**REPORT OF PROCEEDINGS BEFORE**

# GENERAL PURPOSE STANDING COMMITTEE No. 2

## INQUIRY INTO THE OPERATION OF MONA VALE HOSPITAL

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**At Sydney on Monday 21 March 2005**

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**The Committee met at 2.00 p.m.**

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**PRESENT**

The Hon. P. Forsythe (Chair)

The Hon. A. Catanzariti
The Hon. Dr A. Chesterfield-Evans
The Hon. A. R. Fazio
Reverend the Hon. Dr G. K. M. Moyes
The Hon. M. J. Pavey
The Hon. C. M. Robertson

**CHAIR:** Welcome to the third public hearing of General Purpose Standing Committee No. 2 into the operation of Mona Vale Hospital. At today's hearing we will be taking further evidence from representatives of NSW Health. Before we commence I would like to make some comments about aspects of the Committee's inquiry. At the start of our first hearing I made a detailed statement regarding the number of submissions received, most importantly, regarding procedural issues relating to the conduct at the hearing. These procedural issues related to the non-disclosure of patient details and the extension of parliamentary privilege to the evidence given by witnesses. I do not propose to repeat that statement here today. It is part of the transcript of the first hearing, which is accessible on the Committee's web site. However, I will refer to that statement if required during today's hearing.

With respect to broadcast guidelines, the Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of guidelines governing broadcast of the proceedings are available from the table by the door. In accordance with the Legislative Council guidelines for the broadcast of proceedings, a member of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the focus of any filming or photographs. In reporting the proceedings of the Committee the media must take responsibility for what they publish or what interpretation is placed on anything that is said that before the Committee.

Witnesses, members and their staff are advised that any messages should be delivered through the attendants or the Committee clerks. I also advised that under the standing orders of the Legislative Council any documents presented to the Committee that have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person. With respect to in-camera deliberations, the Committee prefers to conduct its hearings in public, however the Committee may decide to hear certain evidence in private, if there is a need to do so. If such a case arises, I will ask the public and the media to leave the room for a short period. Finally, could everyone please turn off their mobile phones for the duration of the hearing. I welcome our witnesses from NSW Health.

**ROBYN KRUK**, Director-General, NSW Health, 73 Miller Street, North Sydney, and

**STEPHEN CHRISTLEY**, Chief Executive, Northern Sydney Central Coast Health, Locked Bag, 2915, Central Coast Business Centre, on former affirmation,

**MICHAEL ROBERT DART ROXBURGH,** Director, Northern Sydney Central Coast Health, Locked Bag, 2915, Central Coast Business Centre,

**MALCOLM McDOUGAL FISHER**, Specialist, Intensive Care, Royal North Shore Hospital, Area Director of Intensive Care Services, Northern Sydney Area Health Service, Chair, New South Wales Taskforce into Intensive Care, St Leonards,

**PATRICK CHARLES CREGAN**, Surgeon, Chair, Surgical Services Network for the Sydney Western Area Health Service and Chair of the Surgical Services Taskforce, NSW Health, P.O. Box 1124, Penrith, and

**JONATHAN MARK MORRIS**, Professor of Obstetrics and Gynaecology, Royal North Shore Hospital and Director of Maternal Foetal Medicine for the Northern Sydney Area Health Service, sworn and examined:

**CHAIR:** Do you wish to make a brief opening statement prior to questioning?

**Mr ROXBURGH:** No, I do not.

**Professor FISHER:** I would like to do that.

**Dr CREGAN:** No.

**Professor MORRIS:** No, thank you.

**Ms KRUK:** Dr Christley is keen to make an opening statement, if that is at all possible.

**CHAIR:** If any of you should consider at any stage during your evidence that certain evidence or documents that you may wish to present should be seen or heard in private by the Committee, the Committee will consider your request, however the Committee or the Legislative Council itself may subsequently publish the evidence if they decide it is in the public interest to do so. Those wishing to make an opening statement may do so.

**Dr CHRISTLEY:** I will kick off. Madam Chair, thank you very much. There is much that the health service, clinicians and the local community agree on, and it has been interesting to read transcripts of evidence. We are all united in a desire for a first-class health service to meet local needs and a desire to see it happen as soon as possible. We agree on a two-hospital model for health care on the northern beaches, with one being the major acute hospital and one providing a complementary, but no less important, range of services. We hope to provide a greater range of services, particularly those that can meet the needs of an ageing population and provide good primary and emergency care.

We want those services to be staffed by competent and caring professionals, who have patient safety and wellbeing as their major consideration. In any process like this, the community needs to trust that the area health service, who are the stewards of public money, will make fair and decent decisions in allocating those funds to the health care of the community. The community needs to trust that the health service will consult them, listen to their needs and act with their needs in mind. I believe strongly that the health service has acted with fairness and honesty in this process and we have presented evidence to back this up.

Some groups in the community do not believe this and have presented their opposition and advanced their cause in ways that have surprised and distressed many of us. Our health service has always welcomed a diversity of views from clinicians and the community. We have striven to

recognise those views and have adopted professional and transparent processes for finding a solution where conflict existed. Some myths or misunderstandings have arisen during this planning process or during this inquiry. These myths relate to three areas: general health service planning and site selection, consultation and the interim recommendations for intensive care.

The advocates for Mona Vale Hospital being the major acute hospital have put forward a number of arguments. We do not believe these stand up to scrutiny, but further in the planning process they will be able to be tested again. We have heard people say that Mona Vale is the best site for the five hospital, being halfway between Barrenjoey and North Head, but planning where to site a new hospital needs to take into account access, travel time and distance, critical mass of population and location of other hospitals and health facilities. Northern Sydney Health asked experts in geographic mapping to help us identify the population centre of the northern beaches—that is the point from which the whole population was most equally distributed—and where the travel centre was, the point where travel times for all potential users were minimised.

The population centre was found to be in Cromer, both now and in the coming decade, while the travel centre was Brookvale. Potential hospital sites were then found which were within this general area, which includes Dee Why. The Northern Beaches Accessibility Study in particular, which was the study that was the final study done, which followed a great deal of community input and criticism of previous studies and community involvement in drafting its terms of reference and selection of consultants, found:

> ... the Brookvale sites are easily the most accessible of all the hospital sites, especially from the perspective of the study area residential population within the 10 minute travel time band. More people can reach this site in a shorter travel time than the other sites both now and in the future years 2011 and 2021 during the AM and PM time periods.

Mona Vale is approximately halfway between the extremes of the northern beaches. However, because the population is concentrated in the south, Mona Vale would lead to poorer access for most of the northern beaches community. A second argument we have heard is that making Mona Vale the major hospital would be the least expensive option. Land is a small proportion of the overall cost. From our investigations Mona Vale could easily be one of the more expensive options because of the need to put additional services at Royal North Shore for outflows from the southern portions of the beaches.

A third argument is that implementing the Mona Vale option would be far quicker than any other because the land is already owned by Health. It takes two to three years to plan, design and document a major hospital. Land purchase and rezoning, which if required could take up to 18 months, could easily be accommodated within this time without delaying the completion date. The pros and cons of Mona Vale and other sites will be considered through the next stage of the planning process.

Let me then move on to the important issue of community consultation. We have frequently heard the message that the community consultation process used by the health service was "flawed" or "biased". Let me respond to this charge. In 2002, when we established the Northern Beaches Community Consultative Health Planning Group—and we did that on the basis of a community forum and advice on how best to get community input into the planning process following criticism of previous methods of gaining that—we invited each council to nominate five community members to a group that would steer the whole consultation process. This group advised the area health service how we should consult, who should be consulted and what the options should be. They helped design questionnaires. They spoke to community groups and they sat on advisory committees. Together we put advertisements in the local papers, information on a web site, put up displays in shopping centres, distributed leaflets and conducted phone surveys.

Let us just consider the scale of this consultation: 88,000 newsletters were put into letterboxes; nearly 10,000 hits were recorded on the web site; nearly 3,000 written responses were received and documented; and over 1,600 people came to presentations. All of this information was collated by an independent consultant and presented to the health service in reports, which were placed on the area's web site. Among all our consultation strategies, the most scientifically rigorous was the Taverner Research phone survey, which was conducted by a market research company and reached a randomly selected 1,168 residents across the northern beaches, with a representative proportion from each LGA.

Among other questions, the survey asked people if they wanted one or two hospitals, and if two, which one they wanted to be the major acute hospital. This was a random survey, and could not be affected by large numbers of people filling in form letters. It showed that people wanted two hospitals, but wanted the closest one to them to be the major one—not surprising. Clearly, resolution of this question requires more than a vote by residents. It needs also to be informed by what is clinically feasible, what can be staffed and which decision will result in the best outcome for everyone.

Finally, I would like to respond to some issues related to the interim arrangements for intensive care put forward by the Greater Metropolitan Clinical Taskforce [GMCT]. And again, I would wish to emphasise that this is a separate process from the longer term planning. Our ultimate aim is to have a health service over two hospital sites that can improve the quality and complexity of care being offered locally to the residents of the northern beaches. In the interim, there are urgent. demands to ensure that intensive care services can be provided safely within the constraints of the two existing hospitals, Manly and Mona Vale. There are three myths or misunderstandings on this issue I wish to highlight.

The first misunderstanding is that Mona Vale ICU would close under the GMCT proposal. Mona Vale Hospital will retain a high dependency unit—level three ICU—which will be able to support complex patients, but patients requiring longer term ventilation or more complex life support would be transferred to Manly hospital or, indeed, other tertiary referral hospitals. The level of service at Mona Vale would be the equivalent of many more busy hospitals, such as Canterbury. Another thing said about these interim arrangements is that once intensive care services are moved to Manly, this will spell the end of Mona Vale Hospital.

Mona Vale Hospital will remain in its current location. The new, purpose-built hospital in the population centre would be networked with Mona Vale Hospital and supported by improved community health services. Issues of patient safety and critical mass have arisen in relation to the important services of intensive care and maternity under the current configuration. Professor Kerry Goulston and his team were invited to work with clinicians to find an interim solution. The problems with these services relate to a shortage of suitably skilled specialist staff that cannot be solved in the short term, and which is compromising patient safety. Last year, fewer than 2 per cent of overnight surgical patients at Mona Vale, that is, surgical only, required ventilation. Preoperative screening would be used to ensure that elective surgery patients with potential risk factors were referred to another hospital if required. This is an issue of utmost urgency. Planning for future services will seek to ensure that intensive care, maternity and other key services will be provided in a sustainable way, but we cannot allow risks to patient safety to occur at the present time while those changes are being implemented.

We have also heard that surgeons and other staff at Mona Vale Hospital have not been consulted about proposed changes to and networking of services. A working group has been established by the Northern Beaches Health Service, to implement either the GMTT recommendations or an agreed alternative. All surgeons and relevant stakeholders have been invited to attend meetings of this group, and that group is working through from a clinical perspective what is the best way to deal with this interim proposal. To date, no proposal as an alternative to the GMCT proposal has been advanced and considered sustainable, but we await the outcome of that process.

As the Minister has announced, Mona Vale Hospital will remain. To decide on the best location for the new Northern Beaches Hospital, we will now be reviewing the sites that many of you visited this morning together with community and clinician input, again against the criteria that were determined locally and those criteria were determined with community input. Once this is completed and a preferred site emerges, we will again engage the community and clinicians in a transparent process to identify how services should be provided across these two sites. The services will be networked to ensure high quality, regardless of site. When this is achieved, we will attract more staff to our service and increase the range of services we provide.

Northern Sydney-Central Coast Health has a legal and, more importantly, a moral responsibility to the whole Northern Beaches community to make the right decision. We have brought the extensive experience and expertise of clinicians and planners, and the goodwill and commonsense

of a large number of community members to this project. I hope that this inquiry will consider these issues objectively and fairly, and recommend that the considered views of clinicians and the community be heeded. We needed desperately to resolve the situation: it has been going on for far too long.

**CHAIR:** Dr Fisher, do you wish to make a statement?

**Dr FISHER:** Firstly, in the discussions I have had with people from the peninsula in the past week it comes forward that the naming of the site for the new hospital is an absolute priority before these matters are taken forward. Secondly, I pay great tribute to the nurses from Mona Vale in the intensive care unit. These nurses have worked for many years. Indeed, they first raised the issue of medical cover in 1990 and this has been an ongoing problem since then. These men and women have laboured under great duress for some time and this has now been compounded by the interaction they have had with some members of the community and other members of the staff which has been unfair and undeserved. Indeed, the nurses on the peninsular are leading the way on this project. They have already combined in terms of their educational activities and meet regularly and the nurses are now cross-pollinating and working in the two hospitals. I believe that the resolution is urgent from the point of view of nurses alone, not just patient safety.

When Craig Knowles became the Minister for Health there was then the Menadue report and the intensive care advisory committee was formed under the chairmanship of Dr Theresa Jacques and Ms Kate Needham. This group, largely at their own expense, visited every area of New South Wales and reported on the state of intensive care as an opening gambit for trying to improve the situation in intensive care. They visited the units in the North Sydney Area Health Service. Their report was in my submission but I want to read a very edited version of their conclusions. I assure this committee, although I have edited it, I have not changed the context of it. It reads:

> The optimum number of ventilated patients from 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 4 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. A significant and growing body of literature now documents the improved outcomes and even financial efficiency obtained following the employment of accredited intensivists to direct patient care in the ICU. With current clinical workloads being insufficient at both campuses to ensure optimum outcomes the uniting of both ICUs and ultimately the facilities are strongly supported. 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 the united combined purpose would stimulate morale and support all forms, of health care delivery on the peninsula pending the site 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.

A later report by this group discussed the problem of small metropolitan and rural units in New South Wales. Small metropolitan intensive care units are virtually a unique problem of New South Wales and there are major problems with sustaining these in many areas. Most of these units began as as the teaching hospital units did, as a one-man band, a person totally committed to providing care for that unit 24-hours a day, seven days a week, with very little support. Some of those units developed a critical mass and became effective intensive care units, some of these units were in hospitals that closed, and some of them were unable to reach the critical mass where other people could be justified and attracted.

The critical mass is very important, not just from the point of view of being able to employ colleagues to discuss cases with, but also in giving people enough to do and enabling the important things that make Australia the leader in the world in terms of intensive care survival. Those things are morbidity and mortality meanings, they are quality reviews, they are individual projects, they are individual programs, they are research, they are having social workers and having pharmacists being big enough to justify these people. One of the things we find when we visit the smaller units is that these things do not exist. And indeed in most of the small units when we begin to seriously look at the unit we find they were probably not as good as people thought. Northern Sydney Area Health Service is blessed with three such units—Ryde, Mona Vale and Manly—and with the new amalgamation we now have Wyong to deal with as well.

I note in reading the proceedings of this inquiry that all the people who have experience of intensive care support the GMTT plan. There is an implementation group on the peninsula that is considering four plans. I believe, of those the GMTT plan is the only one that is valid and is the only one that addresses the problems of critical care mass and the difficulty of recruiting intensive care specialists. There are a number of reasons for this, which I would be happy to discuss with the committee at a later date. The second thing is that I am concerned both as a citizen and in my official role at the number of misleading statements that have been given to the media, that have been given to the local populace and have been given to this group regarding the problems of dealing with small units in the Northern Sydney Area Health Service.

Mr Brogden stated in the media that if the proposed GMTT plan, which is supported by the intensive care community is implemented then people on the peninsula will die. This statement is correct. Mortality on the peninsula will be 100 per cent. There is nothing we can do to change that. The important thing is to put in structures that minimise the risk of patients dying due to error or due to not having fair access to facilities. I believe with my intensive care colleagues that the proposed plan for intensive care if implemented will reduce the prospect of adverse events.

It is said that patients will die during transport. I believe that is fallacious as well. One of the ways that intensive care, with Australia's unique geography, is able to survive is by having transport facilities equal to or better than virtually any other country in the world. It is extraordinarily unusual for people to die during transport. The people who may need transporting under the GMTT plan are generally the people who are not all that sick, who are patients who have surgery where they cannot be extubated and require ventilation. The Medical Retrieval Unit [MRU] has a great track record with moving critically ill patients, and these patients will be particularly easy to move. Indeed, in the Northern Sydney area we have set up a unique system which we call the automatic transport system where patients who have time-sensitive injuries which cannot be dealt with locally need to be transported they can be sent to North Shore without consultation. They just need to tell us that the patient is coming. This is to avoid the problems that occur with trying to organise beds which mean many phone calls. The rationale for this is that often those patients will be safer in the hands of the MRU or the paramedics than they will be particularly after hours in the emergency department.

It is said that patients with asthma will be disadvantaged. Of the 13 patients admitted to Mona Vale ICU because of asthma, two were ventilated, one was discharged in 48 hours and the other was transferred to Royal North Shore. When we studied asthma sometime ago when it was much more of a problem than it is now, we found that if patients were delivered to any hospital with an intact heart and with an intact brain they would survive. It was very unusual for them not to do so. Indeed, it is the paramedic transport that has been the major success in the treatment of asthma and the major inroads into asthma as a problem made by general practitioners and specialists. At North Shore we used to ventilate 20-40 asthmatics each year, we now ventilate two. I believe there is similar misleading information about obstetric patients which I will leave to my colleague.

There have been allegations made that the people who expressed an interest on the advertised intensive care positions on the peninsula were talked out of it by the intensivists there. I spoke to a number of those people myself. When the precise details of the activities of the units were explained to those doctors they did not wish to pursue the appointment. This was because of the cover available and the workload being too small. It is interesting to note that over this period there have been no problems with recruiting intensivists for Hornsby Hospital, which has a critical mass and a sound infrastructure. Mount Druitt and Auburn in similar positions have been unsuccessful in recruiting or retaining intensivists. Rightly or wrongly doctors who have trained for eight years to do intensive care wish to work in large units with colleagues.

The only coercion or bullying that has been brought to my attention is that alluded to by Dr Nolan before this committee. It is said that the surgeons and the anaesthetics are united in opposing this plan. The anaesthetists to whom I have spoken in the past 24 hours from the peninsula say that they would prefer the system as it was six months ago, but their real wish is that if there is a change in the intensive care backup that can be provided there should be a reorganisation of surgical activities. I have not heard one reason why the surgeons from Mona Vale could not do their major cases in another hospital with safer facilities.

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

It is alleged that this is a covert attempt to close Mona Vale and to sell off the real estate. Virtually all the planning for intensive care has been done by clinicians who are interested in patient safety and optimum facilities for the residents of the area and have no interest in real estate whatsoever. It has been alleged that this is an attempt to move services to Royal North Shore Hospital. Royal North Shore Hospital has the oldest intensive care unit in Australia and is in urgent need of reservicing.

It cannot expand in any way. Currently it has the largest number of no-bed days of any teaching hospital in New South Wales, although we have reduced the out-of-area transfers. The best thing for North Shore would be to have a much larger unit on the northern beaches so we could retain patients there and maybe send them patients. Is this a money-saving exercise? A budget for supplementary funding has been applied for and the service is likely to cost more. Surgery cannot be performed safely without an intensive care unit. I will leave that to Dr Cregan to deal with as a surgeon. It would seem to me that if that were so, there would be probably half the amount of surgery done in New South Wales than is being done now.

In summary, people with expertise in intensive care believe that the GMTT plan will improve critical care services on the peninsula. I believe that much of the alleged evidence which has been given to talkback and other media, politicians and to the community in general has been misleading; partly based on ignorance of intensive care and partly mischievous. I believe that if that plan or a variant of it is not implemented soon, intensive care in any form at Mona Vale will have to close. It is absolutely vital that whatever is necessary to augment the emergency department is done. If it is possible to recruit sufficient specialists to the unit—which if it happens will be only temporary I believe, because the demand for jobs in the bigger hospitals will increase soon—then maybe specialists, at least in consultation, should be available to both hospitals. Thank you very much for listening.

**CHAIR:** For the record, when you referred to the GMTT did you mean the GMCT?

**Professor FISHER:** Yes, the areas and letters keep changing.

**CHAIR:** I am not sure who may wish to answer this question. In relation to Mona Vale Hospital, I understand that a number of community groups have raised funds in the hospital over recent years, particularly in the past two years. Is someone able to indicate how much of the money that has been raised by community groups has actually been used to purchase the equipment for which the money has been raised?

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

**CHAIR:** When you said "a small balance", what are you talking about?

**Dr CHRISTLEY:** I will have to take that on notice.

**CHAIR:** A figure such as $80,000 or greater?

**Dr CHRISTLEY:** It is possible there would be $80,000 in the account. I will have to take that on notice, because I really do not know.

**Ms KRUK:** Chair, is there a specific concern behind your question?

**CHAIR:** Yes, that the hospital is to be downgraded and that funding being raised is not being applied to the equipment.

**Dr CHRISTLEY:** No, I deny that absolutely. I can give you the balance in the account.

**Ms KRUK:** Chair, we can also give you comprehensive information about the level of upgrade that has been undertaken at the hospital in the past 10 years if that is of interest to the Committee.

**CHAIR:** Why would NSW Health maintain an acute hospital at Mona Vale level three hospital if a new level five were to be built at Dee Why?

**Dr CHRISTLEY:** The level three and level five intensive care between Mona Vale and Manly is the interim proposal. When the new site is identified there will be service planning across the two sites. There has been no description of level of either site at this stage made in advance of the planning process.

**CHAIR:** Let us take that a bit further. If you have a level five hospital constructed, for example, at Dee Why and you are referring to an interim situation at Mona Vale—

**Dr CHRISTLEY:** No, the language of level three and level five has been a description of the interim proposal. The hospitals will be complementary and the nature of the services provided at each hospital has not yet been determined. That has always been explicit, we have always said that we would determine the services when the sites are identified.

**CHAIR:** Professor Fisher, in earlier evidence Miss Needham suggested that you wrote to John Brogden on 9 December. Is that correct?

**Professor FISHER:** I will check the date, I have a copy of that letter with me. I wrote because of my concerns about this process to all members of State Parliament who come from the peninsula and to the shadow Minister for Health. I believe I also sent a copy to the Minister for Health. Essentially my letter outlined some of the points I have made here. I have a copy of my letter but it is not dated I am afraid. It went to Brad Hazzard, Morris Iemma, Barry O'Farrell, Mr David Barr and Mr Andrew Humpherson. I received a response from Mr Hazzard and Mr Barr. That letter is part of my submission which I formally put in, and I have a copy of it with me. Do you have any specific questions regarding it?

**CHAIR:** I wonder why Miss Needham was so certain that you had written to John Brogden on 9 December?

**Professor FISHER:** Almost certainly it was, she is the co-chair of the committee with me. I most certainly would have asked for her advice prior to sending the letter.

**CHAIR:** There is no record of such a letter having been received at the electorate office or the parliamentary office of the Leader of the Opposition.

**Professor FISHER:** It was certainly part of my submission that I sent by email. I am happy to table it if you wish.

**CHAIR:** Where is a new level five hospital on the forward capital works plan for NSW Health?

**Ms KRUK:** Chair, I think I have answered that previously. Planning funding is allocated for the hospital on our forward capital works program. I do not have the details with me.

**CHAIR:** Of the six sites that have now been identified, it would seem that some, notably Brookvale, the golf club and Dee Why civic centre, involved the purchase of land, otherwise it is

outside New South Wales Government-held land. Does NSW Health propose to fund such purchases from the sale of existing sites? If so, could you give the details?

**Dr CHRISTLEY:** At this stage I do not think funding is allocated for the purchase of those sites, but funding would come. All projects come in a package of total project funding. Asset sales may or may not be part of that. It is generally government policy that where assets are surplus to requirement be considered for sale.

**Ms KRUK:** Chair, can I restate that. It is important in this regard: Obviously we have a number of sites that are on the table and I think the committee members had the benefit of seeing some of them this morning.

**The Hon. AMANDA FAZIO:** All of them.

**Ms KRUK:** Good. There are advantages and disadvantages. Obviously the capital implications will vary for some of the sites. There is a very clearly articulated process in relation to site disposal. If your concern is whether it is predicated on the sale of a particular site, no.

**CHAIR:** For example, Mona Vale is sitting on eight hectares. Of all the sites the Committee members have seen there has been an indication that no more than four hectares seem to have been proposed for any site. It would seem that some of that land could potentially be surplus to the need of a level three or level five hospital.

**Ms KRUK:** I think it comes down to the ultimate role of what the second hospital would be. As Dr Christley indicated, there would be a complementary role for Mona Vale Hospital. As I indicated in testimony last time, there is a range of obviously other than acute services that would also need to be provided from Mona Vale. Those factors would have to be taken into account.

**Dr CHRISTLEY:** A range of other things we consider as complementary related purposes; aged accommodation and so forth. In Health one opportunity to do things better is the co-operation between Commonwealth and State funded services. One thing I would like to see through this process from the health service perspective is to optimise the opportunity to co-operate at that interface, particularly when looking at the elderly. Mobilising the resources of Commonwealth and State to provide better integrated care is quite a potential.

**The Hon. MELINDA PAVEY:** Earlier you said that any land purchase is a small fraction of a cost of development of a new level five hospital. Would that be around $200 million for a level five hospital?

**Dr CHRISTLEY:** Probably a bit more than that.

**The Hon. MELINDA PAVEY:** Between $200 million and $300 million?

**Dr CHRISTLEY:** Of that order.

**The Hon. MELINDA PAVEY:** It is reported that the Dee Why site is worth about $40 million. You are looking at 25 per cent of the cost of a new hospital being the land, is that right?

**Dr CHRISTLEY:** Yes. If we translate that back to recurrent terms, our budget is over a billion dollars a year, and that is a relatively small expenditure to get the right result. The important thing in health planning terms is to look at the functionality and clinical benefits access of each of the options. We then translate that into a cost and make sure that in comparative terms the cost is factored in against other virtues of any particular health service configuration. That would be part of the value management study that we are now moving towards.

**Ms KRUK:** Could I clarify that Dr Christley has a number of other capital works in his area. Probably the most significant is the upgrade of the Royal North Shore Hospital. There is no expectation that the capital upgrades are met from within his own area of health service. From memory, I think the capital upgrade of Royal North Shore is a $500 million development.

**Dr CHRISTLEY:** $450 million in May 2002 dollars.

**CHAIR:** Dr Christley, earlier you referred to the importance of the clinicians' views, yet we have heard from some doctors who have very strong views about the closure or downgrading of the Mona Vale intensive care unit at this time. Why are their views not being considered?

**Dr CHRISTLEY:** Their views are considered. Their participation in some of the processes to discuss this has not been full. They have stated to me that they deliberately stay away from some of the GMCT processes so that they can come back later and conduct the sort of debate that I suggest spells out something about the strength they felt in their position. For whatever reason they are involved in the process. There will have to be some give somewhere; but where that is I do not know. My reference to clinicians was also about the longer-term perspective and on that one I can very confidently state that there is barely a diversionary voice from the health services recommended position except perhaps that are large number of clinicians would believe that we should have only one hospital. Although we listen to both voices, the proposal is for two.

**The Hon. CHRISTINE ROBERTSON:** Your submission states that at Mona Vale, over the past five years, approximately $10.2 million has been spent on maintaining and improving infrastructure. Projects over that time included a list of very powerful things such as the procurement of the first CT scanner on the northern beaches. Can you comment on why people are getting a perception that capital funding has not been spent on Mona Vale when you have made a statement that it has?

**Dr CHRISTLEY:** It is always difficult to work out why people get a perception. There is a range of capital developments across the beaches ranging from upgrades to emergency departments, building emergency medical units, upgrades to obstetric departments, new oncology wards and outpatient areas, CT scanners, airconditioning of theatres. They received good coverage at the time, but I suspect that points are made that probably get lost in the heat of the debate when points are being made that have a different view on where health service is heading. The evidence is of continued improvement in health services on the northern beaches, recognising the difficulties that strike us at times and the intensive care debate now is one of those. The paediatrics debate at Manly a few years ago was another one. We can grow and develop services where we do not have work force issues or critical mass issues to contend with. Where we have those work force and critical mass issues to contend with we can rationalise or reconfigure services.

**The Hon. AMANDA FAZIO:** The supplementary submission we received from Dr Christley reads at page 8:

> Ongoing discussions with surgeons and other medical staff have continued through the Greater Metropolitan Clinical Taskforce consultation process. There were specific meetings with surgeons at Mona Vale on 27 October and 2 November 2004.

Professor Fisher, I understand you were involved in those meetings, were you?

**Professor FISHER:** No, I do not believe so.

**The Hon. AMANDA FAZIO:** In that case Dr Christley may be able to answer my question. What have been the results of these ongoing discussions with surgeons and medical staff on the Greater Metropolitan Clinical Taskforce?

**Dr CHRISTLEY:** I have not attended any meetings that the Greater Metropolitan Clinical Taskforce has had with clinicians; I have thought it was very important that that was separate to the administrative discussions. There is no common view between the surgeons and the GMCT; that is being worked through the implementation committee that has now been set up by the Northern Beaches Health Service. Professor Fisher is on that group, as are the surgeons and anaesthetists, physicians, nurses, allied health professionals, and community representatives.

**The Hon. AMANDA FAZIO:** Professor Fisher, what do you think is the ideal intensive care unit configuration for Northern Sydney Health?

**Professor FISHER:** I think there needs to be a super specialty unit in one hospital which supports cardiac surgery and neurosurgery. The North Shore unit is the major neurovascular unit in the State. It is the only unit that can treat burns, trauma and spinal injuries, and therefore it is an essential part of it. Then we need units to enable less sick people to be looked after in their community wherever possible, with a service that is timely and expert. I believe there should be one intensive care unit on the peninsula. I believe we still need to make some improvements in Ryde hospital, which has a model that is functioning quite well but it can be improved. We certainly need an active unit in Gosford; they have a good unit with specialist staffing and a solid core of nurses and the various infrastructure things you need to make a good unit. We have only just started to learn about Wyong. I believe there is a proposal on the table from the intensivists at Gosford to look after Wyong. I think that can figuration is probably the best.

I am less certain about the numbers of beds or where the site of the level five unit should be on the peninsula in the interim, before the new hospital is built. Some years ago I met with people from both ends of the peninsula, BEACHES and Save Mona Vale, and they could both give me a very compelling case for that unit being at their end. I certainly decided that at that time there was nothing I could do to solve the problem. Indeed, I do not believe anyone will ever get consensus on both the site of the hospital and the site of the level five unit. Someone will have to make a decision and wear the flak.

The Mona Vale unit is the better building. Manly has the better infrastructure in terms of all the things that are needed to make a unit excellent. I guess I have a slight bias in terms of the patients who have been referred to North Shore over the years. I think I have seen more patients who have not been optimally managed from Mona Vale than I have from Manly. Again, that may be biased. I have worked at Manly and covered Manly when there have been no specialist staff there.

**The Hon. CHRISTINE ROBERTSON:** Dr Cregan, are there models of surgery that operate with level three high-dependency units that you can discuss with us?

**Dr CREGAN:** Yes, certainly. 60 per cent of elective surgery in Australia is carried out in private hospitals. The vast bulk of private hospitals have what you would loosely describe as a high-dependency unit at best. To carry out more major surgery, in the sense of major vascular surgery, thoracic surgery, et cetera, without the back-up of a large intensive care unit, I think is asking for trouble. You have to screen patients; you have to do them at an appropriate place. In my view, two ventilated beds of care is not an appropriate place to do major surgery. A high-dependency unit, however, will enable you to do 80 or 90 per cent of all the surgery you would need to do.

**The Hon. CHRISTINE ROBERTSON:** I understand that level six surgery is now sometimes occurring at Mona Vale. Is this correct?

**Dr CREGAN:** I believe so. I do not have any data to support that.

**Dr CHRISTLEY:** I think Mona Vale has stretched the margin at times. I think the safety of some of the things that have been happening is one of the issues we need to address as a health service.

**The Hon. CHRISTINE ROBERTSON:** We have received from Pittwater Council a copy of what I think is a pamphlet from the Save Mona Vale Hospital Committee together with a quite precise role elimination plan that someone has put together. I show you that document, which has been tabled through the submission. Could you give us some information about the complexity of working through role delineations for specific hospitals, in relation to services provided and in relation to specialty services? This document has been given to Pittwater Council as a document of fact.

**Dr CHRISTLEY:** I think this document is an attempt by members of the community to describe a set of levels and the interrelationship, to describe what they see as the potential hospital configuration on the Northern Beaches. They have put a range of levels across different services. There is an interdependency between different services. Just looking at the document quickly, it is hard to work out whether that is a rational thing that is put forward in this document or not. There is a huge science for this. I think one of the issues that has come forward is that a lot of the background planning work that has unfortunately been done by the Save Mona Vale group outside the planning

process involves people trying to interpret fairly complex documents. I think bouncing around between level six for an operating suite in a level five hospital is probably fairly fanciful. I guess that is something I would rather have the planners work through than have a document like this.

**Ms KRUK:** Madam Chair, I am always nervous to go here because this is where we lay people fear to tread. I think it is a document that purports to interpret the role delineation guidelines as released by NSW Health. I am sure one of the clinicians at the table would explain to you their purpose in more detail. In effect, it looks at what services a hospital can provide safely based on a whole range of factors, including clinical services, critical mass, et cetera, some of the issues that Professor Fisher picked up in his submission. To me, the document looks like a local interpretation of that.

The reason the former Minister, the current Minister and I have asked groups of clinicians such as the GMCT group to go out and work on some of the interim planning arrangements is to seek to apply the role delineation guidelines but to do it in a manner with local clinicians. What has been regretful—and I say this as a lay person—is where there has been disagreement expressed by clinicians that has one way or another been perceived as being political. Whereas, from my viewpoint that sort of disagreement would not be an unusual statement of events. Professor Fisher, can you assist me in this regard?

**Professor FISHER:** There is a document of which I am aware that relates what surgical services you can safely provide in relation to critical mass and intensive care services. That is an old document now, and I believe it is being revised. I think the overwhelming international evidence is that a critical mass is a very important thing in terms of the care of surgical patients, and indeed all patients who have severe illness.

**Reverend the Hon. Dr GORDON MOYES:** Dr Christley, with regard to the document that you just spoke about as being a local interpretation of various levels, would it surprise you if I were to say that the document came from a PFP Internet site from Royal North Shore Hospital?

**Dr CHRISTLEY:** That particular document would not have come from that site.

**Reverend the Hon. Dr GORDON MOYES:** Which site do you think it might have come from?

**Dr CHRISTLEY:** The role delineation document itself, which is the science for how you apply levels, I am sure did come from the Northern Sydney Health web site. However, that application, which describes a particular set of numbers to a particular hospital, is the product, I would think, of the Save Mona Vale group.

**Ms KRUK:** Madam Chair, can I ask that the document be circulated, because it causes a bit of confusion. That is not an area health service document.

**Reverend the Hon. Dr GORDON MOYES:** Ms Kruk, are you saying it was not taken in November 2002 from a PFP Internet site?

**Ms KRUK:** Dr Christley is best placed in terms of what the source of the document is. But I do not want any confusion in relation to what the document purports to do and how it links back to Dr Christley's planning processes.

**CHAIR:** It is an appendix to one of the submissions we have received.

**Dr CHRISTLEY:** It is the Save Mona Vale Hospital submission. In circulating the document they advocate the case for Mona Vale Hospital as level five—I think it was called "Mona Vale, the Perfect Location for a Hospital", or words to that effect—and put forward a configuration of services between two sites. We would come up with a document similar to that at the end of the next phase of our planning process, where we had sat down with clinicians and looked at how services would be distributed across the two hospital sites and come up with numbers that would describe the level in each of those sites.

**Reverend the Hon. Dr GORDON MOYES:** Could I push a little further on that. Dr Christley, can you confirm that the approximate mix of services being considered for the site on the Northern Beaches, regardless of where the site is, does include, however, a level five metropolitan hospital of about 350 beds?

**Dr CHRISTLEY:** The original planning said that you need about 350 beds to provide services for the Northern Beaches—that is the current public sector, not changing the flows to the private sector. You then add whatever you are going to do with flows from the private sector. We believe that with new facilities there would be a reversal of flows from the private sector to the public sector. You then work out your service configuration between the two sites, and you come up with the service configuration and bed numbers that you would end up with between the two sites.

What we have said—and I go back to my evidence at the last hearing—is that, in terms of looking at the capacity of sites, we have planned to push in the margin in size of hospitals, if we have not planned for the size of the hospital. There is work in the first PFP that describes numbers. All of them are up for review because there is a range of assumptions built into them.

**Reverend the Hon. Dr GORDON MOYES:** Are you still planning for all six sites the potential of a 350-bed public hospital, plus a co-located private hospital, plus community health facilities?

**Dr CHRISTLEY:** We have looked to see whether we could accommodate such options. We are not planning for those. But in terms of considering the feasibility of the sites, they needed to be able to accommodate that order of magnitude of health service.

**Reverend the Hon. Dr GORDON MOYES:** Do all six sites provide that?

**Dr CHRISTLEY:** All six sites do that.

**Reverend the Hon. Dr GORDON MOYES:** In your previous evidence you identified that you had minimum land requirements of approximately three to four hectares, is that right?

**Dr CHRISTLEY:** I do not think I quoted that at all, but go on.

**Reverend the Hon. Dr GORDON MOYES:** I was looking at the plans on the material you released on the weekend. Do you make allowance for all co-located private hospitals on all sites?

**Dr CHRISTLEY:** Yes.

**Reverend the Hon. Dr GORDON MOYES:** Can you give us the area of each of the six sites, because it is not mentioned?

**Dr CHRISTLEY:** I might defer to Michael on that.

**Mr ROXBURGH:** On the Dee Why site we are looking at about 3.1 hectares. I have to go from memory a little bit here. On the greenfield Brookvale option we are looking at 5½ as an ideal. On the Brookvale bus depot we are looking at 3.1. The Beacon Hill site is 4.5, and that leaves Mona Vale at 8.8.

**Dr CHRISTLEY:** The difference between the different sites is more about the constraints of the particular site. When we talk about the Brookvale greenfield, we are allowing for preservation of vegetation around the edge, water flows, and so on, buffer zones. When we talk about Frenchs Forests, we are allowing for Duffys Forest vegetation and so forth. I think we have got a little bit overhung about size. I think St Vincent's Hospital is built on two hectares.

**Reverend the Hon. Dr GORDON MOYES:** I am not hung up about sites, what I am hung up about is conflicting commentary about the sites. For example, you have just quoted to me, I think, Dee Why 3.2 hectares, is that right?

**Mr ROXBURGH:** 3.1 hectares.

**Reverend the Hon. Dr GORDON MOYES:** We had evidence from Warringah Council that there would only be 2.6 hectares available. What happened to the other half a hectare?

**Mr ROXBURGH:** I think it has been reasonably well discussed and documented by now that the Dee Why Civic Centre site is not just about the Dee Why Civic Centre site, but adjoining land.

**The Hon. TONY CATANZARITI:** Is 2.4 hectares enough land on which to build a level-five hospital?

**Mr ROXBURGH:** In that regard, Stephen just mentioned probably a reasonable example. It is not something you would strive to do, it is something you would try to make better than that, but a good example of what can be done is St Vincent' Hospital at Darlinghurst here in Sydney. You have a private and public hospital co-located. You have a 290-300-odd bed public hospital and you have, from memory, a 230-odd bed private hospital co-located on approximately two and one half hectares.

**Reverend the Hon. Dr GORDON MOYES:** And impossible parking.

**Mr ROXBURGH:** It started that way before redevelopment, and traffic conditions along Victoria Street were a lot more difficult than they are now. There was not an ambulance slipstream as there is currently and neither could the ambulance drivers previously control the traffic lights. There have been vast improvements and I think the hospital is said to be working extremely well.

**Reverend the Hon. Dr GORDON MOYES:** Dr Christley, can you confirm the exact mix of services in a second hospital?

**Dr CHRISTLEY:** To repeat, this will be different depending on where the sites are. That is why we need to identify the sites. When we identify the sites—

**Reverend the Hon. Dr GORDON MOYES:** Will the second hospital, whichever one it is, will it be—

**The Hon. AMANDA FAZIO:** Will you let him answer the question before you talk over him?

**CHAIR:** Dr Moyes can finish asking the question.

**Reverend the Hon. Dr GORDON MOYES:** I was asking, before I was interrupted, the mix of services in an acute hospital, will it have what might be described as a full range of services in the second hospital?

**Dr CHRISTLEY:** If you are talking about an acute hospital and a full range of services, it will not have a full range of services, because things like neurosurgery, bone marrow transplantation, and so on, only happen in a limited number of hospitals, so no hospital will have a full range of services.

**Reverend the Hon. Dr GORDON MOYES:** Will it have, for example, cardiovascular, the second hospital?

**Dr CHRISTLEY:** Are we talking about the major acute hospital?

**Reverend the Hon. Dr GORDON MOYES:** No, the second hospital.

**Dr CHRISTLEY:** I would be very doubtful if the second hospital would have cardiovascular, because you are then talking about a level-five service.

**Reverend the Hon. Dr GORDON MOYES:** Can you go back to my original question, what range of services will be in the second hospital?

**Dr CHRISTLEY:** That will depend on what the clinicians and the community determine is the best service mix between the two hospitals.

**CHAIR:** Earlier you said the mix may be dependent on the sites. Can you elaborate on that? What is dependent on the sites?

**Dr CHRISTLEY:** Can I use an example? Maternity services have been put aside for the moment in this debate but at a point in time within the next five years inevitably they will not be sustainable. We have been able to operate an innovative model between North Shore and Ryde Hospital, where we have a midwife-led service at Ryde, which is supported out of North Shore. If there is an emergency or the need for a patient to be transferred from Ryde to North Shore it takes 11 minutes to get them from one hospital to the other. So, it is very safe to offer a midwife-led service in the smaller hospital. If that distance was half an hour—I will defer to Professor Morris—there may be a different answer to that question. So, the answer to your question is it depends on where the sites are and how we plan the service configurations between the two hospitals in consultation between clinicians and community.

**Reverend the Hon. Dr GORDON MOYES:** In your earlier evidence, under "Fairer Access", I note you kept a balance between access 30 minutes travel time and 20 kilometres. Are you still adhering to that as a basis?

**Dr CHRISTLEY:** I do not believe I gave evidence around 30 minutes or 20 kilometres.

**Reverend the Hon. Dr GORDON MOYES:** It is in appendix 25 of your submission to this inquiry under 2.2.

**Dr CHRISTLEY:** They are the criteria—and remember all criteria need to be relative to one another—proposed by the emergency department services implementation group, which is one of the clinical groups set up, a parallel one to Professor Fisher's clinical group. That is a criterion they put forward. They also say it is a balance between criteria. Not one criterion is absolute and sufficient unto itself.

**Reverend the Hon. Dr GORDON MOYES:** I notice in the material you released on the weekend you have dropped any reference to distance. Is that no longer a criterion?

**Dr CHRISTLEY:** The criteria we released on the weekend were the ones that have been used by the health service for a long time. The particular one you described was framed by the community group, as I recall it, who advised us on criteria to the northern beaches community consultative health planning group.

**Reverend the Hon. Dr GORDON MOYES:** Can you take on notice and give us a distance from, say, Palm Beach to each of the six sites?

**Dr CHRISTLEY:** I can give you that. I remind you though, that we are talking about a two-hospital configuration, not a one-hospital configuration and I suggest your question is not wholly germane to the debate.

**Reverend the Hon. Dr GORDON MOYES:** Let us take just the Dee Why site. Would you care to give us the distances involved on the Dee Why site?

**Dr CHRISTLEY:** I think it becomes a matrix given that Mona Vale is a fixed site. It really becomes an issue of what is the distance to Mona Vale than what is the distance to other locations. I think your Palm Beach question is answered by Mona Vale being a site agreed and determined through the health planning process.

**Ms KRUK:** I would like to refer to Professor Fisher's comments, which basically indicated that we face an issue about the sustainability of intensive care services as a whole if the current situation goes on. We are then talking of basically having to transfer people from the peninsular to Royal North Shore. Distances in that regard are obviously far more significant. What we are trying to

do in setting up an interim set of arrangements is to ensure the sustainability of these services in the short to medium term. Professor Fisher, am I right in saying that?

**Professor FISHER:** Yes, I believe that is true.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** It has been put to me in a submission from some private hospitals that the size of hospitals is no longer particularly relevant. It is a question of service mix. It was said by Dr Cregan that 60 per cent of surgery in New South Wales is done in private hospitals. I understand that 70 per cent of elective surgery on the northern beaches is done in private hospitals. According to your answer, Dr Christley, to the question on notice, there were 1,164 overnight surgical admissions to Mona Vale in 2003-04 and only 22, 1.9 per cent, required ventilation. If that happened in a year that would be less than one a fortnight being transferred. Surely you would not build a new hospital for the sake of one transfer a fortnight?

**Dr CHRISTLEY:** I might pass that to Professor Fisher in the first place, if I may.

**Professor FISHER:** I think also, fortunately or unfortunately, intensive care does not depend solely on surgery. Indeed, the majority of patients in Mona Vale intensive care are medical patients. As our population ages, the number of medical patients is going to increase and both medical and surgery patients will be in intensive care longer and probably have poorer outcomes. But, sure, you would not build a new hospital just to deal with those 22 patients. Indeed, I do not believe you would staff a level-five intensive care unit just to deal with those 22 patients. I think the combination of those two hospitals to provide an intensive care unit for the people on the peninsular capable of achieving excellence is a important and valuable goal.

**Dr CHRISTLEY:** I think there have always been two possible outcomes. One is that we keep the hospitals where they are and the highly complex services move from the beaches to North Shore, or we change the configurations to try to make one of the hospitals the more acute hospital and retain acute services on the northern beaches. If you look at the workforce statistics, the Australian [Medical Workforce] Advisory Council figures for intensive care, you need a population of around 250,000 to support an intensive care unit. You need similar numbers to support a fully fledged emergency service as well. You can have satellites from that but it really comes down, and I have argued before, to what level of service do we want to offer the people on the northern beaches? Do we want to offer them level-three services, which ultimately would be in both hospitals if we maintain this huge geographic split between the two so they cannot effectively work together, or do we want to provide more services. If there was an easy answer, believe me, we would have taken it years ago, but there is not an easy answer to that.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You are going to have to rebuild North Shore. A devil's advocate would say it is not all that far from the northern beaches. With the number of transfers you are getting if you do not admit people who would need those transfers, in other words, you do not do your elective surgery on your thoracic or bad cardiovascular cases, why do you not simply do level three or level four in the hospitals you have except that you have to transfer them to a new hospital at North Shore which is not that far away and do a more population-based one based on the proximity of lower-level hospitals? People in the country are travelling a lot further than from Mona Vale to Manly or North Shore.

**Dr CHRISTLEY:** As I said before, that is a potential outcome. It is not one that is favoured by the community or the clinicians. Access to North Shore is not good. Travel studies show the length of time it can take to get to North Shore in various peak times and others. It is not a particularly accessible hospital. We have to build the capacity somewhere. It is more expensive to build that capacity in a level-six facility than it is in level-five facility, so we are not saving any money by not building as high a level of service as we can possibly provide as close to the population that needs it. When we went through our early planning exercise with clinicians, one of the options put forward and then torn down was that we could build one acute hospital in Chatswood or somewhere like that and have everything go to there. These things are put up to be torn down. The view was that combination of getting a balance between access and quality and sustainability in our workforce issues was such that you could have three major acute hospitals in the old northern Sydney—one for a 250,000 population, one of them, as Professor Fisher said, picking up the tertiary referral role, and the other

providing safe care to sick people close to home. And then other hospitals could fill a complementary role to that.

**CHAIR:** Given the reference you made earlier to the Ryde-North Shore maternity relationship—midwife, maternity—is there any proposal not to have maternity at either of the northern beaches hospitals and simply to have midwives?

**Dr CHRISTLEY:** We have certainly looked at that as a solution for Manly at the moment because there are issues supporting Manly at the moment. They are not there right now, today. They appeared as if they would be there six months ago but we have been able to keep the roster going. The difficulty in trying to do it Manly to Mona Vale or Manly to North Shore is that the distance is too big. If there was misadventure we would not be able to cover that. I might ask Professor Morris to make comments on maternity service configurations because he is the expert in that regard.

**Professor MORRIS:** Across New South Wales at the moment there are changes to the provision of maternity services. That is guided by the principles of choice, access and risk management. Recently we have looked at the number of women that require admission to intensive care following childbirth in a paper about to be published this week, I think, in the *Medical Journal of Australia*. We have shown that of women who are low-risk the likelihood of admission to an intensive care unit is 0.1 per cent, one in 1,000. The majority of those women who are admitted would not require major cardiorespiratory support but perhaps fluid monitoring and things like that. So the likelihood of a low-risk woman requiring admission to an intensive care unit is quite low.

We now recognise the need to manage risk so the majority of women who may end up requiring higher-level tertiary care can be identified either on the background of medical risks or problems prior to pregnancy or problems arising in pregnancy like placenta previa. This is quite a sea change and a paradigm shift for the management of maternity services. As we implement the changes we recognise that there are women that can be identified as being of acceptably low-risk who can be managed by a primary model of care delivered either by midwives or by general practitioners. It is quite exciting times for maternity services. Our area health service is leading the way with models such as Ryde. We are being approached by people throughout the country asking how they can implement this, because it is very necessary.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Is this not a case of obstetricians more or less leaving obstetrics? The percentage of births being done by obstetricians is falling, is it not? It has fallen dramatically in New Zealand. It is contracting to much more centralised services. Midwives are effectively filling the void, with the problems mainly being their getting liability insurance, surely?

**Professor MORRIS:** It is certainly complex but I think it would also be fair to say that traditionally in Australia there has been a fairly patriarchal delivery of maternity services. That is not the case in parts of Europe. For instance, in The Netherlands 40 per cent of deliveries still occur at home. We have been responding to women's choice. Some women choose the obstetrician-led model, but there equally are women who prefer a lower level of midwifery-led care. They certainly deliver outcomes that are as good as if not superior to the traditional obstetric-led model. We now recognise that this is a very suitable model of care for low-risk women.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Surely the paternalistic "you cannot do anything without an intensive care unit" model is effectively being rejected by the mothers and also rejected by the fact that the obstetricians, as I said, have gone into larger and larger hospitals in general, is it not?

**Professor MORRIS:** There are certainly considerable work force issues. More than 50 per cent of current trainees in obstetrics and gynaecology are female. Many of them choose sub-specialties where they are not required to be on call 24 hours a day seven days a week. That means that we need to be more innovative in how we deliver care. Also, it is occurring at a time when what women choose and wish is also changing. It is exciting times for maternity care provision. I do not think it is just a question that we no longer have the obstetricians to deliver that care, but I think it is one key issue.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Many of them are going into IVF so they do not have to get up in the night. While one might be all for women obstetricians, the other problem is that many women GPs do not work full-time. So for every graduate you might get only three days of work.

**Professor MORRIS:** That is true but I think what we are about is midwives and obstetricians working more closely together.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** In terms of delivery of obstetric services on the North Shore, an obstetrician gave evidence last week that he would not like to do deliveries without an intensive care unit available.

**The Hon. CHRISTINE ROBERTSON:** He did not.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** I think he did. He said very close to that. Yet he had never sent a patient to intensive care. So is that not the tail wagging the dog in terms of the provision of these sort of services?

**Professor MORRIS:** I think we have data to suggest that the likelihood of a woman requiring intensive care support is very low. If someone has been practising in an area where the service is there, even though they have not used it, change always creates feelings of uncertainty. But I think we have very strong data to suggest that you can deliver a very safe maternity service without an intensive care service on site.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** I would have thought so. In the sense of maintaining obstetric services, in Europe where they have more home deliveries, they do have a flying squad, do they not?

**Professor MORRIS:** That is right. Obviously, the provision of any maternity services needs the appropriate support services for that configuration. Dr Christley mentioned what we have in place at Ryde Hospital, a model that has generated considerable debate and certainly opposition from my specialty and my colleagues. But I think in the first 12 or 18 months of its inception it has been shown to be acceptable and safe. We have a system in place for obstetricians to attend if there is a level one category emergency. In the first 12 months that has not occurred.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Given that in Campbelltown Hospital we almost reached high farce in keeping the maternity unit open at about $750,000 a year and we have these you beaut medical retrieval systems that Dr Fisher was telling us about are the best in the world—and he is probably right—why do we not have a flying squad here in obstetrics in order to deliver services more in the home and less needing of big centres?

**Professor MORRIS:** The provision of maternity services is undergoing a lot of restructuring at the moment and certainly many measures, including the provision of flying squads, are being considered.

**Dr CHRISTLEY:** If I may, the health service's position has been that you do not need an intensive care service to support a maternity service. That is not part of our planning. The only reason that issue came up was the action by the Mona Vale clinicians over Christmas. But every bit of evidence that has been heard has said that you do not need an intensive care unit to support a maternity service. Our philosophy is very much as you are espousing, I think, that what we want is to provide a range of options for women who choose different delivery options.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But he did hint at the idea that there would be only one maternity service on the northern beaches.

**Dr CHRISTLEY:** My comment was around the obstetric work force and the capacity to support with obstetrics rather than any other comment. It was not related to intensive care.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You were talking about rationalising maternity services on the northern beaches, which I took to mean that you would only offer maternity services in one place, and that would be in the new hospital.

**Dr CHRISTLEY:** No, what I said was that it was easier to support a midwife-led model if you have a geographical proximity so that that support could be accessed. It became more difficult the greater the distance from the unit where the obstetricians and paediatricians and anaesthetists were versus where the midwives are. I gave no definitive comment about anything, because at this point we are not clear on where the site for the new northern beaches hospital is and we do not know how to translate that into service options; nor have we sat down and done that detailed planning. I reiterate that I express a concern that if we were to have work force issues in one of those two hospitals in their current site, Manly or Mona Vale, it is a long distance to the next. So supporting a midwife-led service would be more difficult in that context than it might be if the hospitals were closer together.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But you have a gun medical retrieval service already. Is not maternity support, as was just stated, mainly about transfusion and quickly and not so much about ventilation and so on?

**Dr CHRISTLEY:** There is a range of things it is about.

**Reverend the Hon. Dr GORDON MOYES:** Can I follow up on the medical retrieval unit comments with Ms Kruk? Professor Fisher said that we have one of the best in the world. It was described by Dr Arthur Chesterfield-Evans as a gun retrieval service. When Mrs Needham was giving evidence she gave an example of category one patients at Auburn hospital who said that 80 per cent arrived within 60 minutes. Dr Jollow said it was not unusual for a four to six hour wait to transfer patients. Could you tell us about the data that you have on medical retrieval unit waiting times for Manly and Mona Vale?

**Professor FISHER:** First of all, these things are prioritised. That may sometimes be unfortunate. If the patient is safe where he is and there are other patients who are unsafe where they are the shift may take a little longer. Dr Manning, who runs the medical retrieval unit, has provided us with some data which Dr Phipps provided. If this is not tabled I am more than happy to table it. In the calendar years 2002, 2003 and 2004 there were a total of 52 transfers from the Mona Vale hospital conducted by the Sydney Aeromedical Retrieval Service. Of the 52, seven were high clinical emergency transfers; 23 medium clinical urgency transfers; and 22 low clinical urgency transfers. All of the high urgency transfers were conducted by helicopter; 38 of the medium and low urgency transfers were undertaken by road, and seven by helicopter.

One percent of the high urgency cases had a team at the patient within 60 minutes; 78 per cent—18 out of 23—medium urgency cases had a team at the patient within 120 minutes; and 100 percent of cases within three hours. Ninety-five per cent—21 out of 22—of low or no urgency clinical cases had a team at the patient within three hours. High urgency cases are infrequent. All high urgency cases were conducted in clinically appropriate timeframes. Medium urgency cases were conducted in clinically appropriate timeframes. There were no documented clinical incidents, death or deterioration with any of the patient transferred from Mona Vale by adult medical retrieval teams between 2002 and 2004. There were a total of four deaths in transit out of 2,757 total inter-hospital transfers undertaken by Sydney Aeromedical Retrieval Service from 2002 to 2004.

**Reverend the Hon. Dr GORDON MOYES:** What do you have to say about Dr Jollow's evidence that it was not unusual for a four to six hour wait?

**Professor FISHER:** I guess these are for lower priority. Normal transfers go through the medical retrieval service. Some of them are done directly by ambulance, and I guess that is a problem with patients who are not transferred through the service. It is a bit like waiting lists: where better to wait than on a waiting list? Priority is given to patients who are in situations which are unsafe.

**CHAIR:** Will you table the document from which you are quoting?

**Professor FISHER:** Yes, certainly.

**Professor MORRIS:** Sometimes the need to transfer patients from Mona Vale will be because a pregnant woman is at risk of delivering pre-term and therefore the need is for the availability of a level three neonatal intensive care bed. Even though North Shore obviously services the need for all its feeder hospitals, sometimes it is necessary to locate one in one of the other centres. That process can often take several hours and may in part account for Dr Jollow's comments.

**Reverend the Hon. Dr GORDON MOYES:** Dr Christley, to finalise a few seeming inconsistencies or issues that I picked up in what you said, you indicated a number of times that Dee Why is the preferred site. You have also indicated that the site would need to have at least some of the Salvation Army land added to it. Have you had any conversations with the Salvation Army about that land?

**Dr CHRISTLEY:** I have not. Some people who are looking at site feasibility have. They are preliminary but there have been some discussions.

**Reverend the Hon. Dr GORDON MOYES:** Do you have any indication that the Salvation Army intends to sell all or some of its land?

**Dr CHRISTLEY:** I do not think I want to speak for the Salvation Army but I believe—

**Reverend the Hon. Dr GORDON MOYES:** No, I was asking whether you have any indications that it would be willing to sell.

**Dr CHRISTLEY:** I have an indication that we may have a positive ground for discussions but I would not want to go further into that.

**Reverend the Hon. Dr GORDON MOYES:** Would your plans involve resuming that land?

**Dr CHRISTLEY:** No, we are not looking at resuming the Salvation Army land.

**CHAIR:** Can I clarify that use of the word "resume"? Are you looking at acquiring the land?

**Dr CHRISTLEY:** We would be looking at acquiring, yes, but resume has a different connotation.

**Ms KRUK:** My understanding is that all of the sites would have to undergo a due diligence process anyway. We thought it was important, given the community debate and some of the concerns about misinformation, that people see the sites. I think Dr Christley has made it quite clear that that is not committing parties to it at this time.

**Reverend the Hon. Dr GORDON MOYES:** Ms Kruk, do you agree with Professor Goulston who, when he gave his evidence, said that "it does not matter so much whatever site it is, frankly, so long as the staffing is first class"? Do you agree with that?

**Ms KRUK:** What was the context of his comments?

**Reverend the Hon. Dr GORDON MOYES:** It was concerning the site for a new northern beaches hospital.

**Ms KRUK:** I think it is consistent with the evidence you would have heard from all parties that the site considerations are one component and the clinical service considerations are another.

**Reverend the Hon. Dr GORDON MOYES:** No, his point was that it does not matter so much where the site is so long as, frankly, the staffing is first class.

**Dr CHRISTLEY:** Can I put the context around those comments? They are probably comments that Ms Kruk has not heard in context. He was talking about intensive care services at the time and he was then making a generic comment about services not specifically related to the northern beaches.

**Ms KRUK:** Certainly, the advice that he has given me is quite consistent with the advice that Professor Fisher has given the inquiry today in relation to intensive care services. Can I say quite sensibly that none of the clinicians who have advised me in this regard have a wish to proffer what is the ideal physical location. Their advice has been largely factored around clinical services configuration issues.

**CHAIR:** Professor Fisher, in your opening statement you said, "small units, they are not as good as we thought." Can you elaborate on that?

**Professor FISHER:** Intensive care has become much more complex and difficult. Intensive care in this State began, even in the teaching hospitals, usually with one clinician who worked day and night and then attracted two, then either attracted a critical mass or fell by the wayside. In particular, the in-depth study done by the people in the western region of Auburn hospital; everyone believed the guy who worked there was a complete saint and a very good clinician, but when they went in in detail and looked at the outcomes of this hospital over a number of years they were not acceptable. I think there have been similar findings when they started bonding between Blacktown and Mount Druitt at the meetings I attended out there. While it was believed that what was going on there was fine, again when people went into what was happening there in detail they had really not kept up with the standards of intensive care that were acceptable for the year 2000 plus.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Are you not comparing very elaborate units with a large number of clinicians, registrars and residents, as opposed to the old one where there was one dedicated person, a registrar who was reasonably savvy and some pretty savvy nurses?

**Professor FISHER:** Certainly one of the things, when we actually looked some time ago at outcomes in hospitals across New South Wales based on APACHE scores which had been checked, proven and validated, we find that the differences in outcomes are not all that significant between Tamworth, Ryde and North Shore, for example. But as I alluded to before, part of that is that the sickest patients are moved out and are ticked off in the box that says, "left the unit alive", and may well perish somewhere else. You looked puzzled. Am I not making myself clear?

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Not really. You are saying that the results of those units are the same because of the transfers. That is fine. If the units are doing what they can do and transferring what they cannot do, what is the problem with that? Why then do you have to build larger hospitals with larger intensive care units? Why could you not have two on the northern beaches and, for example, send them to new North Shore?

**Professor FISHER:** I am sure, though we probably have not reached it yet, just as there is a critical mass at the bottom end, there will also be one at the top end when an intensive care unit becomes too big to be efficient.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Surely it divides itself into two empires—

**Professor FISHER:** I am sure we can do that.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** —and clinicians beaver away at their rivalry for a while.

**Dr CHRISTLEY:** Can I perhaps go back to when we were probably both interns and residents? I remember working in intensive care units working under the model that Professor Fisher is outlining of the single intensivist, and there were people who suffered because there were no skilled and experienced staff around. The whole contention now is that wherever you enter the system, wherever you are, you need to be in a place that can provide you with an equal standard of care and I think that is the fundamental about this debate. It is whether the intensive care units in the current configuration on the northern beaches are safe places for patients and whether they will remain safe places for patients into the future. Given that the intensivists have told us that they do not believe that is the case, I as a health service manager feel fairly motivated to see some change in the way we do business.

**Professor FISHER:** The other things that we found are that the things that we believe are important in producing excellence, such as morbidity and mortality reviews, targeting problems, finding problems, did not exist in any of the smaller units. The other thing that tends not to be done well in these units is that, as you properly alluded to before, there are major problems now in the way intensive care has changed with appropriateness, with providing people with care from which they will benefit and which is care that they want. There tends to be, I think in smaller units, particularly when someone is on there own and has no-one to talk to, I think there is a lot more inappropriate prolongation of dying than there may be in units which have effective systems and experienced people who are used to dealing with this.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Are you suggesting that the decision to let people die is made more quickly and more efficiently in bigger units?

**Professor FISHER:** I can provide you with some evidence. In the northern region, for example, one of the complaints of the nurses in Ryde is that there is no-one there who will actually say, "Stop this, this is not in keeping with the patient's wishes" and this burden is falling on the nurses. It is something we are addressing at the moment, but yes I believe it is slow.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** This is a personality factor, to a large extent, because the whole issue of dying is only being addressed by a few people, admittedly yourself among them.

**Professor FISHER:** I do not know if it is a personality factor. It is a factor in New South Wales that 80 per cent of the people who die in intensive care units in this State die when something is being withheld or withdrawn, when the goal is comfort and dignity and not cure.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Eighty per cent of deaths.

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

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** The point you are making though is that if you saying, "Well, in 80 per cent of cases we could have kept going but we elected not to", if you then say in a smaller unit, "We did our best but they died", the outcome may well have been the same. So what you said was a bad outcome in the small unit may well have been then triumphed as a very good outcome in the bigger unit.

**Professor FISHER:** Yes. We have taken patients from other hospitals to die—absolutely no question.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** That is a very expensive outcome, in a sense, is it not?

**Professor FISHER:** I think people who pay the amount of taxes the people in New South Wales do are entitled to that. For someone to manage death as appropriately, kindly and in as dignified a manner as possible, I think that is a valid function of an intensive care unit.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You do not think that intensive care units need to be looked at more closely in terms of their cost benefit? It would seem that with the lack of admission policy, the lack of a dying policy, the lack of achievement of organ donors, the amount of money being spent per quality achieved is perhaps excessive in intensive care units.

**Professor FISHER:** It is a huge problem. One in 11 people in Australia, according to our figures, now die in an intensive care unit. In the United States it is one in five. We are heading for those figures. The United States estimate that by 2020 they will need twice as many intensive care units for people to die in. It is something we are very cognisant of and very concerned about. Most

units in this State will have policies. The guidelines for end-of-life care have just been released. It is a very important part of what we do, which we take very seriously.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Coming back to my contention that the tail is wagging the dog with intensive care units determining the sites of hospitals, is it not better to have convenient hospitals to people, with one at the top and another at the bottom of the peninsula and let the intensive care sort itself out with transfers?

**Professor FISHER:** If you take that approach there will be no intensive care on the northern end of the peninsula within six months. But I do not believe people will work—there is a shortage of people for a start. That shortage is likely to get worse. People who train in intensive care want to work in busy intensive care units. I believe that some of the activities that have occurred on the north of the peninsula have telegraphed to a very small community of specialists that this is not a place that would be a good place to work. If we cannot form one unit that supports both of these places but shifts all the sick patients to one place in the interests of safety, Mona Vale intensive care will fall apart.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** When you talk about the difference between a high-dependency unit and an intensive care unit, presumably you are saying that if they are ventilated they go to intensive care, it is no longer high dependency. Is that the—

**Professor FISHER:** It is a criteria that is used and bandied about a lot, and it is part of the way that funding is allocated for intensive care units in this State. They have tried various different ways, and one of the funding things is that 70 per cent of patients being genuine intensive care—sorry, if you look at the number of ventilated patients and call them genuine intensive care patients, and then add a factor, say 3 per cent or something, you get pretty close to what is an intensive care patient. But as you will well remember—and it is one of the ways the figures on the peninsula have been fudged—to actually stop someone being ventilated may be very much more difficult, very much more stressful. People with cardiac failure, for example, who are not classed as ventilated but require all sorts of other things may be far more complex people to look after and far more expensive than someone with a broken neck who is on a ventilator and needs a change of tubing and food once a week. So ventilation is a marker, but there are certainly other people whose diseases are being prevented or treated who are genuine intensive care patients.

High dependency is a whole new set of difficulties. We do not really know what to do with it. Both the college and the intensive care task force are trying to prepare position statements and recommendations on how to look after high-dependency units. Most of the thinking now is that they should be part of intensive care units, apart from people who are high dependency because they need particular surgical skills such as burns dressings or management of lots of drains and tubes and things like that. There is just a whole new set of things that we have to deal with.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** But you have an increase in technological skill and an upskilling of the nursing work force. As the top goes higher the middle must be able to look after things like high dependency on simple ventilated cases.

**Professor FISHER:** I have tried for some years to get someone to get into running high dependency units with advanced skill nurses and no residents, no registrars, one doctor who was available who is their resource. I believe we will have to go this way, particularly as the number of intensive care specialists and registrars dwindle and they become harder to attract.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** It certainly worked when I used to work in Port Kembla, although we could have done a bit better with our case selection.

**Professor FISHER:** What happened when you worked in Port Kembla may not be acceptable today.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** I understand that, but what you are saying about high-dependency units being effectively intensive care units is once again this sucking of everything to the big centre and that has its downside in terms of service delivery near people.

**Professor FISHER:** We have no desire to suck everything to the big centre in the Northern Sydney Area Service because the walls are the best part.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You have got to build a new hospital there anyway.

**Professor FISHER:** It will not be in my practising time. We are struggling to maintain the type of service we wish to maintain and the physical plant is such that we cannot expand. We are expanding Hornsby. Hornsby takes first go at Ryde, for example. We are looking at creative ways to keep going until this new hospital appears. It is not easy.

**Ms KRUK:** Can I add to Professor Fisher's comments? It has come up a couple of times about the sustainability of the current service. It is a real issue. The members, like myself, would have been impressed with the professionalism and commitment of the clinicians that have appeared before your inquiry so far, and I know the stresses that a number of them are under. My greatest fear is that I have a situation where I can no longer attract the necessary requisite skills to run a safe service and then the whole service is put at risk.

What we are trying to do—and it is worth restating—is to try and get an interim solution in place that can keep high quality staff there and let the people of the peninsula have those services as close as possible to their current configuration. I am genuinely concerned about it. I have got external scrutiny in relation to the quality of services I offer right through the hospitals in the State, and that is an issue. And when I hear Professor Fisher say the same point, that we will not have a service in six months time, that concerns me and it is a real issue.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Do you agree with Dr Fisher that you cannot get high dependency unit staff by nurses with outside help?

**Ms KRUK:** I totally believe that it is a thing we have to push at, and we have already put in place a whole range of initiatives to try and upskill that work force. I think the Committee was introduced to Kate Needham in its earlier testimony and saw the people who are working in that area, but it is not going to be an overnight fix. The point was made quite clear to me when I worked with the Mount Druitt and Blacktown clinicians that this is a problem that a blank cheque will not solve.

All too often I hear—and I am sure I will hear it again in relation to Mona Vale—"Give them more money and their problem will be solved." This is not a situation where that is the case, because it is a matter of getting people with the requisite skills to provide that service in a safe manner. If it were as easy as money arguably, as Dr Christley has indicated, the issue would have gone away a while ago. So, yes, that has to be part of it.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** You are saying that only 2 per cent of your elective surgical cases are getting transferred. Dr Boland, the surgeon, is saying that he is happy with the service being offered as such—

**The Hon. CHRISTINE ROBERTSON:** Level six.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** He is saying he is happy with the level in terms of his willingness to take on the elective surgery that he wants to do. One of the models that Dr Fisher is mentioning is well-trained nurses running a high dependency unit and transferring out what they could not do—although there seems to be some difficulty about who takes responsibility for the transfer, which created a problem more recently but surely could be fixable by some protocols. Why are we not simply getting staff along those sorts of models and going ahead? The doctors seem happy with that sort of service.

**Ms KRUK:** I will leave that to one of the doctors here.

**Dr CREGAN:** I guess I would like to make a few comments. The first thing is the importance of critical mass, and that applies to surgery as well as everything else. There is now, I think, overwhelming evidence that the number of procedures that an institution does and the number of procedures that an individual surgeon within that institution does has an absolute link to patient

outcomes. If you do not do enough procedures, you get bad outcomes. It is as simple as that. That means that you have to have a larger service and the implications are the same for intensive care. You need a certain size of service before you can provide safe and effective care.

I have a concern. I am a westie and I am going to say this—I am sorry, Robyn—but this is about a small group of people in a relatively privileged position. I chaired the Metropolitan Hospitals Group of the Greater Metropolitan Services Implementation Group, which became the Greater Metropolitan Transition Taskforce, which was the father of the GMCT. These are generic problems. They apply to all of the 23 metropolitan hospitals scattered around the Sydney region—they are not just unique to Mona Vale—and we have to solve them for all of those hospitals in a reasonable and rational fashion.

The work that Professor Goulston is currently doing with the GMCT is part of that. In particular, the role delineation document, which I see being quoted here, I would just like to draw to the Committee's attention that the differential between a level five and a level six service is transplantation. I am not sure what transplantation is proposed for Mona Vale, but I am sure that there is probably something proposed. The role delineation document of 2002 outlines the background services you have to have to support a particular level of activity.

The hole in that delineation document and the thing that Professor Goulston's group is now working actively on is that it does not get back to staffing. And staffing is not one dedicated specialist. Staffing goes back to how many registrars have you got? Are they working safe hours? How many residents have you got? Are they working safe hours because if they are not working safe hours, you have not got them, and if you have not got these junior medical staff, then you have not got a hospital and you have not got a safe, functioning, effective hospital.

One thing that the Camden-Campbelltown trouble highlighted was the lack of effective support staff. So this discussion about small units run by dedicated individuals is a non-discussion, in my view. People are just not going to work in a two-ventilated bed intensive care if they wish to continue practising and not be investigated by the medical board.

**CHAIR:** Dr Christley, taking up the words of Dr Cregan about reasonable and rational fashion, why would you increase the services at Manly ICU when we have been told that, as an acute care hospital, it is going to close? Why are we going to spend money on refurbishment of the ICU? Why would you not have relocated it to Mona Vale?

**Dr CHRISTLEY:** Can I just go back? I will answer that, but just to go back to a question that underpinned something that Dr Chesterfield-Evans has asked, and I think quite legitimately: Why is intensive care determining so many things? Intensive care is the subject of discussion because it has been said that it needs to change to be sustainable and safe for the northern beaches. It needs to change within a hospital configuration that has problems across a range of specialties. What is driving the hospital location debate is not intensive care—that is a symptom now—but the underlying disease is how we can get enough clinicians aggregated together to have an acute hospital that is able to service the northern beaches. That is the underlying disease. The issue of why Manly or why Mona Vale can go backwards and forwards until the cows come home.

**CHAIR:** Except you are closing Manly as an acute care hospital.

**Dr CHRISTLEY:** This is an interim solution. We are designing a new health service for the northern beaches. There are different ways that people have talked about this debate. One of them is relocating Manly to a new location and that is relocating a working team, if you want to look at it that way. What I think Professor Fisher said and what every clinician has spoken about is the teamwork that is part of an intensive care service and a whole hospital. To use the words of another: it is not a bicycle; it is a frog. You cannot actually take it to pieces and try and reassemble it because it will not work when you try and reassemble it, so to pull apart a working intensive care service and try and reassemble it somewhere else as an interim measure makes no sense.

Although some people talk about what is happening on the northern beaches under the proposal as a relocation of Manly, it is actually not just that. The bricks and mortar are partly that but it is actually about redesigning a health service so we have a major acute hospital that has elements of

both Manly and Mona Vale as part of it and building a new team. I could rephrase your question in human team terms: why create two separate disruptions in a five-year period when you could create one disruption to what is probably the more functional currently higher-level ICU service?

**CHAIR:** Well, how serious is Mona Vale as a site option for the expanded level five hospital?

**Dr CHRISTLEY:** I think the seriousness of that—there has been a lot made of the public comment and I think Reverend Moyes certainly put a lot of weight—and legitimate weight—behind the fact that there has been a lot of community unrest. I could go back—and I can see it happening now—to the reaction we got, as a health service, to Mona Vale being one of the six. The only reaction we have had, admittedly limited, was condemnation from the people down the south: Why is the location, that is in the north, remote from the bulk of the population being considered?

The VMS process has it on the table. It will be considered. We will not be making, I do not believe, final decisions around the ICU. We are planning to do that VMS fairly quickly and they will run parallel, but every bit of evidence, without prejudging the outcome of that VMS process, and every consultant we have seen who has given us an opinion has said to us that the major acute hospital should be at the population centre. Sure, there is all that other argument, that can be revisited, but what we are trying to do is keep the very delicate organism, that is intensive care services on the northern beaches now, alive. And it has copped a lot of assault over the last period of time and I think Professor Fisher's comments about what will happen if there is not some action within the next six months is my concern is well and I am sure it is the concern of everybody in the clinical and management area in Northern Sydney Health because we do not want that to happen.

**CHAIR:** We keep talking about the northern beaches and population centres. I suppose I should confess an interest because we were talking about those this morning as we inspected the sites. It seems to me that if you located a level five hospital, for example at Mona Vale, you would attract potential catchment from an area greater than merely one end of the peninsula to the other, and I was thinking, in particular, up Mona Vale Road, particularly in the area I live in, through St Ives and areas like that. That is the logical place you would go. I read that document that suggested Ku-ring-gai council's natural hospital is Hornsby. To me that is not accurate. At least half of the Ku-ring-gai municipality would not associate with Hornsby hospital, so I just wonder about the demographic material that has been presented to us.

**Dr CHRISTLEY:** Part of the issue about Hornsby hospital's catchment is actually that we need to prop that one up as it stands because, you are right, where we draw the boundary is actually not where the people flow to and from.

**CHAIR:** If you put it up at Frenchs Forest, it is 10 minutes away from St Ives.

**Dr CHRISTLEY:** But the traditional health service planning and expertise we have got tells us that you build your hospitals where the people are; you do not build them somewhere else and expect people to travel. There is the famous *Yes, Minister* skit of the hospital that is there with nobody in it. That is my concern. We spend a whole bunch of taxpayers dollars on a hospital where the population is not and the population keeps going where it is, and I might point out that most people attend a hospital in the afternoon or early evening when the traffic is actually heading out from the centre of Sydney so it is more difficult for them to go north rather than south. We are trying to put the hospital in a location that evidence tells us it should be, not trying to say, "Well, we will put it there" and try and justify reasons why it might work, because I think that has been shown not to work on many occasions before.

**The Hon. CHRISTINE ROBERTSON:** My question goes back to the original question from the Hon. Patricia Forsythe in relation to the funds that have been gathered together by the community. You have taken that on notice.

**Dr CHRISTLEY:** I can answer it, actually.

**The Hon. CHRISTINE ROBERTSON:** Coming from the health sector I know that the community often raises funds for equipment and resources that they perceive are required but that do

not match the delineation of the hospitals at large and so, quite often, you are dumped on with, say, $50,000 to buy some neonatal intensive care machine or something that is impossible to deliver. I would appreciate information on whether that has happened at either Manly or Mona Vale?

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

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Hope Healthcare is private?

**Dr CHRISTLEY:** Hope Healthcare is an affiliated health organisation. They are the palliative care provider for the northern Sydney area.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** That is a private organisation, a non-government organisation?

**Dr CHRISTLEY:** It is a non-government organisation. It is under the auspices of the Anglican deaconess group—I probably have not got the title quite right, but it is a schedule 3 health provider, like St Vincent's is.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** So that would be a PPP situation, would it?

**Dr CHRISTLEY:** No, they are equivalent to any other provider. Royal Rehabilitation Centre at Ryde is also an affiliated health organisation. It is merely that we have a number of different donations that we could aggregate. We are trying to free up the capacity to provide the recurrent resources to open that hospice.

**The Hon. Dr ARTHUR CHESTERFIELD-EVANS:** Who would own and control that?

**Dr CHRISTLEY:** We have not got to that point as yet, but they are a public provider in the same sense as if we did it. They are not a private organisation.

**CHAIR:** Ms Kruk?

**Ms KRUK:** If I could just make a few closing comments. One of the reasons the area health service undertook such a very public and transparent process is because I think this inquiry, as arguably the Camden and Campbelltown inquiry, also put very clearly before the community some of the pressures facing the health system and, arguably, some of the greatest pressures do fall in relation to our constraints in providing every clinical service from every hospital. Secondly, I would hope that I do not face the situation where arguably members of both persuasions of government also do not have that understanding. I think very rarely do I visit a location where each member is not, in effect, advocating that their hospital get the full range of services. I hope we have demonstrated to you today and in earlier testimony that we have given that that is just not feasible, nor is it, arguably, clinically giving the best care.

Third, I would hope that I do not have to face this inquiry again where the Manly residents subsequently feel aggrieved because we have a recommendation from the inquiry which may suit the Mona Vale residents in the knowledge of the fact that 80 per cent of the population actually may not consider that to be the most readily accessible service to be provided for the peninsula. Finally, thank

you for the opportunity to address you both in an earlier session and also in this particular session. We will be very happy to take any additional questions on notice. I would also like to thank my colleagues on the right side of the table, who I think have all given up clinical practice to attend this meeting this afternoon.

**CHAIR:** Thank you, Ms Kruk, and thank you for being willing to take some additional questions on notice. I will just conclude so that members are conscious of what we might need to do. Ms Kruk, at our first hearing you wished to place on record that NSW Health was both willing and very happy to provide commentary on many issues that have been raised in submissions to the inquiry, and you might appreciate there are a lot and we are still working through them. As I have previously indicated to you, the Committee appreciates this commitment on your part. The Committee is conscious, as no doubt you are, that many people who have raised concerns or questions in their submissions did so in the hope that the inquiry will be able to resolve or allay them.

I feel that that there are some issues that we have not yet fully examined that would benefit from some comment and clarification from your department. To that end, at our deliberative meeting I will raise with other members the opportunity to submit written questions to the department. If this is the case, we will seek your co-operation with the provision of responses to those questions.

**Ms KRUK:** Please do so, Chair.

**CHAIR:** If I could thank everybody for giving us their time. I appreciate your time is precious, perhaps more precious than some, and we really did appreciate you being with us this afternoon.

**(The witnesses withdrew)**

**The Committee adjourned at 4.05 p.m.**