PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN THE LONG ROOM, PARLIAMENT HOUSE, HOBART ON FRIDAY, 8 SEPTEMBER 2017

ACUTE HEALTH SERVICES IN TASMANIA

Dr BRYAN WALPOLE WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Valentine) - We are taking sworn evidence. Welcome, as I said before. This is the acute health services inquiry being conducted by the Government Administration A Subcommittee of the Legislative Council.

By way of introduction, the procedure we intend to follow today is as follows. First, you will be provided with the opportunity to speak to your submission, if you wish to do that. Following that, the committee will address questions to you. We are seeking information specifically relating to acute health services in Tasmania. You, no doubt, have the terms of reference. It is important we try to address those terms of reference as part of the hearing.

I remind you it is a public hearing. You have already said you have read the information provided for witnesses. If you are at all concerned about the nature or appropriateness of any evidence you want to provide to the committee, you can ask us to hear that in camera. In that case the committee will consider your request and determine whether to receive that information in private or public. Please advise if at any time you wish to make such a request to the committee in that regard.

Brian, over to you to make your opening statements.

Dr WALPOLE - I will talk about my perspective on the Tasmanian health system and how it can improve, then maybe take your questions.

I came to Hobart from Melbourne in 1984 when I was appointed director of the emergency department and served there till about 2005, then part-time till 2010. I have not practised at Royal Hobart since then, but have practised at Hobart Private and been on the staff of University of Tasmania - UTAS. I consider myself fairly contemporaneous with the Tasmanian health system.

When I arrived from Melbourne, I had come from Alfred Hospital - Monash University Baker IDI as really one institution. I perceived in Tasmania that the University of Tasmania had never really been united with the health system as it is in most other states of Australia.

If you look around the world at the really top-quality health institutions, they are all closely associated with a university. In the United States a number of universities actually own their own hospitals. Harvard and Johns Hopkins always come out as top around the world. Look at Columbia and Brooklyn and then go to Britain with Cambridge and Addenbrooke's, Oxford and Nuffield, the university in the hospital. They are really one institution.

There is ample evidence that your best guarantee of quality and safety in health is to have an active and vibrant research sector working alongside. You have researchers, who basically sit in the university; teachers, who overlap between the university and the health institution; the clinicians; and alongside them are the administrators. They are the four arms of health care.

Here in Tasmania you have eight institutions. The Royal Hobart Hospital; Launceston General Hospital; the two hospitals on the north-west coast; Clifford Craig in Launceston; and the Menzies Research Centre here. There are three clinical schools - Hobart Clinical School, Launceston and on the north-west coast - and there are nursing, pharmacy and now parameds, which is quite a big faculty. None of them is integrated into clinical care so no synergy whereby the researchers who do some clinical work, the clinicians who do some research and all of them teach the students, so a continuum. In Tasmania it does not happen. When you work for the Health department, which I did for 30 years, the predominant word is budget. When you go and work with the university, the predominant word is quality. Health in Australia is driven by numbers.

What does our minister go on about? He goes on about waiting times in the emergency department - waiting lists and the throughput in the operating theatres. Which one of those has quality built into it? None of them. I do not blame them. The people who hold the purse want a number. They are outputs; they are not outcomes.

The clinical academic people want outcomes. They want healthy, well patients. Give health institutions and universities autonomy to drive things on quality and safety, then in general the budget ought to look after itself. Doing it properly the first time is often cheaper than not doing it so well.

This is not a simple solution, but I gave you Professor Peter Brooks' paper, which you may or may not have read; and the government through the National Health and Medical Research Council and the McEwan review in 2016. I do not know if you have heard of that. Alistair McEwan, one of the senior executives of NHMRC, was asked to look into the administrative arrangements of the quality in Australian hospitals. His recommendation is to establish six or seven academic medical centres around the country.

CHAIR - This is McEwan review?

Dr WALPOLE - Yes. Have you heard of it?

CHAIR - I think I have.

Dr WALPOLE - It came out last year. He recommended six or seven, and Peter Brooks refers to them in the paper, the same sort of principle. The National Health Service in Britain recognised they were spending masses of money and had no indicators of quality. They recommended Britain set up six big academic medical research centres. They now have 20 and the preliminary review is fairly positive about the economy of scale of administration crossing those three branches and clinicians participating together. The NHS said, 'We are not putting in more money, we expect the universities and research institutions and teaching to unite and produce economies of scale'. McEwan recommended Australia has six or seven of those.

In Melbourne, the University of Melbourne, Walter and Eliza Hall Institute, Melbourne Hospital, the Royal Children's Hospital are tied. You cannot untangle them.

To apply for a job, you go before the panel and the job description is written. You will have the amount of research, teaching and clinical work you are going to do and then any extra bits - administration or some private practice or something. That is set up to match their interests and employ people who are complementary to all the institutions.

We had the near-catastrophe in Hobart where, 10 to 15 years ago, we employed a professor of surgery at UTAS, who was a cardiac surgeon in the United States with a good academic record. I do not know if you remember this. He then went to the hospital and said, 'Look, I am a cardiac surgeon' and they said, 'No vacancy', so he refused the professorship. Would you not have thought, before they appointed a professor, they would get together with the Health department on clinical responsibilities. You tell me one health researcher in Tasmania who has a worldwide reputation -

CHAIR - No, not off the top of my head.

Dr WALPOLE - No, nor have I because there is not one. Why is there not one? If I were to start again in Tasmania, an island of 500 000 people with three or four hospitals, a university in the world top 500 and two research institutes - the Menzies with a world-famous reputation and Clifford Craig and its reputation - would you not put them all together and create a joint board? Have a CEO who ran the lot, an appointments committee with members from all the institutions. We are the ideal size for an academic medical centre in this state.

Ms FORREST - Melbourne has a much bigger population. Is the critical mass here to have that sort of model work effectively? You talked about the cardiac surgeon, but is there enough to actually make it work?

Dr WALPOLE - I am not the expert on that, but it must be better than having eight separate institutions. They can still maintain their own identity. We are not asking them to merge, we are asking them to come under a common aegis so their research, clinical and teaching goals can be aligned. Talk about teaching - and Rob will remember this well - do the clinical staff do enough teaching for the university? The answer is they do not. The reason is mostly because they are not paid for it. They integrate it into day-to-day activity in the hospital where the goal is to get the throughput of patients and teaching is seen as an extra.

When institutions are together, teaching and research are part of your ordinary work because there is bench space. You know, statisticians are available through the university. So here is my revolutionary proposal -

CHAIR - This is addressing terms of reference (2)? Perhaps factors impacting on the capacity of each hospital under the current projected demand in the provision of acute heal services, I presume?

Dr WALPOLE - Sure, yes. The proposal is we create a new Tasmania university medical centre. We abolish Royal Hobart Hospital as a name because the word 'royal' is anachronistic. The word 'Hobart' is divisive and it is more than a hospital. It has a whole lot of community and outpatient arms - a traditional hospital has inpatient beds - they are much wider than that. So you have the Tasmania University Medical Centre, right? It has three campuses - Hobart, Launceston and the north-west. The hospitals are brought under one administration, which the current minister has done to some extent. It has a way to run. It is a pity you established in Launceston

because that was another divisive move. We could argue that endlessly, but the principle was good. I mean Lara Giddings actually proposed that some eight or nine years ago, but it went off the rails for a while. That is all I have to say.

Mr FINCH - Had you previously put this idea forward?

Dr WALPOLE - I have been putting this idea forward for 25 years and nearly always get people saying it is an excellent idea, but it is either too hard, not now, there are too many things on our agenda. I went to Andrew Wilkie's office last week with Peter Stanton - the professor of surgery. We talked to Andrew about how we could get some federal imperative because the NHMRC has said Australia needs six academic medical centres. That is what they are asking for. I said to Andrew, 'How can we be part of that and get a proposal? Parliament is sitting'. We have agreed to try to meet with Peter Rathjen in October, the senior people from the Health department, Peter Stanton and I to see how we could plant this seed locally and federally.

Mr FINCH - Federally-

Dr WALPOLE - I did it when Ron Parker was the head of the Health department, and he said it seems like a good idea, but you see, this will take 10 years to pull off and few people have a 10-year vision in Health these days.

CHAIR - Under that scenario, how do you see the funding working?

Dr WALPOLE - This is the issue. People do not want to put in money unless they have their own accountability. As you will see from Professor Brooks' paper, it is built on good faith in that each has to give up something to get something.

The hospital budget is consumed with putting people through on a daily basis. They do not want to concede time - that is, the clinicians doing research for money.

The university is built on its research and output and its student throughput - their numbers - and they don't want to see the hospital absorb that money for patient care. Research, of course, is usually tied to grants and they very jealously guard that money.

If you have a look at Cambridge and Addenbrooke's Hospital, they are just one union.

CHAIR - You are really taking a helicopter view here, aren't you?

Dr WALPOLE - Yes, I am.

CHAIR - You are looking broadly across the whole scene across the nation as opposed to just Tasmania. How do you see this being progressed within the state, as an idea at least, to get some traction?

Dr WALPOLE - The first practical thing to do is to have a joint appointments board so that when senior people in medicine, nursing, pharmacy and so forth are appointed, the committee they go before has someone from the university, someone from the health department, someone from the hospital and someone from teaching and research, and that panel selects a person who is the best fit. They get a salary and that salary comes out of a pot to which those institutiones contribute.

CHAIR - Would you have a set of protocols about the engagement of each of those institutions?

Dr WALPOLE - Sure, yes. It's nothing revolutionary. This happens in 100 institutions around the world.

Ms FORREST - You seem to have been talking about this for a long time. I have often wondered about this myself. To the points made about the name of the Royal - it is divisive, it's a state hospital. If you live on the north-west coast and your premature baby needs neurosurgery, that is where you have to come.

Dr WALPOLE - You have to go to the Royal.

Ms FORREST - No, it is not the Hobart Hospital, it is the Tasmanian Hospital. What are the key barriers to moving something like that forward, and a long-term vision, which is lacking in many areas?

Dr WALPOLE - It is Tasmania, isn't it, and the line is through Oatlands.

Ms FORREST - Parochialism reigns supreme.

CHAIR - You mentioned that in your report. 'Royal' is an anachronism and it is also divisive along the north-south line.

Dr WALPOLE - There is no need to have the term 'Royal' or 'Hobart' in it anymore. Launceston is a statewide hospital, too. It takes people from the north-west.

Ms FORREST - And so is the Mersey now in its dedicated day surgery. The thing applies across the whole state. But what are the barriers? What is stopping this from happening or what needs to be addressed first?

Dr WALPOLE - You have been in politics a lot longer than me. It is just entrenched attitudes.

CHAIR - There is a political side but there is also the academic and clinical side, and that is where it would be interesting to hear some of the -

Dr WALPOLE - Lara Giddings drove this idea with networks, which was really successful - that is, we have a trauma network in the state so that people dealing with injured people all around the state work together.

There is a neurology network because currently there is no neurologist in Launceston, nothing on the north-west coast, and there are issues down here. She drove it so that statewide all the people involved in certain aspects of clinical management perform in a network and can move patients through the system. All that fell apart after she left.

Ms FORREST - When the Mersey debacle happened and the federal government came in and bought it, that put a big halt to where Lara Giddings was heading.

Dr WALPOLE - She had a lot of momentum and she had a lot of clinical support. I don't know if you have heard of the Garling Report in New South Wales following a whole series of catastrophes, basically in smaller hospitals in Western Sydney. I read the Garling Report and it was tragic. These hospitals that hit all the numbers and were okay had these catastrophic clinical failures. Garling said that the biggest single failure, and I liken it to the Great Schism of 1053, is the divisive wedge driven between clinical staff and management, and this is utterly destructive of clinical care.

Ms FORREST - The commission's report says the same thing.

Dr WALPOLE - Yes. What then happens is that the clinicians say, 'I'll come in and do my work and then I'll go home' - no teaching, no research, no administrative support, no clinical governance, no quality and safety - because they do not perceive an ownership of the institution. That became worse.

Ms FORREST - I will take you back to where you said that Lara Giddings was heading down a particular path. We are almost back to where she was heading in terms of the overall structure now. We have the One Health Service, with the Mersey now back in state government ownership and management. Is there now time and opportunity to look at integrating things more fully and having people take responsibility for all those roles you just mentioned?

Dr WALPOLE - There would be, but this potentially has to be top-down driven. You will not get this from the bottom up.

Ms FORREST - So good leadership is important?

CHAIR - Yes, and to that end, it is important that there is tripartisan support for this.

Dr WALPOLE - I managed to sit beside Peter Rathjen on a flight to Sydney last year and I recognised him and said hello. I talked about this, and he said, 'Look, we were keen on it; we went to the Health department and we just got a pushback so we have given it up.' So, there was the university then looking at a $1 billion budget institution, the Tasmanian hospitals, and it is completely ring-fenced from the university. It makes no sense.

Mr FINCH - Bryan, I read that report you recommended about what was going on in the United Kingdom and the NHS, and the fact that they managed to pool six together. Now you are saying you are at 20 that have done this, so there is a template that could be examined and perhaps utilised to see whether it could be overlaid here in Tasmania. Because of the smallness of our state and the connectivity that could be developed, we could be cherry ripe for this sort of situation.

Dr WALPOLE - And we have only one university, one health administrative unit and two research centres, one of which is 10 times the size of the other.

Mr FINCH - Do you have much detail about what has gone on in the United Kingdom?

Dr WALPOLE - Only from my reading; I have not been there, clinically, for 10 years.

CHAIR - The NHS has not always enjoyed the best reputation, but it seems to me that this may have been a new structure that has been placed over it. When did that commence there, do you know?

Dr WALPOLE - I am not sure, but the American model is 50 years old and very mature. Stanford own their own hospital and Cleveland has their own hospital and Mayo Clinic has their own hospital - the academic institution runs its hospital.

CHAIR - Thank you, Bryan. Unless you have any other information you wish to provide -

Dr WALPOLE - No, I planted that. I know it is a bit outside the terms of reference because fundamentally it is about the micromanagement of the system, but I think you have picked up on what is wrong here, which is that it is not driven on quality and safety. I am sorry to have to say that.

CHAIR - You say it may be outside the terms of reference, but in actual fact is it? You tell me. If properly implemented, it would have to have savings associated with it, and patient outcomes would be better.

Dr WALPOLE - If we want to attract world-class people to this institution, what do we have to offer them? We do not have a bucket of money to offer them. What do people want? They want some research, some teaching, they want some clinical work and they want it all wrapped up so they are not getting something like Peter Stanton tells me - he used to get some salary from the university, some salary from the hospital, some salary from his time up in the north-west, and a bit of private practice. He had four bags of money involved.

CHAIR - Thank you very much for that. Are there any more questions from members?

Mr FINCH - I took your point earlier, Bryan, when you were saying about the American chap who might have been attracted here. Given that opportunity to come and to do those elements that the skills could be applied to would make it an attractive proposition to attract not only world-class people but highly qualified people to come and be part of our processes in Tasmania. I am agreeing with you.

Dr WALPOLE - He expected, in getting a professor of surgery job, that there would be some clinical work. He is a cardiac surgeon, for goodness' sake. He expected a day-and-a-half of clinical work, and it just was not there.

Mr FINCH - And to have the ability to teach as well. I imagine that would appeal to a lot of people who are highly experienced.

Dr WALPOLE - It builds the next generation.

CHAIR - To that end, we have had quite a number of submissions suggesting setting up specialist clinical teams to try to address people's issues and concerns from the medical perspective, of individuals who live in more isolated locations. Do you see this structure being able to assist in that regard, say, if there were needs in the north-west or in the far north-east?

Ms FORREST - If someone in Queenstown needs some attention but they can't get out.

CHAIR - Or Queenstown. That is a classic example, when it is snowed in. Do you see this sort of structure being able to -

Dr WALPOLE - If you want a model in Tasmania that works, it is the retrieval service - again you have to thank Lara Giddings for starting that off.

Now we have one doctor every day who walks around with a mobile phone, taking calls from GPs, community health nurses, paramedics all around the state. He has control of a helicopter, a fixed-wing aircraft, a number of ambulances, a team of paramedics so that if someone has a heart attack in Queenstown and they need cardiac surgery, there is one call to this person and it is fixed.

If you take somebody now who has a hernia in Burnie and he needs the hernia operated on but the surgeon is sick, it will take you 20 phone calls to find someone to get him in because there isn't a system. The retrieval system for sick, ill and injured people works seamlessly.

Mr FINCH - I am wondering, where has the system run off the rails? You came to work in the emergency department here in 1984. Where has the system broken down? Is it just that we are victims of circumstance with the ageing population and more demand on the emergency department?

Dr WALPOLE - First, the system was never on the rails. When the university set up the medical school here in 1967 and so forth, it did so without any discussion with the hospital about integrating the two and having dual clinical appointments so that the professors of surgery and medicine and gynaecology and paediatrics were all on the hospital staff. They were just an appendage to the hospital staff.

Every other place I have been in, people have had what is called a joint appointment - your Adjunct Professor of Surgery at Royal Hobart Hospital. Here, that never happened.

Ms FORREST - It is historical.

Dr WALPOLE - It is historical, yes. They were never put together.

Mr FINCH - I was thinking more about the activity that takes place in the emergency departments.

Dr WALPOLE - That, aha! The world of medicine has completely changed in 50 years. You used to die. You would go along and kerchunk, you would have a major trauma, a big heart attack, a big stroke, serious cancer and you would die. Cancer has now become another chronic disease. Heart disease is basically fixed until the organ wears out eventually. Things like your lungs and your liver and stomach, all those things can now be sorted because of huge medical advances. The whole illness has run up the scale so that when people present at hospital, they do not tend to present anymore with single-system illnesses like vomiting blood or a heart attack.

They have type 2 diabetes; they have high blood pressure; they have early onset dementia and so forth. So you shunt all those people into the cardiology service. They require a whole lot of other services as well. When people come to the emergency department, deaths from road trauma are down from over 100 to under 50 in the last 25 years. Deaths from heart attacks are way down. When you come to the emergency department, the real emergency has actually almost disappeared. We are now what is called a continuity manager - that is, people come in with a

failure of health, an inability to access the system for a whole range of reasons - financial, social and clinical - then they are required to be sorted out, which you cannot do in a couple of hours like you used to be able to do. Things like your EMU - the Emergency Management Unit - and APU - the Assessment and Planning Unit - are all growing up because it takes time to work out what the problem is and what we can best do about it in a dignified and quality fashion.

Ms FORREST - The nature of the presentations has changed?

Dr WALPOLE - This is going on all around the world. These people are expensive, you see. You have to watch clinicians a bit because when they say, 'Oh, we can fix this, we will be able to save you a lot of money', you save a bit of money now but you just transferred up the scale. Look at what is coming at us with the dementia epidemic. These people are very expensive to warehouse and store because the brain is the last organ in the line that we really haven't come to terms with. We write out in the top storey when everything else is looking fine.

CHAIR - Bryan, before you depart today, in terms of reference 4 - the level of engagement with the private sector in the delivery of acute health services - in your experience, do you see any bottlenecks because of the lack of effective third-party services to provide what the hospitals need to keep people flowing through the hospital?

Dr WALPOLE - Talking about the private system?

CHAIR - Yes, pathology or physiotherapy - any of those services.

Dr WALPOLE - I am a bit remote from it, but there are a couple of things I would say. The union of Hobart Private and the Royal Hobart was a modest success because it meant that clinicians could be full time at the Hobart and yet they could have private patients. People who are privately insured could be treated on site and did not necessarily have to go to the public hospital. They paid there - is it $400 000 a year that goes into the Royal Hobart research fund? That is the rent they pay for the institution, which supports quite a worthwhile lot of research. That is where the money came from for that Jack Jumper program that briefly put us on the world stage. That money came from the rent of the old Queen Victoria - that is what funded Simon Brown's PhD.

Ms FORREST - Queen Alex, wasn't it?

Dr WALPOLE - The Queen Alex, yes. It would have been nice to have seen Hobart Private get in with University of Tasmania in academic work and jointly fund some academic positions, some professors and associate professors - which is what happens in the United States because most of their hospitals are private - and that never happened. They still tend to run as a fairly separate model, but then I am a bit remote from it.

CHAIR - Thanks, Bryan. We appreciate the fact that you took the time to put in a submission and then to come along and have a chat to us. Just before you go, I remind you that parliamentary privilege is attached to what you have been saying today. As soon as you walk out those doors, that parliamentary privilege no longer exists so you need to be aware of that if you are talking to the media.

Dr WALPOLE - Which I will not be, no.

CHAIR - Thank you.

Dr WALPOLE - Okay, folks, thank you.

THE WITNESS WITHDREW.

Dr SIMON JUDKINS, AND **Ms FATIMA MEHMEDBEGOVIC** AUSTRALASIAN COLLEGE OF EMERGENCY MEDICINE WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Valentine) - This is a Legislative Council Government Administration A subcommittee inquiry into the acute health services of Tasmania. It is specifically focused on acute health services, and no wider. All evidence taken at this hearing is protected by parliamentary privilege and I remind you any comments you make outside the hearing may not be afforded that privilege.

A copy of the information for witnesses has been made available, and you are aware of the contents of that?

Dr JUDKINS and Ms MEHMEDBEGOVIC - Yes.

CHAIR - Thank you. The evidence you present is being recorded and the *Hansard* version will be published on the committee website when it becomes available.

I advise the procedure we intend to follow today is as follows: first, you will be provided with the opportunity to speak to your submission if you wish and following that the committee will then want to ask questions of you. We are seeking information specifically relating to acute health services.

In the event you want to give any evidence in camera, you need to inform the committee. The committee will then consider and either say yes or not on whether they will take in camera evidence. If you feel you need to do that during your presentation, just let us know.

It is important the terms of reference are the focus of our hearing today because we have to report against those even though we could range far and wide. Dr Judkins, you have an opening statement?

Dr JUDKINS - I do. Thank you for the invitation to participate in today's hearing. We welcome the opportunity to outline our experiences for our specialist medical practitioners working with the Tasmanian hospital emergency departments.

Our submission to the committee has two components. The decision to submit the new competence component was taken to ensure patient and staff privacy. I understand this may have been subsequently given in a more public forum. In some respects, this may be a welcome development as it brings the significant concerns we have about the issues in the public health system in Tasmania to a more open forum.

Emergency physicians care deeply for the health and wellbeing of Tasmanians. Patients who come through the doors of emergency departments deserve the opportunity to experience quality care in a timely manner with the greatest chance of positive outcomes.

Patient care and patient outcomes must be the heart of healthcare systems. We have all experienced health services and know the reassurance that comes with receiving care within a system that is caring, professional and person-centred.

Regardless of the pressures facing any health system, patients have the right to that care and it should be provided to them. However, increasing demand for services is not being matched with the increasing supply of services and resources necessary to improve patient outcomes. But it is not just about the increase in supplying resources. It is also about using what resources Tasmanian Health has better. There is great expertise in your emergency departments, which being under-utilised, not through lack of desire of those skilled clinicians, but by a system and a working environment which is significantly hampered by bed block or the inability to get admitted patients out of the ED wards for ongoing care and subsequent emergency department overcrowding.

The dedicated staff who work in EDs are unable to do their job to the best of their abilities due to the dysfunction of many other parts of the hospital system and the failure to recognise where real solutions lie. The situation endangers lives and significantly impacts the sustainability of healthcare workers' careers.

Access block or bed block and overcrowding may not be terms you are familiar with, but they are terms we recognise well. It refers to the daily occurrence in Tasmanian EDs where care is compromised by having patients who should be cared for by inpatient teams spending unacceptable and long periods of time in emergency departments, hours and hours, and, in some cases, days after their emergency care is over, waiting to move to the next point of care. This not only compromises their care, but the next patient and the next and the next.

Dedicated emergency positions, like many other emergency department staff, work in Tasmania's emergency departments. They spend many years in training programs which gives them the skills to care for anyone who needs emergency care. They have chosen to dedicate their career to the public health system and to care for their communities.

Emergency physicians undertake a complex variety of tasks and care, given the nature of emergency departments' presentations. To excel in their roles, these doctors require support from the leadership body that is strategic in its planning and utilises their clinical expertise in developing responses to issues as they arise.

Our staff want to work with healthcare leadership, for example, the THS - Tasmania Health Service - executive to improve patient outcomes. Staff regularly attempt to engage with the leadership teams to identify issues requiring responses. That executive should be inclusive, consulting with skilled clinicians and using their knowledge to deliver better health systems. Sadly, the experience of emergency physicians in Tasmania is one of distant and disinterest management with a culture of blame and bullying as opposed to one of inclusiveness and leadership.

Clinical expertise is not being respected. In fact, the current leadership, which is a term I use loosely, seems more interested in centring the message to control damage. Clinicians have been told not to make submissions in this forum despite their grave concerns for patient safety. There are many examples of clinicians raising their concerns regarding the safety of patients only to be dismissed. It reminds me of many of the issues highlighted in well-known public health hospital failings of governments such as the Mid Staffordshire Trust in the UK and the Garling report in NSW. Clinicians know when things go wrong. To dismiss their concerns is a failure of leadership.

Addressing the issues facing Tasmania's acute health services requires support from all sides of government. Improving the system will require culture change, strategic planning and clinical engagement, strong leadership, accountability and transparency.

Insights can be drawn from the Victorian Government's response to the Bacchus Marsh inquiries, with the government accepting the recommendations to create Safer Care Victoria. I strongly encourage the members of this inquiry to access that report and reflect on the situation we are discussing today.

The work we can do to see strategic and evidence-based system improvements will have a positive impact on patient outcomes. Again, we know many times over that the response to ambulance ramping, overcrowded EDs, poor patient outcomes, stressed and burned-out staff, avoidable morbidity and mortality should not be a finger-pointing exercise at individuals or individual departments in the attempt to find a scapegoat, but to look at the system issues which have put patients and staff in a compromised, unsafe and unstable situation. I implore this inquiry puts Tasmanians who and when they need an ambulance and access to emergency care - the best emergency care that can be provided - first to ensure they get the treatment they deserve.

We have to look at the system from the top-down to ensure everyone understands their role, is responsible, accountable and acts in a way which is not in their own interest, but in the interest of patients and their care. That is what we do as registered physicians. Our only interest is in those who come through the doors day and night, everyday. We are here to advocate for a better system which will meet the needs of the public and will deliver the best outcomes for our patients.

CHAIR - Thank you. There are a number of things we can get from that. I am interested in your take on governance structures for hospital systems and how they can change for the better, especially with regard to Tasmania's situation. Do you have any comments on how the governance structure is and why it should change and what it should change to?

Dr JUDKINS - Interestingly**, t**he conversation we have had in the last few days with the number of staff working in emergency departments is that there has been a little light recently with some new roles put in place. The staff at the Royal Hobart were talking about - I cannot remember the lady's name - somebody else who has come into a role in management who seems to be very engaged, given some of the things troubling the emergency department.

The most important thing is that whatever governance structure is put in place, it needs to actually understand what is actually happening at the coalface. It needs to understand what is actually happening and causing poor patient outcomes, causing physicians and clinicians to be stressed and distressed about what is happening in their departments. Clearly the message we get back from emergency department staff in Tasmania about governance is that there is very much a large void between the staff in emergency departments, the executive and health system. Trying to develop links with the executive staff to discuss issues around patient care is very difficult.

There was an example of one of the directors telling us that for 18 months she did not know who she was supposed to report to. There was no firm reporting structure. When there was issues at the frontline, there was nobody she could go to to report her concerns.

Ms FORREST - Has that changed with this new appointment, do you think?

Dr JUDKINS - Certainly recent feedback is that they feel that the lines of communication have improved. But for 18 months there was no go-to person. It was problematic in trying to escalate any concerns, whether about staffing or access block, overcrowding, and so they had no -

Ms FORREST - I come from a health background and have worked in these areas so I understand what you are talking about. I think you are saying - and please clarify this for the record - is that there needs to be local clinical leadership that directly communicates with the management structure.

Dr JUDKINS - Yes, absolutely. They need to be engaged and heard as well, because for a lot of the problems happening in emergency departments, the solutions lie outside the emergency departments. Access block, overcrowding and ambulance ramping are symptoms of an overcrowded system and the solutions are not within the emergency department. Having people who will actually understand that and act to put changes in place to try to improve the capacity, or bring the whole system on board to improve capacity, is something that is vital.

Running a hospital is a team game; it is not just a bunch of silos working separately. You need everybody on the same page. From the feedback we get, that has not been the case for quite a long time. We have heard a couple of examples of that changing and things looking a little bit better, but there is still a long way to go.

CHAIR - We were doing a tour yesterday and were made aware at the Royal, that they are improving the situation with almost staging points for patients in beds and chairs.

Ms FORREST - Short-stay centre.

CHAIR - Yes. Any of those processes put in place must improve that patient flow problem.

Dr JUDKINS - I think you need to be aware that putting in more beds is a tiny part of the solution.

CHAIR - It is outside of the ED?

Dr JUDKINS - It is about how you use the beds. For example, the ED is a big pond and there is this waterfall of patients coming in every day and there is all streams running off - one is to medical, one is to surgery, one is to ICU, one is to theatre, one is to home. If you block off each of those little streams, if you just fill them up with more patients but patients do not leave the hospital, all that will backflow to the ED and the ED will continue to overflow.

Putting more beds in is great and recognising investment in infrastructure is a significant investment, but unless you have the systems in place to keep patients moving through to the next point of care, then those beds - you are just going to end up with a bigger car park for a lot more people in line. It really is about engaging people at all levels of the hospital to understand that it might be one extra day for one patient somewhere, or another extra day for another patient there, but all those extra days then build up to decrease the capacity of the system, and then patients wait for the next point of care.

CHAIR - Your understanding is that the numbers coming through emergency departments are on the increase Australia-wide?

Dr JUDKINS -Yes, absolutely. We are seeing that across Australia, it is getting busier and busier. I think one of the challenges locally is going to be with population growth and the people who access the health care system in Tasmania - again, across all of Australia - it is an ageing population as well, so you have people who are living longer, with more complex problems. Once they get into the hospital system, they tend to stay for longer, so your patient cohort is going to become more and more complex. That is why I think you need to be ahead of the game about looking at systems in place to ensure that patients move through the system in a very timely manner and they also have places to go when their acute care is finished. You do not want people occupying acute beds when they could be in subacute beds et cetera.

The way to free up capacity in the emergency department - I mean, a whole lot of people have tried things like diversion and putting after-hours GP clinics and all sorts of things in, but despite all of that, people still turn up to the emergency departments. That will continue to grow. The way to free up capacity in the ED is to make sure that when you finish your acute episode of care, you move to your next point of care. An example would be - you have visited the Royal Hobart Hospital - over the last couple of months they have had 145 to 150 patients each month in the last two months staying more than 24 hours. That takes the ED capacity down from 27 cubicles down to 25 cubicles; you add on top of that all the patients who stay 12 hours, 16 hours, 20 hours, and all of a sudden you are seeing the same number of patients out of a very small number of cubicles because all those patients have finished their episode of care and need to be somewhere else.

Mr FINCH - Dr Judkins, you have touched on an area I wanted to go to first of all. In respect of the other emergency departments around Australia, I assume that your members feed information to the Australasian College of Emergency Medicine on a regular basis. Is it part of their operation to give feedback to your organisation? Are we similar to what is occurring in other emergency departments around Australia?

Dr JUDKINS - Data is gathered in a number of different ways. We certainly do a twice-yearly snapshot survey looking at access and capacity and compare that. We have been doing that on a year-by-year basis. We are seeing pockets that are improving; there are pockets that are deteriorating. Certainly there are hospitals that are functioning incredibly well in terms of patient access and flow with much higher numbers of patients.

I suppose the number that alarms me the most is - you would be aware of the four-hour targets, the NEAT targets. I know in Hobart over the last six months - I will have to get the exact numbers for you - their transition for admitted patients going to an inpatient ward under four hours is only 16 per cent. That means that less than one patient in five gets out of the ED in less than four hours to an inpatient ward. One of those patients will be identified from the time they walk in as needing an admission. A patient comes in by ambulance, they have a fractured hip. Our guys know within 30 seconds, while they are on the ambulance trolley, that patient is going to need an inpatient bed. You do the X-ray, you do the bloods, you put the block in and our emergency care is over, we have done our bit. The next is up to the orthopaedic surgeons. If that lady or man spends the next 8 to 10 hours lying in a bed in the emergency department, where in fact -

Ms FORREST - At risk of other complications.

Dr JUDKINS - At risk of complaints - they are getting delayed care. That is why we see studies that show that if you come into an emergency department which is overcrowded or you

spend a long time in an ED when you do not need to be there, you have an increased risk of morbidity and an increased risk of mortality. Only 16 per cent of patients getting out within four hours is probably one of the lowest in the country. There are not too many places that would be sitting at that level. I would be surprised actually if there were any, but we can find that data for you. It is a significant number.

CHAIR - It is a significant number, isn't it? Isn't the avoidable mortality in EDs higher than the number of Australian road deaths?

Dr JUDKINS - Absolutely, yes. We know that. This is one of the stresses on the people working in the system. That is why they so strongly advocate and why they get so upset. It is because they know their patients in that department are going to suffer the longer they spend there. They are actually just strongly advocating for the patient and just trying to get people to understand that it is a significant problem that does impact patient care.

Mr FINCH - We witnessed yesterday what goes on in emergency departments when we had a look. We saw the corridors where they had patients. They had them in chairs and in side rooms, but it seemed that is where we have developed to at the Royal Hobart Hospital. Is that a circumstance that you would find in other emergency departments elsewhere?

Dr JUDKINS - I think one of the things that has happened in Hobart is that it has been bits built on top of other bits. It does seem like a bit of a rabbit warren as you go through there. Certainly most emergency departments will have things like fast-track or assessment areas where patients who are mobile - who are self-caring, say with a fractured wrist - will come and sit in chairs and we will move them through the department quickly. It is what we call patient flow.

We try to cohort the main beds, the monitor beds, for patients who are sick and need one-on-one attention and care. Patients who are mobile who might have limb injuries, rashes, shortness of breath, asthma - we can put them in a chair or a lounge chair and treat them and get them on their way. In fact, that is a very efficient system. It is one of the things that actually keeps the hospital's overall NEAT target up, because the emergency department is very good at getting patients who only need X-rays, plastering, suturing - they get them out very quickly.

CHAIR - Can you explain 'NEAT target' for the *Hansard*?

Dr JUDKINS - 'NEAT' was the old National Emergency Access Target. That was back in the Kevin Rudd days when we agreed we needed to get everybody - it is about the four-hour target, really. But a lot of departments will run separate areas - short-stay, fast-track, main cubicles. What they have experienced in Royal Hobart is the fact they are now treating patients who should be in that main area on trolleys in hallways. They have given us many examples of patients being resuscitated in the hallways or on ambulance trolleys when they have been unable to get patients into the main department to be looked after. In fact there have been some quite poor patient outcomes because of that situation.

Mr FINCH - With these factors, do you suggest that it amounts to a system in crisis?

Dr JUDKINS - Yes, there is no doubt. There is no doubt that patients are not getting the care they deserve, and our clinicians are unable to deliver the care they want to deliver because the system is in gridlock. There are many, many examples people have fed back to us about patients waiting for hours and hours and hours for things that - an example I had the other day of a

young girl with a dislocated elbow. For us to fix that problem, it does not take long. We can get that patient in and out well under four hours, but there was no resuscitation cubicle. We need to do that with monitoring. You give the patient sedation; you need one physician to do the anaesthetic, another one to reduce the elbow. There was nowhere for them to do it so that poor girl waited hours and hours and ended up spending seven hours in the emergency department to get something done that should only take an hour. It is many examples like that where you are just seeing delays to treatment and delays to care which are avoidable.

Ms FORREST - I want to go down the path of the morbidity/mortality associated with these extended stays. Not only is the location suboptimal to be resuscitated in the corridor, for a range of reasons, but it also increases your risk of things not going so well. Are you aware of any work that has been done on the actual - and I do not want to reduce it to money, but I am going to for a moment. The financial cost of the increased morbidity/mortality associated with this situation: if you could put a figure on it and say you can deal with the systemic problems here, then this money will not be -

Dr JUDKINS - Invest money up-front to save money in the long term. That has not ever been something public health has been very good at - investing money up-front to save money later. It is a very budget-driven cycle, but I do not want to get into politics and economics.

We certainly have figures. I can give you a copy of this paper which indicates the morbidity and mortality improvements as the system gets better.

Ms FORREST - In financial terms?

Dr JUDKINS - I do not have the financial terms, but I am sure there would be something we could find.

From the Australasian College of Emergency Medicine perspective, we are not particularly interested in the finances, we are interested in patient care and outcomes.

Ms FORREST - To make a political argument, you have to talk dollars. I am all for patient outcomes.

Dr JUDKINS - I am sure we can find that.

Ms FORREST - It would be great if you could provide that. If you have some sort of financial incentive, we have some hope of change.

Dr JUDKINS - I can leave or send copies. This refers to the morbidity and mortality associated with improvements. As the system becomes better, you see a decrease.

I am interested with the point you made about the performance of the emergency departments. This looks at the NEAT targets or admission into wards all the way from 100 per cent down to 20 per cent. It actually does not go as low as 16 per cent, which is where Hobart is sitting at the moment. This indicates there are probably not too many hospitals sitting at that level.

We can leave that paper with you and provide you with copies.

Ms FORREST - If you can find any financial assessments.

Dr JUDKINS - Sure.

Ms FORREST - In your opening statement you talked about increasing the number of people who come in the door, which is what you do - to make it more accessible for people knowing they are going to be seen, rather than perhaps going to their GP. Can you talk us through who is presenting?

I sat in a committee a number of years ago, and we are hearing the same things again. There was a view at the time that a lot of people who presented to the emergency medicine department do not necessarily need to be there. They could be with their GP; they could be with their mother -

Dr JUDKINS - Yes.

Ms FORREST - With your experience and knowledge, what are we talking about? Are we talking about people who have been diverted before they get there? Do we need public education around that or do most people need to be there?

Dr JUDKINS - There are a number of different things to set this conversation. The group of people who do not necessarily need to be there, whoever that group may be, do not cause us the biggest amount of angst. That is probably the most significant point.

Every time we have this conversation, people say 'Oh yes, it is because you have got these people turning up'. They are not the people who cause us grief. People who cause us grief are, for example, the lady with the fractured knuckle who spends 18 hours in the ED getting a delirium, missing out on her other medication, not getting good pain care, all because the emergency department is busy looking after everybody else.

Those patients who might have been able to get their health care somewhere most often are patients who come to our fast-track areas with soft tissue injuries. We see them, sort them and get them on their way.

Most of the studies our colleagues have done in emergency department point to that number. The number is probably a lot lower than most other studies. Most other studies basically put all category 4 and 5 patients in the one big bucket and say when they are lower-care patients, they do not need to be in emergency departments.

A gentleman from an aged care facility has developed an acute delirium. A category 4 or a 5 patient, just because they do not need to be seen right now, does not mean they do not need to come to the hospital to get their care.

People will use various numbers, depending on what their motivation is. Our point is people come to the emergency department because they think whatever they have is an emergency. That may be fever in a febrile infant at 3 o'clock in the morning. If they are concerned about a febrile infant, they actually do not have anywhere else to go except to ring someone like a nurse on call who often tell them to come to the emergency department.

We accept part of what we do is actually seeing people, assessing and reassuring them the chest pain they have is not cardiac chest pain. There is always going to be that cohort of patients.

We accept that is part of what we do and is what we do to serve the community. Our biggest problem is those patients who need to be in hospital and are stuck with us; they cause us the most headaches.

CHAIR - Can I touch on the terms of reference 5 and 6 about -

> The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services; and
>
> Any other matters incidental thereto.

We obviously want to see patients get the best treatment they possibly can in the time and with the resources available. I am concerned about what might be happening with the doctors themselves - their levels of stress. Is it possible there could be mental illness involved as a result of the stress they are going through? Can you give us some sort of an idea of what the staff are going through?

Dr JUDKINS - Last year the college undertook an [inaudible] sustainability survey in which we ask all of our clinicians to respond and to look at issues around stress and burnout - wanting to leave their medical career, violence and alcohol use. The levels are not surprisingly high, but distressingly high. Fatima and I were talking about this on the plane on the way down. It sometimes feels like you are stuck in the middle of a war zone because you are surrounded by people who are suffering; you are trying to do the best for them and you feel like you are just plugging holes sometimes.

We accept that is part of the job. You are looking after sick people and people who are going to pass away. When you have to battle against the system to try to make things work, that is probably more stressful because it is going back to those figures we were talking about.

We know we can provide better care. We know patients who spend a long time in emergency departments have an increased morbidity and mortality. You work in a system where you see that happen. That again can become wearing for people. There is constant advocating for patients, talking to your executive - they are not listening, nobody seems to listen. Eventually you lose the will to fight the battle. I know many medical clinicians who have said, 'Well, I cannot do the clinical stuff anymore, it is just too hard.'

CHAIR - How many of them are actually hiding stress, because to admit there is an issue or a problem is almost like saying, 'Well, I'm not capable of doing the job.' How relevant is that?

Dr JUDKINS - It is like anything. The reported numbers we get probably undercall the extent of the problem. I know personally a lot of people who go to work and tell me they just do not like coming to work anymore. They know they are going to turn up on a Monday morning and there will be 27 patients waiting for admission and five ambulances ramped and they feel they cannot impact and make that better. People who have dedicated their career to work in public health are in a situation where they know they are not providing the best care they can. An incredibly stressful thing to have to live with.

Economically, we spend a lot of money training emergency physicians. Putting them in a work environment you know is going to burn them out does not make economic sense.

CHAIR - No, that is right.

Dr JUDKINS - It costs a lot of money to train them and then you put them in an environment where they are going to be worn down. It is not good management.

Mr FINCH - Dr Judkins, I appreciate the answers you are giving; they are excellent. Fatima, could I ask your role with the Australasian College of Emergency Medicine?

Ms MEHMEDBEGOVIC - I am the manager of policy and advocacy with the Australasian College for Emergency Medicine. I work with Simon and various entities of the college to craft their college's position on a number of policy issues, like the practice of emergency medicine. Workforce sustainability is one of our key issues, along with rural and regional emergency medicine and a range of issues across the specialty.

Mr FINCH - You are based in Melbourne?

Ms MEHMEDBEGOVIC - Yes, I am based in Melbourne.

Mr FINCH - Do these reports come back from your colleagues who trained in Melbourne or trained throughout the country?

Dr JUDKINS - They trained throughout the country.

Mr FINCH - Those reports come to you, Fatima, or do you have oversight on those reports from your colleagues?

Ms MEHMEDBEGOVIC - Can I ask which reports you are referring to?

Mr FINCH - The reports of how things are developing.

Ms FORREST - Are you talking about the anecdotal stories?

Mr FINCH - Yes and the problems they are encountering with their EDs probably from Tasmania and from other parts.

Ms MEHMEDBEGOVIC - Yes, I am engaged with our members and in contact with them regularly. I communicate with them as part of the policy and advocacy work we do, so, yes, absolutely.

Mr FINCH - That would help you formulate your policies. Does it concern you when you see these reports coming in? We have an assessment in the report here. A lot of it is negative but is there positivity blended in with negativity?

Ms MEHMEDBEGOVIC - Absolutely, Simon has already touched on this emergency medicine positions. Overall in my work with them, they love their work and they love serving the community. Just now, we were at Royal Hobart Hospital, we popped in to Billy's to say hello and they were organising the roster for this evening and we observed and listened. One of the

physicians popped his head around and said to his colleague, 'I can stay back tonight, if you need'. That is their attitude and approach to work. It is all very team-based, and they do everything they can to serve the people coming to see them and look after each other.

It is a very collegiate, positive specialty. My work with the members constantly reinforces how much they enjoy their work within a challenging environment and how much they ultimately will do to deliver the best care they can to the patients, often in very trying circumstances.

Mr FINCH - As we have seen in your report and in other reports and submissions that have come to us, there is increasing pressure on the system. In part of your submission, unless there is investment in creating capacity in the inpatient arena, the situation in acute care will not improve. Could we explore that more? As to when you say investment, is that in the physical or financial situation where you need to throw more money at it?

Dr JUDKINS - I think there are three things. It is well known we have been doing some work at our hospital. Kate Brockman is somebody you might know; she did some work with the Tasmanian Health Service over a couple of years recently. I met with her yesterday and mentioned I was coming here. She said one of the things she has done with her work is she recognises in any hospital at any time in Australia probably 30 per cent of the capacity is being used by people who do not need to be in hospital, possibly because they are waiting to go somewhere or home or it is a Sunday and there is no ward round.

When I say investments, there needs to be investment in the way we run the hospitals better. There is a whole lot of capacity in the hospital system not being used to its maximum efficiency. There will always be a patient in a bed somewhere who probably does not need to be there.

When you have up to 30 per cent of patients who actually could be in rehab or at home, you have waste of capacity. We can create a lot of capacity by investing in making the inpatient areas, in particular, more effective and efficient. Like doing daily ward rounds, for example. A lot of hospitals only have ward rounds three or four times a week. Leaving the running of a big and busy hospital to doctors who often cannot make the decisions that need to be trained. Investing in the way we run the inpatient system is part of what we are talking about.

Going back to the economic argument, we have hospital systems will run on a visiting medical officer model. People come in and are employed for two days a week and then they go off and work in the private system for the rest of the time. Trying to get people in that sort of role to come and invest in the system to be leaders, to create change, to look at system reviews. They do not buy into the system and they do not accept that is part of their job.

Maybe one of the investments would be to have more full-time directors of departments working in inpatient areas so there is that responsibility, and patient flow and access and creating capacity is part of their job. Most hospitals don't really have that role.

Mr FINCH - Does it give you heart, Dr Judkins, that the state Government has invested in this redevelopment work at the Royal Hobart Hospital in particular and that 250 beds will be coming into line in the future? Does that give you heart about the future for your colleagues?

Dr JUDKINS - Yes, I think it does. A willingness to invest financially is always positive. The problem is that health care is a bottomless pit of money. That is a problem. You can build the best and shiniest new hospital but unless you have the right people working there for the right

motivations and the right systems in place to make sure it is effective and efficient, you are just going to have a much nicer-looking car park and a much nicer waiting room for people to spend a lot longer in. You can build 10 new beds but unless you are using those beds and patients are moving through the beds, it will just become a bigger waiting area. We are very mindful that putting in new beds is only part of the solution. It is the way you use them - maximising the efficiency of the way you use those beds is important.

CHAIR - Before passing to Ruth, do you have any metrics about clinicians and support staff and the need for their operations? For a clinician to operate effectively in an ED situation like that, is there an average or a standard of staffing needed to make these beds coming online, for instance, effective?

Ms MEHMEDBEGOVIC - The college has some guidelines around workforce for emergency departments, but that focuses on what we define as senior clinical decision-makers. It does not account for allied health.

CHAIR - Does not cover the operational side?

Ms MEHMEDBEGOVIC - No. If we are talking about inpatient beds, the college itself doesn't collect those metrics, but the AMA reports on an annual basis. They use number of beds utilised by patients over 65 years as an indicator of capacity and how that has changed over years.

Ms FORREST - They talk about it in their submission.

Ms MEHMEDBEGOVIC - Yes. What ACEM collects mainly focuses on patient presentations. We do what we refer to as snapshot surveys where twice a year, at a given point in time, all our accredited training EDs report on how many patients they have waiting to be seen and how many are waiting to access a bed for those who are admitted. That is the main data we get and then we also have our general data in relation to how many trainees there are and where those trainees are placed.

Ms FORREST - Do you publish that data?

Ms MEHMEDBEGOVIC - Yes.

Ms FORREST - Is that accessible on the website?

Ms MEHMEDBEGOVIC - Yes. We can definitely send it. That is our annual specialist training activities report.

Dr JUDKINS - Certainly, as far as the college and staffing goes in emergency departments, we have what we think is benchmark data. Again, depending on where you are coming from, that is flexible, but I would compare it to, for example, according to our numbers, Royal Hobart Hospital probably needs another three or four full-time clinicians to get to where we would think the benchmark is in a similarly sized hospital in other parts of Australia. Launceston is probably about nine FTEs down. They only have 3.5 FTEs of emergency physicians. They would need a vast and significant improvement.

CHAIR - And North West?

Dr JUDKINS - North West is the same; I think it has 4.5 FTEs. You can't staff an emergency department with those numbers.

CHAIR - You are saying North West needs more?

Dr JUDKINS - I think on the numbers we have, it probably needs another 5 FTEs, but again, we can get that data for you. Certainly it falls a long way behind what would come close to what we consider an appropriate level of staffing.

Going back to the point you were making before about inpatients, it is a bit more difficult though. If you look at Stephen Duckett's report, *Targeting zero*, one of the things he points to is a hospital system running basically a visiting medical officer model when it is bigger, busier and has more complex patients. That is something we have been doing for the last 50 years and something we need to change. I know there is certainly a lot of resistance among other groups and among the AMA to look at changing models of care and models of employment for specialists. The concern is that we do not actually look at the way we run and staff the inpatient units, and put senior clinicians in there and not just rely on trainees to make decisions. We are going to be having the same conversation in 10 years' time.

Ms FORREST - This leads perfectly into the question I had for you. If you were given the job of prioritising what should happen to address the whole access question, right through from point of entry to discharge, what would your wish list be?

Dr JUDKINS - I would think that we would certainly look at how we run emergency departments 24/7. We have patients coming in all day, every day. Our hospital system runs pretty much nine to five, Monday to Friday, and shuts down over the weekend. If I wanted to change things, we would have staffing which was senior staff and decision-makers who were on deck at least seven days a week. They do not need to be on extended hours like emergency physicians do, but we need to be able to admit and discharge patients, and particularly discharge patients when they need to be discharged, not when it is convenient for the clinician to come in and do their ward round.

I think we need to have more senior clinicians in charge of big and busy units, like general medical units, general surgical units, orthopaedic units, who are there when it is their job to be in the hospital - not to be in the hospital for a little bit and then go and do a private list somewhere. They need to be in the hospital when the hospital is in crisis. They need to be available.

Ms FORREST - On that point - and there may be other priorities you want to go to - I have not worked in a hospital for some years now, but generally you have a ward full of patients with a senior medical professional. They have a treating consultant and they will not all be under the same consultant, for a variety of reasons. Are you suggesting that this leadership position, for want of a better word, of a senior medical professional oversees all the other consultants' patients? How does that work in this hierarchical structure? Is that going to be a point of pushback?

Dr JUDKINS - It will be. As I said, medicine is often about hierarchical structures, which is, as you would be aware after working in the system, sometimes does not work so well. From our point of view, we are able to see things very differently in emergency because, as Fatima said, we work as a team. Everybody pitches in and looks after each other. I understand that obviously it is not necessarily looking after each other's patients, but it is actually having somebody who is

in charge who understands how to improve efficiency, who understands how - an example at our hospital which I probably will not put on the record, but we had a -

CHAIR - It is on the record at the moment, so -

Dr JUDKINS - I can just say 'our hospital'; I will not know the hospital. We went from a director of one of our surgical units who was 0.2 FTE - eight hours a week as a director of a busy unit. They then employed a full-time director. All the surgeons agreed to streamline the way they do certain operations. They use the same equipment. All of a sudden, their lengths of stay dropped down and their infection rates dropped down because everybody knew how you were going to manage this condition and everybody did it the same way. There is no doubt that decreasing variation in the way you do things increases efficiency. That is just one example.

If every surgeon wanted different equipment for every person, operating different times of day and discharging them on different days, then the staff will be confused and not know what to do. It is things like that. People need to think about how we can make significant changes. All we have done since I have been in emergency medicine is tinker around the edges with little bits of this and a little bit of that. We have not really looked at more significant changes to make the system more effective.

Mr FINCH - Fatima, I am curious about the advocacy work you do. Does that require you to be in communication with administrators of hospitals, expressing concerns or discussing issues? Can you apprise us of the responses you might have received when you deal with Tasmania in respect of that advocacy work?

Ms MEHMEDBEGOVIC - I have to say with regard to Tasmania that I have not been involved. That is done at a much more local level. I can say generally with my work at the college that when we receive reports or notifications that we need to engage with the hospital on behalf on members, responses can vary - sometimes offers for meetings to discuss the relevant issue and try to address those, to engage with the members at the coalface at the local level and advocate on their behalf are received very positively. Sometimes there is less of a reaction.

I am not sure if Simon has been involved with local Tasmanian issues.

Mr FINCH - Do you encourage your members to deal with their immediate operation and communicate their concerns to senior people and to administrators?

Ms MEHMEDBEGOVIC - Absolutely.

Dr JUDKINS - We would prefer that local levels are sorted out by local people because that is the best way to do it. Some feedback we have had is essentially that access to senior management in the Tasmanian Health Service has been very poor. I contrast that to other places where senior medical staff will have meetings with the board. In Victoria we now have clinicians on boards. Most emergency departments would have access to the CEO for regular meetings, access to acute operations directors for meetings, and they would engage in the direction and strategy of the hospital, in what we are trying to achieve.

The information we have received is that certainly there has to be that conversation about hospital strategy and how we are going to manage the increase in demand and the flow. It just has not happened.

Mr FINCH - Do you think some of the imperative for planning and structure around the improvements and the changes taking place in the hospital physically might be blindsiding the management and administration a little bit more?

Dr JUDKINS - It is always possible. We have all worked in hospitals where they have undergone rebuilding. Part of good leadership is engaging your team, your clinicians. Unless you have a team that is engaged and feels like it has been listened to, staff morale is impacted and that is a significant problem.

I have heard of many hospitals that have undergone major restructures and they still have great relationships with their executive because they were involved in the planning. They are involved in how they are going to manage the hospital when they get to the new facility.

When we did a major restructure of the hospital I worked at, we helped design the units and the patient flows, and we spoke about staffing levels. They said, 'You guys tell us what you need and we will put it in the plans'.

Mr FINCH - Would you like to see an improvement in that area of cooperation and discourse between your people and the administrators?

Dr JUDKINS - Absolutely. Our directors have a lot to add. They know a lot about public health; they know a lot about what their patients need. They know about what is happening in other hospitals in relation to patient flow and other initiatives. Part of good leadership and good management is engaging people and making them feel as though they are being listened to and belong and are making a significant contribution. That is part of good leadership.

CHAIR - Can I pick up on one thing you said in relation to this? In your submission, where you say you 'Call on the Government to engage with the inquiry findings in a bipartisan spirit', to clarify, are you talking about them engaging with the clinicians or are you talking about cross-party lines here?

Dr JUDKINS - Cross-party lines is the most important thing. One of the things that is incredibly frustrating for anybody who works in health is when they see health used as a political football.

We get ambulance offload times and key performance indicators. We get measured on those sorts of things, which are all about process and nothing about outcomes. They measure times and they say that minister X is obviously not doing their job because ambulances are waiting out the front of the hospital, then the CEO gets a nudge from the minister and the minister goes to the emergency department and says, 'I don't care how you do it, just make sure those numbers look better'. It is a political football.

Then there are the budget cycles. They just want to do their job; they want to have some consistency and they want to have some certainty that whatever happens today is not going to be changed next week at the whim of somebody else. We just need everybody to agree on what the important things are in health and have more of a collaborative approach.

CHAIR - Presumably not just what is needed tomorrow, but to have a long-term strategic focus so that it is not fiddled with so often?

Dr JUDKINS - Yes. There are things we could put in place tomorrow that are going to help the situation we are talking about with the ramping et cetera. But you are not going to solve the problem by changing the plan every election cycle. You need some consistency and to understand what your end goal needs to be so people actually know what they are working towards.

CHAIR - A 16-year time frame, not a four-year one.

Ms FORREST - Thirty years, I'd suggest.

CHAIR - If you can make it happen.

Ms FORREST - The challenge here is, on that point, we know the medical advances create change and that actually contributes to the complexity of the patients appearing at the emergency department these days as opposed to the more single issues people use to turn up for. Perhaps not locking into too long a time to allow some flexibility, but you can still have a long-term strategy, can't you, that has some flexibility around how you approach the various challenges.

Dr JUDKINS - Some of this needs to be future-proofed. One of the things we do in health is just trying to catch up on the deficit from the last 10 years. The concern is that every time we build an extra few beds, or it is because we have been needing them for the last five years, and then often you get to the part where, okay, we will survive for a bit longer. Again, it is about the long-term investment, about the systems and about the employment structures, and there are all sorts of things you can take a long-term view on. The relationship between aged care facilities and public hospitals - do we actually provide more services in the aged care facilities to avoid people coming into hospitals for care that can be delivered elsewhere?

Again, the frustrating thing because of different staffing or funding models is that the state funds the public hospitals, the federal government funds aged care and there is no strategy about who is going to do what. Once again, it becomes a political football.

Ms FORREST - Can you talk us through the hospital standardised mortality ratio and how Tasmania is performing in that area?

Dr JUDKINS - I can give you the data. I do not have that data with me. I can leave you with the paper that points to the standardised mortality data, but I do not think we have data specifically for Tasmania. What it does point to on this scale is looking at those access targets we were speaking about before - the more effectively and efficiently you run your system so you do not have those long stay patients in emergency departments, and as soon as you improve your inpatient that you are transitioning towards, your morbidity and mortality actually start to improve. It gets to a point where you drive the system to be really efficient, but then you can drive it too hard and have adverse outcomes. There is a sweet point where everything runs smoothly. We are looking at these graphs and where Tasmania is sitting as far as inpatient need goes does not actually even register on a scale of a graph because they are only start at 20 per cent and at the moment we are sitting at 16 per cent.

CHAIR - We only have a couple of minutes, if you can have one more question and then I will go to Kerry for one.

Ms FORREST - I was informed some time ago about the challenges in the DEM at the moment - this was before the committee was established - and that there was a deemed need by the staff working there to call a code yellow, and that it was blocked at the minister's office. Are you aware of that - if it was actually the case - and what happened?

Dr JUDKINS - I am not aware of it but I can find out some more details. I do know, for example, that we have been told that staff members who wanted to make submissions to this inquiry were told that they should not do that. One of our concerns is about that level of censorship. You get to the point where clinicians are saying, 'Things are now unsafe, we need to escalate.' That should be a clinical decision; that should not be something where a manager or administrator says, 'This is going to look bad and we will need to talk to the minister if we do that, so we are not going to call it.'

That is the sort of feedback that concerns about patient safety are not being listened to. An example of people going, I want to look after myself rather than look after the system so I not going to let you report it'.

Mr FINCH - There was a suggestion in your submission about clinical engagement that frontline staff should be a necessary outcome at this hearing. You cited also the work done with Safer Care Victoria. Why do you highlight that? What can we glean from what goes on in Victoria that might benefit us here in Tasmania?

Dr JUDKINS - Again, we can share information with you and send you those reports. The Safer Care Victoria work was borne out of issues in Bacchus Marsh where they had an increase in infant mortality.

Again, some of the concerns happening around patient care were raised with the hospital administration, but were not listened to. Similar to what happened in the Garling report in New South Wales and the Mid Staffordshire Trust, there was a complete governance disaster where clinicians kept raising concerns about staff and patient safety.

The hospital executive was more interested in key performance indicators and targets. As long as they met targets, they did not care about what happened on the floor. That resulted in a significant increase in patient mortality.

We can measure clinician engagement. A lot of hospitals deal with an outcome. The clinician engagement is really about having clinicians feeling safe about raising issues of patient safety, staffing, concern at outcomes and not feeling as though they are going to get blamed, not feeling as though they are going to be not listened to.

As soon as you get a culture where clinicians feel nobody is listening and nothing is changing, they are going to stop reporting adverse outcomes and events because nothing changes.

It is incredibly important senior clinicians have that link. They are not jumping up and down saying the sky is falling in and everything is unsafe, but when there are significant concerns about patient outcomes, they need to be taken seriously.

From the feedback we get they are just not listened to.

CHAIR - I must draw it to a close here because we have run out of time. I want to thank you very much for coming today and presenting your submission, which brings me to the point of your confidential submission: are you willing to have that published at this point or not?

Dr JUDKINS - I do not think there is anything in there we have not spoken about. We are happy for that to be published.

CHAIR - Okay, thank you very much. That means we are able to refer to the content and reference it. I appreciate that.

Dr JUDKINS - If you need any more information, there are obviously some things we need to get. As soon as I walk out the door, I will probably forget the list. Let us know what you need and we will get that for you.

CHAIR - Jenny will certainly be writing to you and helping that through.

To remind you about parliamentary privilege. Whatever you say outside this hearing is not afforded that, which is something to remember if the media grab you on the way out. Thank you again.

Dr JUDKINS - Thank you very much for your time.

THE WITNESSES WITHDREW.

Mr MARTYN GODDARD WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Valentine) - Welcome, Martyn. This is a Legislative Council Government A Subcommittee inquiry into acute health services in Tasmania. All evidence taken at the hearing is protected by parliamentary privilege. I remind you any comments you make outside the hearing may not be afforded that privilege. A copy of the information for witnesses is available. Have you read that?

Mr GODDARD - Yes, I have.

CHAIR - The evidence you present is being recorded. The *Hansard* transcript will be published on the committee website when it becomes available. By way of introduction, I advise the procedure we intend to follow today is that you will have the opportunity to make an opening statement if you wish to do so. Following that, members of the committee will have questions - probably many questions - for you. We are seeking information specifically relating to acute health services only, not the wider health services. The terms of reference you will be aware of; there are six of those. We like to try to make sure the questions asked and the answers provided focus on those terms of reference.

If you get to a point where you feel you want something in confidence or in camera, the committee can consider that, and then we may allow you to present in confidence if you so wish. Over to you for your statement.

Mr GODDARD - In this submission, I have tried to give you, on the basis of publicly available data, a picture of how this state is comparing in acute health with the rest of the nation. There are a few complications here. One, nobody is doing that well. There is something of a crisis in hospitals right around the country. By comparing this with the rest of the country, it is not that kind of benchmark. The second thing is that when you look accrued averages, they do not actually tell us much, because not every state has the same type of population or the same population needs.

Fortunately, the Commonwealth Grants Commission does a lot of work sorting that out for us and paying us more GST because we have an older, sicker, poorer population. By the weightings the Grants Commission gives us, and I have photocopied some of these for you so you can have a look at what is here -

CHAIR - So you are tabling that?

Mr GODDARD - Yes. The figures I have been using are on the last page of table 20. The Commonwealth Grants Commission runs a very detailed examination of each state's relative needs not only in terms of what they need per capita to make up for what they cannot raise themselves, but also what the particular demographics need in terms of health, schools, roads, justice and so on, right the way through. They redistribute GST cash every year on the basis of those weightings. For admitted patient care, which is the main one I have used in trying to get a meaningful comparison with the rest of the country, there are under (a) Weighted Facts - unadmitted patients. For Tasmania, we get 1.091 of every dollar, so we have nine cents more in every dollar than everybody else. It is only when you look at those figures, you get a true picture of what the chances are of a Tasmanian getting a equal level of care, given we have more people wanting care, as the average of the rest of the country.

The whole basis of federation is that because you are Australian, it should not matter which state you live in, which state is a poor state. Important things like getting an education, being able to drive on a decent road and being able to go to a hospital should be basic to you as an Australian. That is one of the things that makes a federation work. One of the reasons the EU does not work is because they cannot do that. We can and we are. We have a terrific system and the Commonwealth Grants Commission gives us these weighting lists for a reason. The commission knows we need that money to provide an ordinary, not a Rolls Royce, level of care.

Look at national comparative figures and strip out what state governments are putting in from their own coffers, which includes GST, but which do not include the money they raise through private health insurance or workers comp - they do not include the Commonwealth contributions - then you will find how they compare across the country on two levels. One is they are putting in as much per head as everybody else. No, they are not in this state. Are they using the extra money they are given through the GST for health or are they diverting it and not using it?

The precise amount the Grants Commission gives us every year varies on health.

Ms FORREST - Are you talking about specific purpose payments, national partnership payments?

Mr GODDARD - No. That is worked out separately. Applying health weightings changes a little bit depending on how much money they have to redistribute. This financial year that is worth an extra $263 million to us.

If that money was being used for health, you would expect the total amount the state was putting in from its own resources to be higher than the national average. It is not; it is lower. It varies a bit, but on an average year we are probably putting in about $100 million less.

CHAIR - It is accumulative deficit almost.

Mr GODDARD - Yes, it gets worse and worse. On top of that, they are not spending a dollar of the $263 million.

Ms FORREST - On health.

Mr GODDARD - On health. They are spending it on plenty of other things, but it is not going to health, even though I would argue we are given that because of our health needs.

The reality of intergovernmental federal financial ratings is the Commonwealth Grants Commission cannot tell a sovereign state how to spend its money. They are not breaking any laws but that is why we are in such trouble in the hospital.

CHAIR - It might mean if they are not spending it on health and spending it elsewhere, they need it to prop up the state's economy. Is this always an argument that keeps coming back?

Mr GODDARD - No, it is actually not. If you are looking to stimulate the economy, health and hospitals is highly labour intensive. Most of those people do not earn huge salaries, so they will spend that money here. That is a very direct way of stimulating and supporting the economy. It is not evident in the budget precisely where that money is being used. It is being used on all

sorts of things. Stated government priorities have been wanting to reduce the relevant size of governance. They have been wanting to pay down debt and not borrow for things like productive infrastructure. This is $350 million in a $6 billion budget, so it can get lost.

Mr FINCH - Of that $263 million from the Grants Commission, what are you suggesting?

Ms FORREST - It is the GST money.

Mr FINCH - The GST. What are you suggesting should go to health?

Mr GODDARD - We need what we are given. Unless somebody can prove the Grants Commission's calculations are wrong and they are being too kind to us.

CHAIR - That is the 1.09 you are talking about?

Mr GODDARD - That is right. Unless somebody can argue we are getting too much money, that money is being given to us because of our demographic needs in health. The cost of not spending that money on health is we are going to fall further and further behind the rest of the country in terms of providing health care.

CHAIR - In terms of providing health care or in terms of the health of the state individuals?

Mr GODDARD - In terms of people's ability to seek acute health care. There are limits to what any government can do in terms of the overall health of the population. In terms of being able to treat people who are sick, that is why hospitals are -

Ms FORREST - We could argue you could throw as much money to life and health and it is a bottomless pit and would never stop. Throwing money at it, even if there is money that rightfully should be spent on health which is not, let us put that aside. Surely it is not just money. There must be other things we need to focus on in terms of health outcomes we are trying to achieve for people. It is not just about money is it? Or in your view is it?

Mr GODDARD - Money has a fair bit to do with it. If you do not have the money, you are in real trouble. Yes, there is a question about how efficiently you use the money. This state has had significant problems with the efficient use of money and still has. You have talked in the past more [inaudible] less hospitals. You used the line once which I rather like, which was some people in communities do not want a hospital, they want a building with hospital written on it.

There are maybe a couple of hundred beds in those hospitals. This is just one example and the political reality is we are not going close those. Certainly in the north-east, there was an RTI which Emily Baker did from the [inaudible] which you are a member, which showed average occupancy rates for those hospitals was as low as 30 per cent. That is not efficient.

Ms FORREST - We are building the St Helens hospital.

Mr GODDARD - Yes we are, and we have another one down the road and another down the road.

Ms FORREST - St Mary's is having a bit of work, yes.

Mr GODDARD - That is an added complication. In terms of efficiency, there are two broad ways: we can work smarter and make the system work better. Clinical redesign was underway here but has come to a halt. Funded by the Commonwealth, the University of Tasmania group in charge of the clinical redesign did a lot of pretty good work. They were able to effectively add to the number of acute beds. Not hugely, but they found new things. They found new ways of making the system work more smartly. There is a huge range of things, in immense detail, that can be done through this sort of exercise.

The other one is just to make people work harder. To put more patients in without putting a commensurate number of staff. To pursue the nonsense there is such a thing as frontline and non-frontline staff. We do not employ people because we like them. We employ them because they have a job. It is not only doctors and nurses, however important, it is also IT people, ward clerks, people who do the payrolls, cooks and cleaners.

Ms FORREST - Cleaners are vitally important.

CHAIR - All of the back office.

Mr GODDARD - Paring down these things, particularly where the public cannot see it, is going to increase skewed labour unit productivity and will not give a genuinely more efficient system that is able to do its job of treating sick people properly.

Ms FORREST - Paying a nurse to answer the phone is a very expensive business. Can I take you to the minister's submission? I am not sure if you have had a chance to read the submission?

Mr GODDARD - Not in detail.

Ms FORREST - Back to your funding argument about how much we do fund. He makes quite a political statement, so I will take out some of the political nonsense. He is saying his Government has continually increased funding for Tasmania's health system to record levels and has worked hard to address the long-term challenges faced. He said in budget Estimates this year, ad nauseam, that we are spending more in health than we have ever spent. We are spending more and more and more. I could not get the estimated outcomes out of them to see how true the statement was at the time.

You say we are not spending as much as the Commonwealth Grants Commission says we should. In your view, is what the minister is saying true?

Mr GODDARD - Lies, damn statistics. I am not accusing the minister of lying, but what is not clear is what he is counting in those figures. For instance, if he is counting Commonwealth expenditure, the amount of money they raised through private health insurance, the amount of money they get from patients through the outpatients pharmacy - then no, I do not believe that is true. The other thing is 'record' amounts of health. If you have a system and you add 5 per cent in dollar terms to it next year, then that is a record amount. If costs have gone up 20 per cent, you get a rather different picture.

The comparative figures we have here are sorted out and made so we can be reasonably confident they are comparable across the country with the Australian Institute of Health and Welfare and other statisticians.

CHAIR - Is this figure one you are talking about in your submission?

Mr GODDARD - That is all these figures. If we believe these outcomes, not only in terms of the dollar figures but in terms of patient days, number of beds, waiting times, all of those things, if we really are doing as well as the minister says, then how come? Those two statements are not comparable. I trust the AIHW figures. I trust what the hospital staff are telling me. There is an overwhelming amount of information out there about what is going on. If we were genuinely putting the sort of resources in that the minister would like us to think he is, we would not be having this conversation.

Ms FORREST - You could argue the additional consideration the Commonwealth Grants Commission gives us because of our health needs could also be addressed by increasing funding to manage or mitigate some of the other social determinants of health, such as homelessness, Aboriginality, low educational outcomes, all those things we know are social determinants of health. It would effect better health outcomes if you put money into housing as opposed to a hospital system. I haven't heard that argument used by the minister, but I am saying it is an argument you could put. What do you say to that?

Mr GODDARD - It is not either/or. We need both. We need decent public housing because we need decent public housing. The broader argument about whether you can reduce the number of people in hospital, hospital demand, through various means of prevention is an attractive one but unfortunately it is not true. Demand continues to rise. Disease prevention is not something new. We have been at this for a couple of hundred years when you look at the things that have improved the public's health over the past century or two, things such clean water, clean air, clean food and vaccines, maternal health, antibiotics and getting rid of childbed fever, which used to kill many women. Those things have helped increase life expectancy and have improved the life and health of the population. What they haven't done is turn the number of patients who are knocking on the doors of hospitals downwards.

Ms FORREST - Those that turn up are sicker.

Mr GODDARD - They turn up eventually, anyway. Even if we can cure this disease, they will get something else. It would be much cheaper if everybody died when they were 40.

Laughter.

Mr CHAIRMAN - You wouldn't have an inquiry.

The Australasian College for Emergency Medicine - ACEM - recommended we should have more data collected. For the emergency department you have deaths, adverse advance, access block, available emergency department capacity at 8 a.m. each morning, the 'did not waits', and the greater-than-24 hours ED stays. Is there any data you feel needs to be collected for the government to assess its performance in that clinical space?

Mr GODDARD - Quite a bit of this is available, not necessarily in a very timely way, but it is there. There is one specific thing we should look at and that is the mortality effect of bed block.

CHAIR - The effect of bed block. Are you talking about how staff are affected?

Mr GODDARD - No, on patients, on mortality effects, on risk effects.

CHAIR - Sorry, I am not dismissing the patient side, I understand that, but how broadly are you going when you say that statement?

Mr GODDARD - I am talking about the risk of patients dying. I have referenced this in the submission. There has been a lot of work in Australia and globally on the relative risk of being affected by bed block. Bed block in this country is usually defined as not being able to find a bed for eight hours or more. Generally, that increases your relative risk of dying by about 20 to 30 per cent.

When this work was done about 15 years ago, drawing on data from the early 2000s, the Australian researchers concluded the number of deaths that would not have occurred, or would not have occurred then as a result of bed block, was around 1500 nationally in the early 2000s.

Ms FORREST - 1500 people.

Mr GODDARD - 1500 deaths. People did not die of bed block. They died of whatever they had. They would not have died of whatever they had, or at least not then. A lot of people would have died soon, but not then.

CHAIR - You are talking about avoidable deaths.

Mr GODDARD - I am talking avoidable deaths. If we have a 20 per cent chance of death, it becomes a 23 per cent chance of death. If you have a 50 per cent chance of death, it really tilts the balance against.

Since then, the number of patients in hospitals has pretty much doubled. We know that through table 18 on page 15. That is the 90th percentile. We are talking about people who have been waiting at the 90 per cent mark, some of the longest. For those people, patients who need to be admitted, the top line, there is no reason for them to be there other than bed block. You do not keep people in emergency for 10 or 20 hours, you just don't. As you can see there, it is basically about twice - this is between 2015 and 2016 - so it has been getting worse, particularly at the Royal Hobart Hospital.

We take all of those things into account and do a basic extrapolation of it. You would conclude there are something like 120 avoidable deaths through bed block per year statewide. Of those, because this is our biggest hospital we are more affected by bed block than anywhere else, I would expect that something like 70 or 80 are avoidable deaths occur a year.

CHAIR - You would get some similar situations in the LGH, would you not, and the North West Regional at a different level?

Mr GODDARD - Yes, but they are smaller and there are fewer people involved. There are not the same pressures in emergency. They are pretty bad at Launceston, but they are not as bad as they are here.

CHAIR - No, but they are reported occasionally.

Mr GODDARD - This is just speculation and it is too important to speculate about.

Ms FORREST - I missed the question I asked about the emergency medicine college. They were going to get some information back to us. I am really interested in the financial cost of this. I do not want to reduce it to money, but I think if we are going to have the argument about the efficient use of money - there is a certain sized pot of money and how you make the best use of it. Are you aware of any work done on the financial cost of the avoidable deaths? Not just the mortality but also the morbidity because morbidity costs a lot of money too. There is obviously the human cost, but I am interested in the financial cost that goes with that. Are you aware of any work or have you done any work on that yourself?

Mr GODDARD - Well, I certainly have not. That would be quite a significant project for a card-carrying health economist, which I am not.

Ms FORREST - So you are not aware of work that has been done?

Mr GODDARD - I am not, but what do you need to look at? Is it not just the direct costs?

Ms FORREST - I am not just talking about the direct costs. I am talking about the whole cost like the loss of productivity from them being out of the workforce all that sort of thing.

Mr GODDARD - You would put that into life years of some sort. Disability adjusted or quality adjusted life years and doing that is a highly technical process, but there are plenty of people in this country who could do it. I am not aware of the work.

Ms FORREST - Okay, thanks.

Mr FINCH - Your submission qualifies the lack of funding and resources by showing the poor performance of Tasmania in providing capacity for our hospitals to do their job. It also shows that in order to provide a level of care comparable to other states, which you say the benchmark is pretty low anyway, this state would need an extra 300 beds by the end of the next parliamentary term.

Mr GODDARD - Three hundred certainly. I looked at that figure again yesterday and I think that figure is probably a bit low.

Ms FORREST - On page 19 you say 429 beds.

Mr GODDARD - It really depends which year you look at this.

Mr FINCH - I am also interested in your breakdown. I would like to know your breakdown of where those numbers might be needed from your perception or understanding - North West, Mersey, Launceston, Hobart. Do you have a percentage or a breakdown?

Mr GODDARD - No, I do not have a percentage, but where the pressure is, there is nowhere with as great pressure as the Royal Hobart Hospital. That is where the population is and that is where the shortage is. It is the main hospital so numbers of people are referred down here from other parts of the state. It is our main teaching hospital. Here and Launceston, as of right now - and it depends which year you look at because these averages move around a bit - I reckon that we need about another 200 beds statewide.

There are many problems in the North West, but I do not think the main problem is lack of beds. As a rule of thumb - and this is a guess - if you had 200 beds now, magically, I probably would put something like 120 into the Royal Hobart Hospital now and maybe most of the rest into Launceston.

Mr FINCH - I do not know if you are up with the development of the Royal Hobart Hospital, what was the block converted into K Block to provide the extra 250 beds? Obviously the Government's intention is to alleviate this need for the extra beds.

Mr GODDARD - There are a couple of things here. One is that minister is carefully using the figure 'capacity' for 230 or 250 or whatever it is. He is not actually saying we are going to have the beds and there is certainly no money in the budget for them that I can see in the forward Estimates.

Let us look at the annual recurrent cost of 200 beds, of which about 80 per cent would be acute and take into account the 45 per cent that the Commonwealth is going pay you, it might be more if government changes and they have a different policy. The amount of money they make from patients through private health insurance, assuming that does not go back and the federal health minister would like to eliminate it, I reckon it would cost you about $70 million to $80 million for those beds out of what the state government has to provide.

CHAIR - They are counting that as revenue?

Mr GODDARD - Yes of course. The amount of money the state would have to put in from its own resources, assuming it is going to go on taking that money from patients, is of the order of that. I can not give you a figure for buying the bed itself and the machine that goes ping next to it.

CHAIR - And the staff needed too.

Ms FORREST - That is what he is talking about.

Mr GODDARD - It includes the staff because that is based on the national official price which includes the cost of treating that patient and includes staff right through. That is actually achievable. It is not a vast amount of money but it could make a big difference. The snag is that if you make the assumption, as I have on the final page, that the five-year average of the increase in inpatient days, which is 3.2 per cent statewide, if that goes on and it is lower than that lately because the hospitals are full, it works out to between 47 and 53 beds - let's say 50 new beds a year. How long will it take before the rebuild at the Royal Hobart Hospital is full, about five or six years?

I am told you can get maybe another 40 or 50 beds into the LGH but no more. There are a few things you could do - you could talk to Calvary about putting a public elective surgery centre in what is currently the roof at St Vincent's because they could easily build on there. I have been talking to them about doing that. There is another good reason for doing that too.

CHAIR - Public ward?

Mr GODDARD - What we are not used to in this state is having non-government owned public hospitals run by the Catholic sector. St Vincent's Sydney and Melbourne, and the Martyrs are common elsewhere but not here.

I am not suggesting we have a full blown new hospital that, say, Calvary or whatever would build, but the option is to have elective surgery centres so that the elective surgery - that is, for low-to-medium acuity patients up to and including hips and knees, not the heart bypasses and those sorts of things - would be separated to have their own staff and their own budget. They would be insulated from being bumped by more urgent cases - a lot of them are, it is very constant.

CHAIR - Isn't that what they are trying to do with the Mersey?

Mr GODDARD - Not very successfully.

Ms FORREST - They are also not doing hips and knees; they are only doing minor arthroscopy, colonoscopies, things like that - lower acuities.

Mr GODDARD - The Alfred did this some years ago. They built an elective surgery centre in the car park. They had a hospital-instigated cancellation rate for elective surgery of 20-something per cent, similar to what we have here. Through doing these things and separating them from emergency cases so the two did not conflict, and having a protocol-led patient journey so it became like an assembly line, which it can do with those sorts of patients, they got hospital-initiated cancellation rates down to zero.

Ms FORREST - You have to get it away from the other part of the hospital, though.

Mr GODDARD - That is right.

Ms FORREST - You need some degree of separation to make it work.

Mr GODDARD - You could do that in Hobart on the Repatriation Hospital site.

Ms FORREST - We did ask them about that when we were on the site and they indicated that because of the current state of the Repatriation Hospital, it is uneconomical to do it.

Mr GODDARD - There are places there that are being decanted at the moment. I know there are four theatres that need refurbishment. When the decanting happens in reverse, there should be space in the Peacock Building.

In Launceston, the only place I am aware of is St Vincent's Hospital. Calvary is interested, in principle, in building on top and putting on another ward. This is very initial. I would actually rather this was not in public - just the stuff about Calvary - because I am talking to them.

Ms FORREST - We can come back to that, at the end perhaps.

Mr GODDARD - I can talk about the idea because it is my idea. The idea is that Calvary would pick up the capital cost of doing that and they would be paid on the basis of the national efficient price for each patient. They would be part of the THS.

Ms FORREST - But it would be Calvary staff running it?

Mr GODDARD - They would be responsible for employing their own staff - doctors, nurses and everybody else. It would be run on a service level agreement at the national efficient price.

Ms FORREST - It is a lucrative suggestion, in many respects, for a private hospital because activity-based funding and national efficient price are all about outputs. You can expect there to be reasonable outcomes if you are dealing with pre-planned surgery - people in a relatively healthy state going in for their surgery, going through the system and coming out the other end, usually on the same day. Many of these places in Melbourne do this. Economically it would be attractive.

Mr GODDARD - I took a written proposal to the minister about 18 months ago on doing this and seeing whether Calvary or whoever was interested, but there was no interest.

Ms FORREST - At the ministerial level?

Mr GODDARD - From the minister.

Ms FORREST - Why was that? Was there a reason given for that? We can pursue this and ask the minister.

Mr GODDARD - No, there wasn't. He listened politely and said yes. He largely said nothing, but that was it.

CHAIR - It wasn't an overall governance issue or anything that concerns the Government?

Mr GODDARD - We are not inventing the wheel here. The governance issues exist.

Ms FORREST - I am not the minister and I am not speaking on behalf of the minister at all, but if you take out the easy-to-deal-with patients in your hospital system, which is effectively what you are talking about, it is easy to get your targets met and all that sort of thing. If you push them over to the private sector, even though they are under the THS, you then end up with much more complex patients in the Royal, LGH and other places.

Do you think that is the barrier?

Mr GODDARD - No. I don't know what the barrier is. I speculate that there are two. If I can go back to the Calvary thing. I have had those conversations. I was authorised to say that there is initial interest and they would have a look at it. That is fine; that is all we need to worry about. Sorry?

Ms FORREST - The reasons why?

Mr GODDARD - The plan is that the Mersey is going to become the state's elective surgery centre.

Ms FORREST - Only for low acuity though, not for -

Mr GODDARD - Well, for whatever acuity. From what you are saying, there is not a lot of high level of acuity there.

CHAIR - So where do you see the downside in that?

Mr GODDARD - I am not sure whether I see an obvious downside. These things never work smoothly.

CHAIR - It means that people would have to travel from all parts of the state.

Mr GODDARD - For the Mersey?

CHAIR - Yes.

Mr GODDARD - I do not think it is going to work. There is always going to be a problem with recruitment. Are people going to want to live in Devonport? If they come across from Launceston, that is going to be quite inefficient.

Having one centralised place for the whole of the state; the problems of accommodation for people who are going in and out of hospital for tests, for their carers, for their families and so on, are just going to be immense.

I have never thought that would work. I have always thought the idea was nuts.

CHAIR - By the same token, if you are living in the north-west and you need procedures in Hobart, you still have those accommodation issues. You have the issues of your family having to go out of their way to facilitate.

Mr GODDARD - Yes, but there are more people living in Hobart than there are in Devonport.

Ms FORREST - There are more people in the north of the state than there are in Hobart.

Mr GODDARD - Yes, there are. I am not for a moment suggesting that there shouldn't be elective surgery at the Mersey. What I do not think is that it is going to serve the hospital adequately.

CHAIR - It might be a boost to the economy of Devonport.

Ms FORREST - I am not sure the intention was to serve the whole state.

Mr GODDARD - That is what he said.

Ms FORREST - We will ask the minister about that.

CHAIR - Can I ask a question and then we will have to think about wrapping up, depending on whether you want to have an in camera component.

Mr GODDARD - No.

CHAIR - Dr Bryan Walpole was talking about academic and medical centres. Have you heard of his suggestion?

Mr GODDARD - I have read his submission. It is not something I know anything about.

CHAIR - That is okay. I was interested to know if you had come across that and the metrics and costs associated with it.

Mr GODDARD - I think we need to think seriously about how we are going to provide further accommodation, particularly in Launceston and Hobart. We are going to have to do a lot more building. If we need 50 more beds statewide, then those two major hospitals are going to need to be expanded often and a lot. I don't know where it should go in Launceston but I know we should have plans now for a major extension of capacity in Launceston. We should also be aware that the Royal Hobart Hospital is going to be full again in another few years. Now is the time to start thinking about what we do because we are going to need new buildings.

CHAIR - Isn't that where preventative health strategies come in?

Mr GODDARD - No, it is not. Preventative health strategies might keep individuals out of hospital now, but history shows they do not reduce the demand. Whatever you do in terms of prevention, whatever we have ever done in terms of prevention, demand on hospitals continues to rise.

CHAIR - Isn't that a bubble? Isn't that the baby boomer bubble moving through, people becoming older -

Mr GODDARD - No, it is not. Some interesting work was done by Jeff Richardson and his group some time ago at Monash, and others. Looking at the acute hospital costs of the aging population, the reality is that a large amount, maybe 18 to 20 per cent, of lifetime health costs occurs in the last two or three years of life. When you take that into account, when you feed that into the equations, what they found was the cost of acute hospital care as a result of the aging population was much, much less. It was there, but it was much less and they thought entirely manageable. The idea the aging population is going to blow out the system doesn't stand up to that kind of scrutiny. I don't think that is the problem.

The question is of our rising demand at the moment. Hospital demand has taken off for the past five or six years or a bit more. If it is not the aging population, what is it? I suspect it has something to do with unmet demand, with people who can no longer be ignored.

Ms FORREST - There are a few things we need to follow up on.

CHAIR - Especially that Monash University, Jeff Richardson, it sounds like an interesting read.

Mr GODDARD - I will email it to you. I did a paper drawing on that as well so I will send those to you.

CHAIR - You naturally think there is this baby boomer bubble -

Mr GODDARD - It is not equal. Just because you turn 65 doesn't mean you suddenly get sick.

CHAIR - Thank you for taking the time to put in a submission. Your submission is full of fascinating facts and figures. I am not sure I have my mind around every part of it, but it is very much appreciated. I think the other members will agree with me on that score. You were going to ask another question -

Mr FINCH - If you do not mind, Chair, in the submission you talked about the blame game; the Commonwealth government is inadequately funding the nation's hospital system but that Tasmania's relative inadequacy compared with the others is the responsibility of the state Government. Would you like to touch on that, the blame game and Tasmania's inadequate contribution?

Mr GODDARD - Broadly, that the nation's hospitals being in trouble has more to do with the Commonwealth than with the states. The issue that our hospitals are worse in their capacities than the average of the rest of the country is up to the state Government. One of the interesting things is that when you look, and this is in the submission, hospitals have become more cost efficient around the country. Some have become more cost efficient more quickly than others, like Victoria's. When you look at the figures, the states with the more efficient hospitals are not putting that money back into health. They are taking that money away.

From the hospital system's point of view, you have to ask whether there is any great advantage in becoming more efficient. The money is taken away from them anyway. The other thing worth thinking about is the number of people treated as private patients in our public hospitals. Twenty-five per cent of inpatients in Tasmanian public hospitals are treated as fee-paying private patients. In New South Wales it was 24 per cent. Those figures are in here.

That, I reckon, is currently worth something like $90 million a year. The federal government wants to stamp it out because it is under immense pressure from the private health insurers and the private hospitals. Greg Hunt said he wants to contain it or eliminate it. He said nothing about replacing that funding stream. I think that is something the states have not gotten onto yet but it is another one of the time bombs facing us.

Ms FORREST - You cannot eliminate it, particularly in Tasmania, because some services are not provided in our private hospitals. It is never going to be -

Mr GODDARD - Well, what do you have a free public hospital system for? I do not know. I reckon let them in free.

Ms FORREST - Not charge them?

Mr GODDARD - No.

Ms FORREST - Oh right, yes - make them public patients?

Mr GODDARD - Yes.

CHAIR - Is this an interest you might have in terms of how the structure has changed in the planning? Do you see having a long-term strategic framework where all parties sign off on rather than politics being played every four years as a way forward?

Mr GODDARD - It would be lovely. The problem is I cannot immediately think of a long-term plan that has lasted longer than about 18 months.

CHAIR - I understand that, but is that not the problem?

Mr GODDARD - We need to know where we are going, whatever you call long term. If we are going to build, we ought to have an idea about what we are going to need in five years' time.

CHAIR - It needs to be in the context of the whole, doesn't it?

Mr GODDARD - Of course it does.

CHAIR - Even though we were talking about preventative health strategies and those sorts of things?

Mr GODDARD - We need to take these things into account and budget for constantly increasing demand and not just constantly catching up.

CHAIR - Thanks very much. Any other questions before we go? I remind you again that parliamentary privilege does not exist once you walk outside through those doors. You need to be careful of that if you are speaking to the media. Thank you for putting in your submission. It is tremendous and we really appreciate it. Thank you.

Mr GODDARD - The other thing is Catholic Health Australia has put out quite a good report on private health insurance in public hospitals. If you like, I can email that to you. I would be happy to.

CHAIR - Email it to Jenny.

THE WITNESS WITHDREW.

Ms HELEN BURNET WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Valentine) - Good morning. To make sure we are all on the same page, this is the Legislative Council Government Administration A Subcommittee inquiry into acute health services in Tasmania, so right across the state for all major hospitals.

All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded that privilege. Even if you repeat what you say in here, it would not have that same privilege.

Have you read the information for witnesses?

Ms BURNET - Yes I have. I might make a couple of date addendums to my representation if I may.

CHAIR - Date addendums? We can do that in a minute. I have a little preamble to give. The evidence you present is being recorded and the *Hansard* version will be published on the committee website when it becomes available. By way of introduction, I advise the procedure we intend to follow today is as follows: first, you will be provided with the opportunity to speak to your submission if you wish to do that. Following on from that, committee members will direct questions to you.

We are seeking information relating to acute health services. Should you come to a point in the hearing where you would like something to be heard in camera, you need to let us know the nature of it and we can deliberate and decide on that. As with your submission, our interest is in the terms of reference. Acute health services involves wideranging topics but it is important we stay on track with the terms of reference.

Ms BURNET - Thank you, Chair, and thank you for the opportunity to put in a submission. I appreciate the parliamentary inquiry. I would also like to make some opening remarks and some comments, if I may. My submission accords to my principles of being a servant of the public. As I said in my written submission, I proudly worked for the Tasmanian Health Service - THS - from 2005, finishing in April 2017. I resigned at that point. I was striving for the good health of the community. However, I believe delivering good outcomes for patients and clients of the podiatry service was severely compromised over the past three-and-a-half years. It was not well served with a dysfunctional bureaucracy and cuts in 2014 to allied health professional staff, particularly in the south. That was due to budgeting and effectively meeting targets to reduce the number of full-time equivalent staff, the introduction of management of patients by waitlists and so forth.

Subsequent staff demoralisation, stress and increased amounts of resultant sick leave compounded the problem, inevitably weakening the health service and in turn increasing the health burden. People were ending up in the acute hospitals because of lack of timely intervention in particular.

I also act in my role as an alderman. While not representing the council today, I am representing, and have spoken to, many people affected by the health system and its current crisis. That includes health workers, former colleagues, patients and relatives of patients who have had poor experiences, some of which I would like to share with you today.

I firmly believe there is a problem with a disconnection between the organisation and the THS executive and in the length of time it has taken to develop an organisational structure. It took a really long time after the structure was altered. There are doubts about the implementation of a clinical plan, given the Health department has been down the path of restructuring many times, and the functioning of the THS and DHHS as an effective bureaucracy. Much of this dysfunction rests with the minister, who, while warned of significant problems by the AMA, the Medical Staff Association and other organisations, has neither taken that advice nor made effective changes and allocated sufficient funds and personnel to run an effective acute health system. I firmly believe that has had a huge impact on how the acute health services have functioned.

Can I go on, Rob, or is -

CHAIR - You may go on. You were going to correct some dates at one point?

Ms BURNET - Yes, and I will do that in a moment.

Acute health services are closely linked to other services within and external to the Tasmanian Health Service. I saw a decline in the ability to provide timely care, both preventative and remedial. I am not sure if I should explain the role of podiatry in the health service?

Mr FINCH - I would like that.

Ms BURNET - Podiatrists are allied health professionals. They are not doctors; they are more akin to physios. We train interstate. In Tasmania a number work in the public health service, but there are private podiatrists as well. When we could refer to the private sector, we always did. That was a standard thing to defray some of the burden on the public health system. Podiatrists do a lot of preventative care. It might be sort of cut and chip; it might be corn and callus work and orthotic work, often for older patients, but quite often for people with diabetes.

Complications of diabetes include eye disease, kidney disease, systemic amputations and foot amputations, nerve damage, and arterial disease, which is one of the biggest burdens. It is one of the biggest reasons for people to be referred or admitted as inpatients to the Royal Hobart Hospital and other hospitals in Tasmania. We - I keep saying 'we' because it has been a big part of my life for many years - the Royal Hobart Hospital Southern Podiatry Service ran an outpatient clinic, a foot ulcer clinic. It is different from leg ulcers. That happened twice a week. We had an emergency clinic for people who needed emergency foot ulcer care.

CHAIR - From anywhere around the state?

Ms BURNET - We had a certain amount. Our service is a tertiary service. They do have foot ulcer or high-risk foot clinics in the north and north-west but if it were more complicated, they would have to come down to us because they did not necessarily have the vascular or even endocrine support that they needed in the north-west. That is something I have referred to in my submission, the telehealth arrangements. Does that give you a bit of an indication? A lot of it is preventative. Most of it is out-patient work and in the community health centres across southern Tasmania that I looked after, but also inpatient services twice a week. That is all we had allocated for. A lot of it was preventative care and, mostly, outpatient work.

A lot of the remedial work was done outside of hospitals. While continuous improvement should always occur to get the best results of any health service, the cuts to allied health professional staffing in 2014, soon after the government came in and Mr Ferguson had to reduce the number of staff, were severe. We had to reduce the number of allied health professionals in our area and it meant there has been a chronically reduced capacity to provide the level of optimal care by that service ever since - by podiatry in particular.

It is critical to the health of our community and the health of our city and state that the health crisis is addressed. The RHH must recruit and retain good staff so it can become a centre of excellence to provide the best health results for Tasmanians, and THS becomes an employer people want to work for. I have a number of examples of patients and people related to patients of the RHH. I have six examples here.

The first was somebody who talked to me - a woman probably in her 40s - who had a relative who was unwell in the RHH. Unfortunately he was very unwell. He was an older relative and he was discharged earlier than expected and probably for the best of his health. He was sent home but the family felt they were unable to provide the care he required because he was still very sick. She was very concerned about that. That is only one example.

Another example is of a woman I know whose daughter was sent to the acute adult psychiatric ward. She is in her fairly late teens and required medications and treatment to sort out her mental health issues. She was in the acute adult psychiatric ward for a few days; then she was told to pack her bags and in 20 minutes, out of the blue, she was walked by the nursing staff over to the Mistral Place facility which is on the corner of Campbell and Liverpool streets. It is a step-down psychiatric facility.

The young woman was very confused and anxious which is part of her condition, but particularly because of the unplanned transfer. She rang her mother very distressed. She did not know where she was. She had to look out the window and say where she was. She was on the first floor at Mistral Place and she sounded like she was really distressed.

There were very few or no programs to support this young woman. There were shared bathrooms. There was a real mix of mental health patients in this facility, some recently released from prison, others suicidal and often coming back into hospital for treatment because they were not necessarily in the best place for recovery, particularly if they were all in there together.

The woman said that the staff are doing their best, but they have limited resources and are limited in what they can do, which causes real boredom for the inpatients. She felt it was suboptimal to recovery.

A former colleague I spoke to this week said there had been a blowout in the number of inpatient referrals to podiatry. Certainly when I left there were only two sessions a week where podiatrists could have inpatient care. Podiatry is located in the Telstra Building, along with the pain management, diabetes and other allied health centres.

CHAIR - Is it on the corner of Collins and Argyle?

Ms BURNET - Yes, that is right. She was saying that there were certainly a lot more presentations of foot complications. Consequently those who needed to be seen could not always be seen during their stay as an inpatient. There has also been an increase in calls to go over to the

Royal Hobart Hospital on days where podiatry staff are not allocated to attend those inpatient clinics.

We have a very limited service, as I said. The reason they were called over on Friday afternoons, for example, was because patients were being discharged to go home. If somebody has a foot that is still healing, post-surgery or they cannot not bear weight because of some sort of neuroarthropathy or wound, they are at high risk of falling as you could imagine, or they might be systemically still unwell. Sometimes it seems that the treatment might be compromised if you need to get somebody out of the door pretty quickly.

There has also been an increase in dissatisfaction by patients who have had to wait longer between podiatry appointments and, again, suboptimal care.

Three other examples. Recently a doctor told me she was concerned that senior clinicians were not being listened to by the THS executive. She was also concerned that the escalation plan and bureaucracy were not providing good health outcomes.

A quote from a health worker -

> I found it stressful over the years having experienced nepotism, bullying, had worked sabotaged, unsupportive management (not all), too much time taken up with employer/employee issues and less spent doing the job of caring for patients. Finally, increased bullying and harassment from senior staff. There is no longer a community feel to the RHH, less strive from employees to help out other departments with issues. It is not my job.

The corrections were a couple of dates. I believe that Dr Alcorn started in 2015, but it was announced in December 2015 and he started in February 2016. At the top of page 4 -

> On occasion it appeared that Dr Alcorn was rather rude towards senior clinicians.

He did feel that; I witnessed that. That is the main thing.

CHAIR - I am just trying to find it.

Ms BURNET - It says -

> Often he appeared quite rude ...

I have to change that to 'on occasion', which is at the top of page 4. I can give you these notes. I will table these.

On page 6, I will read it to you -

> Despite business cases asking for greater podiatry staff employment to meet this ever-increasing demand, there was no success in gaining funding to employ more staff for hospital care.

Ms FORREST - 'He often appears quite rude', on page 3, the next paragraph below that date.

Ms BURNET - Yes, thank you.

CHAIR - You say, 'in gaining funding for more staff'?

Ms BURNET -Yes.

CHAIR - Thank you for that. Just for the record, Helen was deputy lord mayor when I was lord mayor.

Ms FORREST - I think we know that.

CHAIR - I do not know whether Kerry does.

Helen was deputy lord mayor when I was lord mayor. That was just for the *Hansard.* It is not a declaration of interest; it is a declaration so that everyone knows.

Helen, you talk of a sustainable model. This is looking at terms of reference (1), which is current and projected state demand for acute health services. You talk of a sustainable model needing to be implemented for clinical staff, specialist nurses and allied health professionals in the north and north-west, otherwise demands for services at both the Royal Hobart Hospital and the Launceston General Hospital are likely to increase. Do you want to emphasise any particular strategies that are a must in this regard to be able to gear up for that demand? You say that telehealth services are proving too time intensive because there is no additional resourcing provided for the clinic, so basically, where to from here?

Ms BURNET - Thanks for the question. For a functioning health service, there has to be stronger recruitment and retention means.

When I first became manager, I was manager across the state and while we had fairly robust recruitment, it was always quite difficult in the past to recruit to the north and north-west. That is partly to do with lack of specialist services - vascular, endocrinology and neurology to an extent as well. Some of those medical professionals are quite difficult to recruit and retain, so that has a flow-on effect on services such as podiatry and other allied health services. It is harder to get good outcomes if you do not have an endocrinologist who can write the appropriate prescription and modify and have better control for diabetes care.

If diabetes is poorly controlled and other things associated with that, such as blood pressure and so forth, you have flow-on effects to worsening complications or greater complications. That is part of it.

CHAIR - Have you read the Neurological Alliance Australia submission to this inquiry?

Ms BURNET - No, I have not. I have not read any of these.

CHAIR - They suggest that a clinical team approach be employed so a greater number of services available are to individuals in those more remote locations. I was wondering whether you saw that as a way forward.

Ms BURNET - Multidisciplinary teams have the proven track record. Where possible, nurse practitioners are really useful when specialists cannot necessarily be around. Podiatry is looking to have prescription rights so the professional will be able to step in, particularly in rural and remote areas where you cannot necessarily have a doctor or who may not know the GP or they might help with the treatment anyway.

Telehealth is an interesting one. The specialist podiatrist in the south spent a lot of time and energy setting that up and making it work so it had to sit as part of the high-risk foot clinic in the south, which, as I said in my written submission, took away about the equivalent of, if it were done every fortnight, a couple of patients every fortnight who cannot be seen down here. The endocrinologist has to see the telehealth patients from here in that time; that is the only time allocated. It would be far better if we had even more endocrinology time associated with the high-risk foot clinic and podiatry as well because it takes away from the patients we can see down here.

CHAIR - Are you saying that telemedicine is a way forward provided it can be arranged properly with some of those specialist facilities?

Ms BURNET - I understand it is very labour intensive or time intensive to the endocrinologist. Unless you have everything at your fingertips, you have to ask a lot more questions. While that can be tweaked, you can get that information from good triaging and good contacts at the other end where the patient is, making sure you have information about prescriptions, treatment, modalities, how that has been run, how often they are treated - all that sort of thing. That can work okay, but it is very labour intensive so it takes away from the time you can have.

My point really is that if there were more resources, we could easily spend greater time doing ulcer care and preventative care for those complex patients, so a multidisciplinary team here is good. Having the resources in the north-west, in particular at the Diabetes Centre, would be very worthwhile as well. That is making sure there is a workable model to ensure that you have the specialist team up there and the full specialist team. A multidisciplinary team is the best way to approach that, and also resourcing things properly.

Mr FINCH - Could you clarify something for me please, Helen? You talked about two days only being available at the hospital. That means there are -

CHAIR - For inpatients.

Mr FINCH - For inpatients?

Ms BURNET - For the inpatient services?

Mr FINCH - An allocation. So what you are saying is that because only two days are allocated, you get a mad rush or overloading at those particular times when - what should it be - three days, four days?

Ms BURNET - I think you could easily have a full-time podiatrist allocated to the Royal Hobart Hospital.

I had two podiatrists going across so effectively it increased the time, but you could easily spend more time in the emergency department and helping with that, keeping people out or doing that emergency treatment when people present with foot ulcers or foot wounds. We worked closely with the wound care consultant nurses. We have a good relationship with the ED doctors and other consultants, but if we could increase that time over there, we would provide more timely treatment. Sometimes we have to get footwear sorted; sometimes we might have to put somebody in a below-knee total contact cast so that they are not weight-bearing on a foot that is either a rocker bottom or a misshapen or deformed foot or an amputated foot. Sometimes you might want to have that kind of intervention, which just takes time. You have to take people up to the plaster room and get them in plaster casts and so forth.

Mr FINCH - Helen, where does that limit for podiatry come in? Is it because of a lack of funding in the hospital system? Does it come out of the hospital budget to pay for the podiatry services or the podiatrist so the hospital says it is only going to pay for two podiatrists for two mornings per week?

Ms BURNET - There is funding- it is not that black and white. It is a matter of where we need to allocate resources. I held the budget for both acute and community services. Because it is such a small service, we have been across acute hospital services and subacute services. It was an allocation. I had to decide about how much time we could afford to spend in the hospital. There is also all this other preventative work and keeping people out of hospital because it is much cheaper keeping people out of hospital than spending, on average, $10 000 for somebody with so many comorbidities - a weighted value of length of hospital stay for podiatry patients.

Mr FINCH - How was your allocation propagated? Where did it come from? Out of the hospital budget itself?

Ms BURNET - It was statewide. There was state and federal funding so it was across two funding sources.

Mr FINCH - Yes, and then that was divvied up by whom?

Ms BURNET - I had a business manager and it was allocated to my department. I had obligations to provide services to about 13 community health centres as well as subacute services - that is, outpatient services - as well as some inpatient services. The bulk of the work was preventative care in the community.

Mr FINCH - Did you seek more of an allocation, and this fell on deaf ears?

Ms BURNET - Yes, on many occasions.

Mr FINCH - Where would you make your submission in seeking more of an allocation?

Ms BURNET - I sought increased funding through putting up business cases. Dr Greenaway was involved with the inception of our high-risk foot clinic. I cannot remember how long ago it was now - until when he left. At one stage we did not have enough staff to run that high-risk foot clinic, that multidisciplinary team, so we needed more podiatrists and he helped with our case for that. That was probably about three or four years ago, and Dr Greenaway helped support that case.

Mr FINCH - In what capacity?

Ms BURNET - Writing a letter in his role as the endocrinologist directly associated with the high-risk foot clinic for many years.

My most recent request for funding was to identify what sort of problems, foreseen shortages or shortcomings there were in providing podiatry health care in the acute sector and in that burgeoning community of disease in the community sector.

Mr FINCH - Tell me, Helen, the quantum of the budget allocation and what you thought might have been needed top cover, what you saw as a burgeoning issue -

Ms BURNET - I cannot remember exactly how much it was.

Mr FINCH - Was it $100 000, 200 000?

Ms BURNET - The budget for podiatry is roughly $1 million. It was pared back a little bit. It is roughly $1 million for financial years and that has been pretty stagnant and static. I had a number of models to say that we need an extra FTE for the acute sector, we need so many podiatrists, two-plus podiatrists in the community sector, and we have a foot care assistants, who are not trained as allied health professionals but they are like allied health assistants and are trained in podiatry care. They take away a lot of the work of what a podiatrist does, which is a cost-effective way of providing that care.

Mr FINCH - In your budgeting or your requests for more, did you ever bring it down to dollars as to where you think it might be? Money, as distinct from people?

Ms BURNET - Yes I did, but I cannot recall that, Mr Finch.

Mr FINCH - It fell on deaf ears?

Ms BURNET - It fell on deaf ears, unfortunately.

Ms FORREST - Helen, we visited the Royal Hobart Hospital yesterday and looked at a couple of the areas, not all of it. We also looked at their new patient flow models and how they work. One of the things that was apparent was that patients are sometimes waiting discharge but are waiting on certain services such as physiotherapy or OT. I assume one of these could be podiatry if they need to see a podiatrist before they are discharged. If it is only two days a week, can that potentially impact on the readiness to discharge some of those patients? Do you want to talk about that?

Ms BURNET - Yes, it certainly does. Quite often patients have other services, either showering, diagnostic services such as x-ray, rehabilitation or some sort of treatment during the time we have allocated. We are always competing. We have tried to hone that over the years - the podiatrist would always call the ward to make sure we were using the time in the most effective way.

We would also triage patients so that inpatients who were referred for things that were not urgent and were not high priority would often not be seen in the time they required. Sometimes there might be an inappropriate referral. We have tried to tighten up that referral process, mainly

by nursing staff. That has been effective. However, sometimes the demand - the increased number of referrals and those urgent referrals - might mean that sometimes you will not see them on the Monday or Thursday in the allocated time that the podiatrist would go over and see them. Perhaps they could not been seen in that time and it would click over to the next week. Sometimes they would be discharged. Sometimes the discharge would be hindered by not having appropriate postoperative footwear or not being seen by the podiatrist. I would imagine that was a reason to hold up discharge.

Ms FORREST - I have a couple of points I wanted to go through in your submission. Under term of reference (5), you talked about some of the challenges you think are leading to adverse outcomes. You note -

> I believe the restructure to a statewide system and the way it has been implemented has been not only a very expensive wasteful exercise (time, travel, petrol, financial cost), but that it had an extremely negative impact on the running of the RHH, the chain of command, roles and responsibilities and clear decision-making for the hospital.

You state -

> I am of the very strong view that without a CEO of the RHH and executive, the RHH was severely weakened as a functioning institution.

You go on to say -

> Importantly, with the senior executives' relocation to Launceston, I found that there was a significant disconnection between staff and the THS executive. The CEO rarely visited Hobart to engage with staff.

You made further comment. Can you expand on that a bit? While we are where we are now, how could these failings, as you see them, in the system be addressed so we have one statewide health system? How should it work or how could it work?

Ms BURNET - A statewide system can work. We are a small state. I do not see there is a problem simply having a statewide system. It is the way, unfortunately - the bureaucracy is unwieldy, in a sense, but this particular approach to the restructure has been pretty disappointing.

I felt there was a disconnection with the placement of the executive up in the north. I know it is going to be the same wherever it is placed. The physical separation was the reason members of the hospital executive or my director, the director of Allied Health Professional Services, had to go up the road up to Launceston so many times for meetings. It appeared it was not a good use of time and there was not an effective connection with the hospital.

Ms FORREST - How do we improve it from here?

Ms BURNET - I do not know if the nature of it was meant to have been so -

Ms FORREST - Disjointed, as a word?

Ms BURNET - Yes, disjointed is probably a good word, but so far away.

CHAIR - Remote.

Ms BURNET - Yes, thank you. That management has to be a consultative management. There has not been, from my observation, the consultation with senior clinicians or even senior management. I did not have much to do with the clinical services plans, which were another process. I know my allied health professional advisory committee colleagues, OT and other managers were feeling we needed to have input into the plans and the organisational structure, but there was not very much guidance there. I think asking and involving, having meaningful communication and input, would be really beneficial. I think that was really missing.

CHAIR - So you are saying it is reactive rather than proactive? They are there and they are saying, 'Call us if you want us, rather than being on the phone asking if you have any issues'?

Ms BURNET - No, I would not say that at all. If I had problems and I needed to speak to somebody, I would speak to my manager, but then who did she speak to? There was no clear chain of command.

Having a clearer chain of command or responsibility - and even as a manager I would have liked more responsibility for my budget. Expecting responsibility, taking on those challenges as well would be more beneficial to the organisation. Having a clearer goal overall. A clear pathway, as to what -

Ms FORREST - Communication strategies and that sort of thing?

Mr BURNET - Communication, yes. Certainly communication strategies.

Ms FORREST - And feedback mechanisms? Could I just take it over further on in your submission - you were talking about where I was going to with this -

> There is little clear direction or involvement in decision-making for senior clinical staff, medical nursing and allied health as well as other service staff to be consulted and engaged in decisions for the effective running of the hospital.

And you went on -

> Coinciding with Doctor Alcorn's appointment, there is a pervading cultural cover up and lack of response of needs to staff.

What I am hearing is that this lack of decision-making at the clinical coalface and there is no feedback mechanism. We heard from other witnesses that when people raise concerns about adverse outcomes, those people are almost bullied or are bullied. Is this what you are saying, the same thing? Are we hearing that from you? How do we fix this? Because this is a key part of a functioning system?

CHAIR - Of any component of the system, is it not?

Ms BURNET - I believe that there were situations where things were not acted upon. There might have been warnings about or suggestions to put in tenders for particular things. I know I put in a submission to Primary Health Tasmania to provide podiatry services for them and there

was just this vacuum of support. That is not acute services, but there was just this vacuum of support and -

Ms FORREST - From whom? Where were you looking for support and it was not forthcoming?

Ms BURNET - From management. From my manager who was trying to do the best she could, but she was not getting any direction. It was just unclear.

Ms FORREST - Where is the leadership void? What we need to be able to clearly articulate is: where is the leadership void?

Ms BURNET - Prior to the DHHS and THS and the statewide executive, there was the hospital executive. Sometimes I was acting in the role of allied health director and I would be a member of that executive. They would make decisions on vacancy control and various things as a hospital executive would do. Once that went, it was not clear. Wendy Rowell was in the role of - I think she was chief operating officer, or whatever - but she did not seem to have the responsibility to make decisions. It was not clear what her -

Ms FORREST - She did not have the power to do it? Is that what you are saying?

Ms BURNET - Did not seem to have the power to do it, yes. To respond and advise, but also to report up.

Ms FORREST - What we are hearing is that the loss of that clinical decision-making and decision-making at a local level - and I was a strong supporter, and still am, of the One Health System. We are small state; we need to work together to get best outcomes. But can we have one Tasmanian health service and still have that local clinical decision-making? Now this may not be a question for you to answer as much as some of the other medical staff perhaps, but I am just interested in your view because this is what we are hearing - that we have lost the good part of the old system and we have not been able to replicate that in a way which is having the impact that appears to be needed.

Ms BURNET - Yes, I think it is a really wicked sort of problem. A bureaucracy can work, but I think there are real concerns with the THS and DHHS bureaucracy as it is now. The hospital executive is paramount and having those clinical leadership teams feeding into them and having greater input that is listened to and acted upon, and also directed the same way, can work. So I agree with you.

We could have a statewide system. We should be having a statewide system. We should be referring to and from every part of the state, back and forth, but there are too many roadblocks at the moment for that to occur. I feel strongly that we should be able to do that and we should be able to use that sort of safety in numbers or whatever with large, supported health teams. Larger, supported health teams like multidisciplinary teams or using nurse practitioners in those more remote areas.

CHAIR - Can I just ask a question following on from that? You were in that space for quite some time. To what extent has this lack of clinical staff contributed to avoidable hospitalisations? Have you a gut feeling for how many people are actually coming into hospital as a result of just not having their needs met in time?

Ms BURNET - I think it is increasing all the time.

CHAIR - Is there a percentage you can put on it? I know it is a hard thing - maybe I should not ask that question - but if you can, that would be interesting to know.

Ms BURNET - Well, there would be figures on increased burden, but I do not know those off the top of my head, I am sorry, but -

CHAIR - Hard to say.

Ms BURNET - Yes. Just the increased burden of disease. There is a lot of gold standard things we can do to treat those as well, but you have to have the resources to be able to do that.

CHAIR - Just one other question and I will pass to Kerry. You talk about professional isolation, burnout and reputational risk in your submission. How prevalent is this? Is this something that happens occasionally or it is just there confronting people all the time? I am talking statewide here.

Ms BURNET - I was fortunate enough to be involved in collating some of the responses for HACSU in its staff survey. I read about quite a number of situations where there is no doubt burnout, stress and anxiety. You can see it from sick leave figures as well. It is unfortunate that when you lose people, you lose that organisational, corporate knowledge.

CHAIR - Corporate knowledge, yes.

Ms BURNET - Yes, so that is going. That occurs quite a lot. It is also with small departments like podiatry. I had a text from a colleague - one of my former staff - who is now going back to the mainland because there is no way she can get from a baseline podiatrist to any senior position because it is just too flat. It was very important to me to make sure we had a very supported staff and team. Giving them professional development opportunities as well was really key to keeping them going, but there is only so far you can stretch somebody.

Mr FINCH - Helen, you must have been very frustrated if you have witnessed all of this and were not able to make any inroads into improving the situation in respect of staff morale and that sort of thing. You talked about losing people because of dissatisfaction and losing the significant skills and the corporate knowledge. In your own journey, what is open to you, when you leave your position, of maybe an opportunity to have some influence on senior management or the system? Or do you feel you had to cut your ties with that? What is awaiting you in the big world outside of the hospital system? Did you go to HACSU - you mentioned HACSU - or did you have your own podiatry practice?

Ms BURNET - I will do some private podiatry work, but I have a lot of constituent work to do at the moment and council could be a full-time job. So at the moment I am not doing any podiatry work. I shall to keep my hand in the game, if you like.

Mr FINCH - How long ago did you leave?

Ms BURNET - I left in April 2017, so I resigned because of this particular problem. I felt that I was knocked back with so many requests over the years for greater staff numbers, and I can

see a reduction in standards. I am not saying that against my staff. It was the system not responding to the health needs of Tasmanians.

Mr FINCH - When you talk about staff morale being at its lowest level, have you experienced the hospital system elsewhere?

Ms BURNET - No, not really. I spent 23 years across the hospital system in Tasmania.

Mr FINCH - You mentioned earlier that senior clinicians are not being listened to and an unsupportive management - not all - when you reflect on it. Have you seen that deteriorate in that time? Is that why you have made that comment about not being listened to? Have they been listened to in the past?

Ms BURNET - Yes, absolutely. It is partly because of the toing and froing up to Launceston perhaps having a new boss, or maybe with Dr Alcorn, and maybe just the demands of setting up the new organisational structure. There seems to be less time available for the executive to respond.

Going back to those safety and quality issues and sweeping things under the carpet, I think that culture become more pervasive in recent times, which is a real shame. You can't have a hospital system that isn't looking at that continual quality improvement. You have to have improvements and recognition of problems in order to fix those problems. That culture was not apparent.

Mr FINCH - So the focus went from the ideal operation as you see it to probably more concern about the system that is being set up and the change of system and the uncertainty that might have created for everybody, not just the executive.

Ms BURNET - Yes.

CHAIR - Out of interest, is there a figure on the number of part-time or casual podiatrists employed in the system?

Ms BURNET - No casual ones, but some podiatrists are working full time. About three would be working full time in the south and most would be working three or four days. Some podiatrists work privately and many are studying. They were keen to improve their professional knowledge and increase skills.

CHAIR - Are you talking about training podiatrists and students from the mainland coming over here as well?

Ms BURNET - Yes.

CHAIR - And it goes the other way?

Ms BURNET - There is no podiatry school, as there is no physiotherapy school, so undergraduate placements would occur with the RHH, based at Telstra. It was probably one of the best placements available.

CHAIR - In the nation?

Ms BURNET - Yes, and we prided ourselves on that because it is a really good hospital and ulcer clinic experience.

Ms FORREST - A diversity of experience, a broad range of experience.

Ms BURNET - Yes, community. It was always very good but we had not received payment for that. Maybe there is a payment system from the universities, which would be beneficial to increase funding.

CHAIR - How many students are we talking about here?

Ms BURNET - Probably about a dozen a year on placements ranging from two weeks to six to eight weeks.

CHAIR - Okay. What you were saying in your submission about losing the psychiatry situation could also flow on to other areas.

Ms BURNET - If, for instance, the status of the training institution went to medicine or other physician training or endocrinology, for argument's sake, as a speciality, we would not have our high-risk foot clinic. We would not have that contact with registrars and interns coming through because they would not be placed with the senior physician such as an endocrinologist.

CHAIR - Okay.

Ms FORREST - The risk is you lose your registrars who do a lot of the grunt work, so to speak.

CHAIR - Yes. It starts to bite in though, doesn't it, there is a reputation.

Ms FORREST - This is not about podiatry, this is about the medical specialties and withdrawal of accreditations.

CHAIR - Yes, I understand that. I am just saying the flow-on effect is what I think you are pointing out, isn't it, Helen?

Ms BURNET - Yes. It would have a huge flow-on effect. Then in turn, you would have more hospitalisations - that is the thing. If you cannot do a lot of that preventative work in the community by podiatrists or physios or OTs, whatever, then you are going to have more in-patients.

Mr FINCH - You mentioned bullying. You were talking about it when the K Block building comes into existence. If there is no cultural change in that cultural bullying, it is not going to be as good a work environment for the staff. Tell me, how does that occur? What are your observations? What do you mean by 'bullying'?

Ms BURNET - These were comments made by a senior nurse. She was talking about the students and new staff when they were doing orientation, when they were discussing things. They were concerned that they were coming into a hospital culture where people were bullied.

I thought that was pretty extraordinary for the CEO to hear those comments. I don't know whether he reacted.

Mr FINCH - Did you witness that? Did you have a sense that bullying was occurring in any shape or form?

Ms BURNET - I did not witness bullying as such. Lack of response to requests had occurred, such as the request for proper security in areas such as the Telstra Building, on which I have put in that representation. Lack of response was more my concern but I was pretty concerned about that kind of comment as well.

CHAIR - Thank you very much, Helen, for providing your submission and for coming in and presenting. That is very much appreciated.

To remind you again, parliamentary privilege applies to everything that has been said here. If you go outside those doors and the media talk to you, it does not. You need to be careful, even if you refer them to what you say here. It takes that outside, in a sense, so you are aware.

Ms BURNET - Thank you for the opportunity and your time. I will table those changes and those opening remarks as well so you have those.

THE WITNESS WITHDREW.

Mr JIM FRANKE, HOBART PATIENT HEALTH GROUP, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Valentine) - Thank you Jim. As for the witness statement, have you had that read to you?

Mr FRANKE - Yes.

CHAIR - You are aware of what is in that. Welcome, this is the Legislative Council Government Administration A Subcommittee inquiry into the acute health services in Tasmania, which is acute health services, not health services per se. All evidence taken at this hearing is protected by parliamentary privilege but any comments you make outside the hearing may not be afforded such privilege. Do you understand that?

Mr FRANKE - Yes, I do.

CHAIR - We have talked about the information for witnesses, which you have had read to you and which you understand. The evidence you present is being recorded and the *Hansard* version will be published on the committee website when it becomes available. By way of introduction advice the procedure we intend to follow today is as follows: first, you will be provided with the opportunity to speak to your submission if you want to do that, and then committee members may ask you questions in relation to your submission.

As we move through the questions, if you get to a point where you feel you wish something to be in confidence, you can put that request to us and we will consider whether that will be heard in confidence, depending on what we believe is the case. Do you understand that?

Mr FRANKE - I do.

CHAIR - You would be aware that the committee is focused on a set of terms of reference. Have you read those terms of reference in the past?

Mr FRANKE - I initially read them when they first came out but because of the issues with my blindness, it was a little while ago.

CHAIR - Do you want me to read them to you to refresh your memory on that?

Mr FRANKE - I understand they come under different categories.

Ms FORREST - Excuse me, Chair, the submission says you are only going to address terms of reference (5) and (6); maybe you could refer to those?

CHAIR - Just refer to those two, (5) and (6). Term of reference (5) reads -

> The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services

Term of reference (6) is, 'Any other matters incidental thereto.' Reading your submission, it quite clearly fits under term of reference (5) in terms of adverse patient outcomes. Jim, would you like to speak?

Mr FRANKE - Can I say a couple of things first of all? You said in my submission I have been involved with the Hobart Patient Health Group. I cannot see very well but Bec Lyons did most of the work on that, so she should be congratulated; I cannot take any credit for that. Her submission was amazing and she has done a lot of work behind the scenes so I would like to express that. I really appreciate being here because of that submission and the work she did, so I wanted that to be recognised.

I want to address my personal experience over 21 years in the acute health system. I have had a form of terminal cancer. Over that 21 years, I have been in and out of hospitals a lot of times. As I have said often, there has been a systemic problem in the health system. Over the last two years I have never seen it as bad as it is. I am talking about the acute health service and particularly how it affects me with my type of cancer. I have acute problems and I have been in the privileged situation of being a patient, so I am coming at from a little bit of a different angle from a doctor, politician or anybody else.

What I am talking about in my evidence in regards to the submission is personal experience. The experiences of meeting the families who have submitted stories to the inquiry have had a lasting impact on me because I relate to what they have been saying. I suggest the committee obviously has read them, but I do not want to hear too many more because they are very hard to hear and the effects it has had. My concerns around acute health services are what is going on at the Royal Hobart Hospital, particularly at the moment in regards to patients going in with acute health issues and being discharged too soon because of a lack of beds.

I understand some of those issues are not around acute health, but they affect acute health patients. I have survived cancer for 21 years now and I would hate to lose my life because I was waiting for a bed in emergency and no beds were available. The patients who suffer with acute health are telling me they cannot understand the disconnection between what the Health minister is saying and what they are seeing and experiencing personally. Again, the committee would have read some of that through the stories - that there is no crisis in the hospital with beds, yet they cannot get a bed because there is bed block, or they are sitting in the back of an ambulance but there are no ambulance ramping problems because everything is fine.

What the acute health patients are coming back to me with very clearly is that they are not seeing what is said by the Health minister as fact. In fact, exactly the opposite. These are patients living and experiencing first hand the situations in the Royal Hobart Hospital. They are not people who just see what is going on in the media or hear what Mr Ferguson is saying. Most of these people have been through the situation I have been through - of being stuck in there with acute health problems and waiting for a bed, being very scared with all the extra expediential noises and wondering what is going on. That is the first part of the problem.

The second part of the problem in the acute health service as far as a patient goes is the mistakes that being made at the hospital. Not because of the nurses or doctors, who do a fantastic job - we cannot afford to lose those doctors or nurses - but because they are under extreme pressure; they under-resourced in all the things they need and the amount of hours they are doing. That directly affects their ability to provide the acute health services you are talking about.

In finishing my address to the committee, under parliamentary privilege, I would like to say the Health minister had said to me on several meetings, 'Jim, I live the health system 24 hours a day.' I believe that is a true statement - he does live it - but living and acting on the problem are

two different things. Second, his constant denial of there being a problem at the hospital has an effect on us. We are too scared to go to the hospital knowing what is going on. I have had patients tell me that they refuse to go to the hospital because nobody is listening. They are sick of the blame game on what happened with the previous government. We are living in a crisis in 2017 and we need to fix this crisis - we need to look at the acute health services. I appreciate the committee allowing me to speak. Thank you.

CHAIR - It is an absolute pleasure to hear your stories. It is important to the committee.

Mr FINCH - Jim, I see the Hobart Patient Health Group commenced in 2017. Could you give me some idea of the genesis of that, the numbers you might have, how you all got together and how you compare notes and discuss things?

Mr FRANKE - Certainly. If you will bear with me, I will give you a brief background of how it started.

I was fundraising for a charity. I have a warped sense of humour so please excuse that. I went to collect some money from Scott Bacon for a promise for a donation. It is always hard getting money out of politicians. When I was there, I heard some of the horrific stories that patients were going, not just to his office, but offices around the state, worried about the Health system, which is still going on today. I jokingly said, 'Wouldn't it be great if we could form a patients' voice? They can ignore politicians; they can ignore doctors, but they can't ignore the voice of patients who are experiencing that firsthand and those very patients vote governments in and out.' From that, it was the birth of the Patient Health Group. We gradually had more people coming on.

CHAIR - Is that statewide?

Mr FRANKE - It is statewide. For example, before I lost my eyesight, I was up in Mersey campaigning about the essential services at the Mersey Hospital and we were working with the Mersey group.

The reason it is called the Tasmanian Health Service Centre is that we have a vision statement that all Tasmanians should have the opportunity to have quality acute health care and our mission is to hold any government to account through the patients' voice to make sure that happens. That was our mission statement. We had a slow beginning. As the group became known by the media, really good quality people came on board. Don't forget we are still very young. This happened in March.

We formed a committee of key quality people who are absolutely amazing and do an amazing job - the secretary and logistics. It is not just one person doing it; we are trying to get the whole process going. There are a lot of people involved.

It evolved from that to forming a committee. We did not want to be seen just as complaining about the system. We wanted to be a part of the solution, so just before I became ill, we were working - and I believe the group is still working - on a strategy on how to keep people out of hospital with education on wellness. It is linking with other key groups that might be able to provide outpatients' assistance. For example, we have joined partnership with the Linc's 26Ten program for the elderly and for people who cannot read computers or have to submit papers. We

have had meetings with the Mental Health Association in Mayfair to find out what services we can get our patients to go and see. That is a brief history and we are continuing to evolve.

As the Patient Health Group continues, we will continue to work towards providing the best available voice and service we can for our patients, ensuring we are always heard.

CHAIR - Jim, before I ask any more questions, I apologise I did not introduce to you the panel in front of you. We have the honourable Kerry Finch to my right and on your left, the honourable Ruth Forrest, who is the other member of the committee. Jenny Mannering is the secretary to the inquiry, and Majella is the Hansard person. I am sorry; I apologise for that.

Mr FINCH - Jim, how do people contact your organisation? How do they hear about it?

Mr FRANKE - We have several means. We take every opportunity to go to the media with the patients' voice. We make people aware that the patients' voice is available. We actually have a Facebook site. We have contact lists on the Facebook and the hardworking volunteers have printed brochures and flyers, which we can hand out to people to make them aware of the health group. We have a logistics officer. Her job is to link in with other groups and get the word out that we exist by promoting it in all sorts of ways. Media has played a major part, and we have had a good response with that - putting out flyers whenever we get the opportunity, using word of mouth and linking with other groups so that perhaps we can work together and they can let their people know as well.

Mr FINCH - Do you work closely with HACSU or do you feel you are a separate body to HACSU?

Mr FRANKE - No, this has always been a joint effort. We feel that HACSU has workers on the frontline, like ambulance people. The Australian Nursing and Midwifery Federation has nurses who work in the hospital. The AMA, Dr Frank Nicklason - because one of the things I am very keen on is that we provide our patients with the truth. We work in partnership with all those people to work towards a better acute health system. The reason for that is when we are talking to someone about a situation, we are hearing from the frontline. We are all like a family, basically.

Mr FINCH - Have you been surprised at the response you have received from patients? The number of complaints or are they measured? Have you a number of complaints? Can you put a number on it?

Mr FRANKE - Apart from the ones you have there, it is very difficult. This is an honest statement again. Because of the fear factor of nurses and others speaking out, a lot of paid people have phoned me and said, 'Jim, I would be more than willing to submit a story but I am concerned about my job', being in a hospital or being in the Health department or simply a patient. Am I allowed to give you an example of that?

CHAIR - You can give an example, as long as it is without names.

Mr FRANKE - A particular person who works for the Mersey Hospital posted a story and comments on the Mersey Facebook site. She was brought before the [inaudible] at the Mersey and forced to stop posting on the Mersey site because it was embarrassing for the Health minister. That is factual. That is the type of thing I am talking about. That is the fear factor. It is a crystal

ball. I don't know about the rest of the group. I am sure they will speak, but I can recall at least 30 conversations with people apologising but because of fear they were too scared to speak out.

CHAIR - It is real for them?

Mr FRANKE - It is very real for them. If there was an opportunity for them to have the confidence to speak out, and that is by no means the fault of the committee, because of past history and the pressure they had been put under, if they had the confidence to speak out without the fear factor, I am sure you would be flooded with stories from people working within the hospital system.

Mr FINCH - Do you get a sense there is lack of connection between the frontline workers and the people who work in the system - the executive, management and through to the minister's office or the executives or the management he has working to the department?

Mr FRANKE - Absolutely. Again, without naming names, a lot of phone calls have revolved around that disconnection, and comments that they feel they can't contribute. They don't have faith in the Tasmanian Health Service. They don't have faith in the minister. This is not just one or two people; this is why I am making this statement boldly. There are a number of people within the Royal Hobart Hospital and some of those stories come out in the media obviously are as well. There are a lot of people out there in the minister's own department who are working in hospitals who have a real disconnect with the Tasmanian Health Service and the governing body and the Health minister.

Ms FORREST - On a couple of those things, Jim, do you believe the minister is aware and informed of all of these personal stories as well as the concerns raised by nursing and medical staff in the hospital? Do you think it ever makes it that far through, from your discussions with him?

Mr FRANKE - I do not think, I know. I have had many patients tell me they have approached the minister personally and have been promised he would get back to them and it has never eventuated. He has known their story full well.

Ms FORREST - You believe he does know their stories?

Mr FRANKE - Yes. Without naming names, I will give you a classic example. There was a patient with a son who had a particular problem and he could not walk. He needed rehabilitation urgently. He was talking to the media outside the hospital. This is one of the stories submitted to the committee, so you could be aware of it. The Health minister happened to be out the front at the same time. The media person approached him and in front of the media person, he said, 'This is terrible. I will make sure this is handled, and all of this'. He never heard from him again.

This person came along with his son to the Minister for Health's forum in Hobart recently. The Health minister did not even recognise him and did not acknowledge him. I have had lots of people tell me, 'The reason we have come to you is because we have spoken to the Minister for Health, he promised to get back to us and that has never eventuated.'

Ms FORREST - Do you think it is lip-service being paid? Is that what you are saying?

Mr FRANKE - Lip-service, absolutely. When I was at the Health forum - and quite often he has made it clear to me, personally, and this is my evidence - he said that perhaps he would work with me if I had concerns and I had any patients that 'needed help', he would be prepared to look at that. It is a form of, 'Hey, I will do the right thing by you.'

I had a face-to-face meeting with Mr Ferguson in the hospital when I was extremely ill. I sent an email, which I have records of, asking him to meet with me over concerns the group had. Then I said, 'Please understand, minister, the whole group want to meet you.'

That night I was very seriously ill. He came into the hospital. I tried to express to him my concerns. I tried to express to him why I wanted to him meet with the group. He immediately went into how wonderful the Royal Hobart Hospital was and what did I think of the room I was in and, 'Jim, perhaps if you were to stop playing political games and work with me then there wouldn't be an issue.

He was simply talking about the money he has spent and the things he said. Everything I wanted to say about the patient group immediately went back to what he is doing and what he has done and he walked out. Those are a few stories and I hope that answers your question.

Ms FORREST - Thank you. A couple of other questions for you. You talk about your group using social media and the mainstream media. There is an old saying that you attract more bees with honey. Is there any push within the patient group to give the media good news stories? Sometimes they can be as instructive as bad news stories.

Mr FRANKE - We did. Tim Jacobson was with me from the HACSU; we were giving a joint conference about the forum we had in Hobart recently.

CHAIR - Is that the Menzies forum or was that a separate forum?

Mr FRANKE - That was the Health forum we had in Hobart with the public at the town hall recently, Mr Chairman. Tim spoke about the issues revolving around the problems at the hospital. I announced we had a good news story. We were working towards those and working with those other groups. We wanted to be of assistance, not just whinge, to the government by providing those services.

For some reason or other that story did not run. We made it clear - and it began before I got sick - that we were working on a very positive situation where we were going to get groups involved. We are doing a wellness campaign on how to keep people out of hospital. We are trying to assist with positive stories and not just negative stories.

If a patient comes to me and there is a crisis, we will always tell the story but we are trying to be balanced as we go along. I will be honest. I have made some terrible mistakes in not addressing that sooner, but I am very passionate about patients, being a patient myself. You have to understand sitting in front of somebody who has just lost a loved one, who has been through a coronial report and is not getting anywhere, telling you a story; you get affected by it. I am a human being.

CHAIR - Absolutely.

Ms FORREST - Jim, we get a lot of those in our offices too. I know I get a lot.

Mr FRANKE - Sometimes, unfortunately, being a human being and being so passionate, if I had my time over again, I would most probably would have listened to some people in the group a bit more and perhaps put that program into place from the start. You have to understand that we had patients wanting to get some help so we took immediate action to try to draw attention to what the issues were.

Ms FORREST - Yes, and I accept that. I am saying it is important to try. If there are good news stories that show the system working well, you can use those as an example of how it should work.

Mr FRANKE - Absolutely. We would. If the Health minister did something really good and positive - I have said this to the media as well - then we would be the first to sing his praises.

Ms FORREST - We have touched on this but if we could explore it bit further. You talk about wanting to look at solutions and ways to address the challenge. You talked about education and wellness programs. Some people cannot avoid hospital, as much as I think it is the best place to stay out of for a whole range of reasons. What are the solutions you see within the hospital that need to be considered?

Mr FRANKE - Absolutely. Working with the groups - and I am not the expert so I will be basic on this figure -

Ms FORREST - This is a patients' perspective I am after.

Mr FRANKE - Yes. From the patients' perspective there are other options they could be exploring. I have been to buildings - for example, repatriation - both as a patient and to speak to staff, that could be used to take the pressure off.

The same goes up north with Calvary St Vincent's Hospital. The big issue is that when they demolished the B Block, I guess there was not a plan B. That caused the shortage in beds. I do not know how you get round that. The Minister for Health would say that himself. Once the hospital is built, we will have we have the capacity for 200-and-something odd beds. I think there are solutions for patients where we could go. I think we cannot wait another two years for the hospital to be finished. We are well in crisis now, especially around mental health. What is it going to be like in two years' time?

Ms FORREST - I recognise a number of these stories because these people and their families, particularly the coroner's reports, have been to my office. I have assisted a lot of constituents over the years with accessing the Health Complaints Commissioner. I have assisted them in completing the paperwork, even being the support person for one constituent when she went through a conciliation process, which is very effective.

From your experience and the experience of the patients you have been dealing with, is the Health Complaints Commissioner process easy enough to navigate and use? Does that need changing? A lot of the stories contained in here would definitely be the subject of health complaints.

Mr FRANKE - I can only speak from my point of view. I knew some sort of complaint system operated within the hospital. I used that but had not had a response. I do not know if that is what you are talking about.

Ms FORREST - There are two. Initially I always encourage a patient to go to the hospital concerned. Should they not receive a satisfactory response or no response, there is the Health Complaints Commissioner. It is an independent body, similar to an ombudsman, and the Ombudsman Tasmania's office is where this sits. There is a formal process you can undertake. There is a statute of limitations in the amount of time but they can, depending on the circumstance, sometimes extend that. It is a separate process and an independent assessment of the circumstances. I have engaged with a family member through this process. The Health Complaints Commissioner often makes recommendations about how to prevent this thing happening again, whatever this thing was. If you have not used that, you probably cannot answer it and you are not aware of it, but there are the two places. One is in hospital, the local, immediate, internal complaint. Then there is an external body that is more independent and broad which can make recommendations to the hospital or service involved. I am not sure if you know about that.

Mr FRANKE - No, I wasn't aware of that at all.

Ms FORREST - I do not expect you to answer that if you have had no experience of it. It would be worth asking your members, though, and even doing a survey of members as to how they think the complaints process works.

Mr FRANKE - Thank you for that. I am sure that will be followed up. I believe that Bec is going to be here today and she is very good at taking things on board. I wasn't aware of it.

Ms FORREST - I will ask her if she knows about it.

Mr FRANKE - Sure.

Ms FORREST - A lot of people use it. They put out an annual report which de-identifies all the people who have contacted them but talks about their recommendations.

CHAIR - It is important too, with these attachments you have provided us with and there is a huge amount of evidence of peoples' journey through. It is valuable information and thank you for that. Jim, with regard to the Patient Health Group, you make a statement -

> The Tasmanian Health Group has serious concerns regarding the current adequacy of relevant services in terms of quantity, quality, capability and coordination.

To clarify, your own experience at the Royal, from what you are telling us, would bear out that statement. Are we hearing that for the Mersey as well as for Launceston General and North West Regional Hospital?

Mr FRANKE - As I said, I was up there recently with Bec Lyons. I suggest Bec would be able to contribute to this if she feels she wants to. There is a lot of confusion around the Mersey. It is a bypass hospital, as I understand it, where ambulances can't pull in. They don't have essential acute health services there. I don't live there but the people are saying it really is an

issue relating to all those points we brought to the commission in the report, even more so because it is the fastest growing area in the state. The Mersey is sitting there. My question from outside is: what is it doing if we can't have patients go there because it is a bypass? If someone has a serious issue with health, they have to go to Launceston or Burnie. What happens if someone is critically ill, acute? That could be the difference between life and death.

There is going to be a helipad put in there. If you are going to have a helipad, it would make sense, from what the people are saying up there, that they have the essential services to service it. Otherwise, what is the helipad there for? To fly patients to Hobart. Again, a patient could be dead by the time the helicopter gets there. It is mainly around what is the role of the Mersey? What is it going to provide the community? There is a lot of confusion. The Health minister is calling it an acute hospital. There are no acute services there at the moment. They keep hearing the same promises that things are going to happen.

From what I am hearing, the driving and the disconnection for pregnant women especially between the Mersey and the North West is an issue. They can have their babies at the North West but they have to have their prematernity at the Mersey. If you have an acutely ill patient who is discharged at 3 or 4 o'clock in the morning from Burnie Hospital, they do have a service but there is no way of getting back from Burnie Hospital to their home at the Mersey. Especially for elderly people, what is the solution if they get discharged because of beds?

Again, a story was submitted to the inquiry about a patient who was waiting a long time and another patient was discharged at 1 o'clock in the morning to free up that bed in the North West Hospital. There is a whole range of issues around our submission in regards to the Mersey. But I am not an expert; I don't live up there. I can only speak of what I have seen firsthand and being in the Mersey itself, the concerns around acute health. I had to have potassium and they did not have enough potassium in the hospital. They had to wait to get supplies. That came straight from a nurse in front of witnesses. In emergency I had to be careful of the cannula I had because it was the only one of the size they had. That is quite alarming for me. I can imagine what it would be like for the confusion around the Mersey, the fear factor around the Mersey is enormous up there.

Ms FORREST - On that point, again - you do not have to answer this, Jim - but the whole issue of the Mersey is a matter that I deal with regularly. There is lots of solid, robust evidence that you are much better off being in the back of an ambulance being treated by paramedics en route to Burnie or Launceston than to be in a facility that is not equipped to cope with the nature of your condition, say, a cardiac condition or major trauma or massive bleeding. You could say they could go to the Mersey and be treated there, but if you do not have the skills and expertise there, we have to have this discussion about what we can provide where safely. The critical mass of patients would not require a full contingent of skilled specialists, so you end up with one or two, and that is not sustainable because they cannot cover 24 hours a day, seven days a week. We are better off having beefed-up transfer services - hence the helicopter and other options - than trying to be all things to all people everywhere. Patient outcomes will suffer if we do that, but if we can get people in a timely manner, with appropriate support, in the back of an ambulance with skilled paramedics, isn't that a better outcome?

Mr FRANKE - I totally agree with you and I cannot argue. It gets back to the Health minister making his mind up: is it an acute hospital or is it a subacute hospital? If you mentioned the word 'acute hospital' to me, that signifies a fully functional hospital that is able to cope with lifesaving situations. If you are going to make it a subacute hospital, let people know that.

I believe, and I am only speaking for myself, and after speaking to people and being in the Mersey, I agree with you that it would great to be able to have people in there who are qualified to try to sustain life until that helicopter gets there. At the moment, they are bypassing it totally to go to Launceston. These paramedics have to make life-changing decisions in an instant and they are not qualified to do that; only doctors and specialists can do that. If they were able to pull into the Mersey in an extreme emergency situation and prolong somebody's life until the helicopter got there, that would be ideal. It is not happening at the moment. All it is is a bypass; some people use the word 'bandaid hospital'. I have used that word because you are absolutely right and I agree with you, but it has to be better than what it is now. He has to come to a decision on what he wants the Mersey Hospital to be and let the public know very clearly what that decision is.

CHAIR - I am interested in exploring the discharge process from hospital. You have been through that a few times over your 23 years of experience. Are the support mechanisms there to assist patients when they are leaving the hospital, getting the documentation they need and making sure they are getting back to their community or their home? Do you have any comments to make on that side of hospital operations?

Mr FRANKE - Absolutely, that is crucial. I want to make it very clear that doctors, nurses and staff are not responsible for this. I have experienced personally being sent home before I should have been to free up a bed at the hospital for somebody else, and have been promised community support for rehabilitation.

I will use my personal story to explain this. At Christmastime I had a really nasty blood infection. It almost killed me in March. When I was being discharged home, I could not walk properly; they got me up sufficiently enough to get home and then promised they would have Community Services come and look after me, get me to rehab and get me up and going. The District Nurses who came out to administer the drugs were fantastic, but I want the committee to be aware that the flow-on affect of this is that the District Nurses are now overworked with the overload from the Royal Hobart Hospital. On that particular morning, the nurse started at 6 o'clock in the morning and had already put 15 drips up for patients at home. She said the District Nurses were under extreme pressure and could not keep up the pace.

I never got that rehab. Six or seven weeks after I left hospital, it was left to my wife and me to get myself on my feet. That has not just happened to me; it has happened to lots of people at the hospital.

In my conversation with the Health minister, I tried to address this concern with him. It makes perfect sense if he discharged somebody well enough, while the services are in place. They do not have to come back into the hospital and put strain on the hospital.

At the moment, they are being discharged from the hospital before time and then having to re-present because the problem was not fixed in the first place.

Without naming names, I can speak for some members of my patient group who have had experiences. Again I cannot speak for that as you may say something on this.

One of our patients had an infection and a clot after an operation. She was sent home because of a lack of beds. I am trying to be as quick as I can.

CHAIR - No, it is okay. I was looking to see what the time was rather than hurrying you up.

Mr FRANKE - She went home under great concern. Her local doctor was very concerned she was getting nowhere and getting very frustrated. She became quite ill and finally got in and was seen to, but that is a regular story. Patients going home and then having to be readmitted to the hospital.

CHAIR - It really works against the system.

Mr FRANKE - From a patient's point of view, that can be life-threatening. If they are being sent home, in my case with a terminal illness, and not having the ability to move around. The other thing is I was always scared of falling, putting pressure on my family. There were no resources out there. I felt absolutely isolated and scared.

CHAIR - Thanks, Jim.

Mr FINCH - Jim, you have presented a litany of issues in your submission. A lot of problems on a lot of fronts. Would you, on behalf of your Hobart Patient Health Group, give us some ideas as to what might be the solution?

I am thinking of people who are going to read this evidence and are searching for ways forward out of this health inquiry. What do you think are the things that need to be investigated, looked at and changed? How can those improvements come about in the system that might address these problems you have highlighted?

Mr FRANKE - From the group I am working with, from the medical point of view they have some of those solutions with bed block and some solutions about how to get key patients out of hospital.

From my perspective, Royal Hobart Hospital is not going to be an easy fix. We have a crisis in 2017. What I would like to see come out of the inquiry - and I do not know how we do it - is an alternative for patients who are too scared to go into hospital or get discharged too soon and go home.

From my perspective, the Repat Hospital and St Vincent's have office space with room for beds. The overall quick answer is from other rather than me, from people who are working on the front trenches; they have the answers to those questions for the people they are dealing with. But they are simply not being listened to.

If they were to listen to doctors, nurses and ambos working on the frontline, they are far better qualified to answer the question, instead of trying to see there is not a problem.

As a patient, I am more focused on how to get the services I need at home if I am discharged from hospital. If they are going to discharge me from hospital because of a lack of beds, what are the services out there and how do we address that? How do we improve the acute health services for patients out there, especially the big hot topic at the moment - mental health patients?

As a patient, how do I access the services? What are the services? I am at New Norfolk Hospital at the moment. Again, they do a wonderful job and they are working with me very hard. They are trying to access services for me that are bound up in government red tape. Or the services have been slashed or no longer exist. I desperately need an alarm system, which would

make a huge difference for my wife and me, so when I am out and about - I am about quality of life now because I am - sorry -

CHAIR - It is okay. Take your time, Jim.

Mr FINCH - How does the alarm system work, Jim?

Mr FRANKE - It is a 3G alarm system that does not require monitoring. I do not have to be at home. If I got lost, being blind, I would simply push the button and it would go through to my wife, or if I had the ambulances first, it would go up. If I fell over, it automatically notices I have fallen over and calls an ambulance for me. Now, common sense would tell you it does not take somebody in the Health system to get me to the hospital, but there is simply no funding out there. I am on a pension and I am not crying poor; I am in a similar boat to a lot of people. They suggest all these services outside the hospital that we simply cannot afford. To make solutions - we want to be part of the solution.

You asked, how do we be part of the solution? It is very hard - being part of the solution means we have to try to find money to try to help from a personal point of view. When I lost my sight it was bad enough for me and my family. My wife is now terrified if I have a fall. It is such a simple thing, but that the government funding was cut. So instead of nurses and people in the hospital concentrating on other patients to try to provide services for them, they are being overloaded trying to find the resources to get me home. I am going to be down there for a few more weeks simply because they do not have those services you talk about in the community to look after me.

Every single night I think of my family. How am I going to survive? How am I going to go through this? This is just me. There are patients out there - hundreds of them - who think the same thing with acute health services and health systems. We honestly feel we do not want to bag the government - we want to be positive - but if I am the captain of the ship, the boat stops with me. We are simply being fed rubbish because we are living in the system. We know how it works.

No matter what government it is, they can make any statement they like, but it is the patients who know the true stories. It is the patients who experience this every day. If somebody gets on television as a politician, they can make it sound really good when it is really bad. That is the problem. We live this every day. Acute health patients live this every day. Where do we find our acute health services? What do we do when we leave hospital? The questions you are asking me. We have families that love us very much. It is a nightmare for them. It is a nightmare for me.

Can I give you a practical example, please? Would you bear with me and be patient?

CHAIR - Absolutely.

Mr FRANKE - Would you mind standing up? I did not have my sight. I had my sight before this happened to me. Could you please close your eyes and walk to me?

There is no need to go on. Can I get my point across?

CHAIR - You get your point across.

Mr FRANKE - If I do not have those support services out there to support me, what am I going to do? When I say, 'What am I going to do?', I speak for every single patient who is out there facing the same problem.

CHAIR - It is a threshold thing, isn't it? If a person is blind over a period of time, they can apply for a guide dog or they can apply for some other assistance. What you are saying is that when this happens as a result of some hospitalisation and it happens very quickly, it is that support service you need between today and the next major step.

Mr FRANKE - Yes. I did not use that example just for a blind person, but it is for anybody.

CHAIR - No, it is for anyone who has a threshold issue that is a mobility issue or some other issue; it is a threshold of a nature. I appreciate that. We are out of time.

Jim, coming today was not an easy situation for you given the status of your health at the moment so we really appreciate the submission that was made. We know it was made on behalf of the Patient Health Group and that you were not the only person involved. We appreciate that, and we appreciate the breadth and depth of that submission. Thank you very much for coming in today and sharing your story. It has been appreciated.

Mr FRANKE - I just like to say thank you to the committee for the opportunity and for holding the inquiry - thank you.

THE WITNESS WITHDREW.

Ms REBECCA LYONS WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Valentine) - Rebecca, welcome to the private hearing. This is the Legislative Council Government Administration Subcommittee inquiry into the acute health services in Tasmania. All evidence taken at this hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded such privilege. As it is a closed hearing, you probably are not terribly interested in making statements outside.

You have read the copy of the Information for Witnesses paper?

Ms LYONS - Yes.

CHAIR - The evidence you present is being recorded. It is being recorded by Hansard because we need to have it on the *Hansard*, but it will only be available for the committee.

Ms LYONS – [Three lines redacted]

CHAIR – [One line redacted]

Ms LYONS – [Two lines redacted]

Ms FORREST – [Three lines redacted]

CHAIR – [Two lines redacted]

Ms LYONS – [Two lines redacted]

CHAIR - From that perspective, it can be totally public. The only thing is it hasn't been advertised. To that end the *Hansard* version will be published on the committee website when it becomes available. By way of introduction, I advise the procedure we intend to follow is that first you will be provided with the opportunity to make an opening statement if you wish and then we can ask questions after that.

As Ruth said earlier, if you want to make something confidential, let us know and we can consider that. Would you like to make an opening statement?

Ms LYONS - Basically, Jim covered the majority of what we are here for, why our group started and why we are doing this, how the submission came together for all of us. On my part of that I met Jim after he decided to start the ball rolling with forums. In conversation the concerns were exactly the same. I was going through the health system, having major issues. My story is in there. It resonated with me that we needed to do something and we have the capability to get up, talk, advocate for other patients. That is where my role came in.

I see it as very important for patients. My role is an advocate. Jim is more on the media and trying to get the message out there in a more formal way. I work more quietly with patients and try to reach solutions and negotiate with hospitals and nurses. That gives you an understanding of where both of us fit within this.

CHAIR - Is there anything extra you want to add to what Jim has said?

Ms LYONS - I am trying to think about it. He has gone through a fair bit of what I wanted to talk about. The main thing with it is communication: everyone needs to be open - doctors, nurses, patients, everyone. You were talking about solutions before. I feel that is the area we need to start to look at. There is not open communication. It is fractured.

CHAIR - Why do you think that is?

Ms LYONS -I think it is fear. Fear of retribution. With my first hospital stay for the first operation, the nurses would talk at night. They would come in and have a cuppa on their breaks. They were very stressed and tired. They would sit and they were exhausted. They would talk around 9 or 10 o'clock at night about issues that were impacting their work. I had an inside look at how they were working, the stresses they were under. They didn't feel they could talk openly. I asked them several times, 'Why don't you take it forward?' I talked to them last year. I didn't realise how bad the system had become at that stage because it was my first time in hospital for a long time.

Prior to that I nursed my mum up in Launceston. She had leukaemia and I can't fault the care. That was four years ago. She had a two-year treatment, constant chemotherapy etc. There was nothing within the system I could find fault with. Nurses were working. Mistakes were not being made. The whole culture did not look stressed. When I went in last year, it was a shock to me to see the system like this and I thought, 'Maybe this is Royal. It is working differently to the LGH'. As you will see by my story I have had several times back.

CHAIR - It has been a rollercoaster.

Ms LYONS -It is still going. I am getting to a frustrated end of treatments for this and I am still waiting. I am not the only one. That is what I was seeing. I was hearing it from other patients who were in beds bedside me. There were ladies crying, talking about prior times they had been in, issues with hospitalisation, readmission with infections et cetera, with stomach problems and they kept returning.

We would sit at night talking and I am thinking, 'I am furious, what is going on here? This is not right'. Nurses are running around. They are so tired they do not know what they are doing. They are making mistakes; they are stressed. Patients are suffering.

I went through that process and then I met Jim. I tried several avenues to get myself fixed. I won't go into my story as you can see it.

CHAIR - We have certainly read it.

Ms LYONS - Through that journey we have met a lot of people through the TPHG. Either they have come in and seen us personally or they are on the phone. Stories worse than mine. I was horrified. I thought mine was bad.

That is when I started to get fairly nosy about it and wanted to get involved. Someone has got to stand up and someone has got to do something about this. We have never had a system like this. Not in my awareness.

CHAIR - One question, and I will pass to other members in a minute. I would say we have covered most things but I am interested in your opinion in terms of post-hospital, the discharge process. How did you find that side of it?

Ms LYONS - I found I was taken out before I should have been. It was done very quickly. The morning I was put out, the last one, a code yellow called. We had heard the code yellow the day before and there was a flurry of - how would you term it? - a hierarchy of doctors coming around with clipboards, looking at every room.

They put me up in Oncology for the last day. It was very interesting. The nurses were in a flip, getting patients' notes, taking them to these doctors in the hallways. They were trying to clear beds.

The upper management was clearing the beds, instructing the nurses to write 'She can go home'. I had a doctor come in, who said 'We are going to order a medication for you. Wait two hours. If we can get your blood pressure down to 160, you are going home'. So they did. They gave me two pills and it went down and I was discharged. I was discharged with no treatment on my shoulder that I could not move.

CHAIR - Did you have anyone to pick you up?

Ms LYONS - No. I am very lucky. I will say this to the man sitting behind me who is my housemate. I owe him my life and I will say that to all of you. I owe that man my life. He stuck it in hospital with me for days. He saw them giving me medication that I should not have had because I was not in any fit state to know what was being given to me. He questioned it and thank God he did.

I have a medic alert for all opiates. I cannot take them. I have severe reactions with my heart et cetera. They tried to give me tramadol on four occasions. It was only thanks to him that this was stopped. These mistakes should not have been made. I am worried. I suppose I am a bit clinical when I go through things. I like investigating why something is happening, how it is happening, how you can resolve it.

CHAIR - With that tramadol experience, or their attempt to give you tramadol: I presume there would have been many opportunities for that information to be put into the system?

Ms LYONS - It is on file, yes.

Ms FORREST - You would have had a red armband on?

Ms LYONS - No.

Ms FORREST - You did not have a red armband?

Ms LYONS - It is on my file, quite clearly on the front of the file.

CHAIR - Is that about the health complaints?

Ms FORREST - These stories are all disturbing. I have no doubt they all come from people with the experience. There may be explanations for some of the things that happened, but when there's poor communications -

Ms LYONS - This is what I was trying to come to when we come to this system of communications.

Ms FORREST - Yes. The majority of our health problems relate to poor communication. I am really interested in the health complaints process here. It is not so much a matter for this committee as such. It is informative but we have to recommend change or whatever to fix it. It relates to term of reference (5) but maybe (6) too because they link together in this regard.

The health complaints process is the internal in-hospital complaint you can make directly to the care proposed at the time. Some people find that effective; some people do not. Then there is the Health Complaints Commissioner. I think you probably heard us speaking about it earlier. Did you actually make a formal health complaint?

Ms LYONS - No, and I will say that we explored that. I threw it around whether to do it. I still have it in the back of my mind to refer the patients who have come to us to do that. My fear, until I can resolve the ins and outs of it - and I am really glad you have raised it - because I still require treatment, if I put a complaint in, is that I am going to be prejudiced.

Ms FORREST - That will sharpen their focus; I can tell you that from experience.

Ms LYONS - I am really glad to hear that because no-one can give me answers on it.

Mr FINCH - Sorry, I missed what you said there.

Ms FORREST - From personal experience, assisting a family member through this process, only because of my health background I thought, 'This is just ridiculous, this should not be happening'. I assisted a family member to make a formal complaint. Then on the next visit to the specialist, I went with the family member, who was very cautious and said I did not have to do that. I said, 'Well, you are not the problem, the system is the problem.' The system needed to change and we were hoping to get the system changed, and now the problem that this person experienced does not happen to anybody else. Unless we do that, systems do not change.

Ms LYONS - That is basically why I have come on board here because I want to see things change.

Ms FORREST - It is probably important then that these processes in place are used because if they are not, systems do not change. It is okay for people to talk about the problems, but unless we go to a body that can make recommendations, the government and the hospital administration can ignore those recommendations, but at their peril because there is the annual report of a legally constituted body.

I would be interested to know if you could talk to your group about whether people have used that formal Health Complaints Commissioner process, and whether they find it difficult or helpful and whether it needs to change.

Ms LYONS - I know the ones in the inquiry have not. I can say that up front - they have not - but it is something we discussed at a committee meeting. We have held a couple of committee meetings. With our committee, because everyone on the committee is suffering an illness or another and we have been trying to get the inquiry in and we ran rallies and forums, it stretched the time to try to have another meeting to discuss all the forward plan from this. We were discussing where we are going from here after the inquiry; once we put that in we want to start working on solution bases.

Ms FORREST - Yes, it would be really helpful for the committee to hear how the users, and those who have had particular challenges with the system, believe the system could change. Is that one of the best mechanisms for making the system change? I do not know whether it is or not. It is the question.

Ms LYONS - We can test it out by putting them in and the only way is to test.

Ms FORREST - Yes, that is right.

Ms LYONS - If we do not test it - personally, I have been ill as well and I have been wrestling with 'Do I put it in?', 'Do I not put it in?'

Ms FORREST - And how many times do you need to put it in. You might as well wait until you get to the end of your health journey before it gets -

Ms LYONS - It is getting worse and worse. How many times do I have to explain this before something is done? There is the frustration. That is just mine personally.

Ms FORREST - I accept that.

Ms LYONS - When you talk to the other ones I have spoken to, it is very similar rationales. They are beating heads up against a brick wall and they are getting sicker, and they cannot understand why this is all happening. Myself, I am floored by it. I can mention this. My girlfriend did not want to a story in because she is still undergoing treatment for - funnily enough - leukaemia as well. I seem to be attracted to people with leukaemia. She has myeloid leukaemia and she had come to the Royal in January to have stem cell treatment. I went to visit her and the second day I visited her I realised there was something really amiss in nursing care. As I said, I nursed Mum for nearly two years and that was daily. I was at the hospital and she was rarely home. Most of it was done in hospital so I saw all the processes and no complaint, it was beautifully done.

I was shocked with my girlfriend, she is in a wheelchair, with no sensation below the waist so she does not necessarily feel when she has to go to the toilet. She was having one round of chemo and then the stem cells so it was highly critical that she was in an immune area. When I went in and she was in tears with the sheet up over her. She kept pointing down and the communication was that she had soiled herself. I said, 'That's all right. Have you called the nurses?' She replied, 'Yes, two hours ago.' For two hours she could not get out of her own faeces.

I went out to them and they were on their Facebook page at the middle desk, drinking coffee. They said that they would come and change the bed in a minute. I said, 'It's not the bed I am worried about, she has to get out of this; we have to get her into the wheelchair and clean her.' They didn't come, I took her. We struggled like hell, it took us nearly two hours.

CHAIR - Which hospital?

Ms LYONS - Royal Hobart, Oncology. We struggled to get her clean and the wheelchair clean. When I came out, the bed had not been done, so I lost my temper with them. I said, 'Get the cleaner, now.' From that day - Chris can testify - I went to hospital from morning through till night-time to make sure she was okay and I would leave at night and wash her things. Her room was not cleaned by a cleaner for three days. I do not know how it has got to that. From what I saw with my Mum, with the same illness, to what I see now, it is horrific how something can change so drastically. It seems all fractured; there is no communication, the care level has gone down, for whatever reason, I do not know.

CHAIR - How long ago are we talking about?

Ms LYONS - January this year. As I said, I had not had a hospital experience since Mum, she died four years ago. That was the last time I had any interaction with any of the healthcare system because I did not require it. My first instance was last year when I had the operation and it really was an eye-opener as to what the heck is going on here. The systems are breaking down, the communication is breaking down and people are fearful. We have had multiple people come to us, not just my girlfriend, saying they cannot speak up. I have had people talking to me that actually work at the hospital in various roles - internal workers, allied health workers and their stories of what is going on in there beggar belief. They are scared.

Mr FINCH - With that story you told, did you make an official complaint about that circumstance?

Ms LYONS - I went to the nurse unit manager and complained. We had a rather heated argument about it and her answer was, 'Isn't she lucky she has a wonderful friend like you that cares?'

Mr FINCH - You do not know if it went further or whether it was just a conversation between you.

Ms LYONS - Annie did want to have a formal complaint put in because she is still undergoing treatment and she is petrified of -

Mr FINCH - Incriminations.

Ms LYONS - Yes. She is not as strong minded as I am. When I see something wrong I will stand up and speak out because I do not like injustice. We go down the path, we open up, we talk, we find solutions and new resolve, and is the way I think it should be done. I cannot speak for other people such as Annie. I know she is not strong enough to go through that herself and she does not want to.

Mr FINCH - In respect of the system, unless the powers that be hear about these issues, they are not mind-readers. They cannot have an understanding of what is going on the ground floor if those issues are not highlighted to them. I am not making excuses; I am just suggesting that the communication we have heard about that is not available to people. They feel they do not have that communication to be able to put forward their concerns.

Ms LYONS - We need a process to make that available.

Ms FORREST - There is a process, the internal Health Complaints Commissioner.

Ms LYONS - We need something. With patients in particular, even the nursing staff in allied health, they are fearing for their jobs. They have told me personally that they are scared their shifts are being cut if they speak up. There is a code of silence going through and they are distrustful of each other because one is scared to say something in case it gets back to another one and they get in trouble.

Yes I agree, we need the process. We need to be sure they have a format everyone can feel safe to do this without recrimination. That is where the blockage is.

Ms FORREST - You have told us different stories and one of them shows a failing of nursing care, others a failure of system. They are two quite different things in many respects. As far as we are concerned with nurses being afraid to speak out, they have representative bodies through the Health and Community Services Union and the Australian Nursing and Midwifery Federation. They can get protection through them if there is inappropriate treatment of an individual; it is not easy, but that is there. Patients do not have the same advocacy group except perhaps now for your group.

Ms LYONS - We are trying, but as Jim said, it is a very new group. We have been trying to structure committees, trying to get everything together, but we will.

Ms FORREST - That is why they need to access the facilities there. It is important to know whether those systems are working well enough, or whether they need tweaking to make them more efficient and effective for the patients. Otherwise stories are just stories; they are all important but if they do not effect change -

CHAIR - That is right, you need to effect change.

Ms LYONS - It is change that brought me into this. We need a change in the system so it does not happen to people. It is no use me saying, 'This happened to me. What are you going to do about it?' What processes are going to come from actions speaking up? That is my concern.

CHAIR - It is quite clear the compendium of -

Ms FORREST - It sounds like the Health Complaints Commissioner could be overrun very soon.

Ms LYONS - No, I am not sorry for attacking them.

CHAIR - I do not think you should be sorry; it is information.

Ms LYONS - Someone actually asked me, 'Why do you go through all the coronial reports and attach them? I said quite bluntly, 'That is the end result and we do not want that for people'. We do not want families having to go through those coronial reports of their family members if we can prevent it. We can do something. We can take notice of what is in the coronial reports and the recommendations and build a better system by listening. Listening and communication is vital.

CHAIR - A coronial report - it is official and has been properly scrutinised.

Ms LYONS - It is law; it is legislative, yes, and it has to be listened to.

CHAIR - It is not legislative, but it is an official judicial process. Unless there are any other questions?

Mr FINCH - Rebecca, would like to give us a conclusion? You are going to work through with the Patient Health Group, have you any ideas at this time, prior to that discussion, as to what needs fixing? Where things might start to give you a better feeling about the hospital system?

Ms LYONS - I would like the communication to be more open. I would like a protective measure so people can feel comfortable coming forward, whether patients or staff. There has to be no fear or retribution for everyone. They have to be able to come forward.

To fix any system, you have to have all the information in front of you. An open book of it. Not hidden because people are frightened.

Mr FINCH - And people listening.

Ms LYONS - Listening is a big one, with the ears working, connected.

CHAIR - You have been heard today.

Ms LYONS - Thank you. I appreciate that. Not just myself, the other people.

CHAIR - That is right.

Ms LYONS - The ones who did not feel they could stand up are just as important.

CHAIR - We have to rely on it too. In (5) and (6) of the committee's terms of reference we outlined to Jim, and you probably heard it, are in particular the matters that relate to your stories.

Ms LYONS - Yes. We have, as I said in the submission, heard from HACSU because we have been working with them, been at forums with them and heard the speeches and seen the data. We are aware that is there, but it is not pertinent for our group to go into that. It is not our area. We do not have the expertise.

CHAIR - Can you explain the type of health forums you have been running as a group?

Ms LYONS - Okay. We ran one in Devonport for the Mersey group.

CHAIR - What do you do in those forums?

Ms LYONS - Basically we act as advocates and get people to the forum to hear information from key speakers in the industry. Up in Devonport it was the AMA, Stuart Day. We had the mayor of Devonport, an ambulance paramedic officer, and Emily from ANMFU spoke.

They basically spoke on the system. What is happening within the system and where nurses are suffering et cetera on shifts, on double shifts? A lot of statistical data coming out.

Particularly up in the Mersey, Jim referred to, there is a lot of confusion. People are angry. When we got up there, we were quite shocked. They invited us up to run it for them as MC et cetera, and we were quite shocked at how angry everyone was.

CHAIR - Are these all staffing hospitals and patients?

Ms LYONS - It is a combination of staff and people in the community. The anger level from my perspective was confusion. There was misinformation, no-one knew what was going on. They felt left out of processes. They did not know what was going on with the Mersey. They felt unsure.

When they did not feel sure, they were starting to get angry when they were talking. They wanted clarity on what was going to happen. What was going to happen in their area in their life is the understanding I got from them.

CHAIR - Thank you. Any other questions? We will call it to a close. Thank you very much for coming in. To reiterate about the parliamentary privilege, if you walk out through those doors, whatever you say to the media is not protected, even if it is telephone or whatever.

Ms LYONS - No, I do not talk to the media. I stay right away from media. Things are more beneficial doing other ways.

CHAIR - Thank you.

Ms LYONS - There was something before we go. Our submission was put online and the phone numbers were attached; one of the patients actually brought my attention to it. If possible, could the patients' numbers be blacked out? Thank you. They were fine with the names but they were concerned about their phone numbers.

CHAIR - I can appreciate that might be the case.

Ms LYONS - Thank you for letting us have the opportunity to air it.

CHAIR - We cannot control what has already been downloaded by people from the website.

Ms LYONS - No, that is fine; we understand. It was only brought to my attention this morning by someone who rang me. I was not aware the phone numbers were there and said I would ask.

CHAIR - Do you know which appendix that was in by any chance?

Ms LYONS - It is Appendix B, from memory. The patient list at the back has phone numbers.

CHAIR - There is one here with a mobile number against her name.

Ms LYONS - Appendix B, patients' stories.

CHAIR - What about where you have a mobile above?

Ms LYONS - If they could black the mobile out, so it is only the patients' stories.

CHAIR - Just the patients' stories, okay. We can attend to that. Thank you and have a good weekend.

THE WITNESS WITHDREW.