**LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY**

# STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

**(Reference: Inquiry into Calvary Public Hospital Options)**

**Members:**

**MR S DOSZPOT (The Chair)**
**MS A BRESNAN (The Deputy Chair)**
**MS M PORTER**

**TRANSCRIPT OF EVIDENCE**

**CANBERRA**

**THURSDAY, 23 DECEMBER 2010**

**Secretary to the committee:**
**Ms G Concannon (Ph: 6205 0129)**

**By authority of the Legislative Assembly for the Australian Capital Territory**

## WITNESSES

## Privilege statement

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*Amended 21 January 2009*

**The committee met at 2 pm.**

**DUNLOP, DR IAIN**, President, Australian Medical Association (ACT) Ltd

**THE CHAIR**: Good afternoon everyone. I welcome Dr Dunlop to this third public hearing of the Standing Committee on Health, Community and Social Services inquiring into the Calvary Public Hospital options. Have you had an opportunity to read the privilege card that has been provided to you and are you comfortable with the contents of it?

**Dr Dunlop**: Yes, understood, thank you.

**THE CHAIR**: I would like to invite you to make an opening statement if you would like to do so.

**Dr Dunlop**: Thank you for making the time available at this time. The AMA has put a written submission into this inquiry, which you received, I think, last week, as to our view on the development of the Calvary hospital, development really of a hospital on the north side, preferably on the site of the current Calvary complex. We are as interested in the staff and human resources as we are in the material infrastructure of how one would build such a site.

It is really on that point that we would say that, although arguably it is financially cheaper to build a new, stand-alone building, we should develop the resources that we have rather than make an entirely new hospital complex in the short to intermediate term on a site that is different to the current Bruce site of the Calvary complex.

**THE CHAIR**: Thank you very much. Dr Dunlop, you are aware, obviously, of the four options that the government has put forward, and we are here to examine all of the four options. I understand your opening statement and your broad directions. Do you consider that a third hospital as such, as the government's fourth option is at the moment, is viable from your association's point of view?

**Dr Dunlop**: No. A third, or, as you say, a fourth hospital on a site different from the Bruce campus would not be viable or useful in the foreseeable future.

**THE CHAIR**: Is that because of the current Canberra population or—

**Dr Dunlop**: That is because of our medical resources and our projection of medical resources, and I include nursing and ancillary staff, in being able to make a new hospital complex function. The ACTAMA believes there is too much dilution of the staff available and we recognise the difficulty in getting staff to come to the territory.

**MS BRESNAN**: When you say "third hospital", do you mean a third, stand-alone acute hospital?

**Dr Dunlop**: A third stand-alone acute hospital that would have the range of specialist services that the Calvary hospital currently has, some of which are mirrored in the Woden campus.

**MS BRESNAN**: So when you say that the ACT would not be able to support a third hospital, that would be a third acute hospital rather than something that would be specialising in, say, subacute services or those types of service provision?

**Dr Dunlop**: A third general broadly functioning hospital, but we have not been asked whether it would be reasonable to build a stand-alone unit for, say, palliative care or oncology medicine or paediatric or women's health. Those sorts of sub-specialty hospitals can be considered in their own right, but the project that was put in front of us for consideration was for a generally functioning hospital.

**MS BRESNAN**: You said in your opening statement that it would be arguably cheaper to establish a new stand-alone site. One of the issues that Dr Peter Collignon raised yesterday around the Calvary site was that if it were to stay as the second primary hospital in the ACT there would need to be some significant work done there because of the age of some of the suites and because of infection control and other issues.

You have stated a preference for it to be on the current site. What is your view on what would need to be done there to bring it up to, I guess, a modern standard? That has been an issue raised by other doctors. Would there need to be significant work done there to actually maintain it and bring it up to a standard and expand it?

**Dr Dunlop**: I am not a builder or a developer; nor am I an infectious diseases physician. However, I understand that it is cheaper to build a new facility than to renovate an old one. In terms of the renovations that would be required at Calvary we would need to change the theatre suites so that the actual flow of patients worked better. We would need to introduce an element where day surgery is easier so that it does not occur under the same rules as must be observed for general anaesthesia cases. I think the ICU needs to be improved, and the communications system within the hospital would have to be brought up to standard.

Those sorts of things are just part of the evolution of hospitals. For instance, we would want to have the high resolution VDU displays for pathology and radiology readily available in the wards and have the cabling that might go with that. You need to have safe and ready access for patients and visitors who might visit, so the integration of the car parking facilities with the main building would have to be prepared.

All of these things can be built into the first sketch of a new hospital but they are more difficult to integrate into an existing one.

**MS BRESNAN**: So if we were to continue with Calvary there probably would need to be some significant work done there?

**Dr Dunlop**: Significant work, yes.

**MS BRESNAN**: So the preference for Calvary to remain as the site, is that based primarily in terms of the AMA's views on the staff issues? Is that the main reason? I am trying to get an understanding of what would be the main reason for you wanting Calvary to be the main site?

**Dr Dunlop**: The primary reason, the primary driver, is so that we can build on something that already exists and is good rather than try to duplicate or triplicate a third set of staffing, so we can use the human resources that we have rather than try to attract and build a whole new set of such resources.

**MS PORTER**: Good afternoon, Dr Dunlop. In your submission you talk about the need for clinical and administrative pathways that need to be clarified and streamlined. You were talking about Canberra Hospital in particular and you were talking about the relationship between Calvary and Canberra hospitals.

When the Australian Nursing Federation put a submission to us—and I am sure you have read it—they talked about some difficulties that they are having with the different standard operating procedures between the two hospitals, between Calvary hospital and the Canberra Hospital, in relation particularly to critical incident reporting and occupational health and safety issues; the fact that there appeared to be two different standard operating procedures.

They were concerned about these because they had tried to solve them at Calvary and up until just recently—we heard from Little Company of Mary yesterday—it appeared that those had been outstanding for quite a period of time and had not been attended to because of the two different ways of operating. This is of concern to both patients and staff because some of it involved infection control. Obviously, occupational health and safety for everyone is of concern.

Is that one of the issues that you see as needing to be addressed? If we are going to continue with the Calvary hospital and the Canberra Hospital, how do you see us getting that streamlining and cooperation and clarification attended to? What is your experience of that, if you have any at all?

**Dr Dunlop**: The practical difficulty is that Calvary, as you recognise, functions under a completely independent administrative structure, but that is not to say that the two administrations should not actually join to standardise procedures or forms or medication charts or critical alerts. In all the hospitals in New South Wales, for instance, there is a standardisation of medication and incident forms that occurs. So I think that the direction to which one would go to solve that problem would simply be to have the two administrations sit down and agree on a commonality of process, which must of course be driven by best practice. There may be arguments on the fringes of that but there certainly are not arguments on what best practice is.

It is particularly acute and present for the Australian Nursing Federation because they are the ones who implement it. In the broader sense, we do need, and the AMA would support, a cross-credentialling of VMOs and staff specialists across the two campuses. Again, this has to be agreed cooperatively between the two administrations, recognising that they are sovereign and separate. But to have those agreements would actually improve the care of the patient population that we treat, and that is really why we are here. The parties to which that concern would best be addressed would be the administrations of the two hospitals, recognising that they are separate.

**MS PORTER**: You mentioned also records and communication within the hospital. Across hospitals it also appears that there is some difficulty in transferring records or

actually transferring patients and what is involved in that should a patient need to come from the Canberra Hospital across to Calvary or vice versa. What is your experience of that?

**Dr Dunlop**: My understanding is that that is often very difficult, and of course hospital notes rarely go from one hospital to another. But, with the development of electronic medical records, those things should be much more available. It is foolish to have the same x-rays done at two different hospitals because you cannot get access to the one that was done in the other hospital. Safety issues would dictate that there should be a commonality of the records and the processes.

But again that is really a major part of redeveloping the hospital, and not just a third hospital on the north but the way our hospital system functions in what is a relatively small territory. To have an integration of the north and the south and to have a commonality of staff and a commonality of the treatment processes will put us, I believe, if you do it properly, within 10 years in a very efficient and high class situation and we will no longer have very expensive DRGs compared with the rest of the country, and it will be an attractive place to come to work.

**MR HANSON**: Good afternoon, Dr Dunlop. In your submission you cite the fact that the public hospital system here in the ACT has got poor morale amongst its staff and that that is affecting recruitment. Can you highlight how bad morale is and maybe some of the causes of the bad morale that we have in our public hospital system?

**Dr Dunlop**: My experience of the bad morale relates to the specialist training registrars. I cannot speak broadly as I do not have experience of general staff. But in terms of recruiting specialist registrars to train in their specialty at Canberra Hospital there is a problem of workload and availability of staff. When these junior or intermediate doctors are training in a specialty they have a commitment to learn the specialty and to deliver services. If the balance is critically upset—say, because they cannot take leave or there is too much service work to do—they simply leave.

In other states, particularly in Melbourne and Sydney where training positions are available in some of the medical subspecialties like neurology or endocrinology, we lose people who deliver services for us here but, more importantly, would be willing to come back and build the medical services in this territory.

So the rigidity of rostering, our capacity to deal with training, doctors' need to study and have tutorials as well as deliver services, and the grapevine that exists around the country for attracting people first to study here and then to return as trained doctors are the main issues that I refer to in that point.

**THE CHAIR**: Dr Dunlop, in the second paragraph of your submission you state:

> In order to protect and enhance these assets we assert that planning for public hospital services should take place as a coordinated process linking primary, secondary and tertiary services. In this context the planning for the future of Calvary Hospital cannot ignore an analysis of the general state of health care in the ACT, including the role and performance of the Canberra Hospital.

In this context do you believe that there has been a coordinated process by the ACT

government in looking into this current situation?

**Dr Dunlop**: Yes and no. The point of that paragraph and the point of putting that at the head of the submission was to recognise that one cannot just plan a hospital in isolation. Much of our discussions this afternoon have been about the way that a new hospital would integrate with the existing and highly specialised hospital campus in Woden. So in planning the new hospital, as I said before, it is more than just infrastructure; it is how the elements of human resources would fit together. So I am arguing that some of the terrible unpleasantness that has come out in the last 12 months at the Canberra Hospital is actually a useful springboard to mobilise people to examine these processes and to improve what we build.

**THE CHAIR**: Has your association been consulted in any way on these four options that are before us at the moment?

**Dr Dunlop**: Insulted or consulted?

**THE CHAIR**: Consulted. I could ask the first part as well, if you like.

**Dr Dunlop**: Only inasmuch as in informal discussions both with the minister and with Mr Hanson we have discussed the options. The formal submission lies here in our submission to this committee.

**THE CHAIR**: Do you feel you should have been consulted?

**Dr Dunlop**: I do not feel any lack of consultation on that particular issue. I think there has been quite useful availability to hear the options and to put our views.

**THE CHAIR**: Thank you.

**MS BRESNAN**: There was an article about some of the issues that were raised by the AMA ACT Advisory Council in *Canberra Doctor* which I thought was interesting. It outlined some of the issues that came up through that process; I am sure you are aware of the issues that were raised. It was interesting that one of the issues raised was the impact on the community of reproductive technologies and associated surgery not being available at Calvary. If Calvary is to continue as the main hospital and is run by LCM, do you think not having the full range of services available there does have an impact on the community given that it is the major hospital for the north side of Canberra?

**Dr Dunlop**: I recognise the point you are making—

**MS BRESNAN**: I just thought it was interesting because it was raised by the advisory council.

**Dr Dunlop**: but it was raised as one of the points in favour of developing the hospital complex on the north side that would be independent of the contractual arrangements that you have with Little Company of Mary and the philosophical way that they deliver health. Where there are specific issues like that particular one, and I think it is very significant, one would have to make those services available in the other

hospitals that we have in the territory. So I would not be arguing that that particular point, passionately held on both sides of the spectrum, should be enough to say, "Look, we shan't develop the Bruce campus; we will develop something quite separate."

Again, I think that is the sort of issue that has to be built into the considerations and to be provided for the community at the south side campus. It is not far to drive.

**MS BRESNAN**: I guess I was just raising that issue in that, as you said, it is not a stand-alone issue; there are a number of issues associated with this whole issue of whether or not we go with another hospital or what happens on the Calvary site. I just thought it was interesting that it was raised by your advisory council and given that that hospital is the main hospital. As you say, it is not far to drive, but I guess Calvary does provide a significant percentage of public health services here in the ACT and there is a reasonable expectation that people will have access to full services wherever they may live in the ACT.

**Dr Dunlop**: That is a historical restriction of the contract that ACT Health has with LCM.

**MR HANSON**: Just as a supplementary on that, I do understand that there are a number of services aside from just those that are specific to the Canberra Hospital that are not delivered at Calvary as well—specialisations, cardiac surgery and so on. That would be the case, wouldn't it?

**Dr Dunlop**: Yes.

**MR HANSON**: You would expect, I suppose, with a tertiary hospital being the Canberra Hospital that there would be a number of services that would be delivered that you just simply would not want to duplicate because of the economies of scale. This is a separate issue and a separate argument but I think you would find that you are not always going to have duplication; you are not going to have mirror hospitals. You would not be advocating that, I assume?

**Dr Dunlop**: True. But, to continue that point, one of the major directions of delivery of acute services or planned acute services is for day surgery. To develop a freestanding day surgical hospital, maybe as part of another hospital but as a functioning unit, will allow greater economies of scale and efficiencies because you will not have to go through the business of being admitted to a formal operating suite. These are operating suites but one can be covered rather than undressed. Many of the processes with day surgery are much simpler and quicker than they are for general surgery. So for the instances of cardiac you need to have your resuscitation things available but many of the cardiac investigations and things could happen on a separate campus if you have an integrated system.

**MS PORTER**: Just to continue exploring this, most of the procedures that are not available at Calvary at the moment, or the investigations that are not available at Calvary at the moment, would be the kind of thing that you would assume would be delivered in a day surgery setting?

**Dr Dunlop**: Many of them would be, yes—

**MS PORTER**: Yes, many of them—not all, obviously.

**Dr Dunlop**: and that is the direction that service delivery in health is going.

**MS PORTER**: Yes. So not having to travel from the north side to the south side for something that could be done relatively easily at another site, rather than going to a major hospital of the size of the Canberra Hospital, would in your mind be an advantage?

**Dr Dunlop**: Yes.

**MS PORTER**: I just want to ask a question about bed capacity. With regard to the Calvary site we were given to understand by Dr Collignon yesterday that that was one of his concerns around the capacity of the Calvary hospital in particular around the number of beds that are available. Of course we need staff to go with the beds, and that was also his concern. He was saying that you need a fully staffed bed; a bed by itself is not a bed.

I just wondered what your experience has been as far as having that capacity there so that people can be admitted rather than having to wait around for a bed to become available. If 100 per cent of the beds are being used, or at least close to 100 per cent, obviously you have no capacity to take any patients that might turn up at the door, through A&E, for instance. What is your experience of those things?

**Dr Dunlop**: The most efficient capacity is 85 per cent because it does give you that flexibility to find beds for those who have been assessed acutely. The other part of that concept is the idea of step-down facilities where people can leave very expensive general hospital wards but still have staff available and still be treated and monitored in less acute facilities.

So again, in considering the whole service that we can deliver, to have step-down facilities that are in between the high dependence of the general medical wards and the total independence of someone living at home, to have fewer staff numbers but still monitoring—these things can provide the relief from the access block because hospitals really are great big sausage machines; you start at one end and you come out the other. With the step-down facility, you can increase the efficiency of the flow and alleviate bed capacity without necessarily increasing the number of acute care beds that you have.

**MS PORTER**: And also one would assume that you could have a step-up facility where people could be waiting within a facility that would allow them to have some assessment done while they are waiting and maybe not have to be admitted to the acute care part of the hospital if that is in the end deemed not necessary, yet may in fact need to stay overnight because of the temporary acuteness of their condition. Would you see that those kinds of facilities would be something that perhaps if we were to have a subacute facility could fulfil?

**Dr Dunlop**: Certainly. The concept of bed numbers is rather rigid and anachronistic

because different sorts of procedures need different sorts of beds—sometimes they are just Jason recliners—and the idea, as I said before, of step-down facilities does relieve the head pressure on the other end. All of those things can be examined in planning how you deliver the services for the territory in the next decade. This hospital thing is only a small part of that but it is crucial because if you get the shape of that right the whole thing will be good.

**MS PORTER**: Thank you.

**MR HANSON**: It seems that the hospital system is not able to cope with current demand. If you look at the My Hospital website and look at elective surgery in emergency departments, we are struggling at the moment. There is increased demand coming. Do you see that we are going to be able to get above the bow wave of demand that is coming or are we going to be swamped by it?

I know that building the hospital is one point we are talking about, but what do we need to do beyond just simply building a hospital? I know that we are focused here on Calvary, but are there other things that we need to be looking at? Are we simply focusing too much on a hospital bed, building, tower block solution or is the solution more about the personnel or about technologies? Are there other things that we should be looking at other than beyond simply the bricks and mortar here?

**Dr Dunlop**: We have covered many of the other things already this afternoon. The one thing we have not touched on is patient and community expectation. Managing demand is partly about managing expectations and where one might go for particular types of services. So in that sense it is a very cooperative thing. I do not believe that we are going to be swamped by a bow wave because our hospital systems, for all of their problems, are still very good at looking after acute problems; it is the long and intermediate term problems that fall through the cracks. So we have to manage community expectations of what actually can be delivered. The crucial forward planning aspect is to actually get doctors and nurses to come to the territory, and that is why it is so poisonous to have these systemic problems which might turn people away.

**THE CHAIR**: Thank you. I think that reaches the end of the time allotted to us, Dr Dunlop, but in closing do you have any other statement or any other points that you wish to make before we conclude?

**Dr Dunlop**: No, thank you.

**THE CHAIR**: We thank you very much for attending at such a late time of the year and we wish you and your family the best for Christmas.

**Dr Dunlop**: Thank you very much for accepting it at this time.

**The committee adjourned at 2.31 pm.**