REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO THE OPERATION OF MONA VALE HOSPITAL

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At Sydney on Tuesday 8 March 2005

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. P. Forsythe (Chair)

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

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

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

Witnesses, members and their staff are advised that any messages should be delivered through the attendants or the Committee clerks. I also 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 Committee or by 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 a need to do so. If such a case arises I will ask the public and the media to leave the room for a short period. Finally, could everyone please turn off their mobile phones for the duration of the hearing. That does not mean placing them on "silent" but actually turning them off, because it interferes with the recording by Hansard. I welcome our first witnesses.

RICHARD (DICK) PERSSON, Administrator, Warringah Council, Civic Centre, 725 Pittwater Road, Dee Why, and

STEPHEN BLACKADDER, General Manager, Warringah Council, Civic Centre, 725 Pittwater Road, Dee Why, affirmed and examined:

CHAIR: Mr Persson, do you wish to make a brief opening statement?

Mr PERSSON: I do.

CHAIR: Mr Blackadder, do you wish to make a brief opening statement prior to questioning?

Mr BLACKADDER: I would prefer not to. I would be happy to answer any questions of the Committee.

CHAIR: If you should consider at any stage during the evidence that certain evidence or documents that 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. Mr Persson?

Mr PERSSON: I would like to outline the history of my involvement in the issue of trying to get a new hospital built to replace Manly Hospital. Fairly early on in my period as administrator, a former mayor of Warringah Council and a number of doctors came to see me asking me to try to get the issue moving again. It was their view that things had stalled, and they were concerned that the previous Minister's commitment to build a new hospital on the northern beaches might be lost. It was their view that there should be a two-hospital solution with a new general hospital to the south of

Mona Vale. This position aligned with the position previously adopted by Warringah Council before its dismissal.

I indicated I shared their view about the importance of securing the funds apparently available, and undertook to raise the matter with the appropriate people when time allowed. As a new administrator, as you can imagine, there is quite a lot to do. So I took a couple of months before I made an appointment to see the chair and the CEO of the then Northern Area Health Service. During that interim period, of course, it had become very clear to me, as I had learnt more about this area and the history of the hospital issue, that they were rightfully concerned and that there was a need to get the issue going. I went to the meeting to find out where things were up to and to lobby, if necessary, about the need for an improvement to the health services available to the 140,000 residents of Warringah Council. At that time I was supporting the council's position of a new hospital at either Frenchs Forest or Brookvale bus depot.

Our discussions quickly revealed that things had stalled and that they were not positive about either of those sites. There was no immediate intention to proceed that I could see. It was in this context that I asked about other sites: the cupboard seemed bare. I asked if they had ever considered the Civic Centre site in Dee Why. I made it clear that if they wished to proceed further with evaluating this option there would need to be a public statement before any discussions were held with council. I felt it essential that any such discussions would be very open and the public aware.

Subsequent to this meeting I contacted the Minister, the Hon. Morris Iemma. I wanted to make sure he was committed to building a new hospital in the area before I invested a lot of time and effort. The Minister gave me that assurance, so I allowed the process to continue. I can assure this Committee that there was no State Government agenda here. The only agenda running was, and still is, a sincere attempt on my behalf to get a decision and a commitment of funds from the State Government before other priorities overtake us. I cannot think of a single more important thing to achieve for the residents of Warringah Council than a new state-of-the-art general hospital.

In terms of where it is located, I do not really have a strong opinion other than it obviously should be located towards the direct demographic centre of the population. As a former Director-General of the Department of Public Works and Services, I am well aware how many communities in New South Wales would do just about anything to get a new hospital built in their area. I still find it astonishing that so much energy and effort is applied to blocking every alternative put forward. I find myself in agreement with the statement of understanding signed by the four local State members of Parliament. They agreed on a number of key points; they disagreed on one.

In terms of what they agreed in the statement I referred to: first, there should be two hospitals comprising a new general hospital to replace Manly Hospital, and an ongoing complementary role for Mona Vale serving its local community. I agree with the four State Members of Parliament on that statement. Another point was that the new general hospital should be located near the population centre within the general precincts of Dee Why, Brookvale and Frenchs Forest. The third point of Messrs Brogden, Humpherson, Hazzard and Barr: the final choice of site should be determined by experts with regard to the clinical needs of the residents of the northern beaches. Their statement concluded by observing that "the community had participated in a lengthy community debate". and that there are strongly held views which, in some respects, are irreconcilable. I share that observation as well.

In conclusion, I point out to the Committee that to remove some of the confusion about Mona Vale hospital—and I mean many residents think that if a Dee Why hospital is built it will mean automatically that Mona Vale will be closed—to remove that confusion and to improve community confidence about the future in the long-term of Mona Vale, I have announced and indicated that if the health department wishes to proceed with the Dee Why site, Warringah Council will make it a contractual condition of any sale that funds be available for the upgrading of Mona Vale infrastructure, and committed for the same time period as construction for the new hospital. I announced that some three months ago. That concludes my opening statement. I am happy, of course, to answer any questions.

CHAIR: In relation to the Dee Why site, can you outline clearly what is the proposal, particularly in relation to the heritage position of some of the buildings and the front car park, what are the constraints on the site?

Mr PERSSON: I will proceed to answer that just with an observation that my commitment to being open and transparent with the community actually meant that this announcement came out before there was any proposal; it was just an idea. Of course, in such a vibrant and active community with representatives from both Mona Vale and other parts of the area, groups started to organise and oppose the idea before there was actually a specific proposal. So it was an idea somewhat left without a champion. I did not feel it was appropriate to champion it and the health department was not ready to. Nevertheless, the heritage issue emerged fairly quickly. The architect is well-known and has a history of defending his designs in court. There is a well-known case in Canberra. At that time the only heritage listed building would have been the library adjoining the Civic Centre, which is a beautiful building, also, part of his design. It is on the local heritage register.

As the debate started to warm up there was a move within the architectural fraternity to get a listing and I think it was the New South Wales Institute of Architects proceeded to prepare and lodge a submission with the Heritage Council for listing. I believe that process is still in train. My advice is that there is every prospect that it will be successful to some extent. I think their application covered not only the buildings of the library and the Civic Centre but also the surrounding bush and greenscape, which is also from a fairly well-known and eminent landscape architect. Advice is that only the buildings are likely to be registered and a little bit of the area immediately adjacent.

We have advised the health department that if they wished to proceed with the site they would have to understand those constraints, and I believe they now do. So I think that answers your question in terms of where the heritage issue is up to. If a hospital was to be built on the Dee Why site with that constraint or that factor to be taken into consideration, it would not be built on the Civic Centre, or the library, or the land in between, or the fairly large car park that many of you would know as you drive through Dee Why heading north, the one on your left behind the big row of Norfolk pines. That would all remain unchanged. I believe the health department's ideas now focus on the Salvation Army site at the rear of the council, the private land at the rear of the council, the major public car park behind and to the side of the council and going through some council land down to Kingsway.

CHAIR: The council's submission refers to the "somewhat unsuccessful search for an appropriate site for a new general hospital". The health department tells us there are six sites before the Minister at the moment, which a number of them I believe would be in the Warringah Council area. So when you referred to an unsuccessful search for an appropriate site you must have some view about some of the other sites that are being considered and I wondered why you believe them not to be appropriate?

Mr PERSSON: I have not said that I do not believe them appropriate. If you look at my opening statement I mentioned that I actually do not have a strong view about the site, as long as it is in a demographic centre. My comments in the submission reflect our understanding of their view of some of these alternative sites. The fact that there are six sites on a list, of course, does not mean that they think that six sites are suitable. I am not privy to the submission that has been made to the Minister in regard to either, or what is said about that site or the Dee Why site. My own view is that a general hospital built on the site known as the Frenchs Forest site would appear to meet a lot of the needs.

The Brookvale bus depot is certainly a good location, although my understanding is there are significant issues there in terms of the size of the site and the STA's determination to stay on. If they stay on then you have got to build your hospital on a concrete structure with very wide turning circles and therefore very wide pylons, which would add huge amounts of money. I have not taken it as my job to challenge their assessment; I believe that is their skill and their background to do so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If this site were sold by the council it would solve Warringah Council's financial problems, would it not?

Mr PERSSON: Warringah Council does not have a financial problem. Warringah Council was on the financial watch list for three or four years prior to its dismissal. The previous council and the general manager, Mr Blackadder, had charted a course to come out of what you might call financial difficulties and had achieved that pretty much at the time of my arrival. We have very low debt; in fact it is negligible. But it is true to say that selling a site of some significance would bring some capital available for spending on other community projects, whether they be environmental projects or sporting projects.

It is my observation that Warringah Council since the separation of Pittwater—and I assure everyone in the room that I am in no way interested in raising that issue or challenging that decision—but it is my observation that the separation has left Warringah Council in a situation where it is unlikely to have a surplus. As a business it is breaking even, with an ever-increasing demand for services from a very vigilant and quite militant community, with a newspaper called the *Manly Daily* that gives everyone a run. In that climate I think it is unlikely that any council is unlikely to significantly change the service rate mix.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there frequently a lot of spare parking space in that car park?

Mr PERSSON: Any proposal that proceeded would have to replace the publicly available car parking. We are talking about up to 800 or 1,000 additional car parking spaces for hospital use, and that would be underground.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a big hole?

Mr PERSSON: Underground, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it true that you can only go down two storeys before you reach sea water?

Mr PERSSON: No. You are confusing two issues. There is another debate about the car park in the Dee Why town centre where that is the case. But we are now talking about the other side of Pittwater Road where it is rock and you could probably go down for a very long way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The rock would keep the water out, would it?

Mr PERSSON: It is an elevated site. Have you not been to the site?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, I have. It seems that you would have to dig out a mountain.

Mr PERSSON: You would have to talk to others about that. I am advised that it is feasible.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand it would be several storeys high because of the topography.

Mr PERSSON: In planning and architectural terms, you only ever talk about above ground level.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you would be digging the car parking spaces out of solid rock, would you not?

Mr PERSSON: Primarily I believe, yes. I would not be digging anything. The council would be disposing of part of its site to the health department, and they would then engage a large, experienced contractor to do it through a tender process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is the size of the Dee Why site if you accept the heritage aspect, and also the reasonably large car park, which I think has four rows of car parking, which is immediately visible from Pittwater Road?

Mr PERSSON: That car park would stay. The car park that goes is the one to the rear of the site.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The one at the top of the hill?

Mr PERSSON: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How big is that site, with those other chunks taken out?

Mr BLACKADDER: It is about a hectare. The whole site is 2.6 hectares.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you take out the front car park, the heritage buildings and the natural rocky outcrop with a few trees on it, you have only about a hectare?

Mr BLACKADDER: At the top, and going down to The Kingsway. I understand that Northern Sydney Health is looking at the Salvation Army site adjoining as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That site is impossible without the Salvation Army site, is that the bottom line? To me it seems impossible to build 800 parking spaces, plus the existing car park, plus a hospital, plus a private hospital on that site.

Mr BLACKADDER: We are looking at a number of designs that Northern Sydney and Central Coast Health have developed, which place the hospital running from Fisher Road at the top down to The Kingsway. It is a location that takes into account the car park at the top and council land going down to The Kingsway and some private land. It would also take in the adjoining Salvation Army land. I am just not sure what area—

Mr PERSSON: We can supply the Committee with the area of the site we are talking about.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that the five-storey design that is in the health department's submission?

Mr BLACKADDER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That does require some private land, which is not the Salvation Army land. Does it also require the Salvation Army land?

Mr BLACKADDER: I believe so, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you did not get the Salvation Army land, you could not do that design, is that the bottom line?

Mr BLACKADDER: It is not us doing the design; it is Northern Sydney Health. But we understand that they do need the Salvation Army land to achieve that design.

CHAIR: When you talk about these designs that NSW Health has developed, do they include within them a concept for a private hospital and co-location with a medical centre, or do they strictly include a general hospital?

Mr PERSSON: They have not specified with us their ideas in that regard. They are talking about a footprint and some design concepts in fairly rough terms. They are a long way short of lodging anything formal for assessment or whatever.

Reverend the Hon. Dr GORDON MOYES: What is the council's value on that site?

Mr PERSSON: I prefer to keep valuations as commercial in confidence at this stage. But we have had a number of valuations, one initially from the State Valuation Office, the Government Valuer, and we have also had a private valuation done. We have indicated to Northern Sydney Health

that if it proceeds, we have indicated the valuation concepts under which we would be looking to discuss the matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask what the percentage difference is between those valuations?

Mr PERSSON: They are similar.

Reverend the Hon. Dr GORDON MOYES: Would it be in the region of $40 million?

Mr PERSSON: There is no point in going halfway down a road. I am looking after the interests of Warringah Council, and in my view it is commercial in confidence at this stage to hold our valuations to our chest.

Reverend the Hon. Dr GORDON MOYES: But there have been things published.

Mr PERSSON: Lots of things get published. Can I add—

Reverend the Hon. Dr GORDON MOYES: I am giving you the opportunity to clarify the matter.

Mr PERSSON: I do not need to clarify. But what I would clarify is that because there is a genuine entitlement of the community to have this as a very transparent process, in the event that any decision to proceed is given the go-ahead, I have established two processes. I have established what I call an Eminent Persons Committee, which has three former shire mayors or presidents on it who will have access to all parts of any transaction, all information, and have the ability to speak publicly on any matter of concern they have. As I said, they are very widely respected and experienced people who have served the shire and the council admirably, and I think that was a good move to cover a potential point of concern that an administrator might be seen to be selling off the crown jewels.

I have also established a committee with three very experienced people with commercial property development experience to advise the general manager and me on all aspects of any commercial dealings, either with the possible hospital site or the redevelopment of the Dee Why town centre. We have had a number of meetings with them to talk through all the information that has come before us and all the ways we are going about it.

Reverend the Hon. Dr GORDON MOYES: We have had some figures for population growth in the future. Is it your understanding that to the year 2031 the major population growth will be north of Dee Why?

Mr PERSSON: I believe that is the indication of the Department of Infrastructure, Planning and Natural Resources.

Reverend the Hon. Dr GORDON MOYES: You mentioned twice in your statement the term "demographic centre". Does that make Mona Vale the demographic centre?

Mr PERSSON: It means Mona Vale will have more people around it. I presume you have read the demographic projections that you are referring to. I think you will see that they do not take it to the majority by any stretch of the imagination.

Reverend the Hon. Dr GORDON MOYES: But it is a projection for the future?

Mr PERSSON: It is an increase, but it does not come close to being half. It does not change the overall balance.

Reverend the Hon. Dr GORDON MOYES: What are the demographic centres that you are concerned about?

Mr PERSSON: They have been well expressed before the Committee. A community-based committee was established to look at this, and that committee judged Cromer to be the ideal place in

terms of the demographic centre. Cromer is within a couple of hundred metres of the Dee Why site you are now talking about. I think most people would concede that. I agree with the four State members of Parliament when they drew an axis around—if I can recall their words in my statement—Frenchs Forest, Brookvale and Dee Why. That would be our view of where it is appropriate.

The reason for the demographic centre being important is that it would be quite unacceptable to expect the people from the southern part of the northern beaches to travel to Mona Vale for their general hospital activities, given that they have had Manly Hospital for a long time. I think that is why the four State members of Parliament, in their wisdom, worked that out and argued for a mix which I would urge this Committee to have a good look at because I think it is quite wise.

Reverend the Hon. Dr GORDON MOYES: You indicated that Warringah Council was unlikely to have a surplus in future.

Mr PERSSON: An operating surplus, yes.

Reverend the Hon. Dr GORDON MOYES: Do you have any further comment on that?

Mr PERSSON: I have had experience in local government before. In Queensland I was the Director-General of the Department of Housing and Local Government Planning for 4½ years, before I became Director-General of Health for a couple of years, before I became the head of Public Works and Services. So I have had some relevant background to all this debate.

In terms of that local government role, it was very much at a strategic high-level change in the Local Government Act at the same time as reforming the planning and housing systems there. But now that I am down here at the coalface I would say, as someone who has had a career in the State Government in the past, it is a good reminder of just how much local government delivers, how much the demands of the community are for services. It is a very wide spectrum, and many State Government departments have a much narrower spectrum, as do the Ministers. It has been a good reminder to me. In my first budget I attempted to make a few savings, and I think the technical term would be that I copped a hiding. So I do not anticipate it being changed through a reduction of services. And, of course, rates are capped. I would be one of the few local government people at the moment who think that rate capping is generally a good thing.

Reverend the Hon. Dr GORDON MOYES: Are you seeing projected deficits in the future—?

Mr PERSSON: No, I did not say projected deficits.

Reverend the Hon. Dr GORDON MOYES: You said you would not be making a surplus. If you do not make a surplus—you must be making a loss.

Mr BLACKADDER: No, you can break even.

Mr PERSSON: I think that is clear to anyone. What is your point?

Reverend the Hon. Dr GORDON MOYES: In light of the fact that you will not be making a surplus, do you see the sale of council assets as a way of solving some of your future problems?

Mr PERSSON: I will make it very clear. The financial issues were not at all in my mind when I offered that site; it was purely an attempt to try to get the debate moving and get a new hospital. As I said in my statement, I can think of no other single more important thing to achieve, on behalf of the 140,000 residents of Warringah, than a new state-of-the-art general hospital. Communities all over New South Wales strive to do the same thing. So I think it is really clear that you do not need any more motivation than that. But if you are saying to me, will it be useful, that council would receive considerable money net of all its other costs involved, the answer would be yes.

Reverend the Hon. Dr GORDON MOYES: Your 2.4 hectares is a total footprint of that area provided you can get the sale of the Salvation Army land—

Mr PERSSON: I am not getting any sale; it is the Health Department. I think it is important for you to untangle our role from their role.

Reverend the Hon. Dr GORDON MOYES: I understand the roles—

Mr PERSSON: You keep saying "you" as if it is us, and it is not.

Reverend the Hon. Dr GORDON MOYES: I understand that you are a significant player in the field. I apologise if you are not.

Mr PERSSON: I am a significant player in one aspect of this. It is appropriate to address questions to the Health Department and its officials for the things they are responsible for, and it is inappropriate to be part of any possible misleading of anyone that we are somehow involved in a way that we are not.

The Hon. AMANDA FAZIO: Mr Persson, if the civic centre site were to be sold, or the council land and the car park to the back of it, what would be the replacement cost to council of those facilities?

Mr PERSSON: The earlier comments about that, regarding the likely heritage listing of the civic centre site, rather tragically mean that the council will be to stay there for a very long time, if not forever. In making that observation I do not mean to cast aspersions on the Heritage Council or its job, but as an individual I find it amazing that when you look at this building and you have worked in this building, to consign a group of people to a long-term future there because it has some architectural merit is rather a tragedy.

In fact I was quite interested in that aspect of the overall package, that this opportunity might free Warringah Council of an ever-increasing debt in terms of the liability to service this building and maintain it. So, unfortunately now we will be staying in the building. We also have a significant number of staff in the Cromer office, which is a few kilometres away.

The Hon. AMANDA FAZIO: The current Warringah Council buildings are inadequate for the work of the council at the moment, in terms of housing all the staff?

Mr PERSSON: I believe they leave a lot to be desired. Staff are not located in the one place—and that is not essential, but it has some advantages for efficiencies when it can be done. I do not believe it is very good in terms of access of people. It is up quite a steep hill. We have a lot of elderly residents who mention that, with regard to accessing the library and the council service offices. There is also a proposal in the mix to look at redeveloping the Dee Why town centre. In the event that that occurs, we would be looking to move our front counter services to the heart of Dee Why so people can have better access, and probably a new library there as well.

The Hon. AMANDA FAZIO: I do not mind which of you answers this question: since this debate about the establishment of a new general hospital on a central Dee Why site commenced, apart from the people who want to retain the buildings because they like them and support their heritage listing, what has been the general response of the ratepayers of Warringah to the proposal to have a central hospital located in their area?

Mr PERSSON: I would have to say that initially it was quite positive. As campaigns have proceeded, I would have to say that there is a significant level of opposition to a hospital in Dee Why, primarily around the view that the area is congested and traffic will be made more difficult and more complex. Our assessment of the traffic is that it will likely extend the afternoon peak period, currently running from between around 4 p.m. to 5.30 or 6 p.m. from 3 p.m. to that same time period. This is largely due to the afternoon shift with some nurses going off shift and others coming in.

The Hon. AMANDA FAZIO: Are the people in your council area supportive of the general hospital being established at Mona Vale or do they want a more central location?

Mr PERSSON: I find it very difficult to answer that question with any certainty. One of the features of this debate is the level of confusion and misinformation that is being put around. Only last

night as I was doing my paperwork I read a letter—written, I think, to the Minister for Health but copied to me—from a person at Newport asking the Minister not to close Mona Vale Hospital. It was clear from the writing that this person was of the view that the Government was about to close Mona Vale Hospital. Despite the fact that Minister Knowles gave an undertaking, despite the fact that Minister Iemma has given an undertaking and despite the fact that I have made it a condition of any sale of Dee Why that there be a physical upgrade, there are still people out there who think that.

You can draw your own conclusions as to why that happens. One thing I will concede about the members of the Save Mona Vale Hospital Action Group is that they has been very successful and very vigilant, and have put in a lot of time and effort. But, whether or not it was that group's intention, I believe a lot of people have the wrong idea about what is intended. It may be that some people view the fact that there is a two-stage step involved, I think that is probably what I would call the paranoid view, that once the new hospital is built somewhere else then, slowly, this other hospital will be allowed to somehow die off or be forced to die off through clinical service mix.

Reverend the Hon. Dr GORDON MOYES: Like Westmead and Parramatta!

Mr PERSSON: No-one can speak with any confidence about that. From my point of view I do not think that that is enough to stand in a way of trying to solve the conundrum. As I say, if the department formed the view that other sites in the area that the four members of Parliament indicated were available suitable, I would be right behind it—which covers the point made by Dr Moyes. It would not bother me if the council did not receive the money. This issue has a lot of local Dee Why people concerned particularly, because they are concerned about traffic. Dee Why has had development at a very fast rate over the last five-seven years. The Sydney property boom has been ongoing and so has the demand to live in that area.

The previous two councils rezoned Dee Why very generously to property owners, stacking a lot of medium-density housing in there. People have seen probably what one would normally see happen in two or three property cycles happen in one. There is a lot of concern about development and their world has changed. From someone who lives outside the area, I do not see the issues in the same way and I think people who travel overall parts of Sydney understand that part of this being an international city is that we get traffic problems. Even the cities that have had the benefit of huge capital Works infrastructure in the form of underground railways still gum up in peak-hour periods and the northern beaches has joined them.

Many people who have grown up on the northern beaches and lived there all their lives, many of them are now becoming senior citizens, see that as an undesirable change and I can understand that. Our assessment is that the marginal difference of a hospital into the mix is not a straw that would break the camel's back. In fact, it may provide us a better leverage with the State Government to bring about some traffic management measures that we have not been successful with in the past in negotiations with the Roads and Traffic Authority [RTA]. If the State Government presses that button, I would be moving into that zone and trying to see what we can do. Our traffic estimates show that there are a couple of intersections that are approaching the point where the RTA says they are not satisfactory. At this stage I do not know how many intersections in Sydney are in that zone and, but I suspect there are a lot.

CHAIR: Are you able to identify which are those intersections?

Mr PERSSON: The primary one that comes to mind is the intersection of Fisher Road into Pittwater Road turning south. A motorist might have to wait for two to three sets of traffic lights because, when you turn south into Pittwater Road, only eight or nine cars can get across before being blocked by another traffic light. They are the sorts of traffic management measures I am talking about. It seems to me as someone who does that every evening that it is something that could easily be dealt with.

The Hon. MELINDA PAVEY: So, development consent for any new hospital on that site would be on the basis of the RTA fixing up the traffic black spot?

Mr PERSSON: No, but if there was to be development consent from the council it would certainly have to be satisfied that the traffic measures were adequate.

The Hon. MELINDA PAVEY: Mr Blackadder, has council's traffic committee looked extensively at the issue of traffic at the site?

Mr BLACKADDER: We have had a traffic study undertaken, , in conjunction with the Dee Why town centre master plan, which established the existing traffic flows and also the expected flows from the development of the town centre. We have passed that on to Northern Sydney health to use in its examination of traffic issues. A preliminary report has been produced by a traffic consultant commissioned by Northern Sydney Central Coast Health. We have been provided with that information and have gone back to them with a series of questions. It is in somewhat of a state of flux of the moment.

The Hon. MELINDA PAVEY: Mr Persson, you mentioned the difficulties in accessing the site at Dee Why Library and Civic Centre, and the number of people climbing the hill et cetera. Does it not concern you that in fact it is not a great site for a hospital?

Mr PERSSON: So far as people walking up from the bus to the Civic Centre is concerned, I know that any design concept would not have them accessing the hospital through the same trek up the hill. I think that picking a site for a hospital is obviously a complex mix of factors. As I mentioned before, I was Director-General of Queensland Health and oversaw a major rebuilding of the Queensland hospital program throughout 1994-95. From my own personal point of view the thing I am most concerned about is that the people who are not able to drive a car, do not have a car or cannot learn to drive one have access to the public hospital. It is not just for the fancy surgery, it is for a whole range of services that people access a hospital.

Mona Vale Hospital does have reasonably good transport access and I think that Dee Why has even better, in terms of the number of bus routes that go through Dee Why. It is very Central. That could also be worked out for the other sites that I have mentioned. I do not believe that those sorts of issues are a blocker to any site particularly, in terms of traffic. I live in the eastern suburbs and the Prince of Wales Hospital is my hospital. I have an asthmatic son. It takes me seven minutes to get there at night and takes me nearly 27 minutes to get there in peak hour on a Saturday morning. The same thing happens on northern beaches. A lot of our hospitals in Sydney are located in very busy areas, whether it be the Camperdown complex or Royal North Shore Hospital, or the Prince of Wales Hospital that I just mentioned.

The Hon. MELINDA PAVEY: Does the department's own traffic management surveys indicate that the Mona Vale site is as easily accessible in terms of time?

Mr PERSSON: You would have to ask the department about that issue but my observation would be that it has reasonable access. It is more a question of where it is located and the travel times. I read the transcript from last week's hearings and one point that came out very clearly is that there is a contradiction in the argument of some people. They do not want to travel to Dee Why from further north because of traffic, but they want to go further than Dee Why if there is to be new general hospital. So they want to go into this traffic that they see as a problem, out the other side and on further. When you read the transcript it stands out very clearly as a contradiction in the argument. Likewise, of course, people who want to have a general hospital at Mona Vale, who do not want to travel to Dee Why or further south, want the people from Manly and other parts of Warringah to travel through Dee Why and up to Mona Vale. I would urge you to re-read the transcripts if you have not had the chance because that does come out very clearly.

Reverend the Hon. Dr GORDON MOYES: Could I ask either of you gentlemen a question about community consultation? I understand from reading the Manly Daily that there was a significant rally of 2, 000-odd citizens in the Dee Why Centre last April. Did either of you gentlemen attend that rally?

Mr PERSSON: No. I was not invited. I think it is important that people who want to have a rally should have a rally. I fully support the right to protest. In fact, I facilitated making sure that that demonstration worked smoothly, arranged for them to have electronic sound and made sure that we protected the site overnight, because it was in a parking lot. It was disappointing that they made no attempt to approach council and seek approval to hold the rally in our library and in our parking lot.

But, nevertheless, I made sure it was successful. No one was counting but, from my information, people who saw 2, 000 people do need to access optical medical services urgently. There was a significant group of people, most of whom I believe were there due to the very efficient and well-oiled machine of the Save Mona Vale Hospital group and, to a lesser extent, people who were concerned about the Civic Centre site, people who I think have been misled about the intentions for the site. But there was a significant demonstration there, yes.

Reverend the Hon. Dr GORDON MOYES: Had there been similar demonstrations urging the building of the hospital on the Dee Why site?

Mr PERSSON: No. Not to my knowledge, no.

Reverend the Hon. Dr GORDON MOYES: In fact, had there been any public rallies to support the Dee Why site?

Mr PERSSON: No, not that I am aware of.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the draft master plan for Dee Why dependent on the moneys from the sale of the car park?

Mr PERSSON: No. The Dee Why Town Centre Plan started before this. Once I got to Dee Why, I went out and had my lunch. I walked around but could not find anywhere to eat my sandwich. I went back to the General Manager and said, "What is the plan for Dee Why? This is appalling in terms of civic amenity and friendliness." They presented me with the plans and I describe them as a loose set of design guidelines that were not worth anything. There had been no provision for amalgamating the site and getting site bonuses. The rezoning that I referred to earlier had gifted huge amounts of development entitlement to the property owners without securing anything back for the public. I bought in the Government Architect, who had worked for me in my previous job—I have a great deal of respect for Chris Johnson, who has worked on a number of town centres. I bought him in and engaged him to start work.

We now have a master plan that went out for public display. We have a very high level of support for that. We organised focus groups at random. The selected residents in those groups supported it totally. There is a source of opposition from a Catholic church adjacent to the car park and I acknowledge that they are very concerned about the possible impact on the church. I continue to try to work through design issues with them. The finances of the Dee Why town Centre also stand alone. Obviously, the redevelopment of the car park I just mentioned is the key to unlocking the area, which would provide a greatly enhanced proper Park. It would provide a proper town Centre and move the parking underground two to three storeys in the same way as has been done at the back of Double Bay, where it gets wet after one storey.

CHAIR: Mr Persson, do you understand that if you became frustrated when you could not buy a sandwich that it might explain some of the concerns that people from outside the area have, even if they cannot envisage what you might be seeing about a town centre?

Mr PERSSON: I had no trouble buying a sandwich; what I could not find was anywhere to sit down and eat it in any sort of a nice setting. That is what Dee Why lacks and anyone who uses Dee Why will tell you that. It is possible that the members of one church might now be a bit cagey about it because they recognise it is an answer leads them to an option they do not want. Can I just say I really love this northern beaches community in many respects. It is new to me. I have grown up in the eastern suburbs. I would add that is important that when administrators are appointed to council, being a one-person decision maker, that they are from outside the area so that the community does not think they are someone's mate or have history with certain people.

Is a very vibrant area with a very robust political culture. In fact, when I got there someone said to me, "You know, Warringah is the Byron Bay of the city." They meant that there are a lot of people who will pay a lot of attention to anything that happens, and who are very active. I think the same could be said of Pittwater and Manly. I think they are good things. They are strengths in the community and you do get very active consideration and opposition. As you all know as politicians—

and I have worked for politicians for some 30 years—the people who make the most noise are the people who are opposing something. Is why you do not have demonstrations for something.

CHAIR: What do you understand of the history of the foundation of Pittwater Council?

Mr PERSSON: My understanding is that it flew in the face of the general direction of thinking about local government in Australia; that there was a group who did not feel they were being well represented by Warringah Council. Having been dismissed for the third time, one can understand perhaps why they felt like that and it looks to me as though Pittwater made a terrific fist of it and is a very good Council. In fact, it won a prestigious award last year, I think, as the best council in New South Wales. Unfortunately for Pittwater, its General Manager Angus Gordon, who I have a long association with from my years in State government, has announced his resignation for health reasons. I think they will find it very hard to replace him.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think, then, that two hospitals are needed on the northern beaches, given the doctors' pressure for one, the fact that they are relatively close together and considering the number of people?

Mr PERSSON: I think two hospitals would be better than one. Whether they are needed or not is a hard call to make from where I sit now, but I think two hospitals are better than one. I think the most important single thing in health care—as the Committee is aware, I was also Chair of the Central Sydney Area Health Service between the time of Mr Puplick's resignation and the Government's decision to abolish the boards, and it was good to revisit health from my time in Queensland—is to make sure that a hospital is within its expertise parameters in that they do not get into territory where they try to do things that they are not qualified to do, where there is not a critical mass of work to do, whether the experience is there. I have to say, having worked in the public sector for a very long time, it is a tragedy when political influences become over dominant. I am not suggesting that they are not relevant and have no legitimacy, but I have seen times when political influences have hijacked the debate. Politicians do succumb to political pressure and I have seen decisions made to keep hospitals open when they should not have been and wards or services open when they should not have been.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Persson—

CHAIR: We will wrap it up there. I think you are asking for an opinion, Hon. Dr Arthur Chesterfield-Evans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the intensive care unit is not maintained is it viable to have a general hospital?

Mr PERSSON: I do not consider my expertise to be in that area. I would rely on the evidence of previous witnesses, which I believe to be generally, yes.

CHAIR: Mr Blackadder and Mr Persson, thank you for the time you have given us and for your submission.

(The witnesses withdrew)

KERRY JOHN GOULSTON, Physician and Chair, Greater Metropolitan Clinical Taskforce, 51 Wicks Road, North Ryde, sworn and examined:

CHAIR: Welcome, Professor Goulston. 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. Would you like to make an opening statement?

Professor GOULSTON: Yes, thank you. I thought I would run quickly through—if you put these documents in front of you rather than have overheads or a PowerPoint presentation—because I see there has been some discussion about what the Greater Metropolitan Clinical Taskforce [GMCT] is. I will then talk about the interim proposal that we put forward. Briefly, in 2000 the Government set up the New South Wales Health Council chaired by John Menadue. He issued a report that was critical of the lack of transparency and clinician involvement in planning and policy making as well as implementation. As a result of that Minister Knowles set up the Greater Metropolitan Services Implementation Group, which I co-chaired. We were a group of 42 appointed by the Minister and we had 162 recommendations. We were then asked, as the Greater Metropolitan Transitional Taskforce, to implement those recommendations. Subsequent to that, Minister Iemma set up the GMCT and asked me to chair it. We have a group of 33 on that committee.

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

The membership of the GMCT committee is on the fifth slide. You can see that it is a fairly large group and includes consumers, general practitioners, administrators and clinicians who are there not representing anyone—they are there as individuals. They are there because they have a breadth of vision outside their own department, outside their own hospital, outside their own area. We have established clinical networks—that is the sixth slide—in a number of service areas. To give you one example, in kidney disease—renal services—we have all the kidney specialists, all the kidney nurses and technicians meeting together. They form working groups. They have established planning for the next five years for dialysis and transplant. They have common protocols for patients throughout the whole of the greater metropolitan area and they work in a collegial fashion. We have broken down the fiefdoms that we have traditionally worked under for years.

So these clinical networks are across area boundaries—we do not care that much about area boundaries. When we say "clinicians", we mean doctors, nurses and allied health and consumers. We are not into a hub-and-spokes model; we are talking about partnerships between large and small. The clinicians are involved in implementation; they have ownership of planning so they implement it. For example, we have set up 23 stroke units through the greater metropolitan area. Those stroke units are situated in hospitals according to certain criteria decided by the stroke clinicians themselves. They are now working so the mortality data from stroke is going down simply because of the specialist stroke units in those hospitals. There is one at Manly hospital, for example.

Similarly, the cardiac group decided that the stenting for heart attacks—putting in an acute stent—was all clustered in the middle of Sydney. So we have set up three new cardiac stenting units at Gosford, Nepean and Wollongong. It is noteworthy that the cardiologists at St George, Westmead and North Shore have helped their colleagues, trained them, trained the nurses and brought them up to scratch. They have worked collegially. Stenting is now occurring outside the central business area of Sydney.

We have also been asked by the Minister to look at what used to be called "district hospitals". There are 22 of these in greater metropolitan Sydney, which is a very large number indeed compared with other States. We have called them "metropolitan hospitals", and I will come back to that later because it is a very important symbolic statement. What we are talking about and what we are concerned with is redesigning hospital services to bring them into this century. We are talking about improving safety and quality of care for patients. We are concerned about what is called a critical mass of clinicians—I will come back to that later—and a critical mass of patients.

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

There is resistance to change—there always will be. There is resistance from the local community and there is resistance from some of our colleagues. But we have to face the fact that our hospitals have changed dramatically since I started working in them some years ago. Patients are sicker, they stay for a shorter time, they require more sophisticated, more expensive treatments and technology has escalated. We work as a multidisciplinary team. It is no longer just the doctor; it is a team within the hospital looking after you when you get sick. I and many others believe that we are facing a work force crisis in Australia, and it is going to get worse. It is not only nurses but particularly allied health, whom you do not hear much about. We do not have enough allied health in our hospitals. This particularly affects the smaller metropolitan hospitals on the outskirts of Sydney. We hear a lot about the rural hospitals but we do not hear much about problems in hospitals in outer Sydney.

We have not been training enough people, whether it is doctors, nurses or allied health. The Commonwealth Government have increased university places this year or next year by about 400, but that is not enough. Even if it were, it is going to take 10 years for them to come out of the system as specialists and work in our hospitals. So things are going to get worse, not better. Not only is our population getting older and sicker but our work force is getting older—nurses and doctors are getting older and a lot of them are opting out and disengaging from the public system.

In Australia we have a private system—not so in a few other countries. That makes it easy for people to get out into the private system. Whether it is a physiotherapist or whether it is a cardiologist, they can move to the private system. Also our young people do not want to work their guts out like we did. They are opting for a better lifestyle. So many of them are working two or three days a week. Central planning in this country did not take into account the gross change in lifestyle of young people. The only part of the medical work force that is increasing is the medical locum work force—you have heard references to locums before. That is increasing because of the lifestyle change.

A critical mass of clinicians is very important and it is hard to convey what it means. It means that you have enough specialists working in a particular area or department to allow a reasonable roster. Some doctors in metropolitan hospitals on the outskirts of Sydney are working a one-in-two or a one-in-three roster and they are cracking. They just cannot keep that up. We need time for them to do teaching because they have to do a lot of teaching, which is all honorary, unpaid teaching of young doctors and other people coming through. They have to supervise them, hopefully they do some research and hopefully they enjoy their work. I want to point out that this restructuring of clinical services is not just happening in Sydney or New South Wales; it is happening in other States of Australia and it is happening in every country in the world.

I have included in my submission a few quotes from a few reports. One is from British Columbia in Canada, talking about the same issues. There is one from Ireland, which is really moving very quickly and changing the whole hospital scene there. There is another from Toronto in Canada, which says, "The status quo could not and should not be preserved. A redesign of the health system requires people, government and health care workers to change their attitudes." There is one from Scotland saying that it is inevitable that we have to change the way we are working.

Coming to the specifics, as part of our brief we were asked to facilitate, working with the area health services and working with the clinicians, some redesign of hospital services. We have done that in Bulli and Shellharbour, and in Mount Druitt and Blacktown and we did that in Manly and Mona Vale. What we put forward was an interim proposal to the Minister and to the director-general. It was interim because we concentrated not on where the new hospital should be but on the next five or six years until that hospital is built and patients start entering its doors. We were concerned about the safety of patients in the next five or six years. We were also concerned about the continued adversarial role between Manly and Mona Vale. So our proposal really stressed that a new hospital should not be called the new Manly hospital but be called the new Northern Beaches Hospital and that it should be planned by consumers and also by clinicians from both hospitals.

They had to start networking here and now and they had to work in an integrated way between the two hospitals. Our proposal was not saving money; it was costing money. Roughly, what we suggested was about $1.5 million capital and about $1 million recurrent. We concentrated on the care of critically ill patients. We suggested that northern beaches clinicians should form a critical care department incorporating the intensive care unit [ICU] and the emergency department [ED] at both hospitals. There should be a level three high dependency unit [HDU] at Mona Vale and a level five unit at Manly. We suggested that the emergency department at Mona Vale was understaffed and that its facilities were underresourced.

We recommended that the emergency department at Mona Vale be enlarged significantly and that there be increased staffing, and we suggested ways of doing that. We also suggested that there should be better transport for patients between the hospitals, although it is not bad. So at Mona Vale we suggested that there be an upgrade of the emergency department, an outpatient fracture clinic and a level three ICU. We suggested that acute medical, surgical and orthopaedic rosters should remain. We looked at the idea of having just one roster to cover both hospitals and we decided against that. We also suggested that a new unit of cardiac rehabilitation be started at Mona Vale but that paediatrics should continue. I guess we were aiming at better co-ordination between the two hospitals.

We also recommended that the facilities at the Manly ICU be upgraded. We suggested a critical care grouping so that we would attract more intensivists and ED specialists to the northern beaches. We think that would work. We suggested that the two hospitals should have a joint medical staff council rather than separate councils and that each clinical department should be called a northern beaches clinical department rather than Mona Vale and Manly. We suggested that all doctors be offered cross-appointments at both hospitals. We believe that the interim proposal we presented to the Minister and the director-general would result in better resourcing and increased staff for patients who are critically ill, either in the ED or in the ICU at both hospitals currently. We are talking about the next six years until the new hospital opens its doors. It would cost money; it would not save money. That proposal is still on the table.

CHAIR: Why did you prefer Manly over Mona Vale for the level five ICU?

Professor GOULSTON: It is difficult. It is not as though you have one large hospital and one small hospital. Here you have two hospitals that are almost the same. Manly intensive care had more ventilation beds and more intensivists, and staff were better trained and available to do things like cardio-echoes and pulmonary artery pressure measurements. They were more conversant with sophisticated things. So we decided eventually on Manly.

CHAIR: You are talking about one staff member across both units. In a geographic sense one of your principles relates to fairer access. I presume you meant that in a physical sense. Surely Mona Vale met that criterion better than Manly?

Professor GOULSTON: No. We are talking about fairer access to the right treatment at the right time. For example, at Ryde Hospital, it may be better for patients to go to North Shore. It is getting the right treatment and that requires the expertise of critical care specialists.

CHAIR: Given that Manly had more ventilated beds, why would you not have considered increasing the number of beds at Mona Vale?

Professor GOULSTON: We did. We looked at it fairly carefully. We talked to all the players, in particular, people in the emergency department and intensive care staff. We decided that, on balance, it should be at Manly for the reasons I have stated.

CHAIR: At Christmas time surgeons and anaesthetists made a decision to withdraw services on the grounds of safety. They made the decision that no intensive care would be available during the Christmas rostering period. What is your view on that safety issue?

Professor GOULSTON: I am very concerned about safety. I presume it has been brought to your attention that members of the Australian Council of Hospital Standards [ACHS] visited Manly and Mona Vale in about September last year. I met with them on their return visit in January. I am concerned about the level of staffing for critically ill patients, in particular, at Mona Vale. I think this proposal will solve that problem because it will attract new blood. We talked to intensivists and they agreed that they would staff both hospitals. They agreed that they would provide cover at both hospitals. That was a big step forward. There is a history relating to and a lot of baggage between those two hospitals.

CHAIR: In relation to the Dee Why site we heard from the local council that it believed in a contractual sense it would have the Dee Why site only if Mona Vale Hospital was able to keep functioning. What would be the role of Mona Vale Hospital if the northern beaches hospital was located 10 minutes away, at Dee Why?

Professor GOULSTON: As I said, the Greater Metropolitan Clinical Taskforce [GMCT] purposely kept out of discussions about the site of the new hospital. We said two years ago that on population grounds it would make sense to have one big general hospital to serve quarter of a million people. When you look at other parts of Sydney that would be rational. But we also said that we did not want to get into that discussion. The delayed decision about the site of the new hospital is affecting the morale of clinicians on the northern beaches; there is no question about it.

CHAIR: Let us leave the specific site out of the equation and refer to the work that has been done by the task force. Do you envisage a level five hospital and another hospital, which is part of it, being located 10 minutes away?

Professor GOULSTON: Sure, that is possible. You could have a large central hospital and a smaller hospital. That is quite feasible.

CHAIR: What sorts of services would you anticipate in the small hospital?

Professor GOULSTON: As I said, I have read all the stuff and I purposely have not got involved. There are places around Sydney where you have things like rehabilitation and elective surgery. A lot of planned elective surgery is now done in smaller hospital rather than in big hospitals. You could have a surgical hospital for planned elective surgery. Eighty per cent of surgery is now planned elective stuff, and often day only. So it could be that, but I do not know.

The Hon. CHRISTINE ROBERTSON: We have heard quite a lot about changing the intensive care unit at Mona Vale Hospital to a high dependency unit but we have heard nothing about upgrading emergency services. One of the big issues confronting this Committee is acute asthma. Could you refer to emergency services, outline why that is happening and tell us what it means to someone with acute asthma?

Professor GOULSTON: Certainly. Part of our proposal related to an upgrading of emergency services at Mona Vale. We think that is important. Their workspace is too small and cramped and they do not have enough bays. We got costs done of how that could be improved, that is, capital costs. I think that should be done quickly. I sympathise with the people working at the Mona Vale emergency department. They are working under a difficult situation at the moment. So far as staffing is concerned, until recently there was only one emergency specialist at Mona Vale. In a week that hospital would cover only 32 of its 160 hours a week. As I said before, a lot of that staffing was done by locums who quite often were strangers to the hospital. That concerned us, as it did the ACHS accreditation team.

We strongly believe that if there is a critical care unit across both hospitals—ED and ICU across both hospitals—that would provide a bigger critical mass and that would be more attractive. The northern beaches is blessed compared, say, to some places like Shellharbour. Shellharbour is an attractive place to live and it would attract people. The deterrent to people coming to work there, especially at the ED or ICU, is what we call the small critical mass. Only one ED specialist would be there. There would be no registrars to supervise staff and they would not be able to discuss things with their colleagues. Last year there was a good ED specialist at Mona Vale. She left to go to the North Shore for those reasons. She works in a critical mass of eight or nine ED specialists. So we think we would get ED specialists. As I said, we have had discussions with Stephen Christley about the ways of getting there. We are confident that it would happen.

Reverend the Hon. Dr GORDON MOYES: I thank you for the important work that you are doing—planning the strategic development of our health services. You said earlier that consumers should plan the new hospital. I did not take that as a blanket statement as I am sure you did not mean it. However, consumer consultation is important. What consumer representation was involved in making the decision relating to changes to the ICU at Mona Vale?

Professor GOULSTON: I said that the planning for hospitals should be done by clinicians and consumers working with health planners.

Reverend the Hon. Dr GORDON MOYES: Certainly, but it is wider than that. I have been a chairman at both public and private hospitals so I understand.

Professor GOULSTON: We met with members of the Save Mona Vale Hospital Committee and we had representations and emails from various people in the community. The difficulties related mainly to getting clinicians to agree to the concept of working together. So we concentrated on that. But we did meet with them.

Reverend the Hon. Dr GORDON MOYES: With a high dependency unit projected for Mona Vale what additional staff would you recommend for that area?

Professor GOULSTON: As I said before, I think it is better if we look at intensive care services across both hospitals. By doing that it would provide better staffing arrangements at Mona Vale. In other words, the Manly intensivists and the Mona Vale people would provide a roster across both hospitals. That would apply also to nursing. They would have the option of working at both places.

Reverend the Hon. Dr GORDON MOYES: While the GMCT was involved in making the decision about the location of the ICU and the high dependency unit, did NSW Health make any announcements about what would happen before you had finished your recommendations?

Professor GOULSTON: I am trying to remember. I do not think so.

Reverend the Hon. Dr GORDON MOYES: Did NSW Health make any recommendations before you made your recommendations?

Professor GOULSTON: I do not think so. I cannot remember any in the press.

Reverend the Hon. Dr GORDON MOYES: I refer to the closure of the ICU at Mona Vale. Were you aware that that was likely to happen?

Professor GOULSTON: You mean for a short period over Christmas?

Reverend the Hon. Dr GORDON MOYES: Yes, I mean the temporary closure.

Professor GOULSTON: About a week before—probably in mid-December.

Reverend the Hon. Dr GORDON MOYES: What strategy did you have in place to prevent that?

Professor GOULSTON: It was not my role to plan that. That was the problem of the local people. I guess we were looking at the next five or six years. That is likely to keep happening because of the difficulty in staffing it.

Reverend the Hon. Dr GORDON MOYES: Is it only a staff issue?

Professor GOULSTON: Yes, it is; it is a work force issue.

Reverend the Hon. Dr GORDON MOYES: We have heard, for example, that wards and units in other places are closed down for financial reasons.

Professor GOULSTON: I think that is different. That is quite true and clinicians would say it is true, but in relation to Mona Vale over Christmas it was purely a work force or staffing issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it true that metropolitan hospitals or district hospitals are in trouble because the work that they used to do—non-critical elective surgery—has gone largely to private hospitals?

Professor GOULSTON: No, I think it is much more complex than that, I really do. I think it is to do with society's change, public expectations, the huge number of people now coming to emergency departments, particularly at nights and weekends. There are multifactorial influences on the role of the smaller hospitals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But are they not coming to emergency departments because Medicare has been wound back and doctors are not bulk-billing?

Professor GOULSTON: In some parts of Sydney there are no GPs who provide services out of hours, for example, up at Wyong. It has nothing to do with Medicare. There are no GPs providing those services at nights and at weekends, so Wyong ED is one of the busiest in the State. There are many reasons, and it varies from area to area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That must be a contributing factor, of course?

Professor GOULSTON: It could be a contributing factor.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In terms of the number of ICU admissions to Manly versus Mona Vale, is it not true that the difference between the admissions relates largely to the fact that Manly is on the ICU transfer list, in other words transfers into there are not generated from their own surgery and that has made the difference to the numbers?

Professor GOULSTON: No, it is more to do with the paediatric patients coming to the ED at Mona Vale. I have the figures here somewhere. There are more patients coming to Manly ICU than Mona Vale ICU, mainly from the emergency departments, some from the ward. The attendances at the ED at Mona Vale are bolstered by the children coming to Mona Vale selectively. It is true that there are more admissions to Manly ICU from other hospitals. Because of its high ranking, if you like, it gets more transfers from other hospitals in the ICU network throughout Sydney, and that is some of it but not all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you take the transfers out of the numbers, what are the numbers then?

Professor GOULSTON: The numbers I have here, at Manly there are 39 in a year transferred from other hospitals to Manly ICU and that is in addition to, maybe, a 30 per cent higher rate coming from the ED at Manly compared with Mona Vale. So they have more acutely ill patients, if you like, going through the ED to the intensive care at Manly. I do not know why, but the figures show that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could it be that you have a more generous admissions policy in that you have more facilities available?

Professor GOULSTON: No, the protocols are laid down.

CHAIR: Could you repeat that?

Professor GOULSTON: The protocols are laid down People are transferred according to protocols.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But would not the application of those protocols have some degree of judgment and habit and custom?

Professor GOULSTON: There is always clinical judgment, but just to remind you, sir, Paul Phipps, who is the Director of Intensive Care on the northern beaches, works at both intensive cares.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In terms of doctors getting appointed to both hospitals, is it not true that doctors do not want to be on two hospitals because they may have to be called on the same night to two different places or they have to be on call twice as often?

Professor GOULSTON: I alluded previously to resistance to change, and what you are saying is correct to a certain degree: there is some resistance by some clinicians to be on at both hospitals. Rosters can be arranged so they are not on the same night.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But then they are on twice as often?

Professor GOULSTON: Not necessarily. If you have a bigger critical mass by combining services that is not necessarily true. Plus, if you redesign services so that if, for example, at Mount Druitt only elective surgery is done and there is no on call at Mount Druitt but the same surgeons operate. This works, for example, between Fairfield and Liverpool. The orthopaedic surgeons at Liverpool, which is the biggest trauma centre in New South Wales, probably Australia, do their elective hip replacements at Fairfield—the same surgeons.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were the surgeons happy at Mona Vale after you had attended? Do you think you represent their views?

Professor GOULSTON: No. The four surgeons at Mona Vale, the four general surgeons, made their position clear: they were not happy with the recommendations. They were not prepared to operate, as you say, at Manly. Now, just say that I am a physician but I have worked with surgeons for decades. There are many surgeons who are on a number of hospitals, and a lot of them are private hospitals. So surgeons do travel to where the operating theatres are.

The Hon. AMANDA FAZIO: I noticed on slide five, I think it is, when you are talking about the GMCT committee you have this Professor Malcolm Fisher who is the head of intensive care on the northern beaches. He is part of that committee.

Professor GOULSTON: Correct.

The Hon. AMANDA FAZIO: What was his response or his view of the GMCT's proposed interim changes for the northern beaches, which was that you have a single northern beaches intensive care service that would work across both hospitals?

Professor GOULSTON: To preface my remarks by reminding you that Malcolm Fisher is on that committee, but not because he is from North Shore or the chair of the intensive care group; he is on there because he is Malcolm Fisher.

CHAIR: You may wish to add to that, but I could indicate that Professor Fisher is appearing before the Committee next week and you may choose to ask him directly.

The Hon. AMANDA FAZIO: I will probably ask him as well, but I would like to continue with my question today.

Professor GOULSTON: Yes, sure. We talked to Malcolm Fisher because he is in charge of intensive care services for the whole of the northern area, and he agrees very strongly with the concept because he is aware that seems to be the only solution, to upgrade intensive care services on the northern beaches. They are floundering at the moment, and this is the way forward, to upgrade them. He agrees.

The Hon. TONY CATANZARITI: I am concerned about the statement you made regarding the number of doctors and nurses that we are lacking in both the short term and the long term. What ideas would you have to try to change that? What should be done?

Professor GOULSTON: I guess we are trying to convince the Commonwealth Government to further increase university places for doctors, nurses and allied health. But, as I said, that is the long term.

The Hon. MELINDA PAVEY: And the Royal College of Surgeons?

Professor GOULSTON: Yes. A lot of our colleges we are working on to get them to realise that things are different and they have to change their attitudes. We are doing what other people, particularly the United Kingdom and Canada are doing, looking at job redesign. A young intern is doing what I did many years ago. Jobs have not changed in the hospital, and they have to change. We need more clerical and administrative support staff for front-line clinicians. A nurse unit manager in charge of a ward spends a lot of her time doing administrative work, not nursing, not looking after patients.

So whether it is doctors, nurses or allied health we have to change the way we work within the hospital. That is, again, a hell of a thing to ask of a pretty traditional mob of people who are used to things the way they are. That is probably the main way. I guess we have to make the public system attractive to work in, and I am not talking about money I am talking about them feeling valued, and that is hard for politicians and for administrators to come to terms with. Many of our doctors, nurses and allied health all of whom are working very hard within our public hospitals do not feel that their services are that valued.

The Hon. TONY CATANZARITI: I am from a country area and other things that we find is that the doctors now are more specialised in whatever they do and the thing that is lacking are more general-type surgeons, as we used to know them. What are your thoughts on that?

Professor GOULSTON: I agree completely. We have become super specialised. There are no longer surgeons who would do joints and chests and heads. Not only do they do joints, now they are orthopaedic surgeons, but some of them only do shoulders. So we have become highly specialised. This is particularly true with regard to physicians. We lack general physicians and this is probably the biggest area we have a problem with. So I guess what we are working on at the moment are things like what is called a hospitalist model, having a new sort of specialist, a hospital specialist inside the hospital who is a generalist. That is a new concept for Australia, but it is one that we are going to have to think about because Manly and Mona Vale happen to have very good general physicians on the northern beaches, but that is not true in many of our other smaller hospitals or the country.

The Hon. TONY CATANZARITI: It is a big issue in country areas.

Professor GOULSTON: Yes, I agree.

The Hon. TONY CATANZARITI: And the thing that concerns me is that when we are talking about bigger hospitals in the metropolitan areas, that there are going to be problems in the future so where is that going to leave the country hospitals when we will not be able to attract that type of person, so we need that general specialist?

Professor GOULSTON: I could not agree with you more. I think you are absolutely right. We are not training enough general physician and specialists. We are just not training them. The young people are not attracted to it. Cardiology, gastroenterology, doing things with your hands and earning a lot of money are more attractive. So we have to tackle the problem and think how we can solve it, and there are things we can do and we are starting to do and that will help the country, too.

The Hon. MELINDA PAVEY: Just on the country, there are specialties developing in some of our regional centres, which should be encouraged. On a broader question, you have stated that effectively the northern beaches needs a quick remedy, a solution, which is a brand-new hospital bringing together all the clinical specialists in one unit. To my way of thinking, and again as a country-based member of Parliament, there are six options on the table. Dee Why is one of them, as is the Mona Vale Hospital. I look at the Mona Vale site as an 8-hectare flat site that everyone is ready to go in terms of the Mona Vale community. Would you have a problem, as the Chair of the Greater Metropolitan Clinical Taskforce, with Mona Vale as the location for the new hospital in the interests of getting on with it on the basis that traffic and time travel to that site, although it is not the demographic centre it is the geographic centre, and there are arguments put that the travel time to that site is as efficient as any other centre that has been suggested within that 30-minute ideal time frame?

Professor GOULSTON: Just to preface my remarks you said a quick fix. It ain't a quick fix. It will take six years before patients go into the new hospital, wherever it is.

The Hon. MELINDA PAVEY: But it might be six years from today if we go with Mona Vale.

Professor GOULSTON: That is right.

The Hon. MELINDA PAVEY: But if we continue discussions and negotiations and talking and talking and talking—

Professor GOULSTON: I could not agree more. As far as the clinicians on the northern beaches are concerned, they want a decision. As far as GMCT goes we said very clearly that we think the decision should be made. Whatever decision is made will be criticised. It will create flak. To answer your question, there have been similar problems in Canada with two small towns where they wanted to put a hospital halfway or one-third of the way between the two towns. I do not think it is that important to the sorts of things I am talking about, which are the right service and having good people there. It does not matter so much whatever site it is, frankly, as long as the staffing is first class.

The Hon. MELINDA PAVEY: And in the process you could save up to $50 million or $60 million without having to buy a new site.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe the AMA supports the work of the General Medical Clinical Taskforce?

Professor GOULSTON: I have met with the hospitals committee of the AMA and they have given us their support. The chairman is Dr Andrew Keegan, and he attended the meeting at Westmead on Saturday morning with 140 doctors from the smaller metropolitan hospitals and spoke well in favour of the work we are doing. He agrees there has to be hospital redesign, and his committee does also.

Reverend the Hon. Dr GORDON MOYES: I noticed in reading the evidence again by Dr Stuart Boland that he contradicted you in the decision of the GMCT's decision to downgrade the ICU at Mona Vale, et cetera. What new evidence would you need to reverse that decision?

Professor GOULSTON: I cannot see what new evidence there would be. We have all the data regarding intensive care. We have spoken to all the intensivists and the ED people. We have looked and we have had meetings of the medical staff councils of both hospitals, which endorse the proposal that we put forward. I think it stands as it is. It is either accepted or it is not accepted. If it is not accepted and our proposal does not occur, things will get worse for critically ill people on the northern beaches. It is as simple as that.

Reverend the Hon. Dr GORDON MOYES: Professor, could I clarify what you said? You said you consulted all the clinicians involved with Mona Vale. We have had statements that only those aggrieved by your decision were consulted.

Professor GOULSTON: We held a joint meeting at Harbord Diggers Memorial Club. We circulated by email, phone and letter all the clinicians at both hospitals. The Mona Vale general surgeons chose not to attend.

The Hon. AMANDA FAZIO: I want to ask you about comments you made in response to questions from the Hon. Melinda Pavey about just having the hospital at Mona Vale. We heard evidence the other day that if the new general hospital were to be located at Mona Vale, the people who currently go to Manly hospital from the lower end of the area would go to Royal North Shore Hospital, and the consequence would be a new general hospital that did not actually cater for the whole catchment area. What is your comment on that?

Professor GOULSTON: I think the site of the new hospital is very difficult indeed, and that certainly is a factor, apart from geography, demographics, traffic times and all the rest. It is true that a lot of people from towards that end may well go to North Shore. For example, if you have a sick child, you are quite likely to drive past Mona Vale, Manly and North Shore, and take the child to the Children's Hospital at Westmead. There still is that indefinable thing that people go to a hospital that they think is the best place. We are trying to ensure that if you get to any hospital you will be taken care of, not necessarily at that hospital, because you may be transferred. For example, if you have a heart attack in the northern area at the moment, you are taken to Royal North Shore Hospital, not Mona Vale or Manly hospitals, and you will have immediate stenting—a bypass. It is a complex question, but you are quite right.

CHAIR: Professor Goulston, has your decision about the intensive care unit effectively pre-empted any decision-making about the site of the level five hospital?

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why was the proposal to accommodate maternity at Mona Vale not proceeded with?

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many maternity patients end up in intensive care?

Professor GOULSTON: Very few.

CHAIR: Thank you, Professor Goulston, for the time you have given us and for the work that you do.

(The witness withdrew)

(Short adjournment)

KATHLEEN ANN NEEDHAM, Co-chair, New South Wales Intensive Care Clinical Implementation Group, and Acting Director, Intensive Care Services, Sydney West Area Health Service, sworn and examined:

CHAIR: What is your occupation?

Mrs NEEDHAM: I am a registered intensive care nurse.

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

Mrs NEEDHAM: I am the co-chair of the New South Wales Intensive Care Implementation Group. I am also the Acting Director, Intensive Care Services for Sydney West Area Health Service. And, just to complicate it a little more, I am also a local resident of the Warringah Council.

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

Mrs NEEDHAM: I do.

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 it decides it is in the public interest to do so. You may commence.

Mrs NEEDHAM: Madam Chair and Committee members, thank you for this opportunity to appear before you today. I am an intensive care registered nurse with over 25 years of experience in the intensive care specialty. I have worked in rural, metropolitan and tertiary intensive care units across New South Wales. I have been the nursing co-chair of the New South Wales intensive care implementation groups since April 2000, and I have reviewed most of the intensive care units and high dependency units across New South Wales, and some in Victoria.

I am a member of the Greater Metropolitan Clinical Task Force. I am currently the Nurse Manager at Westmead Intensive Care Unit, as well as Acting Director, Intensive Care Services, in the new Sydney West Area Health Service. I believe that this brief curriculum vitae justifiably allows me to give you expert commentary on the issues pertinent to why there should be only one intensive care service across the northern beaches; that is, a level five intensive care unit at Manly and a level three high dependency unit at Mona Vale, and patients requiring tertiary or level six intensive care should be managed at Royal North Shore Hospital, whilst one new state-of-the-art hospital is being built centrally on the northern beaches.

The other reason for highlighting to you my years of intensive care experience and positions I have held relates to the comments that Mr John Brogden, the local member for Pittwater, made at this Committee's hearing last Monday concerning Professor Malcolm Fisher. Mr Brogden's comments were that he had never met Professor Fisher, and had no interest in his comments, and he can pick up the phone at any time. I was extremely disappointed, and really quite shocked, at the apparent total disregard by a potential Premier of the learned opinion of Professor Fisher on this issue.

Professor Fisher is the area director of intensive care at Northern Sydney and Central Coast area health services, and one of the original trailblazers in intensive care medicine in Australia. He is internationally published and acclaimed, is a past president of the World Congress of Intensive Care, and in 2003 was awarded the Order of Australia for his services to intensive care. Professor Fisher in fact wrote to Mr Brogden on 9 December last year detailing his concerns for the safety of patients at the Mona Vale intensive care unit should it be allowed to continue in its current state. I may be naive, but I would not expect political expediency, even in a blue-ribbon seat, to compromise the safety of patients at the Mona Vale intensive care unit, and I would have expected Mr Brogden to consult more

widely than just seek the opinions of the local surgeons and anaesthetists and one intensivist, Dr Phipps, on the matter of the provision of intensive care services for the peninsula.

The shortage of nurses is a worldwide phenomenon, and is well documented both locally and internationally. The National Health Workforce strategic framework, released in April 2004, comments that the national work force currently grows at an annual rate of 170,000 a year. By 2020 this is predicted to be just 5,500 a year. In the health sector, the aging of the population, and also the health care worker, will increase demand for services and demands on the work force. Combined with the breathtaking advances in technology and pharmacology, as well as community expectation, the requirement for intensive care beds will grow. And so will the need for highly skilled intensive care registered nurses. Intensive care nursing is an exciting, rewarding, albeit challenging, specialty. It attracts registered nurses who thrive on managing the sickest of patients, such as the patient depicted on screen. I understand Committee members have a number of photographs before them.

CHAIR: We do.

Mrs NEEDHAM: Patients in intensive care require complete life support, and therefore must be nursed by nurses who are confident managing, interpreting and responding to a patient's condition rapidly. Small units, such as at Mona Vale, Mount Druitt, Ryde, Auburn and Fairfield, are unable to provide the volume of patients, that is, critical mass, to expose nurses to the diversity of intensive care patients and treatments. Intensive care registered nurses must continually be exposed to new modalities of therapy, changing technologies and pharmacology to maintain their knowledge base and skill sets, to ensure they are capable of providing safe patient care. Even registered nurses who have post-graduate qualifications in intensive care nursing are unable to remain current unless they are continually exposed to the complexities of a constant throughput of critically ill patients, ongoing professional development opportunities and education.

Casualisation of the nursing staff and reliance on agency nurses also impact on the ability of small units to access quality intensive care nurses on every shift, particularly where there is sick leave. It is my experience that small units are more vulnerable because, if only one or two registered nurses are rostered to be on night duty and one of those is off sick, the registered nurse on duty needs to be sure that the casual registered nurse is capable of responding appropriately in an emergency situation or is able to manage any resuscitating procedures. This is not always the case in some small units.

Some of the issues surrounding the intensive care medical work force were discussed last week. However, I also would like to comment briefly on those issues. Intensivists, like neurosurgeons, some physicians and geriatricians, are scarce. In September 2004, of the 31 senior registrars across Australia sitting for the joint faculty of intensive care medicine examination, to qualify as an intensive care consultant, only 14 passed; and, of that 14, only 2 were Australian trainees—a sobering statistic.

At the hearing last week Mr Brogden also commented that when Dr Phipps and Professor Goulston told him that a serious intensive care work force shortage had precipitated the Mona Vale issue before Christmas, he disputed their claim, saying all indications that he had received from other surgeons was that this was not the case. Those surgeons have given Mr Brogden wrong advice. There is indeed a national and international shortage of intensive care specialists.

Intensive care is a difficult specialty, and changes in it are occurring probably quicker than they are in many other specialties, with advances constantly taking place in technology. Intensivists treat patients and families when they are at their most vulnerable. Intensivists work 24-hour days, 7 days a week, when they are first on-call, which is often one week in three or four. However, in the case of Mona Vale intensive care unit, it has been one week in two that they are first on-call. Clearly, this is not sustainable from any perspective. International literature shows the ideal size of an ICU is somewhere between 10 to 12 intensive care patients to ensure intensivist skill sets are maintained with a robust infrastructure in place, including a senior registrar trainee, 24-hour registrar cover, qualified and competent RNs, and access to sub-specialty consultants and other services available 24 hours a day.

These are the minimum requirements for a two-bed ICU or for a 10-bed ICU. Neither Mona Vale nor Manly ICU have all of this infrastructure support currently, although Manly is in a much better position because of the numbers of consultant staff and other infrastructure available to build up

to a level five ICU, with Mona Vale providing a high dependency unit that supports elective surgery and the medical admissions from the emergency department.

It was for some of these reasons that as director of intensive care services for the old Western Sydney Area Health Service, we were forced to look at changing the role of Mount Druitt Hospital. The Blacktown-Mount Druitt situation was not dissimilar to the Manly-Mona Vale intensive care circumstances and had functioned as one intensive care unit over two campuses under the direction of one director of intensive care since May 2002, with intensivists covering both ICUs. In January 2004 the resignation of two intensivists resulted in Mount Druitt being unable to be supported as an intensive care unit. A decision was taken by the clinicians, together with the area health service, that Mount Druitt would provide a high dependency service managing post-operative patients and medical patients requiring close observation and monitoring, but not ventilation.

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

It is my firm recommendation that a proposal similar to the Blacktown-Mount Druitt critical care service would function well across the Manly-Mona Vale critical care service, whilst a resolution to the political issues, such as the location of the Peninsula hospital, is sorted out. Mona Vale would not close its intensive care units, rather it would provide a network of critical care services across Manly-Mona Vale hospitals to ensure safe and effective patient care for the patients of the Peninsula.

On the screen, and also with the photographs in front of you I wanted to show you briefly some of the changes in technology over the years. When I started my intensive care the Birds machine was the main fallback for ventilation for critically ill patients. Last week Dr Boland commented on the wonderful skills and the wonderful years of service Dr Ian Love gave to Mona Vale intensive care unit. I was fortunate to work with Dr Love at the Mater public intensive care unit in 1979-80 and some of 1981 before it was closed by the then health Minister, Mr Laurie Brereton. The Birds machine was what we used to ventilate patients then. Things have changed markedly. Here we have another ventilator, which you can see the complexity has changed again over the next few years. The Birds machine has three or four buttons that control the types of ventilation and when we get to the servo you are starting to see that the complexity of the machinery is changing.

We have then upped the ante a little bit and you can see that the servo 300 on the left-hand side of the screen is again more and more complex and delivers vast and different types of ventilation strategies that have been developed over the next few years. We then get to the servo; which is the current state-of-the-art ventilator. You actually cannot see many things on this, it is all touch screen, but it delivers something like over 20 types of different ventilation that nurses need to actually become competent and be continually educated in to ensure they are capable of using this at any given moment.

We have a life pack—this was a portable defibrillator and monitor. This particular machine has also changed and whilst there are still some around in some units, we then moved to a more complex type of monitoring defibrillator for an emergency situation. Here we have some infusion pumps, and I have to say right now this was a photograph I took last year for a presentation that I gave at a nursing intensive care conference. We have now gone to even more detailed types of infusion pumps. These particular machines deliver time-critical drugs that keep patients' blood pressure up and pulse rates at a normal rate. We look at the complexity of this picture, which is showing you the types of technology that nurses continually have to keep up to speed with. Thank you for your attention, and I welcome any questions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that intensive care as a specialty has grown, which is no doubt true. I confess I was a whiz with the Mark III to Mark VIII Birds and with burettes and pipettes and the paediatric breathing sets that were used before the infusion pumps. But while it might be convenient for intensive care staff to be frightfully clever with very complicated ventilators and work in tens in certain units and would like everyone to come to them, it is true, is it not, that there is an increase in general expertise in intensive care among the nursing profession generally and the lower grade people who may have to be ventilated for a period of hours do not require this degree of fancy equipment?

Mrs NEEDHAM: What is true about the patients that may need to be ventilated only for a couple of hours in hospitals such as Mona Vale intensive care unit is that if you are only ventilating one or two patients a week and you have got a full-time equivalent staff of around about 17 or 18, and it is a Saturday night and you have got an RN that has been on maternity leave and has come back to do two shifts a week, she may not have seen or put in place the institution of setting up a ventilator for some time and the figures that I have gotten from other intensive care units is that it is only under one patient per week that they are ventilating. So it is not always the case that the particular nurse on duty is as up to speed in the small units as they would be in a larger unit. I acknowledge that not all patients need to be in a level six intensive care unit, but certainly the complexity now is that you do need to remain current and need to be up to speed with a ventilator.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you not setting up a straw situation where anyone who is not in a 10-bed unit with the latest fancy technology with 20 different ventilator settings is not able to do simple ventilation? That is really your postulate, is it not, and is that not reasonable for a middle-size hospital?

Mrs NEEDHAM: I am not setting up any postulation at all, I am just telling this learned group that it is difficult, if you are not seeing a lot of ventilation, to remain as current as you should be to be able to institute this form of therapy. If you are flying a Cessna plane, is it going to be always easy to actually skill up and fly a jumbo jet? If you are playing for the Wallabies and you train once a week—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I mean this is setting up the idea that anyone who is not doing enough state-of-the-art cannot do something at a lower grade. It is not rocket science to keep someone on a ventilator.

Mrs NEEDHAM: I beg to differ.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The level of expertise for patients who are undergoing elective ventilation should be able to be done by most doctors and many nurses these days, should it not? There is a level of skill in the organisation.

Mrs NEEDHAM: Ventilation is never elective. I would suggest to you that an anaesthetist who is anaesthetising a patient would wish to extubate a patient post-operatively and it is only in the circumstances where that is not able to happen that they would keep a patient intubated and ventilated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Some surgical procedures have 24-hour ventilation as part of their protocol.

Mrs NEEDHAM: There are not as many as there used to be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It always seems silly to me, but that is by the by.

Mrs NEEDHAM: Cardio-thoracic bypass surgery, for example, now they are extubated within six hours. Aneurysms, abdominal aortic aneurysms, are now sometimes not actually intubated at all, they are done by the endoluminal technique. It would be nice to think you could keep your skill sets at that level, but I am talking in the real world about, as I said, an RN that has come back from maternity leave that works two days a week, that works in these small hospitals and may not be exposed to that level of ventilation or instituting it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you have got a cadre of people running your recovery room where you have got them with ventilated patients there so you have some ongoing training for ventilation and working with intubated patients, it does not mean that you have to draw stumps in middle-size hospitals. Working with ventilated patients who may be a bit slow to come off their ventilators, you can still do that surgery in those hospitals and have adequate staff.

Mrs NEEDHAM: It is not normal protocol nor policy, nor should it be, to ventilate patients in a recovery room, and it is only done at times of lack of intensive care beds.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure, but there is a period between when they have the operation and when they go back to the ward, where they require varying levels of care, do they not?

Mrs NEEDHAM: When they leave the operating rooms they go directly to the intensive care unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, if there is one. If there is not one they won't. Private hospitals do not have one, do they, they have some interim arrangement and the patients then go back to their wards?

Mrs NEEDHAM: Well, they do not ventilate the patients then, do they?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, but the point is you could still do surgery, and the issue here is surgery at Mona Vale.

Mrs NEEDHAM: Absolutely. I need to clarify that surgery at Mona Vale is very important and should continue. However, what is important is to look at the co-morbidities of the patients; it is to look at whether you as an anaesthetist believe that that patient will require post-operative ventilation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it is a question of the surgeons, they being the ones obviously coming to us with concerns, being sure that there is adequate support in the post-operative phase?

Mrs NEEDHAM: The anaesthetist is responsible for the patient's intubation and anaesthetic during that intraoperative period and therefore they must be satisfied that the patient is going to be operated on in the right hospital by the right surgeon.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure, but the surgeon is the one who decides whether he does or does not pick up his knife at that hospital.

Mrs NEEDHAM: Yes, but the anaesthetist has a role to play as well. If the anaesthetist does not think that the patient is well enough to be anaesthetised, I have seen many times the anaesthetist put off the surgery.

CHAIR: Does the loss of the ventilation beds from Mona Vale effectively mean a downgrading of Mona Vale?

Mrs NEEDHAM: No, because you are changing the role of it and you are changing it for safety reasons. Should a patient, and acknowledging that there will be an occasion—I was going to say an occasional patient—there will be times when a patient will require post-op ventilation despite every best intention of the anaesthetist. In those times the anaesthetist is quite capable of managing that time until the medical retrieval unit is able to get there. That is the bread and butter of an anaesthetist, managing an airway and managing ventilation intraoperatively. So I would suggest to the group—in fact I would more than suggest to the group, I would say to the group quite strongly that the anaesthetist is capable of keeping a patient at Mona Vale hospital for that odd occasion when a patient requires post-op ventilation until the medical retrieval unit comes and the patient is safely transferred to Manly.

The Hon. AMANDA FAZIO: I wish to ask a couple of questions about the example you gave about Mount Druitt in your opening statement. When you were forced to change the role of Mount Druitt intensive care unit to a high-dependency unit, did you or any other of the intensive care specialists face any backlash or harassment from the surgeons or anaesthetists?

Mrs NEEDHAM: This is a fairly hot topic and questions were asked about this last week. Certainly we all did. I was not told directly by a surgeon, but it was sent to me via a line that was going to get to me that my career would be destroyed. One of the intensivists, who was actually the director of both Blacktown and Mount Druitt, and who worked very, very hard, had a lot of abuse hurled at him. He had abuse on his answering machine when he was not at home but his wife was at home with her four little children. There was another occasion—

Reverend the Hon. Dr GORDON MOYES: Could you clarify that? From whom did the abuse come?

Mrs NEEDHAM: It came from one of the interested health care workers who did not like the fact that the Mount Druitt intensive care unit was going to be changed to a high-dependency unit.

Reverend the Hon. Dr GORDON MOYES: Would they be people vitally involved in operating the ICU?

Mrs NEEDHAM: No, not the ICU.

Reverend the Hon. Dr GORDON MOYES: Either surgeons or—?

Mrs NEEDHAM: Surgeons do not operate ICUs; they use them for their patients. It was from the health care worker.

The Hon. AMANDA FAZIO: I understand that it is already difficult enough to get intensive care staff, whether they be doctors, nurses or whoever, to go to any of the smaller hospitals because they do not get that critical mass and they do not have a peer group to bounce ideas off and to learn from. Is recruiting intensive care specialists made all the more difficult when you have that sort of animosity by surgeons and anaesthetists who do not like their little patch being disturbed by having an intensive care service that cuts across two hospitals?

Mrs NEEDHAM: Some of us know that medicine is a very small world. Intensive care is even smaller across Australia; everyone, if they do not know each other individually, knows of each other. At one stage where we had these two resignations across Blacktown and Mount Druitt intensive care service, we did advertise. We advertised across Australia, and we received three applications. One of those applicants withdrew when they contacted somebody in Sydney to find out what was happening at Blacktown and Mount Druitt. From my perspective, we lost a potential candidate. That was really unfortunate, because when they were queried by the medical director it was said that they would not be touched with a barge pole because of the animosity present.

The Hon. CHRISTINE ROBERTSON: Did you have any statistics from South West Area Health Service and the hospitals you have referred to that reflect the numbers of transfers out because of the changing role of the intensive care service at that hospital to a high-dependency unit?

Mrs NEEDHAM: Yes. In Sydney West, as we are now called, Auburn hospital is also changing its role because of the inability to recruit an intensivist. They only had one, who worked one in one, which is worse than the Mona Vale situation. Having looked at the figures last year, there were 66 patients requiring intensive care transferred out of Auburn hospital. Of those 66, 15 were sent from the high-dependency/ICU unit. Of those 15, only two were surgical. Medical patients predominantly were the patients that were transferred out, and that was with the separation of about 9,500 patients who were admitted in that calendar year.

When you look at that percentage—and I had cause to break that down last week for some service planning we are doing within our area health service—it is 0.07 per cent. It is not the surgical

patients that are requiring the transferring; as patients are getting older with more co-morbidities, it is medical patients.

The Hon. CHRISTINE ROBERTSON: Last week we heard a lot about medical retrieval units and the length of time it sometimes takes for them to pick up a patient who requires intensive care. Can you tell us about your experience in the smaller hospitals?

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

The Hon. CHRISTINE ROBERTSON: There are many different issues related to health service planning when one tries to work out the best location for an intensive care unit. Apart from available clinicians, what other issues are measured when you are trying to work out what should happen with critical care units?

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

The Hon. TONY CATANZARITI: Are registered nurses placing themselves in risky situations working in small intensive care units without the appropriate infrastructure support you referred to?

Mrs NEEDHAM: We have talked a lot about the infrastructure and why. I guess we all saw the Campbelltown-Camden issues unfold in front of our eyes on the front pages of the press. That was pretty scary as a nurse. Again harping back to that Saturday night when you come back from maternity leave, I have been there and done that. It is really hard if you do not have that skilled junior medical work force to back it up. Whilst I might have had it 20 years ago, it is not there in the quantity or the quality as it was back then. As a registered nurse you often find, at 3 o'clock on a Sunday morning, that that does not institute a lot of ventilation in some of the smaller hospitals, and you are then charged with trying to ensure that that junior medical officer is up to speed or is directing the state of the management of a patient.

Because of the skill sets issues and the quality issues, that is not always the case, and you often find that that registered nurse is probably more knowledgeable than some of the junior medical work force. From my perspective, intensive care nurses in big hospitals have always trained the junior medical work force to some degree or other. It is becoming more and more obvious in the smaller units that the nurses are the ones doing it, but they are not necessarily the nurses that are exposed to that degree of intensive care. So, yes, they are at risk in some cases.

The Hon. TONY CATANZARITI: Have you had any discussions with the registered nurses at Mona Vale or Manly about how they feel concerning this ongoing debate about intensive care and the location of a new hospital?

Mrs NEEDHAM: Yes, I have. In 2003 I reviewed the whole of the Northern Sydney Area Health Service, which included North Shore, Ryde, Hornsby, Manly and Mona Vale. At that point we reviewed the services, and both the nursing unit manager, and the education people at Manly and Mona Vale stated that they were in favour of one service, located on one site. But what they really wanted was to have that decision made quickly. Last week it was stated that this has been going on since 1999. In fact, it was mooted in 1996 that there were going to be changes to service provision within the northern beaches.

The nurses, having spoken to them at Harbord Diggers before Christmas, are feeling burned-out, they are exhausted, and they are sick of reading about all this in the media. But they want a decision made about where the central hospital will be, and they want a decision made about the intensive care unit sooner rather than later. They are frustrated. They are sick of the bad blood between some of the clinicians. Basically, the nurses just want to look after patients; they do not want to get caught up in the politics. They go to work to do their job, and this is distracting them from patient care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems that intensive care is the tail wagging the dog. The pictures show very complex medical equipment. Are there good studies of the cost effectiveness of intensive care units?

Mrs NEEDHAM: Yes. In my submission, which I submitted on the 31st, there are many articles about cost effectiveness. As I said in my presentation regarding the cost effectiveness of intensive care, you need the same resources for two beds as you need for 10 beds, so it stands to reason that you would put them all together.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have cost-effectiveness studies been done on this complex medical equipment? Stereos have become more complex because they have flashing lights and other features that people do not use very much. Is it really necessary that all this equipment is cost justified in terms of outcomes? What is the failure rate of the least expensive equipment?

Mrs NEEDHAM: I could not comment on that, and I would have to take it on notice. Intensive care outcomes are very good in Australia, in fact we believe the world, with our outcomes. I suggest to you that that equipment, over the last 30 years, is now better able to provide care for patients with better outcomes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How strict are the admission criteria for intensive care?

Mrs NEEDHAM: Very strict. If you have watched the media regarding intensive care beds over the last few years, you will know that they are as rare as hens' teeth. We need to use them as a valuable resource. Dr Chesterfield Evans, the days when you were in intensive care were probably around the time when I first started, I would suggest. Back then you could get into intensive care without requiring ventilation, whereas now you cannot.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People have told me that people who have a very poor medium-term prognosis are being admitted to intensive care units and getting vast resources.

Mrs NEEDHAM: I think that is the point that should be discussed about end-of-life decision making. A patient should not get to intensive care if that is the situation—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they do, do they not?

Mrs NEEDHAM: Yes, they do get there. But in saying that, it is up to the surgeons and the physicians that are their primary care team to advise them about their disease process and what is the likely outcome should they have a critical event. Again, end-of-life decision making, and having the bells and whistles and all of that expensive technology and how that impacts on you psychologically and on your family, should be discussed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have the expense of all the fancy equipment as a pre-funeral expense, if you like, while the people at Campbelltown might not have enough staff to run an after-hours service. That is the danger of the tail wagging the dog, is it not?

Mrs NEEDHAM: I guess that is why we are here. This is not about resources. You heard from Professor Goulston—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is about resources.

Mrs NEEDHAM: Hang on. You heard from Professor Goulston, confirmed by the GMCT's submission, that he has asked for money to be sunk into Manly and Mona Vale.

CHAIR: We have to talk specifically, though, about Manly-Mona Vale.

Mrs NEEDHAM: Can I just move on, instead of being interrupted? It is really important that we look at where we put our resources. I know that one quarter of the New South Wales budget is spent on health. That is serious. Unless we start to make some decisions about intensive care beds we are wasting time and effort—all the people around this table and all the people who have put in lengthy submissions—because of the inability to make a decision. We are held at the mercy of lobby groups or political factions. Leave it to the clinicians to tell you. Yes, we should talk to the community. The community needs to be more and more informed, and needs to have some say. But, once again, about where intensive care services are, we cannot have all things in all places, we really cannot. The workforce is not there, the money is not there. We need to be sensible about how we distribute it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you leave it to the clinicians there is the danger that intensive care will become a pre-funeral expense.

Mrs NEEDHAM: No, our statistics—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many dollars—

CHAIR: I think you will have to wrap up Dr Chesterfield-Evans.

Mrs NEEDHAM: I cannot actually give you that. However, I can tell you that an intensive care bed is an expensive commodity. Within our units 10 per cent to 15 per cent of our patients die but we save 85 per cent of our patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: "Save" meaning leave the unit alive?

Mrs NEEDHAM: That's right. Some of them do go on to require more ongoing care. But that is a moral and ethical debate, and we are not here to talk about end of life. But we can do that some other time.

(**The witness withdrew**)

CHRISTINA McRAE HEATH, 2 Sturt Street, Frenchs Forest, and

PAUL COUVRET, OAM, 2 Hindson Place, Belrose, sworn and examined:

CARLO PATRICK BONGARZONI, 9 Russell Street, Clontarf, affirmed and examined:

CHAIR: Mrs Heath, what is your occupation?

Ms HEATH: I am a part-time community nursing sister.

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

Ms HEATH: I am here as a community representative of the Warringah shire.

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

Ms HEATH: No.

CHAIR: Mr Couvret, what is your occupation?

Mr COUVRET: Retired schoolteacher and lecturer.

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

CHAIR: I was selected by Warringah Council to represent the Council on the special committee.

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

Mr COUVRET: Yes.

CHAIR: I would just complete the formalities. Mr Bongarzoni, what is your occupation?

Mr BONGARZONI: Management consultant.

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 BONGARZONI: I guess I am a private individual and one who has been involved in the community consultation process.

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

Mr BONGARZONI: No. I think we have agreed that Paul will do that for us.

CHAIR: Mr Couvret, 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 may subsequently published the evidence if they decide that it is in the public interest to do so.

Mr COUVRET: I would like to make a general statement on behalf of the three of us. We have all joined the committee because we are firmly convinced that Warringah, Manly and Pittwater, the peninsula is in dire need of the new hospital. All that we want to do is make sure that that hospital, the latest development and up-to-date hospital is built for the people of the peninsula, which has been sadly neglected over past years. We have two run-down hospitals now and we want to have a new up-

to-date hospital and we will do anything we can. In no way are we going to try to make it difficult for that to happen.

CHAIR: Do you support the concept of one level five hospital and another hospital offering reduced services?

Mr COUVRET: I do support a level five hospital and a second community hospital, which would be at Mona Vale.

The Hon. CHRISTINE ROBERTSON: I do not mind who answers this question. What are your feelings about the consultation process that Northern Sydney Health has undertaken in relation to the planning that is taking place for these two hospitals? This is the consultation with the community. I am not interested in the clinicians; we have had plenty of that.

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

The Hon. CHRISTINE ROBERTSON: Would you tell me what sort of cross-section of your community is turned up to the meetings and discussions?

Mr BONGARZONI: I think the cross-section was heavily weighted towards the Northern end because there was a much more organised process and group making sure that happened. So, if you are asking was it fair from the point of view of who came to the public meetings, the answer is probably not in the sense that those public meetings were weighted. As indeed, I suspect, the supplications to yourselves have been weighted from the northern end.

The Hon. CHRISTINE ROBERTSON: What sort of numbers did you get? What sort of health people came to work with you when you have the community consultations?

Mr BONGARZONI: I think the public places that I went to, in terms of hearings or gatherings, during the formalities as consultation as opposed to what has taken place subsequently, I think there was only room for about 300 people, for instance at the Dee Why club. But I think you have to take it beyond those public gatherings and say how many other meetings were attended by the people in the consultation committee to engage and discuss and debate the whole issue with parents and citizens associations and Rotary and other community groups.

The Hon. CHRISTINE ROBERTSON: What sort of health people were undertaking the discussions? I know there was a consultancy, but there must have been people from Northern Sydney Health who participated?

Mr BONGARZONI: Well, not really in the public gatherings, although they did speak from the floor. But certainly not in the people who went around the community groups because it was a community process of debating.

The Hon. CHRISTINE ROBERTSON: Community-controlled process?

Mr BONGARZONI: That was the whole purpose of the community consultation process.

The Hon. TONY CATANZARITI: How would you describe the behaviour of the Pittwater representatives on the northern beaches community consultative health planning group?

Mr COUVRET: During our meetings I would say they tried to dominate the meetings. I went to the trouble of even timing the times that the representatives took, whilst they were still on the committee in the early stage or the first half of the deliberations. They would take up about three-quarters of the available time and the rest of the time was taken up by the other ten candidates. Obviously, they had a lot to say and they were trying, to put it bluntly, to hog the floor. They did that

very successfully. It was obvious that they wanted to get the other ten people onside to make sure all that we were all going to vote for the new hospital to be established at Mona Vale. But the representatives of Warringah and the representatives of Manly would not buy that. We thought it had to have a more central position on the peninsula.

Mr BONGARZONI: Could I add something to that? I am not sure that during the formal process of community consultation that they were so much interested in having the central hospital at Mona Vale; I think they were more interested in ensuring that there was a hospital facility being kept at the Mona Vale end. I would describe their behaviour politely as dedicated to their cause, and in that process I do not think they did themselves justice, because they lost sight of the trees for the woods, as it were.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand you are a member of BEACHES, is that correct?

Mr BONGARZONI: I am a member of BEACHES more latterly, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand from the evidence last week that there was a rally organised by BEACHES, is that correct? Did BEACHES ever have a rally?

Mr BONGARZONI: Well, if they did it was not while I was a member so I cannot answer that question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not aware of there being a BEACHES rally?

Mr BONGARZONI: Well, I think they would have done that when they were trying to save Manly Hospital some years ago.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I believe beaches has existed since 2001?

Mr BONGARZONI: They may have done. I cannot remember. I was not a member then.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you know how many members there are in BEACHES?

Mr BONGARZONI: I haven't a clue. I have only recently become a member.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were involved in the northern beaches health care planning consultative group. Do you support the findings of that process as outlined in the reports prepared by Mandis Roberts Consultants?

Mr BONGARZONI: I think the report was a pretty fair one on the basis of what came out of the consultation process, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your submission to the inquiry you say that in the Taverner research of 2002, 50 per cent of northern beaches residents prefer a Brookvale area location for the new general hospital.

Mr BONGARZONI: Did I say that?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is my understanding.

Mr BONGARZONI: In my submission?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Mr BONGARZONI: Well, if I did, what is the question?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The results of the research suggested that the preferred location for a general hospital was Mona Vale 35 per cent, Brookvale 28 per cent, Frenchs Forest 25 per cent and other 12 per cent. You seem to be lumping Brookvale and Frenchs Forest together to get your figure.

Mr BONGARZONI: The point is this: The population centre is way south of Mona Vale and those figures reflect where the population centre is.

CHAIR: Can I ask each of you to explain how you were chosen to be members of this community consultative group? Who chose you? What was that process?

Ms HEATH: I will start. There was an advertisement in the *Manly Daily* and, as I was interested in health, I applied in writing. I received an answer a month or so later to say that, yes, I was accepted, along with other members. There were five from Warringah, of which I was one. I was the only female representative; the other four were men.

Mr COUVRET: I replied to the advertisement placed in the *Manly Daily* by Warringah Council, asking for volunteers to represent the council on this consultative committee. I put my name in, the council then voted for five people, and I was one of the five selected.

Mr BONGARZONI: I also applied to a Manly Council advertisement in the *Manly Daily* and, through the process—whatever they used—I was selected. I think it might be worthwhile asking whether you have asked the same question of the Mona Vale or the Pittwater groups because it was very clear that all the members selected there had some allegiance to the Save Mona Vale Hospital committee, which does not sound as fair as the processes of Warringah and Manly councils.

CHAIR: Because you are representing the community I am interested in how the process worked. The other members identified themselves as representing their particular groups. How many people applied for the positions outlined in the advertisement to which you responded?

Mr COUVRET: I do not know because that was confidential on the part of the council. As a matter of fact, I asked the deputy general manager and he said, "Sorry, I can't let you know that".

The Hon. AMANDA FAZIO: I have a couple of questions for Mr Bongarzoni on issues that you raised in your submission to us. You seem quite emphatic in your belief that the new northern beaches general hospital needs to be closer to the population centre of the area than is Mona Vale Hospital. You say in your submission that many Save Mona Vale Hospital supporters have strongly disagreed with that position.

Mr BONGARZONI: Disagreed with what position?

The Hon. AMANDA FAZIO: That position that theirs is not the population centre or the best site with regard to the population centre on the northern beaches. When you were involved in the community consultation process, apart from supporters of Save Mona Vale Hospital, what was the general feeling among people involved in that process in terms of the best site?

Mr BONGARZONI: I would like to raise the fact that I put my name forward more than others, I think, to go north because I felt that there was convincing to be done there. I spent a lot of time in the northern area and I would have to say that we were competing on the same sites as the Mona Vale group. I think we presented very fairly the options that came up. In the process, you would have to say that at the northern end, in particular, there was a preference for the Mona Vale Hospital site. You would expect that in many respects. However, I did find—and surprisingly so—that a number of people from the northern end quite clearly, if given the ability to speak openly without being taken to task by the northern end, would have said plainly that it should be in the population centre or near it.

The Hon. AMANDA FAZIO: Thank you. I think you were all present for the evidence of the previous witness, who talked about the changes that took place in terms of Mount Druitt and Blacktown hospitals, which is something akin to the proposal put forward for the new northern

beaches hospital, with Mona Vale to remain as a hospital and for Manly to become more of a community health centre and aged care facility. As part of the consultation process, were you taken to look at any models such as that? I am interested in any of your comments on what you thought about that.

Mr BONGARZONI: Yes, we saw Blacktown Hospital, and it was an exemplary model in many respects. I am not sure I would agree with you that the Mount Druitt example is the right one because the previous speaker said, I think rightly, that we have to collect our resources in the best possible place on a scale that can be afforded and is needed by the community. I think we have gone well past the time of having small hospitals where the staff are dedicated to trying to do their best but, because of the resources, just cannot do it. We do not spend the time in hospitals that we used to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In the sense that the model that seems to be favoured is a major level five hospital and another that has sufficient resources to do a significant amount of surgery and would presumably have an emergency department, is there anything particularly wrong with having a reasonable size community hospital on the Dee Why site, which is a small site, and then having the level five hospital at Mona Vale? The hospital at the southern end of the peninsula is near a population centre and would still be able to look after most people.

Mr BONGARZONI: So you are suggesting, No. 1, that the majority of the population ought to travel the furthest distance for any major care they need; and, No. 2, if that were to happen you would find certainly that people at the southern end, and maybe even in the western part, would go to Royal North Shore—it is simply easier to get there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That assumes that the southern hospital would not be able to deal with most cases. The fact is that only a small number of cases need that extra grading.

Mr BONGARZONI: Well, why do you not put it at the other end where there are fewer people?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The advantage is that the Dee Why site is very small and the site at Mona Vale is very large and the number of people requiring the extra level of care may not be huge. You are talking about how many people need to go there not just how far they need to travel.

Mr BONGARZONI: I do not know where the site is, for a start, because it has not been selected. I know there is a preferred to site. I do not know what its size is in relation to putting a hospital on it but I do not think it would have been selected if it were not sizeable enough. I refer to my previous statement: At the end of the day, if you are going to put a major hospital anywhere in any place, you would sensibly try to locate it where the majority of people are and have the best access to transport.

CHAIR: A few minutes ago you referred to the fact that we have got past the era of small hospitals. Yet we are still talking about one large hospital and a community hospital. Do you understand why there is some concern on the northern beaches about that model and the downgrading?

Mr BONGARZONI: Yes, and if I lived up there I would be concerned. But I think and hope that I would take a balanced view that it is a very short distance down to Dee Why or Brookvale. You have to go where the centre of excellence is and the predominant level of service.

The Hon. MELINDA PAVEY: It is all relative, though, is it not?

Mr BONGARZONI: Of course it is.

The Hon. MELINDA PAVEY: A short distance for someone travelling from the country to have a baby is five hours. In this case we are talking about 10 minutes and we have an eight-hectare hospital site ready to go at Mona Vale. I cannot understand the tensions here.

Mr BONGARZONI: What tensions? If you lived at the southern end you would not want to go to Mona Vale; it is quite simple. To draw a parallel, what about the people who live at Watsons Bay, for instance? They are not agitating for a small hospital and they have to travel quite a distance along tortuous roads.

CHAIR: As to the various sites, we were told last week that there are six sites before the Minister. Has your committee been apprised of each of those sites and was your input sought about the six sites?

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

The Hon. AMANDA FAZIO: You have all said that you were appointed to the community consultation group after you saw the advertisement that was run in the *Manly Daily*. I have a copy of the advertisements, which describes the attributes that members of the consultative planning group would need. It says, "All members will need to work together on the benefits of planning for the welfare of the northern beaches community rather than individual interests". Do you have any comments about how well the people appointed to the consultative committee complied with that requirement?

Ms HEATH: The Pittwater members resigned from the committee at one stage, which meant that the rest of us had to take over their responsibilities. As Carlo mentioned earlier, we had to go to the Pittwater area to canvass people's responses to the options. We did that in an unbiased way. We set up mobile stands at various clubs and things during the saturation period from August to September. We tried to gather as much input from them as we could in an unbiased way. The facilitator organised for paid employees to help in that way because we were understaffed. We tried to do what we could. There was a letterbox drop for every household in the whole of the northern beaches area and the leaflet was very colourful—so hopefully everybody saw it—and explained everything.

The Hon. TONY CATANZARITI: Do you think there was a genuine attempt by the two groups to come to some sort of common point as to where a hospital should be sited to benefit most people? Has there been a genuine attempt to reach that point?

Mr BONGARZONI: I would like to answer that first, if I may. I have been involved in all sorts of community consultation, from an employer point of view and many others, and I think that Warringah and Manly people generally went into this process in a very unbiased way, with the hope that we would certainly get a central hospital on the northern beaches and improve the standard of health care there. I have never in my life seen any group so biased as the northern end, to the point where, as I think Paul mentioned, meetings became almost intolerable in terms of being able to get any worthwhile activity. So if you are asking us whether it was an unbiased situation and scenario, the answer is that I think we would say from our point of view that we tried but it failed in that respect.

Very early on in the piece, and without the others knowing, I went to talk with members of the Save Mona Vale Hospital Committee to try to get them to see that we were really all on the same side and that if we worked together we could probably reach some sort of consensus that would try to match some of their requirements. I am afraid that I failed horribly and miserably and the process did not improve.

The Hon. TONY CATANZARITI: Do you think that the other group would be in much the same position?

Mr BONGARZONI: I am sure that they would say we were in the pockets of the chair and the Northern Sydney Area Health Service. If you content analysed anything they put in the paper and anything they said, you would realise that they are a professional and dedicated action group that has only one point to make.

The Hon. TONY CATANZARITI: Have you or any of your committee members been approached by the Mona Vale people to try to reach that consensus?

Mr BONGARZONI: Never to my knowledge.

The Hon. TONY CATANZARITI: Formally or informally?

Mr BONGARZONI: No. Let me just ask you, as a group of professional people who do not have a lot of time on your hands: Do you ever stop to ask why this inquiry is being held? It is only from the cause at one end.

CHAIR: Thank you for appearing before the Committee today.

(**The witnesses withdrew**)

(**Luncheon adjournment**)

STEPHEN ROBERT NOLAN, Intensive Care Specialist and General Physician, Mona Vale and Manly hospitals, 202/20 Bungan Street, Mona Vale, affirmed and examined:

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

Dr NOLAN: While I work for Northern Sydney Central Coast Health I am appearing as a private individual.

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

Dr NOLAN: I do.

CHAIR: If at any stage during your evidence you consider 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 may subsequently publish the evidence if they decide it is in the public interest to do so.

Dr NOLAN: I thank the Committee for giving me the opportunity today to talk about issues concerning the intensive care unit at Mona Vale Hospital. I appear before the Committee as an individual expressing my own views. I would like to cover a number of points in my opening statement: firstly, my involvement in the provision of medical services on the northern beaches and my ongoing commitment to the provision of those services; secondly, my intensive care commitments outside the northern beaches and why I choose to work in western Sydney; thirdly, why intensive care units should be staffed by intensivists; and, lastly, the need to rationalise intensive care services on the northern beaches into a level five and level three intensive care unit and the reason why intensive care physicians thought Manly was the best option.

Firstly, I started working in the northern beaches in 1995 as an intern both at Mona Vale and at Manly. Over the years I have worked as a resident, a basic training registrar, an advanced training registrar in thoracic medicine, a careered medical officer in the emergency department, and now as a consultant at both Mona Vale and Manly. I have my professional rooms in Mona Vale. I trained in intensive care at both Royal Prince Alfred and Concord hospitals and I finalised my intensive care training in December 2002. I have worked as an intensivist at Mona Vale since December 2001 and as a physician since early 2003. In addition, I have worked as a visiting medical officer [VMO] at Manly since mid-2003 on a locum basis. I also cover Manly ICU on an as-needs basis. I enjoy working on the northern beaches and I believe I contribute in a major way to the provision of medical services in this area.

Last calendar year I had 906 admissions under my care on the northern beaches—484 at Mona Vale and 422 at Manly. To put those figures into context, there were 851 surgical admissions in total at Mona Vale Hospital in 2004. I am committed to the northern beaches and I intend working the whole of my professional life in the area, hopefully both as an intensivist and as a respiratory and general physician. My primary intensive care position, however, is at Blacktown Hospital where I am employed as a 5 per cent staff specialist. My contract as a VMO intensivist at Mona Vale represents a 10 per cent staff specialist position, or about 270 hours per year. My colleagues know that I work far in excess of that commitment to Mona Vale.

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

Medical education is my passion. Each time I work at Blacktown I am reminded what a 350-bed hospital and modern intensive care could be like on the northern beaches. It would be able to unite both local communities and clinician groups. Each time I drive back to Palm Beach I wonder why I

am not providing those state-of-art services to the people on the northern beaches. Intensive care is a highly specialised sub-speciality. Doctors who are trained or who have extensive experience in looking after these patients should only do the care of the critically ill. A rapidly growing body of evidence is emerging that shows survival is much improved if intensivists look after the critically ill patient. For that reason the majority of intensive care units in Australia are closed units. By that I mean the intensivist is the only person who makes decisions about patient management, independent of whether he or she comes from a medical ward, a surgical ward or an obstetrical ward.

I believe that explains the recent change in work practices observed by Dr Jollow. The community should know that the standard of intensive care in Australia is world class and, I would argue, world leading. I would like to read a statement in the *Lancet*, a prestigious medical journal, made by Jean-Louis Vincent, arguably the most famous intensivist in the world. He said:

> With the wealth of evidence now supporting the beneficial contribution of the intensivist it is amazing that some non-intensivists still believe they are qualified to run the ICU. Their position is increasingly hard to sustain. These people would surely like their coronary artery bypass operation done by a trained cardiac surgeon rather than a general surgeon with some experience in cardiac surgery. Similarly, the ICU patient now requires continual surveillance and treatment by a doctor with specialist ICU training.

In my view, intensive care services on the northern beaches are in urgent need of reconfiguration. At present we have two struggling units, both of which are too small to be viable in today's standards. Rosters for senior staff cannot be filled by existing clinicians. Nursing vacancies are high—at 30 per cent—and staff morale is low. Clinicians and nurses are being forced into a situation where they are working in an unsupported environment, where the safety of the patient is potentially compromised and where modern standards of care are not being met. Both our hospitals, to different degrees, suffer from these problems.

The community and clinical bodies at both hospitals need to understand that people's lives are more at risk from a small intensive care unit and the cover it provides which is understaffed, overstressed and inexperienced, than the risk of being transferred to another hospital with a bigger intensive care unit. I believe that the plan by Professor Goulston results in an upgrading of intensive care services to the northern beaches, so all members of this community will benefit. It is difficult for individuals who are passionate about their hospital to think of the wide-ranging benefits to other members of the wider local community if they perceive their hospital as being adversely affected. It is also difficult for clinicians who work in only one of these hospitals to be unbiased, particularly when they do not fully understand the issues behind the need for change in intensive care.

There is no doubt in my mind that the intensive care service needs to change. This needs to occur in the medium term. Change is always difficult. Change always produces anxiety and distrust between parties. However, without this change sustainable intensive care services on the northern beaches will not be achievable. The proposed changes that will lead to a sustainable intensive care, which is world class, and to a new Northern beaches hospital, if built. In my mind there are misconceptions from both the community group and clinicians on why Manly was chosen as the preferred site for the ICU. I support this decision, despite the fact that I need to travel further to work. Safety of, and quality of service to patients, is always far more important and inconvenience it might bring to clinicians.

At the start of this process I thought that Mona Vale Hospital would be the preferred site, given the physical set out of the intensive care unit. It soon became clear, however, as a result of other issues, such as work activity differences between the units, junior medical staff, the advanced training that would be lost if it went to Mona Vale and the lack of physical space for extension of the unit for clerical and medical officers. In addition, skills of nursing staff at Manly match the demand of a level five intensive care better than that at Mona Vale. Other services, such as heart ultrasound, is much more available at Manly campus. For these reasons I agreed with the move of ICU services to Manly, but only on the guarantee that a significant renovation of the existing unit was undertaken prior to the move.

In summary, I enjoy working in both general medicine and in ICU at Mona Vale and Manly. I have a young family of five children. We are currently building our family home at Bilgola. I hope I have 20 to 25 years of clinical service in front of me for the people of the Northern beaches. I am not moving. I am not retiring in the near future. Once the Northern beaches hospital is built it will provide

state-of-that-art ICU services and provide modern care for the people of the Northern beaches, which we deserve. I continue to work in Western Sydney. This allows me to maintain my intensive care skills and I bring these skills back to the Northern beaches. We need a bigger level five ICU as this will allow recruitment of intensivists into our area. It is an undisputed fact that intensivists looking after intensive care patients reduce death rate, patients have shorter ICU stays, patients stay shorter times on mechanical ventilation or life support, there are fewer consultations, they are better serviced and there are reduced ICU costs. For these reasons intensive care services must be changed in the Northern beaches in the medium term. Thank you.

CHAIR: At Christmas time there was a decision to close the ICU unit at Mona Vale. Surgeons and anaesthetists had a view that there were safety issues at stake if that were to occur. What is your view about that concept of safety considerations?

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are grades, are there are not, of intensive care patients from the most sick to the ones requiring some elective postoperative ventilation period?

Dr NOLAN: Of course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has there been any looking at, by the anaesthetic deaths review committee or any other similar body, of cases where there have been deaths that would not have happened had there been a better intensive care unit?

Dr NOLAN: I am not sure of the specific data you are talking about, and I suspect Dr Nigel Thakkar, who runs the Anaesthetic Department at Mona Vale, would have that figure for you. We do have a morbidity/mortality intensive care meeting, which I have attended over the last couple of years. I am not aware of those cases that you may be alluding to. So the answer to that is that I am not the most appropriate person to ask for that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you talk about wanting quality, it is fine to talk about the rhetoric of finely trained people and so on, but at the bottom line if you have a highly trained unit with a huge shortage of staff globally in Australia, New South Wales and on the Northern beaches it is a question of what can be delivered of reasonable care for the operations being done by the surgeons in reasonable proximity to the patient, is it not?

Dr NOLAN: I think that is a very true statement. I would like to make the following statement, and that is that the intensive care specialists at Mona Vale have, for some time, supported the surgeons over and above what would be considered reasonable for a level four hospital. For example, we do level six surgery. We have surgeons who do abdominal aortic aneurysms or large vessels of the abdomen repairs. We have people who do carotid artery surgery. We have people who do liver resections and major pancreatic resections. That surgery is being done with the current structure at the Mona Vale Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if that is the case, presumably under Heinrich's theory of accidents—10 minor mishaps for every major mishap and 10 major mishaps for every death—if you were looking at that data you could say whether there was likely to be deaths and you would look at real data rather than saying the better the intensive care unit the better, which is the line that has been pushed?

Dr NOLAN: I suppose data from the operating theatre into intensive care, which is what you talked about, the anaesthetic person should be able to make a decision at the end of his or her operation whether that person is going to be in need of intensive care, as you describe it, or whether that person is going to need to be ventilated overnight. In the current situation we would accept both of those patients back. If Mona Vale were down to a level three situation then we would need to retrieve the former patient.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure, but the point is it is one thing to have an anaesthetist making a judgment about each individual patient. If you are going to plan you have to stand back and look at the data as it is happening, do you not?

Dr NOLAN: I would agree with that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In a sense, when you say, "we can't deliver this" are there any studies of this? We have this emotive stuff about how important it is to have excellence—we had a good example of it this morning—but we do not have any data about whether patients are actually dying for lack of intensive care services and, if so, how would patient selection allow Mona Vale to continue operating at a reasonable level.

Dr NOLAN: We have data on surgery patients and intensive care, which I could present to you. That is the data for 2003-04. That data suggests that there were 53 elective admissions to the intensive care effectively and 37 admissions on an urgent basis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Of surgical patients?

Dr NOLAN: These are purely surgical patients. Of those 37 emergency cases, 16 of those were ventilated. Of those, two were ventilated greater than one week and 12 were ventilated greater than 24 hours. Most of those patients came in between the hours of 1600 and 2400 so we think that over the course of one year there would be 16 surgical patients. If we kept the same surgical structure then the hospital would need to be moved to a higher unit, such as Manly when it was organised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is elective ones coming in the late afternoon?

Dr NOLAN: That was emergency surgery coming in the late afternoon. Elective surgery, there were 53 patients, of which six needed to be ventilated, two needed to be ventilated for greater than 24 hours and the mean time of ventilation was 1.7 days. So ready we are looking at a total 16 surgical patients over the course of one year who required to be moved out of Mona Vale Hospital for longer-term ventilation if we kept our current surgical structure and surgical operations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the pressure is to reduce the current intensive care, and you are saying that if that happened only 16 people would have to be transferred?

Dr NOLAN: That is right. If we reduce intensive care to a level three then we would expect 16 patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Some 16 transfers per year, which is what, I bit more than one a month?

Dr NOLAN: A bit more than one a month, that is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, in fact, the critical nature of intensive care if the intensive care were rationalised to one site, assuming that 16 transfers could be done adequately by medical retrieval, Mona Vale could continue with the surgical load and profile it currently has?

Dr NOLAN: And I would have thought that was the same situation in December of last year. But I would agree that if Mona Vale surgeons thought that they could do that and their anaesthetic

counterparts were happy to provide the ongoing intensive care ventilation over the first night then there would be a consultant intensivist come around the next day and then make a decision on where the patient should be. Clearly, there are patients who, obviously, are going to be ventilated for a long period of time and you know that from day one.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But this morning we had evidence that if you have these things where an occasional person is ventilated overnight you have a big drop in the skill level of your staff, you have the ones that really are interested in that issue go somewhere else and, effectively, you have a spiralling downward of that expertise.

Dr NOLAN: I put it to you that that spiralling down of expertise and skill level has occurred long before you get to that situation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would say that residual level of skill that people can manage intensive care—

Dr NOLAN: Are currently at Mona Vale Hospital and Manly Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That degree of support, shall we say?

Dr NOLAN: With the degree of support they have now, that is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that could be maintained with 16 transfers per year? It would be your contention, would it?

Dr NOLAN: My figures suggest that there would be 16 surgical patients leave Mona Vale Hospital over a year period because they needed to be ventilated for greater than one day.

Reverend the Hon. Dr GORDON MOYES: I noticed when I was making comparisons between the staffing levels of the ICUs at Mona Vale and Manly that there were a greater number of intensivists at Manly. What do you put that down to?

Dr NOLAN: A greater number of intensivists at Manly?

Reverend the Hon. Dr GORDON MOYES: Yes.

Dr NOLAN: The Manly Hospital intensive care unit, I think, has been providing an excellent intensive care service for many years. There are three staff specialists who work in intensive care and they work in thoracic medicine. Manly intensive care works because they have a combined practice. The reason there are three there is because there has been one person there who has been able to attract other people into the intensive care who have an interest, and one individual had training in intensive care from the European society and another person who has had longstanding intensive care experience in the Brompton Hospital in London, who also both practise as respiratory physicians. So it works nicely in that environment, in the environment of thoracic physicians also practising intensive care.

The Hon. TONY CATANZARITI: At any time have you been subject to harassment or intimidation from other medical professionals as a result of expressing your views?

Dr NOLAN: Unfortunately, the answer to that question is yes. When I met with the Minister last year with the group that Dr Boland was talking about in his submission—with the anaesthetists, with the intensive care specialists, obstetricians, orthopaedic surgeons—immediately after that meeting I received a very threatening phone call from a person who was at that meeting suggesting that this individual was going to impede my career. It is suggested that he thought I was selling out Mona Vale and he was going to make sure that everyone knew about that. Those sorts of things have continued, unfortunately. I have received further phone calls from that individual about various things.

I have a letter, which I am prepared to give to the Committee, outlining the harassment that individual gave me. I have had recent examples where senior nursing staff at Mona Vale Hospital have complained to administration that I was not meeting my requirements to see my patients, which

meant I had to go around all of my patients and get the time they were in the emergency, when I saw them, what I had documented and it was clear that I had seen every patient within 12 hours, which is, I think, an achievable thing and should be done by VMO physicians. However, I do not believe that I should be subjected to having to go and collect that data when I have been doing it effectively and I see the most patients in hospital.

CHAIR: I caution you about naming anybody. If you wish the Committee to be aware of the details of the allegation you may wish to do that on a confidential basis.

Dr NOLAN: If the Committee would want to know the person's name I would be prepared to give that, but an in camera and I do not want to soil my relationship with my colleagues anywhere.

The Hon. TONY CATANZARITI: Are you aware whether any of your colleagues have been subjected to harassment or intimidation?

Dr NOLAN: Yes, I would say another intensive care colleague of mine at Mona Vale has suffered similar things, not in the same nature as I have suffered, but has certainly had problems with staff after he made his views known about the intensive care unit.

The Hon. TONY CATANZARITI: Have you at any time expressed your concerns about the safety of critically ill patients under the current structure at Mona Vale hospital to surgeons and anaesthetists at the hospital?

Dr NOLAN: Indeed I have. I have written a letter to the Director of Intensive Care, Dr Paul Phipps, and that was given to him on June 12. We went to the medical staff council meeting and explained our concerns about this. It would be good to talk to the anaesthetists and surgeons at the medical staff council meeting. However, the surgeons tend not to turn up to our medical staff council meetings to listen to the general opinion of the medical staff within the hospital. Yes, we have articulated our concerns on multiple occasions, through our multiple root cause analyses, which have looked at concerns of intensive care patients in Mona Vale hospital, and they are obviously in the Department Of Health. So, yes, that is the answer.

The Hon. CHRISTINE ROBERTSON: On that issue, are the surgeons actually being questioned about the role delineation of the hospital and the level six surgery that they are apparently providing?

Dr NOLAN: I cannot answer that question at all.

The Hon. CHRISTINE ROBERTSON: It is probably not your job. I was just interested.

Dr NOLAN: No, I agree.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I pick up on what you were talking about in relation to root cause analysis of problems at Mona Vale. It is that really a case-by-case answer to what I was saying about anaesthetic deaths and the reviews thereof?

Dr NOLAN: When you have an anaesthetic death, the most likely source of the data would be through the coroner, because within 24 hours that death becomes a coroner's case. I have not been on a root cause analysis that has looked at an adverse outcome from an anaesthetic on a patient in intensive care, so I cannot fully answer that question for you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You talked about root cause analysis looking at Mona Vale intensive care patients, did you not?

Dr NOLAN: No, I talked about root cause analysis of all incidents that are deemed to be level one incidents at Mona Vale hospital, and I have been on those hearings.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would not some of those relate to the intensive care unit and support thereof?

Dr NOLAN: I cannot answer that question because I have not been on all of the root cause analyses. I suspect Dr Bruce Sanderson would be able to answer that direct question for you and I would defer that question to him.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there not some overall report produced on those sorts of analyses?

Dr NOLAN: You have to understand that I do not go to all root cause analyses. I believe that, in relation to the ones I have been to, a submission is made to the Department of Health and the Department of Health would hold that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if there were inadequacies in the intensive care unit at Mona Vale, the collation of those root cause analyses would be available to the Department of Health and it would be able to provide them to this Committee. Is that a reasonable conclusion?

Dr NOLAN: I do not think it is a reasonable conclusion because not all adverse outcomes are reported as a root cause analysis. Intensive care has its own quality assurance programs and those programs evolved around aims forms, whereby anonymous and private forms are filled out by nursing staff and medical staff to review as a unit as a whole. There are morbidity and mortality meetings where these things are reviewed as a whole. You are more likely to get the information you are seeking for this committee from Dr Paul Phipps and his review of the morbidity and mortality and aims forms that have occurred at Mona Vale hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So we could get that data, and if someone were saying that the intensive care at Mona Vale was inadequate they should cite that data rather than simply make the assertion, should they not?

Dr NOLAN: Can I correct your grammar for one moment? No one has said that the intensive care service at Mona Vale is inadequate. I do not believe it is inadequate. I believe the intensive care service is doing a very good job at Mona Vale. I think the data suggests that both Manly and Mona Vale intensive care units are doing very good jobs with the resources that they have. Please do not say we are doing an inadequate job.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not suggesting that, but people have said here that because intensive care staff have to work in units of eight or 10 and it is a specialty, and you can only have one on the northern beaches, therefore it is impossible at Mona Vale. I am saying that if that is the case, let them make the case that Mona Vale has not been adequate with the resources it has.

Dr NOLAN: It is not a matter of adequacy, it is about providing state-of-the-art intensive care services to the majority of the people. It is not about whether you can provide an adequate service, it is about whether you can provide a modern 2005 intensive care service. That is a very different statement. I think we should focus on providing modern 2005 intensive care services, not just an adequate service. Let us not shoot for mediocrity, let us shoot for standards that we should all be happy with. Whether we enter at Mona Vale or at Prince Alfred, we should have intensivists looking after us. That is the issue, that is where we should be focusing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not making the case for mediocrity, which you will appreciate. I think intensive care units will swallow whatever resources you give them.

Dr NOLAN: Correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if you are going to make the case for intensive care units, one could say that the tail wags the dog in the health system in terms of the position of intensive care units.

Dr NOLAN: The tail does not wag the dog. The tail allows the dog to do what it needs to do. That is the purpose. You cannot do these things without the tail. You need the tail to be able to do the

complex surgical procedures and to look after the critically ill patients who come through the emergency department. That is why you need a level five intensive care on the northern beaches, so that the people on the northern beaches are not deprived of 2005 intensive care standards and the intensivists that have been shown to improve mortality, decrease intensive care stays, decrease medical and mechanical ventilations, decrease renal failure and decrease costs.

CHAIR: If you do not have it at Mona Vale, does that mean it is a downgrading of the services?

Dr NOLAN: I do not believe we should be looking at the two communities, Manly and Mona Vale, and looking at upgrading the Manly service and downgrading the Mona Vale service. I truly believe, given my experience of working in both hospitals at every level over the past 10 years, I have an unbiased northern beaches perspective. I encourage all the people of the northern beaches—not Manly, not Mona Vale, not Warringah. I am saying we need to provide services for the northern beaches. We are upgrading the intensive care services for the northern beaches. That is what we are trying to do but we are being stopped at the moment. I just hope there will be some sensible arguments soon that we will move intensive care to wherever it will be best. If someone can come up with a reason it should be at Mona Vale, fantastic. At the moment, we have looked at the data—we have been there for six months—and it says Manly. We want to take two intensive care beds to Manly. We do not want to take nurses, secretaries, ward clerks, echocardiogram machines to Mona Vale, we want to take the patients to Manly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are the admission policies of Manly and Mona Vale's two intensive care units the same?

Dr NOLAN: No, they are not the same. The policy at Manly intensive care is that you get admitted under the intensive care physician of the day. The admission policy at Mona Vale is that you get admitted under the surgeon or physician or obstetrician on call on the day. They are different.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there differences in the patients? If a patient were in the wards or post-operatively in the two hospitals, would their chance of being admitted to the intensive care units be the same? Is the data the same for the two hospitals?

Dr NOLAN: I understand your question. The question is admission into the ICU and who determines that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Or what.

Dr NOLAN: Admission into the ICU is always determined by need. ICU is a very expensive resource and intensivists are very wary of that and we only admit patients who we think will actually benefit from the intensive care unit. We admit patients who we believe are sick enough to be in the intensive care unit. Many times I have gone to the ward both at Manly and Mona Vale and not admitted a patient into the intensive care unit, for various reasons. It is a judgment decision made by a consultant at that time. If it is late at night, the resident at Manly, or usually a locum in the emergency department, will assess the patient on the ward and then call the intensivist directly, and after discussion about the case a decision will be made about admission into the unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that procedure. Would you say the results of that assessment process in both hospitals are sufficiently the same that the criteria for people in intensive care are the same? I acknowledge that there is a higher level of expertise in some of the more extreme levels of intensive care in Manly. Because of the length of stay and so on, the point has been made that the Mona Vale intensive care unit did better. Would you say that that is not the case and the admissions and outcomes are the same for the two units?

Dr NOLAN: I personally think that both the intensive care units do well given the resources that they have. I have read the transcripts of the Save Mona Vale people in which they talk about Apache data. Quite frankly, that was not a conversation I could follow because it was clear that those people did not understand what Apache data meant and how it is generated. I am not the person to talk about Apache data, but I happy to discuss how an Apache score is formed. Apache data is very

difficult to interpret. You need people who know to interpret it and who know the influences on those numbers and what has happened.

You cannot just get a number and say that a place does better or worse than another. If you did that, you would then say Mona Vale hospital was the best hospital in the world because our standard mortality ratio is about 0.3, whereas standard is 0.72. We do not get the same patients as North Shore, so you need to interpret it. Unfortunately the Save Mona Vale people had a number but they did not know how to interpret it. They wanted to make the point that Mona Vale was better because its Apache data was worse and more survived. That is not right. Professor Fisher is an expert in Apache data—I think he is to appear before this Committee —and that would be a good question to ask him. I am sure he would have a very strong opinion on that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask you also about the cost effectiveness of intensive cares generally in terms of quality. It worries me that it has been said to me—not in this inquiry, but at other times—that a large number of people are spending a large amount of money in intensive care as a pre-funeral expense, to put it rather bluntly. What would you say about that? If it is the case, is the tail a very heavy tail in terms of the weight of the dog?

Dr NOLAN: Can I ask you what percentage of people would die in intensive care units?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not a question of whether they die in intensive care units.

Dr NOLAN: It is, because if you are talking about quality of life you have to relate it to a time frame. If you die in an intensive care unit you have no quality of life, therefore that number is very low.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The quality relates to quality of life years thereafter.

Dr NOLAN: The quality will depend on the age groups of the people going into the intensive care unit. There are people who have an interest in intensive care. You need to understand the body of research in intensive care is very great. Dr Graham Reese is an expert on this. He is doing his PhD on quality and the intensive care unit. I know the papers and I can tell you the respiratory outcomes. I do not know the number for qualities but I am sure Dr Graham Reese would be able to give you that information if you wanted to pursue that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We are talking quality-adjusted life years.

Dr NOLAN: I understand what you are talking about.

The Hon. CHRISTINE ROBERTSON: What difference do you think the Metropolitan Clinical Taskforce plan that we are actually debating here will make to safety for people on the northern beaches. Can you also talk about the functions of a level three high dependency, because everyone talks about downgrading but it has a high quality component of its own. I would like to hear what you have to say about that.

Dr NOLAN: I will deal with the first question. As a registrar, I was involved with the Greater Metropolitan Taskforce Committee, the very first committee that was formed and has led to these other committees. I was always of the opinion that gone were the days when we had our silos at North Shore, such that everyone wanted to go to Royal North Shore and no-one wanted to come out to the northern beaches or to Manly. I was always committed to always working at Mona Vale and Manly. I did not want to be in the silo. Why should all the best people be there? Why don't we come out to the metropolitan hospital? The days of the 500-bed or 800-bed hospital are well and truly gone.

What we need is a tertiary hospital that provides level six services. Then we need a step-down hospital, like Blacktown, where I work, where we provide fantastic and excellent care to the majority of patients. But, most importantly, we need another hospital to which people can be moved after their operations to rehabilitate—so that we can keep the level six hospital open, doing what it

needs to do; and we can keep the level five hospital open, doing what it needs to do; and then we have the level 3 hospital, which is close to the patient's home, doing what it needs to do, that is, rehabilitating and getting back to their local environment, where families and friends can come and visit patients. That is the role, if there is going to be a role, for a level three hospital on the northern beaches. That is the role I think that level three hospital should play.

What is the impact on safety? I think these programs have an enormous impact on safety. The highest quality, most dangerous and high-tech things are being done where they have to be done, at the level six hospital. You then have the step-down things that can be done at the level five hospital, providing a safe environment with intensive care. Not only that, but you can provide a safe emergency department. You can have full-time emergency physicians for the majority of the day. This argument has been lost in the intensive care argument. Mona Vale has one emergency physician who provides 30 hours a week of consultant cover. Intensive care on the northern beaches is not in crisis; emergency is in crisis. The front door of the hospital at Mona Vale is in crisis, yet we are talking about intensive care, where I think we have been doing quite well.

While I do not have the data for Bankstown and Mount Druitt, I can say that the exit block and input block into the emergency departments have improved. I believe not one surgical operation at Mount Druitt has been postponed. The throughput of medical patients at Bankstown and Mount Druitt has increased, and the length of stay has decreased, because we have the critical mass of registrars, who are being supervised by consultants, so that patients are not being left on the ward for extra days at these smaller hospitals, where the VMO might come in every four or five days. They are being seen by a top-quality registrar on a daily basis, and are being discharged sooner.

Quality is unequivocally better. Let us not deny these benefits to the people of the northern beaches. Let us bring these benefits to the northern beaches. Let us get the level five hospital. Where it is, that is not my decision. I believe in my heart it should be at Mona Vale, but my soul tells me that it has to be where the majority of the people live. So I believe it should be somewhere in the golden triangle between Frenchs Forest, Brookvale and Dee Why—even though, with my heart, I would love it to be at Mona Vale. But I just cannot see people coming to Mona Vale from Seaforth. They will go to North Shore. My biggest fear is that if we put it at Mona Vale the problem will be that 80,000 people will go to North Shore, and we will not get our 350-bed hospital, because we will not need it. We need a 350-bed hospital, and it should be where we know the people are going to be. I am not the expert; the health department and the health planners are the experts.

CHAIR: I am going to bring proceedings to a close at this point. But, before I do, Dr Nolan, could I indicate that if as a result of your evidence today you believe you suffer any threats or harassment, you are entitled to—in fact, I would urge you to—contact the Committee, because such behaviour would amount to contempt of the Parliament and of the Committee. If you feel the need to do so, I encourage you to do so. I thank you for your time today and for your submission.

Dr NOLAN: I would like to thank Madam Chair and the Committee for a very fair hearing.

(The witness withdrew)

(Evidence continued in camera)

ALEXANDER JOHN McTAGGART, Pittwater Councillor, 67 Park Avenue, Avalon Beach, and

LINDSAY JOHN GODFREY, Manager, Community and Library Services, Pittwater Council, 882, sworn and examined:

CHAIR: Mr McTaggart, what is your occupation?

Mr McTAGGART: Retired teacher.

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 McTAGGART: I represent Pittwater Council.

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

Mr McTAGGART: I do. Mr Godfrey would also like to make a brief opening statement.

CHAIR: Mr Godfrey, what is your occupation?

Mr GODFREY: Manager, Community Library Services, Pittwater Council.

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 GODFREY: Representing Pittwater Council.

CHAIR: If either of 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 publish the evidence if it decides is in the public interest to do so.

Mr McTAGGART: Thank you for the opportunity to address the Committee. You have before you Pittwater Council's submission into the General-purpose Standing Committee No. 2 Inquiry into the Operations of Mona Vale Hospital. Mr Godfrey, council's Manager, Community and Library Services, and I are ready to answer any questions you may have in regard to Council's submission for any other matter pertaining to your inquiry. Please note that the recommendations on page five of council's submission are those of the elected council. Further note that Mr Godfrey and I will be making a recommendation to council after reviewing oral and written submissions to this inquiry. Council has a desire for a speedy resolution of this most dysfunctional planning process.

Pittwater Council, whether of the 2003 Blewitt Award for Best Council in New South Wales prides itself on its involvement with community and community groups. Indeed, 7,000 residents are involved in one form or another in council-sponsored community activities. On the issue of Mona Vale Hospital the community's response has been truly astounding. The community has spoken and council has responded. As a council, when you involve the community in so much of the decision-making process, corporate governance is questioned. You require a higher level of transparency, accountability, probity and inclusiveness. Our community expects area health to perform to these standards, and sadly they have not.

On Monday 28 February, at this inquiry you heard Ms Kruk, Director-General of NSW Health, stated that the issues being discussed here are relevant to health services across the State. We agree. We agree wholeheartedly. The proposition is that a level five metropolitan general hospital on the Mona Vale site offers considerable dollar cost savings to the Department of Health, as well as certainty, completion and reduced risk management. These considerable savings belong to the people of New South Wales to fund desperately-needed health resources.

Further, this is a matter of public health; not of public hospitals. You heard last Monday that 50 per cent of northern Sydney beaches residents attended private hospitals, yet very little in the submission of area health or its 2002 PFP statement addresses this issue. Public health can only be improved in partnership with private and public investment. he only location available for a co-located public and private hospital with sufficient land that meets the necessary Department of Health access parameters is Mona Vale Hospital.

Council wishes to publicly state its support for the medical and nursing staff of both Mona Vale and Manly hospitals, who provide our community with health care. We will refer to Northern Sydney Central Coast Health as "Northern Sydney Health". We will also refer to Northern Sydney Health's procurement feasibility plan [PFP] and the greater metropolitan clinical task force [GMCT]. I would now like to hand him over to Mr Godfrey, who has been council's senior officer responsible for reviewing health planning. He has a short statement and a presentation to the inquiry. I have copies of the presentation for distribution to members of the Committee.

Mr GODFREY: In my almost 15 years in local government, the health planning process on the northern beaches conducted by Northern Sydney Health, now called Northern Sydney Central Coast Health, is undoubtedly the worst process I have ever been involved in. hat few people are prepared to admit is that this debate about health services on the northern beaches has been dominated by politics, power and influence. It is about a Labor Government who will not consider placing a level five hospital in the electorate of the Opposition leader. It is about a State Government supporting the Independent member for Manly to help keep that seat out of the hands of the Opposition.

It is about the member for Manly giving support to a quasi-Northern Sydney Health-backed community group. It is about pandering to a small group of doctors and nurses at Manly, particularly when considering the issue of where a level five intensive care unit [ICU] should be placed. It is also about an area health service led by Dr Christley that is out of control; an area executive that has always wanted a single acute hospital on the northern beaches and is pursuing that agenda against the wishes of the community.

It is about an area health service executive that a last nurses at Manly to speak out publicly and joined pseudo-community groups to support their claims, whilst at the same time creating a culture of fear and intimidation amongst staff at Mona Vale Hospital should they speak out against the area health service agenda. It is also about a Health Department and a Director-General of Health, Ms Kruk, that have gone missing. As the State's health system lurches from one crisis to another, one code red to another, whilst the doctors resign over waiting lists, where is the Department of Health?

What do we expect that this inquiry? A Director-General looking to respond to the concerns of the community and the best for long-term needs of the northern beaches residents? No, Madam Chair. Rather what we find is a Direct-General on the first day of this inquiry defending the failures and lies of the Northern Sydney Area Health Executive led by Dr Christley. Finally, if this debate was about good health outcomes and the best use of public funds, the Government would have already invested in a site it already owns and that has community support. It would have redeveloped Mona Vale Hospital into a level five metropolitan hospital, and redeveloped Manly Hospital into a modern community hospital. That concludes my opening statement. Councillor McTaggart and I would now like to present a brief overview of what we believe are the critical issues in this debate.

I will refer to the handout that has been circulated to members of the Committee. At Pittwater Council we consider that this debate has been dominated by what we consider to be great lies and myths. The community is not divided; the community has overwhelmingly, time and again, displayed its support for a level five metropolitan hospital at Mona Vale. On the first day of the inquiry we heard that 80 per cent of people live south of Mona Vale. This in fact is not correct, and is based on a planning horizon that, in the words of Dr Christley, "goes out to 2011," which is a likely date that any new hospital would be built.

We have heard that the Department of Infrastructure, Planning and Natural Resources [DIPNR] has just released population projections to 2031. Based on those figures, 25 per cent of people live north of Mona Vale Hospital, 60 per cent to the south and 15 per cent to the west. We have heard claims that a 350-bed public hospital and a 120-bed private hospital, plus ancillary services, can be squeezed onto the Dee Why site. We heard this morning that the best available land, including the

Salvation Army land at Dee Why, is 2.4 hectares. Regarding the myth that Mona Vale is going to be upgraded, throughout the two days of this inquiry time and again we have heard evidence about one single hospital for the northern beaches, or at best a second hospital, which has been called a "community hospital". We are at a loss to understand how you can take a level four metropolitan hospital, that in the words of Dr Nolan, is " doing a good job in terms of intensive care", turn it into a community hospital and regard that as an upgrade.

Would you turn over to the second page, dealing with what the community has said. This is a summary. There seems to be a lot of confusion about what the community has said. In 2001 the Northern Sydney Health Commission consultants conducted a number of surveys. One of those was a household survey to all 85,000 households, of which 56 per cent of respondents favoured option B—a single northern beaches hospital at Mona Vale. In 2002 Northern Sydney Health conducted another household survey of 85,000 residents.

Earlier today we heard members from Manly who were involved in that community process indicate that they thought that process was a fair and open process; that the community knew all about the process; that "everyone" I think was their word, knew about the process. What was the result of that open, fair process? It was that 91 per cent of respondents supported metropolitan north—that is, a new metropolitan hospital on the Mona Vale site and Manly Hospital rebuilt as a new community hospital in the Manly-Warringah area.

Interestingly, on day one of the inquiry we heard from the member for Manly, who seems not to be in touch with his own community. A survey of Manly residents in 2002 clearly showed that Manly residents prefer to have Manly Hospital upgraded, including an emergency department and small specialist services, and not a new Manly Hospital at Frenchs Forest or Brookvale. Throughout the last four years there have been many rallies and petitions. Over 35,000 residents signed petitions supporting Mona Vale Hospital and more than 14,000 attended rallies.

On page three we have attempted to understand the whole issue of site assessment and how much land is needed. Earlier today we heard from representatives of Warringah Council who, if my memory serves me correctly, indicated that with the Salvation Army land the amount of available land at the Dee Why site was approximately 2.4 hectares—although I must admit they seemed a little hazy on it, Madam Chair! At one point it seemed there was 1.0 hectares of Warringah Council land available and another amount of Salvation Army land, and I assume they meant that in total there was 2.4 hectares.

As you can see from page three of our handout, Northern Sydney Health over the last three years has consistently said that approximately four plus hectares is required for a new hospital, including additional land for a community health centre and, on top of that land, for a proposed new co-located private hospital.

Mr McTAGGART: And the replacement car park.

Mr GODFREY: And, as Councillor McTaggart notes, the replacement car park for the car park at the back of the Warringah Civic Centre site that would be lost. The single thing to note on the bottom of page three is that Northern Sydney Health has conducted a number of feasibility studies, none of which have been provided to this inquiry. In fact, I have them with me today, should the inquiry like to look at that information that Northern Sydney Health has not provided. In one of those studies in January 2004 six sites were identified and the approximate areas of those sites are listed on the bottom of page three. At that time they were suggesting that 3.0 hectares was available at the Warringah Civic Centre site, but we heard today from the administrator of Warringah Council that part of the site is no longer available; that the staff had been consigned to continue to work in the building on the Warringah Civic Centre site, and that the heritage building of the Dee Why Library is to be maintained.

CHAIR: Could I just interrupt to say you referred to information about feasibility studies. If you have some material to submit in relation to sites, The Committee would be pleased to receive it.

Mr GODFREY: That information has not been provided, but we have it and would be happy to provide it to the Committee. In terms of intensive care, which seems to have dominated: the

evidence given today, we have heard from a number of people, including Mrs Needham, about the need for critical mass in regard to intensive care and nurses maintaining their skills base. We know from Dr Nolan that both intensive care units—and I emphasise "both"—are too small, but are doing a good job. The evidence given by Professor Goulston earlier today was clearly ambiguous when he was talking about the total number of admissions to ICUs. In addition, on page 36 of the Northern Sydney Health submission provided to this inquiry, appears information about the number of admissions to ICUs. Unfortunately, it only provides information on admissions for 2003 and 2004.

The information before you today includes information for 2002-03 that was included in Dr Boland's submission to this inquiry. You will see that in 2002-03 there were in fact more patients at Mona Vale that were ventilated for greater than 24 hours than at Manly. The issue of patients being ventilated for more than 24 hours is seen to be a significant issue when discussing the need to transfer patients from Mona Vale to the proposed new level five ICU at Manly. Professor Goulston, when he presented earlier today, referred to his two-page proposal to the Minister about ICU. Interestingly, he said—and I quote from his submission to the Minister—"If patients are sick enough to need intensive care they need the most expert team. It is not the address that counts".

Turning to page 5, on day one of the inquiry we heard from Dr Matthews, the Deputy Director-General of NSW Health. He indicated that there were four separate components to looking at the intensive care issue. His first component was that you need to consider bricks and mortar, which effectively can be put anywhere. On page 6 of our presentation today we wish to debunk some of the myths surrounding access, travel times and accessibility. On page 6, unlike Northern Sydney Health, we have provided the full information from the Department of Infrastructure, Planning and Natural Resources [DIPNR], with population projections out to 2031.

Interestingly, Dr Christley gave evidence on the first day of this inquiry that indicated they had taken into account DIPNR's new projections, but only until 2011—they had not adjusted their planning and their figures out to 2031. As we can see, the change between 2011, of which Dr Christley gave evidence they had taken into account, and 2031 sees an additional more than 16,000 people living in the north of the northern beaches in Pittwater and a declining population in Warringah. Looking at the map that council has provided for the inquiry today, council finds it interesting that the New South Wales Government is spending well over $200 million on the redevelopment of Central Coast hospitals on their existing sites—at the existing Gosford site and at the existing Wyong site. As I understand information on the former Central Coast Health web site, the new Gosford redevelopment will see that hospital moved to a level six.

Interestingly, when we look at population projections to 2031—again provided by the State Government via DIPNR—approximately 65 per cent of the Central Coast population will live north of Gosford Hospital. At the same time, we find that if we look at the northern beaches out to 2031 and if we look at the real fact—that 80 per cent of people do not live south and a large number of people live to the west of Mona Vale Hospital and those people who live in the Forest area have similar access either to Mona Vale Hospital or to a proposed new hospital at Dee Why or Brookvale—we will have a situation in 2031 where on the northern beaches approximately 25 per cent of residents will live north of Mona Vale Hospital, 60 per cent will live south of Mona Vale Hospital and 15 per cent will live to the west.

On page 7 we look at the issue of travel times, which has been much debated and mentioned during this inquiry so far. We see the original travel study undertaken by Northern Sydney Health, the so-called Poulson study, which, again, in reviewing the material provided to this inquiry by Northern Sydney Health, they have not provided to you; council has a copy and we would be more than happy to provide it to the inquiry. We see from Professor Poulson when we look across all time periods for the northern beaches that Mona Vale Hospital has a very favourable and not too dissimilar range of average travel times as does the proposed options of Frenchs Forest and Brookvale. It is important to note on this page that the average travel times to Royal North Shore Hospital—we will refer to this in a moment—are far greater than to Mona Vale.

Turning to Page 8, we have heard talk of a demographic centre. The Poulson study, which has not been provided to this inquiry, identifies the demographic centre in 2001 or 2011—not in 2031—at Cromer. We have that marked on the map today. Given that we have not taken into consideration the additional 16,000-odd people who will be in Pittwater out to 2031 and the declining

population in Warringah, it is reasonable to assume that the demographic centre will be further north, which is indicated on the map here. The question then becomes: From the true demographic centre into the future—when we should be planning hospital services for—how far is it from that demographic centre in travel time to get to Mona Vale Hospital or a proposed hospital at Dee Why or Brookvale. I think we can all see from the map that it is about a similar distance and a similar travel time.

The other interesting question that no-one has asked in the two days of the inquiry is: What do 80 per cent of people living south of Mona Vale matter if the Government and North Sydney Health are truly committed to two hospitals on the northern beaches? It seems like the whole basis of their argument revolves around only one single hospital for the northern beaches. That could be the only reason why they start quoting figures such as 80 per cent of people live south of Mona Vale.

On page 9 we have listed a number of documents that Northern Sydney Health have either not provided to this inquiry or not provided easy access to for members of this inquiry and the public. They have failed to provide, as far as we can tell, any information about site assessment—one of the key issues that this inquiry is dealing with. There are a number of documents there that I do not believe Northern Sydney Health has provided to the inquiry. We have access to those documents and they are publicly available on the web site yet I do not believe they have provided them to the members of this inquiry. They have not summarised the outcomes of the community consultations, which we have done earlier in this presentation. They have not given the inquiry or the public any idea of the economic appraisal of the options that are being considered. For some reason they have not provided information to this inquiry about the DIPNR projections to 2031. They have not provided the Poulson travel and accessibility study.

CHAIR: Is that publicly available?

Mr GODFREY: Madam Chair, I believe that is still on the former Northern Sydney Health web site. If not, council has copies of that and would be happy to provide those to the inquiry.

CHAIR: We are checking at the moment.

Mr GODFREY: Today we heard evidence from Warringah Council representatives, particularly the General Manager, Stephen Blackadder, that Northern Sydney Central Coast Health, as they are now known, has provided Warringah Council with a preliminary traffic assessment for the Dee Why site. I am not aware that that has been provided to the inquiry or to the community. In addition, I am not aware that any information has been provided other than the evidence given today by Mrs Needham about waiting times for the medical retrieval service, which has been much mentioned in the inquiry to date.

On page 10 of our submission today we step back and for a moment take stock of where is the most appropriate site for a level five metropolitan hospital on the northern beaches. Clearly council's position and the community's position is that Mona Vale is the perfect site. If we have a look at the aerial photos, we have a site at Mona Vale in government ownership, 8.8 hectares of land. I do not intend to run through that list but the comparisons are stark of the advantages of Mona Vale Hospital over the disadvantages of the stated preferred site of the Government at Dee Why.

Finally, the recommendations of Pittwater Council are contained in our submission to this inquiry. To recount briefly, Pittwater Council recommends that ICU at Mona Vale be retained and upgraded to a level five—in the words of Dr Nolan earlier today, it should not be about mediocrity; it should be about what we can deliver in terms of state-of-the-art services to the northern beaches community—that the Mona Vale site be the site of the new general hospital, including the possibility of a co-located private hospital; and, finally, that immediate planning commence for Mona Vale to be upgraded to a level five metropolitan hospital and a co-located private hospital. Thank you, Madam Chair.

CHAIR: Thank you, Mr McTaggart and Mr Godfrey. We will confirm whether we can access some of the material on the web site otherwise we may consult with you further. In relation to the Mona Vale Hospital site, would there be any impediments on the Government's capacity to sell the site if they so desired?

Mr McTAGGART: Madam Chair, I can answer that question. There are no impediments; they own it in fee simple.

CHAIR: Thank you. In paragraph 5.2.34 of your submission you state, "Overall, the community newsletter provided a biased presentation of information and was a confusing document." I think we are talking about the first newsletter. You continue, "Significant information was left out and the distribution package to Pittwater households was seriously flawed, with many residents not receiving the newsletter". I need to check which one it was; it might have been the second one. Can you outline a little further?

Mr GODFREY: Madam Chair, I think I can assist. I refer you to page 2 of our handout today. There were two major all-household surveys conducted on the northern beaches throughout this process—one in January 2001, which is the one you referred to, Madam Chair. On both occasions Pittwater Council has publicly critiqued those processes and on page 2 of our submission today we say that the results for Mona Vale that have come back from these consultation processes are overwhelmingly supportive, in spite of the fact—as you quite rightly point out, Madam Chair—that the processes have been very poorly conducted. One of my roles in my public life has been to manage consultation processes for local government. These processes have been very poorly managed and a number of council reports have been included as attachments to the submission by council that outline the deficiencies in those processes conducted by Northern Sydney Health and their consultants.

CHAIR: Thank you. Do Government members have any questions?

The Hon. AMANDA FAZIO: Yes, I have a few questions. Mr Godfrey, you said in your opening statement that this is all about the Government trying to protect the member for Manly instead of putting a hospital in the seat of the Opposition leader, John Brogden. In fact—and I would like your comments on this—the sites that are being considered are either in the seat of Wakehurst, which is held by Brad Hazzard, or in the seat of Davidson, which is held by Andrew Humpherson. How can you construe that this is an attempt to prop up the member for Manly? Explain yourself.

Mr GODFREY: Madam Chair, it is easy to construe that when you listen to the member for Manly and the evidence he gave on the first day of the inquiry. It is all about one single acute hospital—and the member for Manly wants that in the southern end, closest to his electorate, not at Mona Vale.

The Hon. AMANDA FAZIO: Mr Godfrey, are you the author of the report to council entitled "Mona Vale Hospital Update", which is dated 27 November 2004?

Mr GODFREY: Through you, Madam Chair, yes, I am.

The Hon. AMANDA FAZIO: Are you familiar with the Pittwater Council code of conduct?

Mr GODFREY: Through you, Madam Chair, yes, I am.

The Hon. AMANDA FAZIO: In section 4.1 the code of conduct states, "A councillor, member of staff or delegate must take all reasonable steps to ensure that the information upon which decisions or actions are based is factually correct and that all relevant information has been obtained." It also says that you must not take opinions into consideration. In this document you present that in the past four years when Northern Sydney Health has consulted the community there has always been strong support for Mona Vale being the site of the metropolitan general hospital—that is on page 5 of the report you prepared. How do you then explain the fact that professionally conducted market research telephone polls have consistently found that only residents of Pittwater favour that option and that Warringah and Manly LGA residents favour other alternative locations for the major metropolitan hospital? On what do you base your assertions in that report?

Mr GODFREY: Those reports that you referred to go into quite some detail about the flaws in a number of processes conducted by Northern Sydney Health and their consultants. The two telephone surveys, one of which you referred to, both had flaws in composition. Throughout my local government career I have had the opportunity to work with a number of consulting firms, in particular,

the Hunter Valley research firm when I worked at Parramatta council and also at Pittwater council. I have some experience in the construction and implementation of telephone surveys. Those surveys conducted by Northern Sydney Health consultants were flawed in the way that they were implemented, in the way that questions were formed, and in the available information that was given to respondents for them to make an informed decision.

The Hon. AMANDA FAZIO: So what was the basis of the information that you used to back up your assertions in your report to council?

Mr GODFREY: The information was an analysis of the process conducted by Northern Sydney Health and their consultants. In regard to the first major process of consultation conducted by Northern Sydney Health, which was conducted by consultants GHD Pty Ltd, both Councillor McTaggart and I were involved with the working group put together by Northern Sydney Health and their consultants. Through that process we gained extensive information about the failings of the way that the telephone survey was constructed and the way that it was implemented.

The Hon. AMANDA FAZIO: You have told us that, but you still have not told me what was your information base for asserting that there has always been strong support for Mona Vale as the site of a metropolitan general hospital? You must have had some basis for making that assertion. I am not talking about a critique of other people's research. What was your research?

Mr GODFREY: Other people did the research. Council and I were in a position of critiquing that research and determining that the way that it was conducted and the way that it was implemented were clearly biased. The way they constructed the questions, for example—

The Hon. AMANDA FAZIO: No, I do not want an example. I want to know whether you—

Mr GODFREY: Madam Chair, may I be allowed to finish?

CHAIR: Order! The witness—

The Hon. AMANDA FAZIO: He is just evading the question. I want to know on what he has based his information.

CHAIR: The witness is entitled to answer the question.

The Hon. AMANDA FAZIO: He is not answering the question. He is answering a question that I did not ask.

CHAIR: He is entitled to give an example. You may ask a supplementary question.

The Hon. AMANDA FAZIO: I have asked him the same question three times. He still seems to be incapable of answering it.

CHAIR: The witness is entitled to answer the question. I rule that the witness will answer the question and that the Hon. Amanda Fazio will not interrupt him.

The Hon. AMANDA FAZIO: Fine, as long as he answers the question that I asked.

Mr GODFREY: To give one example, in one of the surveys—

The Hon. AMANDA FAZIO: No wonder he cannot come up with any research. He does not have any listening skills.

CHAIR: Order! The Hon. Amanda Fazio will not interrupt.

Mr GODFREY: If I can be allowed to finish, I refer to one of the telephone surveys conducted by Northern Sydney Health. Now that the member referred to a biased approach I can look at all the processes conducted by Northern Sydney Health. In the resident telephone surveys the way that the questions were phrased and the way that the information was given were clearly biased.

The Hon. AMANDA FAZIO: Madam Chair, I did not ask him—

Mr GODFREY: That is the answer to the member's question, whether or not she likes it. That is the reality.

The Hon. AMANDA FAZIO: No.

Mr GODFREY: The way the information was presented and the way that it was presented, it was clearly biased.

The Hon. AMANDA FAZIO: You are refusing to answer my question.

CHAIR: The Hon. Amanda Fazio can ask a supplementary question.

The Hon. AMANDA FAZIO: I have asked this person the same question four times.

CHAIR: Mr Godfrey is entitled to answer the question as he wishes. The Hon. Amanda Fazio may ask a subsequent question, but she will not interrupt.

The Hon. AMANDA FAZIO: No. I have not—

CHAIR: The Hon. Amanda Fazio will not interrupt.

The Hon. AMANDA FAZIO: I do not want to hear this because I did not ask that question. I want to know what information or what research he had.

CHAIR: No, Mr Godfrey may finish answering the question.

The Hon. AMANDA FAZIO: I do not want to know what he thinks were the flaws in the surveys conducted by Northern Sydney Health; I want to know what sort of survey he did to come up with the information that allowed him to make the assertion to council that he did in that report. It seems to me that he has no information.

Mr GODFREY: Through you, Madam Chair, I am happy to answer that question.

CHAIR: Thank you.

Mr GODFREY: There was no need for me to conduct a survey. That is not the issue at point The issue at point was determining whether there was a bias in the way that Northern Sydney Health and their consultants conducted their research. To allow council to do that it was necessary to review the way that they conducted those surveys and the way that they implemented them. That is what we did which allowed council and me to come up with the finding that it had been biased.

The Hon. AMANDA FAZIO: That was not the finding that you reported to council.

CHAIR: Dr Moyes, do you have any questions?

The Hon. AMANDA FAZIO: I would like to ask the witness some more questions.

CHAIR: You can ask him those questions shortly. We will give every body a fair go, which is what we have done throughout this process.

The Hon. AMANDA FAZIO: It would be interesting to see whether I get an answer to my question.

Reverend the Hon. Dr GORDON MOYES: You state in your report:

> Many of the decisions and actions made by Northern Sydney Health have resulted in a complete lack of trust by the community in the belief that the Mona Vale Hospital will be significantly downgraded and eventually closed.

Has this been a growing awareness? In other words, have you been seeing more evidence of that over a period?

Mr GODFREY: We have heard throughout this inquiry that this process has been going for many years—either from 1996 or from 1999, depending on when you want the starting point. Yes, it is. Over that time, throughout the processes that Northern Sydney Health conducted, both council and the community have become increasingly concerned and distrustful of the processes that have been used. We have had examples of residents not receiving mail-out packages and of distortions of results. Countless numbers have been documented in council's submission to the inquiry that Northern Sydney Health and their consultants have conducted very poor processes. From that council and the community have lost confidence. In addition, there is this myth about whether we are talking in this debate about two hospitals on the northern beaches or one single acute hospital.

The Northern Sydney Central Coast Health submission provided to this inquiry is full of contradictions. On the one hand they talk about two hospitals and a redevelopment of Manly Hospital and on the next page they talk about a new hospital for the northern beaches. They talk about two hospitals—a new level five metropolitan hospital and a community hospital—yet the Minister announced an upgrade for Mona Vale. In anyone's language how a level four metropolitan hospital can be upgraded to a community hospital is beyond our understanding.

Reverend the Hon. Dr GORDON MOYES: I follow that up with a question about the relative sizes and responses in patient admissions to Ryde hospital and Hornsby hospital. How do they compare in admission sizes and also in funding to, say, Mona Vale?

Mr GODFREY: In council's submission we look at the issue of funding and we look at it in comparison to admissions. The information that is gleaned from annual reports from the former Northern Sydney Health clearly raised some serious concerns about the pro rata funding for Manly and Mona Vale hospitals compared to Ryde and Hornsby, based on the number of admissions to hospitals in the former Northern Sydney Health region.

Reverend the Hon. Dr GORDON MOYES: Could you state that more clearly?

Mr GODFREY: When looking at this council realised that unfortunately the amount of financial information provided by Northern Sydney Health has been minimal. Certainly prior to this inquiry they provided some information within their submission. Therefore council has not been in a position to conduct a detailed analysis of that. But we were able to look at a simple analysis which council and I believe is fairly telling, which is that on a pro rata basis when you look at the funding compared to admissions for Manly and Mona Vale it is less than compared to Ryde and Hornsby.

Reverend the Hon. Dr GORDON MOYES: Could you do a comparison with, say, Wyong?

Mr GODFREY: No, we have not looked at that data in terms of admissions and funding for Wyong. We thought that the most compelling issue in regard to Central Coast Health was why is it acceptable for the Government to redevelop on existing hospital sites in the Central Coast area and to pour a large amount of government funding into redeveloping Gosford hospital, which is in a very similar situation to the northern beaches. When we look at these two maps we see that we are talking about not totally dissimilar geographic regions—long peninsulas, a major hospital in terms of the Central Coast being located in the south and with the bulk of the population in the north. To some extent the reverse is true on the northern beaches. Yet for some reason Northern Sydney Health and Central Coast Health are unwilling to consider Mona Vale as an option for a level five metropolitan hospital. Yet the same Northern Sydney Central Coast Health is pouring lots of taxpayers' dollars into upgrading Gosford hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am confused about all these community consultations. What has the community supported? Were those surveys up and down the northern beaches area conducted evenly, or were they concentrated primarily in the Pittwater area? What surveys were conducted? Could you comment on any bias in those surveys?

Mr GODFREY: On page 2 of the handout that we provided to the inquiry today we attempted to try to summarise this to make it easy. There have been two all-household surveys. There

are approximately 85,000 households in the northern beaches region. Northern Sydney Health and their consultants on two separate occasions effectively sought to get a response from those 85,000 households about a series of options. We heard earlier today from community representatives from the Manly end that they felt that the process conducted by Manidis Roberts in 2002 was a fair process and one that involved everyone on the northern beaches knowing what was going on.

From that it is reasonable to assume that if people were passionate or interested in the debate they would have responded. If we look at that response we see that almost 2,500 people responded to three options that were put to the community—metropolitan north, metropolitan south and one hospital. It is true that the majority of those 2,400 odd responses were from Pittwater residents. I do not consider that a bias. All residents on the northern beaches were given the opportunity to respond. We heard from Manly representatives who said they were out on the streets at shopping centres providing information and talking about the issue to residents up and down the northern beaches.

So the community was aware of the process that was going on. In fact, when you see how much coverage this issue had in the *Manly Daily* you would have had to have been hiding somewhere on the northern beaches not to have been aware of the debate that has gone on over the last four to five years. On that basis it would be seen to be reasonable that the people on the northern beaches, including Pittwater residents and those living in the north of Warringah, are vitally concerned about this issue and can see the clear merits of a level five metropolitan hospital being on the Mona Vale site.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If more people at the northern part of the peninsula responded to the survey that would have resulted in bias. It is not just enough to say that the survey was distributed evenly; you would have had to look at whether the responses were distributed evenly and then you would have had to correct for that, would you not?

Mr GODFREY: That is one approach that I disagree with. There was an opportunity for all residents to respond. Given the heat of this debate in the community and given the overwhelming amount of advertising and the editorials in the local paper, which is widely read, in particular the *Manly Daily* and some other local publications, all the people on the northern beaches had an opportunity to respond. Interestingly—I do not have the information with me, but I can supply that to the inquiry—remembering that the combined residents of Pittwater and Warringah make up the majority of northern beaches residents, from memory, the residents in Warringah were about evenly spread. However, I would need to take that question on notice and provide information to the inquiry relating to their preference for metro north, metro south, or one hospital—the three options provided in that 2002 household survey.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the survey conducted by Northern Sydney Health was the bigger survey but you still got a fairly good result. Was that survey evenly distributed?

Mr GODFREY: Again I can provide that information to the inquiry. My memory is that the majority of responses were from the Pittwater local government area. So it is a similar situation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So respondents up north are more enthusiastic?

Mr McTAGGART: They have more to lose.

The Hon. AMANDA FAZIO: They were whipped up into more of a frenzy.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We heard evidence today from people who supported the Dee Why site or the single hospital option. Do you have any response to that?

Mr McTAGGART: Do mean the clinicians or the three community representatives?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We had both. You can respond to anything that they said. What would be your response?

Mr McTAGGART: From my understanding, none of the clinicians prefer a specific site. They all want to see an increase in clinical services to better enhance health services. Nobody has made out a case for why it should be at one end or the other. At the moment there are some infrastructure resources at Manly Hospital. Clearly, Mona Vale clinicians and the northern beaches community are saying, "Why would you pour money into a hospital that you are going to pull down?"

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is your position that the demographics will say Mona Vale in the longer term, or that the difference in the demographics is sufficiently small that Mona Vale should be the primary hospital? Which is the position, or is it both?

Mr GODFREY: We have provided quite a bit of information to the inquiry today. Clearly, council's position is that the demographic issue is not the dominant issue in this. If we look at the map, if we look at the DIPNR population projections to 2031, which Northern Sydney Central Coast Health has ignored, then we have a demographic centre moving north from Cromer, and Cromer was determined by the Polson study on behalf of Northern Sydney Health. Clearly, that is going to move north to 2031. We look at a demographic centre, we have heard evidence before this inquiry in the past two days of hearings about a so-called golden triangle of the demographics on the Northern beaches—Frenchs Forest, Dee Why and Brookvale. That is not the demographic centre. According to the Polson study the demographic centre was in Cromer. But that was flawed if we are talking about planning for hospitals for the next 20 to 50 years.

If we are really talking about planning for hospitals not for 2011 when any new hospital might only just be built and opened, but if we are really talking about the needs of the Northern beaches community into the future for the next 20 or 50 years then we have a demographic centre that is definitely moving north based on the State Government's own department projections. If we then look at where that demographic centre is you can see that the travel time distance between that new demographic centre as it moves north from Cromer to Mona Vale hospital or a hospital at Dee Why or Brookvale is about the same. Clearly, demographics are not an issue. Travel time is also not an issue. If we look at the Polson study and we look at average travel times across the Northern beaches we can see that average travel times to Mona Vale are comparable. They certainly are a little bit higher, but they are not significantly higher, than the average travel times to a proposed Brookvale site or a proposed Frenchs Forest site.

Mr McTAGGART: You also heard today that 80 per cent of acute admissions are elective—quite a significant number.

The Hon. CHRISTINE ROBERTSON: Can either of you tell me, or are you aware, whether the new DIPNR figures assume that a housing development of 4,900 housing lots will be released and developed at Ingleside?

Mr McTAGGART: Yes, let me just clarify that. There are two parts to this.

Mr GODFREY: Maybe I can assist. The urban development program [UDP] that the State Government maintains across greater metropolitan Sydney has a number of development sites listed. The Ingleside site has been listed on that for some time. The Government approved the release of the Warriewood part of the Warriewood-Ingleside land release sometime ago, and council is working with the State Government to develop Warriewood as we speak. Ingleside, because of potential infrastructure constraints, has not been released at this stage. However, it does sit on the UDP program.

The Hon. CHRISTINE ROBERTSON: And those figures are included in it, are they?

Mr GODFREY: In terms of the DIPNR projections, our understanding is that the Ingleside release would be included in the DIPNR projections.

Mr McTAGGART: And it is reasonable to note that the urban development plan, DIPNR says that on their figures on the urban development plan there is a significant amount of land in Ingleside, south Ingleside, up through Terry Hills and Duffys Forest—it is on the map—that is not on the urban development plan because, at the moment any way, there are not sufficient funds to provide

the infrastructure necessary and whatever else. But some time between now and 2031 you cannot have banks of land, and my understanding from our Director of Planning is that there are roughly 5,000 lots up there. You cannot have a bank of land up there that is three kilometres from the beach and 20 kilometres from Sydney Harbour sit there forever. It is only a matter of time before the infrastructure is found to include that into the urban development plan. Once it is in the urban development plan then DIPNR will, of course, include it in their projected figures.

The Hon. CHRISTINE ROBERTSON: Has there been any community consultation on Ingleside?

Mr GODFREY: The original release was for Warriewood-Ingleside, and there were extensive community consultations and studies done many years ago on the combined Warriewood-Ingleside. The State Government, approximately six years ago, decided only to commence at this stage with the Warriewood land release. But at the time all the studies and community consultation was for the combined Warriewood-Ingleside land release.

The Hon. CHRISTINE ROBERTSON: And the community views it well, do they?

Mr McTAGGART: Can you repeat that?

The Hon. CHRISTINE ROBERTSON: The opening up of Ingleside, the committee looks forward to this happening for them?

Mr GODFREY: I think it is fair to say that across Sydney communities have concerns about land releases and about the State Government's policies on urban consolidation, particularly where the State Government continues to fail to provide adequate infrastructure to communities, but it expects them to take more and more housing without providing adequate services.

The Hon. AMANDA FAZIO: But if those 5,000 housing lots in Ingleside are not developed, is it not true that there would be a negligible population growth in the Pittwater Council area over the next 25 years?

Mr McTAGGART: I can answer that.

CHAIR: We are not talking five years.

The Hon. CHRISTINE ROBERTSON: No, 25 she said.

The Hon. AMANDA FAZIO: I said 25, which is more than what we are talking about.

Mr McTAGGART: Ingleside is divided into two areas, Ingleside south and Ingleside north. Ingleside south, which we commonly call Wilga Wilga, council has given the community landowners an undertaking that as soon as we have cleared the books, for want of a better word, on Warriewood with regard to our planning department that we will then be able to set our resources aside for the development of Ingleside, south Ingleside.

The Hon. AMANDA FAZIO: In relation to the submission that council put in, I have read both the Pittwater Council submission and the Save Mona Vale Hospital submission. The two submissions are almost identical down to having the same typographical errors in them. Did the council prepare, or help prepare, the Save Mona Vale Hospital submission?

Mr GODFREY: I am probably best to answer that. One of my roles for council in the last 4½ years has been to provide administrative support to the Save Mona Vale Hospital Committee. I also provide support to a range of other community organisations. The hospital debate is probably the key community and social issue within Pittwater Council area, which is one of the reasons that council has asked me to provide that support. Over that time there is no secret that council and the Save Mona Vale Hospital Committee have worked closely in reviewing and assessing the various information provided by North Sydney Central Coast Health. So I dispute that the submissions are quite similar. In fact they are quite different. There are many different elements in those two submissions. I am familiar with both, and I have provided—

The Hon. AMANDA FAZIO: Did you write them both?

Mr GODFREY: No, I did not and I resent the implication.

The Hon. AMANDA FAZIO: Is it true that the Save Mona Vale Hospital web site is registered to Pittwater Council?

Mr GODFREY: Yes, it is. It is part of the administrative assistance that we provide to that community group.

The Hon. AMANDA FAZIO: It is my understanding that the registered owner of the domain is responsible for the content of the web pages, so council has been happy to take responsibility for the content of that web site?

Mr GODFREY: We provide assistance to the Save Mona Vale Hospital Committee in providing information to the committee. On that basis, yes, council is.

The Hon. AMANDA FAZIO: Has council also provided funding to the Save Mona Vale Hospital Committee?

Mr GODFREY: The Save Mona Vale Hospital Committee in my experience of working with local community groups is amazing in terms of their capacity and the support that they receive from their community. The council does provide support. The majority of that support, the overwhelming majority of that support is in terms of my time, in terms of providing administrative support to that committee. Council has, over the years, provided small amounts of funding to assist them with photocopying and that would be the principal amount of support that we provide.

The Hon. AMANDA FAZIO: And what percentage of your time would be spent on the Save Mona Vale Hospital campaign?

Mr GODFREY: Council requires me to provide it with advice, professional advice, on health planning matters as part of my portfolio that I look after for council. So in terms of my involvement in that—the Save Mona Vale Hospital Committee has a range of expertise—my council function in gathering information on health-related services that I can report back to council I find it effective to spend quite a bit of time with the Save Mona Vale Hospital Committee. I would probably spend, on average, somewhere in the vicinity of five hours a week directly providing administrative support or professional commentary to the Save Mona Vale Hospital Committee and then in addition to that spend many more hours on behalf of council researching health issues in the local government area.

The Hon. CHRISTINE ROBERTSON: Can I please ask what your health planning credentials are?

Mr GODFREY: I do not have any formal health planning qualifications, but as I just indicated I have been spending probably around 10 to 20 hours a week for the last 4½ years on behalf of council and as part of that working with the Save Mona Vale Hospital Committee reviewing what we estimate to be in excess of 10,000 pages of material. I consider myself to have done almost an undergraduate degree in health planning on the Northern beaches and in Pittwater in that time.

The Hon. CHRISTINE ROBERTSON: This role delineation document that you submitted to us, could you tell me who put this together?

Mr GODFREY: If I could just get some assistance in terms of what the document is that the member is referring to?

The Hon. CHRISTINE ROBERTSON: Mona Vale, the perfect hospital site is the name of the pamphlet and within it, it was given to council, there is a role delineation document of Manly, Mona Vale and North Sydney.

CHAIR: What page is the submission?

The Hon. CHRISTINE ROBERTSON: Page 15, attachment 1, section 1.

Mr GODFREY: I think the document the member is referring to is Mona Vale, the perfect hospital site which is a four-page document that the Save Mona Vale Hospital Committee produced. On the last page of that, I think that is what the member is referring to, is suggested a mix of services for a level five hospital at Mona Vale Hospital and a second hospital on the Northern beaches. My understanding, having provided some support to the Save Mona Vale Hospital Committee, is that they actually extracted that information from the very weighty PFP submission made by Northern Sydney Health to the State Government.

The Hon. MELINDA PAVEY: In your opening statement you made a pretty powerful allegation that the Northern Area Health Service are acting on the Government's political wishes to undermine the Leader of the Opposition and support the Independent member for Manly and in the process confuse, deny the community and procrastinate on the decision of the location of a hospital. Can you give us any evidence to back up your allegation through conversations you have had with peers and other councillors, or conversations you have had with the area health service officials?

Mr GODFREY: That assertion comes from having been involved in this debate for the past 4½ to 5 years, having been the principal officer within council looking at health planning issues, having worked closely with the community, in particular Save Mona Vale Hospital Committee, having reviewed, as I said, many, many thousands of pages—

The Hon. AMANDA FAZIO: It is your opinion only, is it?

Mr GODFREY: —of material. It is the considered opinion of council and myself that Northern Sydney Health is clearly driving a Government agenda. There can be no other conclusion that you can draw based on the weight of evidence for Mona Vale Hospital. We have heard evidence today that the Dee Why site, the so-called preferred site, has got 2.4 hectares yet Northern Sydney Health in their own planning documents talk about a minimum area needed just alone for a public hospital of 4 hectares, for a community health centre of 1 to 1.5 hectares, let alone a private hospital. What other conclusion can you draw when Northern Sydney Health is pushing ahead with the desire for one large acute hospital on the Northern beaches on a totally inappropriate site that they are doing anything else other than supporting this Government's agenda?

The Hon. MELINDA PAVEY: In your estimation and knowing the Northern beaches as well as you obviously do, what sort of extra cost would be incurred by the Government in buying a site instead of just going along with the development on the Mona Vale site?

Mr McTAGGART: I believe I can answer that. You heard Mr Persson, the administrator, this morning not wish to give—or give us a commercial in confidence. My understanding is that on 6 April 2003 the *Manly Daily*, after the announcement of the preferred site at Dee Why, reported a figure of between $35 million and $50 million. In a conversation with Mr Blackadder, the General Manager, at a council to council function, he reported to me that they were endeavouring to look for in excess of $40 million. They were conversations. Given that the Dee Why site subsequently has been reduced in size and pieces have been taken out, we have to say at least $20 million and that is a layman's figure only. Bearing in mind that there has been no cost attached to the Salvation Army component, which is 1.1 hectares and to our knowledge there has been no discussion with the Salvation Army.

Clearly, the community owns Mona Vale hospital. The community also owns the Seaforth TAFE site, and were we to flip-flop the proposal the Seaforth TAFE site would make a fairly good site for the complementary or community hospital at the southern end. There are significant cost savings on the purchase of the land alone. Mona Vale is a flat site. You can move in and go ahead straightaway. At Dee Why, once you have done the necessary demolitions and whatever else and put in the necessary road reconfigurations to get access to the site, you have to cut into rock. It is a considerable expense and there is really no need. We own Mona Vale and it fits the criteria for access. Nobody can really understand why the Dee Why agenda is being pushed.

You also heard Mr Persson say that when he spoke to area health in early 2003, I think it was, it was going nowhere. The other sites had fallen over. The Frenchs Forest site had fallen over, the Brookvale bus depot site had fallen over. Nobody has stopped them from redeveloping the hospital on these sites. The sites have not come up to scratch. That is the tragedy of this whole debate. Three years ago, when they realised their sites did not come up to scratch and there was no land available, they could have moved to Mona Vale. We would have had this thing half built by now and saved an awful lot of community aggravation, anxiety, and funds. It has not happened, and we are still debating a flawed site and wasting valuable community funds.

The Hon. AMANDA FAZIO: Mr McTaggart, as an elected representative of council you would be aware that, as mayor and then as councillor, Patricia Giles over the years has accused Dr Christley, of North Sydney Central Coast Area Health Service, of all sorts of things, including attempting to sell the Mona Vale hospital site and, to quote from Alan Jones' show, putting the money in his pocket. Is this the same Patricia Giles who ran on a Christian Democratic Party ticket at the last Legislative Council election?

Mr McTAGGART: Patricia Giles, the former mayor of Pittwater, ran on a Christian Democratic ticket in the federal election last October.

CHAIR: What is your estimation of the value of the Mona Vale hospital site, based on land sales?

Mr McTAGGART: I am not a valuer, I would not have an idea. It is waterfront land and it has significant value.

CHAIR: Thank you to both of you and to Pittwater Council for its submission. I thank everybody present for being here for the day. Before we adjourn, I advise that prior to this session we heard evidence in camera from three nurses. With the nurses' agreement, the Committee has resolved to publish their evidence. It will be on the Committee's web site with the rest of the transcript tomorrow.

Mr McTAGGART: Thank you, Madam Chair. Thank you Committee members for a fair hearing.

(The witnesses withdrew.)

(The Committee adjourned at 4.50 p.m.)