REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO THE OPERATIONS OF MONA VALE HOSPITAL

———

At Sydney on Monday 28 February 2005

———

The Committee met at 9.25 a.m.

———

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 first public hearing of the General Purpose Standing Committee No. 2 Inquiry into the Operations of Mona Vale Hospital. Before we commence I would like to make some comments about aspects of the Committee's inquiry. The inquiry terms of reference require the committee to examine the operation of Mona Vale hospital, including the nature and effect of proposed and any future changes to the level of services it provides. This examination must take place within the context of the planning for the future role of, and services to be provided by, all the northern beaches hospitals in the overall provision of safe, modern health care to the people in communities of the northern beaches. This inquiry has attracted enormous community interest. The Committee has been staggered at the response to date. To date we have received over 2,230 submissions.

We believe that this is a record for a New South Wales upper House inquiry, and on behalf of the Committee, I would like to thank all those individuals and organisations that have taken the time to make a submission to the inquiry. I will say something about mobile phones shortly. Because of the volume of submissions, it is not practical to place all of them on the Committee's web site. The Committee Secretariat has placed to some key submissions on the web site and will add to those as the inquiry progresses.

Many of the submissions to the inquiry have recounted personal details of being admitted to Mona Vale Hospital, often in life-threatening situations, and of the exemplary attention and service they received from the hospital and its staff. Authors of these submissions have either recounted their own personal experience or that of a family member or someone known to them. We have also received submissions from volunteers, fundraisers and medical staff at Mona Vale and Manly hospitals. I would ask that witnesses be mindful of the ethical and legal implications of disclosing personal information about patients. Health practitioners and managers and other witnesses should discuss personal information about a patient only if it is specific to the terms of reference and that person has authorised them to do so.

Evidence given to the Committee today by witnesses is protected by parliamentary privilege. This means that witnesses are given broad protection from any action arising as a result of what they say during the hearing and that Parliament has the power to protect them from any action that disadvantages them on account of the evidence they give before the Committee. I also remind you that the giving of false or misleading evidence to the Committee may constitute a contempt of Parliament. However, the extension of parliamentary privilege to those proceedings is not intended to provide a forum for people to make adverse reflections about others. I therefore ask witnesses to minimise their mention of individual administrators, medical staff and others unless it is absolutely essential to address the terms of reference.

Individuals who are subject to adverse comments in this hearing may be invited to respond to the criticisms raised either in writing or as witnesses before the Committee. This is not an automatic right but, rather, a decision of the Committee which will depend on the circumstances of the evidence given. I need also remind witnesses that the protection of parliamentary privilege applies only to what they say while seated at the witness table. Any comments made to the media after they have concluded their evidence does not attract the same privilege.

I note that the issue of the future role of the Mona Vale Hospital has been the cause of ardent community concern and action for some time, and I appreciate that members of the public observing today's proceedings will be keenly interested in what is said. I wish to emphasise that although this is a public hearing, it is not an open forum for comment from the floor. While the Committee welcomes members of the public here today, the purpose of the hearing is to have the Committee hear evidence on oath from those appearing as witnesses. Members of the public are asked to give the Committee's selected witnesses the opportunity to give their evidence without interruption. Only the questions from the Committee and the evidence from the witnesses are recorded on the transcript of today's hearings.

The Committee has previously resolved to authorise the media to broadcast the 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 broadcasting of proceedings, a member of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In

reporting the proceedings of this Committee, the media must take responsibility for what they publish or for whatever interpretation is placed on anything that is said before the Committee.

Witnesses and members of their staff are advised that any messages should be delivered through the attendants or the Committee desk. I also advise 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 a Committee or by way of any other person.

The Committee prefers to conduct its hearings in public. However, the Committee may decide to hear certain evidence in private if there is the 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 your mobile phones for the duration of the hearing. I add to that that it is a requirement to not just turn them to silence mode; it is actually necessary to turn them off because incoming calls cut across electronic recording of evidence by Hansard.

I now welcome our first witnesses who are representatives from New South Wales Health and the Northern Sydney Central Coast Health. I now turn to each of the representatives and I ask each in turn to take the oath or affirmation.

ROBYN KRUK, Director-General, New South Wales Health, 73 Miller Street, North Sydney, and

STEPHEN CHRISTLEY, Chief Executive, Northern Sydney Central Coast Health, C/- Hornsby Ku-ring-gai Hospital, Palmerston Road, Hornsby, and

PAUL ROBERT PHIPPS, Director of Intensive Care Services, Northern Beaches Health Service, P. O. Box 465, Manly 1655, and

RICHARD JOHN MATTHEWS, Acting Director-General, New South Wales Health, 73 Miller Street, North Sydney, affirmed and examined:

FRANK BAZIK, General Manager, Northern Beaches Health Service, P. O. Box 465, Manly 1655, sworn and examined:

CHAIR: Ms Kruk, what is your occupation?

Ms KRUK: Director-General of New South Wales Health.

CHAIR: In what official capacity are you appearing before the Committee—as a private individual or as a representative of an organisation or business?

Ms KRUK: Official capacity.

CHAIR: Dr Christley, what is your occupation?

Dr CHRISTLEY: I am a health service manager with the medical background.

CHAIR: In what official capacity are you appearing before the Committee—as a private individual or as a representative of an organisation or business?

Dr CHRISTLEY: Representative of an organisation.

CHAIR: Mr Bazik, what is your occupation?

Mr BAZIK: General manager.

CHAIR: In what official capacity are you appearing before the Committee—as a private individual or as a representative of an organisation or business?

Mr BAZIK: Representative of an organisation.

CHAIR: Dr Phipps, what is your occupation?

Dr PHIPPS: I am a full-time intensive care specialist.

CHAIR: In what official capacity are you appearing before the Committee—as a private individual or as a representative of an organisation or business?

Dr PHIPPS: I am representing an organisation and I am a director of intensive care services for the northern beaches.

CHAIR: Dr Matthews, what is your occupation?

Dr MATTHEWS: I suppose I am a health bureaucrat with a medical background.

CHAIR: In what official capacity are you appearing before the Committee—as a private individual or as a representative of an organisation or business?

Dr MATTHEWS: As a representative of New South Wales Health.

CHAIR: Ms Kruk, do you wish to make a brief opening statement? Is it intended that each of your witnesses will make a statement, or will you make one on their behalf?

Ms KRUK: Madam Chair, I will not make an opening statement. I will ask Dr Christley to make an opening statement, but can I make a few comments in response to your opening statement?

CHAIR: Yes.

Ms KRUK: Firstly, we welcome the opportunity to appear before the inquiry. I think it is an incredibly important issue, not just in relation to the services for the Northern Beaches Area Health Service but because of the fact that in many ways the issues are being discussed here are relevant to health services across the State. I welcome your comments that, despite the somewhat narrow terms of reference of the inquiry focusing on Mona Vale, it is inappropriate that we focus solely on Mona Vale because it is the provision of health services for the area, and arguably for the State, and the nature of intensive care services, the nature of the specialist services as a whole that are considered on a statewide business.

Thirdly, Madam Chair, in relation to the receipt of the 2,230 submissions, can I place on the record that we are both willing and very happy to provide commentary on any things that may come up in those submissions. Fourth, I welcome your comments that are a cautionary note in relation to comments being made about individuals. Obviously, matters of privacy are significant. Fifth, one of the most distressing things surrounding the discussions on Manly, Mona Vale and the northern beaches health services as a whole I think have been some of the matters of disinformation that have gone before the community. This inquiry is an important chance for members of the health service and arguably the health administration as a whole to put some matters very clearly on the public record. It is clear, and has been made clear by this Minister and the former Minister, that Mona Vale Hospital will not shut.

Can I also say that some of the personal attacks on the staff within the health administration and also a number of the clinicians have been incredibly distressing. It is my responsibility, both statutory and professionally, to look at the sustainability of health services as a whole, and it has been both unprofessional and incredibly disturbing to see the nature of some of the personal attacks on staff across the health system. So, in summary, we welcome the opportunity to place some of those matters on the public record. I am very conscious—I come from a very small country community—how very significant health services are to a community. I know the northern beaches actually very well in relation to the community, but obviously the provision of health services has to be considered in a broader context.

Dr CHRISTLEY: Thank you for the opportunity to appear before this Committee. It is a welcome opportunity to try to put some facts and understandings that we have on the table. Firstly, I would just like to talk about our responsibilities as an area health service under the Act. We are required to consult with the community, to support, encourage and facilitate the organisation of community involvement in the planning of health services. We have to achieve and maintain adequate standards of patient care and services and we have to ensure the efficient and economic operation of health services and health support services and use of resources. There will often be some tensions between these aims. I think this is a core issue behind this inquiry—to ensure that future health services meet local needs; that the services we provide are safe; and that we use the resources that the taxpayer provides in the most effective way.

As a health service, we believe we have acted honourably and diligently in attempting to find the best solution for a difficult problem. We have used consultants who have expertise in community consultation to ensure independence, professionalism, and that we have reached a representative sample of the community. Our methods have been questioned by some vocal opponents but we believe that our consultation program has been comprehensive and fair. All members of the community have received information and opportunities to respond. We have conducted phone surveys. We have involved community members in the shaping of terms of reference for various consultancies and conducted a deliberative poll. All of these have given us an understanding of a range of views across the community.

Our work is about matters of life and death. Our staff dedicate their working lives to caring for ill and vulnerable people. We need well-trained staff who are capable of providing services at the highest standard. It is vital that we properly resource services such as critical care, emergency and intensive care. If we find that such a service cannot be provided safely, we are obliged to act, and we have acted in the past in such circumstances. This is now the case currently with intensive care at Mona Vale. We have reached a crisis point and we have consulted widely with our medical and nursing staff and the public to find an acceptable solution. There remains controversy about that. We plan further consultation regarding this proposal in the coming months. Ultimately, at the end of that, we have a responsibility to ensure the provision of safe patient care.

We have been planning for a new hospital and community health service on the northern beaches since 1999. This planning process is separate from three interim solutions around intensive care that have been proposed by the Greater Metropolitan Clinical Taskforce [GMCT]. Our planning process for the northern beaches is looking ahead 10 years. The review of facilities in 1999 showed that the Manly hospital had outlived its ability to provide modern and effective health care and needed to be rebuilt. The Minister provided funding to allow this planning to proceed. Studies showed it could be rebuilt at a more central location for the community to use it at a similar cost to rebuilding it on site while maintaining services. Manly hospital is poorly located relative to the population it is meant to serve. We found that the population centre of the catchment area was actually Cromer and that the Brookvale area was the best location for transport, now and in the future.

Through extensive community consultation we gained agreement for three outcomes: to rebuild Manly hospital in a new location in the Brookvale area; to upgrade the Mona Vale Hospital on its current site; and to build new community health facilities, two hospital sites with the possibility of a third site that if is required. Service planning was to follow identification of the site for a new Manly hospital. We have examined the number of sites for the new hospital. Warringah council site in Dee Why has come top in our ratings, and we have examined a number of other sites and forwarded that information to the department and the Minister.

One of the issues raised by some in the community is that it would be preferable to simply build a major hospital on the Mona Vale site. Indeed, if you look at the *Manly Daily* article last week, which talked about the playing dead or dying at the Minister's electorate office, a statement is made that Northern Sydney Health has time and time again ignored the overwhelming voice of the community calling for Mona Vale hospital to be a level 5 hospital for the northern beaches. And that is the central premise of some of the people who have submitted to this inquiry.

Our submission presents clear and persuasive arguments why we have not pursued that option. Central to the argument is that the population of Mona Vale catchment area is simply too small to support the range of services, including intensive care, required to meet the acute care needs of the entire northern beaches population. More than 80 per cent of the northern beaches population lives to the south of Mona Vale. This is not likely to change substantially in the future. If we project 100 years, with the commitment to retain Mona Vale hospital, there would be the opportunity to respond to any changes in demography that occur over that time.

But for the moment, if the major northern beaches hospital were at Mona Vale, patients from the southern part of the northern beaches would flow across to Royal North Shore Hospital and we would lose the critical mass that we need to maintain services for the northern beaches. This is exactly what happened when the paediatric unit was closed at Manly a few years ago on patient safety grounds. Paediatric patients flowed to North Shore, as well as to Mona Vale, and the numbers at Mona Vale did not increase significantly enough to be used as justification for any centralising of services there.

The other issue addressed by this Committee is that of funding. Some have implied that Mona Vale hospital has not been funded fairly compared to other hospitals in northern Sydney. Our submission clearly addresses this complex question. There is no evidence that the people of the northern beaches have been short-changed when it comes to health care.

In summary, the area is keen to go on to complete and build better health services for the community of the northern beaches. We are committed to ongoing involvement of community and clinicians in planning for those services, and we believe that having done that the new health service

configurations will be able to attract and retain well-trained staff and provide them with modern, efficient workplaces. We believe this is the best possible outcome for the people of the northern beaches whom we serve, and we will continue to work with health professionals and community representatives to determine what services will be offered at each hospital site and community health centre.

CHAIR: Dr Christley, both today and in the submissions we have received you have identified that Manly hospital is poorly located to serve the needs of, for example, the people of the Pittwater area. Why therefore would you concentrate intensive care unit services at that hospital?

Dr CHRISTLEY: The issue about location of services is primarily about access to the community of the front door of the hospital, and Manly hospital is very much down the southern end. Interestingly, when you look at travel times to get to Manly hospital across a variety of different parameters, because the bulk of the population is located in the south of the northern beaches there is very little difference, in most accessibility scores, between Manly and Mona Vale hospitals. However, probably on the ones that are regarded as the best estimate, that is the tenth busiest time, Mona Vale hospital is marginally ahead of Manly hospital.

If you look at admission numbers from the hospital to intensive care, Manly hospital has a higher number of admissions from the emergency department to intensive care and a higher number of intensive care admissions. Mona Vale hospital has a higher number of presentations, and that has been increasing over time. Largely we believe that relates to less well-developed primary care services in the Mona Vale area, with a higher level of presentations to Mona Vale emergency of lower triage categories than to Manly. But the fundamental is that at the moment Manly hospital has a busier intensive care unit; it has more admissions to the intensive care unit from the emergency department.

A critical care service will operate across both hospitals, and anybody who attends the emergency department at Mona Vale will receive access to skilled staff in the emergency department. Should they need to go to what will then, under the proposal, be a level 3 ICU, the majority of people presenting would be able to be looked after quite adequately in that level 3 ICU. Dr Phipps is probably the better one to talk to this than I, but with regard to those who are more unwell and require to be looked after in a higher level of intensive care, the advice to us from people like Dr Phipps is that they are much better cared for in a place that has the resources to care for them safely and appropriately. I can certainly relate to that from my own past clinical experience. So the proposed arrangement of providing a higher level of intensive care service on the northern beaches than currently exists is in the interests of those patients.

Ms KRUK: Madam Chair, could I ask Dr Phipps also to comment, because I think what will come up a number of times during the course of this inquiry is the difference between the bricks and mortar of the hospitals and the actual level of clinical services and the significance that has for both quality and safety considerations. This is more a message for the members on this side. We use the terms level 3, level 4 and level 5 probably a little too often, and I would ask that we explain what those services mean, because there is significance in that and I think that is probably at the heart of some of the unease in the community about what services are encompassed in the various levels of care.

Dr PHIPPS: I guess the difficulty with intensive care service provision on the northern beaches is that we have two small intensive care units and the main issues we have to improve the quality and safety of care are that we need a critical mass of doctors and a critical mass of patients to make the system work more safely and bring the units up to modern standards of intensive care.

There are differences in the clinical structure of both units, although they are of a reasonably similar size. Mona Vale hospital has intensive care specialists that do a ward round but they are not required to be on site. Manly hospital has intensive care specialists who are there on site in working hours so they are more available. There are other differences between the units. If you are going to have all ventilated beds in one place, it would make Manly the better place for that.

Because of the staffing and resource structure at Manly, sicker patients are able to be looked after. There is more invasive cardiac monitoring, and the nursing staff are experienced in that the nursing staff are experienced in renal replacement therapy or dialysis, which cannot be done at Mona

Vale. The staff are also generally more familiar with complex ventilation. There are 24-hour dedicated ICU resident staff doctors that work in the unit and are trained by the unit, which we do not have at Mona Vale. There is also a senior registrar at Manly, which we do not have at Mona Vale. There are a number of other things. We do not have a ward clerk at Mona Vale, we do not have secretarial services, and we do not have doctors' offices. All those other structural things are also in place at Manly.

When you are looking at which hospital, the most important thing is that we have all the ventilated patients in one place for critical mass issues. Once you have made that decision, you then have to make the decision about whether they should be in Manly or Mona Vale. Because of the clinical structure at Manly, I think it makes sense for those ventilated beds to be placed there.

The other important thing to say is that the Northern Beaches Health Service is integrating, if you like. We are doing that already. The Greater Metropolitan Clinical Taskforce proposal goes one step further, and says that we should fully integrate the northern beaches intensive care service. So the ventilated beds are the northern beaches ventilated beds. They are located at Manly, but they are available, obviously, for patients on the northern beaches wherever they present, whether it is to Mona Vale or Manly. The same thing with the level 3 unit, or the hi-dependency type of beds that will still be in place at Mona Vale. The unit is not being shut; it is still part of the northern beaches intensive care service and will be available for patients from Manly or Mona Vale.

That certainly will mean that there would be more traffic of patients transferred between the two hospitals. I do not think it is a long-term solution; I think the new hospital would certainly improve services further, but as an interim solution I think that is by far the best way of managing the service.

Ms KRUK: It is worth clarifying that the Greater Metropolitan Clinical Task Force is a group of clinicians and community representatives who really are a good independent form of advice to both the Minister and me. In this instance they were asked to specifically work with clinicians and undertake some quite wide-ranging consultations to support the area's consultations about the best clinical configurations of services. Their brief was not to look at site-specific matters, which are obviously one part of the scheme of things. So they have been an important contributor in this regard. I am unsure whether they have made a submission to this inquiry, but certainly I think the commentary has been significant in relation to the models put forward.

CHAIR: Could we have an update on the current position in relation to site options, if there is a movement towards a general hospital? What information has been provided to the Minister, how many sites are on the table, and what criteria is the department using in the identification of sites?

Dr CHRISTLEY: It is probably best if I answer that question. We recently provided the most recent update on that to the department. I am not sure whether the department has looked at that any detail as yet, or whether any advice on that has been provided further. We have been through a series of exercises in looking at sites for a new northern beaches hospital. We have been asked by the Minister to go back and review what we have done to make sure that we had tried to overcome any obstacle there was to any particular site, so there was no way we could be perceived to have been identifying a site, working through how we overcame its difficulties, without having given the same rigour to every other site.

The most recent document looks at six sites. It includes Mona Vale hospital, which has been a concern of a number of people. The criteria we have used are outlined in our submission. A set of criteria was agreed in consultation with the community, and it includes issues such as access, buildability and capacity for sustainable services. We have used those, we have done various rankings and various sensitivities around that, and presented some recommendations.

In essence, there are a number of sites where one could build a hospital. I think it is fair to say that the area's recommendation at this point—and I would not mind if it was not what came out at the end—is that Dee Why is the most suitable site. However, there are other options, and they will be evaluated by others as we go through the process.

Ms KRUK: Dr Christley's submission details the consultations on site, and also clinical service configurations. This is not an area that we would expect a consensus in. Looking back over the documentation, it is quite clear that there has been significant input from the community and clinicians in relation to site options. As Dr Christley has indicated, there are currently six that the Minister has asked he looked at in some detail. The criteria are in the submission.

It is also quite clear, given the level of interest that you referred to, that some communities will have a stronger view than others. What is significant again—and I cannot overemphasise it, and it is confirmed by Dr Christley's comment about where the population hub is based—is the fact that 80 per cent of the population lives south of Mona Vale, and it is an issue of providing services to the Manly end of the equation and to the area health service in the peninsula as a whole.

Site considerations are one component. Accessibility is obviously incredibly significant to ensure that you do not get a situation where people feel obliged to go to Royal North Shore because services are perceived to be inaccessible on the peninsula. There are a range of technical considerations, including transport considerations, and they are detailed.

Equally significant—and this is where Dr Phipps' testimony is relevant—over and above that we have to look at the clinical service configuration. It will take four or five years at best for that bricks and mortar to come into place. So we need an interim services solution in addition to a long-term solution in relation to health services for the area.

The Hon. TONY CATANZARITI: What percentage of patients who visit the northern beaches hospital currently need access to a bed in an intensive care unit?

Dr CHRISTLEY: From memory, it is about 1.4 cent. I think it is detailed in our submission. Not all those patients would require a ventilator bed, which are the beds that will be relocated as a result of the proposal of the Greater Metropolitan Clinical Taskforce.

The Hon. TONY CATANZARITI: Under the proposal for a new critical care structure for Manly and Mona Vale, would most patients still be treated at the same hospital as they are being treated now?

Dr CHRISTLEY: That is true. Our estimates are that somewhere between 70 or 80 would require a transfer. I might ask Paul to comment on that.

Dr PHIPPS: The vast majority of patients will continue to be treated where they are now. The Greater Metropolitan Clinical Taskforce proposal suggests that there be an upgrade of the emergency department at Mona Vale. The Mona Vale emergency department is busier in its number of presentations, although fewer patients are admitted to the intensive care unit from Mona Vale than Manly. So, yes, there is an enhanced emergency department service and there is still a high dependency service at Mona Vale that is still operated by the northern beaches intensive care service. So we have responsibility for both units.

Dr CHRISTLEY: It is important to recognise that at the moment anybody who is really sick does not stay in either Mona Vale or Manly. At this point in time major trauma, myocardial infarction, burns and neurotrauma patients all go to the North Shore. The other parallel to this discussion is probably when the Manly paediatric ward was closed. It was closed on the grounds of safety because of patient numbers and patient distribution. We offer a safer service now than we did before. As a result there have been no issues around patient movements or transfers.

The Hon. CHRISTINE ROBERTSON: What vision do you have for intensive care services on the northern beaches? Quite a few of the submissions that we have received relate to acute asthma and people's perception of what can happen to those who are suffering from acute asthma. Would you mind using that as an example?

Dr PHIPPS: Currently, the main contrast is what we have now in relation to intensive care services and what we really could have. We could have a single intensive care unit on the northern beaches that had enough critical mass of doctors and patients to provide modern intensive care. We have two small units—two ventilator beds in Mona Vale and three ventilator beds in Manly—and we

also have high intensive beds. I will refer to the asthma example. Currently, if a patient has acute or severe asthma at Mona Vale, he or she will be transferred to the emergency department at Mona Vale. The emergency department would be an upgraded service, if you like, so the patient would be managed and treated there. That is not forgetting that for asthma and most conditions therapy starts when the ambulance arrives.

The patient would get oxygen, salbutamol, adrenalin, or whatever is required. That is when the treatment starts. The patient would then be further stabilised by an improved service at Mona Vale. The ventilation of a patient with acute or severe asthma is very complex. So when the patient is transferred to intensive care you would want him or her to be transferred to a high level of intensive care where there is nursing and medical expertise to manage a difficult intensive care admission. At the moment I do not think that is possible; I do not think the patient would get the highest level of care at the intensive care unit at Mona Vale. So it is likely that the patient would be transferred anywhere as the conditions stand. The patient would then be transferred to Manly. The transfer would be undertaken by a medical retrieval team—a statewide medical retrieval service—which provides highly trained retrieval of intensive care patients that is safe and has been shown to be safe.

The patient will then be transferred to an upgraded intensive care unit at Manly. So that is an example of how patients would be better looked after in the new configuration of services than they are currently. I refer now to our vision for intensive care. It takes the same sorts of resources to look after one or two ventilator patients as it would to look after, say, 10 or 12. In most intensive care units, depending on the sort of size of the unit, the beds required to run a good unit are about 10 to 12. It is what is called a pod. So you need an intensive care specialist, an experienced junior doctor-registrar who can assess, recognise and initiate treatment of a very sick patient in intensive care, and you need well-trained nursing staff. You need that whether there is one or two beds or 10 or 12 beds.

In relation to the amount of resources required, with similar resources you can look after more patients if you have the ventilator beds all in one place. So it makes sense from a point of view of economics as much as anything else, as well as training, education and research that can come from a bigger unit. All those aspects are there on the northern beaches, but they are spread across two sites. With the nurses, the doctors and the equipment we have—some junior doctors are very keen to be trained in critical care—we also have the possibility with the new system of being able to train intensive care specialists of the future. Of course, as you know, there is a shortage of those. Overall, a well-run intensive care service on the northern beaches would be fantastic and well regarded throughout the State.

Intensive care beds are a statewide resource. In other words, there is an intensive care network of beds throughout New South Wales. So when the beds in one hospital are full sometimes sick patients have to be transferred to where there is an intensive care bed available in another hospital. The intensive care beds on the northern beaches can be used for patients from all over New South Wales. We have a responsibility to ensure that we provide the highest level of intensive care service because they are not just for the people of the northern beaches; they are for the people of New South Wales. It is imperative that we provide a similar level of care to any other hospital—to a North Shore hospital or to a Nepean hospital—so that when patients come in they know they are getting a certain standard of care. The only way of doing that is to pool our resources in intensive care and run a higher-level service than we are currently doing.

The Hon. AMANDA FAZIO: You referred to the shortage of intensive care specialists. I believe that NSW Health has had to recruit people from overseas. Why is it so difficult to get people to become intensive care specialists? What are the problems in getting them to go and work in hospitals like Mona Vale and Manly?

Dr PHIPPS: In the area of intensive care specialists it is a well-known specialty where there are unsociable and long hours. Many doctors are on call. The on-call for intensive care specialists is fairly arduous in that they often have to turn up at 2 o'clock in the morning to help resuscitate somebody. From that point of view it makes it a little bit harder. I refer to the problems we are having in recruiting to smaller intensive care units. Intensive care specialists like to work with sick patients. They like to have enough work to keep them busy. That keeps up their professional interest, it gives them enough clinical material to be able to teach and learn, and it also gives them some reasonable remuneration.

In a small intensive care unit such as Mona Vale that has only two ventilator beds—there are only five beds altogether and some of those are coronary care beds—there is not enough work to keep them busy and to maintain their skills. There is not really enough clinical material to teach and train junior doctors as well. So there is a lack of material. I know we overuse the term "critical mass" but there are just one or two other intensive care specialists at Mona Vale and there is only one emergency specialist. If you are working on your own trying to provide a service you do not really get much help and it then becomes a struggle and it is not such an enjoyable job.

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

The Hon. AMANDA FAZIO: You said that if you had this one intensive care service across Manly and Mona Vale you would be able to attract junior doctors who would want to train to become intensive care specialists. How long does it take to train to become an intensive care specialist?

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

Ms KRUK: Madam Chair, could Dr Matthews just add to that? His area of responsibility in the department is looking at the coverage of intensive care services on a statewide basis. I think Ms Fazio has hit the nail on the head about some of the difficulties in that regard.

Dr MATTHEWS: To summarise, it is important to understand with intensive care units that you actually require four separate components: you need the bricks and mortar, which effectively you can put anywhere; you need a critical mass of a trained work force; you need the ancillary services that support the ICU, which are other clinicians and the availability of 24-hour imaging and diagnostics; and, lastly, you need a sufficient throughput of patients who require ICU otherwise, one, staff lose their skills, and, two, they feel that they are not working in an intensive care unit where they can maintain their skills so they leave and gravitate towards the larger systems.

What we are talking about here is something that is well established in New South Wales, and that is the establishment of clinical networks. As long ago as the early 1990s we recognised that sick neonates and sick children could not be cared for everywhere and we developed a clinical network to bring sick newborns, premature babies and sick children to high-level services, mostly in Sydney or in the Hunter Valley. We have done the same thing with trauma services. We recognise that not every hospital can deal with multiple traumas so in 1997 we established the adult medical retrieval system that Dr Phipps referred to, which is run by the Ambulance Service and which transports critically ill patients from all around the State to the centre that can most appropriately care for them, has an available bed and has all the services they need.

We have done the same thing with severe burns. We have done the same thing with brain injury rehabilitation and trauma. We have established major trauma centres across the State. All this is in recognition that we cannot have hospitals that do all things for all people. What is happening at a local level on the northern beaches is an appropriate consolidation of ICU services in Manly, where the four components can be provided; and a service in Mona Vale, which does not ventilate patients but still has a high-dependency unit and a well-established medical retrieval system that appropriately and safely moves patients to the place where they can be most safely and appropriately cared for.

CHAIR: Dr Matthews, while you may have a clinical network and it is appropriate to bring patients together, is it not a fact that the surgeons and anaesthetists at Mona Vale Hospital have said that without an IC unit it is a safety issue in terms of their capacity to operate?

Dr MATTHEWS: Dr Phipps is the expert so I am happy to pass that question to him or I am happy to answer it. The high-dependency unit that is proposed for Mona Vale will satisfy the needs of most of the surgical procedures.

Dr PHIPPS: Again, there will be a northern beaches intensive care service available for patients in both hospitals. It is not like in another situation where we are actually taking a service away from a hospital. If you like, it is not like losing a daughter; it is like gaining a son—that sort of thing. Mona Vale Hospital will gain a higher-level intensive care service. I think it is very important that we make sure that the system supports acute care services at Mona Vale Hospital. I think that should continue. I think that can be done as it is done in other hospitals around New South Wales, such as Canterbury Hospital, for example. It has a high-dependency unit and no intensive care specialist on call. They perform emergency and elective surgery there.

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ms Kruk, do you support one major hospital for the northern beaches?

Ms KRUK: Dr Chesterfield-Evans, as I have said, in this debate there has been fact, assertion and preference about where people want to work. I rely on good clinical advice. There are a series of known facts, which Dr Phipps has referred to, in relation to what a critical mass is in relation to intensive care services. The work of Professor Malcolm Fisher has been incredibly important for our advice in that regard. There is a strong view from clinicians about the need to actually aggregate those services to provide a quality service to the community of the northern beaches. So that is a very strong consideration in the advice I will give to the Minister ultimately. Whether I believe in terms of the site—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the department's position that there should be one major hospital—level 5, I think that is the understanding—for the northern beaches?

Ms KRUK: My view—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not your view; the department's view.

Ms KRUK: Would you let me answer? My view, as I have indicated on the basis of clinical advice, is that we will need to have a networked service. The greater metropolitan clinic or task force advice, the advice that I get from the intensive care implementation group, has been consistent about

the need to actually have aggregated services. The Government has made its position clear in relation to the fact that Mona Vale Hospital will not be shut. The service configurations that ultimately apply to the northern beaches will be largely dependent on where the physical infrastructure is also based.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask the question again? Do you support one major hospital—that is to say, one central hospital—for the northern beaches? They have one central hospital in Wollongong for the Illawarra and they have Bulli and Port Kembla above and below it in that area of land. Do you support one hospital for the northern beaches?

Ms KRUK: I have answered that, Dr Chesterfield-Evans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No—

Ms KRUK: No, I have. The Government has indicated its position in relation to two hospitals. This is a matter of government policy. My advice and my responsibility is to ensure that there is the safest and most accessible service configuration to support that. So that position has been made clear. I have to look at the services that are provided in that area health service as a whole. What is important for me is that the community that lives in Manly is also given a quality health service. I am obviously very conscious of the needs and desires of the Mona Vale community. There is a need to have an aggregated service of a level that attracts and can retain qualified clinical staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Look, I do not know what planet we are living on here. My understanding is that Dee Why is a preferred site for the major hospital and that Manly and Mona Vale both have promises not to be shut. Is that or is that not the situation?

Dr CHRISTLEY: Can I perhaps respond to that? There has been some interesting commentary in the media around what has been said. To be very specific, if you go back to September 2002, I think, there was a statement that said Manly and Mona Vale hospitals will not close. Mona Vale will remain on its existing site and for Manly there will be a planning process that looks at its location. That was quite open; it was in media releases and was reported in the newspapers quite openly. The consultation process then around the future options for Manly hospital that came up with the Brookvale area as a location for the new Manly hospital involved, within a whisker, equal members of the community and health services staff. So it was a very open process conducted, as the whole process has been, in the full glare of open scrutiny. So I think there are some semantics in that. The undertaking has always been two hospitals: Mona Vale on its existing site and Manly at a site to be identified through an open process against clearly explicit criteria.

Ms KRUK: Dr Chesterfield-Evans, I am sorry, I did not mean to be short with you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were not short!

Ms KRUK: I also have to look at the full range of health services. If I look at the population figures in that area, if I look at the demographics in relation to the over-75s, it is acute services and also the level of support we can offer them by way of ambulatory services. It is not inconsistent to look at a far more integrated model, such as Dr Phipps has described in relation to intensive care, and to look at the functions of each of those facilities across that area health service. So there are no inconsistencies in that regard. It is what is actually offered at those various facilities. There is unease in the community about what constitutes a level 3, a level 4 or a level 5 ICU service. I am quite conscious of that and I think we have to address that. But it is a full spectrum of health care services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Look, I am going to plug on here.

Ms KRUK: Okay.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the intention to have one central level 5 hospital and the others networking into that? Is it the intention to build a new major hospital for the northern beaches—yes or no?

Dr CHRISTLEY: The area health service's planning says that when the site of the new Manly hospital is identified—and people are very keen that we call it the new "northern beaches

hospital" because it will involve clinical staff from both Manly and Mona Vale in its operation—at that point in time the clinical services planning will take place to identify the services at the new Manly/northern beaches hospital and the existing but physically upgraded Mona Vale Hospital. Given then—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do I take that as a yes? We have had about six answers so far—yes, you want to build a new hospital or, no, you do not.

CHAIR: Dr Chesterfield-Evans, the same rules apply in Committee as during parliamentary question time: The witnesses may answer the question as they wish.

Dr CHRISTLEY: To continue, I am on the record as stating that, given the transport demographics and all of the analysis that we have done, the site of the major acute hospital is most likely to be the new Manly hospital. That is because it will be built at the travel centre for the northern beaches or as close to that as it can be. Therefore, it is only reasonable that, if we want to optimise the size of those services and the mass of those available on the northern beaches, we build a hospital where the most people will go to it. In doing that—and this is the concern I think of the Save Mona Vale people—there is a very long end with not a lot of people in it relative to the density of the southern end. That is why Mona Vale Hospital has a role to look after those people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is going to be a new hospital?

Dr CHRISTLEY: That is a decision for government.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The answer is, yes, we are going to have a new hospital and it is going to be at Cromer. Is that what you are actually saying?

Dr CHRISTLEY: No, that is a decision for government. The area health service's advice is that the new hospital to replace Manly hospital be located in the travel centre of the northern beaches, and that is defined in our work as being somewhere between Brookvale, Dee Why and Frenchs Forest. In that triangle is where the site investigations have occurred. In three separate travel studies that is the travel centre of the population. Cromer is the demographic centre of the population. The travel studies identify that triangle as the travel distance centre.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the critical element in the siting of this hospital is its geographic location in relation to the travel centre of the population. That is the key criteria, is that correct?

Dr CHRISTLEY: One of them, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What do you mean, "one of them"? It is or it is not.

Dr CHRISTLEY: There is a ranking of about, I think, eight or 10 criteria. There is a couple that rank highest and that is one of the ones that ranks highest in evaluating sites.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In terms of intensive care, if 1.4 per cent—I think that was your figure—of patients admitted to hospital go to intensive care or are seen in hospital intensive care units—

Dr CHRISTLEY: Presenting to emergency departments.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: and they are all networked magnificently so that all the burns go one way, the major traumas go another and no really bad cases stay on the peninsula at all at present, are you saying that what the intensive care unit does is perhaps the tail wagging the dog?

Dr CHRISTLEY: The things that have driven our planning process—if you go back to 1999 when we first sat down with clinicians—are the services at the very heart of the safety of the hospital that we need to support all the other services that are identified as being critical to the planning of the

major acute hospital. We were very clear that there were other sorts of hospitals and other roles but when you had a place where sick people were going to be aggregated you needed to have the backing of intensive care. The other services that were critical were obstetrics and emergency. To have a higher-level emergency service you need massive support from health service, diagnostics, and so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a 24-hour theatre, though, is it not?

Dr CHRISTLEY: It is more than that. As Richard Matthews answered, for intensive care, all of these things are not just buildings. They are staff, they are expertise, they are back-up resources and so on.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Currently you do not have hospital that does a really bad case on anyone, they get networked to North Shore, and there are loads of private hospitals with critical mass that seem to manage really well with 40 or 50 beds.

Dr CHRISTLEY: It is interesting when they were talking before about what the impact on surgery and other services might be, that is true. But when you have emergency services and you have an ambulances presenting to those emergency services, you need a very well networked back-up for those. At the moment one-third of admissions on the northern beaches are to northern beaches hospitals. About 50 per cent now go to the private sector and the remainder go to North Shore or other high-complexity hospitals.

Our aim is to increase the self-sufficiency on the northern beaches. We want to be able to provide a more complex and higher technology range of services so that people from the northern beaches do not have to travel for the same range of conditions that they do now. That has always been the stated aim of this exercise. The northern beaches have a population of around 250,000. That is not that different to the population of the Penrith area. Nepean Hospital is a teaching hospital that provides a very high and complex range of services. The people from the northern beaches have two barely struggling level-4 hospitals. Sure, there is a high rate of private sector—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that, but we must move on. If you know you need a single hospital and it has to be in the centre, is the consultation process somewhat of a propaganda exercise? You know you have to build a major hospital in the middle, so why not face it?

Dr CHRISTLEY: At the very beginning of this exercise, I said we spoke with clinicians first to get an idea of what their view was. Their view very strongly for having one hospital. Even as late as February 2001 the medical staff of the northern beaches, from both hospitals, took out an ad in the *Manly Daily* which they paid for saying that they support a single hospital on the northern beaches. When we started out with community consultation we had three options that we put forward. One was a single hospital. Another was two hospitals in complementary roles. If we merely listen to the initial advice we got from clinicians—and we never thought of that as being our final position—and we had not listened to the community we would be arguing for one hospital for the northern beaches. We are not arguing for that at all. We have had more extensive community involvement than any other planning process you can point to in health in New South Wales, and probably in the world, probably because we spent a lot of time looking at web sites. I have been over to talk to people in Glasgow, where we thought we might be able to learn something from the people in Glasgow. I was over there on holidays so I dropped up to talk to them. I thought we ran rings around them in the things we had done.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One would not take much of an example from the British National Health Service.

Dr CHRISTLEY: The Scottish national service, I think, is a bit better. What I am trying to say is we have always valued community input into our planning process. We will continue to have input into our planning process, because that is the next phase. There are some successful examples. Ryde had a non-viable maternity service. One of the options might have been to close it. We sat down with community members, general practitioners and specialists and over a period of about nine

months we came up with a model of maternity services for Ryde that is now being held up as an example for the rest of the State.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is managed without an intensive care unit and any obstetricians, I gather?

Dr CHRISTLEY: There is obstetrician back-up but there is no on-site obstetrician. The back-up comes from the other hospital. That service celebrates its first birthday this year.

Dr MATTHEWS: That is a good example of appropriate services provided safely with higher-level services moving to another area that will in relation to the siting of this hospital, I assume you are not arguing against consultation?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I mean real consultation.

Dr MATTHEWS: The criteria were established in consultation with the community. When Manly hospital was built most of the area around Cromer and Dee Why was sand hills and market gardens. Things have changed since then. So, access is one of the most important criteria, and I do not think anyone would disagree that the new hospital should be sited as much is possible to provide the maximum access to the maximum number of people.

Reverend the Hon. Dr GORDON MOYES: Can I take up that point, Dr Matthews. As access is one of the criteria, is it not a fact though that the main roads, and I include in that Mona Vale Road, Wakehurst Parkway, Pittwater Road and so on, are all easily accessible to the Mona Vale site, whereas Dee Why is a traffic mess?

Dr CHRISTLEY: I think—

Reverend the Hon. Dr GORDON MOYES: Dr Matthews—he spoke about that.

Ms KRUK: Can I get Dr Christley to respond to it in the first instance?

Reverend the Hon. Dr GORDON MOYES: I have other questions for Dr Christley.

Ms KRUK: I know, but the issue is it comes down to the criteria. I stress again, there were—

Reverend the Hon. Dr GORDON MOYES: Dr Matthews said it was a major factor, so I am asking him to substantiate whether Wakehurst Parkway, Mona Vale Road and Pittwater Road are major access?

Ms KRUK: Before I pass over to Dr Matthews, may I say—

Reverend the Hon. Dr GORDON MOYES: You are protective, Ms Kruk.

Ms KRUK: Some may not say that. What is significant in relation to the criteria was that the community had input into the criteria in addition to there being technical criteria about access. Traffic is obviously an issue for the peninsular. That has been well and truly accepted. As Dr Christley's submission to the inquiry indicated, some criteria was suggested in relation to what was the best access so that people living in that community would not go out of the area will be obliged to go to Royal North Shore. I now hand it over to Dr Matthews, whom I am not protecting.

Reverend the Hon. Dr GORDON MOYES: Yes, but Dr Matthews has received advice in the meantime while you were filling in.

Dr MATTHEWS: The director-general knows that I am a delicate little flower and need lots of protection. The No. 1 criterion for access is population. You have population studies before you that show that the vast majority of people live close to that site. You are quite right, I have received advice that quite significant traffic studies have been—

Reverend the Hon. Dr GORDON MOYES: If I might refer you to the northern beaches accessibility study, Mona Vale hospital ranked at 100 per cent for accessibility.

Dr MATTHEWS: For residents of the peninsular, yes, but hardly for residents of Dee Why.

Reverend the Hon. Dr GORDON MOYES: Seeing you mentioned the fact about the demographics of the area, is it not a fact that the Australian Bureau of Statistics report indicates that the northern areas of the northern beaches have a proportion of older people that is higher than the southern areas of the northern beaches?

Dr MATTHEWS: Yes, but the travel studies show clearly that in the afternoon peak hour Mona Vale has less access availability than Brookvale, but I am happy to pass—

Reverend the Hon. Dr GORDON MOYES: Does Mona Vale have less accessibility than the Dee Why site?

Dr MATTHEWS: Yes, in the afternoon peak hour, yes.

Reverend the Hon. Dr GORDON MOYES: How can that be so? I dispute your information.

Dr CHRISTLEY: Can I pick that up? One of the things about statistics is that there is a range of different things you can use to argue any case. The important thing is to look at all of the available information. The first thing to say is that your comment about the aged on the northern beaches, the Pittwater local government area, is absolutely correct. But we are not talking about one hospital, we are talking about two. Mona Vale hospital will continue to exist. We are talking about what is the best place for the bulk of the population to locate the acute services, and this is still a matter for debate.

I would use another example. If you were to take Hornsby, Hornsby hospital services from Roseville up to Wisemans Ferry. If you were to pick the most central location by the argument of people who challenge the health analysis, you would probably put Hornsby hospital in the middle of Galston Gorge, because that is probably, if you look at the travel distances, roughly equal. You do not put it there, because the majority of people in the catchment area served by Hornsby hospital live towards the south.

Reverend the Hon. Dr GORDON MOYES: Is it not the case that the Mona Vale hospital site has access to these other major roads whereas Galston Gorge has only one road? When you look at the northern beaches area you have Mona Vale Road, Wakehurst Parkway, et cetera?

Dr CHRISTLEY: The same argument works both ways. The same roads go in every direction. We have already set Mona Vale is the location of one hospital—

Reverend the Hon. Dr GORDON MOYES: The reason for this, Dr Christley, is that you studied the traffic flows in Beijing on your holidays.

Dr CHRISTLEY: I have never been to Beijing. Can I just finish answering your question? There are a range of different ways you can look at accessibility. If you take it that you want it for the bulk of the population, you weigh the population, which has generally been the analysis around most of our studies. It is surprising that across the range of am peak, pm peak—the tenth-busiest time, Saturday peak and Sunday peak, interestingly, if you look at those tables—and they may not be visible and I am happy to pass them on—there are a couple of places that obviously look higher. Mona Vale is down there and the shape of the lines, Manly hospital is more accessible than Mona Vale hospital on all but two of those indicators, because that is where the bulk of the population lives. The bulk of population lives in the south. We want the people to go to the new hospital. We are only identifying the site for a second hospital to be complementary to Mona Vale, so we are using the evidence we have to identify the site that is the best site on the northern beaches for that hospital.

Reverend the Hon. Dr GORDON MOYES: When will the feasibility study on the new proposed hospital be released?

Dr CHRISTLEY: I am not sure what you mean. If you are talking about the hospital sites—

Reverend the Hon. Dr GORDON MOYES: Yes.

Dr CHRISTLEY: That is up to the department and Minister.

CHAIR: You said complementary to Mona Vale. Did you not mean Mona Vale would become complementary?

Dr CHRISTLEY: They are both complementary to one another in a sense.

Reverend the Hon. Dr GORDON MOYES: Some years ago a redevelopment feasibility study of Mona Vale hospital site was undertaken. The resultant report indicated that that site was capable of the development of a 400-bed hospital. Are there any plans to revisit that earlier feasibility?

Dr CHRISTLEY: We have revisited that study. I presume you are talking about the initial planning, which showed that you could build the hospital and you still can. Mona Vale hospital would be a very good site to build the hospital you want.

Reverend the Hon. Dr GORDON MOYES: You are on the record as saying that you preferred a 350-bed public hospital located with the 150 bed-private hospital. Now, which sites are suitable for a co-located hospital?

Dr CHRISTLEY: Probably all of those. One of the things in the next phase—

Reverend the Hon. Dr GORDON MOYES: Can I just clarify the point—

Dr CHRISTLEY: Can I keep answering the question?

CHAIR: Please allow the witness to finish.

Dr CHRISTLEY: Any of those sites, and the next phase of the planning process, when we go into it, will be to look at private hospitals, whether there should be a co-located private hospital at what site, because as I indicated earlier around 50 per cent of admissions of patients on the northern beaches, and around 70 per cent for elective surgery, occur in the private sector.

Reverend the Hon. Dr GORDON MOYES: So, if your preferred option is the co-location of public and private, bringing together a total of 500 beds on one site, what is your comment about the Dee Why site?

Dr CHRISTLEY: First of all, you put words in my mouth. I did not say my preferred option was that. The feasibility study needs to be able to accommodate those options. When you do the service plan you then determine which of those sizes and configurations you want to put in place. As far as the Dee Why site goes, what we have just described or what is in the planning process—and we are a few beds out in it, we are not looking at 150, but it was 120—the Dee Why site accommodates that very well, as do all the others.

Reverend the Hon. Dr GORDON MOYES: Can I clarify, you are saying that what you have previously quoted as the preferred option for co-location of a 350-bed public hospital, a private hospital capable of 150 beds—I make that 500 beds on the Dee Why site, if that was the preferred option?

Dr CHRISTLEY: I think we looked at splitting 450 beds, but can I go back for a second. You have been quoting me as saying things. One of the things that has really disturbed me in this debate is the number of times Dr Christley has been quoted saying X, Y or Z by other people, by third parties. While I have not chosen to get into a dialogue about what I have said or what I have not said, the reality is that had I chosen to do so, a vast amount of what has been reported in the public domain as my comment or my views are not things I have said.

Reverend the Hon. Dr GORDON MOYES: I have certainly read a lot that you have said in the *Manly Daily* and other places.

Dr CHRISTLEY: If they were my words, I stand by them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You certainly have to read quite a bit to get definitive words.

Reverend the Hon. Dr GORDON MOYES: Can you try to be more accurate, then, for us. I was rung by a member of the staff of the Mona Vale hospital about a recent visit you made when you explained some of those things. This particular staff person told me that you have been most dismissive of this inquiry.

Dr CHRISTLEY: No, I don't believe so.

Reverend the Hon. Dr GORDON MOYES: Could you tell me what you did say about this inquiry?

Dr CHRISTLEY: The only words I can recall uttering about this inquiry was that I welcomed the opportunity to put on the record, without the intervening process of what I have just described, the views that I and the health service have.

Ms KRUK: Madam Chair, could I just make a comment here?

CHAIR: Certainly.

Ms KRUK: As I indicated in my opening statement, there has been a whole range of assertions made about what have been the preferences or otherwise of the Chief Executive of the Area Health Service in relation to the siting of the hospital. It is very difficult for Dr Christley to say, " I believe this is the one and only solution". He has been charged with the task to put forward a series of options, both in relation to bricks and mortar and site and clinical service configurations. It is not ultimately his call. I have had members of Parliament personally say to me that Dr Christley has an agenda.

That is not the case; he has a statutory responsibility and would be negligent in his responsibility if he did not consider a full range of options and the various feasibility studies that have previously taken place. It is his responsibility to provide advice to the government of the day on what he believes, on technical, community, health grounds, to be the best configuration. What he has also indicated is that there will be a range of options in relation to site. There will not be consensus on this issue.

The Hon. MELINDA PAVEY: Dr Christley, on pages 13 and 14 of your submission you include population projections sourced from DIPNR to the year 2011. It shows the Pittwater area with fairly low projections. Are you aware that DIPNR has just released more projections, taking them up to 2031, which show a marked increase in Pittwater LGA compared it with Manly and Warringah—Manly at 17.7 per cent and Pittwater at 36.3 per cent? Why were these figures not taken into consideration?

Dr CHRISTLEY: Our planning horizon is 2011. We did adjust our figures. At the end of the day the advice that we got on all the future projections is that the demographic centre of Cromer moves matters of hundreds of metres, rather than anything more significant.

The Hon. MELINDA PAVEY: Will you take into consideration these latest projections by DIPNR to 2031, which has increased?

Dr CHRISTLEY: Of course.

The Hon. MELINDA PAVEY: Given that we are at least five years away from the establishment of a new hospital at any of the six sites that are mentioned, could you tell the Committee how much has been spent by the Department of Health on all of these processes—

community consultation, planning and all the work you have done so far—to bring into balance what has happened on the northern beaches?

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

The Hon. MELINDA PAVEY: So, up to more than one million dollars in planning in the past five years?

Dr CHRISTLEY: There would be, yes. And that would not be out of the ballpark for most projects of this size.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it true that North Sydney health has had both Manly and Mona Vale hospital sites valued? What is the value of each of those sites? Who carried out the evaluation?

Dr CHRISTLEY: All of our sites have been valued, because it is part of our accounting process to value them. I would have to take that question on notice. I assume it would be the Valuer General.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You can get me those figures, though?

Dr CHRISTLEY: I can get you those figures.

Reverend the Hon. Dr GORDON MOYES: I would like to ask Mr Bazik, as Chief Executive Officer, some questions. What is your understanding of the role that Mona Vale Hospital will play if plans are for the major hospital to be built elsewhere?

Mr BAZIK: my responsibility in as General Manager of the Northern Beaches Health Service, is ensure that the health services are provided in a safe and efficient manner in terms of the general operating of the hospital. In terms of my association, in terms of planning, what the area health service has done is looked at the site selection process. My responsibility is to make sure that the hospitals and the general services are provided in a safe and efficient manner.

Reverend the Hon. Dr GORDON MOYES: Yes, sir. You tell me your job is to provide it in a safe and efficient manner, which is a good answer to a question I did not ask. The question that I ask you, if I might repeat that, was: What role will be Mona Vale Hospital play in the case of a new hospital being built elsewhere?

Dr CHRISTLEY: Planning is the area health service's responsibility.

Reverend the Hon. Dr GORDON MOYES: I am asking: What is your understanding?

Mr BAZIK: Certainly, I have not had any involvement in the future planning, in terms of the future of Mona Vale Hospital. My concern is the present; making sure that the services are provided in a safe and efficient manner; ensuring that the service is enhanced; ensuring integration of services. I certainly have not had an amount of input into that particular process.

Reverend the Hon. Dr GORDON MOYES: Could I go back to your "safe and efficient manner", is it not true that staff and others have expressed fears that the Mona Vale Hospital will fail its next national accreditation program?

Mr BAZIK: That is certainly not the case. In respect to the accreditation by the Australian Council on Healthcare Standards, there was an organisational-wide survey conducted in September 2004 in respect of which there were two particular areas of concern to the surveyors. There was an offer to return and re-survey the facility in January 2005, which was undertaken on 17 January. The surveyors were not impressed with **one particular area** in terms of cardiac-protected wiring of the

hospital, which was resolved. The other area was that the level of intensive-care-consultant cover was of particular concern, both in intensive care and in the emergency department.

Reverend the Hon. Dr GORDON MOYES: What strategies did you put in place to ensure that the second concern was covered?

Mr BAZIK: We had discussions with Professor Kerry Goulston, Chair of the GMCT to look at intensive care services for us and to endeavour to undertake consultations with clinicians and staff in respect to those particular issues.

Reverend the Hon. Dr GORDON MOYES: Did you advertise to fill that staff shortage?

Mr BAZIK: We certainly advertised for intensive care specialists.

Reverend the Hon. Dr GORDON MOYES: Have you conducted any interviews?

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

Reverend the Hon. Dr GORDON MOYES: What steps did you put in place to make sure there was good coverage?

Mr BAZIK: Well, in terms of discussions with the Director of Intensive Care, we have managed to provide locum cover to fill the gaps in the roster. In terms of intensive care, specialists required to run Mona Vale Hospital intensive care staff—we need approximately 5.8 staff, we only have two staff plus Dr Phipps helping in that regard. The rest of the cover is provided by locums. As I said, we have advertised without success but the intensive care unit at Mona Vale is basically unsustainable with regard to trying to recruit people to work in that particular environment.

Reverend the Hon. Dr GORDON MOYES: You are responsible for the oversighting of the staffing at Manly in this regard. How are the staffing levels at Manly?

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

Reverend the Hon. Dr GORDON MOYES: The previous Minister, Craig Knowles, set up the Greater Metropolitan Clinical Task Force, was that task force aware that you had a critical shortage of staff during the Christmas period, when you had to close down?

Mr BAZIK: The clinical task force commenced in around October 2004 and entered into consultations.

Reverend the Hon. Dr GORDON MOYES: Were they aware that you had a critical staff shortage?

Mr BAZIK: They were aware that there were issues. They undertook those consultations because they were acutely aware of the numbers of staffing we have. As I have explained in terms of providing locum staff, the ability to recruit the locum staff on an ad hoc basis, especially over festive seasons such as Christmas and Easter, is extremely difficult. We were trying to pay premium rates for anyone wishing to work, but both Dr Phipps and myself were unsuccessful in finding any locum staff for a 5-day period over Christmas 2004.

Reverend the Hon. Dr GORDON MOYES: You are responsible for the management of both Manly and Mona Vale during that critical period when Mona Vale had to close down. Why did you not take action against those intensivists at Manly who refused to travel to Mona Vale?

The Hon. AMANDA FAZIO: Dr Moyes, that's your last question for a while.

Mr BAZIK: Those specialists were employed to work at Manly Hospital. We had endeavoured, I had personally sought out staff from Mona Vale Hospital to assist the head of anaesthetics department, another anaesthetist, to help out over that period. Paul and I had both rung numerous people to undertake that particular responsibility, without success. Paul also had discussions with the staff specialists at Manly hospital, I understand, to see what their availability was. You could ask Paul may if he can recall those discussions.

Dr PHIPPS: This is a major difficulty for me a week-by-week basis. The staff specialists at Manly are 50 per cent staff specialists and they do a one-in-three on-call roster, which is more than they are required to do. They cover some extra weekends. It is really very similar to the situation with the intensivists at Mona Vale, who give far, far in excess of what they are required to do to try to keep the units open. Staff in both the units are working certainly in excess of what would be thought to be reasonable in any other unit.

Dr CHRISTLEY: We certainly had a difficulty staffing the unit at Mona Vale for that Christmas week. Two of the days we managed to get Carpenter and, despite a lot of lobbying the around to try to find some locum staff to cover that period, we were unable to do so. So, it became—

Reverend the Hon. Dr GORDON MOYES: This is an elaboration. Did they have any—

The Hon. AMANDA FAZIO: No. Look, you have asked enough questions. There is limited time.

Reverend the Hon. Dr GORDON MOYES: I did not know that you were chairperson.

The Hon. AMANDA FAZIO: It is about time you got a direction from the Chair.

Dr PHIPPS: I can go into the details of the difficulty we had over that period and I can go into the details of the contingency plan we had to make sure that Mona Vale actually had a reasonably high level of cover, to cover an acute services during that period.

Dr CHRISTLEY: That is actually a pretty important point, if I may say so. You used the word "closed". The Intensive Care Unit was not closed; there were alternative cover arrangements put in place for it and there was an arrangement that if one of those 70 to 80 patients per year came in that they would be transferred. But, for the rest of the patients, the intensive care unit at Mona Vale would have operated exactly as it normally does.

Dr PHIPPS: One of the Manly intensivists did a ward round at Mona Vale intensive care on Christmas Day and Boxing Day, as well as covering the unit at Manly. So, there is certainly a collegiality amongst all the intensivists on the northern beaches, and there is certainly a commitment from them that if we can get a good quality sustainable service together that they will be very supportive in making sure that they look after the patients no matter where they present on the northern beaches.

The Hon. CHRISTINE ROBERTSON: I would like to ask someone from the health service, I do not mind who answers the question. What has been the impact on staff of the misinformation that has emerged about this issue in relation to planning, as well as intensive care?

Dr PHIPPS: From my point of view I think this has been a very difficult period. I have a responsibility, I believe, to make sure that we can provide a very safe, high-level service in intensive care. I believe that is my job. It has been very difficult with certain comments, particularly in the media. I remember a front page of the *Manly Daily*, "People will Die". I think that makes life very, very difficult for us to try to convince the community that we can provide a very good and very safe service. We are up against it, really. Those sorts of comments from very influential people in the area

are very damaging to community confidence. I think those sorts of things make it difficult. For instance, we are having major problems now with recruitment of nursing staff at Mona Vale Intensive Care Unit. There is a lot of difficulty and uncertainty over the future of the service. I would like to see this resolved very, very quickly. It does not matter—whatever way, that is fine. I think we have to make a decision and go on and sort this out. I think that some of the politics and comments in the media have to stop. I think we have to work through this quickly, otherwise we will lose the service completely, and that will be a major problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Bazik, do you believe that there is adequate funding to operate and maintain services at both the Mona Vale Hospital and Manly hospital?

Mr BAZIK: I believe that we have a fair share of the budget, yes, I do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is not the same question. Do you have adequate resources to maintain services?

Mr BAZIK: Yes, I do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was the maintenance of the back-up power generator adequate at the Mona Vale Hospital? Was the back-up power generator adequately maintained that the Mona Vale Hospital?

Mr BAZIK: We have a back-up generator for power at the Mona Vale Hospital. Recently on one particular day, if this is the issue in question, the back-up generator failed because of the extent of the load on that particular generator for a period of 30-35 minutes. Steps have been taken to reduce that alternative emergency load and systems are now back in place.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was there a 35-minute blackout, effectively?

Mr BAZIK: That is right. We had a major blackout to Mona Vale generally which impacted on our electricity supply and the back-up generator did not kick in as it should have, despite monthly tests and trials that we undertake. This was a one-off occasion. We have made arrangements to ensure that this does not happen again.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the whole hospital had a 35-minute blackout?

Mr BAZIK: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why did Never Fail, who supplied water coolers, remove their water coolers? Was it from Manly or Mona Vale Hospital?

Reverend the Hon. Dr GORDON MOYES: Mona Vale.

Mr BAZIK: I understand it was from both, at Manly and Mona Vale.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why did it remove its water coolers?

Mr BAZIK: The area health service and local management had discussions prior about the feasibility of continuing with that type of water supply, and on review of that with our engineering staff, we have now put in place filtered water units in patient areas in lieu of the bottled water situation. We think that is the—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did they remove that because you had not paid the bill?

Mr BAZIK: As I have said, we certainly reviewed the way that we were dealing with our water supply and we believe that filtered water is a more economical way of dealing with that.

Accordingly, Never Fail withdrew its bottled water. There have been issues in relation to orderly payments of bills and, in discussions with Never Fail, I understand from the area finance department that they decided to not continue with us in that regard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say that there have been discussions about the orderly payments of bills, is that a way of saying that you had not paid them?

Mr BAZIK: I think in terms of what their expectations were with financial arrangements and payments of bills, they—

Dr CHRISTLEY: There was a period over the Christmas where the area had a cash issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Oh.

Dr CHRISTLEY: No, no; just let me go on. There had been complex services, particularly those provided by North Shore which had grown significantly in recent times. We have had discussions with the department and received some additional cash, and that situation is now resolved.

Ms KRUK: Madam Chair, can I just—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the supply of water a complex issue?

The Hon. AMANDA FAZIO: Is that in any way relevant to the terms of reference, Arthur?

CHAIR: Ms Kruk, if you—

Ms KRUK: Could I just make a few statements here? The configuration of these services will actually cost more money. This is not a rationalisation of services. All of the proposals that have been put forward actually speak of upgrading facilities. They speak of new services. This is not a rationalisation exercise, so that may be some of the underpinning of the Hon. Dr Arthur Chesterfield-Evans's questions, if I can assist in that regard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I be clear: if we are talking about improving our intensive care networks and so on, and we cannot pay for a back-up generator and water supply, surely there must be a fairly serious situation.

Reverend the Hon. Dr GORDON MOYES: Sell the land to pay for the water.

The Hon. AMANDA FAZIO: This is degenerating into garbage.

CHAIR: Ms Kruk, you may reply to that, if you wish.

Ms KRUK: I think Dr Christley has indicated that he has already responded to it. What is also significant is that there has been a significant amount of capital going into both of these hospitals while these discussions have been under way. I am very happy for Mr Bazik to actually pick that up. It is not as if the capital upgrades have not been ongoing through this period of consultation and discussion. I echo Dr Phipps's comment: there is no doubt that the current dispute, the current assertions, the current attacks on staff in the area health service make this a less attractive place to attract what is already an incredibly scarce work force, and the ability to keep good staff I think is also arguably under threat at the moment.

CHAIR: Thank you for those comments. As it is now just after 11 o'clock, we need to take a short break. Later today the Committee will have a deliberative meeting and we may resolve that. It may be necessary to call back either Ms Kruk or some of the witnesses. We have another hearing next week, but I will also be giving the opportunity to place questions upon notice and I will advise you, if that is the case, of the length of time in which you will have to respond, but that will be not less than a couple of weeks. We have not had the opportunity to resolve that but I am sure that you would be prepared to take questions upon notice.

Ms KRUK: Chair, I welcome that. Again I make the offer that, of the matters raised in the submission that you seek commentary on, we would also be able to do that as quickly as possible. Thank you for the opportunity.

CHAIR: Thank you. I believe there was one that was taken on notice this morning, and we will indicate the date that we would like that returned.

(Short adjournment)

CHAIR: The Committee will now move on to its second group of witnesses. As members of Parliament, neither John Brogden nor David Barr is required to take an oath or an affirmation.

JOHN GILBERT BROGDEN, Member for Pittwater of the New South Wales Legislative Assembly, 1725 Pittwater Road, Mona Vale, 2103.

CHAIR: In what official capacity are you appearing before the Committee—as a private individual, or a representative of an organisation or business?

Mr JOHN BROGDEN: As the member for Pittwater.

CHAIR: Do you wish to make a brief opening statement prior to any questions?

Mr JOHN BROGDEN: Yes I do. Thank you, Madam Chair and Committee members. Firstly, I thank the Committee for taking on these terms of reference that I believe are critical to the entire northern beaches community, not simply the Pittwater community. Do I have a problem that this microphone?

The Hon. AMANDA FAZIO: We cannot hear.

Mr JOHN BROGDEN: Would you prefer me to use another? That is better. Thank you, Madam Chair. Firstly I take the opportunity to thank you in assisting me in destroying the conspiracy to have my microphone turned off for the next 45 minutes. Secondly, I thank you for taking on the terms of reference, which are very critical not simply to the people of Pittwater, whom I have the honour to represent, but more particularly the entire northern beaches community which has a population of 230,000 people, and is growing.

Mona Vale hospital is fighting for its life. I want to note to start with the very strong community interest, in the form of the massive number of submissions delivered to this Committee in varying forms—detailed submissions from representative community groups, from the Government obviously, and from local councils, but also and an enormous number of individual submissions from concerned citizens who have taken the time to participate in this crucial process.

Can I make my position very clear: I support, and have always supported, two hospitals for the northern beaches. You might question, therefore, how this differs from the Government's position, put here through a series of senior bureaucrats earlier this morning, in that they state that they support a two-hospital policy for the northern beaches.

The announcement in November last year that the intensive care unit [ICU] at Mona Vale is to close is the significant difference between my position and that of the Government. In May this year I will have represented the Pittwater community in the New South Wales Parliament for nine years. From day one of my election to this Parliament representing the people of Pittwater, I have been fighting, with the support of the local community, to keep the doors of Mona Vale hospital open.

I think it is very fair to say that if the community had not fought so hard, it is very likely that Mona Vale hospital would have been closed many years ago. I want to congratulate my local community on their outstanding support for the provision of quality health care services through the local hospital. I cannot speak for Manly hospital; very few people in my community use Manly hospital, and I do not know any staff at Manly hospital. Therefore can I speak as the local member on behalf of Mona Vale hospital in saying that the staff are simply outstanding.

Over the last decade, despite very difficult conditions and a lack of certainty relating to the future of their hospital, the staff have continued to provide an outstanding medical service to my community. But more particularly, they have grown in their professionalism and they have worked with the community time and time again to deliver this service. As somebody who took the choice as a local resident, along with my wife, to have our son delivered at Mona Vale hospital in December 2003, I want my credentials to be on the table that I am a strong supporter of our local hospital.

From day one the Government's agenda has been to close Mona Vale hospital, to close Manly hospital, and to build one new hospital on another site. There has been a lot of talk this morning by the bureaucrats present concerning the public attention that has been brought to suggestions of comments being taken out of context or in some way or another abused, of the bureaucrats, in particular Dr Christley. I can indicate to you very clearly that it is my understanding from 1996 onwards that it has been the view of the Government to move to a one-hospital policy. I have had discussions in which the view of Dr Christley has been put very clearly to me that he does have a view for one hospital.

The fact of the matter is that earlier today Dr Christley stated that in 1999 the Government started planning for a two-hospital policy. In late 1998, prior to the March 1999 election, in response to the strong position put forward by me and the other Liberal members on the northern beaches prior to the election of the current member for Manly—and that is important in terms of the dynamics at the time—that the Government's position was for one hospital, Dr Christley was forced to come out and issue a statement in conjunction with the then Minister for Health, Craig Knowles, that there would be two hospitals. At that stage it was the Government's intention to move to one hospital. It is my firm belief that that still remains the bottom drawer policy of this Government.

What I want to know today is: How is it possible for the Government to put in place its current stated policy of two hospitals on the northern beaches, including an upgrade of Mona Vale hospital, when the specific policy now is to close the intensive care unit and to downgrade it? How is it possible to upgrade something when you are closing an intensive care unit? How is it possible to upgrade the hospital when you are closing the ventilated beds in the intensive care unit?

I took a moment to consult the *Australian Concise Oxford Dictionary* to refresh my memory of what "upgrade" means. It indicates that "upgrade" means a raise in rank, or an improvement. Closing an intensive care unit is not an improvement. How can the Government argue at any stage that it intends to upgrade Mona Vale hospital if it closes the intensive care unit? Over the last decade we have seen the Government run down both hospitals, until they have been put into a crisis situation. I have always held the view that the real estate value of Mona Vale hospital has been a factor in the consideration of the Government's policy at all times.

I would like to deal presently with the intensive care unit. There is no doubt that the closure of the intensive care unit at Mona Vale hospital is the de facto downgrade of Mona Vale hospital. It is the beginning of the end for Mona Vale hospital. The closure of the ICU is a de facto closure of Mona Vale hospital.

On 11 November—by coincidence, not cognisant of the signatories at that moment—the four peninsula members of Parliament signed a memorandum that, I understand, has been circulated to the Committee in submissions. The purpose of this was to move the issue forward. For too long the Government had said, both in public but most particularly behind closed doors, that until the northern beaches community can agree on the way to move forward, nothing will happen at Manly or Mona Vale. So in view of that position put forward by the Government, the four northern beaches members of Parliament—the member for Wakehurst, the member for Davidson, the member for Manly and I—signed a statement to move the issue forward.

It was, as one might imagine, with enormous distress that we discovered one day later, on 12 November 2004, the Government's announcement of a set of interim measures for Manly and Mona Vale hospitals. They include that the intensive care unit at Mona Vale be closed and moved to the Manly intensive care unit; that the maternity unit at Manly be closed, moved and merged into the maternity unit at Mona Vale, and in addition there be significant capital expenditure at the Mona Vale maternity unit to improve it; that a new bone fracture clinic be established at Mona the hospital; and that there be increased transportation services between the two hospitals to allow for this new set of measures to be put in place.

At no stage prior to the announcement of these changes was there any consultation with the local community. There was no consultation with local members of Parliament, and there was no consultation, but simply a meeting, with Mona Vale surgeons and staff. I was advised of these changes by distraught hospital staff at Mona Vale hospital, and then subsequently by the local media. I had received no contact from the Minister, Morris Iemma, or the area health service director, Dr Christley, prior to this announcement being made.

I want to make that statement very clear because I think, and I trust, that the Committee will see that as a demonstration of the lack of consultation at every stage through this process on critical decisions. I demanded publicly a briefing from somebody in government—anybody—about what the Government's proposals were.

On 2 December I met with Professor Kerry Goulston, who is the chair of the GMCT, Dr Phipps, who was part of this Committee's evidence a moment ago, and Brad Hazzard. The purpose of the meeting was for me to receive a clinical briefing on the importance of the changes as outlined publicly. As the plan was outlined to me by Professor Goulston and completed, I asked him whether it was his view that the plan he put forward to the Government—intensive care going from Mona Vale to Manly, maternity going from Manly to Mona Vale, a bone fracture clinic at Mona Vale, and other capital and recurrent expenditures to support them—was an all-or-nothing option for the Government; whether it would take all of those proposals or none of them.

His answer to me was yes. You might therefore imagine my surprise and cynicism when I discovered that, despite the submission, Manly is to keep its maternity unit and there is to be no movement of the unit between Manly and Mona Vale. If that is the case, why is it that Mona Vale is to have its intensive care unit [ICU] downgraded as part of this process? My view is that the Greater Metropolitan Clinical Taskforce process, as delivered by the Government, has more do with politics than it does with medicine. I express extreme disappointment with the GMCT process and I indicate that I have a total lack of faith in the process and in its outcome.

Today Dr Christley gave evidence indicating—I hope to quote him directly, but his intent was clear—that the Mona Vale Hospital intensive care unit has reached crisis point. When did it reach crisis point? How has it reached crisis point? No-one in our community has ever been advised or informed by the Government, the area health service, NSW Health, the Minister, or anyone at the hospital that the ICU is at crisis point. When did it reach crisis point? At what point were lives put at risk? The Government has not explained one of those things. It appears, once again, to have more to do with politics than with medicine.

Mona Vale Hospital ICU has two ventilator beds. Surgeons advised me last week that the two ICU ventilator beds at Mona Vale Hospital have been in full use. The Government has argued that there is a lack of need for them at Mona Vale. That is simply not supported by the fact that, for the last calendar week, staff and patients at Mona Vale Hospital desperately needed ICU ventilator beds. The Committee is aware of the fact that in the week immediately prior to Christmas the ICU was closed at Mona Vale due to a lack of work force issues—a phrase that I think the Government likes to use. No members of staff were available to keep a reasonable level of care at Mona Vale ICU. In response to that, local obstetricians indicated that they were no longer able to supervise births at Mona Vale Hospital.

So not just the ICU was closed. Effectively, the maternity unit was closed, forcing pregnant women with literally days to go before the birth of their children to find a new place in which to have their babies. It is not simply the closure of the ICU that is being considered by this Committee and by the Government. If you close the ICU you begin to close down many sections of this hospital. The point that has been made many times is that patient safety is used as the reason to close Mona Vale intensive care unit when the exact opposite is the case. Mona Vale surgeons have indicated to me that patient safety will be put at greater risk by closing the ICU. On Saturday morning I met with 11 surgeons from Mona Vale Hospital. They clearly stated to me that the intensive care unit at Mona Vale hospital is functioning satisfactorily right now. For them and the community the closure of the ICU at Mona Vale would mean the following. I quote from one of the surgeons who said:

> Patients are placed at extraordinary risk at their most unstable time of management.

The surgeons all agreed that the closure of the ICU was a process in the dumbing down—their words—of the whole hospital. They indicated—and this is also of concern—that, as surgeons, they would no longer conduct many surgical procedures at Mona Vale Hospital because of the closure of the intensive care unit. This is all substantive evidence to demonstrate the point that the closure of the Mona Vale Hospital intensive care unit is a de facto closure of Mona Vale Hospital. They referred also to the Ryde and Royal North Shore experience, with Ryde having a closed intensive care unit and

the Royal North Shore intensive care unit acting to support it, and the downgrading of the Mount Druitt intensive care unit, which will be supported by Westmead hospital.

Those examples are simply not analogous with the Manly and Mona Vale situation. To suggest that Ryde equals Mona Vale and Manly equals Royal North Shore, and to suggest that Mona Vale Hospital equals Mount Druitt hospital and Manly equals Westmead hospital is simply unsustainable. In both those cases a smaller hospital is having its services downgraded and incorporated into a larger hospital. In the case of Mona Vale and Manly, effectively they are two equal hospitals. It simply cannot be argued that that is analogous. Another point that was made that adds to the concern and cynicism about the process relates to the GMCT recommendation of the creation of a bone fracture clinic at Mona Vale, as part of the deal, if you like.

It was indicated to me that the bone fracture clinic was not a new proposal. It was created over the past four years by orthopaedic surgeons at Mona Vale. Crumbs were thrown off the table to Mona Vale Hospital and it was told, "You will get a bone fracture clinic", which was a fallacy from the outset as it already had a bone fracture clinic—the one that orthopaedic surgeons at Mona Vale Hospital had developed over the past four years. I put to the Committee two other issues for further consideration and investigation. These issues relate to the Mona Vale and Manly intensive care units and the difference between them. I ask the Committee to investigate the following issues. Do surgeons working at the Mona Vale Hospital intensive care unit in its current configuration earn as much as surgeons working at the Manly intensive care unit earn?

Reverend the Hon. Dr GORDON MOYES: They do. I asked that question.

Mr JOHN BROGDEN: The other matter relates to work force issues. Local surgeons advised me that in response to the Christmas closure nine locums expressed an interest to Dr Phipps—I accept that it may not have been Dr Phipps; it may have been somebody within the area health service or within the joint hospital management—and indicated their willingness to act as locums at Mona Vale. Nine doctors indicated an interest but not one was engaged by the northern beaches administration to keep the ICU open. I have also been advised that doctors are willing to discuss with the Government and the area health service ways in which they can participate in providing ongoing intensive care services.

One thing that is clear to me as this debate moves forward is that the Government does not want to maintain intensive care units at Mona Vale Hospital. It is not an issue of the unavailability of staff, it is not an issue of unsafe practices, and it is not an issue of patients' lives being put at risk. The issue is the agenda of the Government to see the de facto closure of Mona Vale Hospital. I make very clear the point that the closure of the intensive care unit at Mona Vale Hospital is unacceptable to the northern beaches community. The proposal from the GMCT for Mona Vale Hospital is nothing other than a downgrade. There will be no improvement in the provision of maternity services, an already existing bone clinic will be continued and the intensive care unit will be closed.

I refer next to issues relating to site selection. Prior to 2004 the location of a new hospital in the Dee Why business district was never discussed or considered. Until the government-appointed administrator of Warringah council put forward the option of generously giving up his own council administration site to the area health service for a new hospital it had never been considered an appropriate place to site a hospital. Anybody who knows the northern beaches area would know that Dee Why is the centre of traffic congestion. It is a highly inappropriate place for a hospital that is meant to save lives when people's lives are at risk. The only reason Dee Why is being considered as a site for a new hospital is that Mr Persson, the Labor-appointed administrator of Warringah council, came forward with that as a suggestion.

When Mr Iemma was Minister for Public Works prior to his appointment as Minister for Health, Mr Persson was director-general of that department. I understand that he was also a board member and later president of the Central Sydney Area Health Service. Dee Why is a disaster area for the location a new hospital because of traffic congestion, parking and the size of the site and, in particular, the Government might wish to co-locate the private hospital. In this day and age we do not build 20-storey hospitals. The only way we would get a building that would take a public hospital and a co-located private hospital would be if it touched the sky. I understand that the Government is

having significant problems with the heritage issues relating, believe it or not, to the brutal era of Warringah council.

There is—and this is a significant point—outstanding and overwhelming community opposition, from Manly to Palm Beach, to the location of a hospital at Dee Why. The community of the northern beaches from one end to the other regard it as quite possibly the worst place to put a new public hospital. I make another comment about Professor Goulston's GMCT interim measures. I have been concerned from the outset about this process. Once a final site or a final option has been put forward as the Government's preferred option it would be, if you like, government policy. In view of the movement of health services on the northern beaches, in whatever configuration is put forward, we would expect the Government to put in place interim measures. In contrast, we have interim measures without a final result.

It is little wonder that there is a strong level of cynicism in the community with respect to this issue. It is clear to me and to the surgeons at Mona Vale in particular that the interim measures are being used to drive the final results. In other words, if you close the intensive care unit, obstetrics will die pretty quickly, followed by a vast range of other surgery. The Government would then argue, "There is nothing left at Mona Vale. We will close it down and move to one site." That is the agenda of the Government. I believe that the Government is misusing the good name of Professor Goulston to shield it from political criticism.

I conclude with two points. Firstly, I noted Dr Christley's and Ms Kruk's concern about the use and misuse of their names and reputations in this process. If the Minister and his successive Ministers had fronted the community, Dr Christley and Ms Kruk would not have to be doing their dirty work for them. What is annoying about this process is the lack of involvement, over a long period, of successive ministers in this long-term solution. It is for that reason that Dr Christley has had to engage himself in part of a political process because of the Minister's refusal to do so. I believe it has been grossly unfair on members of the public service to require them to do the Government's dirty work time and again.

Lastly, the entire Manly and Mona Vale Hospital saga has been a cynical attempt by the Government to divide and conquer the people of the northern beaches. We are now facing a situation where the de facto closure of Mona Vale is forcing communities at each end of the peninsula, yet again, to quarrel and bicker about the best place to locate new services. I believe that the Government is seeking to benefit from a divide-and-conquer approach. It is my view that the community will not do so. The community wants to work towards a solution. Four members of Parliament have shown a willingness to work towards a solution. We feel somewhat betrayed by the Government in its response, one day later, to our open hand on this issue, which effectively was to commence the closure of Mona Vale Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: John, you are the member for Pittwater and your community obviously supports Mona Vale as the preferred site. Why do you not support Mona Vale as the level 5 metropolitan general hospital?

Mr JOHN BROGDEN: Arthur, I have made my position clear from day one. That is a two-hospital policy. That two-hospital policy effectively has had a number of complexions to start with—and this has been a matter of debate over some period of time. The original complexion was—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you do not believe that we are going to have one hospital on the northern beaches.

CHAIR: I think we can allow the witness to finish his answer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: He has had a pretty long time to answer this very simple question. Why does he not?

CHAIR: The witness has the floor.

Mr JOHN BROGDEN: The fact of the matter is it is not as simple as you would like it to be, Dr Chesterfield-Evans. The situation is as follows. There have been many complexions. They

include the fact that we looked at upgrading both hospitals on their current sites. There is, I think, a majority view, yet to be fully tested, that the Manly site is, first, a set of very old and increasingly dysfunctional buildings; but also that its location is not perfect in contrast to, I think, a very good location for the Mona Vale Hospital. Therefore, at one stage the strong view was, looking at one of two options, an upgrade of Mona Vale to the large—if I can use "large" and "small", Dr Chesterfield-Evans—hospital at Mona Vale and a smaller hospital at the southern end of the peninsula. Brookvale was often the venue used in these discussions, or the reverse: the maintenance and upgrade of Mona Vale Hospital but the construction of a level 5—if that is the phrase we are using—or large hospital at the southern end, likely at Brookvale.

It is my view that, moving forward, the principal argument is to maintain services at Mona Vale at any cost—that is the debate we are in at the moment. Moving forward, it is my view, as has been stated publicly, that the likely construction of a new hospital in Brookvale, for example, at the southern end—genuinely at the southern end—would be probably a preferred option for the level 5 hospital. Having said that, the slap in the face that the community has received from the Government, frankly, put everything back on the table and particularly notes the strong opposition of the northern beaches community to the location of the hospital at Dee Why. Let me be very clear: If you build a new hospital at Dee Why that is the end of Mona Vale Hospital. I do not know how the Government can sustain an argument that they can pour hundreds of millions of dollars into Dee Why and pretend to keep Mona Vale open. It is 10 minutes away by vehicle. No government can seriously argue they will do that. That is another reason why Dee Why is the wrong site.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So do you stand by the statement of agreement that you signed with other northern beaches members of Parliament, given that Dee Why is the Northern Sydney Area Health Service's preferred site?

Mr JOHN BROGDEN: If you note that statement, Doctor, it is indicated very strongly that the three Liberal members of Parliament are strongly opposed to the Dee Why site. That was part of the agreement. So there is a conflict within your question. With respect to the member for Manly, I will let him speak for himself other than to say that he took a proviso out of that agreement. As I recall—Mr Barr can speak for himself—the only area of dissent was that Mr Barr was happy to keep that in consideration. We three Liberal members of Parliament refused to consider that as an alternative site.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You did talk about the two hospitals. You do, though, concede that there will be only one level 5 hospital.

Mr JOHN BROGDEN: That has always been conceded. No-one has ever argued that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you now do concede that that will not be at Mona Vale. Is that your position?

Mr JOHN BROGDEN: No, no, no, no, no. The Government is going to make a decision in the next two years, possibly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is your position, though?

Mr JOHN BROGDEN: I have made that clear. It is in the statement you have in front of you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not clear to me.

CHAIR: Do Government members have any questions?

The Hon. CHRISTINE ROBERTSON: Yes, I have some questions. Thank you, Madam Chair. Professor Malcolm Fisher, the head of the intensive care services for Northern Sydney Area Health Service, said in November last year that intensive care specialists do not have a high regard for John Brogden's knowledge or understanding of what they do. How do you respond to that comment?

Mr JOHN BROGDEN: Never met him and no interest in his comments. He can pick up the phone to me any time.

The Hon. CHRISTINE ROBERTSON: That is another of my questions. Have you spoken to any of the intensivists who work in that area?

Mr JOHN BROGDEN: I have spoken to Dr Phipps. So the answer is: Yes, I have.

The Hon. CHRISTINE ROBERTSON: What is your impression of what he had to say about the in-total plan in relation to intensive care rather than the "downgrading"—I think that is the word you used—or "closing", which is not what they are saying at all?

Mr JOHN BROGDEN: Well, they are downgrading the ICU. If you close ventilated beds that is what I call a downgrading. You cannot argue anything else; you simply cannot argue anything else. In terms of Dr Phipps, Dr Phipps presented in the meeting with me with Professor Goulston his position that he believed, due to work force issues, there would be an inability to get suitable staff coverage for Mona Vale Hospital's ICU into the future. All of the indications that I have received from other surgeons suggest that is not the case.

The Hon. CHRISTINE ROBERTSON: You keep moving along very nicely to my next question. Thank you.

Mr JOHN BROGDEN: I am here to assist in any way I can.

The Hon. CHRISTINE ROBERTSON: Thank you so much.

Mr JOHN BROGDEN: Thank you.

The Hon. CHRISTINE ROBERTSON: Are you aware that not any doctor can become an intensive care specialist overnight and that locums are not necessarily regarded as being safe? You need staff specialists, registrars and people around. A locum can help.

Mr JOHN BROGDEN: Based on that suggestion I have to argue that, having heard evidence from Dr Christley and Mr Bazik earlier, the Manly intensive care unit must be unsafe because from time to time it uses locums.

The Hon. CHRISTINE ROBERTSON: Yes, I guess as the inquiry goes on we will get some more information about staff specialist cover in relation to locums.

Mr JOHN BROGDEN: Well, they indicated they use locums. So if locums are good enough for Manly they are good enough for Mona Vale.

The Hon. CHRISTINE ROBERTSON: On what information do you base the uninformed claims that only serve to scare your community and undermine the experts in intensive care, whom your community relies upon to maintain the intensive care services in your area?

Mr JOHN BROGDEN: Can you repeat that question because there is no question in it; it is a statement.

The Hon. CHRISTINE ROBERTSON: No, there was a question.

Mr JOHN BROGDEN: On what basis do I what?

The Hon. CHRISTINE ROBERTSON: On what information do you base the information you are giving your community that contradicts the intensive care specialty people?

Mr JOHN BROGDEN: As I indicated to you earlier, on this Saturday just past I met with 11 surgeons who exclusively—not exclusively, I am sorry—who work at Mona Vale Hospital. I assume they have private practices as well—I know some of them have private practices as well, of course. They indicated to me very clearly that the intensive care service at Mona Vale provided now is

suitable to their needs. So I base that on 11 surgeons whom I met with on Saturday, all of who indicate that the intensive care coverage for Mona Vale presently received is adequate for them to undertake births—obstetricians were present, anaesthetists were present and general surgeons and orthopods were present. They all indicate that they are satisfied with the ICU service as presently provided.

The Hon. AMANDA FAZIO: Mr Brogden, I might ask you to clarify something first. In your opening statement you kept referring to something called the "GMCC". There is a greater metropolitan clinical task force. Is that what you were referring to?

Mr JOHN BROGDEN: I thought it was a committee not a task force. I thought it was regularly called the GMCC. I am sorry.

The Hon. AMANDA FAZIO: Okay. Are you aware that it is the view of Dr Phipps and the greater metropolitan clinical task force that a single critical care service over two sites—Manly and Mona Vale—is the safest way to go forward?

Mr JOHN BROGDEN: I am also clear that it is their view that the maternity should be moved from Manly to Mona Vale. So why is that not happening?

The Hon. AMANDA FAZIO: I was not asking about maternity.

Mr JOHN BROGDEN: The Government cannot pick and choose the GMCT's—or GMCC's—advice as they wish to, and that is what is happening.

The Hon. AMANDA FAZIO: I am asking: Are you aware that a single critical care service over the two sites—Manly and Mona Vale—is the safest way to go forward?

Mr JOHN BROGDEN: I am aware that is their view. I am also aware it is not the view of 11 surgeons presently working at Mona Vale Hospital.

The Hon. AMANDA FAZIO: Have you consulted with any of the staff at Manly hospital?

Mr JOHN BROGDEN: No, I have not—not in recent times on this matter. But they are not working at Mona Vale Hospital; they are from Manly hospital. I am talking to the staff at Mona Vale Hospital about what they think is suitable for Mona Vale Hospital and the community that it serves.

Reverend the Hon. Dr GORDON MOYES: John, can I ask you whether you have any reliable information on the real estate value of the Mona Vale Hospital site?

Mr JOHN BROGDEN: No, I have not, other than to say that it is a very large site. Indeed, the site presently is larger than it would appear to the eye because it includes part of the Mona Vale Golf Club, in which I declare an interest as a non-playing patron. So it is a very large piece of land. It is a piece of land—and there is some dispute over the history of the land—and a common view, that I understand to be incorrect, that it was gifted to the Mona Vale community by the Salvation Army for the exclusive purposes of a hospital—in other words, with a covenant. I understand there is no covenant over the land but I do understand that the land was, in some form or another, gifted to the Government for uses for health purposes.

So I believe, frankly, that in view of the fact that the Salvation Army—which has a history of land ownership on the northern beaches, in particular around the Collaroy area north—their view, their vision and their gift to this community was for health services, that deserves some significant consideration. All I would say is that I do not know how much it is worth, Dr Moyes, but it is an extremely expensive piece of real estate. I do not know next to a couple of golf course of any area of land that large with that sort of view that easily accessible that is available except at Mona Vale Hospital.

Reverend the Hon. Dr GORDON MOYES: Have you had any reliable information about the value of the Dee Why site?

Mr JOHN BROGDEN: No, I have not. But, for the information of the Committee, it is not clear what the Dee Why site includes: whether it is simply the council car parks in addition to the council chambers or whether in fact—back to our friends in the Salvation Army—it includes their aged care facility, which is behind the site. Either way, I simply do not believe it is large enough. Putting the size of the land aside, it is a very steep piece of land and I would argue that, standing at Pittwater Road, Dee Why, it would almost be three, four or five storeys up to where the Salvation Army is at the top of that land.

Reverend the Hon. Dr GORDON MOYES: And in order to get the total number of beds for a collocation of both public and private hospitals we would have to envisage a very high set of buildings.

Mr JOHN BROGDEN: I think it would be Centrepoint on the northern beaches.

Reverend the Hon. Dr GORDON MOYES: And you would certainly see New Zealand on a clear day. We have had evidence from Dr Christley that the Dee Why site has the better or the best public access, particularly in the afternoons. As the member covering that area and moving through it, is that your opinion?

Mr JOHN BROGDEN: No, it is not. To quote Dr Christley, you can get consultants' reports and figures to tell you exactly what you want them to tell you. Anecdotally, there is no doubt in my mind that the traffic congestion through the Dee Why site now is critical. It is bounded, if you like, by a significant and at times dangerous intersection at Warringah Road and Pittwater Road down at Brookvale. The site that is being referred to would be no less than a kilometre or two north of that site. It is a very restricted site in many ways for access. In terms of the traffic, anecdotally—and I think I would voice the views of the majority of the residents of the northern beaches—getting from Palm Beach to the Dee Why site, or more particularly from Manly to the Dee Why site, the likelihood of being stuck in traffic in a critical peak hour is very high.

The other issue with access, Dr Moyes, that cannot be ignored is there are over 1,000 people whose permanent residence—not their holiday home—is on either the western foreshores of Pittwater or Scotland Island. For them, having an injury, a heart attack or indeed should a pregnant woman feel the onset of birth, they have to get across by water access only and then link to an ambulance, which will then take them to hospital. I might say that, in discussions with the previous Minister for Health, Mr Knowles, he was not aware of this. I understand that; we cannot be expected to know all the geographical nooks and crannies of the State. It is such a matter of concern that one of the permanent roles of the water police at Pittwater is, in part, as a baby delivery service. If you visit the water police at Pittwater they have a list of who is due and when they are due so they can assist them in getting from Scotland Island, Mackerel Beach, Elvina Bay and so on across to Church Point or Palm Beach, depending on where they are, so that they can quickly get to a hospital. They are, if you like, in a Sydney geographic sense, not unique issues—there are other water-access communities—but I think they are the largest ones.

Reverend the Hon. Dr GORDON MOYES: But it makes the point that moving the maternity section to the most southern part of the northern beaches, at Manly, does not seem to take into account the needs of people in the most northern?

Mr JOHN BROGDEN: Agreed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I come back to the question of what exactly is the Opposition's model? Do you want a level-5 hospital separately and new? If not, what do you want to be the principal hospital on the northern beaches and what do you want to do with the other hospital?

Mr JOHN BROGDEN: Do we want a new level-5 hospital on the northern beaches—absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do, a new hospital?

Mr JOHN BROGDEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What do you want to do with the other two hospitals?

Mr JOHN BROGDEN: Oh, I see. Whether it is Mona Vale hospital that is level 5 or not, Mona Vale must be upgraded on its current site. As for the Manly site, in all likelihood the redevelopment of the Manly site for a level-5 or even a level-3 hospital would be a little difficult, to say the least. As a consequence, people have all talked about a Brookvale site. Let us not get tied up with Brookvale, let us just say a southern site, certainly south of Dee Why. But Brookvale has been used time and again as a possible site. What then would be done with the Manly facilities? There has been some argument sometimes that as there are good staff, chronically underfunded and critically underresourced, providing mental health services at the East Wing at Manly, it may be that the maintenance of those mental health services at the East Wing at Manly would be a consideration for the future. There are heritage issues with some buildings on the Manly site, as I understand it—not as many as you might imagine—but certainly there is the capacity for the continuation, as I would view as necessary, of some ancillary health services on the current Manly hospital site. In other words, I would not want to see it flogged off.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You want to upgrade Mona Vale?

Mr JOHN BROGDEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You want a new hospital and you want to downgrade Manly?

Mr JOHN BROGDEN: No, the new hospital would effectively replace Manly. You would not have three hospitals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you would downgrade Manly in order to build the new hospital.

Mr JOHN BROGDEN: Downgrade is probably the wrong word. You change the status of it completely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said level 3.

Mr JOHN BROGDEN: No, I did not say that. I said you might build a new hospital or revamped facility at Manly, but that is extremely unlikely, so whatever is done at the southern end is more likely to be on a new site. What you then do, effectively, with the facilities—presently a hospital—at Manly needs to be a matter for extensive public consultation but it is my view that that site should not go on the Carr Government's auction chopping block.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not going to sell Manly but you want another hospital in a southern area to replace Manly?

Mr JOHN BROGDEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You want to upgrade Mona Vale, so are you asking for two high-grade hospitals rather than one?

Mr JOHN BROGDEN: No, it is not sustainable for two. You would have one level-5 hospital—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which one is going to be the dominant one?

Mr JOHN BROGDEN: I have indicated in the past that it would be more likely at the southern end but, having said that, as everything is now up for grabs with this Government in terms of the betrayal of trust on the continuation of the intensive care units, the Government has to come to us as to which it regards to be the better site. There are good arguments because of the size of the Mona

Vale site and the fact that is already owned by the public that you could put the level 5 there and co-locate it with a private hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would not commit yourself to that earlier in this discussion today?

Mr JOHN BROGDEN: That is exactly what I said.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I said, do you not support Mona Vale as a level-5 metropolitan general hospital? If there is only going to be one on the northern beaches, if you support it, then it is the key hospital for the peninsular, is it not?

Mr JOHN BROGDEN: I think I have been around that many times.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not think you have been clear at all. You have been evading it. Are you supporting Mona Vale as your main hospital for the northern beaches if there is only going to be one level 5? It is a level 4 now and if you want to upgrade it surely it becomes a level 5?

Mr JOHN BROGDEN: No, not necessarily.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A 4½ perhaps.

Mr JOHN BROGDEN: Perhaps.

CHAIR: Do you wish the Carr Government to rule out the Dee Why site?

Mr JOHN BROGDEN: I think that is critical. I think it has to rule out the Dee Why site. It was never under consideration. At no stage in the many years we have been debating this, talking about a new site for a southern-end hospital, has the Dee Why business district been up for consideration. It only came up for consideration, out of the blue, when the government-appointed administrator of Warringah Council, Dick Persson, put it forward a suggestion. Before that it was not so much that nobody had considered that site because it was owned by the council; it was that it was never considered appropriate to place any facility in the middle of an already congested Dee Why business district. I made my position very clear. That is, that the Government has to reject the Dee Why site.

The Hon. CHRISTINE ROBERTSON: Do you know where you want it?

Mr JOHN BROGDEN: I have made it clear it should be somewhere in the southern end. Dee Why is not real south, it is nearest to the centre. Having said that, the Brookvale option is one that has been considered time and again. The honourable member for Davidson suggested a Frenchs Forest site. In other words, there needs to be genuine and ongoing clinical input and public consultation. There are other issues. For instance, if you close Mona Vale hospital and put a single hospital at the southern end—let us say it is not Dee Why, let us say it is Frenchs Forest—the Wakehurst Parkway floods several times a year. People will die sitting in an ambulance while there is a flood in front of them. To make it very clear, it rises very quickly. You can be on the road with no flooding likely and by the time you get there, there will be a flood through which, particularly these modern low ambulances, would not make it. Pittwater Road is congested. Mona Vale Road is in part only a two-lane road and very dangerous. So none of this can be seen in isolation from the roads around the area.

(The witness withdrew)

DAVID BARR, Member of Parliament, appeared before the Committee:

CHAIR: Are you appearing in your official capacity or as a representative of an organisation or as a private citizen?

Mr DAVID BARR: I come here as member for Manly and as a founding member of Better & Equitable Access to Community & Hospital Services [BEACHES],

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

Mr DAVID BARR: Yes, I do.

CHAIR: Before you do, I need to indicate that should you consider at any time during your evidence that certain evidence or documents you may wish to present should be heard or seen 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 it decides to do so in the public interest.

Mr DAVID BARR: I certainly do not want anything in camera. I believe this inquiry is misconceived. It is far too narrow in focus. The issue is not about Mona Vale on its own. The issue is about how we can get the best quality hospital and health care along the northern beaches. There are 233,000 people in the northern beaches, and I have given figures in the BEACHES document. There are 57,000 at Pittwater; 39,000 at Manly; and 138,000 at Warringah. The issue is in what way can we get the best outcome for everyone on the northern beaches. It is not an issue of Manly versus Mona Vale. It is an issue of how we can get the best services for absolutely everyone.

I am quite astounded by some of the statements that have been made here. For example, one of them was about the issue of access in Dee Why and how it is congested, and so on, and that the Wakehurst Parkway floods. Let me put this to you. If you live in Harbord or Curl Curl or Manly and you have to go to Mona Vale, if it becomes a level-5 hospital, you either drive past Dee Why, and considerably further north, or you go up Wakehurst Parkway. So, if people say those two are too difficult, you are consigning 80 per cent of the population of the northern beaches to indecent access to a hospital site. That is how absurd those two propositions are, and I have no time for that.

There has been far too much politicising of this event. That has worked counter to the possible benefits, the great benefits, that would derive from a central hospital. BEACHES and I have always taken the one position. That is, that there should be a central, level-5 acute hospital at the demographic centre. That demographic centre is somewhere around Brookvale, Dee Why, Cromer, stretching out west towards Frenchs Forest. That would give maximum benefit for the most people. We have supported a complementary role for Mona Vale. The challenge for the planners and for the Mona Vale community is to work together and to come up with a coherent package as to how that can work best. We support that.

As far as the Manly site is concerned, it should not be a hospital at all. Mention was made of the Eastern Wing, the mental unit there. You do not locate mental health patients outside of an acute-care hospital. They have to be co-located with the new facility. It is that simple. That would not be a site for the Eastern Wing to continue. What I have proposed and what I think has very strong community support is that there should be an aged care facility up there. There is a chronic shortage of nursing home beds and there is a possibility of State and Federal governments working together to come up with a decent facility. It could involve as well public-private participation of some sort and some mixed forms of housing for the various stages of aged people. That has been my position. I certainly do not support a selling off of that site or of the Mona Vale site. They should both be retained in the public interest.

So, the issue that faces us on the northern beaches is that we have two hospitals, both of which are unravelling. The intensive care unit [ICU] discussion today about Mona Vale—and it is an unfortunate one, it is unfortunate it has happened at this time—is one example. The paediatrics ward at Manly hospital closed three years ago. That was a six-bed facility. It had a 47 per cent occupancy rate. A child had died in unfortunate circumstances. There was a critical coroner's report followed by a professorial study and it was announced that it was not going to reopen in the New Year—it closed

down in December. The community and I and the medical staff council put a proposal to the Government to keep it open and there was yet another professorial study into that by a professor from South Australia, an expert in paediatrics. His view was it was unsustainable and basically not safe. The Minister at that time, Craig Knowles, said to me, "I am sorry, I would like there to have been some other way, but I am told it is not safe. I cannot keep it open."

The problem was there were so few patients—47 per cent occupancy of a six-bed facility—that it could not attract the specialist paediatric nurses or the paediatricians. But that is just an example of the problem that faces the two hospitals. Each in its own right is not big enough to sustain the full services. So what you will see, whether we get a new hospital or not, is a rationalisation between these two hospitals. Something will go to one and something else will go to the other. That means that each will then be incomplete as far as offering full services. I do not think that is sustainable in the long term and I think the public has the right to expect a modern facility with the most up-to-date and expensive equipment and specialised staff.

BEACHES has taken the view all along that it should be a new centralised facility. This is the way northern health has been moving for a long time now with our support. One of the stumbling blocks to this has been the fight from the north. It has destabilised things. I found it quite astounding that we are facing the prospect of getting a big new hospital—a 350-bed facility—and people are fighting this. Shadow politics played a part in this and I think there has been a lack of statesmanship in regard to it. It is about time we said, "This is what must happen". There may be an element in the community in that would rather have the hospital down on the road from them, but not everyone can have a hospital down the road from them. If you look at, say, country towns, people may have two travel hundreds of kilometres to get to a decent hospital. We are not talking about a very small number of kilometres on all of the northern beaches. We are talking about the need to place the hospital where the most people are and most people are at the southern end. The figures that the Committee has before it showed that 80 per cent live south of Mona Vale Hospital.

This issue is about access, equity, quality and safety. That is what this issue is about, how you can get the best outcome for the most people in the most equitable and fair way. That is what I believe to be the case, that that is the road we should be going down. I will briefly go through each of the issues raised in the terms of reference of this inquiry, the first being the Intensive Care Unit [ICU]. I would agree with the member for Pittwater in that it was unfortunate that the announcement about the ICU came a day after we had made our statement of understanding. That was certainly unfortunate. None of us knew that that was about to happen.

I would also say that in January 2004 there was a two-day workshop involving community people about the ICU and obstetrics services. At that time the possibility was touted that maternity would go to Mona Vale Hospital and the upgraded ICU would go down to Manly. That was, at that time: part of the community consultation. It was not something totally unknown; there have been discussions in that direction. My view of all of this is that these are interim measures and when we get a new hospital most services will be rationalised into that new hospital, certainly including an upgraded ICU.

We are looking at the short term, the next, say, five years. The pity in all of this is that if the Government had announced the site and people could see that it had progressed, announcements about downgrading, upgrading, sidegrading or anything else would not have had quite the same impact. The critical issue is that the public can see that there is a road forward, that there are going to be new and better facilities available. That is my comment on the ICU. Later this afternoon when BEACHES makes its presentation, Lyn Hopper will be talking in more detail about the ICU and statements that have been made in submissions, so far as that is concerned.

So far as funding is concerned, we have pointed to the lack of capital funding for Northern Area Health over a 12-year period. You have the table that shows clearly that Northern Area Health had been underfunded significantly in terms of capital works funding. A new hospital on the northern beaches will go a fair way to rectifying that, in conjunction with works that are being undertaken at Royal North Shore Hospital. But, for a long time, we were the Cinderella—and we are still the Cinderella—so far as capital works funding is concerned.

My position is that we demand of government that we get our fair share; that we get a decent hospital—not just hospital in terms of bricks and mortar, but also community health outlets. This is not just about bricks and mortar; it is about a whole array of services, community health services, that will be located not just at a hospital but up and down the peninsula. At the moment there is something like 42 community health service outlets. It is debatable whether they are operating as efficiently as they could. One could argue that people may have to go to two or three different locations for different aspects of their problem. There is clearly a need to rationalise those and to bring some order into them and some benefits for the community. It is not merely bricks and mortar, it is the whole array of services.

The issue of community consultation will be addressed by Sandy Hudspith from BEACHES this afternoon. There has been more community consultation on this issue than in respect of any other health service. I sincerely believe that. It has been never-ending, to the point where we have had consultation coming out of our ears. In my view, if anything it went too far. I would make the point about consultation that there are times when the public health experts have to make decisions. They may not necessarily win favour with a community. I will give me Committee an example. Let me take the issue of needle exchange centres. That was done in the interests of public health, and I do not think anyone he would argue against it in terms of prevention of HIV, hepatitis C and whatever. But there would be a fair number in the community, I think, who would have disquiet about needle exchange centres in their local suburbs. Some communities may say they do not want it. You then have to ask yourself what is in the greater public interest.

There are times when, having taken into account what the community's desires are, the experts have to shape that and try to give the public what they want. But it has to be done in the context of health planning and not in the context of people jumping up and down and saying, "This should not happen," or, "That should happen," or that they believe the ICU would or should not be closed. Complicated medical issues are involved. Politicians or members of the community who jump up and down may not have an informed idea of the issues that are involved. There comes a point when we have to rely on the experts so that a safe service can be provided. Safety is critical. As we know from recent events within the State, the issue of safe hospitals is a critical one for every politician in this place.

The last item is: Why is Mona Vale not the new centralised hospital. Frankly, it is to far north and its population catchment is too small. It is just not on for the people lower down on the peninsula to be moving up to Mona Vale. The hospital should be at the demographic centre. It has been claimed by the Save Mona Vale Committee that it is the geographic centre. As the BEACHES document points out, Ayers Rock is the geographic centre of Australia but we do not put our facilities there. You put the facilities where the people are and that is where you get the maximum benefit.

I would say this, too, that the issue of two hospitals has always been clear in my mind but the major hospital has to be at the demographic centre. That is totally unambiguous and I believe the statement of understanding that the local members of Parliament had, which was signed in November last year—and I might add that there is not one word there that is a deviation from my previous belief; it has certainly been the BEACHES position for a long time. There is nothing in this that changes from the fundamental BEACHES position. Where it says that there is to be new hospital—I believe it should be called the Northern Beaches Hospital, not a new Manly hospital, because it is for everyone—and complementary role for Mona Vale Hospital. That is what this document says.

Clearly, implicit in that is that Mona Vale will not be the level 5 hospital, nor should it be, nor can it be. We have to be very clear about this. The so-called battle to save Mona Vale has two forms. One was to save Mona Vale, and it was noble to do that. But it is more, it has changed to: Mona Vale is the best site for the new hospital. Well, I'm sorry. No way Jose! It is not acceptable to the majority of people on the northern beaches to be the centralised level 5 acute hospital. It just is not, and it is unrealistic to think that it is.

As politicians it is our responsibility to state clearly and unequivocally where we stand, what we think the critical issues and principles are and that here to them, even if it means that we lose some support or that people do not like what we are saying. Speaking personally, after I became a member of Parliament in March 1999, one of the first meetings I had was with Stephen Christley and the Medical Staff Council at Manly Hospital. They said, "Our hospital has gone. We need a new hospital.

This one is not working and it does not have any future." They said that there would be no marches and down the hill to Manly Oval, as there was in 1996 when there was a proposal simply to shut down the hospital.

This debate has been ongoing for six years since 1999, all the time that I have been a member of Parliament. I have taken the position, at some political risk, of saying that Manly hospital is no longer up to the job; we need a new hospital. People might accuse me of selling out my local facility. People get emotional about the hospitals and that is understandable. People have histories of themselves or their families being born at a particular hospital or of having been operated on there. I have consistently adopted that position. I continue to adopt that position and always will. There is no ambiguity whatsoever in that. I cannot say that for some of my colleagues on the northern beaches and the various positions of that they have taken.

That is clearly my view and Manly will not continue as a hospital, but I will support it as an aged care type facility, a nursing home facility in particular, and an ongoing complementary role for Mona Vale have Hospital. Those are the issues that still have to be nutted out. What I would like to see now, clearly and unequivocally, is for the Government to announce the site so that we can get moving on this project. It has been dragging on for too long.

CHAIR: Thank you for your comments about the Committee's terms of reference. Earlier today we were reminded that the Dee Why site is just 10 minutes from the existing Mona Vale Hospital. Are you somewhat exaggerating the position of Dee Why as the centre?

Mr BARR: That is interesting. If it is 10 minutes away, what is the problem? We are getting all sorts of contradictory statements about how congested Dee Why and Wakehurst Parkway are, and in another breath some people say it is only 10 minutes away. You cannot have it all ways. The issue is for I hospital further north to cater for the needs of people in the Pittwater area but the acute facility to be at the demographic centre. That could be Dee Why; it could be Brookvale. Quite honestly, Brookvale is only 1½ kilometres from Dee Why. There is little or no difference in terms of whether it is Brookvale or Dee Why—and possibly as far west as the French's Forest site.

All members of Parliament agreed that the hospital should be the demographic centre. I am the only one who has said that I do not have a problem with the Dee Why site. Prima facie, I think it is a good site, but we have all made it clear that that is subject to the expert analysis relating to traffic and all that sort of thing. Somewhere along the way you have to fall back on the expert advice to say what is and what is not possible.

Reverend the Hon. Dr GORDON MOYES: I believe you received, correct me if I am wrong, that massive petition of 18,000 signatures from Mrs Joan Harris?

Mr BARR: I have not received any petition.

Reverend the Hon. Dr GORDON MOYES: You were never asked to present that tradition to Parliament?

Mr BARR: No. I am aware a petition was presented but I had no part in that. I would think it highly unlikely that it would be given to me because the people who would have presented it are the people who do not support the stand that I have taken. BEACHES was formed to provide some sort of sanity in this whole hospital debate and to remove some of the hysteria that has been present.

Reverend the Hon. Dr GORDON MOYES: Could I ask you a follow-up question on the BEACHES issue. Has BEACHES received any funding from the Manly Medical Staff Council?

Mr BARR: BEACHES has received one a lot of funding, if you could call it that. We had a public meeting about the paediatrics ward closure and there was something like—I think you may have been $2,000 or $1,500I am not sure of the amount—collected at that public meeting, which then sat in a bank account. When they paediatrics ward was closed there was the issue of what we would do with the money—just leave it sitting there indefinitely or use it as part of the battle for a new hospital which would contain a paediatrics ward with appropriate critical mass. I approached the Medical Staff Council and that council deliberated on it and determined that that amount, whatever it

was, could be handed over to BEACHES for its campaign. That is, I might say, the only dollars that we have handled as such. We have worked on really no budget at all.

Reverend the Hon. Dr GORDON MOYES: In the close of your statement you finished up by saying, "and with the complementary role provided for the Mona Vale Hospital". What did you mean by "complementary role"?

Mr DAVID BARR: I also said that is the challenge of Northern Area Health and the community to nut this one through, and I would have thought that the considerable energies of the Save Mona Vale Hospital people would be much better directed to addressing this issue than trying to argue that their hospital should become a centralised facility.

The Hon. TONY CATANZARITI: Just a couple of quick questions, time wise between the two hospitals, Manly Hospital to Mona Vale, what would you say that would be?

Mr DAVID BARR: I would not I like to be quoted because I do not drive that very much. I drive to Dee Why quite often from Manly and from Balgowlah where I live, and I can get to Dee Why in 15 minutes without any problem whatsoever. To get further north to Mona Vale from Manly or Balgowlah would be, I would think, at least another half an hour, but I do not want to—they are laughing, but one of their submissions says it takes up to 60 minutes to get from Palm Beach to Dee Why. That is a submission in their submission, so you cannot have it all ways once again. But it may be, say, if we say 15 minutes from Dee Why, let us say 20, another 20 minutes from there, give or take.

The Hon. TONY CATANZARITI: The other question I have is there seems to be some concerns about the traffic control around Dee Why and also flooding around, which would probably stop the people coming from the Mona Vale area down from—

Mr DAVID BARR: As I have indicated, that is a two-edged sword. You can hardly talk about people going up to Mona Vale if you are grumbling about traffic conditions in Dee Why of the Wakehurst Parkway. The Wakehurst Parkway issue is, I think, greatly exaggerated. It does flood sometimes, and sometimes there are fires. But if you were to look at how many days of the year that happens you probably would come up on average in the last decade maybe with one day a year, if that, maybe a couple, but it is not significant. I might say that the member for Pittwater, as the Leader of the Opposition, held a shadow Cabinet meeting on transport recently at Balgowlah RSL, two weeks ago today. At that meeting he said there is only one entry. He is supporting a new tunnel under The Spit and as part of the justification he said there is only one road into that area. You cannot talk about having a centralised facility out there, and at the same time, mention that there are difficulties of access.

The Hon. AMANDA FAZIO: You probably heard, I noticed you in the room earlier, the member for Pittwater talking about any new hospital going in as being just a part of a ruse to eventually close Mona Vale Hospital. I am not sure if you saw in the weekend issue of the *Manly Daily* there was a feature on Dr Christley and there were some comments on it. He stated in there that the development of a new northern beaches hospital to replace the Manly Hospital was proposed to be at Brookvale. Then he goes on to say the upgrade of the Mona Vale Hospital. In your dealings with Dr Christley and the Northern Sydney Central Coast health service have you at any time doubted the commitment to maintain Mona Vale Hospital?

Mr DAVID BARR: Never doubted it at all, nor have I doubted it in my dealings with the previous health Minister, Craig Knowles, or the current health Minister, Morris Iemma. I have never doubted that. To say that it is a ruse when it has been going on for six years and had enormous levels of consultation, enormous levels of planning, it is quite extraordinary that someone can say this is a ruse. This is dead cert serious about getting a new hospital, and Stephen Christley has kind of made it his aim in life, to get a new hospital. It is quite extraordinary, as I have said before, that people of the northern beaches are backing theirs as though it is some demon when, in fact, it obviously and clearly is for the public of benefit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could I ask you, if you think the Dee Why site is suitable, is there any transport problem? Would you abdicate putting in light rail or some other way of meeting the transport needs?

Mr DAVID BARR: No, I would not advocate light rail at all. I am opposed to light rail. Obviously issues of buses, issues of, maybe, tidal flows or how these matters are dealt with and different entry points to the hospital, all those sorts of things. But that is up to the experts to work through. And no matter where you propose to site, if you propose, say, at the Brookvale Bus Depot which it did, at one stage, look as though it were a possibility you would have the same issues, the same road, Pittwater Road, and there it is opposite Warringah Mall and the issue of what you do with the buses and so on. If you have it at Frenchs Forest on the corner of the Wakehurst Parkway and Warringah Road, early morning is pretty grid locked there; there are certainly traffic difficulties there. It is not that easy and appropriate a site. I think the Dee Why site, as a layman, is a pretty good site. I think it is most unfortunate about the so-called heritage buildings, these ugly 1960s pre-Brutonist, buildings and I think it is architectural vanity to think that they should be reserved for posterity. Certainly I think that works against the greater public good, if it meant that that site could not be considered for that reason. That issue is being worked around, but I would much rather see those buildings demolished and the northern area could start with a clean slate on that particular site.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your position is very clear—

Mr DAVID BARR: Absolutely clear.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: —you want a hospital in the demographic centre?

Mr DAVID BARR: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The downgrading of Manly to an aged care facility?

Mr DAVID BARR: "Downgrading" is the wrong term. It is a new use.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: New use of Manly from an acute hospital to an aged care facility?

Mr DAVID BARR: Yes, which would include housing, I believe.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean being developed?

Mr DAVID BARR: No, but I do not mean—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean aged housing?

Mr DAVID BARR: Aged housing, correct, different stages of aged housing in the same complex.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not nursing home entirely?

Mr DAVID BARR: Yes, a mix.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Some self-care units?

Mr DAVID BARR: Self-care, that sort of thing. I think that would be quite acceptable to the public because it is for the community benefit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And an upgrading of Mona Vale, or at least the maintenance of Mona Vale so that it could do significant surgery and, perhaps, transport out its severe cases, which, I believe, it is doing now and, I believe, Manly is doing now, also.

Mr DAVID BARR: Absolutely, and all hospitals do that. If we look at children, severely injured children do not go to Manly or Royal North Shore they go to Westmead. The public are used to the notion that for severe types of trauma the hospital down the road is not the appropriate place to be treated. He wants to go where the experts are and where the best facilities are, and it is unrealistic to think that every hospital can have all these facilities down the road so that they can have their casual stroll down there and be fixed up. You have to look at where to properly site clinical services and how to get the maximum benefit for most people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think all this discussion on intensive care is actually the tail wagging the dog in that 70 per cent of the people are done in private hospitals, 70 per cent of elective surgery is done in private hospitals where no intensive care is anyway, and these hospitals have been surviving without a central maximum intensive care unit already?

Mr DAVID BARR: Yes, I think that is the case and the BEACHES submission does say that de facto what has been announced is what has been happening anyway at Mona Vale in terms of its being ICU or high dependency and basically that is what has been happening anyway. I think it is also true to say that there are many people who live at Pittwater who drive past their hospital to go to a private hospital. I think there is no doubt about that, and I think the idea is that we can get a good facility on the northern beaches so that people will not have to do that.

The Hon. MELINDA PAVEY: Did you have any discussions with Mr Dick Persson before he announced the availability of the Dee Why site?

Mr DAVID BARR: No, I do not think I did. The Dee Why site came as a surprise to me, although what I have been subsequently told—

The Hon. MELINDA PAVEY: When you say "a surprise", you just read it in the paper?

Mr DAVID BARR: There was an announcement made in the Parliament by the Minister that the Dee Why site was the preferred site. Subsequently I have been speaking with Northern Area health people and have been told that Dee Why was in their calculations for some time anyway.

The Hon. MELINDA PAVEY: But the first you heard of it was when the Minister made the announcement in the Parliament?

Mr DAVID BARR: Basically, yes.

The Hon. MELINDA PAVEY: Basically yes or no?

Mr DAVID BARR: I am not sure if I—

The Hon. MELINDA PAVEY: I am just wondering whether you had a discussion with the Minister or any of his staff?

Mr DAVID BARR: No, I certainly had not had a discussion with the Minister or with the Northern Area Health.

The Hon. MELINDA PAVEY: Or the Minister's staff?

Mr DAVID BARR: Not about that as a site, no. It came late in the day and it was a surprise. That does not discount the validity of it as a site or otherwise, but I had been expecting the Brookvale Bus Depot site to be probably the preferred site and now I have been told there are various difficulties with that. But for a long time I was saying to people, "It looks as though it is the Brookvale Bus Depot site."

CHAIR: You said earlier you were having consultations, I think your words were, "coming out of your ears". How could it be that a as site such as the Dee Why site came to you as some sort of surprise?

Mr DAVID BARR: Because the issue of sites has confidential aspects to them in the sense that when the health planners are putting their slide rules over a site there are issues of resumptions and all sorts of things, so they cannot come openly and say, "Well, we are looking at this site. We are going to go up to Joe Bloggs who owns the adjoining site and see how much needs to buy him out." It does not work like that. So all that I have been aware of over the years is that there have been a number of sites, and I have heard different ones named, say, the TAFE site, Beacon Hill came into the picture in more recent times. My understanding is two things: Frenchs Forest looked to me originally, if you are going back to or three years, as though it was going to be the site and I have no problems with that. And then it looked as though it was going to be the Brookvale Bus Depot. So when it became Dee Why it was a bolt out of the blue that it was Dee Why and not somewhere else, but that is the nature of the beast, I think, as these negotiations have to take place to see what is possible. It cannot be in a public domain. Afterwards it can be and should be, and still has to be subject to if it is going to be the Dee Why site or wherever would still have to go through all the planning processes of council and public consultation and public input and all the rest of it. So it is just early days, whichever site is named.

CHAIR: Were you surprised that the Government in its six sites as referred to this morning has Mona Vale as one of the six sites?

Mr DAVID BARR: I think Mona Vale always should have been one of the sites that it looked at because it has to be able to say clearly, "We have looked at sites X, Y and Z and we think site Z is the appropriate one." I have not heard Mona Vale before, and I am not privy to each and every site that they have looked at. No-one has come to me and said, "David, we are looking at all these different sites and have named them all. "I have heard bits and pieces over the months and over the years. I had not heard Mona Vale.

The Hon. MELINDA PAVEY: Are you familiar with the Northern Beaches Accessibility Study?

Mr DAVID BARR: Broadly, yes.

The Hon. MELINDA PAVEY: What is more important to you, for the new level five hospital to be located in the demographic centre or the area that is more convenient in terms of accessibility?

Mr DAVID BARR: I do not see them as mutually exclusive. I think if you are placing a hospital where the bulk of the population are then you are dealing with the accessibility issue anyway.

The Hon. MELINDA PAVEY: But this study here shows that the Mona Vale site is as, if not more, convenient than the Dee Why site. You made the point earlier that Dee Why is just as accessible, but for anyone who travels on the northern beaches area—

Mr DAVID BARR: I cannot possibly see how the Mona Vale site could be as accessible. It just does not ring true. It cannot possibly be.

The Hon. MELINDA PAVEY: But in terms of travel times and accessibility we have the congestion and that is well documented in the Dee Why area—

Mr DAVID BARR: You are going back to the congestion at Dee Why and I point out to you that if it is at Curl Curl, Harbord whatever you drive through Dee Why to get to Mona Vale, they cannot talk about traffic congestion at Dee Why and, in the same breath, talk about having it at Mona Vale, because not only are you having to drive to Dee Why but then you have to go beyond there. That makes no sense at all.

The Hon. AMANDA FAZIO: We heard a lot before from Robyn Kruk and Dr Christley about the impact on medical and hospital staff of the controversy surrounding this issue. Have you had any feedback from either staff at Mona Vale or Manly hospitals about any damage to morale in the way that this issue has been run by some of the community groups.

Mr DAVID BARR: I think there has been enormous frustration at the lower level of debate, I am speaking for the Manly hospital staff, and some of the comments and outrageous claims that have been made on the Mona Vale the side of things, and it has disheartened them because they clearly, unequivocally, want a hospital and overwhelmingly staff at Manly want a new hospital at the demographic centre.

The Hon. AMANDA FAZIO: Do you think that some of the comments that have been thrown around have actually helped to erode public confidence in the health services that are provided on the northern beaches?

Mr DAVID BARR: Well, there have been hysterical claims made. There have been outrageous claims made. The standard of debate has declined. It has not been a mature, measured debate. It has been about hysteria, and that is a great pity. That is why I am calling on the Government to resolve this issue quickly now, to name a site and let us get moving on a site and make it clear to the people of Mona Vale once again that their hospital will stay and it will have an ongoing role as an integral part of hospital services on the northern beaches.

The Hon. MELINDA PAVEY: So you would get behind Mona Vale being chosen as the site for that very reason, just to get on with it? If the Government seeks to relieve pressure—

Mr DAVID BARR: No.

The Hon. MELINDA PAVEY: No, I am just making the point—

Mr DAVID BARR: No, Melinda. I have made very clear to you the reasons why I think the hospital should be a demographic centre.

The Hon. MELINDA PAVEY: But if the Government decides that Mona Vale is the easiest, best and quickest choice for the peninsula, you would get behind it?

Mr DAVID BARR: I do not think—I would not support that and I do not think it will be the case because clearly, it is not. It is not the easiest site to get to, and it is just a nonsense to suggest that it is.

CHAIR: Thank you, Mr Barr.

Mr DAVID BARR: Thank you.

CHAIR: The Committee will have a brief deliberative meeting. I ask all members in the gallery to now all leave. The Committee will resume at 2 p.m.

(Luncheon adjournment)

CHAIR: We will now move on to witnesses representing the Save Mona Vale Hospital Committee. I understand that a couple of the intended witnesses are now no longer available.

HARVEY MAXWELL ROSE, Deputy Chair, Save Mona Vale Hospital Committee, 13 Urara Road, Avalon, 2107, and

PARRY WYNN THOMAS, Chairman, Save Mona Vale Hospital Committee, 8b Wyanga Road, Elanora Heights, 2101, sworn and examined:

CHAIR: Mr Rose, in what official capacity are you appearing before the Committee—as a private individual or as a representative of an organisation or business?

Mr ROSE: As deputy chair of the Save Mona Vale Hospital Committee.

CHAIR: Mr Thomas, in what official capacity are you appearing before the Committee—as a private individual, or as a representative of an organisation or a business?

Mr THOMAS: As Chairman of the Save Mona Vale Hospital Committee.

CHAIR: Before I ask whether you wish to make a brief opening statement prior to questions, may I just note that if you should consider at any stage during your evidence that certain evidence or documents you may wish to present should be heard or seen in private by the Committee, the Committee will consider your request. However, the Committee or the Legislative Council itself may subsequently publish evidence, if they decide it is in the public interest to do so. Do you wish to make an opening statement?

Mr ROSE: Yes, I do.

Mr THOMAS: Madam Chair, we have actually structured this. With your indulgence, both of us were going to make relatively short statements, if that is all right.

CHAIR: That is fine. Mr Rose, would you like to commence?

Mr ROSE: Good afternoon, Chairperson and Committee members. My name is Harvey Rose. I am the deputy chair of the Save Mona Vale Hospital Committee. Our executive of about 20 members has met practically each week over the last four years or more than four years, and there is an overhead there which our Treasurer is about to put up. It just tells some details about our committee. I would just like to establish our credentials. As you see, we were formed in late 2000 and reviewed over 10,000 pages of material. We have well over 100 members and there are several hundred committed helpers who assist with letterbox drops; 35,000 people have signed petitions supporting our message to the Government; 16,000 people have attended rallies which we have organised; over 10,000 postcards were sent to the Minister for Health at our initiative. Thousands of letters of support have been written to politicians and the media.

Members of the Committee, this committee of ours has endured, grown and persisted because it is truly representative of our community and has the overwhelming support of our community. This is not the case with all community groups and I would hope that any other community group making submissions would be willing to establish their credentials, just as we have now. It is simply wrong for groups with limited membership who meet very occasionally to claim they are really representative of their community and that they have community representative status.

Having said that, this afternoon I will particularly look at issues related to community consultation and the siting of a new general hospital. Just to establish my credentials—as well as being the deputy chair of Save Mona Vale Hospital Committee, I was for a period the spokesperson for the Northern Beaches Community Consultative Health Planning Group which was composed of five representatives from each council area appointed by the councils to work with northern Sydney health. As such, I was also the community representative on the steering committee to plan their future

health services for the northern beaches. So I have been very much part of the process as well as with the Save Mona Vale Hospital Committee.

The Northern Sydney Central Coast Area Health Service's submission claims that it has undertaken successful community consultation process. If this is true, I simply ask: How do you explain the ongoing opposition from the community to northern Sydney health proposals? At that level, it certainly is not a successful process. What I believe northern Sydney health has in fact done is pay lip-service to community consultation while continuing to pursue its goals of a single dominant hospital in the Dee Why-Brookvale forest area—a hospital to be financed primarily by the sale of the present Manly hospital land and as much of Mona Vale Hospital land as it can get away with selling. That is the only conclusion I can come to after over four years in this process. Really, it is very frustrating. It is really a very sad, sorry and expensive business, all of this. It is perhaps summed up best in a comment on the consultation process in the Pittwater Council's submission where it states:

> The community consultation process was poorly conceived, inadequately designed, and riddled with implementation problems. Throughout all stages of the process there has been a clear bias in the way information was presented by Northern Sydney Health.

If I could have the second overhead which looks at the consultation process—the major stages of it—four phases, if you like, and some of the responses from the community. Look, the faults in the process are detailed both in our submission to your Committee and in the Pittwater Council's submission to your Committee. The phone survey: There was just very little information given and the questions are not well put together. The newsletter and feedback: Well, the options in the newsletter were not the same as in the feedback form. Even so, the option which said to upgrade Mona Vale got the most returns. The health summit was a joke: 60 people were supposed to go, 37 turned up and listened to a variety of experts put the northern Sydney health line, essentially. So we have got failed processes.

What was the response to these clumsy attempts at manipulating the process? Well, we had a rally at Rat Park at which 6,000 people overwhelmingly called for the retention and upgrading of the Mona Vale Hospital, and 15,000 people signed a petition asking the State Government to retain and upgrade Mona Vale Hospital, and so we had to go into phase two. Northern Sydney health had not got the answer they wanted at the end of phase one and we went into stage two and it is centred on the Northern Beaches Community Consultative Health Planning Group of which I was the spokesperson at one stage and also on the steering committee. There were more attempts at manipulation which resulted in Pittwater delegates leaving the process, but even so, the major measuring instrument—that is, written responses on a preferred option—resulted in the option for a general hospital at Mona Vale and a community hospital in the south getting the most responses: in fact, 60.8 of the entire vote, and this included 58.7 of the Warringah respondents. It was not just from Pittwater. Of the Warringah respondents, 58.7 said they wanted Mona Vale as the major hospital and another hospital in the south.

There has been a consistent failure to recognise community support for Mona Vale throughout this whole process, and that is something I want to really try and get across to you. Whether all of these results of this is a flawed process, it still comes out that the bulk of the community wanted Mona Vale as the major hospital and another hospital in the south. Out of all this—we had the rally at Brookvale and there were 3,000 people at the rally at Brookvale who endorsed the resolution that Mona Vale and Manly hospitals be maintained and upgraded. And then we had the petition—and that was from all parts of the northern beaches—when 20,000 people signed a petition supporting one network, two hospitals. Out of this, as I say, came the PFP. Just before northern Sydney health submitted the PFP to the Health Department but for consideration in the 2003 budget, the Health Minister announced the two-hospital decision for the northern beaches, with Mona Vale remaining and a new Manly hospital in a more accessible site. Councils and community groups all agree on a one network, two hospitals solution. Again, more community responses and the rally at the Dee Why site—I am sorry, the rally at the Brookvale site—and all of that.

So and then we go on to phase three which was the announcement on the Dee Why site. There was no community consultation about this: I do not care what they say. They appointed three so-called eminent citizens—ex-politicians—but there were no meetings; nothing was held. Brad Hazzard did a bit of polling on this showing that locals were predominantly opposed to the Dee Why site—Pittwater Council, Manly Council, Federal MPs, Tony Abbott, the Health Minister, and Bronwyn Bishop as well as John Brogden and Brad Hazzard and Andrew Humpherson were all

opposed to the Dee Why site, yet apparently this is the preferred site. Only David Barr from whom we heard this morning and the unelected administrator of Warringah, Dick Persson, were in favour, so what was the community response? Again, a rally was held that Dee Why mainly organised by the Save Our Civic Centre Group. We were involved as well as a group from Manly. Everyone got together. This called on the Minister for Health to abandon any plans for building a new major hospital in the Dee Why Civic Centre area. This was the biggest rally, I was assured by the former Mayor, that has ever been held in Warringah. We have got all of this opposition.

We come to phase four, the GMTC recommendation that intensive care at Mona Vale be downgraded. Look, I was at a workshop a year and a bit ago and we put thousands of hours into this. I was at a workshop and the decision of that workshop and all clinicians and community people there was that intensive care would remain at both Manly and Mona Vale hospitals, and a year later we find out that intensive care is being downgraded and it is going from Manly and Mona Vale—just as I sat down with Stephen and three other Pittwater people we were told that there would be one network, two hospitals, and there would be no downgrading of Mona Vale. If that is not downgrading, taking intensive care out, if what we are seeing now is not downgrading—not upgrading as we were promised—I do not know about the definition of ordinary English words.

The community responded again and we had 3,000 people attend the rally saying that intensive care services must be maintained and upgraded at Mona Vale and that Mona Vale Hospital is the perfect site for a major general hospital on the northern beaches. But they have gone on from then. The latest is they have got an implementation group going. They had two community groups on the implementation group, and I think it is an insult to this Committee. They started implementing these things before this Committee hearing and I personally thought that was very wrong, that they should have waited until this Committee had brought down its decisions and considered those things. Instead, like a bull at a gate, ahead they go; two community reps, one of them did not turn up—we had never heard of either of them—we asked if we could go and we were told, "No, you can't go". So much for community consultation.

The whole thing is a sorry history of flawed consultation, an attempt at manipulation on the part of Northern Sydney health. On the other hand, it is a gain history of effort by a community to make sure good health services emerge and public land is not sold off for development. My other concern, and I have already touched on this this afternoon, is the site of the new hospital. Before I put up the last overhead may I simply say that I believe Mona Vale is the perfect site for a new hospital on the northern beaches. The Mona Vale site is the geographical centre of the northern beaches. The Mona Vale site generally fulfils the accepted criteria of 20 kilometres or 30 minutes travel from all parts of the northern beaches, and this is the criteria accepted by everyone, I think, in this process.

It is true that the Mona Vale site is not the demographic centre of the northern beaches. So what? It has very good access; much better than Dee Why, and it is the northern part of the northern beaches which will grow most rapidly in the next 26 years. This morning and in his paper Stephen Christley talked about the figures to 2011. The DIPNR paper projections come down to 2031 and they clearly show the population of Pittwater increases by 36 per cent or 20,000 during that period, while Warringah declines; Warringah goes backwards at 1,310. And I ask why Northern Sydney health figures stop at 2011? The hospital will not be completed until around this time, but hopefully will be fully operational right through 2031. Why stop at 2011? Perhaps because the figures after that date do not suit.

In any case, access is more important than the demographic centre and Mona Vale's access is better. The travel studies certainly show that. There is one very important travel study which was mentioned this morning and it clearly shows that in the morning peak it is easier a.m. to get to Mona Vale; in the afternoon peak it is easier to get to Brookvale. So it is just not simple. Any of this is not simple. I would ask you to consider the complexities of the whole thing.

The last overhead is a comparison of Mona Vale and Dee Why. We have at Mona Vale ample land, 8.8 hectares; limited land at Dee Why. I do not know where they are getting their land from. It is rubbish. We are there, we know. Dick Persson said they cannot use the front car park and they cannot use the heritage building. There is less than 2 hectares of land at the back. Even if they get the Salys' land—the Salys will not sell it to them, and there are heritage buildings on the Salys' land. It is not even 3 hectares. I was told right through this whole process, which we were in for ever, that you

need at least 4½ hectares to build an efficient general hospital. As for the statement this morning that you would have co-location at Dee Why, that is just farcical. You could at Mona Vale, obviously, you have got 8.8 hectares. You cannot have co-location; it is just rubbish. Commonsense has to prevail somehow through all of this process.

At Mona Vale we have got ample land; we have limited land at Dee Why. There are a few constraints on development at Mona Vale; major constraints on development at Dee Why; there are heritage issues; they have to procure land. The major thing is that Mona Vale has support from the community; at Dee Why it is opposed by the community; their local groups opposed it there. There is good road access to Mona Vale. It is a terrible place. I have lived there for 60 years on the northern beaches. Mum and Dad were born there. I had four kids born at Mona Vale Hospital and the things they say are incredible when you know. I taught down the road at Manly boys high for ages—

CHAIR: Mr Rose, could you wrap up your—

Mr ROSE: Yes, I will wrap it up, I'm sorry. The rest of that clearly shows that Mona Vale is the superior site. Dee Why is a totally inadequate site. Mona Vale is the perfect site; it is inappropriate and uneconomic to consider any other site; the whole thing is a sorry mess. I would just leave you with one thing: we have set the way forward. This needs a way forward, a circuit breaker. We have sent a letter to Minister Iemma asking:

> We formally request that an independent working party be established to consider strategic direction and recommendations of the necessary short and long-term changes to take planning for the one network two hospitals strategy forward. We would suggest an independent person of sufficient stature, credibility and ability and impartiality be the chair. One such person who would most likely have the support of NSW Health, the Government and all sections of the northern beaches community would be Mr Laurie Brereton.

We want a way forward. I am sorry for taking so much of your time but it becomes very frustrating over the years when the case is fairly clear to us. Thank you.

CHAIR: Mr Thomas?

Mr THOMAS: I would like to make one point before I start and that is that this morning and in a number of documents we get quoted the 80 per cent rule. By the way, 100 per cent of people live south of Manly and they are going to put intensive care in Manly. The 80 per cent of people living south is very misleading. In fact, it is staggeringly misleading because I could very simply say you could draw a line and it is not a line of who lives north, south, east or west, it is how far are these people away and what is the access for these people? Of course, what it creates the illusion of is that there is a narrow strip about two kilometres running the northern beaches. That is not true. The northern beaches, which is part of Warringah, goes all the way back to the Roseville Bridge.

It is interesting to note that the furthest distance from Mona Vale Hospital by everyone on the northern beaches is in fact about 17 kilometres, which is the extreme end of Killarney Heights. If we talk about to Dee Why it is 28 kilometres from the people at Palm Beach. So I think it puts into perspective that the reality is about equity of access, but equity of access for all. To go to my first slide: Dr Christley wrote a letter which was published in the *Manly Daily*. The really depressing thing about that letter to me was that if for some quirky reason by mistake that letter got swapped with a letter that Dr Christley wrote five years ago nobody would have noticed. The truth is that nothing has changed; nothing has happened; nothing has moved forward. Despite overwhelming community demands for something different, Northern Sydney health seems incapable of really admitting that they just may have got it wrong.

I would like to address all of the spin in the letter but time will not permit that. The other thing that amazes me is that we use this sort of statement, the first and most obvious benefit is that it is going to get better when you take something away. I find it amazing that Manly can be considered as the site for moving the ventilated intensive care unit. Tell me that is an improvement for the ventilated intensive care at Mona Vale. It is just not an improvement, it is a downgrade. You tell that to a seriously ill patient lying in Mona Vale Hospital in urgent need of ventilated intensive care, waiting for an intensive care ambulance, which is driving around Sydney or the State trying to find a hospital that will admit their current patient. It is this sort of warped thinking that has driven health planning on the northern beaches for years and, to be honest, the community is pretty sick of it.

There is no logical argument that can be made for locating all the ventilated ICU beds at one extreme end of the northern beaches. Bad processes will produce bad outcomes, and the process that has produced the recommendation to move the ventilated ICU beds to Manly was a very bad process. It is typical of the ad hoc reactionary approach to planning that is entrenched in Northern Sydney health. But, to be honest, we actually expected more from the greater metropolitan clinical task force. Their web site certainly illustrates that they create the illusion they do it better. The principles, as stated by their web site: transparency—there is just no detail at all in this proposal. It is a two-page document with no evidence and certainly there has been no communication with the community on this and I know there has not been open and honest communication with the clinicians. Clinician and consumer involvement has just been very, very poor.

Population base—where is the evidence in the population base that it should be down at Manly? We would have expected to see some sort of plan and organised response to predictable healthcare needs based on age, gender, health risk, size of population. It is just not there. Equity of access and outcome—Palm Beach, Hornsby, Homebush, Strathfield and Canterbury are all about the same distance from Manly intensive care. I guess that is equitable access, is it? One extreme end of the community is not equitable. Equity of outcome is a very critical issue and this is really important. If we can go to the third overhead. When we first saw the document we made a point of saying we needed some information to make some judgements on what was really going on in intensive care so that we could judge this claim of 50 to 70 patients a year that need to be transferred from Mona Vale. What you have there is an extract from—and I have documents I would like to table as part of this—Northern Sydney health intensive care services activity reports from July 2002 to June 2004. So we have two years worth of figures.

Now I am not a clinical expert, but I have reviewed these figures and I have reviewed them with people who are clinical experts. Their reaction to these figures demonstrated far greater concern than my reaction. Let me explain what we have. The top line is the total admissions into intensive care. When I have taken Royal North Shore figures I would like to stress that what I have done is only include their general intensive care unit; they are not the total figures for Royal North Shore, and the detailed figures that I will provide you show where these figures come from. What is particularly interesting is the numbers of people who have been admitted to Manly's intensive care in a ratio. In fact, if you look at non-ventilated patients, Manly put 635 non-ventilated patients in over a two-year period; Royal North Shore put 599. That figure raises some serious questions in my mind and I know some other people's minds.

Of that we have a high number being ventilated in places like Hornsby and Royal North Shore—to be expected. We have though 137 being ventilated at Manly and 133 at Mona Vale. Let us get something straight here: we have two ventilated beds at Mona Vale, three at Manly. We have though some transfers in. My advice is that Transfers in are patients coming into intensive care from other hospitals. My advice is that transfers in will generally go to ventilated beds. I think you can be pretty sure that Mona Vale actually generates more ventilated patients than Manly. Not only that, the score down the bottom—and I will drop down to this thing called Apache—is a score which dictates severity of illness: the higher the score the more severe the illness. The Apache score from Mona Vale is higher. Not only that, with a lower Apache score they keep them in Manly's ICU for a heck of a lot longer than they do in Mona Vale. In fact, not just in Mona Vale, they have got them in longer than anywhere else.

There are some serious questions this has to raise about the intensive care unit at Manly. The questions are: why do they put more patients into intensive care than Hornsby, a much bigger hospital? Why do they have more non-ventilated than the general intensive care at Royal North Shore? Why does Manly ventilate them for so long? If Professor Goulston was asked that—the gentleman who did the survey—I am sure he would know, would he not? Because what he would have done is he would have looked at these figures in making his judgments of where we were going to place this consolidated intensive care unit. I doubt it. I do not think he looked at it; they are not there at all. In fact, it is my understanding he told one clinician on their first meeting that he had no preconceived ideas, but if he did not have the full support of clinicians across the northern beaches for this he would walk away from it. A short time later in that same meeting he started talking about effectively downgrading Mona Vale's ICU. They did not do any research on this; this is reactionary; this is getting an answer you want.

CHAIR: Mr Thomas, could you wrap up your—

Mr THOMAS: Yes, I will wrap it up. What I would like to point out and say is I do not know the answers, but, I tell you what, there are some possibilities. It could be that there is a lack of confidence in their general nursing ability in Manly. It could be because they have got either poor or different admission policies. Maybe it is just because they have got more intensive care beds and more intensive care staff and they want to keep them busy so they just keep them in longer there. Maybe there are funding implications. Maybe they have got quality problems in ICU staff, I do not know. Maybe it is empire building; or perhaps it is just because Mona Vale does it so bloody well. Excuse me, I apologise for that, but that is the essence of it.

I have a number of recommendations I would like to make, and I will finalise with those recommendations if I may. We have already submitted to this Committee a series of recommendations. One is intensive care to retain the upgrade to a level 5 at Mona Vale. If you are to consolidate intensive care, there is only one place to put it, and that is Mona Vale. The second is that the Northern Sydney and Central Coast Health Service should be directed to confirm Mona Vale as the site for the new metropolitan general hospital; that the community, the active participants in future planning of health services—and I want to add one more that is not in the submission—that any further planning for hospital services on the northern beaches be made the responsibility of a totally independent group, and not remain the responsibility of Dr Christley and Northern Sydney and Central Coast Health.

I have a number of documents I would like to table. One is a set of documents which is a our response to the Minister on the intensive care unit. There are also copies of the documents that those numbers were taken from, plus a copy of what I have just spoken about. There is also a letter that I would like to table, but I would like you to remain confidential because it goes to the heart of intensive care. It was written in August 2003. It is my understanding—and I have had it reported to me by doctors—that these problems still exist.

The Hon. AMANDA FAZIO: Mr Rose, in your opening statement you said that you continue to oppose the plan of Northern Sydney Central Coast Health. Does that mean that you are opposed to a new level 5 hospital for the northern beaches, because that is what the plan is for?

Mr ROSE: Not at all. We totally support a new level 5 hospital for the northern beaches. What we support, though, is what the community consultation predominantly has shown—that is, in the major community consultative areas, it is shown that people support the level 5 hospital at the Mona Vale site. We see many other reasons, as shown on the last overhead, for having it there.

The Hon. AMANDA FAZIO: We have heard contrary evidence this morning, so it is probably better if we leave it there. I have had a look at all the material you have put in the submission you sent to us. Who funds your organisation? You have some reference to members funding it.

Mr ROSE: We are funded by our community. I said in my opening address that we are very much representative of our community. We have had trivia nights, in which we have raised $8,000 or $9,000. Every time we are out on the streets with newsletters—and we are very often—we have a bucket over our arm and we get donations. We get donations from the clubs in the area, the various community groups in the area—

The Hon. AMANDA FAZIO: Throughout the whole area, or only the northern part of the northern beaches?

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

The Hon. AMANDA FAZIO: On page 8 of your submission you say that Mona Vale hospital is centrally located and easily accessible to all of the northern beaches community. Given the evidence that we heard this morning, how can you justify that statement?

Mr ROSE: I do not know which evidence you are referring to. As I said before, the travel studies all show that Mona Vale generally satisfies the 20-kilometre 30-minute travel aspect. As I said before, in the morning it is easier to get to Mona Vale—

The Hon. AMANDA FAZIO: It is easier to get to anywhere if you are driving against the peak hour traffic flow.

Mr ROSE: No, it is not easier to get to Dee Why in the morning than it is to get to Mona Vale. It is not easier to get to anywhere.

The Hon. AMANDA FAZIO: You have stated that Mona Vale has very good access, much better than Dee Why. The honourable member for Manly said this morning—I think it was compelling evidence—that anybody who lives in the southern part of the northern beaches has to go through Dee Why to get to Mona Vale hospital. Therefore how is it easier for them?

Mr ROSE: It is not true. It depends. It is not a straight area; it goes up west.

The Hon. AMANDA FAZIO: I am familiar with the northern beaches. People who come from Manly or Manly Vale, which has a higher population concentration than the northern part of the northern beaches, would have to go through Dee Why.

Mr ROSE: From that part, yes, they would have to go through Dee Why along Pittwater Road or make their way around one of the alternative routes in Dee Why, or go up Warringah Road and down the Wakehurst Parkway. They are the routes they could take.

The Hon. AMANDA FAZIO: Were you here this morning when other witnesses gave their evidence?

Mr ROSE: I was.

The Hon. AMANDA FAZIO: On page 14 of your submission you ask why has Northern Sydney Central Coast Health not conducted research into Mona Vale hospital for a modern hospital. This morning we heard that it is one of the six sites being considered. How do you explain that inconsistency between your submission and what is fact?

Mr ROSE: It is not an inconsistency. We have been in this process the whole time and it is only in the most recent outpourings from Northern Sydney Central Coast Health that we have heard that Mona Vale has been considered. Therefore, we had never been given information about it being considered. As far as I know, it is only in this latest checking for negatives of sites—and that is what they are doing; they are looking to see if they can overcome the negatives of each of the sites—that I believe Mona Vale is being seriously considered. We have had the bus depot, as was stated this morning. We had the forestland to begin with, then we had the bus depot, and then we had Dee Why. As David said, Dee Why did come out of the blue. Although, Stephen says he has been thinking about it for four years. For everyone on the peninsula, it came like a bolt from the blue.

The Hon. AMANDA FAZIO: I put it to you that it would not matter what happened; if you do not get the level 5 hospital at Mona Vale you would not be satisfied. Is that right?

Mr ROSE: No, it is not right. We believe that there is a terribly strong case for having a level 5 at Mona Vale. What worries us more than anything is that if the level 5 is at Dee Why, it will be the death knell, inevitably, of Mona Vale. And I believe that the thinking behind this is all about finally selling off as much of the Mona Vale land as you can to finance something at Dee Why, on land that is too small, and about clearing Warringah's debt. Dick Persson gets $40 million. It will clear Warringah's debt and Dick will go out like a shining knight.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You talked about one network and two hospitals. Do you think there should be one dominant hospital on the northern beaches, a level 5 hospital?

Mr THOMAS: We have developed a number of strategies early on. Fundamentally we started this program to save the hospital. That is the basis on which we started. The more we got involved, the more we saw that there was an unquestionable drive, from a whole range of areas, to have a level 5 hospital on the northern beaches. The question is: Do you go to two level 4s, or have one level 5 and a level 3, or something like that? I think these days we have come to the conclusion that it is probably appropriate to have one higher-level hospital on the northern beaches; I think we are reasonably comfortable with that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your next position is that you want that hospital to be at Mona Vale?

Mr THOMAS: Yes, that is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would want Mona Vale to be the level 5 hospital and the new Manly hospital to be a level 3 or level 4 hospital, and that would be your two hospitals?

Mr THOMAS: Yes. Which makes sense, because if you have a hospital in the southern end and you have your level 5 hospital in the northern end, catering for those additional level services you require, you are not taking away health care, but you are providing access for people from the extremities, where access is difficult—the Palm Beach end, the foreshores, offshore areas. In addition, you are providing a site that is, on average, closer to the majority of people than any other site they are picking.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your only disagreement with the BEACHES mob is that you want Mona Vale to be the dominant hospital and for there to be another southern hospital, and the BEACHES mob want the southern hospital to be the dominant hospital and Mona Vale to be the subordinate hospital?

Mr THOMAS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In a two-hospital system, you both agree one has to be dominant; all you are disagreeing about is which will be the dominant one?

Mr THOMAS: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The GMCT is the medical mob.

Mr THOMAS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say that that is basically the medical interest, or do you think that is a public health evaluation as opposed to a clinical evaluation?

Mr THOMAS: I have had a lot of discussion with clinicians. There is absolutely no doubt that the clinicians on the northern beaches would like one acute hospital. That is their position.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And they would like it to be south because that is where they live, is it not?

Mr THOMAS: No, that is not right. I think you will hear today from someone who wants it to the north.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Most of them live on the southern side. Where are the private hospitals—?

Mr THOMAS: There are no private hospitals north of Dee Why. So it would be rather nice to have one up our way.

The Hon. CHRISTINE ROBERTSON: In your submission you refer at length to technical information. What sort of measures do you think the health system should use to measure clinical excellence, good outcomes for people, or what happens to people in hospital? Have you worked through any of that?

Mr THOMAS: No. As I said, we are not made up of a group of highly specialised clinicians in those sorts of skills. That is not our group; our group is a community-based group. Yes, we have done some planning. Our planning has been done on community-based commonsense and the research we are able to do. We have never professed to be able to get in and tell people how to measure the competence of hospitals.

The Hon. CHRISTINE ROBERTSON: What is your idea of high dependency in relation to intensive care? You refer to terms such as "downgrade" and "removal", and you do not seem to value high dependency. I am from the country, and we rely on it to survive.

Mr ROSE: It is not only our view. The doctors at Mona Vale came out strongly and said it was a downgrading of intensive care to go from level 5 to level 3, to get rid of ventilated beds. It is the doctors who said they could not operate with safety over Christmas. We are just taking note of the views of the doctors from our local hospital. We are not experts, as Parry said, but we are guided by the clinicians.

The Hon. CHRISTINE ROBERTSON: My next question relates to transferring people who are too sick for your institution and need to go to the next level of service, and your perception that it is operated by people being put into an ambulance. Can you tell me what you think happens to people who need to go to the next level of service?

Mr THOMAS: I referred to using intensive care ambulances to transport people who require intensive care treatment. We also have helicopter access at Mona Vale—which, by the way, is a pretty handy thing to have. I am not sure that Dee Why people are going to be happy about helicopters landing there. Yes, they have specialist transfer teams that move people, but you have to be able to get them to the site. If they are on the other side of Sydney and they are needed at Mona Vale because someone is having a severe asthma attack—and that question on the asthma attack was never answered this morning—the fact is that they are going to die; you are not going to get them moved.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that the GMCT is basically what the clinicians want.

Mr THOMAS: No. In terms of the recommendations about centralising the services, yes, I think that is right. I certainly do not think that the clinicians at Mona Vale want Mona Vale's ventilated intensive care beds moved; they do not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But there are more clinicians in the south, are there not, because of the private hospitals—?

Mr THOMAS: I see what you are saying. When I talk about clinicians, I am talking about clinicians that operate out of Mona Vale hospital. Yes, clinicians have their rooms spread up and down the peninsula. There are a lot at Dee Why, there are a lot at Manly, and there are quite a few at Mona Vale.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There has not been any discussion about alternative transport. Whenever I talk about the northern beaches in any non-medical context the main issue seems to be a lack of transport. There has been no discussion on public transport in terms of light rail or any other sort?

Mr THOMAS: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it your position that there should be a second harbour crossing? It all seems to relate to either the Spit Bridge or road, as far as I can see?

Mr THOMAS: Transport issues are certainly an issue on the northern beaches. When I was growing up we actually had trams.

Mr ROSE: We had to get a punt over the Spit Bridge.

Mr THOMAS: Yes, it is an issue but, as a community group, we have not tried to look at the solution to that whole transport issue. It is not within our realms of skills or ability to address it at this stage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems in this whole issue that the question is how much intensive care there is—level 4, level 5, the number of ventilated beds seems to be the critical factor yet 70 per cent of elective surgery happens in private hospitals with no intensive care at all and only 1.4 per cent of presentations to emergency departments get transferred to intensive care and, presumably, it would have been pretty obvious which ones they were going to be before they got to the door.

Mr THOMAS: Yes, general.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For most people going to hospitals they are not going to go into intensive care and most surgery is not going to go to intensive care either and the doctor knows it when he starts.

Mr THOMAS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So why is the tail wagging the dog. It seems to me that the whole hospital system has become hostage to what half a dozen intensive care physicians want to do.

Mr THOMAS: I might say that I do not think it is just to do what intensive care physicians want to do. In our submission there is a *British Medical Journal* paper which refers to centralisation as one of its elements and in the back of that submission it talks about there is really no good evidence that centralising works. It is one of the premises it makes in there; it is about planning hospitals. Ever since we have been involved in this process from day one, the words that have continually been thrown at us every time—every time you ask a question you get, "Critical mass, critical mass, critical mass." Again, it is somewhat difficult for us to judge the requirements or the validity sometimes or otherwise of critical mass, and we do get conflicting arguments. We get conflicting information from people who often run the wards and the units about critical mass versus some of the doctors who want to have more high-tech equipment, and you cannot blame them. I guess if I were a doctor, I would want the latest and greatest high-tech equipment too.

Reverend the Hon. Dr GORDON MOYES: I am not sure which of you two gentlemen said it, I came in late because I have been hosting a function in the dining room and I apologise for that lateness, but one of you said that the area health service had some recent inquiry and two community representatives were invited, one of whom did not turn up and the other was not known to anybody.

Mr ROSE: That is right. Yes, this is the implementation group, which Frank Bazik got together.

Reverend the Hon. Dr GORDON MOYES: What kind of consultation was that?

Mr ROSE: Yes, the clinicians were there. There were two community people whom we did not know, we had never heard of, invited. One turned up. We asked to go but, no, we were not required. It was indicated that further down the line we might be able to go. But the second of those meetings has been called off. It was on the 24th, last Wednesday (sic), and it did not occur, so I do not know where it is. I do not think it should have been on until this Committee's decision had come down in any case.

Reverend the Hon. Dr GORDON MOYES: It is a total disregard of what we may have suggested?

Mr ROSE: That is right.

Reverend the Hon. Dr GORDON MOYES: Go ahead anyway. I understand that there was an occasion, however, when the area health service under Dr Christley, put out an options paper.

Mr ROSE: Yes.

Reverend the Hon. Dr GORDON MOYES: Basically a letterboxing of residents and opinions.

Mr ROSE: Yes.

Reverend the Hon. Dr GORDON MOYES: What was the result of that?

Mr ROSE: I did mention that when I spoke before. The result of both of the major, phase one and phase two of that kind of research was favourable to Mona Vale. In the options paper you are talking about—

Reverend the Hon. Dr GORDON MOYES: Was that widely spread?

Mr ROSE: Yes, very, 85,000. It went to every house.

Reverend the Hon. Dr GORDON MOYES: And the majority of people wanted Mona Vale upgraded?

Mr ROSE: Yes, 60.8 of the respondents wanted the major hospital at Mona Vale and a hospital in the south, and the interesting—

Reverend the Hon. Dr GORDON MOYES: I am sorry to interrupt you but my line of thought is: I presume if it was the case that 85,000 were asked about the Mona Vale site, the same thing would have been done for the Dee Why Civic Centre?

Mr ROSE: There was no consultation on the Dee Why Civic Centre.

Reverend the Hon. Dr GORDON MOYES: I just heard this morning that there is I think the phrase was "general consensus" that the Dee Why Civic Centre would be a wonderful site.

Mr ROSE: Well, it is the exact opposite. Pittwater Council, Manly Council, the Federal members, Tony Abbott and Bronwyn Bishop, State members, John Brogden, Brad Hazzard and Andrew Humpherson, as well as 2,000 people at a rally at the civic centre site all said they opposed that site, so how there could be any consensus that anyone, apart from David and Dick Persson, want that site, I do not know—maybe Beaches want it.

Reverend the Hon. Dr GORDON MOYES: Would it not be logical that if you had a 86,000-citizen referenda on Mona Vale, to have a 86,000-citizen referenda on Dee Why?

The Hon. CHRISTINE ROBERTSON: How is a letterbox drop a referenda?

Mr ROSE: It was delivered to every house and people were asked to respond.

The Hon. TONY CATANZARITI: How many responses did you get?

Mr ROSE: I have not got the exact figures with me. I am sorry I cannot just off the top of my head.

The Hon. AMANDA FAZIO: I think that if it were significant you probably would have them with you.

Mr THOMAS: It was significant.

Mr ROSE: It was very significant. There were very significant numbers.

Reverend the Hon. Dr GORDON MOYES: You said 86 per cent.

The Hon. CHRISTINE ROBERTSON: No, 86 per cent were in favour.

CHAIR: There is some debate about this but if you have the figure later.

Mr ROSE: No, we can find those figures. They are in the documents we have here.

The Hon. AMANDA FAZIO: So you will take that question on notice?

Mr THOMAS: Absolutely.

Mr ROSE: Yes. In fact, it will not take very long.

Reverend the Hon. Dr GORDON MOYES: I made reference earlier to an 18,000-signature petition that came in.

Mr ROSE: Yes.

Reverend the Hon. Dr GORDON MOYES: That concerned the upgrading—

Mr ROSE: Look, can I take this up, Dr Moyes? You asked this morning if David Barr had received the petition. We were told that a Mrs Joan Harris did give a petition of 150 signatures and asked David to table that. It was not tabled so she brought it to us and it formed part of the basis of what became an 18,000-signature petition. Now you would have to check that out, but that is certainly what we have been told. We have that 18,000 one.

Reverend the Hon. Dr GORDON MOYES: However, even the 150-person petition was not presented by Mr Barr?

Mr ROSE: That is what we have been told by Mrs Harris.

CHAIR: I am not sure this is entirely relevant to our terms of reference. As it is not an opportunity for a discussion about Mr Barr, we might move on.

Reverend the Hon. Dr GORDON MOYES: If we want to have a look at some of the base issues in this, Madam Chair, I would suggest that it is extremely relevant to the preservation of Mr Barr's Government-friendly seat.

The Hon. AMANDA FAZIO: That is an offensive comment. You are a very despicable person.

The Hon. CHRISTINE ROBERTSON: Is that relevant to the terms of reference?

CHAIR: Are you actually asking a question or making a statement at this point, because we are going to have to wrap up fairly soon, Dr Moyes. I will give you an opportunity if you wish to pose a question.

Reverend the Hon. Dr GORDON MOYES: There are a number of focus groups currently meeting and are those focus groups being attended by widely spread community representatives?

Mr THOMAS: We have certainly held focus groups in the past. We do not currently have focus groups running. We have tended to run focus groups when we are looking at options and

strategies. When positions have been put by Northern Sydney Health we have looked at those positions and developed our own options, a number of which are contained within the document. At those stages we have brought people together in focus groups. In terms of the second part of the question, yes, they are widely spread. They included clinicians, community representatives—basically as many people with the right sorts of skills that we felt would be appropriate to bring into that.

Reverend the Hon. Dr GORDON MOYES: I notice that the recommendation that Dr Christley has mentioned earlier on was the collocation of a private hospital together with a public hospital. How many private hospitals are there north of Dee Why?

Mr THOMAS: Zero.

Mr ROSE: There are none.

Reverend the Hon. Dr GORDON MOYES: Are there a large number of retirement centres north of Dee Why?

Mr THOMAS: Yes, they are.

Mr ROSE: There are a very large number.

Reverend the Hon. Dr GORDON MOYES: Are the numbers of persons requiring significant medical attention found in the upper age groups of people?

Mr ROSE: We are certainly told so.

Mr THOMAS: That is what we believe.

The Hon. AMANDA FAZIO: We were told this morning by the member for Pittwater that the land on which Mona Vale Hospital is built was given for that purpose by the Salvation Army. Have you done any research or do you have any knowledge of the fact whether the caveat over that land would actually permit a private hospital to be built on it?

Mr THOMAS: There is no caveat over that land. I was originally told that that land—I do not know if it is the term "regazetted", but anything like that, any limits or caveats over the land, had gone. The Government has the legal ability, without making any changes, to dispose of that land as they see fit. The only thing it would require, of course, would be council rezoning and, of course, the Government is the consent authority when it comes to that anyway.

The Hon. AMANDA FAZIO: Thank you for clarifying that because the evidence you have just given is at direct odds with the evidence given by the member for Pittwater.

Mr THOMAS: No, that is not correct.

Mr ROSE: Could I say that it is quite cloudy. It is difficult to pin down exactly what the situation is with the Salvation Army. People have tried to do it. We have had numerous feedback, but I do not think we really know what it is. Parry, did you want to say something?

Mr THOMAS: Only to say that I think my recollection of what Mr Brogden said was that it did not have caveats on it. I am sure if you check *Hansard* you will find that is the case.

CHAIR: I am going to have to call a halt at this time. If you think there are further issues that you wish to draw to our attention, we are more than happy to take further evidence. The documents that have been tendered are not yet public documents, and we will have a meeting later.

(The witnesses withdrew)

STUART LEIGH BOLAND Specialist Surgeon, representing the Surgeons and Anaesthetists of Mona Vale Hospital, 30/7 Bungan Street, Mona Vale, sworn and examined:

CHAIR: If you should consider at any stage during your evidence that certain evidence or documents you may wish to present should be heard or seen 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. Do you wish to make a brief opening statement?

Dr BOLAND: I do. I would like to thank the Committee for the opportunity to publicly present the views of the surgeons and anaesthetists at Mona Vale Hospital. I would also like to apologise for my voice. At a meeting of the surgeons and anaesthetists at Mona Vale Hospital on Saturday morning, they unanimously resolved that the submission that I am presenting and speaking to here today accurately reflected their views and they unanimously endorsed my presenting and speaking to the submission on their behalf.

The submission has been prepared in close collaboration with the New South Wales Branch of the Australian Medical Association [AMA] and I am grateful for their attendance here this afternoon to support this submission, with Lawrie Pincott, the CEO of the New South Branch of the AMA, and with Allan Thomas, Director of Medico-legal and Strategic Policy and Planning. If there are any deficiencies in the submission it is because activity in all public hospitals winds down over the Christmas-New Year period. Many people are away and it was only in the last week of January and in early February that the group was able to get together and have an embryonic development of this submission that I am going to be speaking to today.

Essentially, as you know, the submission is in two parts. The first part concerns the need for and the processes involved in achieving a long-term solution to the problem on the peninsula that doubtless you have heard plenty about this morning. It is the unanimous view of the medical and surgical staff at Mona Vale Hospital, and I think at Manly hospital, that we should have a single hospital at the best possible site that is realistically available, that contains a new combined northern beaches hospital and not a rebuilt Manly hospital, that contains a co-located private hospital, that is a well-resourced specialist medical centre, and that is a centre that co-ordinates outreach centres to the whole peninsula.

The submission talks about the lack of consultation, the current two-hospital procurement feasibility plan, how that has become manipulated and how we are still lacking a transparent process to choose the best available site for the single combined hospital complex. The shorter terms issues in the submission relate mainly to intensive care and the need for intensive care services to remain on site at Mona Vale Hospital until the new hospital is built. The main issues for discussion at the surgeons and anaesthetists meeting on Saturday morning again focused on proper process. One surgeon described the process adopted by the area as merely a mechanism not to achieve the best result but merely to support an unacceptable preconceived outcome.

The most recent example of poor process was the announcement of a series of implementations of the GMCT proposal meetings to be held on the basis of generalised agreement with the proposals when Professor Goulston and the area knew very well the positions of the surgeons and anaesthetists was total opposition to that proposal, as articulated in paragraph 22 of the submission and in attachment 2, which went with that paragraph. We were also told that the one thing that the GMCT wanted was to get conditional support for the proposals. We noted again with incredulity that the one proposal to attract initial support, that is, the merging of obstetric services at both Manly and Mona Vale on one site was walked away from and not proceeded with.

Again at that meeting on Saturday morning the GMCT came in for particular criticism for a number of reasons, including the non-disclosure of the Northern Sydney Area Health Service representatives on its board, including Dr Christley and Debra Letter. It was also noted that the GMCT does not represent the feelings of the medical profession or institutions like the AMA. Various surgeons and other medical groups are not represented on its board. The AMA is taking a close interest in the GMCT and its role in providing government justification for hospital rationalisations that are unpopular and, in our view, damaging to the hospital system.

The surgeons and anaesthetists unanimously believe the interim proposals as recommended by the GMCT and as related to intensive care services worsen rather than solve the current problems, make the safety issues worse and inevitably will dumb down the hospital skill base with poor morale, resignations and difficulty in recruitment. In preliminary discussions with the college of surgeons and anaesthetists there is a real risk that our specialist trainee registrars in those two disciplines will be put at risk if we lose the intensive care service. Before concluding—I will then be in your hands to speak to the submission—I want to draw the attention of the Committee to paragraph 48, and to attachments 7 and 8.

Those attachments clearly indicate that whatever work force issues and whatever work force problems there are amongst intensivists there are other important issues in the equation. Attachment 8 has been presented with the names and signatures whited out because of fear of retaliation by those in authority in the area who signed the document. I have the original document that I am prepared to submit if the Committee agrees to respect their privacy and their contention in the last sentence that they should be referred to merely as health care workers. With that I am in your hands.

CHAIR: I indicate that attachments 7 and 8 are already confidential. We will accept that document on a confidential basis.

Dr BOLAND: Thank you.

CHAIR: Can you shed any light on the claims that were made this morning about the difficulties in obtaining staff for the intensive care unit at Mona Vale Hospital?

Dr BOLAND: I can share some but necessarily this is second-hand. Clearly, the sword of Damocles has been held over the head of staff in this intensive care unit at Mona Vale Hospital for some considerable time. Clearly, people are feeling insecure about their positions. If something better turns up they would start applying for it. We have also heard that a number of applicants for the intensive care position have made contact but, apparently after making contact, they showed no further interest. A young surgeon who went to another hospital referred to the meeting on Saturday of surgeons and anaesthetists. Someone involved in his year said, "I would love to work at Mona Vale Hospital intensive care. I live at Frenchs Forest. No-one has asked me."

CHAIR: One of the things we have been told is that the Dee Why site apparently does not have helicopter access. How important is that issue in the site considerations?

Dr BOLAND: I think it is an important issue. If we are getting a bigger hospital, which is what we all want, we want the best possible access. It would be nonsense not to have helicopter access in the twenty-first century.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You criticised the GMCT as not being representative of AMA opinion and the opinion of your group of surgeons and anaesthetists. Whose opinion do you think it represents?

Dr BOLAND: Their own.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean the committee that runs it?

Dr BOLAND: It is very difficult to find out who runs it. There is a whole raft of people on it. Some of the people on the committee that I have spoken to say that they have never been involved in any of the decision-making processes. So I presume it has an inner sanctum where all these things are arrived at, but I do not know who they are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It sounds like the opinion of a general medical group, but it is not.

Dr BOLAND: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is directed, conveniently, by some other political force?

Dr BOLAND: Absolutely. They dress up a given position and say that there is clinician support for it. When we make inquiries as to which organisation or which groups endorse that position, we cannot find any.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has been said that there are more clinicians in the south of the peninsula than there are in the north of the peninsula because of the number of private hospitals. I gather that Manly is a slightly bigger hospital than Mona Vale. If someone were taking a confidential poll of clinicians would it not be possible to get to the position to which the GMCT has come?

Dr BOLAND: I would have thought that it might have been a broader position than polling the number of doctors about the best hospital. If we are talking about intensive care services I can think of two of the worst possible sites for it. One is North Head and the other is Palm Beach lighthouse. The Manly option is tucked within a kilometre of North Head. In relation to access and so on, it is one of the issues somewhere in this submission that will not take too long to find. We believe that it is an inappropriate site for a single ICU. That is the reason why Manly hospital has not been chosen as one of the sites for the new hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously that is an interim position. One could say that it is politically convenient to put the intensive care unit in a position where it has to be moved.

Dr BOLAND: I think I talk a little about the intensive care unit somewhere in this submission. May I take a second just to see where that is? It starts at about paragraph 29 and then it goes to paragraph 32. It is somewhere near the bottom of page 6. I think, Dr Chesterfield-Evans, that those paragraphs answer your questions, so I can save my voice. We believe that an intensive care unit should be at Mona Vale because it is the best geographic site available. Transfer of the ICU to Manly means taking the sickest patients on the peninsula to be treated at the worst possible site. It follows that access to Mona Vale Hospital is much easier for the 220,000 residents of the peninsula than Manly.

There are excellent helicopter facilities but there is no helicopter facility at Manly, or I do not think so. If there is, it has not been used for seven years. We believe that at Mona Vale the figures speak for themselves. It has the busier emergency department and it has 23,000 presentations annually, whereas Manly has 17,000. That compares with Hornsby hospital at 27,000 and Royal North Shore at about 40,000. Mona Vale handles these patients more efficiently, as measured by the department's own parameters, in relation to what I understand is called bed access block or code red times. In other words, it gets them processed more quickly and efficiently.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Seventy per cent of surgery is done in private hospitals, which obviously have no intensive care facilities. So there is only a suggestion of networking. Most acute cases get transferred to the North Shore from the peninsula in any case. Is this issue of transfer such a big deal when such a small percentage of patients end up in intensive care? Will you change what elective surgical cases you do because of changes to intensive care support?

Dr BOLAND: I will tell you what I do if you like, but I would rather tell you what the surgeons and anaesthetists at Mona Vale have said. They have said that they will. They have said that they do the scope of work that they do there now, both elective and surgical emergencies, on the basis of the knowledge that the intensive care unit is there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they need it.

Dr BOLAND: If they need it and in support of it. They will not do a certain scope of work. In a supplementary statement later I can provide the sort of work that they say they will not do if the intensive care service is downgraded.

Reverend the Hon. Dr GORDON MOYES: I was particularly concerned to hear you say that you were representing the clinicians at Mona Vale when a number of those clinicians feared retaliation if their names were revealed. Is that the normal way of operating within an area health service?

Dr BOLAND: I do not know that. What I do know is—

Reverend the Hon. Dr GORDON MOYES: Is it genuine in your area health service?

Dr BOLAND: It just seems to me that when you have a poor case to make and you are struggling to make it, one of the things to do is to retaliate against those who oppose you. I can give some evidence here if you like, with letters to doctors and veiled threats to them. Over the Christmas period—

Reverend the Hon. Dr GORDON MOYES: I think it is a very serious matter.

Dr BOLAND: Our group feels that it is degrading of the area to turn what we regard as a safety issue into a grubby, industrial one.

Reverend the Hon. Dr GORDON MOYES: Were those doctors threatened because they would not work as intensivists?

Dr BOLAND: They were threatened because over the Christmas period, and with only three days notice, the area health service announced that it could not provide an intensive care service. They said unanimously, as it turned out, except for one group, that they could not provide services under those circumstances. The people who were rostered on over that period received threatening letters. But the threats that you referred to were from paramedical people and whatever. The document I presented does not relate to clinicians at the hospital it relates to others.

The Hon. AMANDA FAZIO: To your knowledge have any intensive care specialists or other medical staff been warned or harassed because their view does not accord with those that you have expressed on behalf of the surgeons and anaesthetists?

Dr BOLAND: I have no knowledge of that. I have heard that some of the intensivists have been upset. I am here to tell us that our group has been upset but I have nothing I can add or give to you.

The Hon. CHRISTINE ROBERTSON: Does your group operate like a medical staff council? Are you a medical staff council?

Dr BOLAND: We are part within the medical staff council yes. But our views and our needs are different to the wider medical staff council that would include psychiatrists, physicians and other groups that might have different views and have different needs for intensive care.

The Hon. CHRISTINE ROBERTSON: The structure of your group's performance–it is good to have a group that sits down and talks about problems within its hospital—does not report through the system anywhere?

Dr BOLAND: It is reporting to you. Yes, it has reported to the medical staff council and I think the chairman of the medical staff council will be here a bit later. It is certainly when we were sought by Professor Goulston to meet with him, we certainly report back to him and sent copies of those reports not only to Professor Goulston but to the area authority and to the Minister.

The Hon. CHRISTINE ROBERTSON: Does your group participate in role delineation projects or clinical excellence-type projects at Mona Vale hospital: collecting information for the quality programs?

Dr BOLAND: Yes, we do indirectly. It is an interesting question that I have not mentioned in my submission today. But one of the other issues that we do have is the fact that we were locked

out of a process recently when the Australian Council on Healthcare Standards [ACHS] came to accredit the hospital.

The Hon. CHRISTINE ROBERTSON: We have been through an inquiry recently.

Dr BOLAND: You probably know more about them than me. But I have been through four or five of these processes over the years. On this occasion the surgeons were not invited to participate, and certainly not invited to participate when the Goulston proposals were brought before them.

CHAIR: Why do you believe that to be so?

Dr BOLAND: Probably an oversight.

The Hon. CHRISTINE ROBERTSON: Have you ever performed surgery at private or public hospitals that do not have an ICU?

Dr BOLAND: I have and I do.

The Hon. CHRISTINE ROBERTSON: Do you measure what you are going to do in those places?

Dr BOLAND: Yes, I certainly do. I operate at one of those small private hospitals at the southern end of the peninsula to which the Hon. Dr Arthur Chesterfield-Evans drew attention of the committee. It does not have an intensive care service and certainly the type of work I do there is much different to the type of work that I do in other private hospitals, like the Mater Hospital and The San (Sydney Adventist Hospital) where I do the more complex work. The point I am making is that is exactly what we will be doing at Mona Vale hospital. We will be downgrading what we do there to the equivalent of what I am just talking about and the more major stuff will have to be done somewhere where there is an intensive unit. In other words, we are going to operate in an environment where we do not feel we have got a hand tied behind our back.

The Hon. CHRISTINE ROBERTSON: Campbelltown Hospital has a high dependency unit and does quite high-level surgery. Do you approve of that?

Dr BOLAND: I do not know much about Campbelltown but I do know that out at Campbelltown when systemic issues came into focus, and were brought into focus by the Health Care Complaints Commissioner who identified them as systemic episodes, she got sacked. Then we had other committees and now we find that individual doctors in an unsupported hapless environment are wearing it individually. That is one of the issues about which we are very conscious at Mona Vale hospital. We are not going to get ourselves in that situation.

The Hon. CHRISTINE ROBERTSON: Do you actually believe that had something to do with the role delineation of the intensive care there?

Dr BOLAND: I do not know anything about intensive care there, I am just talking about the general environment where people get forced into a situation of working in an unsupported situation and systemic things happen. You find the area authorities are out to lunch when it comes owning up to systemic things, and individuals have to pay for it.

The Hon. TONY CATANZARITI: Dr Malcolm Fisher said on radio to Alan Jones that he does not believe that a level 3 ICU service would exclude most births or surgery taking place. Do you agree with that?

Dr BOLAND: It will not exclude most, but may I make the point, I think it is made somewhere in this submission, that I do not take a lot of notice of people who are providing a new drug, a new corner shop or anything else—when they talk about safety or whatever. We were told that Holden cars were safe and 10 years ago they had to be recalled. It is the users of the service who will determine the safety. I do not think that we get a co-ordinated or coherent view until we hear from the obstetricians—you asked about them. They are part of our group and they withdrew service over Christmas on the basis that the intensive care unit was not there.

The Hon. AMANDA FAZIO: Have you ever stated publicly or privately to colleagues that you do not mind where a new central hospital goes on the northern beaches just as long as it is built?

Dr BOLAND: I would not agree to that unless you put it in the context, and the second half of it. The second half of it is unless we have got an open process, a proper process that involves consultation. I have also said that as far as I am concerned, as articulated in this report, I have not seen a site that anywhere near matches the Mona Vale hospital site. But if you come up with one, or if the area or the processes come up with a better site that is instantly available, because we have got a real problem on the peninsula that everyone agrees with: We want to get on with this new hospital.

As far as I am aware the only site on the peninsula that the local residents support is Mona Vale hospital. We will be at trench warfare for years with Dee Why, I understand, trench warfare again at the Beacon Hill site. If they take up part of that Forest High School there will be another group out there. There will be just another excuse to put off processes that we at Mona Vale think is unacceptable. But if you have got a big site and you go down all those things in paragraph 13, and it matches or beats them, we will all go there and the people on the peninsula will be in very good shape.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have seen a letter from people complaining that they were misled in some of their duties in intensive care. Are you aware of anything about that?

Dr BOLAND: No. Letters from who—not my intensivists?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would rather not talk about who they are from.

Dr BOLAND: Are you talking about intensivists?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Intensive care staffing.

Dr BOLAND: No, I do not know anything about that. I do know that over the Christmas period, I personally spoke to two intensivists who were prepared to offer their service to staff the intensive care at Mona Vale hospital for various periods over that time, and for various reasons were told their services were not required. That was probably fair enough because it may be that they were doing a day here and a day before and the day after was not covered. But it seems that there are people out there. As I said, and I cannot go back to attachments seven and eight here, but there are other issues involved.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there people staffing the intensive care unit at Mona Vale that have been under some duress in terms of being stretched from other intensive care units or professionally in terms of the number of hours they are doing and so on in order to maintain the service?

Dr BOLAND: What I know is this that up until about 1995, 1996 or perhaps 1997 Mona Vale hospital intensive care was happily run by one individual who also headed up one of the biggest renal units in the State at the Mater Hospital and, in addition, ran a busy practise. His name is Dr Ian Love. I guess after 20 years he felt he needed a spell and so he said he could not manage that one role any more. What happened then was that we advertised it, of course, and then found that what he had been doing happily all those years we could not get away with less than four intensivists to do the job to fit onto their rosters, nor could we get away without doubling the junior staff, nor increasing the machinery behind the situation to do it. All I am saying to you is that from where we stand we are told that there is a lot of one-issues when we see a hell of a lot of other issues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that raising the bar of expectation because there is a specialty of intensivists has meant that the levels that are required of expertise, particularly nursing and junior medical staff, have now had a bar raised so high that for practical purposes medial size hospitals are being excluded when they may not have been excluded from offering certain services?

Dr BOLAND: I certainly think that the proper feelings of collegiality and whatever that I regard so important in my profession—look, if I have got a problem in the hospital it is marvellous to have another surgeon there to talk to and run through the issues. I think intensivists quite rightly like that environment and these days are not particularly comfortable in not working in that environment. But all I am saying is that at Mona Vale we have a need that I think that if you go down again to that submission in terms of intensive care activity and high-dependency need, paragraph 46, Mona Vale has a greater need from its own patients. Mona Vale has never got the credit or the money saved from that one individual running the joint for 14 years single-handedly when places around us were having these vast numbers there, all very good, but we never seemed to have the money in the bank from that previous saving to staff it.

Reverend the Hon. Dr GORDON MOYES: Do you have any comments about the allocation of funds in the Area Health Service to other hospitals, particularly the seemingly disproportionate allocation of funds to Wyong and Gosford hospitals?

Dr BOLAND: I cannot speak in any personal authority with that, nor is that something that our group has discussed.

The Hon. TONY CATANZARITI: Under the long-term issues in paragraph 7 of your submission, you say "to consider any of the current short-term proposals until a long-term solution is agreed and set in stone". I did not think that was constructive. What do you say?

Dr BOLAND: I think they have been backed into a corner. I do not think they feel they have got any extra cards to play. I said the broken promises, the blighted expectations, the lack of an efficient consultation process, the feeling of the medical staff at both hospitals. I think at Manly hospital they are running out of puff with this proposal too. They have been made promises that are no closer to fruition. I think all of us feel that we have been going around in a whirly bin. We are not getting anywhere and no-one is levelling with us. That is the view of the group.

CHAIR: What will be the impact for Mona Vale hospital if the intensive care unit is downgraded and consolidated at Manly before we get to the stage of the level 5 hospital constructed?

Dr BOLAND: There is the expectation that we continue to process the 23,000 admissions as though nothing has happened when a key resource of the hospital is taken away. I do not know whether intensive care is the heart of a hospital or the soul of a hospital but it is somewhere in between when you are dealing with this sort of thing and we would want the authorities to provide us with the facilities that they traditionally have to enable us to do that. Over Christmas and New Year the doctors said, "In the absence of that facility, we would rather the patient be taken and triaged somewhere else where that facility is available." We do feel that, given that we will lose the complexity—and we are told that the doctors will not do aneurysms and colorectal surgery has been brought into question and certain emergencies that go along with that—if that is downgraded, we are told that the anaesthetic registrars and the surgical registrars will find themselves in a position where they do not have enough to do and we will lose them. Then there is another step in the dumbing-down process.

In my view—this is my view and, I think, the view of the group—we really have got to have a look at some of the other hospitals where this has happened. They say it works well in some instances but the people whom our group has spoken to are bitterly disappointed. Just at a personal level, this weekend I was a surgeon on call at Hornsby hospital. We found that I was taking a patient who had been transferred from Concord hospital to Hornsby hospital—in other words, from one of the great teaching hospitals to a district hospital. This intensive care mess goes a bit beyond Mona Vale Hospital, and we need a hell of a lot more lateral thinking than I am seeing here in closing down units in various hospitals that, as I say in this submission, frankly do not deserve it.

CHAIR: Thank you, Dr Boland.

(The witness withdrew)

(Short adjournment)

DAVID MICHAEL JOLLOW, Obstetrician, Mona Vale and Manly hospitals, sworn and examined:

CHAIR: Dr Jollow, in what official capacity are you appearing before the Committee—as a private individual or as a representative of an organisation or business?

Dr JOLLOW: I am currently the Chairman of the Mona Vale Hospital Medical Staff Council.

CHAIR: If you should consider at any stage during your evidence that certain evidence or documents you may wish to present should be heard or seen 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. Do you wish to make an opening statement?

Dr JOLLOW: No.

The Hon. MELINDA PAVEY: Dr Jollow, how did you hear the news that, despite the original agreement with the GMCT, you were going to be taking over obstetric and maternity services at Mona Vale hospital, that there was a reversal in that original commitment? What do you think led to the reversal of that commitment, and how have you responded since?

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

CHAIR: In the discussions about the ICU being moved to Manly hospital, what was the view of the doctors you represent at Mona Vale?

Dr JOLLOW: I think the view has been mixed. Since it first became obvious to the Medical Staff Council at Mona Vale that there was a problem with intensive care services at the hospital, there have been a lot of mixed emotions and mixed feelings amongst the senior medical staff at the hospital. Almost universally, the feeling has been that this was a downward step for the hospital and that this should not occur. However, at different times, depending on how much information we were given and how much information we sought about the proposal, different persons have felt differently about whether they have been positive for it or not. I would have to say that the vast majority of senior medical staff at Mona Vale hospital are completely against the move. They feel that it will be a downgrade to the services of the area; that it will basically be the beginning of the end of Mona Vale hospital. At some points in time a small minority of the medical staff have thought that the proposals were reasonable, but the vast majority of people seem to think that the proposal as it stands is not reasonable and is untenable, and, even if the proposal goes through as written, at the moment we do not know what sort of back-up that leaves for Mona Vale hospital. So, at the moment, I would have to say the majority of clinicians are completely against any changes to the service.

CHAIR: Could you take the Committee through the consultation processes that would have occurred with the Mona Vale hospital Medical Staff Council in relation to the decision?

Dr JOLLOW: The consultation process probably started six months ago, when the two intensive care specialists who work at Mona Vale hospital were at one of our meetings, and at the end of the meeting put up that they were not happy to continue doing a one-in-two roster and were thinking of resigning if there was no additional help from a rostering point of view. At that stage, obviously people got quite upset; they could not understand where this had come from, because it seemed to have been a problem that had completely come out of the blue, and was almost to a stage that we were not going to be told about it. Normally, we have Medical Staff Council meetings every

two months, so if we had not been told at this stage, it would have been another two months less that we would have known about anything happening.

Soon after that, there were proposals put forward by different intensive care staff to recruit new intensivists, to look at sharing services with Manly hospital. Over the following three to four Medical Staff Council meetings that have occurred since then there has been very heated discussion about the proposals, and I think it would be fair to say that the intensive care specialists at Mona Vale hospital almost universally have been to these meetings and tried to explain things as much as possible. But, still, there is a feeling that we do not completely understand what the reason behind it is, and where that will leave Mona Vale hospital as far as back-up for intensive care type patients. So as to the consultation, realistically speaking, ever since this first came out: the Medical Staff Council meeting, which normally runs for about an hour every two months, quite often has seen people speaking for three hours when this has been happening at ever stage, trying to get their minds around exactly what has been happening, as well as several other meetings that have been happening with the medical staff that have not been under the auspices of the Medical Staff Council.

Reverend the Hon. Dr GORDON MOYES: Dr Jollow, having heard Dr Boland make reference to some of the senior clinicians at Mona Vale having felt harassed or possibly finding some retaliation against them, are any members of the Medical Staff Council at Mona Vale hospital having similar experience, either from the administration of Mona Vale hospital or the area health board?

Dr JOLLOW: Not that I personally know of, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You may have heard Dr Boland talking about the fact that one broad-ranging physician, I guess you would say, ran the intensive care unit, plus a renal unit elsewhere, plus a private practice for 14 years, and now they have a one-in-two intensivists roster and those two intensivists are finding it onerous; and, presumably, the area health service cannot recruit them at the salary it is willing to pay, with the number of beds it has, in terms of their clinical interest. There must be certain hospitals that have the need for intensive care expertise, but they are called high dependence units, and they do not need full-time intensive care in the sense of a critical mass. Do you think there is any possibility of recruiting people for that type of thing, where you have perhaps registrar and high-level nurse cover to handle medical emergencies that need post-operative support? Is there some sort of position for this? Because, if there is not a middle road between having nothing and having a complete critical mass unit, then hospitals of the size of Mona Vale are in trouble.

Dr JOLLOW: I suppose the problem with the way that the current system is set up, with having middle road, is very, very difficult, because it may be possible to say that hospitals are "a little bit quieter, and therefore we do not need an intensivist, but we are going to have the occasion intensive care patient." Unfortunately, things cannot work like that, because at the bottom line there needs to be some sort of specialist consultant responsibility for all the patients in the hospital, whether that is a patient delivering a baby, in my case, or whether it is someone in the intensive care unit. So, from the point of view of "Can we have a registrar with a little bit of extra experience running the place, and then if the occasion intensive care patient is there they can look after them," unfortunately that is not possible because that would be unwise and I think that would be unsafe.

I think the problem revolves around the fact, like you say, that it is obviously incredibly difficult to find intensive care specialists who want to work in a hospital like this. I suppose some of the things have been changing over the years, and I am probably at the beginning of the change. I have been a consultant for only two years, but doctors are looking more at lifestyle issues. I think you would find it very uncommon for people—except obstetricians—who would be willing to be on call 24 hours a day, 7 days a week for their patients, whether that is for a hospital or whether that is for their private patients, or whatever. So it is incredibly difficult to find. I can understand the intensive care specialists having concerns about them doing a one-in-two roster. I work a one-in-two roster between Manly and Mona Vale hospital, and it is obviously difficult running a one-in-two roster in the public system as well as looking after your own private patients, who are paying good money to be looked after by you, as well as having a commitment to your family. That is incredibly difficult. I understand their concerns.

Like I said, I think you would find it difficult to find someone who is willing to do what was done only 10, 15, 20 years ago. But I also find it hard to believe, and the Medical Staff Council finds it hard to believe, that there are not enough doctors around who have the type of experience needed to work in the area and are willing to do that type of work. The intensive care specialists have quite openly said that, because it is a very small hospital it is very difficult to recruit people because they might not be professionally challenged by working in the hospital. In some respects, for some people, that would be quite a positive thing, because a lot of the intensive care specialists on the northern beaches have other interests besides intensive care; they work as general physicians, and they do other things.

So I am sure there would be quite a few people around who might be a physician with a sub-specialist interest in respiratory medicine, or cardiology—someone who wants to help out in the intensive care unit, and under normal circumstances would be allowed to—but the Medical Staff Council gets the impression that those types of people are shunned away and are not offered work because there is this feeling that if you work in an intensive care department now you need to be an intensive care specialist; you need to have the special qualifications to say that you can look after this type of patient.

That seems to be a change that has happened in the past very few years. People were very happy, patients were very happy, administration was very happy only a couple of years ago to have physicians with medical qualifications, who may not have intensive care specialist qualifications, to look after these patients, and they did so very, very successfully. The rule seems to have changed in the past couple of years, and I am not exactly sure why. The administration of the hospital still seems very happy with the majority of intensive care specialists on the northern beaches not having intensive care qualifications, as we speak. My understanding is that there is only one intensive care specialist on the northern beaches now who has full intensive care qualifications. So they are happy for the people who have been doing it for a while to continue doing it, but not necessarily with finding someone new who is just as experienced as the ones they have got already.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have given me a two-bob-each-way answer in the sense that you have said there are more lifestyle issues and there is more stress on the intensivists' expertise, but by the same token there is still a huge shortage of intensivists. There must be career medical officers or people who have worked in intensive care units, and so on, who could do some of these functions? If you work in the recovery room you assume you can pull the tube out and send them off to the ward, but if they have to have the tube in a bit longer they have become intensive-care ventilated by definition, yet the expertise does not go up exponentially to an absolute high post-cardiac surgery standard.

Dr JOLLOW: Sure. And I am sure there are lots of people around who have worked as career medical officers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: High-level registrars?

Dr JOLLOW: High-level registrars that have been working for years and years and have been looking after these patients on a day-by-day basis. Unfortunately from that point of view there has to be a lot of responsibility.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They took the responsibility before?

Dr JOLLOW: No, that type of medical officer has never taken full responsibility in a public hospital. Every single patient in every public hospital in New South Wales today is under the responsibility and care of a senior medical officer like me. The registrar or the resident might be doing a lot of day-to-day work. They might be writing up medication charts and checking that Mrs Bloggs is fine in the morning, but every single patient is under the responsibility of senior medical staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They would be under the responsibility of a surgeon if, for example, they were post-surgical cases that needed a little longer ventilation. They would still remain under the responsibility of the surgeon, I would have thought?

Dr JOLLOW: But that surgeon is a highly trained technician whose expertise is operating on a patient. Their expertise is not looking after the airway, not looking after the amount of fluids they get, looking after those types of things.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, but if they are not happy with the registrar or the CMO who is looking after them overnight, they agree the transfer happens. That is the decision they make. So, they are in a sense taking responsibility as they have done for a long time, are they not?

Dr JOLLOW: I am just missing a little bit of the question. I do not know what you are suggesting?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is possible to get to a situation where you had an increased high-dependency situation, which would be possible for the area health service to staff and which would enable the surgeon to continue working, in the sense that the most acute cases are transferred anyway, or the most extreme cases are transferred anyway. So, it is only a question of what you transfer and when and to take responsibility for the decision to transfer or give the extra support, is it not?

Dr JOLLOW: That is true, but that is presuming that transfer happens instantly, and that when a decision is made to transfer a patient, whether that is from Mona Vale to Manly or Mona Vale to wherever, that the transfer can happen instantaneously once the decision is made, and therefore the responsibility is not on the surgeon or the anaesthetist who was looking after the patient during the operation. Unfortunately, that is not the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Instantly is never possible but quick as possible is always desirable. That has always been the case.

Dr JOLLOW: Quick as possible is always desirable, but personally as an obstetrician I do not have much use for the intensive care unit. I have not had one patient in the intensive care unit of Mona Vale hospital in the two years I have been working there. However, as an obstetrician, the problem for me is that if a patient that Dr Boland, who was here previously, has operated on and they cannot extubate, they cannot take the tube out, and the patient has to go to the intensive care unit to be looked after properly, who is going to look after that patient? The responsibility falls on the anaesthetist who intubated patient in the first place. They have to look after that patient.

If that anaesthetist is responsible for that patient in the intensive care unit and I have a patient upstairs who needs a caesarean in 30 minutes—and that transfer to Manly hospital is going to take longer than 30 minutes, I can guarantee it—we are in a situation where a baby could die or a mother could die, all sorts of things could happen in the emergency department, and that is only one example. What a hospital like Mona Vale needs, for a case where the tube cannot be taken out, is someone who is taking responsibility for that patient. At the moment, the intensive care staff take the responsibility. An intensive care specialist is on call for that type of patient as well as for patients in the intensive care department already. If we lose an intensive care department at Mona Vale, even if it becomes a high-dependency unit where they cannot look after these ventilated patients, if a patient needs a transfer, while that patient needs the transfer the rest of hospital essentially closes down.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You lose the expertise of the person involved, anyway?

Dr JOLLOW: No, we lose the expertise of the anaesthetist, and if that is the only anaesthetist on call how can he help with the operation, with the other person in the emergency department or do my caesarean section, or how can he go to a cardiac arrest is someone has an arrest on the medical ward?

The Hon. MELINDA PAVEY: I just wanted your comments, as chairman of the medical staff council at Mona Vale, on the submission put to us by the North Sydney Central Coast Area Health Service which states clearly that Mona Vale's cost-weighted separation was much higher than the benchmark that they would like or the average industry benchmark, and the cost-weighted separations were $3,000 in Mona Vale compared to the benchmark of $2,300 for other hospitals. It

would be appear from this document in the submission that the council is strongly putting the case against Mona Vale. You have worked at both Manly and Mona Vale. Could you give us your impressions on this information?

Dr JOLLOW: From the costings point of view I have to claim complete ignorance. I deliver babies for a living, I do not balance the books. I do not do my own books at home. I am very sorry on that one, I cannot make any comment.

The Hon. MELINDA PAVEY: It would appear to me, reading the submission, that the area health service is trying to suggest that Mona Vale is not an efficient hospital?

Dr JOLLOW: I would have to say that I think Mona Vale was a far more efficient hospital than Manly. I worked in Mona Vale for two years and Manly for 18 months. Personally I can get far more work done at Mona Vale hospital. The figures that Dr Boland has shown me previously show that the intensive care department can get through a lot more patients than Manly. From a clinician's perspective—how many patients can we see, what can we do—I would say that Mona Vale is a far more efficient hospital. There are lots of different reasons for that and often it comes down to personalities and other issues. To be honest, the money is not my expertise but it is also not important. The important thing is deciding that we need to look after the hospital and make sure that the patients are looked after to the best, and if it costs a little bit more money to do it at Mona Vale, to do a better job, that is fine by me.

CHAIR: In your submission you talk about the fact that Manly hospital does not have a helicopter pad and if a large ICU is linked to a statewide register of ICU beds it is more likely than not that transfers may occur, meaning a helicopter pad would be essential for this purpose. Are you aware whether there are any level-5 hospitals without a helicopter pad?

Dr JOLLOW: I am not aware of any, no. I must admit, when I started working at Manly hospital I was surprised it did not have one.

The Hon. CHRISTINE ROBERTSON: Do you know the kind of patients that are ventilated at Mona Vale in ICU at the moment? What sort of people, are they all post-operative?

Dr JOLLOW: I could not tell you the exact numbers but lots of patients that would go through would be patients who had big operations and needed ventilation for a couple of days afterwards. They may also be quite seriously ill patients that present at emergency departments for medical and/or surgical reasons. Also, obviously a lot of people would go through the intensive care department that are not ventilated, who are there because they need increased nursing numbers and more supervision. There are other issues going on, not necessarily just a ventilation issue. So, by no means are all the patients surgical but a high number of them are.

The Hon. CHRISTINE ROBERTSON: Given that intensive care has changed phenomenally, can you let us know what you think about the specialisation of the intensivists? In the 1960s we used to have two ventilators in the corner of the ward looking after 30 people, and a third-year nurse. It is a massive change. What you think about that?

Dr JOLLOW: I think it does not matter what specialty you are in, whether it is intensive care or obstetrics, the changing nature of medicine is that each area is far more specialised, especially in a metropolitan area where there are enough doctors around who are not specialised in certain areas. I think this is completely different in rural areas. So, I think, without knowing any specifics of intensive care training, because that was something I was not interested in, I would have to say in general that for people working in big teaching hospitals, having the most specialised intensive care training there is is very important. If you work at Royal North Shore or Royal Prince Alfred hospitals you need the best of the best. You need the people who are doing the job. In some respects we have been incredibly lucky at Mona Vale and Manly because our director of ICU works at Royal Prince Alfred as well. Therefore, he is bringing expertise to the northern beaches from another big teaching hospital in a different area health service. We are incredibly lucky from that point of view.

Also, like I said before, the majority of intensive care specialists on the northern beaches now do not have those specialist intensive care qualifications and my understanding is they are essentially

there because they have been doing it for a long time. They have specialist interests and they continue their medical education, just like every other doctor does. I suppose the intrinsic problem with having super-specialised intensive care doctors who are trained to work in big tertiary referral hospitals like Royal North Shore is that small hospitals like Manly and Mona Vale and a couple of dozen other ones you can think of in Sydney alone will miss out if it continues the way it is. If the intensive care specialist we have on the northern beaches now decided to retire tomorrow or slow down work, it would be incredibly difficult to find anyone new, because it would be difficult to attract someone with incredibly specialised intensive care skills to a hospital like Manly or Mona Vale.

The Hon. CHRISTINE ROBERTSON: So, it makes for a different role?

Dr JOLLOW: Completely.

The Hon. CHRISTINE ROBERTSON: Can you tell me how many births there were at Manly and Mona Vale, each year, about?

Dr JOLLOW: My understanding is approximately 700 at Mona Vale and around 800 at Manly, which would put them definitely on the small side for maternity units in the Sydney area.

The Hon. CHRISTINE ROBERTSON: Not if they are networked, but they are not at the moment?

Dr JOLLOW: There is networking and there is networking. If you say they are the same maternity services and change the number of patients going through, they still decide whether they are going to Manly or Mona Vale hospital. I do not think that would make a dramatic difference, no.

The Hon. CHRISTINE ROBERTSON: A hospital like Canterbury delivers 1,500 a year. Between the two of you, you have about 1,500 without an ICU. Yet, the obstetricians at Mona Vale withdrew their services over Christmas because of the ICU issue?

Dr JOLLOW: Yes.

The Hon. CHRISTINE ROBERTSON: How often do you use the ICU?

Dr JOLLOW: Very rarely. If you want me to explain that, the reasons the obstetricians made the decision to leave Mona Vale hospital when intensive care close down were several-fold. Firstly, the general surgeons decided they were not going to cover the hospital, which makes it incredibly difficult for us. A fair number of patients present to the emergency department with abdominal pains and other things, and it is very difficult to know whether it is a general surgical or gynaecological problem. So, it is incredibly important to us to have surgeons' back-up and is incredibly important for the surgeons to have gynaecologists' back-up for these patients. They need someone they can ring at 3.00 o'clock in the morning and say, "We found something we did not expect, can you come in and help." That is the first thing. We would not be able to look after any gynaecological emergencies. That would be the main thing.

The second thing is from an obstetric point of view. As much as people like to talk about being able to predict when there is going to be bad outcomes, you do not have to speak to many midwives or obstetricians to find that it is almost completely impossible to predict bad outcomes. Even though it would be very uncommon for an obstetric patient to end up in the intensive care unit at Mona Vale hospital, you never know when it is going to happen. You never know when a patient is going to start to bleed to death on the operating table after a caesarean section. I need to know I have a vascular surgeon behind me who can help me so this patient does not die. It is as simple as that.

The other concern that we had was the very swift nature of the decision to close the intensive care department. It meant that patients who had actively chosen to deliver their babies at Mona Vale hospital—and these days in Sydney people actively choose where to have their babies, they do not just go to the local hospital, they look into these things quite openly—they are under the presumption there is an intensive care department. If they want to go to a hospital that did not have the same level of back-up that we have at Mona Vale, if they wanted different models of care, they could pick different hospitals. They can pick different obstetricians and do different things.

But whether these patients are from the Mona Vale district or not, they are under the presumption that there is an intensive care department there. There is a sign on the doors saying the hospital operates an intensive care unit. There is a sign on the front desk that there is an intensive care unit. If that is closed, that is not fair on the patient. If it happens, heaven forbid, that if we do not have an intensive care unit in six months and if the patients still decide to have their babies at Mona Vale hospital, that is fine, because they know there is no intensive care department. But when they arranged to have their babies six, seven, eight, nine months ago there was a fully functioning intensive care unit at the Mona Vale hospital. So we thought it was not fair for the patients for that arrangement to change at such short notice.

The Hon. CHRISTINE ROBERTSON: How often in the Mona Vale-Manly system is the intensive care utilised for obstetric patients?

Dr JOLLOW: Very rarely at Mona Vale and only slightly more than rarely at Manly.

The Hon. CHRISTINE ROBERTSON: So the back-up services in high dependency need to be worked up within the role delineation while you work out what happens in the future?

Dr JOLLOW: From an obstetric point of view we could probably cope with a high dependency unit. It would not be ideal, but we could probably cope. Like I said before, we have to take into consideration what the other specialty groups do and what back-up we have got. If we are talking about an ICU in isolation, that is one thing. But if we are talking about a situation where the intensive care department closes and because of that the surgeons do not work and because of that the anaesthetists decide there is not enough work for them to do, anaesthetists are harder to find and do not want to work as much. If you have not got an anaesthetic back-up then we close shop. So they are all related.

The Hon. CHRISTINE ROBERTSON: As to your evidence about transfer times, there are members on this Committee who are from the country. We need to know that transfer times are not horrendous and do not take hours and hours. Actually, they do not. Is there some block to transferring?

Dr JOLLOW: Like I said, it is not my area of expertise, but my understanding is that it is not unusual for a four- to six-hour wait to transfer a patient to an intensive care department at another hospital.

The Hon. CHRISTINE ROBERTSON: Is access to the intensive care unit the issue? Is the argument, "We have not got a bed. Try them"?

Dr JOLLOW: It is access to intensive care beds at other hospitals and also access to the very specialised transport team.

CHAIR: You have made out a case for Mona Vale Hospital being a level 5 hospital. It is a fairly compelling case, I would have to say. You represent the hospital Medical Staff Council. What assurance can you give the Committee that it is not self-interest in which you have presented your evidence.

Dr JOLLOW: All doctors are completely altruistic. I think you have to be reasonable. The fact that you read that as an outsider and you say the argument is compelling is enough evidence for me. For someone who is not necessarily living in the area, not a doctor or not some sort of medical person by training to look at that argument and say that you think it is quite compelling, to me that is enough.

Reverend the Hon. Dr GORDON MOYES: In your own specialty, the joy of birth is a family celebration. That means it is very important for the recovery of the mother to have family members celebrating around her.

Dr JOLLOW: Of course.

Reverend the Hon. Dr GORDON MOYES: What is the access for family members to the maternity ward at Manly?

Dr JOLLOW: Do you mean the physical access to the area?

Reverend the Hon. Dr GORDON MOYES: Yes, in comparison to Mona Vale.

Dr JOLLOW: It is a completely different kettle of fish. I work in both hospitals. You only have to look at a street directory of Sydney to realise that Manly is at one extreme end of the northern beaches. Manly itself, as most people know, is an incredibly busy place. In fact, I used to live in the city. Most weekends at Manly are far busier than the central business district of Sydney. There are only two roads that go from the north of Manly to the site of Manly where the hospital is. It is incredibly difficult. From a personal point of view, I have not had a baby at Manly hospital but I can say when I have been on call for Manly hospital it can quite easily take 15 minutes to get from the north side of Manly suburbs to Manly hospital, not to mention from the rest of the northern beaches. Access from that point of view is incredibly difficult, and that is when you have got a car.

Reverend the Hon. Dr GORDON MOYES: What about public transport?

Dr JOLLOW: If you have not got a car it is impossible. It is a 15-minute walk from Manly wharf or Manly town up towards the hospital.

Reverend the Hon. Dr GORDON MOYES: Uphill?

Dr JOLLOW: Uphill. I have done that walk pushing one baby in a stroller and one on my shoulders, and that was incredibly difficult, I have to say. Mona Vale Hospital is on a six-lane highway. There are buses at the door every five minutes. There is ample room for parking. I know that from Mona Vale Hospital, as I said in my submission, you can get to everywhere on the northern beaches in 25 minutes of driving. That is not possible to say from Manly hospital, and I do not think it is possible to say from the Dee Why site that they have proposed either.

Reverend the Hon. Dr GORDON MOYES: Why would anybody want to concentrate all the obstetric work in the worst site?

Dr JOLLOW: I have got no idea.

The Hon. CHRISTINE ROBERTSON: I did not understand that was part of the proposal.

Dr JOLLOW: The proposal was originally to move maternity to Mona Vale.

The Hon. CHRISTINE ROBERTSON: Yes, and now it is to leave them in both sites.

Reverend the Hon. Dr GORDON MOYES: But it has not gone to Mona Vale.

The Hon. CHRISTINE ROBERTSON: No, they are staying at both sites.

Reverend the Hon. Dr GORDON MOYES: And they have no intention of moving Manly to Mona Vale.

Dr JOLLOW: I do not think they do either.

The Hon. AMANDA FAZIO: Did you attend a meeting with the Minister for Health last year and at that meeting indicate that you were satisfied with the proposed changes to the intensive care units for both Manly and Mona Vale hospitals?

Dr JOLLOW: No. I attended a meeting with the Minister, yes.

The Hon. AMANDA FAZIO: You did not give an indication then about your view?

Dr JOLLOW: From my recollection, I gave a view of the other people at the meeting from Mona Vale as well that the system, as figured out, had not been worked out to its complete fruition and, as such, we could not accept it.

The Hon. AMANDA FAZIO: You said in the opening paragraph of your submission that you were writing a submission on behalf of the Mona Vale Hospital Medical Staff Council but you had not had an opportunity because of the holiday period to have a meeting with them to run it pass them. Have you subsequently had time to do that?

Dr JOLLOW: We have had one meeting since this happened. The meeting was taken over by a discussion about the potential move to the intensive care department. There were a lot of questions of Dr Phipps, who is the Director of ICU, about how it would actually work and what would happen. Have we actually discussed my submission? No. A copy of this is freely available to all senior medical staff in the hospital, however, and no-one has said anything to me to the contrary. In fact, most people said the opposite. They thought it was a good proposal and that everything I have said in there has basically been said in the Mona Vale Medical Staff Council that I have been a member of for the last two years.

(The witness withdrew)

LYNETTE MARGARET HOPPER, Registered intensive care nurse, 35 Sydney Road, Manly, and

SANDRA MADELINE HUDSPITH, Health planner and nurse, 11 Aden Street, Seaforth, sworn and examined:

CHAIR: Ms Hopper and Mrs Hudspith, in what capacity are you appearing before the Committee—as private individuals or as representatives of an organisation or business?

Ms HOPPER: I am appearing as the chairperson of Better and Equitable Access to Community and Hospital Services [BEACHES].

Mrs HUDSPITH: As a representative of BEACHES.

CHAIR: As you were not present when I read my opening statement earlier today, I do not intend to read the entire statement again, but it is timely to remind you of a couple of issues that are of concern to the Committee. Many of the submissions to the inquiry have recounted personal details of being admitted to Mona Vale hospital, or Manly hospital, often in life-threatening situations and of the exemplary attention and service they received from hospital and staff. Authors of these submissions have either recounted their own personal experience or that of family members or someone known to them. We have also received submissions from volunteers, fundraisers and medical staff at Mona Vale and Manly hospitals. I would ask witnesses to be mindful of the ethical and legal implications of disclosing personal information about patients. Health practitioners, managers and other witnesses should discuss personal information about a patient only if it is specific to the terms of reference. Basically, we are asking you to be cautious about personal information or views about medical staff that are of a personal nature. While privilege is provided, we are always cautious in terms of submissions and the nature of evidence taken.

If you should consider at any stage during your evidence that certain evidence or documents 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 may subsequently publish the evidence if they decide it is in the public interest to do so. Do either or both of you wish to make a brief statement?

Ms HOPPER: We would both like to make a brief statement. Good afternoon, ladies and gentlemen of the Committee. As I explained earlier, my name is Lyn Hopper and I am the chairperson of BEACHES and also an intensive care nurse at Manly hospital. With me is Sandy Hudspith. She is a community member from BEACHES. Also appearing with us was to be Dr Simon Abel, but, unfortunately, he has had to be on call at Manly intensive care. BEACHES, which stands for Better and Equitable Access to Community and Hospital Services, was formed in 2001, as we felt there was no lobby group representing the 80 per cent of the northern beaches population living south of Mona Vale.

We support the building of a new hospital in a central location on the northern beaches. Our membership consists of doctors, nurses and members of the general community. At our regular meetings our prime focus has been to lobby for a new northern beaches hospital to provide a comprehensive and safe health service to the public of the northern beaches. Currently, the northern beaches has two hospitals providing service to the general public. This leads to duplication and dilution of valuable resources. If we had a new 300- to 400-bed hospital in the population centre it would facilitate many things. For example, we would get better services available. Things like urology, cystoscopy, day-only haemodialysis are services that are currently provided at North Shore. Members of the northern beaches have to travel out of area to get services that could quite easily be provided in a small metropolitan hospital.

The second point is that we would have better access for the majority of the population, bearing in mind that 60 per cent of the northern beaches population live south of Collaroy. The third issue which I have not heard mentioned this afternoon is the issue of critical mass. Critical mass is an essential part of service planning for anything, whether it be obstetric, intensive care, surgery, stroke units or whatever. A large number of patients allows realistic allocation of financial resources for expensive but essential medical infrastructure. It also allows adequate senior staffing levels to be

achieved around the clock and attracts more medical and nursing staff, which in turn will lead to better maintenance of skills and access to staff training. We believe this, in turn, will lead to a safer and higher quality of service in intensive care than is currently provided on the northern beaches.

Over the past 10 years the Northern Sydney Area Health Service has been underfunded. Finally, we are being offered a brand new hospital in the demographic centre, that is, around the Cromer-Dee Why-Brookvale corridor. There has been extensive community consultation regarding services on northern beaches. This community consultation goes back for at least five years, when many members of the community attended open forums and workshops, and participated in surveys. At these early meetings, 90 per cent of the population wanted a single hospital and, of that figure, 70 per cent wanted it in the central site.

Community discussions progressed and as a result the Government announced that at the end of 2002 that there would be two hospitals on northern beaches, a brand new hospital in a central location and Mona Vale would be retained with a complementary role. This was considered a win-win situation for the majority of the population, and the group at the other end who wanted to save Mona Vale Hospital. Unfortunately, other groups acting in the interests of Pittwater, but maybe not in the interests of the whole of the northern beaches, are now protesting that they want Mona Vale Hospital to be the site of the single hospital, even though it is located at the northern end of the peninsula in a population-sparse area.

The exact location of the new hospital is a decision that should be made by planning experts with regard to size, traffic and transport accessibility, and heritage and environmental issues. But there is no doubt that it should be located centrally, where it has the easiest access for the largest number of people. While this planning and site identification goes on, services at both hospitals should continue to function unless patient safety is compromised. Patient safety is a serious concern with regard to intensive care services on the northern beaches. Similar units, less than 10 beds, are having great difficulty attracting medical and nursing staff because there are just not enough patients to provide the job satisfaction and skills maintenance. Again, the critical mass issues.

Intensive care nurses and doctors choose to work in intensive care because they wish to work with critically ill patients. There is a shortage of specialist intensivists at Mona Vale Hospital. Currently, there are only three part-time Visiting Medical Officers to cover seven days, 24 hours per day. Northern Sydney Area Health has made numerous attempts to resolve this. For several years, manly intensivists covered both hospitals. It proved to be another unsafe alternative as intensivists were often required to be present at both hospitals at the same time. This was clearly unsafe and unacceptable.

The after-hours and on-call commitments were also onerous and unreasonable. Northern Sydney Area Health has also advertised widely for intensivists with no success, critical mass and safety issues again being a concern. We have heard people speak about "interested parties", but they have not applied for the jobs or, when they have applied for the jobs and found out that they will be looking after a maximum of two ventilated patients, they have become disinterested. Intensive care specialists want to work in intensive care units with critically in patients.

In fact, over Christmas 2004 intensive care coverage was not available at Mona Vale, in spite of administration offering generous remuneration to any intensivist who would provide cover. During this period the unit was closed for ventilated patients. The intensivists and on-call at Manly did a daily round and was available by telephone to advise. The New South Wales Intensive Care Implementation Group in 2003 recommended offering an across-sites in intensive care service on northern beaches. Again, following community consultation and workshops in November, it was agreed to offer one intensive care service across two sites. We believe that there are not enough patients to staff or provide two level 2 intensive care units. The next overhead might be a bit fine for people to read. It is the role delineation.

CHAIR: Do you have that as well in something that you will be submitting to the Committee?

Ms HOPPER: I can give you a copy of that, yes.

CHAIR: If you are quoting from the document we would like a copy.

Ms HOPPER: That is not a problem. I can offer that. The plan does not involve closing the ICU at Mona Vale Hospital; it involves changing the level of function to a level 3. The description is, "A discrete unit within the hospital able to supply critical care expertise at less intensive resource levels". Manly intensive care will become a level 5 unit. Once again, as I say, it is very difficult to read the print. It is probably just a tad too tiny for the majority of people. A level 5 unit involves the ability to provide complex mechanical ventilation, extra corporeal renal support services, invasive cardiovascular monitoring and complex multi-system life support. Manly ICU, although officially designated a level 4 unit, already provides these services and so would not require upskilling of the staff. The infrastructure is already in place, there is a sound medical and nursing structure in place, and equipment and allied support services are readily available.

Manly Hospital is located at a more densely populated end of the peninsula, but we do not feel that the current site is suitable to the new hospital. Dr Jollow, in his submission this afternoon, stated that Mona Vale had more emergency department presentations than did Manly, but, if you ignore all the paediatric patients, both Manly and Mona Vale have the same amount of emergency department presentations. Manly, though, has a higher admission to hospital rate. Manly ICU is a busy unit with almost triple the amount of ventilator days—that is, 523 days last year versus 185 for ventilator days at Mona Vale last year.

Dr Jollow is correct in saying that Mona Vale has a decreased length of stay in comparison with Manly, but I think he has his reasoning a little wrong. The reason we have an increased length of stay is because our patients are sicker and we keep long-term ventilated patients, whereas at Mona Vale the long-term ventilated patients are moved to other intensive care units. Both hospitals are on trauma bypass and so all trauma—major heart disease, major heart attacks and that sort of thing—is transferred directly out of the area. It does not come anywhere near Manly or Mona Vale hospitals; it goes directly to Royal North Shore Hospital. This is a Health Department directive and all these patients should be in tertiary referral hospitals, not in the district hospitals.

Dr Jollow also talks about putting Mona Vale on the State ICU register. Manly is already on the State ICU register and receives patients from all over New South Wales. We have done that quite successfully for quite a few years without the need for a helicopter pad. In fact, the number of times Mona Vale Hospital has used its helicopter pad is minimal.

The concept of a combined intensive care service across two sites is not new, and it is working in other areas. Blacktown-Mount Druitt is a good example. Blacktown has 250 beds and 27,000 emergency department presentations. Mount Druitt has roughly 160 beds and 25,000 emergency department presentations. They also experience similar medical coverage problems and safety issues that we are experiencing at Manly and Mona Vale. Mount Druitt has become a high-dependency unit, with patients being cared for by non-intensivists. Blacktown intensivists are available for clinical review and education, but not direct patient care.

The Mount Druitt Emergency Department senior medical coverage has been increased to ensure expert assessment and management of emergency department patients. Blacktown Intensive Care Unit is responsible for keeping an intensive care bed for retrieval of patients from Mount Druitt. Medical staff is across-credentialed so that they operate at both hospitals, and the nursing staff rotate. There are guidelines in place about who should be managed in the high-dependency unit and these hospitals have shown that it is possible to offer safe and high-quality intensive care services across two sites.

In summary, it is absolutely and utterly 100 per cent essential that the northern beaches gets a new hospital in the demographic centre of the peninsula, within a reasonable timeframe. In the meantime, we believe all services should remain unchanged at both hospitals, unless there is a safety and quality issue. The best solution to this issue is to leave Mona Vale with a level 3 intensive care and provide level 5 services at Manly. This allows Mona Vale to continue to perform surgery, received emergency department and admissions et cetera, but also provides a safe intensive care service at Manly for the residents of the northern beaches. Thank you very much for your time.

CHAIR: Thank you. Was that presentations on behalf of both of you?

Ms HOPPER: No, Mrs Hudspith will speak shortly.

Mrs HUDSPITH: I am Sandy Hudspith and I am a nurse of 46 years, having worked in the health system in the United Kingdom and here in Australia. I am a health planner who has worked on international and national projects. My overhead outlines the consultation process following the Health Summit, which recommended the community consultation process be established. It is at this stage that I came into the process. I was one of the five Manly representatives on the Community Consultative Committee.

This overhead outlines a huge number of meetings and we had a huge amount of community consultation. I really take issue with people who say the community was not consulted. As the health planner working in the hospital system on planning projects, I also found that always the medical staff said they had not been consulted. Often they were, but they were not able to come to appropriate meetings. Then of course, when the facility is opened, they are there to complain. So what I have heard today is nothing new.

I believe the community should say what is needed and set the priorities, but not try to design the service. The lay documents prepared by the Save Mona Vale Hospital Committee, I believe and our BEACHES group believes, overstepped the mark in how the community should be involved. The Save Mona Vale Hospital Committee submission states on page 19 that there has not been sufficient community consultation. I table that document and the other two overhead documents.

Documents tabled.

These overheads that Lyn is about to put up indicate the number of presentations at shopping centres where we, as the committee, stood at shopping centres, taking submissions from and listening to people. We documented all the information and Menidis Roberts then put this into the document. They consolidated those comments and they are contained in the PFP document.

CHAIR: I am sorry to interrupted by who is "they"?

Mrs HUDSPITH: Menidis Roberts.

CHAIR: Who is?

Mrs HUDSPITH: They were the consultants.

CHAIR: Yes. By whom were they employed?

Mrs HUDSPITH: Northern Sydney Health to co-ordinate the community consultative process. They were the facilitators.

Reverend the Hon. Dr GORDON MOYES: Could I just get a clarification. They were employed by Northern Sydney Central Coast Health.

Mrs HUDSPITH: Yes. I was one of the group representing Manly, but I was just saying that Menidis Roberts co-ordinated the responses.

Reverend the Hon. Dr GORDON MOYES: So this was not a BEACHES initiative?

Mrs HUDSPITH: Oh no. No, but I was there as a BEACHES and Manly Council representative. I would dispute the assertion that there was not community consultation and I will table these documents, which were the hand-outs given to the community during that process.

Documents tabled.

I have just shown as one of the overheads, this is one of the options.

The Hon. MELINDA PAVEY: That was in the submission made by the area health service, was it not?

Mrs HUDSPITH: You actually have that, but that is the colour one and that is how it was presented, which, maybe, you find—

The Hon. CHRISTINE ROBERTSON: Much prettier.

Mrs HUDSPITH: Much prettier, yes. This was one of the options that was presented and this is the option that is being pursued at the moment—metropolitan general hospital south and community hospital north, so it is the hospital process. All these community consultation documents were also displayed on the Northern Sydney web site. However, I tried to get into them on the weekend and I think there was a glitch. I could not get into them on the weekend, but up till now I have been able to access any of these documents at any time. My interpretation of the Save Mona Vale Hospital Committee with working on the community consultation group, they were unwilling to comprehend the data as it was presented. And in the documents that they have submitted they have also seen that there is a block there to understand technical data. I know I could not get through to them the concept of what critical mass was and that is why Ms Hopper put it up on the overheads. Probably a lot of lay people do not understand the importance of critical mass in the provision of any health service.

CHAIR: I am going to ask you to wrap up soon.

Mrs HUDSPITH: Yes. I do not have much to say now. Another comment on page 30, and this is really something I took issue with, noted that hospital planning is done on the basis of limited research. I think this is a nonsense because in New South Wales we have at least four in universities that undertake specialist training, and research and health planning in hospital management, which I have done this course at New South Wales University at Masters level, and currently New South Wales is upgrading the health building guidelines, and I am participating in those, through research, clinical input and research findings from post occupancy evaluation. There are also specialised journals relating to planning hospitals, both facility planning and service planning, and to find one article that states that planning is not based on research is naive. Then the Pittwater Council, I note that they state there is no community consultation.

The other thing I took issue with the comments today was that I believe it is not the position of the community to participate in the site selection because of the probity issues, and that this should be done with professionals and the announcement announced, and defend the issues discussed after that, how it is going to work. So in conclusion I believe that the peninsula community following this process that I participated in are sending a clear message that there is an urgent need to upgrade our buildings to complement new clinical management and service delivery, so both ends, I believe, this is what we believe. Once we get this new hospital we will be able to attract and retain skilled staff, and this should be based on logic and reason.

CHAIR: Can I just get some clarification for my own benefit about who BEACHES actually is and how one gets to be a member of BEACHES and how many members you have in BEACHES?

Ms HOPPER: BEACHES is, as I said, a community group that was formed back in 2001 in response to the need, as we felt it at the southern end where the majority of the population was, to have a voice regarding health planning.

CHAIR: Can anybody in the community join?

Ms HOPPER: Absolutely anybody in the community can join.

CHAIR: How many members do you have?

Ms HOPPER: I am not the secretary or the treasurer, and I am unaware of our exact total.

Reverend the Hon. Dr GORDON MOYES: Can you give an approximate estimation, 100, 10,000?

Ms HOPPER: Definitely not 10,000 and over 100.

Reverend the Hon. Dr GORDON MOYES: How many would have been present at the most recent annual general meeting?

Ms HOPPER: At the most recent general meeting we probably had about one dozen.

Reverend the Hon. Dr GORDON MOYES: About 12?

Ms HOPPER: About that.

Reverend the Hon. Dr GORDON MOYES: Who is your Deputy-Chair?

Ms HOPPER: Who is my Deputy-Chair?

Reverend the Hon. Dr GORDON MOYES: Yes.

Ms HOPPER: Is this important?

Reverend the Hon. Dr GORDON MOYES: Yes.

Ms HOPPER: David Barr.

CHAIR: Is it by accident that both of you are health professionals? Because you have presented as community representatives, but I am trying to find out whether BEACHES is made up of in essence health professionals or whether it is truly a community representative group?

Ms HOPPER: Is just happens to be an accident that there were two health professionals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Three, were there not?

Ms HOPPER: No, Dr Abel has not presented today.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, but he was the third person to present.

Ms HOPPER: Yes. We thought they were hospital issues so it was important that you had people who had—

Reverend the Hon. Dr GORDON MOYES: Plus Mr Barr?

Ms HOPPER: Mr Barr is not a health professional.

CHAIR: You were talking about going to shopping centres and talking to people about these things. You then referred to the role of the New South Wales Health consultants. Indeed, you presented the documents that were otherwise provided to us by New South Wales Health. Are you just doing the work of New South Wales Health? Are you genuinely a community consultative group?

Mrs HUDSPITH: I think we are, and I am semi retired now so I have the time to spend working with the community and this is what I did as the Manly representative, and I believe that because I have a health experience and background that was one of the reasons why Manly Council selected me because I was able to interpret data and discuss more complex issues with the community when asked questions.

CHAIR: When I read the submission of BEACHES what struck me was the animosity between the Save Mona Vale Hospital community and your community. Why do you not consider you both have a right to present a position without needing to make it all relative to the other committee? Why is it all in reference to the other committee?

Ms HOPPER: I think we do that have a right to present a view, and the reason that we were formed originally is to provide another view for the southern end of the population. It is important that we that have.

CHAIR: This document does not even make reference to the Dee Why site. What is the view of your committee about the Dee Why site?

Ms HOPPER: Our committee is quite universal and unanimous in its decision that we would accept a hospital in any central location, a central population location, whether it is Dee Why, Cromer or Frenchs Forest.

The Hon. MELINDA PAVEY: But not a geographic central location?

Ms HOPPER: Not a geographic central location, no, population—

Reverend the Hon. Dr GORDON MOYES: And not central to the demographics of the year 2031?

Ms HOPPER: Of population.

Reverend the Hon. Dr GORDON MOYES: Of 2031?

Ms HOPPER: Of population.

CHAIR: Are you basing it on current population, or are you looking at projections?

Ms HOPPER: We are looking at projections and current population.

CHAIR: Until when?

Ms HOPPER: Through to 2011.

The Hon. MELINDA PAVEY: What about the DIPNR report that was released in the last couple of weeks, which has Pittwater Council increasing its population base by 32 per cent by 2031?

Reverend the Hon. Dr GORDON MOYES: And Warringah in decline.

Ms HOPPER: The Manly end of the population will also increase and will continue to remain the dense—

The Hon. MELINDA PAVEY: By what?

Ms HOPPER: I do not have those figures right here in front of me, but I do remember reading—and will continue to have the dense end of the population at the southern end of the peninsula.

The Hon. MELINDA PAVEY: Have you seen the Northern Beaches Accessibility Study, which has been referred to today? Like Mr Barr, do you dispute the authenticity of the findings of this that Mona Vale Hospital is within a 30-minute drive for the people who live on the northern beaches from wherever you are?

Mrs HUDSPITH: I am a Seaforth resident and it will take me 30, 35 minutes to get from Seaforth to Mona Vale.

The Hon. MELINDA PAVEY: In peak, out of peak?

Mrs HUDSPITH: I have not done it that often. I have not needed to.

Ms HOPPER: In peak it would take a lot longer, but the majority of patients that would be coming to hospital would be travelling by ambulance if they are sick.

CHAIR: Is not 30 minutes regarded as the time frame—20 kilometres, 30 minutes?

The Hon. CHRISTINE ROBERTSON: Where do you live?

CHAIR: So if it is going to take you 30 minutes, what is the basis of the objection?

The Hon. CHRISTINE ROBERTSON: Where do you live?

Reverend the Hon. Dr GORDON MOYES: That is New South Wales Emergency Services plan.

CHAIR: That is the figure being quoted today, 20 kilometres, 30 minutes. You have just said is it 30 minutes from Mona Vale. I am just wondering what was the basis of the objection?

Ms HOPPER: The problem is BEACHES would like the hospital where the majority of the population are going to have access to the hospital. By putting the hospital at Mona Vale you have a few people who have very rapid access to the hospital, but the majority of people would have lengthy access to the hospital.

The Hon. MELINDA PAVEY: Not according to the study by Northern Area Health Service.

Ms HOPPER: If I lived in Manly and had to go through to Mona Vale to go to the hospital I would have to drive through Brookvale, Dee Why or Cromer. It would make no sense. If I lived in Frenchs Forest I would have to drive through that corridor to get to Mona Vale. Again, it would make sense.

Reverend the Hon. Dr GORDON MOYES: How many buses would you need to get to Mona Vale by public transport?

Ms HOPPER: Gee, golly goodness, I hope I am not going to be going by bus if I am feeling sick and I require intensive care support in hospital.

Reverend the Hon. Dr GORDON MOYES: But you may want to visit relatives, family or friends.

Ms HOPPER: When I am going through to Dee Why I will be on a main route.

Reverend the Hon. Dr GORDON MOYES: Indeed.

Ms HOPPER: And there will be no problems with public transport.

Reverend the Hon. Dr GORDON MOYES: Go straight through to Mona Vale.

Ms HOPPER: But I have to go through Dee Why to get to Mona Vale.

Reverend the Hon. Dr GORDON MOYES: But how would you get to Manly from where you live?

Ms HOPPER: Manly at no stage has been argued as the site for the new northern beaches hospital.

Reverend the Hon. Dr GORDON MOYES: It is for the intensive care currently.

Ms HOPPER: As an interim proposal coming is.

Mrs HUDSPITH: For me, if I went to Mona Vale I would have three buses to catch, and it would probably take me—

Reverend the Hon. Dr GORDON MOYES: And to Manly?

Mrs HUDSPITH: One.

Reverend the Hon. Dr GORDON MOYES: And the walk up the hill.

Mrs HUDSPITH: Well, no, there is another—two buses.

CHAIR: Is there not some nonsense in saying if I live at Manly and I have to go past the Brookvale site and the Dee Why site, because if you live at Avalon you have to go past the Mona Vale site?

Ms HOPPER: That is correct, but there are far fewer people living there. If you remember, 80 per cent of the population lives south of Mona Vale Hospital and—

CHAIR: But 100 per cent of north of Manly.

Ms HOPPER: Absolutely, so that is why it should not have the hospital there because you are going to end up with a few problems with the people at the other end.

Mrs HUDSPITH: Equity of access is about proximity to the services and if the service is provided geographically distant it cannot be equitable, therefore that chart that is in the document in that accessibility study that has the 100 per cent, 80 per cent, et cetera, I think that quite clearly supports the centralisation of the hospital and the demographics.

CHAIR: Is the concept of the collocation of a major public hospital, a private hospital and a medical centre something that BEACHES endorses, or is your focus only on a level five public hospital?

Ms HOPPER: Our focus is on the level five public hospital. We are after what would provide the best medical service, safest and highest quality medical service for the general public on the northern beaches.

The Hon. MELINDA PAVEY: Could critical mass be achieved at Mona Vale Hospital if the Government decided, after reviewing the six sites that it has announced today, to choose Mona Vale? You make the point that critical mass is a very important part of it. If Mona Vale was chosen to be the level five public hospital could critical mass be achieved there?

Ms HOPPER: Highly unlikely.

The Hon. MELINDA PAVEY: Why is that?

Ms HOPPER: There is a very good example of that. Highly unlikely. At the moment, if you look at the geographic access you have Mona Vale at one end of the peninsula, you have Manly at the other end of the peninsula and then you have your tertiary referral hospital, Royal North Shore, on the third arm of the triangle. If Mona Vale was to be the hospital and Manly was closed or whatever, it was a small hospital, and you were living down the southern end of that and at any stage if you had the choice of going to either a tertiary referral hospital with everything or a smaller metropolitan hospital with some services anybody would eventually choose to go to the tertiary referral hospital, which would be equidistant from the Manly end to the Mona Vale end.

CHAIR: When did Mona Vale get to the northern end of the peninsula?

Ms HOPPER: At the northern end demographically, not geographically. There is a fairly good example of that. Some years ago the paediatric ward—both Manly and Mona Vale had a paediatric unit and it was decided and very similar issues to this in fact, that the service was unsafe. Because there were not enough children coming through they were having difficulty attracting staff, medical and nursing staff, and there was a safety issue involved. Area came up with a decision that the paediatric unit was to close at Manly and the paediatric services were to move up to Mona Vale and that there would be an increase, as a result of that; you would have an increase in paediatric

presentations or paediatric admissions at Mona Vale. In fact, that is not what has happened. Mona Vale paediatric occupancy rates have only increased marginally and the majority of paediatric patients are going across to North Shore, so that would happen.

CHAIR: Is the factor of safety also in part determined by the skill level of the clinicians and would not therefore an opportunity to co-locate a public hospital, a private hospital and a medical centre provide the optimum for clinicians to be able to maintain their skill level, working across facilities?

The Hon. MELINDA PAVEY: In a perfect world.

Ms HOPPER: If only we lived in a perfect world. BEACHES I do not think have a problem fundamentally with a co-location but our prime focus is to get a new hospital in the northern beaches.

CHAIR: But is the Dee Why site big enough to allow that co-location?

Ms HOPPER: Yes, the Dee Why site is big enough, but again the actual ins and outs of the planning of the hospital should be done by hospital planners, not by community groups.

The Hon. AMANDA FAZIO: Can I just ask you whether you believe that having health professionals, particularly people with health planning backgrounds, involved in BEACHES has probably given you a better insight into the planning needs of the northern beaches rather than just being a parochial community group that is looking after its own local patch?

Mrs HUDSPITH: I think definitely, yes, it certainly helps because you understand the issues straightaway. You understand the technical issues that are being discussed and presented in the documents, understand the figures that are being presented, and I just think it gives us that extra edge.

Reverend the Hon. Dr GORDON MOYES: Ms Hudspith, are you saying "Leave it to the bureaucrats" because those parochial community groups are just a nuisance?

Mrs HUDSPITH: No. I am saying that the community should say what the needs are and that this community has quite clearly said that they want a safe intensive care, they want a safe obstetrics service and there has been a huge amount of participation in community services which has not been discussed today. But that was a really good learning curve for me to understand what the issues were with the community, and David mentioned briefly about the 40—

CHAIR: You mean Mr Barr, do you?

Mrs HUDSPITH: Mr Barr mentioned the disparity of community services, 40 services. It is not just looking at intensive care. There are lots of other departments that we have had discussions with and at workshops where we have all learnt. I have learnt a lot, even though I participated in all hospital departments. But every hospital that you start to plan has a different slant. There are differences because of the personalities and an example of this is the difference here with the two intensive care units, the greater mass of the personalities, the clinicians, are based at Manly; hence the service will go to Manly. If you have not got the clinicians, the service cannot be provided and that, to me, is quite simply what is happening with the Mona Vale end. You cannot get the doctors, therefore the service will just gravitate to where the staff are, and it is the same with any of the services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that not the antithesis of planning?

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

The Hon. AMANDA FAZIO: Can I just ask you in relation to the overall proposal that has been put up—to have a demographically centrally located new hospital, and upgrade of Mona Vale and aged care facilities to be developed on the Manly hospital site—we have heard a lot about intensive care needs and maternity care needs in the area. Do you have any comments to make on needs of the aged community in the northern beaches and what benefits or deficits you can see in having a concentration of aged care services on the Manly hospital site?

Ms HOPPER: Again, because we are not hospital planners, we do not presume to tell—

[*Interruption*]

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hang on, we just heard that she was.

The Hon. CHRISTINE ROBERTSON: They are not supposed to disrupt you.

Ms HOPPER: Thank you. Again we have said that the major planning of hospital services should be done in consultation with the community but by hospital planners who know what they are talking about. The aged care facilities would be nice to be at Manly hospital because we would like to see the Manly hospital site being used as a health care facility. As to exactly what the services are, that would be up to the planners.

The Hon. AMANDA FAZIO: So BEACHES does not have a formal position on that?

Ms HOPPER: On what sort of aged care services would be located at Manly hospital, no.

CHAIR: Can I just come back to the issue of the one IC unit. Back in 2001 in a document—

Ms HOPPER: One intensive care service.

CHAIR: I am sorry?

Ms HOPPER: One intensive care service.

CHAIR: One intensive care unit.

The Hon. CHRISTINE ROBERTSON: Service.

Ms HOPPER: Service.

CHAIR: All right, unit. In a 2001 document, Developing Solutions with the Community, it was said about options for hospitals that due to accessibility problems for northern Pittwater residents, the option of building one hospital at Manly was not pursued. On the basis of those issues of accessibility it seems therefore an unusual decision that you would locate your IC unit at Manly, even as an interim measure. Would you like to comment on that?

Ms HOPPER: Well, as we have said earlier, it would be an interim measure only, and the reason why you would choose Manly as opposed to Mona Vale for an interim measure is the point that I had already made to you previously when I gave my speech, which was things such as that Manly has the same amount of emergency department presentations as Mona Vale; they are at the more densely populated end of the peninsula; they already have the infrastructure and operate as a level 5 unit; they already have the infrastructure in place; the staff are there; the training is there; the medical equipment et cetera—everything—that is all there and ready to go.

CHAIR: Any more questions?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is your relationship with Dr Phipps?

Ms HOPPER: What is my relationship with Dr Phipps?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms HOPPER: A professional relationship.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You work in the same unit though.

Ms HOPPER: Dr Phipps is the director of the northern beaches intensive care unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. Presumably he is based at Manly.

Ms HOPPER: He has time at Manly and at Mona Vale.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you are also based at Manly with him.

Ms HOPPER: I am at Manly, yes, but he does not work at Manly all the time. He is at Manly and at Mona Vale.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but you are working in the same unit as he is working in.

Ms HOPPER: I work in the Manly unit in which he spends some time, not all of his time. The majority of his time is spent at Mona Vale, actually.

The Hon. CHRISTINE ROBERTSON: Could I just ask about how many people from your group are not actually health professionals?

Ms HOPPER: Again, I am sorry. I do not have access to that.

The Hon. CHRISTINE ROBERTSON: Proportionately, about?

Ms HOPPER: The majority, actually.

The Hon. CHRISTINE ROBERTSON: So at most meetings you have general community people who are just interested in helping in the northern beaches?

Ms HOPPER: That is correct, yes.

Reverend the Hon. Dr GORDON MOYES: Have you ever taken up any petitions at all from the general public?

Ms HOPPER: From BEACHES?

Reverend the Hon. Dr GORDON MOYES: Yes.

Ms HOPPER: Yes.

Reverend the Hon. Dr GORDON MOYES: Have you had any large-scale public rallies at any time?

Ms HOPPER: Yes, we have.

Reverend the Hon. Dr GORDON MOYES: With thousands of people present?

Ms HOPPER: I am not sure, again, of the exact numbers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Of what order of magnitude?

Ms HOPPER: Similar scales, maybe not in the 6,000 but, you know—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What, 40, 150?

Ms HOPPER: Oh no, several thousand.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Several thousand?

Ms HOPPER: Yes.

CHAIR: If there are no further questions—

The Hon. AMANDA FAZIO: No, I have a question.

CHAIR: Oh, you do.

The Hon. AMANDA FAZIO: Do you find it offensive that the credentials of BEACHES has been challenged in the way that it has today, given that the Save the Mona Vale Hospital Committee were not treated to a similar—

Ms HOPPER: Intimidation?

The Hon. AMANDA FAZIO:—grilling about their validity.

Ms HOPPER: I do find that offensive.

The Hon. AMANDA FAZIO: So do I.

Reverend the Hon. Dr GORDON MOYES: It would have been helpful if we had had that all spelled out in the document.

The Hon. CHRISTINE ROBERTSON: It was.

CHAIR: I think that, there being no further questions, I will thank both of you for your time today and for your presentation of submissions.

The Hon. AMANDA FAZIO: Before we wrap up, I am just wondering if you would be able to just get Dr Christley back for a minute.

CHAIR: Why?

The Hon. AMANDA FAZIO: Well, I am just really confused about these two documents. We have got the circulated document, the Northern Beaches Accessibility Study—

CHAIR: You can do that by way of a question on notice. You can get clarification. There is no opportunity today. I will declare the hearing closed. We will have a deliberative meeting.

The Hon. CHRISTINE ROBERTSON: We will ask you later.

CHAIR: I ask the public to clear the room as soon as is practicable.

(The Committee adjourned at 5.09 p.m.)