frenchs Forest

Figure 3.5 Cumulative percentage of population, (Eastings), Northern Beaches, 2011



Source - NSW Health Department Population Projections

3.3 ABOUT NORTHERN SYDNEY HEALTH

Prior to the amalgamation of Area health services and establishment of Northern Sydney Central Coast Health on 1 January 2005, Northern Sydney Health was the health administration entity responsible for the administration of Mona Vale Hospital.

NSH (and now Northern Sydney Central Coast Health) delivered health services in a range of treatment settings including hospitals, community health centres and increasingly, the home setting.

Five acute care public hospitals and their associated community health services are located within Northern Sydney: Hornsby Ku-ring-gai, Manly, Mona Vale, Royal North Shore and Ryde. The Area also includes two affiliated health organisations: the Royal Rehabilitation Centre Sydney and Hope HealthCare North.

For operational management purposes, the Area health service is divided into sectors. Within Northern Sydney Health these sectors include Northern Beaches, Hornsby Ku-ring-gai and Lower Northern Sydney. These continue to function as sectors within the new Northern Sydney Central Coast Health.

Table 3.3 NSH local government areas and hospitals by sector

Planning Sector	Local Government Areas	Public Hospital
Northern Beaches (NB)	Manly Pittwater Warringah	Manly Hospital Mona Vale Hospital
Hornsby Ku-ring-gai (HK)	Hornsby Ku-ring-gai	Hornsby Hospital
Lower Northern Sydney (LNS)	Hunters Hill Lane Cove Mosman North Sydney Ryde Willoughby	Royal North Shore Hospital Ryde Hospital

Average available beds in these hospitals in 2003/04 were as follows:

Table 3.4 Average available beds in NSH hospitals in 2003/04

Hospital	No. of beds
Royal North Shore (RNSH)	547
Manly	185
Mona Vale	164
Ryde	174
Hornsby Ku-ring-gai	256
Macquarie	185
Total	**1,511**

Source: NSH Annual Report.

While residents of the Northern Beaches are able to access most public health services locally through Manly and Mona Vale hospitals, a number of more specialised services are only available at RNSH.

Clinical networks operate across the Area health service, whereby the one networked service, e.g., the Area-wide cancer service, is provided from multiple sites. An example is where radiotherapy services and highly-specialised surgical services are available at RNSH, and other surgical services and chemotherapy services are

available in all NSH sectors. Pre-existing Area-wide services based at RNSH have been in place for some time which reflects continuing trends in service delivery networking, e.g., for neurosurgery and stenting for acute heart attacks.

3.4 ABOUT NORTHERN BEACHES SECTOR HEALTH SERVICE

The Northern Beaches Health Service comprises Manly Hospital and Mona Vale Hospital and associated community health services.

3.4.1 Manly Hospital

Manly Hospital and its community health services have served the community since 1896.

Manly Hospital operates as a major metropolitan hospital, offering services up to level 4 with primary and secondary health care services.

Services currently provided by Manly Hospital:

- **Medical services** include general medicine, cardiology, endocrinology, gastroenterology, medical oncology, neurology (including stroke unit), renal medicine, respiratory medicine and rheumatology
- **Surgical services** include general surgery, ear, nose and throat (ENT), day surgery, gynaecology, urology, orthopaedic and vascular surgery
- **Maternal and child health services** include maternity and neonatal special care unit. There is no paediatric unit.
- Intensive care
- Emergency
- Acute Post Acute Care (APAC) services
- Pathology
- Diagnostic imaging
- Pharmacy
- Operating theatres
- Sub-acute inpatient aged care and rehabilitation service
- Mental health acute inpatient service
- Phoenix Unit provides short-term drug and alcohol rehabilitation for the whole of Northern Sydney Area.

3.4.2 Mona Vale Hospital

Mona Vale Hospital and its community health services have served the community since 1964.

Mona Vale Hospital operates as a major metropolitan hospital, offering services up to level 4 with primary and secondary health care services.

Services currently provided by Mona Vale Hospital:

- **Medical services** include general medicine, cardiology, endocrinology, gastroenterology, medical oncology, neurology, renal medicine, respiratory medicine and rheumatology
- **Surgical services** include general surgery, ENT, day surgery, gynaecology, urology, orthopaedic and vascular surgery
- **Maternal and child health services** include maternity, neonatal, paediatric medicine and paediatric surgery
- Intensive care
- Emergency
- Acute Post Acute Care (APAC) services
- Pathology
- Diagnostic imaging
- Pharmacy
- Operating theatres
- Sub-acute inpatient aged care and rehabilitation service

4 TIMETABLE OF MAJOR EVENTS IN HEALTH SERVICES PLANNING

The following timetable of relevant major events in health services planning in Northern Sydney Health is provided to assist the Committee in understanding the sequence of events referred to in this submission.

Date	Event
1896	Manly Hospital opened.
1964	Mona Vale Hospital opened.
1996	NSH Asset Strategic Plan.
1999	
Throughout	Area Clinical Advisory Groups established to gain clinician input into Area-wide Acute Care Services Framework.
April	Consultation meeting with peak consumer groups[3] (see Appendix 2) for Acute Care Services Framework[4].
May	Preparation of communication and consultation strategy[5] (see Appendix 3) for the Acute Care Services Framework.
May - Dec	Range of communication and consultation strategies for SRP including public dissemination of planning information, public meetings, meetings with key stakeholders, meetings with clinicians, focus groups and consumer consultation forums.
2000	
	Board endorsement of NSH policy document, *NSH Commitment to Community Participation*[6].
March	Report of the NSW Health Council. Recommendations included establishing a Metropolitan Planning Taskforce, increased networking of clinical services, and improved engagement of consumers in planning.
September	Consultants Leighton Irwin concluded review of physical condition of NSH facilities[7]. Review of clinical appropriateness completed by NSH[8]. The main block at Manly Hospital was considered not to meet satisfactory performance levels in terms of clinical appropriateness.
	Gutteridge Haskins and Davies (GHD) commissioned by NSH to undertake a community consultation program with residents of Northern Beaches.
November	GHD conducted randomised telephone survey of NB residents to provide baseline from which to monitor change in community opinion.
	Draft NSH Strategic Resources Plan developed – addressed service development to 2011[9]. Concluded that facilities at Manly Hospital have in general reached the end of their useful lives, that access was poor, and that the hospital should be redeveloped in a more central location. Recommended an option that included consolidation of hospital services on the Northern Beaches into a single hospital on a greenfield site in the Frenchs Forest/Dee Why corridor.
2001	
January	Release of community newsletter re health services planning on the Northern Beaches, including provision of options and call for submissions from the public.
February	GHD-led deliberative poll (Northern Beaches Health Summit). GHD follow-up telephone survey to monitor change in community opinion. Close of receipt of public submissions to GHD.
May	GHD report[10](see Appendix 4) released, detailing community consultation process between October 2000 and May 2001, including a telephone survey, a "Health Summit" and written submissions. The surveys sought opinion on a single hospital option vs two hospitals. The phone survey supported two hospitals, while the summit supported a single hospital.
July	NSW Health Department gives approval to undertake PFP for Northern Beaches.
Sept and Oct	Consultation workshops[11] (see Appendix 5) to determine consultation framework for Northern Beaches Health Services Procurement Feasibility Plan development

Date	Event
	process.
2002	
Jan - Nov	Planning process for Northern Beaches Procurement Feasibility Plan
January	Northern Beaches Community Consultative Health Planning Group established, with Charter[12] (see Appendix 6) endorsed in March 2002.
16 February	NBCCHPG site visits to Manly and Mona Vale hospitals.
February	Northern Beaches Health Services Steering Committee established to oversee development of the PFP. Included representatives from NBCCHPG.
Feb to June	Members of NBCCHPG spoke at 19 community forums.
April and May	10 service stream workshops including clinicians, consumers and NBCCHPG members was conducted.
April and May	15 advertisements in local media urging residents to have their say about NB health service planning.
1 May	NBCCHPG endorses draft criteria for assessing health service options.
21 May	NBCCHPG site visit to Blacktown Hospital.
21 May	NBCCHPG briefs Prof John Black regarding NB Accessibility Study.
23 May	Community forum at Dee Why RSL.
29 May	NBCCHPG endorses Community Involvement Plan that identifies three overarching strategies of information provision, targeted consultation and general communication activities.
June	Community Involvement Report[13] (see Appendix 7) released by consultants Manidis Roberts.
11 July	Pittwater representatives of NBCCHPG withdraw from NBCCHPG.
26 July	Value Management Workshop[14] (see Appendix 1) considered 20 options, and agreed on criteria for evaluation. Resulted in three options to take forward.
August	Community information displays, newsletters letterboxed to all Northern Beaches residents, advertisements, market research, and NBCCHPG presentations to community groups.
August	Report of Northern Beaches Accessibility Study by Computing in Transport consultants. This study favoured Brookvale out of the three sites (plus RNSH) as the most accessible location on the Northern Beaches.
13 Sept	Announcement by NSH that proposed the upgrade of Mona Vale Hospital on its existing site and redevelopment of Manly Hospital at a new site to be determined.
24 Sept	Options workshop[15] (see Appendix 8) to determine the preferred location of the redeveloped Manly Hospital. Workshop agreed on Brookvale as the preferred location, sought ongoing consultation in all key decisions on the Manly Hospital site including its future use, and developed criteria for locating a third community health centre if needed. Manly and Warringah representatives of the NBCCHPG participated.
October	Economic appraisal of proposed redevelopment undertaken by consultants Atkinson Capital Insight. Compared to the status quo (keeping the current two locations safe and operating), the preferred option (redevelop Manly, upgrade Mona Vale, new community health centres) differed by only 1 per cent.
November	Manidis Roberts Consultants produce two Community Attitudes Reports, one for Manly and Warringah[16] (see Appendix 9) and one for Pittwater[17] (see Appendix 10) residents. Manly and Warringah report shows overwhelming support for two hospitals, and Brookvale or Frenchs Forest as preferred location for redeveloped Manly Hospital. Pittwater report shows overwhelming support for two hospitals, and retention of Mona Vale Hospital. Additional issues relate to traffic and transport, access to emergency services, perceived increasing population of the NB area, and the future of the existing Manly Hospital site.
28 November	Draft PFP[18] completed and sent to NSW Health Department. Included study of population distribution, site identification and activity analysis. Identified 25 potential sites for new health facilities in NB.
2003	
July	$200,000 made available in 2003/2004 to progress site selection for a relocated Manly Hospital in the Brookvale area.

Date	Event
November	NSW Health Department provides comments on draft PFP. Feedback regarding community engagement is positive[19] (see Appendix 11).
9 and 17 Nov	Northern Beaches Health Panel (maternity and intensive care services) – two meetings [20] [21] [22] [23] (see Appendices 12-15) including a total of over 70 clinicians, consumers and local community representatives, convened to obtain agreement on the best way of achieving an enhanced, integrated network of maternity and intensive care services. Agreed that implementation groups for maternity and intensive care services be established to meet agreed objectives and report back to the Health Panel in the first half of 2004.
2004	
January	Site Assessment and Urban Design Report[24] by consultants LFA Pacific identified four sites for assessment - Brookvale Bus Depot, Brookvale TAFE, Manly Council Depot and Warringah Civic Centre.
April	Government announces its preference for the Warringah Council site at Dee Why, pending further investigation. Site assessment and urban design study posted on web.
June	Health Minister announces allocation of $500,000 for ongoing planning on the Northern Beaches, including the redevelopment of Manly Hospital and service enhancements to Mona Vale Hospital.
July	Northern Beaches Intensive Care Implementation Advisory Group finalised recommendations for new service model.
10 August	Northern Beaches Maternity Implementation Advisory Group (including clinician and community representatives) finalised recommendations for new service model.
18 August	Summary document put on NSH website explaining why Warringah Civic Centre was chosen as the preferred site.
September	Australian Council for Healthcare Standards accreditation surveyors indicate a high priority Mona Vale ICU staffing safety issue.
September	Detailed new Manly Hospital site selection report placed on NSH website. Heritage issues identified.
October - November	Greater Metropolitan Clinical Taskforce (GMCT) reviews and advises direction regarding maternity and ICU services on the Northern Beaches. GMCT undertakes consultation with clinicians re ICU and maternity services. GMCT meets with Save Mona Vale Hospital Committee re ICU and maternity services.
December	GMCT puts forward proposal[25] (see Appendix 16) for level 5 ICU at Manly Hospital and high dependency unit at Mona Vale Hospital. NSH Administrator publicly states consultation will occur prior to any decision being made.
2005	
1 January	Northern Sydney Central Coast Health established as the health administration entity to replace Northern Sydney Health and Central Coast Health.
Feb/March	Reconvene Northern Beaches Health Panel to review GMCT proposal (anticipated). Site investigations ongoing.

5 INTENSIVE CARE SERVICES ON THE NORTHERN BEACHES

5.1 ABOUT INTENSIVE CARE SERVICES

5.1.1 Definitions

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 intensive care unit provides special expertise and facilities for the support of vital functions, and utilises the skills of medical, nursing and other staff with expertise in the management of these problems[26].

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.

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.

5.1.2 Functions performed

Functions performed by an ICU include the following:

- Monitor patient's vital signs and symptoms closely
- Provide intensive nursing care
- Perform invasive monitoring – with catheters in arteries and veins close to and in the heart
- Perform sophisticated support for vital organs, such as the heart (e.g., provision of adrenaline and other drugs), lungs (e.g., non-invasive and mechanical ventilation), kidneys (e.g., continuous haemodialysis), brain (management of airways and breathing with ventilation) and gut (e.g., 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.

5.1.3 Patient profile

Patients who require intensive care services come from:

- 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 specialised treatment, or the intensive care unit of another hospital is full, or another hospital does not operate an intensive care unit.

5.1.4 Role delineation

The NSW Health Department, in consultation with specialist colleges, relevant professional organisations and other interested parties, has developed a health services role delineation guide[27] to determine support services, staff profiles, minimum safety standards and other requirements to ensure that clinical services are provided safely and are appropriately supported. Appendix 17 provides some background information regarding this guide, and includes a description of the four delineated role levels for intensive care services.

Manly and Mona Vale hospitals are both currently classified as providing level 4 intensive care services.

In July 2001, the NSW Government Action Plan (GAP) for Intensive Care Services[28] (see Appendix 18) was released. This plan confirmed the following for intensive care services (adult intensive care services are defined as all intensive care services except the specialty paediatric services and neonatal intensive care services):

- Units providing a service of role level 4 or above, should be considered intensive care services able to provide a diverse range of therapies.
- Units providing a service of role level 3 or below, should be considered high-dependency units which support surgical services and emergency departments but only to the extent of overnight ventilation, if required.

The plan proposed that Manly Hospital, Mona Vale Hospital and Ryde Hospital should be reviewed in the recommended network model as providers of high-dependency services.

5.2 CURRENT INTENSIVE CARE SERVICES ON THE NORTHERN BEACHES

Northern Beaches Health Service provides intensive/coronary care services for the community through two 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.

Around 1.4 per cent (2003/2004) of all people attending the Northern Beaches Health Service emergency departments are transferred to the critical care area of the hospital. The majority of people attending NBHS emergency departments walk in or arrive by private car (70% in Manly and 78% in Mona Vale in 2003) and are not considered to have life-threatening conditions (triage category 4 & 5). Children represent 26 per cent of all emergency department attendances at Mona Vale Hospital and 10 per cent at Manly Hospital.

In 2003/04 a small number of intensive care patients (34) were transferred to other hospitals from the Northern Beaches by the Statewide Medical Retrieval Unit for specific specialist services such as cardiothoracic or neurosurgery or for intensive care bed availability.

It should be noted that ambulance bypass arrangements exist for severe trauma and acute ST-elevated myocardial infarction (heart attack), with such patients being transported directly to RNSH. All paediatric/neonatal cases requiring intensive care services are transferred via medical retrieval unit as part of a Statewide service that is provided by specialist paediatric facilities. Most paediatric patients who require emergency surgery are also transferred to specialised paediatric facilities outside the Northern Beaches.

Adult patients who present to Manly or Mona Vale hospital with severe heart attack, need for urgent cardiac or neurosurgery or severe burns, along with all critically ill children are currently transferred to other ICUs with the appropriate specialist expertise by the State MRU.

5.3 FUTURE DIRECTIONS FOR INTENSIVE CARE SERVICES

5.3.1 National trends in intensive care

Intensive care services are becoming rapidly more specialised and organised in Australia. New technology, surgical techniques and medical therapies are now available that improve survival in critically ill patients. Australia is a recognised leader in intensive care medical research and organisation of the specialty.

There is a drive to ensure that all intensive care patients receive the benefits of these advances, irrespective of which hospital they first enter.

Intensive care beds are a Statewide resource (e.g., a critically ill patient at Lightning Ridge is transferred to an intensive care bed wherever it is available). This ensures an equitable distribution of expert care. Small ICUs (less than 10 beds) are unable to provide a critical mass of patients, nurses and doctors. The standard of care may suffer as a result. This is a worldwide problem. Small units in more isolated communities are linked to teaching hospitals and research is underway to provide telemedical intensive care backup.

In metropolitan hospitals, with closer proximity to each other and to major centres, intensive care services are being networked to integrate units to be able to provide the high standard of care that is available in larger institutions for the whole community. Patients are stabilised and transferred between hospitals by a dedicated, highly-trained State MRU. Research has shown that transfer by retrieval experts improves outcome in critically ill patients.

College regulations for both standards and training do not support smaller units.

The Joint Faculty of Intensive Care Medicine (Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians) has produced clear guidelines relating to the size, operation and networking of intensive care units. The NSW Health Department has also provided guidelines on the role of intensive care units.

The College of Anaesthetists and subsequently the Joint Faculty produces a series of standard recommendations that do not support the viability of smaller ICUs, in particular in relation to critical mass, workforce sustainability and quality of care. Even the lowest category of ICU requires a medical director who is experienced in intensive care medicine, and consultant support which is always available from a specialist with experience in intensive care medicine. In addition to the attending specialist, there should be at least one registered medical practitioner with an appropriate level of experience must be rostered for the ICU at all times[29].

The severe global nursing shortage has affected all clinical specialties. The high patient to nurse staffing requirement necessary in ICU increases the effects of the nursing shortage.

New graduates are not interested in working in units that do not have adequate resources to support their introduction to intensive care.

5.3.2 Directions for intensive care in NSW

The service delivery model for intensive care in the Area health service is guided by the relevant planning frameworks of NSW Health.

The NSW Government Action Plan for Health (July 2001)[30] articulated plans for adult intensive care services in NSW. The plan recommended the adoption of a network model, formalising and strengthening networks across and between Area health services. It recommended a 'hub and spoke' service model that would ensure an integrated network of intensive care services, allowing for improvements to be made across the whole service instead of just at local sites. This model does not propose centralised management by the tertiary site, rather a model of partnership. The plan proposed that Area health services should ultimately be responsible for meeting the intensive care needs, apart from superspecialty services, of the Area and agreed network services.

The NSW Metropolitan Hospitals Report (2002) recommended appointment of an Area Director of intensive care to facilitate networking and integration of intensive care units on the Northern Beaches. In 2002, NSAHS set up an area ICU network to oversee the development of standards, policy and strategic direction.

Transfer of intensive care patients is co-ordinated and performed by the Statewide MRU.

5.4 PLANNING FOR INTENSIVE CARE SERVICES ON THE NORTHERN BEACHES

Provided below is an outline of the issues and the steps in planning to enhance the quality and safety of intensive care services on the Northern Beaches.

5.4.1 Metropolitan Hospitals Report

In August 2002, the GMTT released the Metropolitan Hospitals Report[31] (see Appendix 19) outlining strategies for improving the services offered by metropolitan hospitals in the greater metropolitan region.

The main principles espoused are:

- Quality of care and safety of patients
- Equity of access to, and outcome within, the health system
- Clinician-driven planning.

Recommendations were made in respect of ICUs at Manly and Mona Vale hospitals as follows:

- Appointment of a Director of Intensive Care (Northern Beaches)
- Appointment of a Clinical Nurse Consultant (Northern Beaches)
- Refurbishment at Manly Hospital to improve the co-ordination of intensive care services and educational support and to improve the provision of intensive care services at the Manly site.

A major recommendation was made to integrate the ICUs at Manly/Mona Vale hospitals.

The outcomes of the recommendations include the appointment of positions of Director and Clinical Nurse Consultant. Integration of units in terms of staff rotation, and uniform policy development is beginning to occur.

Refurbishment of the Manly ICU will follow the review of the GMCT proposal.

5.4.2 Inspection of intensive care services in 2003

On 29 and 30 April 2003, two representatives of the NSW Intensive Care Implementation Group inspected intensive care facilities at Manly Hospital and Mona Vale Hospital.

They made a significant statement about optimum intensive care practice on the Northern Beaches:

> *The number of ventilated patients for Manly and Mona Vale combined for each of the last three years, is less than that recommended by the Joint Faculty to sustain expertise in a Level 2 Unit. Lower throughputs have adverse ramifications in terms of the quality of accredited staff attractable, jeopardise the maximisation of patient outcomes and compromise the cost effectiveness of the technological infrastructure necessary to support a modern ICU.*
>
> *With current clinical workloads being insufficient at both campuses to ensure optimal outcomes, the uniting of both ICUs and ultimately facilities, is strongly supported. The development of a single Unit with an adequate "critical mass" of work on the Peninsula (particularly given the high levels of private health cover and the prevailing standard of living) is in fact paramount if the "new RNS" is to function most efficiently as a true tertiary referral centre. A combined facility on the Peninsula would improve outcomes for individual patients which must be the prime concern of each consultant and, by way of*

creating a "centre effect", support the development of previously unsustainable health services. The visionary establishment of such a centre of excellence with a united, common purpose would stimulate morale and support all forms of health care delivery on the Peninsula. Pending the siting of a new hospital (in a location not restricted by geographical constraints and also well serviced by public transport), it is important that both Units now commence implementing common policies, which act to synergise their functions.

5.4.3 History of difficulty in staffing

Ten years ago the ICU at Mona Vale Hospital was managed by a single physician, who provided a service to the unit on a 24/7 basis. This doctor covered the unit while undertaking other clinical activities. This was possible because there were small numbers of patients in ICU and small numbers of admissions. Significant changes in the medical workforce, the impact of medical indemnity issues and increasing demand for intensive care no longer allow support for this model of staffing.

In 1997 the Mona Vale ICU was only staffed at a senior medical level by a visiting medical officer cardiologist with an interest in intensive care. Given the difficulties of trying to manage such an arduous responsibility on a 24/7 basis, negotiations with intensivists at Manly Hospital were 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 consensus view amongst intensivists that doing on-call for two hospitals was clinically unsound and this experience confirmed those beliefs.

Mona Vale Hospital in 2005 has three part-time visiting medical officers to cover the intensive care roster for 24 hours a day, 365 days of the year. The number of full-time specialists normally needed to provide that cover for an ICU is 5.8, which allows reasonable after hours load, and ability to take leave. This arrangement is believed to be best provided by a team of specialists who are available to be rostered on site. There is a significant shortage of intensive care specialists in Australia and despite advertising through national papers and the Medical Journal of Australia, no suitable applicants were forthcoming. The size of the ICU is a major issue for prospective applicants who view caring for one or two ventilated patients not to be a productive use of their specialist time.

5.4.4 Accreditation

The shortage of intensive care and emergency specialists at Mona Vale Hospital has been a significant issue at the recent accreditation survey by the Australian Council of Healthcare Standards in September 2004.

The accreditation team made a high priority recommendation to "progress as a matter of urgency the current service plan for maternity and intensive care services". They were of the view that "intensive care and maternity services were priority areas for further development".

On 17 January 2005 a further survey team from the ACHS reviewed progress of the high priority recommendations. The team acknowledged the work undertaken by Professor Kerry Goulston and the GMCT with positive comments on the interim strategies for intensive care. They noted that critical mass is important for recruitment.

The survey team decided to maintain the issue of service planning and senior medical staffing in critical care as a high priority recommendation. They specifically referred to the need for firm implementation plans for integrating intensive care services across both sites.

5.4.5 Northern Beaches Health Panel

The Northern Beaches Health Panel (NBHP) comprising over 60 consumers, community members, clinicians and managers met for two days in November 2003 to consider information presented to them on maternity and intensive care services and to agree on ways to improve these services.

An expression of interest was advertised in local papers for people (or their carers) who had recently used public maternity or intensive care services on the Northern Beaches to be involved in the panel.

Local community action groups and consumer advocacy groups were also invited to nominate representatives.

Community action groups were asked to seek additional consumers. Notices were included in Northern Beaches early childhood centres for any new mothers who may have been interested in participating.

In November 2003 the Northern Beaches Health Panel agreed on the following service development principles:

- Safety and quality of services is a key consideration
- An integrated network with common policies, practices and systems is essential to moving forward
- The principle of networked services across the Northern Beaches
- The value of leadership through a single clinical director of each service.

For intensive care services on the Northern Beaches the NBHP agreed in November 2003 on the following:

> *One service across both sites providing a high quality, safe service that meets community needs on the Northern Beaches.*

It was agreed that implementation groups would be established to review and make progress on these issues.

5.4.6 The Northern Beaches Intensive Care Implementation Group

The terms of reference of the Intensive Care Implementation Group (ICIG) describe its purpose as being to determine the structure of intensive care services on the Northern Beaches in the medium- and long-term with reference to the following issues: role delineation; models of care, including division of services between the current two sites; admission, discharge and transfer policy; bed numbers; physical structure; medical and nursing staffing issues; education and training; data collection; policies, procedures and guidelines; interaction with the emergency department; transfers and retrieval; quality assurance activities.

Invited membership included the following:

- Director of the Northern Beaches intensive care service (chair)

- Intensivists and intensive care nurses from both hospitals (Manly and Mona Vale)
- Representatives from surgery, anaesthetics, emergency medicine and allied health from NBHS
- General Manager, Director of Nursing and Director of Medical Services, Northern Beaches Health Service
- Representative of NSH

The Intensive Care Implementation Group met on 18 March, 6 May, 3 June and 1 July 2004.

The following **key conclusions** have been collated by extraction and summary of significant agreed actions from the minutes of all meetings of the Intensive Care Implementation Group.

Staffing Issues and their Impact on the Service Delivery Model

The units do not have the critical mass to attract adequate intensivist, registrar or nursing staff. Options considered, particularly relating to the most crucial question of intensivist staff, were:

- Endeavour to employ more VMO intensive care to work across sites, but mainly at Mona Vale, in order to maintain the current arrangement of ICU services. This was attempted but was not successful due to the unattractiveness of small units below critical mass as a working environment.
- Reduce hours of operation of Mona Vale ICU because of the difficulty in obtaining intensivist cover. This was found to be non-feasible.
- Restructure the Northern Beaches Intensive Care Service (NBICS) so that it operated:

- One level 5 unit. Such a unit would be managed by the NBICS, would be likely to have six ventilated beds and four high dependency unit (HDU)/critical care unit (CCU) beds, would have continuous intensivist cover and continuous registrar presence; and would provide a higher level of intensive care service and better work environment for all staff than is currently available in the NBHS; and
- One level 3 unit (high dependency). Such a unit would be managed by the NBICS, would have four to six HDU/CCU beds, would have daily visiting by an intensive care specialist and would have direct patient care responsibility taken by medical and other consultants with phone advice from the intensive care specialist on-call as necessary. The NBICS would take responsibility for transfer and retrieval arrangements from the campus with the level 3 unit to the campus with the level 5 unit or elsewhere.

It was agreed that in the long-term the Northern Beaches population of 250,000 would be best served by a level 5, 12-bed unit with six ventilated beds on a single site.

Education and Training

- Staff should be rotated between the two units where possible to maintain skills and consistent practice.
- A clinical nurse consultant should be appointed to the NBICS. Action on this has been completed.

Physical Structure

- Action should be taken to improve physical facilities to better meet current standards.

Patient Flow

- Patient flow improvements continue to be required to provide good access to intensive care beds as required.

5.4.7 Greater Metropolitan Clinical Taskforce (GMCT)

The GMCT had been asked by the Minister for Health to work with Area health services and clinicians to facilitate more effective roles for the smaller metropolitan hospitals across the greater metropolitan area of Sydney and to enhance networking of clinical services to make best use of resources.

Professor Kerry Goulston, chair of the GMCT, agreed to consult with clinical leaders at Manly and Mona Vale to assist in the development of a solution to the clinical safety issues, particularly for intensive care and maternity services.

Prof Goulston commenced meetings in October 2004 and held over 26 consultation meetings up to the end of November 2004.

GMCT, in preparing a formal proposal, saw three main drivers for change:

- Workforce shortage
- Critical mass of clinicians
- Increased standards of patient care.

Workforce

While the public is aware of the patchy shortfall of nursing staff in our public hospitals, most are unaware of shortages of allied health and medical personnel. Appropriate levels of staffing are required for the provision of safe and effective hospital care of patients.

Why is there a medical workforce shortage?

Insufficient numbers of medical students are being trained throughout Australia. In 2005 the Commonwealth Government, recognising this, has increased medical students places by over 400. It will, however, be 10 years before these students graduate as specialists or general practitioners. In the meantime, the Commonwealth Government has an active plan of recruitment for overseas-trained doctors.

Feminisation of the medical workforce

For the first time there are more female medical students than male in Australian universities. Females in the medical workforce over their lifetime contribute significantly fewer hours to medical practice than their male counterparts.

Lifestyle change

As in society generally, young doctors want to "live a life" and many have opted for less demanding work roles than previous generations (some choosing to work as locum doctors).

Private sector opportunities

Significant numbers of doctors are now working outside the public hospital system.

Critical mass of clinicians

In modern medicine, a team approach is necessary for best possible care of patients. To staff a hospital at night and on weekends most doctors are on rosters for out-of-hours work. It is difficult to recruit doctors in many hospital specialties when there are not enough staff members in a particular department to permit a reasonable out-of-hours roster. Doctors also seek a reasonable amount of time for supervision and teaching of medical trainees.

Specifically, when there is only one emergency specialist in a reasonably busy emergency department, (e.g., at Mona Vale), it has proven very difficult to recruit additional staff. In contrast, if there is a critical mass of emergency specialists networked and rotating through two emergency departments (e.g., Mona Vale and Manly operating together) it will be more attractive to potential new recruits.

Increased standards of patient care

With recent concerns arising from the King Edward Royal Commission in Perth and the inquiries into Camden and Campbelltown hospitals, there is a justifiable concern on the part of the public, for safe, high quality patient care 24 hours a day 7 days a week. Without the workforce to support it, this cannot be guaranteed.

GMCT proposal

The GMCT proposal[32] (see Appendix 16) for the Northern Beaches recommended a single Northern Beaches intensive care service networked across both hospital sites.

The proposal states:

"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 five to six, 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 four to six non-ventilated beds is proposed.*
- *A new position of Critical Care Nurse Co-ordinator across both sites 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."*

The GMCT reinforced its view that no longer can metropolitan (district) hospitals expect to offer every service for every patient, but rather they should act as "doorways" into a system which provides patients with the best care possible. To assure high quality patient care requires working towards integrating clinical services; in this case 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.

The GMCT stated "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."[33]

Why GMCT proposed that ventilated ICU beds be sited at Manly Hospital

The justification for choosing Manly as the site for the ventilated beds is as follows:

- Although there are more presentations to Mona Vale Hospital Emergency Department (22,301) than Manly (16,567), these are mainly due to paediatric attendances (3,728 adult admissions to Mona Vale and 3,993 adult admissions to Manly). There is no paediatric intensive care service on the Northern Beaches.

- At Manly Hospital there are more admissions to both the general wards and the intensive care unit from the emergency department. There is a greater access block problem at Manly because of this fact but the recent opening of the Emergency Medical Unit is expected to correct this.

Table 5.1 lists the current distribution of services with relevant activity data for intensive care and emergency departments for the 2003/2004 financial year (Area and ICU database). The table shows that Manly is the larger and busier intensive care unit with more resources and staff structure and therefore is the better location for the level 5 Northern Beaches service. The need for transfer of ICU patients will thus be minimised.

5.4.8 Consideration of the GMCT proposal in consultation with clinicians and community

The GMCT proposal is now under active consideration by the Area health service. The health service will seek the advice of key clinicians and consumer and community members in relation to this issue.

An implementation group is being formed to consider the GMCT recommendations. This implementation group will comprise clinicians and community.

The Northern Beaches Health Panel, convened in November 2003 to advise future directions in regard to ICU and maternity services, will be re-convened for broader clinician and consumer consideration of the GMCT recommendations.

The implementation group and panel will provide advice before the end of March 2005.

Table 5.1 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 hrs, 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 index, 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 admission (2003/04):		
• 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

* CVVHDF = Continuous Veno Veno Haemodialysis Filtration (a type of renal dialysis)
** CVP = Central Venous Pressure

6 MONA VALE HOSPITAL FUNDING

6.1 INTRODUCTION

This paper outlines the following:

- The NSW Health funding framework
- The budget and actual financial results for Northern Sydney Health (NSH) and the major facilities within the Area over five years
- The distinction between capital and recurrent budgets
- Mona Vale Hospital's patient activity and costs
- Financial program funding (actuals) for NSH and major facilities

6.2 THE NSW HEALTH FUNDING FRAMEWORK

Expenditure requirements of NSW Health comes from five sources:

- NSW Consolidated Fund from sources such as GST revenue, State taxes and licences
- Australian Health Care Agreement (AHCA) funding negotiated with the Commonwealth
- Commonwealth Specific Purpose Payments (SPP) for items like high cost drugs
- Area Health Services' revenue received from private patient fees and charges, and donations. Revenue is retained by Area Health Services.
- Non-cash expense items such as depreciation and employer's superannuation contribution.

Health services receive initial allocation letters around July each year which follow a series of meetings with the Department of Health.

Health Service Government contributions in the initial allocation letter are determined by the Minister and are based upon the Budget Appropriations to the Department of Health.

Allocations are based upon annual approved budget records which are maintained between the Department and health services and are varied for enhancements, growth, award variations and non-salary escalation factors.

In March 2000 the Government announced three-year budgets to June 2003. Following a recent IPART review the Department intends to move to four-year rolling budgets, but this has been delayed because of:

- the amalgamation of 17 health services to eight
- delays in obtaining latest population projections which reflect growth centres
- the assessment of the above two factors against the Resource Distribution Formula (RDF).

Some components of the allocation, such as Mental Health and Aboriginal Health, are quarantined. This means that these budgets cannot be reduced and must be used for their specified purpose.

Area health services, based upon the Government contribution, develop their own Net Cost of Services budgets using appropriate budgeting practices. These budgets are approved locally at a facility cost centre, and/or program level.

6.2.1 Resource Distribution Formula (RDF)

The Resource Distribution Formula (RDF) is one of the tools used by NSW Health to distribute funds equitably to Area health services.

The RDF takes into account local population needs including age, sex, mortality and socio-economic indicators.

The objective is to improve the equitable distribution of funding across NSW Health so all resident populations can receive appropriate services near where they live, rather than having to travel large distances. It must be recognised that a need will always exist to provide tertiary and other services on a Statewide basis from limited locations. For a number of services the availability of clinicians and nurses and the need to have a reasonable throughput to protect patient safety must also be considered.

The improvement in the equitable distribution of resources is the NSW Health Dashboard Indicator "Fair Distribution of Funding". Page 41 of the 2003/04 NSW Department of Health's annual report identifies it has moved from a weighted average distance target of 14 per cent in 1989/90 to around 2 per cent in 2003/04.

The RDF is applied to all parts of the public health system - from population health, primary and community care to palliative care and teaching and research. The RDF is a model that weights an Area's population's needs according to a range of indices that help describe those needs. These include:

- Population
- Estimated population growth
- Age
- Sex
- Mortality
- Rurality
- Aboriginality
- Homelessness
- Casemix complexity for inpatients.

The factors listed above are based on the population within an Area's boundaries. Patients are able to seek care wherever they wish. The RDF adjusts for these movements of patients across Area boundaries. Movements are difficult to predict and estimates are usually based on historical data sometimes several years old. Patient movements can fluctuate year to year.

The RDF also includes other factors such as use of private hospitals and adjustments for patients from interstate.

6.2.2 Episode funding policies

From 1 July 2000, Area health services were required to use episode funding as a guide for the allocation of resources to their services. There are specific policies for:

- Acute inpatients (excluding ED and ICU)
- ICU for designated level 5 or 6 units
- Emergency departments
- Rehabilitation, palliative care and non-acute care services (policy issued for shadowing from 1 July 2004).

All these models have the following in common:

- A price, cost or benchmark, based on the average cost for the measure being used as an output for hospitals of a similar type. These costs are calculated annually from data collected from around 80 hospitals in NSW
- Activity targets based on the expected level of activity for the year or period
- Activity weightings according to patient complexity (e.g., DRGs). Weightings are calculated annually from the data collection mentioned above.

The policies are budget models, not payment models. This means that health services are not paid per patient as are, for example, GPs via Medicare. The models are used to determine or agree a given level of activity (patients) at a cost outlined in the model. Areas have the capacity to put a case to the Department to justify an episode funding cost above benchmark.

6.2.3 Acute inpatient model

The Acute model is used to negotiate activity targets with facilities for each specialty and to determine the funding required to meet these targets. Targets need to consider historical trends and future changes to activity and the overall budget.

NSH facilities are generally expensive compared to other similar hospitals in NSW. For smaller facilities in the Area, such as Ryde, Manly and Mona Vale, this is due to the small size of their units, which is generally a reflection of high use of private sector alternatives for non-urgent elective surgery. For facilities such as RNSH a significant cause is the many high technology services provided, often to patients across NSW, that are usually associated with higher costs.

6.2.4 ICU funding model

A separate funding approach is undertaken with hospitals with level 3 and 4 ICUs such as Manly and Mona Vale hospitals. Hospitals with the capacity for short-term ventilation receive a mechanical ventilation (MV) component to recognise the extra resources consumed during the periods the patient is being ventilated. This is based on the number of MV hours expected to be required in the following year. This is incorporated into the acute inpatient funding model. This component, like all other funding models, is a budget model. If hospitals need to ventilate more patients than expected, extra funding is not available.

6.2.5 ED model

The ED funding model is used to allocate a budget that is linked to the expected cost weighted volume of patients presenting to each ED.

6.2.6 Funding allocations within NSH

NSH Health is responsible for determining budgets within the Area, using the above policies as guidelines.

The Area's budgeting process uses a mixture of activity-based approaches, bottom-up budgeting, historical budget and financial performance.

6.3 THE BUDGETS FOR NSH AND THE MAJOR FACILITIES WITHIN THE AREA OVER FIVE YEARS

Table 6.1 below shows initial Net Cost of Service (NCOS) budgets (including anticipated budgets) for NSH and NSH facilities for 2001 and 2005. These figures have been adjusted to account for changes in the way NSH now reports, so that valid comparisons are possible.

The NCOS for Mona Vale has increased from approximately $26.1 million in 2000/01 to $34.4 million in 2004/05. This represents an increase of 32% over the five years which matches the NSH budget increase over the same period. The Manly Hospital Budget has increased from $33.8 million to $46.0 million over the five years or 36%. Overall the NCOS budget for Northern Beaches has increased by $20.6 million or over 34% since 2000/01.

Mona Vale Hospital currently receives 5.0 per cent of the direct NSH budget, with 6.7 per cent allocated to Manly - 11.7 per cent to the Northern Beaches sector overall. (These proportions exclude Area overheads, some mental health services at Manly Hospital and some other services that are not part of the sector's responsibility in the NSH structure). The proportion of NSH budget allocated to Northern Beaches has increased slightly over the five years from 11.5 to 11.7%.

During the period under review the following functions have been moved to Area cost centres:

- Human Resources
- Childcare services for Hornsby and Ryde hospitals
- Engineering services
- Drug and Alcohol services
- AIDS
- Provision of Aids for Disabled Persons (PADP)
- Business Units – Radiology, Nuclear Medicine and Central Sterilising Services Department

All reported budgets have been restated to include these functions within the individual hospital facilities.

Table 6.1 Net Cost of Service (NCOS) budgets (including anticipated budgets) for NSH and NSH facilities for 2001 and 2005

NCOS Budget ($'000)	2005	2001
Royal North Shore	262,920	195,431
Hornsby Ku-ring-gai	66,915	48,393
Manly	46,026	33,777
Ryde	38,165	31,635
Mona Vale	34,414	26,054
Macquarie	27,511	19,873
Area Mental Health	40,907	28,839
Affiliated Organisations	32,730	25,604
Community & Extended Care	18,277	16,485
Population Health	7,400	936
Other	110,869	91,100
NSH Total	686,135	518,125

Share (%)	2005 (%)	2001 (%)
Royal North Shore	38.3	37.7
Hornsby Ku-ring-gai	9.8	9.3
Manly	6.7	6.5
Ryde	5.6	6.1
Mona Vale	5.0	5.0
Macquarie	4.0	3.8
Area Mental Health	6.0	5.6
Affiliated Organisations	4.8	4.9
Community & Extended Care	2.7	3.2
Population Health	1.1	0.2
Other	16.2	17.6
NSH Total	100	100

Source -NSH Oracle system

6.4 MANLY AND MONA VALE SHARE OF NSH BUDGET

With 231,280 residents in 2001, the Northern Beaches represents 29.5 per cent of the NSH population. The combined budget of Manly and Mona Vale hospitals represents approximately 11.7 per cent of the total NSH budget. This apparent discrepancy can be explained as follows:

- Complex services usually requiring high cost technology are generally provided from RNSH to residents throughout the Area.
- High numbers of out-of-Area patients (inflows) are treated at Ryde and Hornsby hospitals, while RNS receives patients from throughout NSW and interstate as part of its Statewide tertiary referral role. In contrast, Northern Beaches hospitals treat few patients from other parts of NSH or from outside the Area.
- Many services provided across the Area, including on the Northern Beaches, are provided by services which are funded and managed on an Area-wide basis. These include mental health and community based services. Budget figures reported relate to the budgets for which the Northern Beaches General Manager is accountable.
- Private hospital utilisation varies between sectors and this will also affect funding allocation.

6.5 IMPROVING AND MAINTAINING HOSPITAL INFRASTRUCTURE - CAPITAL AND REPAIRS, MAINTENANCE AND RENEWALS (RMR) BUDGETS

Hospital equipment, buildings and other infrastructure are improved and/or maintained using a range of funds:

Recurrent capital received as part of the annual Department of Health Subsidy and allocated within the Area to facilities and services. These amounts can be used largely at the discretion of the relevant manager to cover purchase of essential equipment, building upgrades and refurbishments and major works. In Mona Vale's case this is the Sector Manager for Northern Beaches.

- Capital from trust funds
- Capital funds received from the Department under its capital program, usually for larger projects such as the redevelopment of RNSH, planning for Northern beaches Health Services and the upgrade of maternity at Manly Hospital
- Funding used to repair and maintain buildings, equipment and other infrastructure (not of a capital nature). This is called repairs, maintenance and renewals or RMR. This funding is also part of the annual allocation to the Area and is distributed within the Area to facilities and services. Use of this budget is at the discretion of the facility manager; the sector manager for Northern Beaches in the case of Man Vale Hospital.
- Salaries and wages for engineering and trades staff

Budgets shown in the previous section are for general fund recurrent budgets only. This includes some capital budget received by NSH as part of its normal Department subsidy as well as RMR. Salaries and wages for engineering and trades staff are currently held in the Area as part of an Area-wide service. They are part of the "other" budgets in Table 6.1 above.

In order to identify the full amount of funding allocated to improve and maintain Mona Vale hospital it is necessary to review all the above categories.

Table 6.2 shows the capital budgets split by the major categories (NSH General Fund (GF) capital, trust funds (TF) capital, Department capital. Table 6.3 shows the total capital budget for NSH from all sources.

Table 6.4 shows the RMR and engineering and trades staff budgets. Table 6.5 summarises the total budget, from all sources, allocated for improving and maintaining facility infrastructure over the last 5 years.

The tables show that overall funding allocated to improving and maintaining hospitals has increased steadily over time, with some minor fluctuations from year to year.

At Mona Vale over the past five years approximately $10.2 million has been spent on maintaining and improving infrastructure. Projects over this time included, but were not limited to:

- Procurement of the first CT scanner on the Northern Beaches
- Establishment of two new x-ray rooms
- Installation of a new paediatric assessment area in Emergency Department

- Upgrade of air conditioning of the entire operating suite
- Relocation of Drug & Alcohol Unit to Mona Vale Hospital site
- Establishment of a 24 hour security service
- Fire and safety upgrades

NSCCH has just recently secured funding for a new aged care community facility at Mona Vale Hospital.

Table 6.2 Capital Budgets by major category ($'000)

	2004/05			2003/04			2002/03			2001/02			2000/01		
	NSH GF	Trust	DoH	NSH GF	Trust	DoH	NSH GF	Trust	DoH	NSH GF	Trust	DoH	NSH GF	Trust	DoH
RNS	2,403	-	16,298	2,701	5,020	9,914	14,801	-	21,865	1,719	4,730	5,106	6,199	4,730	2,700
Hornsby	404	-	3,598	404	80	1,033	461	-	851	61	258	-	591	258	-
Manly	200	-	1,502	794	250	716	228	-	962	428	25	-	258	25	-
Ryde	156	-	112	156	30	5,221	178	-	1,069	228	39	200	492	39	-
Mona Vale	391	-	475	391	160	-	446	-	-	46	30	-	666	30	-
Other	6,164	-	2,481	3986		2,378	5,917	5,376	2,305	3,737	431	1,063	- 1,936	403	- 878
NSH Total	9,717	-	24,466	8430	5540	19,260	22,031	5,376	27,052	6,219	5,513	6,368	6,271	5,485	1,822

Source - NSH Year end capital reports

Notes: RNS budget includes POEM contribution and fit out
Ryde budget includes operating theatres project
Other functions include Area services, PaLMS, Shared Services, Mental Health and Business Units

Table 6.3 Total Capital Budget all sources ($'000)

	2004/05	2003/04	2002/03	2001/02	2000/01
RNS	18,702	17,634	36,666	11,554	13,629
Hornsby	4,002	1,517	1,312	319	849
Manly	1,702	1,759	1,190	453	283
Ryde	268	5,406	1,247	467	531
Mona Vale	865	551	446	76	696
Other	8,645	6,363	13,598	5,231	- 2,411
NSH Total	34,183	33,230	54,460	18,101	13,577

Source – NSH Year end capital reports

Notes: RNS budget includes POEM contribution and fit out
Ryde budget includes operating theatres project
'Other' includes Area services, PaLMS, Shared Services, Mental Health and Business Units

Table 6.4 RMR and Trades Staff budgets ($'000)

	2004/05		2003/04		2002/03		2001/02		2000/01	
RMR and trades staff	**RMR**	**Trades staff**	**RMR**	**Trades staff**	**RMR**	**Trades staff**	**RMR**	**Trades staff**	**RMR**	**Trades staff**
Royal North Shore	7,694	2,796	6,371	2,865	6,521	2,765	6,030	2,720	5,874	2,651
Hornsby	956	816	1,591	879	1,603	848	1,485	835	1,366	873
Manly	1,144	762	1,932	763	1,543	735	1,060	724	910	776
Ryde	960	540	596	560	604	532	809	518	376	598
Mona Vale	757	708	834	709	993	687	798	680	668	689
Other	12,644	1,298	13,235	693	10,746	702	9,907	675	8,482	910
Total	24,155	6,919	24,558	6,468	22,010	6,269	20,089	6,152	17,675	6,497

Notes: RNS budget includes POEM contribution and fit out
Ryde budget includes operating theatres project
'Other' includes Area services, PaLMS, Shared Services, Mental Health and Business Units

Table 6.5 Total Capital and RMR ($'000)

	2004/05	2003/04	2002/03	2001/02	2000/01
Royal North Shore	29,191	26,870	45,952	20,304	22,154
Hornsby	5,773	3,986	3,763	2,640	3,088
Manly	3,608	4,454	3,468	2,238	1,969
Ryde	1,768	6,562	2,383	1,794	1,505
Mona Vale	2,330	2,093	2,126	1,554	2,053
Other	22,587	20,291	25,047	15,812	6,981
Total	65,257	64,256	82,739	44,341	37,749

Notes: RNS budget includes POEM contribution and fit out
Ryde budget includes operating theatres project
'Other' includes Area services, PaLMS, Shared Services, Mental Health and Business Units

6.6 HOW MONA VALE HOSPITAL'S ACTIVITY AND COSTS COMPARE TO ITS PEER HOSPITALS

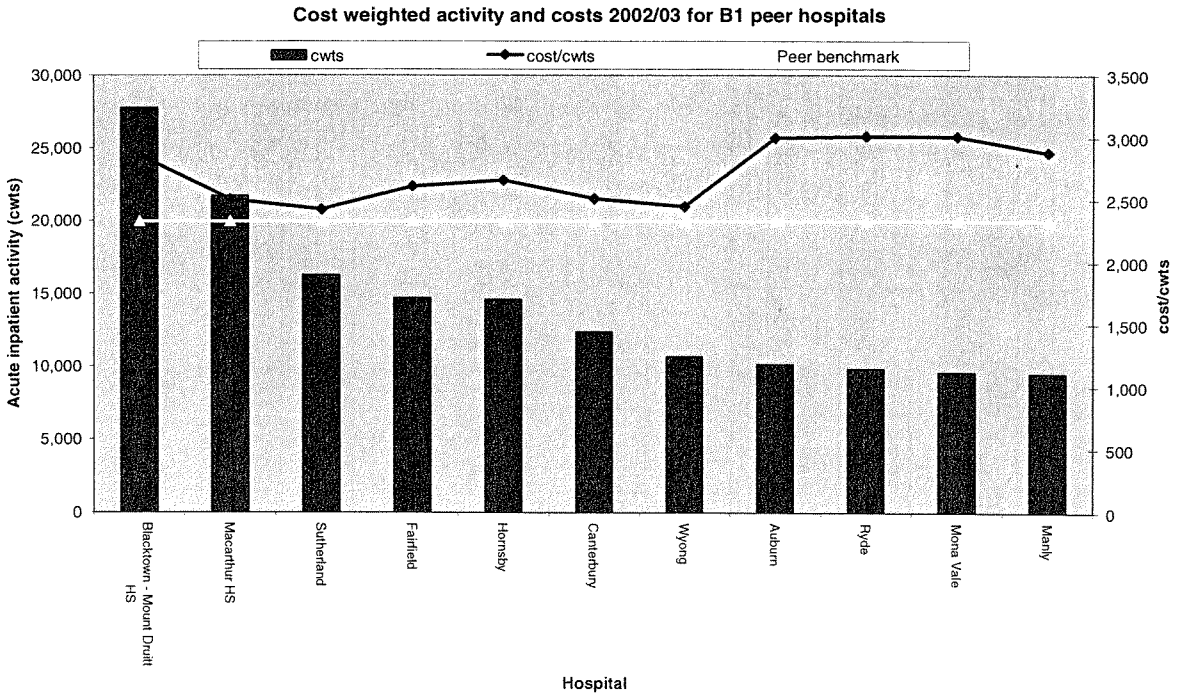
A comparison of hospital costs and volume of activity in terms of acute inpatient cost weighted separations for similar hospitals (as defined by Department of Health peer grouping) is shown below. This analysis uses 2002/03 cost and activity data.

Figure 6.1 shows a relationship between hospital size (in terms of volume of acute inpatients) and cost or efficiency.

Mona Vale Hospital has a relatively low volume of cost weighted activity but high costs relative to its peer hospitals. In 2002/03, Mona Vale's cost weighted separations was 9,601 compared to the peer average of 14,278 cost weighted separations. Cost per cost weighted separations were $3,011 compared to the benchmark of $2,330.

Note Figure 6.1 represents acute inpatient activity only. Patients receiving services such as rehabilitation and mental health are not included. Costs refer to average cost per cost weighted separation.

Figure 6.1 Cost weighted activity and costs 2002/03 for B1 peer hospitals



Source – 2002/03 NSW Health Peer Hospital Activity and Cost Data

6.7 FINANCIAL PROGRAM FUNDING (ACTUALS) FOR NSH AND MAJOR FACILITIES

NSH is required to report financial information on the programs shown in the table below. This table indicates the proportional share of expenditure for each program at the Area, sector and hospital level.

It is important to note that program level expenditure is not comparable across facilities, as proportions depend on the mix of services located at the facility under the control of facility managers. Although expenditure is also not generally comparable at the sector level, Northern Beaches has a similar proportional share of the budget across financial programs to the Hornsby Ku-ring-gai sector, given that all facilities in these sectors have the same role level and are in the same peer group. Program level expenditure in the lower Northern Sydney sector is not comparable to the other two, because Royal North Shore Hospital is a tertiary level facility and has a completely different role and mix of services from the other facilities in NSH. The data is for 2003/04 financial year.

Other refers to Area-wide services such as Northern Sydney Home Nursing Service and business units such as pathology. The financial programs are presented in Table 6.6.

Table 6.6 Financial program funding (actual) for NSH and NSH facilities in 2003/04

Program Name	Area %	Hornsby Ku-ring-gai %	Manly %	Mona Vale %	Northern Beaches %	RNS %	Ryde %	Lower Northern Sydney %	Other %
1.1 Primary and Community Services	6.6	**8.1**	12	2.4	**8**	4.6	5.1	**4.9**	9.1
1.2 Aboriginal Health Services	0	**0**	0	0	**0**	0	0	**0**	0.2
1.3 Outpatient services	4.7	**3.2**	3.2	2.7	**3**	5.8	5.2	**5.7**	4.3
2.1 Emergency Services	9.6	**9.3**	10.2	15.3	**12.3**	13	6.5	**12**	0
2.2 Overnight and same day acute inpatients	49	**52.1**	44.9	64	**52.8**	63.4	61.5	**63.1**	0.2
3.1 Mental Health Services	11.5	**13**	18.8	1.4	**11.6**	3.5	12.6	**4.8**	30.9
4.1 Rehabilitation and Extended Care Services	12.2	**9.8**	7.3	10.8	**8.7**	1.7	5.2	**2.2**	47.6
5.1 Population Health Services	1.7	**0**	0.4	0.1	**0.3**	1.7	0.6	**1.5**	4.9
6.1 Teaching and Research	4.7	**4.5**	3.2	3.3	**3.3**	6.3	3.3	**5.8**	2.9
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100.1**

Source –NSH 2003/04 Program statement as submitted to NSW Health

7 COMMUNITY CONSULTATION

Studies into the reconfiguration of health services on the Northern Beaches have been in progress since 1999. Community consultation has been a feature of, and has informed, planning up to[34] and since that time (see Appendix 20).

7.1 COMMUNITY CONSULTATION TO GUIDE DEVELOPMENT OF ACUTE CARE SERVICES FRAMEWORK (1999)

In 1999 Northern Sydney Health (NSH) embarked on the development of an Area Acute Care 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[35] (see Appendix 2), on advice from the NSH Community Consultative Committee. A communication and consultation plan[36] (see Appendix 3) was guided by advice sought from this meeting). A range of consultation strategies was implemented throughout the development of the framework[37]. The establishment of clinical advisory groups for clinical specialty areas was a key consultation strategy of the Acute Care Services 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.

7.2 COMMUNITY CONSULTATION TO GUIDE DEVELOPMENT OF STRATEGIC RESOURCES PLAN (2000)

In January 2000 NSH developed a Strategic Resources Plan, which incorporated the Acute Care Services Framework and identified recommended distribution of facilities across Northern Sydney until 2011. A consultation strategy was prepared in January 2000[38] (see Appendix 21) 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. GHD has considerable experience in community consultation. The document, Community Consultation Report[39] (see Appendix 4) details the strategies and outcomes implemented from November 2000 to February 2001. Components of this consultation strategy included market research, advertisements seeking public submissions regarding health service options, and a deliberative poll.

7.3 COMMUNITY CONSULTATION TO GUIDE DEVELOPMENT OF THE NORTHERN BEACHES HEALTH SERVICES PROCUREMENT FEASIBILITY PLAN (2001-2002)

Later in 2001, Northern Sydney Health 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, the Area engaged another consultant, Manidis Roberts, which had considerable experience in community consultation processes for major public sector planning initiatives. This company was engaged to facilitate two consultation workshops attended by clinicians, residents of the Northern Beaches nominated by the three local councils, consumer advocacy group representatives, and health service managers and planners. The consultant's report[40] (see Appendix 5) summarises the deliberations and recommendations of those workshops.

A comprehensive consultation strategy followed, including the establishment of the Northern Beaches Community Consultative Health Planning Group (NBCCHPG) and a diverse 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
- NBCCHPG involvement in value management workshop and Options Workshop: Manly/Warringah[41] (see Appendix 8) where the preferred location of the new Manly Hospital was determined
- NBCCHPG membership on Northern Beaches Health Service PFP Steering Committee.

A flowchart[42](see Appendix 22) prepared by NSH provides a sketch of the broader consultation strategy for the PFP from April to November 2002. Manidis Roberts prepared three reports[43] [44] [45] (see Appendices 7,9 & 10/ also available on NSH internet site) which detail the strategies and outcomes of those consultations implemented throughout the course of the PFP development (February to November 2002).

The consultation process was ahead of contemporary practice for community participation in health service planning, a fact that was acknowledged by the NSW Health Department in its response in late 2003 to NSH regarding the draft PFP[46] (see Appendix 11).

The draft PFP 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.

The draft PFP recommendations had the written support of all three communities represented on the NBCCHPG and was submitted to the NSW Health Department in November 2002. 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.

7.4 COMMUNITY CONSULTATION TO GUIDE PLANNING OF INTENSIVE CARE AND MATERNITY SERVICES (2003-2004)

While work continues on pursuing the longer-term changes recommended in the draft PFP, there has been a need to address more immediate health care delivery issues pertaining to intensive care and maternity services (see section 5 of this submission).

In November 2003, a Northern Beaches Health Panel, comprising clinicians, consumers and community representatives, was convened [47] [48] [49] [50] (see Appendices 12-15).

The proposed structure and representation for the panel was agreed by the two main community action groups, BEACHES and Save Mona Vale Hospital Committee before finalisation. Community representatives were then sought by public advertisement[51] (see Appendix 23) and through nomination from relevant community-based associations (e.g., Maternity Alliance). Community representatives on the NBCCHPG were also invited. The panel brought together clinicians, community and management to look at current thinking on these two services and agree on a way forward. The evaluation and outcomes of the two meetings of the panel are appended to this submission[52] [53] [54] (see Appendices 12, 14 & 15). It was agreed that the next step would be that NSH convene implementation groups to review and make progress on the recommendations. The Maternity Implementation Group met until August 2004, and the Intensive Care Implementation Group met until July 2004.

Subsequent to the delivery of advice by the two implementation groups, and separate to this process, the Minister requested that the Greater Metropolitan Clinical Taskforce (GMCT) review, consult and advise the future directions regarding maternity and intensive care services. GMCT publicly released its proposal in December 2004.

The Northern Beaches Health Panel (ICU and Maternity) will be reconvened in February or March 2005 to consider this proposal. Northern Sydney Health will consider the advice of clinicians and community in making a final determination.

7.5 ENDURING COMMITMENT TO COMMUNITY PARTICIPATION IN DECISION-MAKING

Northern Sydney Health has an enduring commitment to community participation in decision-making[55] (see Appendix 24) that is particularly well demonstrated by the comprehensive nature of community involvement in Northern Beaches health services planning over many years.

8 DETERMINING THE ROLE AND MIX OF SERVICES FOR THE NORTHERN BEACHES HOSPITALS

8.1 INTRODUCTION

Feedback from extensive community consultation during 2002 supported the retention of two hospitals on the Northern Beaches. A value management study (July 2002) (see Appendix 1) supported an option with one hospital as a metropolitan general hospital, and one as a community hospital.

Subsequent community consultation demonstrated overwhelming community support for two hospitals on the Northern Beaches. In response to this, on 13 September 2002 the health service announced an intention to maintain two hospitals and undertake the following planning processes:

1. Redevelopment of Manly Hospital. Redevelopment of community health services for the Manly and Warringah areas would form part of this planning process.
2. Upgrade of Mona Vale Hospital on its current site. Redevelopment of community health services for the Pittwater community would form part of this planning process.

The draft Northern Beaches Procurement Feasibility Plan (PFP) was submitted to the NSW Health Department in November 2002. The detail of the draft Procurement Feasibility Plan (PFP) is currently being finalised through discussion between the NSW Health Department and NSCCH. It was noted in the draft PFP that further refinement of service configuration would occur as part of the next stage of planning. Northern Sydney Health has stated that Mona Vale is unlikely to be the major Northern Beaches hospital (i.e., the hospital with the broader mix and more complex level of services), given travel accessibility issues.

8.2 BACKGROUND TO DECISION – STRATEGIC RESOURCES PLAN (SRP)

Planning for health services in the Northern Beaches was accelerated in 2000 by a review of the physical condition of NSH health facilities, prepared as part of the Area's Strategic Resources Plan, which identified projected service demand and facility needs through to 2011[56]. The SRP found that the existing facilities at Manly Hospital had in general reached the limit of their useful lives. It was also 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. The SRP concluded that the hospital should be redeveloped by moving to a more central location.

The NSW Health Department allocated funding in 2001/02 for the development of a Procurement Feasibility Plan (PFP) for the Northern Beaches to respond to the clinical and infrastructure issues identified in the SRP. The draft PFP was developed in accordance with Departmental requirements.

8.3 AGREEMENT THAT THERE BE TWO HOSPITALS

Throughout the Northern Beaches health planning, NSH remained committed to having an open and transparent process for the development and evaluation of

health service options. Determining how best to provide health services across the Northern Beaches was to engage NSH in an extensive process of community consultation and service analysis. The process of consulting with the community and other stakeholders is described in section 6.

The first decision was whether to provide services from one or two hospital sites. The consultancy group Gutteridge, Haskins and Davey (GHD) was engaged to undertake a community-wide, multi-strategy process of determining community attitudes to this question. This included a large telephone survey as well as a deliberative poll ("health summit"), among other strategies. The phone survey showed a marked preference for two hospitals. Pittwater LGA residents favoured Mona Vale Hospital while Warringah LGA and Manly LGA residents favoured a more southern location. The health summit participants, a smaller group of residents who had the opportunity of in-depth analysis of the issues, favoured a single hospital.

8.4 OPTIONS DEVELOPMENT

In January 2002 NSH established a broadly representative consumer group, the Northern Beaches Community Consultative Health Planning Group (NBCCHPG) to oversee the consultation process and review and comment on planning proposals as part of the development of the Northern Beaches procurement feasibility plan. The NBCCHPG was composed of five nominees of each of the local councils. It was established following the recommendations of a broad-based community and clinician consultation workshop.

Early in the PFP planning process NSH developed criteria[57] (Appendix 25) in collaboration with the NBCCHPG, clinicians, NSW Health Department and other stakeholders to guide the development of health service options. These criteria were reviewed and aggregated during the value management study process for evaluation of options.

NSH sought submissions from members of NBCCHPG, local Councils, clinicians and community regarding health service options for the Northern Beaches. To assist in the development of options, a guide book[58] was prepared and posted on the NSH website that included:

- information from the health service stream workshops held in April/May 2002 regarding proposed models of service delivery
- criteria for development of options
- other background information such as current services, population profile, travel study review and policy context.

Twenty options were put forward for review. Five of the 20 were put forward by NSH. The remaining 15 were put forward by individuals and sub-groups of the NBCCHPG, the Save Mona Vale Hospital Committee, Pittwater Council and an individual community member.

8.5 OPTIONS EVALUATION

Northern Sydney Health commissioned the Australian Centre for Value Management to facilitate and report on a phase 1 value management workshop, convened in July 2002. Attending were clinicians from Manly and Mona Vale hospitals and community

health centres, NSW Health Department representatives, NSH representatives, Manly and Warringah members of the NBCCHPG[2], and consultants offering technical expertise. The purpose of this workshop was to:

- Review and agree on criteria by which health service configuration options would be assessed, and
- Review and cull health service configuration options for further detailed development and presentation to a phase 2 value management workshop in September 2002.

The workshop considered the 20 options. There were common themes across all options, and following consideration, the workshop agreed on three to be taken forward for broader community consultation. The workshop also agreed that the base case option (to retain the two hospitals in their current locations), for which there was no support, would be retained for comparative purposes only.

These options were:

- two hospitals with a metropolitan general hospital located at Brookvale or Frenchs Forest and a community hospital located on the MVH site
- two hospitals with a metropolitan general hospital located on the MVH site and a community hospital located at Brookvale or Frenchs Forest
- one metropolitan general hospital, with site to be tested.

Subsequent to the workshop in July 2002, the three agreed Northern Beaches health service options were the subject of extensive community consultation.

There was clear general consensus amongst community members and clinicians on the need to improve health services on the Northern Beaches. There was overwhelming community support for two hospitals.

8.6 PREFERRED OPTION

In response to community support the health service announced on 13 September 2004 an intention to maintain two hospitals and undertake the following planning processes:

1. Redevelopment of Manly Hospital. Redevelopment of community health services for the Manly and Warringah areas would form part of this planning process.

2. Upgrade of Mona Vale Hospital on its current site. Redevelopment of community health services for the Pittwater community would form part of this planning process.

Networking between the two hospitals on the Northern Beaches, together with community health services and home-based care, would underpin further planning processes.

[2] Pittwater members of the NBCCHPG withdrew from the group in July prior to the value management workshop.

The preferred option, discussed in the following section, reflects this announcement and has been informed by the models of delivery that were proposed within the range of clinical, consumer and community consultation processes outlined elsewhere.

8.7 OPTIONS FOR MANLY HOSPITAL

A workshop was organised on 24 September 2002 to examine options for the redeveloped Manly Hospital[59] (Appendix 8). This meeting included community representatives resident in Manly and Warringah LGAs, health service clinicians and managers, NSW Health Department representatives and others. The workshop agreed on criteria for choosing a location. They were[60]:

- proximity to the majority of the Manly Warringah population
- access for the majority of the Manly Warringah population by private transport, measured by weighted travel time
- access for the majority of the Manly Warringah population by public transport, measured by weighted travel time
- value for money and sustainability in terms of capital and recurrent costs
- site capacity and its timely availability to enable an efficient and functional facility design that supports modern health care.

Consideration of these options was informed by a transport access study[61] (Appendix 26) and an economic analysis of the costs of rebuilding on the current site vs a new site.

This meeting agreed that a site in the Brookvale area best met these criteria, being the location of choice of local residents, providing the best transport access and causing minimal disruption to existing hospital services during construction.
The workshop also sought ongoing consultation in relation to all key decision points in the redevelopment project, and called upon the Government to consult with the community in relation to the future use of the existing Manly Hospital site.

This information was submitted in the draft PFP[62] to the NSW Health Department. The focus since then has been on the selection of an appropriate site for the redeveloped Manly Hospital, using the criteria identified at the value management study.

The final decision of Government on the location of the Northern Beaches Hospital will have regard to the planning undertaken by NSCCH, the community consultation, and the availability of a suitable site that best meets the following criteria. These criteria are the subset of the criteria cited in the PFP which were found to differentiate between the site options:

- Fairer access
  - ensures equitable travel accessibility
  - allows maximum 30 minutes travel to health services
  - community health located close to civic facilities, e.g. shopping centres
  - requires minimal travel out of area for health services
  - reduces barriers to access

- Quality health care
  - attract and retain appropriate staff
- Better value
  - provides consumer value for money
  - allows reconfiguration of facilities.

8.8 DECISION ON ROLE AND MIX OF SERVICES FOR THE NORTHERN BEACHES HOSPITALS

The draft Northern Beaches Procurement Feasibility Plan (PFP) submitted to the NSW Health Department in November 2002 proposed a preferred option that includes:

- 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.

It was noted that further review of service configuration would occur as part of the next stage of planning.

A number of factors will play a significant part in informing this review and future role and service mix of each Northern Beaches hospital. The final decision needs to be logical, defensible and sustainable.

Factors would include the following:

8.8.1 Total volume of activity

Clinicians have expressed concern that two hospitals on the Northern Beaches may not have adequate throughput to sustain two acute services into the future, in terms of critical mass and continued staffing.

Data from 2003/04 shows that of the 13 major metropolitan hospitals in NSW, the four with the lowest number of inpatient admissions were Camden, Ryde, Manly and Mona Vale. Camden's activity had increased as a result of networking with Campbelltown. Numbers of inpatient separations for recent years are shown below. Reference can also be made to the appropriate table in section 5 on resource allocation.

Table 8.1 Number of separations at major metropolitan hospitals from 1999/2000 to 2003/2004

Hospital	1999/00	2000/01	2001/02	2002/03	2003/04
Blacktown	20,046	23,180	24,069	24,111	24,959
Campbelltown	21,150	20,718	17,618	16,571	17,308
Mount Druitt	16,088	16,039	16,827	16,539	16,647
Wyong	13,887	14,479	14,814	14,822	16,215
Hornsby	16,381	16,415	15,212	15,495	15,873
Fairfield	14,031	14,481	13,636	14,066	14,381
Sutherland	18,058	18,534	18,000	18,181	14,328*
Auburn	11,920	12,193	12,289	12,922	13,916
Canterbury	12,433	12,640	13,319	13,011	13,576
Mona Vale	10,301	10,956	11,206	11,021	11,462
Manly	11,491	11,280	11,298	11,435	11,087
Ryde	9,511	9,419	9,980	10,306	10,222
Camden	1,911	2,274	5,512	8,613	8,194

* Reduced activity due to Sutherland Hospital redevelopment during 2003/2004.

Source: FlowInfo V5.2. Inpatient separations excluding renal dialysis, chemotherapy, neonates

It should be noted that Western Sydney AHS recently established a networking arrangement between Blacktown and Mt Druitt hospitals to ensure ongoing sustainability[63]. Blacktown Hospital alone has over twice the inpatient activity of Manly and Mona Vale hospitals combined.

The proportion of local demand met by private hospitals is higher in NSH than in other Areas, meaning that the base population required to sustain the inpatient services of a public hospital in this area is greater than in the rest of metropolitan NSW.

8.8.2 Access

The population and travel studies undertaken as part of the PFP show unambiguously that the centre of population on the Northern Beaches is in the Cromer area, while Brookvale has the best access by car and public transport of the major options considered[64]. If acute inpatient services were concentrated at Mona Vale, average travel time for the total NB catchment population would increase significantly. This would affect ambulance delivery (and hence emergency department throughput) as well as potentially increasing outflows of patients from the southern end of the catchment, as occurred when the paediatric ward at Manly was closed.

8.8.3 Clinical effectiveness

Service configurations across the two sites will be informed by factors such as safety, throughput, staffing, maintenance of professional education opportunities, availability of support services and clinical standards. NSW Health Department provides a guide to role delineation of health services that determines the support services, staff profile, minimum service standards and other requirements to ensure that clinical services are provided safely and are appropriately supported[65]. The site for the major Northern Beaches hospital should be able to provide services at the appropriate role level.

Current difficulties in recruiting specialist staff to two acute hospitals on the Northern Beaches will be considered in determining the degree to which acute services can be sustained across two sites. It should be remembered that critical mass as an issue is not confined to ICU. Attracting and retaining suitably qualified staff for all disciplines is mostly determined by peer support, access to safe working practices and a clinical and linked physical infrastructure. Existing hospitals on the Northern Beaches should not be "competing" with each other for scarce skilled workforce. If acute services were to be concentrated at one site to attract the workforce, that site should be in an accessible location.

The creation of a new, purpose-built hospital in the Dee Why/Brookvale area will provide exceptional opportunities for improved services, and is likely to attract staff.

8.8.4 Innovative models of care

Concentration of acute services at one site to ensure quality and safety will lead to concerns about decreased access for certain key services such as emergency and management of chronic illness, as well as access by family and visitors. These are issues facing services across the developed world, and NSCCH will need to consider innovative health care models to ensure that the quality of care available to the NB population is not compromised.

8.9 RESPONSES TO PARTICULAR ISSUES

Community concern about the location of hospital services on the Northern Beaches has focused on a number of issues.

8.9.1 The population centre

It is frequently argued that Mona Vale is the best location for a major hospital as it is halfway between the extremities of the Northern Beaches area[66]. The following points are made in response:

- The draft PFP focuses on the population centre of the area and weighted travel times, to ensure that analysis of accessibility is weighted by the number of people who might use the service. Because the Northern Beaches population is concentrated in the south of the area, the population centre will be further south (in Cromer) than the geographic centre.
- Only about 20 per cent of the NB population lives north of Mona Vale Hospital.
- As not everyone on the NB lives on the coast, the "geographic" centre of the area is, in fact, somewhere north-west of Narrabeen Lagoon.

8.9.2 Population growth

An argument frequently mounted is that the major Northern Beaches hospital should be at Mona Vale because of population growth in that area, such as land releases in the Warriewood Valley[67].

The population study took into account a range of growth scenarios, and found that the centre of population was only marginally affected by these changes[68].

8.9.3 Emergency provision

Concern has been expressed about increased travel time for Pittwater residents to an emergency department in the Dee Why area if the major emergency service is based there. The following points are made:

- No decision has been made about how emergency services will be configured across two sites. However, the NSW Government Action Plan for Health made recommendations for emergency departments in metropolitan hospitals including both a minimum population base of 200,000 and a throughput of 20,000 or more cases per year[69].
- Already many critical emergencies are not dealt with at local hospitals. Under the NSW Trauma Plan patients with traumatic injuries are transported directly to a designated trauma centre such as Royal North Shore Hospital. Under Northern Sydney Health evidence-based guidelines, heart attack patients are now assessed and transported directly by ambulance to RNSH for stenting. With the establishment of a Stroke Unit at Manly Hospital, following the recommendation of Greater Metropolitan Transition Taskforce, NB patients with stroke are transferred to Manly Hospital.
- The value management workshop in July 2002 identified requirements of an emergency service at whichever hospital was designated the community hospital[70]. These included the ability to deal with minor injuries and ailments, resuscitation and referral capacity, access to retrieval and transport, access to specialised consultants, including mental health, and backup with diagnostic facilities.

9 CONCLUSION

Proposals regarding the delivery of intensive care services and future role of Mona Vale Hospital have been based on a diverse range of studies, detailed analysis of historical and projected population and health service data, and extensive clinician and community consultation.

Community and clinician consultation on the Greater Metropolitan Clinical Taskforce's proposal regarding intensive care services on the Northern Beaches is planned for February/March 2005. Northern Sydney Central Coast Health (NSCCH) will make a decision after this consultation has occurred.

NSCCH remains committed to:

- redevelopment of Manly Hospital in the Brookvale area, subject to suitable site identification
- 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
- a continued high level of community consultation in relation to health services planning on the Northern Beaches
- providing improved health services on the Northern Beaches that will deliver safe and modern health care to the local community.

NSCCH is confident that the new Northern Beaches Hospital, an upgraded Mona Vale Hospital and their attendant community health centres will meet and exceed community expectations.

10 APPENDICES

1. The Australian Centre for Value Management (July 2002) Value Management Program IN Procurement Feasibility Planning Process: Workshop No 1: Health Services Configuration Options Review

2. NSH (April 1999) Agenda, minutes and invitation list, regarding consultation meeting with peak consumer groups, 16 April 1999

3. NSH (May 1999) Community and Consultation Strategy for the Acute Care Services Framework

4. Gutteridge, Haskins and Davey (May 2001) Health Services Planning on the Northern Beaches: Community Consultation Report.

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11. NSW Health Department (2003) Excerpt from response to NSH regarding Northern Beaches Health Services Procurement Feasibility Plan

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[8] NSH (October 2000) Clinical Appropriateness Results in volume 4, section 12, attachment D of Strategic Resources Plan 2000-2011 (NSH & Atkinson Capital Insight, October 2000

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