PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY, 1 DECEMBER 2017

ACUTE HEALTH SERVICES IN TASMANIA

BEN MOLONEY, PROJECT DIRECTOR AND **CHERYL CARR**, DEPUTY DIRECTOR, ROYAL HOBART HOSPITAL REDEVELOPMENT TEAM WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR - Welcome, thank you for taking the time to come and present to us. We are taking sworn evidence and so as a result of that we ask that you each make the statutory declaration that is before you there, stating your name and your role.

Mr MALONEY - Benjamin Luke Moloney, Project Director for the Royal Hobart Hospital Redevelopment Project.

Ms CARR - I am Cheryl Louise Carr, I am the Deputy Director of the Royal Hobart Hospital Redevelopment Project.

CHAIR - For the record this is the Government Administration A Sub Committee Inquiry, Legislative Council into the acute health services in Tasmania. It is not a government inquiry as such it is a Legislative Council Sub Committee Inquiry. You are aware of that. All evidence taken at the hearing is protected by parliamentary privilege but I remind you that any comments you make outside the hearing may not be afforded that privilege. A copy of the information for witnesses has been made available to you, I believe you have read that. The evidence you present is being recorded on *Hansard* and a version of that will be published on the committee website when it becomes available.

The way we will run things today is that you will be provided with an opportunity to make some opening statements and remarks and then we will be asking questions after that. If you wish to make some opening remarks, over to you.

Mr MOLONEY - Thank you very much. I will keep it relatively brief. I guess anyone who has driven down Campbell Street recently will have seen the construction of our new inpatient facility in Campbell Street, K block is well under way. The construction of that will increase the bed capacity in southern Tasmania by around 250 beds and that will increase our current capacity by more than 30 per cent. The patients and staff at the Royal Hobart Hospital are already benefiting from over $50 million worth of investment in the existing facilities. That has been in the form of refurbishment of a number of areas and also the construction of the new temporary inpatient facility in Liverpool Street.

We have had to work very closely with the Royal Hobart Hospital Staff to design and build the new spaces and refurbished areas. It has been necessary to ensure that we were able to safely and appropriately accommodate the functions that pre-existed within B block. We needed to demolish B block in order to construct this new K block. Things that we provided include the temporary inpatient facility in Liverpool Street which included 54 inpatient beds there.

Ms FORREST - Known as the J block?

Mr MOLONEY - Yes, J block. The creation of a new unit up at the Peacock building at the Repatriation Centre, there are another 20 beds up there. We have also arranged for the leasing of some offsite administration space as well to move some functions to make extra room available for more clinical services. That has ensured the bed numbers have been maintained.

When we get to the end of the construction of K block, and we are brought on line, the actual floor area of the precinct will be increased by over 50 per cent, but recognising that in order to make space for this new building, it does mean that during this redevelopment, they are operating in a slightly smaller footprint. That has obviously, potentially, limited the flexibility in providing additional new beds in the interim, but we do understand that the THS is in the process of implementing their interim bed strategy to bring on some additional beds while K block is being constructed.

In relation to K block, we remain on target to complete the construction by mid 2019.

CHAIR - Mid 2019?

Mr MOLONEY - That is correct.

CHAIR - Before we to into questions, should there be any situation where we ask a question that you feel needs to be in camera, you need to indicate that to us and we can discuss that and either move in camera or not, depending on our decision. That is an option that is open to you.

Mr MOLONEY -It is matters which need to be held in confidence?

CHAIR - Yes, that you feel need to be held in confidence.

I guess the first question I have is the article in today's paper with regard to the Mental Health Services Unit. I know from a policy perspective, you are not going to comment on any of those sorts of things, but it talks about being opened on 11 December. Is that correct?

Mr MOLONEY - The temporary inpatient facility you are referring to?

CHAIR - There is an article in today's paper that actually -

Mr MOLONEY - Yes. It would have been opened approximately in December 2016.

Ms CARR - The inpatient facility opened 12 months ago. Are we talking about the new Observation Unit for Mental Health?

CHAIR - Yes.

Ms CARR - That does not sit within the remit of redevelopment. That is something that the THS and the hospital are undertaking, not redevelopment.

CHAIR - That clarifies that, thank you.

Ms FORREST - That is down in the -

Ms CARR - Lower ground, A block.

Any works that we undertook from a redevelopment or a decanting perspective ended at the end of last year really. We finished up and so any work since then is being undertaken by the THS.

CHAIR - Okay, so that is not part of your project. Thank you for clarifying that.

Mr MOLONEY - The temporary inpatient facility was operational, I believe, at the end of November 2016.

Ms CARR - They had a birthday party this week actually, their first birthday party.

CHAIR - That is good to get that clarification. With respect to the timeline from go to whoa, can you give us an overview of that? Just an overview, we are not after anything in-depth, but just an overview of the project from start to where we are today.

Mr MOLONEY - A major reset of the project occurred when the taskforce was appointed, which I think was in 2014. The taskforce was set the task of reviewing the scope of the project, what it was delivering, and making sure that it was being appropriately delivered.

The outcomes of the RHH Redevelopment Rescue Taskforce were presented to Cabinet at the end of 2014 and Cabinet endorsed those. That project has been moving ahead with those recommendations since. As part of that, there were a number of initiatives that were recommended including the incorporation of a helipad on top of K block and also addressing the provision for hyperbaric medicine. From that part, there was a redesign of K block to make sure we were able to incorporate the helipad and also find a solution for hyperbaric which ended up being included within K block. There was also a provision for extra mental health facilities as well as part of that review.

By June 2015, we had a revised development design and that design was then priced by the managing contractors to submit a guaranteed construction sum which would enable us to enter into that commercial arrangement with our builder to build that development design. That was negotiated, agreed and accepted in December 2015, and from there we then proceeded into completing the early works program and then embarking on the construction of K block.

Throughout 2016, we undertook a range of early works packages which included refurbishments within the existing hospital, and the construction of the temporary inpatient facility in Liverpool Street. With that, as has been quite public, has been the challenges that we face with that temporary inpatient facility. We had issues -

CHAIR - Are you talking about the mould issue?

Mr MOLONEY - That is correct. We had issues with mould and some other construction issues, which resulted in quite a major refurbishment or basically rebuild of that temporary inpatient facility. That resulted in a prolongation of those early works, which meant that although we were targeting completing that building in the first half of 2016, it was not until the latter half of 2016 that we completed that.

Having completed that, we were then able to vacate all the patients and services safely out of B block and proceed with demolition, which commenced - early demolition started at the end of 2016. The main structural demolition started at the beginning of this year. That went very well. We were very pleased with the way that went.

There were minimal disruptions. It was undertaken very safely and effectively and from there we proceeded into building the foundations and getting out of the ground. Most of this year, from a construction point of view, has been focused on the demolition of B block and the construction of K block.

CHAIR - What are the biggest challenges you see that you have had to overcome in that?

Mr MOLONEY - Certainly our challenges have been a combination - with the temporary inpatient facility, addressing those construction issues. Another major challenge for us has been dealing with buildings that have been refurbished over many years. When we have entered into areas, we have had to make sure that we have dealt with issues such as hazardous materials and other latent defects, which are difficult to foresee until you get into that space.

A lot of those spaces that we have refurbished are operating areas for clinical services, and as you would be aware, space within the hospital is at a premium. Typically, we only get access to these areas, where we can actually pull down the ceilings and get good visibility about what the fabric of the building looks like, at the very last minute.

We make assumptions about what the conditions are likely to be, but it is not until we get in there and are able to turn it into a construction zone and pull out the ceilings and things like that, that we can actually get a serious look at some of those areas. That is where we have faced challenges around the condition of services, hazardous materials and things like that. That has been a challenge for us.

For the next year or two, our main focus is on constructing the new building, so at least that is relatively known to us, because we are not encountering unforeseen issues. As we get towards the latter half of the delivery of the project, we also have a range of refurbishment activities to happen in the existing facility. Again we will need to make sure that we do those safely and effectively, and ensure that the safety of our staff and the workers is paramount to the planning of those works.

CHAIR - The final question from me and then I will hand you to my colleagues. The off-site functions that you are talking about, can you just give us an overview of what that has entailed, and the particular off-site functions that you have -

Ms CARR - The Peacock Centre.

CHAIR - The Peacock Centre.

Ms CARR - Acute rehab to the Peacock Centre. They moved their service up there.

CHAIR - Yes.

Ms CARR - As part of that, an in-reach rehab team has been developed so that they can go into the hospital and provide some in-reach services. We moved nursing education out,

administrative accounts, business managers, some clinical staff from F block over and out of there. That is basically taking those service off, so mainly administrative roles that were able to come back in and in-reach into the hospital.

Mr MOLONEY - With each of those administrative functions we were able to secure leased accommodation within a one-block radius of the Royal Hobart Hospital's campus. It is important to note hospital campuses, if you look around the country, are notoriously quite large and expansive. Ours, as we are in a CBD site, is quite constrained. In terms of walking distance, it is still not an excessive distance for those administrative staff to be able to get to the hospital when they need to, but be able to perform their administrative functions effectively at those locations.

CHAIR - Where do they perform nursing education now if it is not -

Ms CARR - They come back into the hospital. It is really their preparation area, a meeting space for the nurse eds. Then they are on the floor. That is their role, on the floor.

Ms FORREST - I do not know if you have read the evidence the committee has received, particularly raising concerns about the acute mental health inpatient facilities. We understand that the extra 250 beds overall includes the J block beds in that number, or is that incorrect?

Ms CARR - Correct.

Ms FORREST - So once the J block is knocked down there will still be 250 extra beds?

Ms CARR - Correct.

Ms FORREST - Okay. Clinicians are still raising concerns that those extra beds in the J block, which I think is 30 beds -

Mr MOLONEY - Mental health beds - 32.

Ms FORREST - Yes, 32 there. They still believe that some of those will be needed beyond the opening of the K block facility. I understand that the J block needs to be removed because we have heard that it is not part of the heritage of the hospital. Can you explain why the J block has to go?

Mr MOLONEY - It is part of the planning approval that we sought and obtained from Hobart City Council on the basis of the heritage that relates to C block, the main entrance building. The approval to install the facility in Liverpool Street - the temporary inpatient facility - was on the basis that it would only be there for the duration of the redevelopment. A planning requirement under our current approvals is for that facility to be removed within six months of practical completion of K block.

Ms FORREST - What is practical completion in your view? You are saying that there is a lot of ongoing work to do with refurbishment of the existing building, so what is practical completion?

Mr MOLONEY - In relation to K block, practical completion is a formal contractual point at which it is decided that it is fit to be used for its intended purposes and that it is free of defects that would prevent its use and the like.

Ms FORREST - What is your defect period then?

Mr MOLONEY - There still remains a defect liability period of 12 months, but practical completion is achieved basically when the user can physically walk into the building and start using it. So all the power works, all the certifications have been provided that the building is safe for use and it is available for use. From that point -

Ms FORREST - Then you have six months after that and the J block has to be removed by that time? You would have to start the demolition before that if you are going to complete it within six months, wouldn't you? Or do you have to start demolition or removal or whatever the term we need to use for this is?

Mr MOLONEY - We would not be looking to commence the demolition or removal of the temporary inpatient facility until the mental health services are being delivered out of K block.

Ms FORREST - I will get to the K block mental health inpatient facility. We have been informed by clinicians in mental health, particularly those who predominantly provide acute inpatient mental health services, that the design is not contemporary, there is not enough access to outdoor areas, and the internal design is not best practice in comparison with other state-of-the-art and best practice facilities around the world.

I am not sure how much role you have in the interior design of the ward area, but could you talk us through that? There seems to be a major concern here. We are hearing from other people with different views, but I am interested in how the process worked in terms of how it is designed. Is there still time to re-design the interior? I know sometimes the shell is there but the internal design can be adjusted.

Mr MOLONEY - The design of the mental health facility has been developed over quite an extensive period of time and it has been looked at and re-looked at on several occasions. We note that a key area of concern for a number of stakeholders is the amount and quality of the outdoor space. There has been quite a bit of work in maximising the amount of outdoor space being able to be provided from K block. It was reviewed as recently as late 2016 in order to provide an additional or superior outdoor space within K block. It has been-

Ms FORREST - For the acute inpatient mental health?

Mr MOLONEY - That is correct. We face many challenges in the fact that we are on a CBD site and we are operating within a footprint. We fully acknowledge that. We believe that the design that we have achieved is utilising that space as best as it can be utilised. Often when stakeholders talk about best practice and things like that, they are perhaps making reference to other sites that do not have the same constraints that we have at the Royal Hobart Hospital.

Ms FORREST - It is a real shame that we have been forced to do it the way we have, in my view. You can only do what you are asked to deliver. Anyway, but that is saying that the limitations of building on site in a constrained physical location has resulted in some of these less than ideal outcomes in terms of interior design?

Mr MOLONEY - I am saying that certainly what we have endeavoured to do is make best use of the space that is available within this site. There is obviously a decision that we are

looking at redeveloping the existing site. There are many benefits in staying on the existing site from the perspective of being in that CBD location in close proximity to a range of support services, but there are always benefits and compromises made in any of these types of redevelopments.

Ms FORREST - In light of the evidence we have been receiving, is there the opportunity to reconsider further alterations to the inpatient mental health facility in the new proposed K block?

Mr MOLONEY - Just to give an indication of where we are at construction-wise, we are already pouring the concrete slabs for the mental health unit. In that, you are basically laying out the location of all your en suites, all of the services and things like that. In terms of redesign, as I said before, I believe that we have achieved the optimum design layout that is achievable within that footprint, and are delivering a high-quality facility. We have received quite favourable comments about the quality of the facility in J block, which in some ways reflects the broader approach that we are using for K block.

Ms FORREST - How many beds would be in K block once it is completed for the inpatient mental health?

Ms CARR -Thirty-three.

Ms FORREST - It is 32 now and 33 then?

Mr MOLONEY - Yes, that is correct.

Ms FORREST - There are still claims that that is not enough beds?

CHAIR - That has dropped, I think, from 43.

Ms FORREST - Yes, that is right, because there has been a gradual reduction in the number of acute mental health beds. Ideally, most patients with mental health issues would be cared for in the community, but there are some who clearly cannot. For varying lengths of time - this is why some people are saying that the J block should not be demolished until this stage 2 process that will increase the number of mental health inpatient beds, or is that not right?

Mr MOLONEY - The K block project that we are undertaking at the moment is the first stage of a master plan for the redevelopment of the existing site, but at this stage we are basing the delivery of our outcomes through K block to achieve the benefits it needs to achieve. Whilst we are conscious that at some future date governments may make a commitment to further redevelopment on site, we need to make sure that the facility we are delivering is fit for purpose and delivers the benefits it needs to.

That is the focus on us, on our delivery. We are conscious that there will be further redevelopment of the site in the future, but we need to make sure that this K block delivers as much benefit for the community as it can, as early as possible. That is another factor of revisiting designs, reworking designs. It is not just the cost and wastage of going over and over the same ground. It is very important that we actually deliver these beds for the Tasmanian health service as early as possible. That is the task that has been set for us, to complete the works.

Ms FORREST - It is long-term intergenerational infrastructure we are talking about here though, isn't it?

Mr MOLONEY - It is.

Ms FORREST - It should provide a service for many years.

Mr MOLONEY - Yes. We believe that -

Mr FINCH - Cheryl, you might be able to help me here. It is a simple question. In respect of beds, we are always saying that there are going to be this many beds available, 150 beds when we do K block and we lose this many beds when we demolish J block and all those sorts of mentions of beds. Is there a tally kept at any time at the hospital of how many beds are available?

Ms CARR - There is a tally that we keep, yes, in the redevelopment. We have become very good at that. Way back, we did a physical walk around and counted every single bed in the hospital, and yes, there is a tally.

Mr FINCH - How many?

Ms CARR - The current capacity prior to any works that have been undertaken this year - so I have not added these beds in - there are 436 after we decanted B block.

Mr FINCH - So 436 beds were available for use on that site at the Royal Hobart Hospital? When you add beds, lose beds, do you work to that tally? What is the minimum that you need at any given time?

Ms CARR - I cannot speak to that from an operational perspective.

Mr MOLONEY - The Tasmanian Health Service is the best one to respond to how many beds they need. With the tallying of our beds, it is quite challenging in the sense that there are many definitions of what beds are, and at any moment in time, as you indicated, there may be variability in the number of beds being delivered by the hospital.

What we have had to do is to identify one point in time what were the bed numbers before the redevelopment was undertaken. Then we have looked at all the refurbishments and other facilities that we provided, and then we tallied it after. So a before and after look. That identified that, generally, there were approximately 440 beds prior to the decanting of B block and the works that we have undertaken, and then after. So post all the moves we have undertaken and the migration out of B block, there was a very similar number and it was very close to 440 beds.

There is a range of other strategies that are outside the role of our project which are changing bed numbers, albeit on a weekly basis, monthly basis, or otherwise. They are being delivered by the Tasmanian Health Service. We do not endeavour to keep track of that and those numbers would need to be obtained from the Tasmanian Health Service. Then, at the end of the project, we are aware of how many new beds we are bringing on line in relation to K block, and that is where we dive back in, as it were.

Mr FINCH - What does the total look like at the end of the project? We have 436 beds when you start. What is the aim? Do we know what is going to be the figure?

Mr MOLONEY - Not taking into consideration other activities that may be undertaken by the Tasmanian Health Service which are putting these interim bed strategies in place, if there were no other changes and we simply had the 440-odd beds that were in place after we undertook our refurbishments, when we turn K block on, the capacity then will be up close to 700. I believe it is something like 690 to 700 beds. That is the increase of approximately the capacity for 250 extra beds.

Mr FINCH - You might be able to help me with this, Ben. There is limited space on the site. Are there any limitations with going higher if in the future you needed to go higher?

Mr MOLONEY - That is a very interesting question, given the public debate at the moment about buildings in the CBD. The height of the building we are building at the moment is shy of the 70 metres, which has received a lot of public debate. There is a lot of speculation about what is an appropriate height for buildings in the CBD. The construction of K block will create a building that will be just shy 70 metres, and in general that has provided an appropriate facility for what is required. It has provided the area we need.

Going forward, I would not anticipate - I should not go too far into what may or may come about with further redevelopments. But recognising that we have a helicopter landing on K block, one would think that having buildings in the vicinity that were significantly higher, would be a challenge. I anticipate that most future redevelopment would be equivalent height or lower than what is being proposed. That is probably getting into an area of voicing personal opinion rather than anything else, but is the best advice I can give you at this time.

Mr FINCH - Regarding the helipad and the issue with the Theatre Royal, is that resolved? Are they comforted at the Theatre Royal that they can have productions there and not have the sound of helicopters interfering with their productions?

Mr MOLONEY - We received planning approval for the helipad to be incorporated within the hospital. As part of that, concerns were raised about noise so we worked with the Theatre Royal to analyse and understand what the potential noise impacts would be. That included a physical flyover with the intended aircraft and the monitoring of sound, and that information was provided to council and to the Theatre Royal. Subsequent to that, we have finalised and received our planning approval.

Mr FINCH - Thanks for that. It is not much to do with acute health, but it was just an issue that came up recently.

If you would just enlighten me regarding the Repatriation Hospital that you mentioned earlier. Just what is going on, on that site and how will that play a role in the near future in respect of what is going on at the Royal Hobart Hospital site?

Mr MOLONEY - At the Repat, prior to the redevelopment, my understanding is that there were two occupied floors: the Whittle Ward on the lower ground floor and another unit up on level 3. As part of the redevelopment, as I mentioned before, there was a refurbishment of level 2 and that provided an extra 20 beds. Whilst I am not involved in the approach, I understand the Tasmanian Health Service is currently redeveloping level 1 to provide additional beds. That has become a subacute facility providing important services for the Tasmanian Health Service.

Having those critical numbers up there creates an improved efficiency for them but that is more for Tasmanian Health Service to comment on.

CHAIR - I would like to touch on the governance side of things. I am not sure who should be answering this. I am interested in getting an overview of how the governance occurs on a daily basis and when you are confronted with real issues. What is the process? Where do you go to get the decision to be made for where your next move is going to be? Could somebody cover that?

Mr MOLONEY - We can either work from the top down or the bottom up. Essentially we have quite a complex governance structure because of the nature of the project that we are undertaking. It has quite broad implications for the Tasmanian Health Service, for the economy and the like. At the highest level around our governance, below reporting to the minister and Cabinet we have an executive steering committee and that consists of five members. Those include the secretary of the Department of Health and Human Services, the CEO of the Tasmanian Health Service and also the secretary of Treasury. There are two additional independent members, one being the chair and the other being a project director who has been heavily involved in major hospital redevelopment projects throughout the country.

That is our upper tier. They are our executive steering committee, their role is really to steer at a strategic level the outcomes of the project. Below that we have a -

CHAIR - They are not rowing are they?

Mr MOLONEY - No, they are not rowing, I can reassure you. They are an extremely effective decision-making group. That has been shown by the ability of the project to proceed from the outcomes of the task force to get into where we are today. Reporting to that executive steering committee is our project control group and that has representation from both the Tasmanian Health Service and also the Department of Health and Human Services and key members of the project team, including myself and the executive project manager, the consultant who is responsible for managing our builder.

That is where we bring to the table a lot of the issues around value management and making sure that what we are delivering is going to meet the needs of the Tasmanian Health Service and the health system.

CHAIR - Is there any clinical input at that point?

Mr MOLONEY - That is correct, we have clinical representation within that PCG.

CHAIR - How broad is that representation?

Mr MOLONEY - At this stage we have, I am sorry, I am still getting up to speed with the titles.

Ms Carr - He is the Clinical Director of Surgery.

Mr MOLONEY - The Clinical Director of Surgery.

Ms CARR - The Acute Operations Director.

Mr MOLONEY - They are probably the key roles. Going forward, as we enter into more of planning for operational commissioning we are also looking opportunities potentially to broaden out that representation. Now that the RHH executive is much more formalised, it is a discussion we are likely to have with the Tasmanian Health Service about clinical representation on that group, perhaps becoming slightly broader.

CHAIR - The reason I am asking is to get an overview of that. How can we get to a point where we are building a mental health facility that is not something that the clinicians see as being valuable? That is the point. In some part and I do not know how it has got to that point but that concerns me a little bit. It is not for you to answer the policy side.

Mr MOLONEY - That being said we have had our designs reviewed and approved by clinical representatives. There may be stakeholders within the broader system that may be dissatisfied with the outcome but it is important to note that these designs had been developed with heavy consultation with the users and stakeholders. It has gone through a formal approvals process. In addition to the governance structure, below the PCG we also incorporate the RHH executive as part of our approval process, particularly for any change management.

Ms CARR - Further down, each of the divisions have a -

CHAIR - This is under the project control group?

Ms CARR - Yes, under the executive in the hospital. Surgery, medicine, mental health - not so much triple Cs have been a little more silent in the last few months because the design phase had sort of stopped. However leading up to that we certainly met every month with a wide group of mental health stakeholders.

CHAIR - So there was an opportunity from your perspective as project managers for that input to occur?

Ms CARR - Yes. There was a lot of work with mental health services from a redevelopment perspective.

Mr MOLONEY - As an example of that, I mentioned before that the developed design was finalised in June 2016 and subsequent to that there were concerns raised regarding access to open areas for one of the units within the mental health ward. We re-met and worked through with some of the stakeholders to look at opportunities to improve it. We went through a number of iterations there and incorporated a design change so that we could improve access to open space for that unit. We have certainly consulted very heavily and as I said before, I believe that where we are at now is the optimum design within the constraints of the building.

CHAIR - What is the regime of reporting going through this project? You obviously have certain reports that you are providing on a regular basis to keep those above informed as to how the project is progressing. Can you give me an understanding as to exactly what reports are being provided?

Mr MOLONEY - We provide monthly reporting to both our project control group and our executive steering committee.

CHAIR - And those reports handle what sort of aspects?

Mr MOLONEY - They cover broadly all aspects of the project scope: time, quality, those sorts of matters. In relation to -

CHAIR - Pinch points?

Mr MOLONEY - Certainly. Issues and risks, yes. In relation to where issues or concerns are raised by stakeholders, because this is a very large and complex project, it is important that we keep control of scope and cost. In relation to proposals for design changes, the preferred approach is if stakeholders have concerns or issues that they work that up through and seek approval of the Royal Hobart Hospital's executive team before it then comes across to the project team.

That being said, we work quite closely with the stakeholders so if they raise a concern we try to address it as best we can, working directly with them. If it does require a significant change then we have a change management process where they can seek the support of the Royal Hobart Hospital executive. That is then presented to the project control group and then we consider the validity of the change, or perhaps come up with a better option if one exists.

CHAIR - So you have established risk registers which you track each of the issues through to an end point?

Mr MOLONEY - That is correct. The risk register primarily picks up on risks that may come through. In addition to that, we identify ongoing issues and seek to resolve those.

CHAIR - We have about five minutes left and I will hand that to Ruth.

Ms FORREST - Are you able to provide a copy of the list of stakeholders who have been consulted in this process? You talked particularly about the mental health. Can you provide us with lists of either representative bodies or names of people who have been on that consultation? - Particularly in that area, but in all areas. That would be very helpful. Not now but if you could provide it to the committee-

Mr MOLONEY - Just to understand the scope of that because this project has obviously had many years. The list of stakeholders involved in, for instance - perhaps if we focus on the sign-off of the developed design and progressing -

Ms CARR - With mental health, we have undertaken a lot of consultation with many community groups, user groups as well as consultants. Is that what you are after? People who have had all of that involvement?

Ms FORREST - Yes.

Ms CARR - Yes for sure.

CHAIR - Mental health in particular?

Ms CARR - Particularly mental health, yes. There has been a lot of work undertaken with lots of different invested stakeholders in mental health. The design has developed with increased beds. We have looked at the design to make it contemporary and the best we can. We have also

increased the outdoor space from 20 square metres when we first took over the project to about 130 square metres to 140 square metres of outdoor and recreational space. We have done a lot of, I think, some really good development of that, looking at the different spaces and using a landscape architect to provide some really nice amenity for that.

CHAIR - While we are on that list, just before we go, if you could provide us with a list of the reporting structures that you provide as well, so your risk registers and those sorts of things. I would be interested in knowing what those reports are that you are producing and providing.

Mr MOLONEY - We could certainly also provide a copy of our governance structure, which shows representation within that group.

CHAIR - That would be great. Thank you.

Ms FORREST - With regard to the budget, have there been overruns in the budget?

Mr MOLONEY - Essentially, with a project of this nature, we operate with a range of contingencies, contingency funding as well as the baseline project budget that we are working to. At this stage, we have had to draw upon some of the contingencies, but it is not at a point which is extremely different to what we would anticipate at this point in the project.

Ms FORREST - If you had to put a figure on it now, what would you say are the budget overruns?

Mr MOLONEY - As I said, they are not budget overruns. We have utilised contingencies that have been allocated to the project for that purpose. We believe that utilisation of those is generally in line with where you would expect to be at this point in the project.

Ms FORREST - Just confirming: mid-2019 is the date for practical completion. Is that what you are saying?

Mr MOLONEY - That is correct.

Ms FORREST - Have there been any extensions of time granted during the process?

Mr MOLONEY - In relation to extensions of time, that is a contractual matter which exists between the Crown and the managing contractor.

Ms FORREST - Yes.

Mr MOLONEY - The dates that we talk about in relation to completion of mid-2019 reflects the forecasted date of completion as opposed to the contracted date for completion.

Ms FORREST - There have been extensions?

Mr MOLONEY- There have been some extensions of time granted under the contract, but as I said, the date for practical completion under the contract is more of a commercial matter between the state and the managing contractor. It is a matter of a range of other mechanisms. Publicly the most important date to people is when will we actually finish, not when do you have

a contract agreement to be finished by? At this stage, the forecasted date for actual completion of K block is mid-2019.

Ms FORREST - Who picks up the cost associated with the extensions that have been -

Mr MOLONEY - Extensions of time?

Ms FORREST - Yes.

Mr MOLONEY - Where there are legitimate extensions of time granted to the managing contractor, those costs are predominantly picked up by the Crown. That can relate to a range of issues. For example, if we do encounter latent conditions, as we mentioned before, which cause delays, it is unreasonable for the contractor to wear those because the nature of latent conditions are that they were unforeseen at the time. Those are legitimate areas where -

Ms FORREST - You have contingencies for those, do you not?

Mr MOLONEY - That is correct, yes. That falls into the category I mentioned before. The project has appropriate contingencies allocated to it. We have drawn down on some of those contingencies, but we are at a point where we believe the amount of contingencies allocated are about reflective of where you would expect to be at this point in the project.

Ms FORREST - Are there unresolved requests for extensions of time at this stage, or are they all dealt with?

Mr MOLONEY - That is something that I would probably consider to be commercial-in-confidence in the sense that any project of this nature will have ongoing conversations between the client and the builder on these kinds of things. There is a range of things that are always ongoing. There are ongoing discussions with our managing contractor about where we are at progress-wise, what delays are occurring, how we are mitigating those, and we are working through those very well and amicably with the managing contractor.

Ms FORREST - The extensions of time that have been granted to date, have they been at the request of the contractor or other parties?

Mr MOLONEY - Extensions of time, in relation to administration of a contract the process is that the contractor identifies where there may have been a delay to which they believe they have recourse to submit a claim. They lodge that claim and then it is given consideration by the principal's representative, which is appointed by the Crown. Where they are legitimate claims valid under the contract, they are then granted.

CHAIR - A copy of the risk register, is it possible to provide that?

Mr MOLONEY - I would imagine so. There may be aspects of it that we would need to consider as to whether they are commercial-in-confidence. Clearly, some of the risks that we are dealing with are commercial risks so -

CHAIR - I understand that might be the case, but I would appreciate a copy of the register.

Ms FORREST - We can receive things in camera too.

Mr MOLONEY - Certainly I would need to take the advice of the department, but I will seek to provide that.

CHAIR - Thanks. I do not know whether there are any other closing remarks that you wish to make at all, but thank you for coming and presenting. I am sure that building a hospital must be one of the most complex projects that anyone could ever wish to undertake. Certainly redeveloping on site would be one of those. That is an interesting circumstance that you are managing. Thank you.

Mr MOLONEY - It certainly is challenging. I guess what we try to recognise is the actual benefits at the end of the day that are going to be provided. Quite often we do get down into the nitty-gritty and dealing with the issues of the day. What is important in any of these projects of this scale is to recognise the benefit at the end of the day. That is what we are trying to deliver, to get K block completed, get it open and get it utilised by the Tasmanian Health Service. We are bringing online that capacity. It will be hugely beneficial in the longer term. We will have some challenges in the meantime, but it is well worth it.

CHAIR - Just with respect to the risk register, if we could have it as of 1 November, perhaps, the date of the register. Thanks.

Ms CARR - The other thing I just want to say is that the staff in the hospital have been amazing. The support that we have got is amazing. It makes it worth it.

CHAIR - Thank you.

THE WITNESSES WITHDREW.

MERVIN REED, JUSTICE OF THE PEACE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED**.**

CHAIR - Welcome, and as you would appreciate, we are taking sworn evidence so we need to have you make the statutory declaration before we speak and you might outline your role and previous experience in this area at the same time.

Mr REED - My interest is by way of two particular components. I had some time as deputy secretary of the Health department from the early 1980s. Secondly, I have had an interest in various parts of the health sector as I have a lot of doctors as clients. I also provide services by way of consulting advice to the private sector, in terms of health.

CHAIR - Just to make sure we are all on the same page. This is the Government Administration A Sub Committee inquiry into the Acute Health Services in Tasmania. It is not a government inquiry, it is a Legislative Council committee inquiry.

All evidence taken at the hearing is protected by parliamentary privilege and I will remind you that any comments you make outside the hearing may not be afforded that privilege. A copy of the information for witnesses statement has been made available. Are you aware of that?

Mr REED - Many times, Mr Chairman.

CHAIR - Thank you. I am sure you probably are.

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

We will give you the opportunity to make some opening comments first and then we will lead into questions from the members here. Should you get to a point where you feel that there is something you wish to say that should be in camera, you can advise us of that and we will consider that request, should that happen.

Over to you for your opening statement.

Mr REED - I have a copy of my opening statement for the committee secretary to confirm the *Hansard*. I was also thinking when I was walking here, it would be a good idea if we could adjourn the committee to a nice winery at Rosevears which would probably be more -

Mr FINCH - What a good idea.

CHAIR - I can think of some closer, but nevertheless -

Mr FINCH - If it is the quality you are talking about!

Mr REED - Good morning, Mr Chairman, and members of the committee. I thank you for the opportunity to offer comment. I produced this contribution on the way back from Singapore on an aircraft, where I had been for business and I am sorry if it was slightly late. Thank you for accepting it.

CHAIR - That is fine.

Mr REED -I have a short opening statement for you to consider.

The funding of the health function of the Tasmanian Government is, as the committee has discovered, both a disgrace and provides a clear indication that the parliament has been consistently lied to by the health minister. You have been told by other witnesses that the health funding for Tasmania is some $210 million under-funded for acute care services. The governance of acute care hospitals resembles a shambles on a daily basis, with no beds, ambulance ramping and elective surgery waiting lists now continuing to blow out.

The Treasurer in the Budget speech for 2016-17, made the following statement:

> The Hodgman Liberal Government is continuing its record investment in Tasmania's health system with $6.4 billion over four years to help deliver a better health system.

The Treasurer in the Budget speech for 2017-18, made the following statement:

> The total recurrent spending on health will be in excess of $7 billion across the four years, an increase of more than $650 million, and we will see a massive 106 additional beds across the state with more doctors, nurses and health professionals employed in our hospitals.

The Liberal Party has recently put out a pre-election flyer that simply lies to the people of Tasmania, as it says:

> This means 52 beds in Hobart, including 10 emergency department beds and two intensive care beds at the Royal Hobart Hospital, and 22 beds at the Repatriation General Hospital, and 10 beds at the Roy Fagan Centre.
>
> The 22 beds at the Repatriation General Hospital are presently being constructed and they are not able to be usable at least until August 2018.

They do not exist. This statement is untrue. There are no additional medical surgical beds at this time. The relentless pressure on the medical surgical beds at the Royal Hobart Hospital continues, the elective surgery beds are lost in the mists of spin.

The 10 beds at the Jasmine Unit at the Roy Fagan Centre mentioned are simply those 10 beds being reopened after they have been closed down by the minister as a cost-saving measure.

Ms FORREST - By the current minister?

Mr REED - Yes. The current minister closed the 10 beds as a cost-saving measure three years ago and they have been reopened. The two new ICU beds have been going to be opened for the last three years and the other beds are simply deck chair rearranging. This has resulted in increased misery and suffering for Tasmanian citizens and is the direct result of actions by government. These actions are intentional and thought through by the Minister for Health who was responsible for the deliberate creation of the misery and suffering of a large number of our fellow Tasmanian citizens.

The underfunding is no accident but a plan. Recently you will have been told in the budget documents by the Government that they are having a record spend in the health sector. This is also not true. The expenditure for 2016-17 was $1712 million with the proposed spend in 2017-18 being $1722 million with a forward Estimate for 2018-19 being $1730 million. When I apply 2 per cent inflation to the $1712 million for 2016-17, this means the expenditure has to lift by $34.2 million to have a standstill position from 2016-17 to 2017-18.

I note that health inflation is running at over 6 per cent and you have heard from other witnesses on this. The proposed expenditure contained and the budget document approved by this parliament is $1722 million whereas to provide for inflation, the expenditure would have needed to have been $1746 million. Thus what has been proposed by the Government for the 2017-18 budget and what has been agreed to by this parliament is a cut to health expenditure for the present financial year of $24 million.

Ms FORREST - Does that include the capital expenditure?

Mr REED - No.

Ms FORREST - Just the service delivery?

Mr REED - Just service delivery. This excludes CAPEX. This is from the Consolidated Fund expenditure documents, page 183 for the *Hansard*.

Ms FORREST - The minister argued the point with me at budget Estimates on this point if you might remember.

Mr REED - The Government may argue that the large increase from $1244 million to $1401 million containment of figures for 2016-17 is an increase in funding but it is nothing more than the spending overrun from 2016-17 for this financial year provided for on the 2017-18 budget year.

In summary, the present Hodgman Government has cut the health budget in real terms by $24 million over and above last year. They wonder why the hospitals are struggling and a good number of Tasmanian citizens left in misery and suffering. This is the reason why you are holding this inquiry.

That concludes, Mr Chairman, my opening statement.

CHAIR - Thank you.

Ms FORREST - I do not know if you read the *Hansard* of budget Estimates this year but I prosecuted the case that they were actually spending less in real terms. That was absolutely denied.

Mr REED - That is not the case. Whatever they have told you and denied, it is a lie. The expenditure this year will be $25 million on the parliamentary approval of the appropriation less than last year.

Ms FORREST - With health inflation, I think you said about 6 per cent, most people say isn't it?

Mr REED - Medical inflation runs at around 6 per cent presently. Two years ago it was running at 7.3 per cent.

CHAIR - Are you saying nationally?

Mr REED - Nationally. For the purposes of the committee to explain that number. We currently have a CPI in Hobart - across the island - of about 2 per cent, but the medical consumption of services both human resource services and every other input cost is subject to:

(1) market forces of medical practitioners;
(2) the increasing cost of paramedicals, nurses and everybody else in terms of training; and
(3) the cost of pharmaceuticals, technology and drugs and simple things like bandaids.

A lot of this input comes from either a manufacturer in Australia with overseas licences where they are paid in US dollars, or imported coming from Europe, which is the majority of drug manufacturers, or out of the United States in terms of technology where it is paid for in US dollars. Given that the Australian dollar has been up at 80 cents, for every 1 cent you are looking at around about 1.6 percent of inflation. We are continuing to pay somewhere in the order of 6 per cent more of public funds for the same services we had last year.

Ms FORREST - In terms of pharmaceuticals?

Mr REED - Yes.

Ms FORREST - Yes, and other prosthesis and things like that? Does that apply to them as well?

Mr REED - Prosthesis cost, depending on what you are going to use, between $4000 and $12 000 per limb, or hip.

Ms FORREST - The beds you talked about, the new beds, you say they are not completed? These are the surgical beds you are talking about? Can you give us a bit of an understanding of what you believe to be the case?

Mr REED - Some 18 months ago, I made the point to the Minister for Health when he told me that he should he should do a tour of the Repatriation General Hospital facility. This facility was acquired by the state on deed from the Commonwealth some 15 or 18 years ago. There are three unused operating theatres and essentially three full 32-bed wards that have been converted into various functions such as the Whittle Ward - a palliative care facility - and the rehabilitation ward of the Royal Hobart Hospital, which is about 32 beds. There is space up there for an additional 22 to 24 beds. It has never been touched.

I suggested to the minister that if you are going to start to pull the hospital down then you might as well put the money in the front end, fix these beds up, fix the technology up and put people up there. The answer that came back was that nobody wants to work there.

Ms FORREST - I am just clarifying here - I am not aware and I may have missed this - that the minister talked about the rehab beds with the ward that is there. The additional beds, you say the capacity there with the theatres and the potential for post-surgery beds-

Mr REED - I see where you are coming from.

Ms FORREST - Yes. Was that part of the commitment?

Mr REED - No.

Ms FORREST - This is something in addition to it?

Mr REED - It was a separate commitment where the Government funded $5 million - from my recollection of reading the budget documents on capital - to refurbish a 22-bed ward at the Repatriation General Hospital.

Ms FORREST - For the purpose of?

Mr REED - Medical surgical bed overflow from the Royal Hobart Hospital. That was the reason given.

Ms FORREST - Are you suggesting that they should be doing surgery there as well, or just the post-operative care?

Mr REED - I would have no view on that. If it was a balanced decision, the question would be first of all at what particular point would the person be transferred there? Is it after surgery, outside the recovery room and straight to that ward? Or is it from the recovery room to a stay in a one day ward and then moved up there for the rest of treatment? What are the costs of refurbishing the theatres that are probably 15-year-old technology with current technology, and what would be the cost of operating them compared to operating the theatres at the Royal Hobart Hospital, which only eight of the 14 operate now.

Ms FORREST - So wouldn't it be better to get the rest of the 14 working?

Mr REED - Well, there are 14 theatres and they are not operated because there is no staff.

Ms FORREST - If you re-develop the Repat and you cannot staff if then -

Mr REED - If you cannot staff what you have then why would you staff it up there?

Ms FORREST - Yes.

Mr REED - To answer the question in another way, what is the Government doing? Hopefully they are refurbishing or the work is still continuing on 22 beds to at least provide some interim measure to the Royal Hobart Hospital, which will be three and half years away from having any usable medical surgical beds.

CHAIR - Reading through your submission, and thank you for that - we appreciate your submission - where are the solutions? What is basically going wrong? If you were in charge - and you were pretty high up there back in DHHS in the mid-1980s, as you said - what is going

wrong? Is it the governance structure that is wrong? Is it the fact that there are not enough clinicians having an input? Where do you see the main problem here?

Mr REED - Let me answer the question, first, I have no intention of coming back to work for the government. Second, the penance I have is on the chairman or president of the Tasmanian Senior Executive Service Association which are the heads of agencies and SES 2s and above in the State Service currently.

CHAIR - Sorry.

Mr REED - I am the president of an association that represents the heads of agencies and all senior executive service officers SES 2 and above. I have no intention of returning to the fold as much as you would desire that after this inquiry.

CHAIR - No.

Mr REED - My answer to you is two-fold. One is it is a structural problem. The Tasmanian Health Service was a mistake. We had three regions, three health services all rolled into one, and now we have one Tasmanian Health Service and it is headquartered in Launceston, for whatever reason. The cost of operating the Tasmanian Health Service with 700 or 800 people on the top-end infrastructure has now blown out by $50 million or $60 million a year. There is absolutely no net benefit to the people of Tasmania.

CHAIR - I spent 20 years in the department, in ICT, and I went through three iterations of centralising and decentralising to regions, and then centralising and decentralising. There must be something fundamentally wrong with the way the governance is operating.

Mr REED - Correct.

CHAIR - Do you have a comment on how that should be addressed?

Mr REED - Yes, I do. My view would be that each hospital, major acute care hospital, is really a little city in its own right. District hospitals are in that catchment for them. It must work that way, there is no other way to work. Each hospital should have a chief executive officer who is responsible for one person.

CHAIR - Do you not get fragmentation then?

Mr REED - No. You have three hospitals and three CEOs. That is it. There used to be - 30 years ago each hospital had a director of administration or a chief administrative officer, a medical director and a director of nursing. That exercise worked very well. The three of them used to have a meeting every now and again to decide each day what the problems were and where the pressures were. They reported to one single person, the DHHS, which was called the Director of Hospital and Medical Services. That person controlled everything: appointments, staffing, everything.

CHAIR - From each of the sites?

Mr REED - Yes, each of the sites had a budget, and they went ahead and did everything they wanted to do, and they ran their hospitals and they reported progress. They reported DRG outcomes, everything.

CHAIR - Then there was the situation where you had fragmentation, for instance. I know from my perspective, I certainly realised there was fragmentation with respect to software being used on each site, so you did not get an amalgamation of data for the whole state, all sorts of things that occurred. What is the preferred model to be able to take advantage, if you like, of a whole state circumstance, and yet provide each of the hospitals with the autonomy they need to be able to deliver the service properly without having to go further up for decision-making?

Mr REED - Correct. The single biggest problem was that each of these hospitals are in various stages of technological development - brought up at hospital dates from the 1920s. The Launceston General Hospital, part of it dates from the 1930s. The Mersey General Hospital dates from the date that Scott Turnbull [?] decided to build it there. We are now demolishing the piece in Devonport, I think, at some time today. The North West General Hospital dates from the time I picked out the site.

The question, Mr Chairman, is, do all these hospitals have to operate on the same model? The answer is no. The two larger hospitals, the Launceston General and the Royal Hobart Hospital, need to operate on a larger model, but do not necessarily need the other two hospitals to operate on that same model.

CHAIR - From a clinical perspective, providing those clinical services -

Mr REED - It depends on what you provide where.

CHAIR - Obviously, there are economies of scale in appointing the clinicians and the like. How do you see that operating?

Mr REED - I will answer your question with the IT perspective. There is no reason why the admission transfer separation system on all the hospitals cannot be common. I managed to buy one of these systems and install it, because I could not tell the government when I walked into the health department, how much money was being spent on health and how many patients we had and what they cost.

I do not know whether that CDSA software still exists, but some variation of it probably does. You need to have a consistent policy driven from one person controlling this across the state, not a committee, not another board, not eight or nine or 10 layers of management. You have three chief executive officers and somebody who is appointed by the government in Hobart to be the director of hospital and medical services in the state. The short, flat structure like the private sector would have.

CHAIR - Is that where you get a major tertiary hospital like the Royal that takes in patients from across the state. Obviously there has to be collaboration between each of the sites in some way shape or form without fiefdoms being developed that say, 'Do not enter here, this is our business'. How do you see stopping that from developing?

Mr REED - This has the north-south divide for years in Tasmania and in medical terms it is very difficult to explain to a person living in Burnie why they cannot have the same access to

super speciality clinics as they do in Launceston or Hobart. It is better that we be up front about that so that the North West General Hospital and the Mersey General Hospital are going to be regional-based hospitals; that is what they are. The LGH needs more funding and expense on clinics and expansion of specialities and Hobart needs at least another two, three or 400 medical and surgical beds to make it work.

CHAIR - Supplying clinicians to, say, the north-west, and/or the north where there is a shortage, how do you overcome that? If there is a problem there, if you are providing locum services to try to fill the gaps, it is a very expensive way, isn't it? How do you see the model changing to be able to effectively address that?

Mr REED - I would see the model changing to a public/private model where people are contracted to provide the services: private medical practitioners. I am giving you an example, Mr Chairman, how this works. A top end orthopaedic surgeon operating at the Calvary Hospital in Hobart on a single surgical session will do 10 hip replacements in a day. At the Royal Hobart Hospital -

Ms FORREST - Say that again? I do not think they will do 10 hip replacements in a day.

Mr REED - Yes, they will do 10; 10 complete patients because it is done on a system; it works very well. They have operating theatres that are set up properly for this; $2.5 million to $3 million worth of prosthesis sitting in a clean room ready to use everyday.

CHAIR - For the record, where do you get your data for that?

Mr REED - I get my data from various sources, but let us say that it is quite true. The hip replacements at the Royal Hobart Hospital, on an average basis, would be two a day. The resources are exactly the same. The reasons it is only two a day at the Royal Hobart Hospital is because there are no beds.

Ms FORREST - How long does it take to do a hip replacement?

Mr REED - One hour and five minutes. If it goes over one hour and five minutes, the increasing risk of infection is exponential.

Ms FORREST - And we have patients with, and the range of co-morbidities these days, that makes it much harder to essentially position them on the table for surgery, et cetera. It might be the usual shortest time for a patient -

Mr REED - Add the fitter patients, it may be 45 minutes. The ones that are more obese and more difficult might be one hour and five minutes, but it would be around about that.

Ms FORREST - Which does not account for the time of set up, getting them on and off the table? We are talking about the actual hammer and tongs, which is what it is, of a hip replacement.

Mr REED - It would be useful for the committee to actually go to Calvary Hospital and have a discussion because it is done particularly well, both north and south, in the private sector, and it is done to a high level of security and satisfaction and there are very low infection rates.

Ms FORREST - And Calvary does not take on the really complex, higher co-morbidity patient?

Mr REED - I think they do because they have 13 ICU beds, and they keep bailing the Royal Hobart Hospital out from time to time with the use of those ICU beds.

From my understanding, at the present time Calvary is also in the process of building a cardiothoracic centre out there.

The last part of the question, Mr Chairman, how would you change the model? You flatten the structure, remove the Tasmanian Health Service from the cycle because a lot of the people who work there are probably not needed.

If push comes to shove, which people are going to be able to generate an outcome to the patient coming through the door - is it you, or somebody else? If it is not you, you probably do not need to be there.

CHAIR - What about involving clinicians in all of this decision-making?

Mr REED - There is not a normal clinical professional process as there is in the normal clinical nurse professional process. We have more and more responsibilities these days put on to clinical nurses and nurse managers and doctors to do a raft of things that were done by a different structure 50 years ago.

In terms of the supply of those clinicians it has not been very well managed by the Tasmanian Health Service, which does not understand the market for doctors and nurses. I recall the numbers that were exposed in a report recently where there are some 250 nurses short - this is positions that are funded - where there are no nurses in them. There are some 65 or 70 salaried medical officer positions vacant.

You have heard evidence in relation to the huge amount of public money being spent on locums on the north-west coast. Why would anybody put their hand up to be a salaried medical officer when you can make $200 000 a year more being a locum doing the same thing? The classic example, the Launceston General Hospital does not have an endocrinologist and because they do not have an endocrinologist they cannot teach internal medicine.

Mr FINCH - Yes, you made a mention of that.

Mr REED - Yes, and as a result the medical students will not be able to have a medical training process happen in this coming year because the Royal Australian College of Physicians has withdrawn the accreditation. We have recently seen the anaesthetics accreditation withdrawn from the North West General Hospital. We have seen the accreditation for psychiatric training withdrawn from the Royal Hobart Hospital. There is a sort of pattern here, isn't there?

Mr FINCH - Are you aware of Dr Bryan Walpole's submission with respect to one state-wide academic medical centre?

Mr REED - Yes.

Mr FINCH - Do you have a comment on that?

Mr REED - If the University of Tasmania is willing to put through a university medical centre and fund it, then absolutely. What a good idea.

Mr FINCH - On reading that submission - if you have - do you think that is one way forward to address the shortage of clinicians if they managed sensibly in that format that he has suggested?

Mr REED - I understand where Dr Walpole is coming from.

CHAIR - If you want a refresher -

Mr REED - No, I have seen that - that is Dr Walpole's presentation to the committee in writing. It is his way of addressing the clinical shortfalls. One of the reasons we have the shortfalls is that we do not hire enough doctors. We are not hiring salaried medical officers and we are not hiring them for two reasons. One is that the Tasmanian Health Service is so slow in the process of acquiring the human resource function and getting it going that in a lot of cases when they ring the doctor saying that they are still interested, the doctor is working somewhere else in Australia. Second reason, the salaries that we are offering are so small, a pittance, compared to the market price that they then wonder why the doctor says no.

I have explained this to Ms Forrest before, and I have to go. Are we short of time?

CHAIR - No, I am just making sure that I am not running short of time.

Mr REED - Okay. Sorry, Chair. Some years ago - I think I had this discussion, I am not sure - but it goes like this. The Gray Liberal government put the first cardiothoracic unit together at the Royal Hobart Hospital many years ago. The reason was that the cost of transportation of patients to Victoria for acute care heart surgery was immense. The cost of running the unit down here was about $5 million a year and the cost of transportation was nearly $7 million. The cost of the medical practitioner was about $2 million a year. Are there alternatives? No. This is the only person that wants to come and I have to tell them at four o'clock. You have to make a clear decision - yes or no. These are the facts of life in a limited market.

We do not have a reactive Tasmanian Health Service. We have a minister who has stated to the AMA and others that there will be no deals done for doctors. So the doctors do not come. They go to the Queensland Health Service or the Victorian Health Service who will do deals for doctors. That is the reason you do not have permanent medical practitioner positions filled - because they are not at market and they do not understand what the market is. They cannot offer what other people offer. They are probably $150 000 off the mark on most positions.

Mr FINCH - I am very impressed with your grasp of our subject matter. Could you me tell what you think the recommendations should be from an inquiry such as this?

Mr REED - I think there are three basic recommendations you will end up with. The first one is that the structure of the current running of the hospitals is inept and stupid. We have no single clinical direction which is what Dr Walpole is talking about. We have no single person responsible for a hospital, and we have no single person in DHHS that has a grasp of all the reins on this and is able to balance out the needs.

The second recommendation should relate to: let us get on and actually employ some people. The reason we do not have the services is because we do not have the people. I started out on my submission, Mr Finch, saying that hospitals are a logistical operation and they are. You cannot turn off the tap at all. What comes in with ambulance carts Friday night to Sunday night will destroy the elective surgery list for the following week because there is only a limited amount of bed space.

The second recommendation should be: should we get on with it? Let us employ the people. Why wouldn't we employ the 250 nurses? We have been told before. I have listened to people tell committees of this parliament, 'we have a lot of these nurses coming out of the university nursing school and we do not have any positions for them'. We have an older nursing workforce - Ms Forrest is well aware of this - and a lot of these people are going to retire. We need to have a whole bunch of new nurses employed now, not in two years time. You need 250 nurses now to at least provide basic services in the hospitals to allow some of the existing nurses to go on holiday.

How many times have you heard at this in an inquiry about double shifts? They are dangerous. Relentless overtime is dangerous. I have nurses as clients that are really specialist nurses and there is no replacement for them.

CHAIR - Clients? In what sense?

Mr REED - They are financial advising clients. I provide financial advice to them and I will not provide any details because that would breach the Privacy Act. Let me say they come home after two and half weeks of relentless shifts with no breaks and they are so tired they just fall asleep. They do not see their kids, do not hug their husband, and they end up having a mental health day or two. This is what we are doing to our health sector by non-employment of the proper levels of people. It is a logistical problem. If we do not employ the people it is going nowhere.

Mr Finch, the third part of your recommendation should be that we need to do this now not in two or three years' time, otherwise we are all going to be sitting around this table in two or three years' time saying we should have done something three years ago.

CHAIR - Is this basically to allow a smoother transition from the older workforce through to a younger workforce? Is that what you are saying because of the baby boomer situation?

Mr REED - True, there is no reason why you can't fill all the medical surgical positions for medical officers now. There is no reason you can't fill the 250 nursing positions now.

CHAIR - The Government might say it is money.

Mr REED - They have already budgeted for the money. In your case you have already heard they are spending $35 million here in locums. If you employed the people fully you would be about $22 million a year in salaries and on costs, so there would be a saving. I think I can count that much. The real key to it is the nursing staff. If you do not have the nursing staff at the appropriate levels in the hospital you are not going to be able to provide the services to anybody. The Royal Hobart Hospital, this year, got within 24 hours of closing the door.

Ms FORREST - A lot of it was related to the particularly bad flu season where the staff were sick.

Mr REED - This ran over everything; there was nothing left. There are particular cases - that is why I suggest you go to Calvary and have a discussion where the Calvary Hospital has been bailing out the Royal Hobart Hospital in terms of logistics for some considerable period of time.

Ms FORREST - We are a small state. Shouldn't we work collaboratively with whatever health services there are to give Tasmanians the service they need?

Mr REED - The Chairman asked me what we should also do in relation to the second item. We can actually transfer to the private sector all the surgery that we are not good at doing in the public sector for which the hospitals really do not have the present capacity to deliver the volumes, which is hip replacements.

CHAIR - You mentioned that in relation to Mersey, I think.

Ms FORREST - They do not do hip replacements at the Mersey.

CHAIR - That is right, it is elective surgery. You mention here that the cost of delivering services out of the Mersey could exceed the cost of a private hospital being able to deliver the same service. Do you want to expand on that?

Mr REED - Yes. The private sector has a particular process of risk assessment for each patient. The public sector has a similar sort of risk assessment, but there are 27 people involved.

Last year, when the minister discovered after his program using $25 million worth of federal public money to increase elective surgery outcomes - that is, buy the surgery in - had not had any takers, and the question was why? The answer is that none of the private sector people are interested in the public sector view of risk.

CHAIR - It is not a matter of simply logistical issues with where the services were required as opposed to where the service was being delivered?

Mr REED - No, which patients need what. Just send the patients to the private sector and they will do the assessments, which they did, and they put a whole bunch of patients through Launceston, Mersey, North West General, and the Royal Hobart Hospital patients went to Calvary and the Hobart Private.

CHAIR - My question is in relation to the elective surgery that is being delivered out of the Mersey, obviously they would largely be patients from the north-west. What private facility would be delivering those services for the same level of convenience, if you like, to the patients in that area of the woods?

Mr REED - You can either do it two ways. You can bring the private sector deliverers of service into the Mersey General Hospital and use the facilities and deliver the service.

Ms FORREST - Why would you do that when you have surgeons and staff there to do that? They have a highly effective endoscopy service going at the moment.

Mr REED - They have a whole series of particular diagnostic groups that they use looking at elective surgery, which is all mid-level stuff, endoscopy and stuff like that, and that is fine.

Ms FORREST - That is the intention of that facility; it is not to have major surgery.

Mr REED - The question the Chairman wants to know is, where else but the Mersey General Hospital can it be supplied? The answer is that it can be supplied in Launceston, or it can be supplied in Hobart.

Ms FORREST - Or Burnie.

Mr REED - Or Burnie.

CHAIR - But then you have the extra cost going back onto the patient to have to get overnight stays down here, et cetera. While it might be a cheaper way forward, as you are suggesting, isn't it forcing more cost onto the patient?

Mr REED - No, it is not, because it is forcing less cost onto the public and less cost to the patient. Remember there are probably 10 000 to 12 000 presentations at the Royal Hobart Hospital alone in the Department of Emergency Medicine, revisits for patients who have been there for treatment, have not had their treatment finalised, go home, no notes go to the GP because there are no links. If they have a problem, the GP says, 'go back to the hospital'.

In this case, if you had the elective surgery operation done in such a way as the person got treated here or in Launceston, or wherever they got treated, they are not going to come back into the public sector. They are not going to consume more public resources.

CHAIR - I found that interesting in your submission about GPs not receiving discharge summaries. I did not realise that was the case.

Ms FORREST - It used to be, it is a lot better now. Most GPs receive them by email now, as the patient is discharged, so it has improved.

CHAIR - I can remember one of my instances, my GP receiving something.

Ms FORREST - It used to be a major problem, a few years ago.

Mr REED - That is fine, but I suggest what happens is there is some statistic obtained by the committee by just simply asking the Royal Hobart Hospital, how many people reappear after discharge?

Ms FORREST - But you have to look at why they reappear too. The cold hard figure does not actually tell the whole story. You have to look at -

Mr REED -Ten thousand people a year. There has to be some reason why 10 000 people a year reappear.

Ms FORREST - Some of them were discharged too early, all of those sort of things. It is not because the discharge summary was not sent.

Mr REED - Mr Chairman, we have two principal logistical aims here. One is to deliver more elective surgery to the people of Tasmania and, second, to get a better bang for the public service buck, and third, not have them come back onto the public revenue as a cost. In other words, let us make sure that the person gets treated once or twice, not five or six times.

Ms FORREST - You talked about needing a flat structure and what is the intention of the THS, and I do not think it is perfect yet. There needs to be some work on it. You can have local hospital management, like your director of nursing, your director of clinical services or whatever at each major hospital, but still there is one overarching person, body, whatever, that actually controls the same thing. The HR should be the same, IT should be the same, payroll should be the same.

CHAIR - All the essential service stuff.

Ms FORREST - Yes, all that sort of stuff, but also your infection control should be the same.

Mr REED - All that, yes.

Ms FORREST - All those sorts of things should be the same.

Mr REED - I agree.

Ms FORREST - Surely we can do that in a cost-effective way. I mean, statewide mental health, it is already statewide, and it should be, in my view. There is a whole range of services that if you can maintain that one health service in the state of Tasmania, as small as we are, as dispersed in population as we are, with local management that have really good collaboration and communication between them - which goes back to your IT - surely that is what we need, not a completely broken up model again?

Mr REED - If you can find $250 million to add to the current recurrent spending on the hospitals, I will agree with you. If you can't find $250 million to put into the budget, the hospitals will get closer and closer to collapse.

Ms FORREST - Why?

Mr REED - Because we have an ageing population. We have a higher level of diagnostic imaging capacity everywhere. We have more and more people requiring treatment and using gene share technology and a range of other technologies, new -

Ms FORREST - I am interested in why the structure is wrong?

Mr REED - The structure is wrong because we are a small population of essentially half a million people. That has not changed very much in the last 50 years. We added over 1000 people to the structure of the health service in terms of the management component of it. That is why -

Ms FORREST - Surely with one health service -

Mr REED - Twelve layers of management.

Ms FORREST - That is what I am saying, if you flatten that structure within the one - you are saying go back to the old -

Mr REED - No, I am saying if you get rid of the Tasmanian Health Service full-stop: it was a really nice idea, but it didn't work.

Ms FORREST - What do you call your new model then?

CHAIR - It was just implemented wrong, was it? That was -

Mr REED - It didn't work. The Tasmanian Health Service is the Department of Health Services. That is it. That is where the money flows through. Sixty per cent of the money comes from the federal government. They have certain things they want to see. At the end of the day, we can impose a commonality of IT systems across the whole thing. We can impose commonality of all sorts of stuff, purchasing drugs, everything. We can also do that with infection control commonalities - somebody drives it centrally, one person. Two people are responsible for the infection control outcomes. They teach. We get a better clinical outcome. We employ doctors and nurses. We do not not employ doctors and nurses.

If you can find $250 million from the government, then the Tasmanian Health Service can stay, but if you can't find it, then it can't stay because you won't be able to service the people of Tasmania. That is what works.

CHAIR - Can I take you to - and you may have more questions - to page 3 of your submission. You say as part of the end of point 1 that you are making, 'In summary, the logistical base of the hospitals have been overwhelming. Clearly, the capacity needs to be increased by around 20 per cent.'

Mr REED - Yes.

CHAIR - You are talking beds and the like?

Mr REED - Yes.

CHAIR - Is this not just simply a flow issue?

Mr REED - No.

CHAIR - Ignore the fact that you are being reverbed. You have a reverberation happening over there.

Mr REED - It is some sort of message from God, right?

CHAIR - This is a new building and there are glitches occasionally.

Mr REED - Operators of hospitals are an interesting beast. What happens in hospitals is beds do not fill up just to fill the beds. One week the hospital will be having a quiet time and it will increase its elective surgery, and the next week it will stop all elective surgery, because what came in from Friday night to Sunday night in ambulances filled it up for the next week.

We also have older people. They have to stay longer before they can go home. The third thing is, we have more people being diagnosed now with diagnostic imaging and better pathology services and better access to medical services than we have ever had before. There are more presentations to hospital for what is an older population. We have an increased use of the beds. We have a set of hospitals that are structured from the 1970s and 1980s. That is the problem.

CHAIR - My question is, is it simply a management issue as to how patients flow through the hospital that is causing the backup? Is that a possibility?

Mr REED - No. The hospitals regularly sweep their wards of people who can be discharged. I am sure they could bring the ward round through to 11 am, rather than the afternoon. That is a question of clinical management and the discharges can be maybe be three or four hours earlier, but it is going to be the same level of numbers. It is not going to make any difference. For instance, the Royal Hobart Hospital has 500 beds. It should have 650. It used to have 600.

Ms FORREST - With the redevelopment it will.

Mr REED - That is three years away from being commissioned.

CHAIR - 2019.

Mr REED - By the time they commission the hospital it will be 2020. These projects invariably run over time.

CHAIR - Thank you, Mervin. It has been a most interesting discussion. I am sure it will give us something to think about.

Mr REED - It is always interesting coming to see the Legislative Council.

CHAIR - Thank you very much for your time. I will just remind you about the parliamentary privilege. If you walk out those doors you are not covered by that. Whatever you might say to the media -

Mr REED - I have no intention of doing a stand-up interview outside the door. I am sure in due course when the *Hansard* record is out that somebody may wish to take some of my comments and do something with them and that is entirely up to them.

CHAIR - Thank you very much.

Mr FINCH - Before we conclude I was just wondering, Mr Reed, if there is anything along the line of those recommendations? That is going to be a part of our process to start to nail those so that there will be something there that may have some impact. I am curious about whether, upon reflection, as you think about what you have presented and what we have discussed today, if there are some other areas that you think a recommendation might have some impact and some result that you might present back to the committee?

Mr REED - I can do that if you wish. I will send that to the secretary and the secretary can circulate those to the members. The recommendation process and implementation of those recommendations, whether they are going to be implemented or not, is the issue. It starts entirely with structure. I am sorry, the Tasmanian Health Service was a good idea but at the end of the

day it has not worked and the board is irrelevant. You would be better off with CEOs and local community boards in the hospitals.

CHAIR - Thank you, Mervin. We appreciate your time.

THE WITNESS WITHDREW.

PUBLIC

ROBIN JANE WILKINSON WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome to the hearing. It is the Government Administration 'A' Sub Committee inquiry into the acute health service in Tasmania. It is not a Government inquiry. It is a Legislative Council committee inquiry. All evidence taken at the hearing is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded that privilege. Basically anything you say you can say with confidence that no one can take action on it, but if you do that outside that is a different story.

You have a copy of the information for witnesses?

Ms WILKINSON - Yes, thank you.

CHAIR - You have read that?

Ms WILKINSON - Yes.

CHAIR - You are aware of its contents. The evidence you present is being recorded on *Hansard* and will be published on the committee website when it becomes available. We will give you an opportunity to make a statement and then we will ask questions of you. To clarify we realise that your submission was provided in confidence but you are happy for this to be an open hearing, on the record.

Ms WILKINSON - Absolutely.

CHAIR - Thank you, Robin. You may wish to make an opening statement. Tell us what you wish to tell us.

Ms WILKINSON - I want you to imagine you are not really very well and you have been admitted to the hospital, and you end up in the assessment planning unit. The other patient in your ward is very psychotic - I mean very, very psychotic - and you are feeling very ill anyway and you are doing something really private and personal like going to the toilet, and this psychotic person sticks their face through your curtain space. How would you feel?

Once something like that happens you get very tense and then the tension builds on the tension and builds on the tension. You are left in the assessment planning unit for six days one time, eight days another time. The maximum days you are meant to be there, apparently, is three. When you are in the assessment planning unit you do not get to choose your meals - once you are in a ward you do, but there you do not. You just have to have what they give you. They do try to avoid your allergies but it is not really ideal. There are no windows, you cannot see out, and there are grey walls.

My feeling is having had several experiences of the assessment planning unit, there really needs to be almost two separate planning units. One for those who are physically pretty ill because that is why you are there; and one for people who are either psychotic or demented. My heart really goes out to people with dementia, but when you are really sick and you have demented people calling out or trying to get into your bed and all those sorts of things, it is unbelievably stressful.

Ms FORREST - Are you aware that next week they are opening up another five bed/three chair unit for mental health short stay assessment?

Ms WILKINSON - No. Thank God for that then.

Ms FORREST - I am not sure it is going to be entirely ideal as the one you have described, the short stay unit, you are talking about the assessment unit there. It is along the corridor from there. This is the Government's attempt to put some separation between people like yourself, as you are describing, and people with mental health illness who do not necessarily need admitting to the acute hospital, the main ward, but they do need to be kept for a period.

CHAIR - An observation unit.

Ms FORREST - Like a short stay unit.

Ms WILKINSON - Hopefully that improves the system.

Ms FORREST - Yes. I hear what you are saying, and it would be a dreadful experience that you have had, but may they have sought to address it with some measure.

Ms WILKINSON - As some people know, I am an old war horse. Those of us with disabilities, like the rest of the population, are living a bit longer. I do not think the current system knows how to deal with people with disabilities first, and then when you add on the ageing component to that because we are living longer, they do not know what to do with us.

One of the things that I have always wanted to do is somehow be part of the training of all health care professionals on some of the issues for people with disabilities when you have to go into acute care. I used to do a lot of training. I went to see a doctor at the Menzies Centre about something and he asked me what I did. I told him what I did about education on disability issues, and he said, 'We have just done a unit with our medical students on disability and not one person with a disability has been to talk to the students'. I could not believe that.

I am trying to think of things you can do to alleviate -

Ms FORREST - Practical solutions.

Ms WILKINSON - stuff and I think that training is really important; actually talking and getting some understanding of the life experiences of people with disabilities.

I get better care from my carers at home than I get from the nurses. I know that sounds awful, but I do get better care at home because I have trained my carers in my needs, than I get when I have to go to hospital. I am more vulnerable and I get really scared, plus they do not always listen. I find being cannulated really hard and I am now starting to talk more freely with them about my panic and anxiety levels. Sometimes they listen, but mostly they do not. It is about the training.

I am sure that you probably do not need to have grey walls, you could paint them another colour and put up pictures, at least, of scenery or something so people have something else to focus on.

Mr FINCH - A picture of a window!

Ms WILKINSON - That would be actually quite a good one.

Ms FORREST - Nice murals. Maybe have a big interactive screen you can actually have different scenes, so it is not the same thing all the time.

Ms WILKINSON - It would not take a lot to at least make it a bit better. I know they are under stress. I get a lot of that and I am sympathetic about it, but I am just really concerned that the system is not designed to meet our needs.

Mr FINCH - Robin, tell me about the number of times you would use the hospital services. In your life experience, or the past 12 months or whatever, how often -

Ms WILKINSON - The past 12 months I have been in and out quite a bit. It might be about eight times. I broke my foot and then they wanted to put me in a nursing home, so I freaked out about that. They said it is rehab instead.

Mr VALENTINE - Sorry, they sent you to what?

Ms WILKINSON - To rehab instead, thank god. It has been a lot. The other thing is, the times that I have not been, like a few weekends ago I had a really bad high-pain level day. I was desperate and I thought maybe I should ring the ambos, but then I thought no, because I will get down to the hospital and they do not know how to deal with me.

The last time, not when I did my foot, but the time before that when I went in, I was in so much agony. I was in a cubicle instead of one of those chair cubicles, so I was thankful for that. The bed was so uncomfortable and I was so uncomfortable, and I am banging my legs on the bed, and the nurse came up and said, 'Does that not hurt you?' I said, 'Yes, but it is a different pain to the other stuff'. It took them ages to realise, well, maybe I needed a different kind of bed. I must admit, there was one senior nurse there who was brilliant, and she got me one of those air ripple beds, and it was much better. Some of those sorts of things they do not pick up on. I had been banging my legs for a couple of hours before they did anything.

Mr FINCH - Robin, how many people are in a similar circumstance to you? Have you in your networks or your groups -

Ms WILKINSON - It is really hard - I live in a complex where there are 13 units for people with disabilities. I call it 'cripville' - I should not do that. I forgot. All of us are ageing and all of us have a real fear of going to hospital and do not want to go. So by the time you do go, you are that much worse than you would have been if you had gone earlier.

It would be really hard for me to judge those numbers now because the disability rights movement is pretty well defunct now. I would not know now how to get those figures. All I know is that in the units where I live, those of us that were in, say, our 30s when they went in, are now in their 50s. I was not meant to live to this age. It is happening, but I cannot give you a figure. I would love to because it would be important to give more meat to what we want to say, but I do not know the numbers. I know it is increasing. I know of other people with disabilities who are so frightened of going to the hospital they will not go.

Mr FINCH - Robin, you are not unique, but you are a special person in respect of your needs - when you go to the hospital is there anything on the record that says, 'Robin Wilkinson, these are her needs. These are the things that she has highlighted before and the special treatment that she might need. So there is nothing like that in the system?

Ms WILKINSON - I do not think there is because they ask me all the basic stuff all over again. I do not think that there is anything on record. As I said, I used to not be game enough to talk about my panic and anxiety condition because I was scared that they would label me as having mental illness as well - which I have, but mostly it is controlled. I recognise the difficulty but you will find the occasional person that gets it, but mostly they do not.

Mr FINCH - It seems that each time that you, or people in a similar situation to you, go into hospital and into the assessment planning unit, it is like reinventing the wheel every time.

Ms WILKINSON - Yes, absolutely.

Mr FINCH - I was trying to get a handle on how many people there might be in your situation and how hard would it be to keep a record. You know, RW is here - like you would have at your GP. Here are the do's and the do not's or the needs and the requirements of this person.

Ms WILKINSON - No, and if they put a cannula in the back of my hand, for example, they have to use this arm because I do not have any other limb they can use. When they do that, that means I really have difficulty even feeding myself - those sorts of things - and you wait forever if you are waiting for a nurse to help you, say, get your breakfast tray ready so that you can eat what is on there. Particularly the first morning after you have been for surgery or a procedure, you are pretty dehydrated and you are pretty hungry by the time breakfast comes. You just look at it and go 'I cannot do anything.'

I understand that the nurses are busy - I really get that. You are right, I think that if there was a list like that says 'Robin Wilkinson's needs are: needs help with daily living, e.g. showering and making sure the food tray is right for easy accessibility.' They will get it about giving me a straw to drink from a cup, but they do not get much else. They get so busy with all of their trips and god knows what else that they sometimes forget that you are a person there, you know.

Ms FORREST - There are so many competing demands.

Ms WILKINSON - Yes.

Ms FORREST - They do not forget you are a person, Robin. Do not ever think that.

Ms WILKINSON - Also, I am not a person they can fix and they are really into the fixing mode and turfing you out. Well, you do not fix me, unfortunately. It is just that nobody ever knows, although they do because they go 'Hi, you are back with us, Robin.' and I am going 'Yes, but I do not want to be here.' Sorry, I have not made it clear enough.

CHAIR - Please, you do not have to apologise. You are providing us with information that is important and that gives us a personal insight as to how patients are being treated. That is very

important, so please do not apologise from that respect. We are almost out of time, but with respect to your submission, would you consider making that public?

Ms WILKINSON - Yes.

CHAIR - You would?

Ms WILKINSON - I think it has to be, sorry.

CHAIR - Again, you do not have to apologise. It is just a question I place to you.

Ms WILKINSON - I am happy for it to be public. I have probably said some negative things about the nurses, but I have also said that I know they are really busy and stretched.

CHAIR - Thanks, Robin.

Mr FINCH - Robin, one of your paragraphs here is about ambulance services. Tell me something about the situation, when you have to call an ambulance how effective is the transportation of you from wherever you are to hospital when you are wheelchair bound as you are. Do you need to have a special ambulance come?

Ms WILKINSON - No, it will just be an ordinary ambulance and usually the chair gets left behind until one of my carers goes and gets it from wherever and brings it in, or they bring in a walking frame. If I have just got to get from the bed to the toilet I can go on a walking frame but I cannot go by myself anymore. I do not have good enough balance for anything anymore. I know I am going downhill. Do not get me wrong - I am not afraid of dying at all. But I am afraid they might kill me in hospital - I really am frightened of that.

Mr FINCH - That is of concern because you should be able to feel that you can go there and be treated well.

Ms WILKINSON - Yes. Most of the people I know with disabilities do not feel they will go there and be treated well.

CHAIR - Thank you, Robin. We really appreciate the fact that you have taken the time to come in. Obviously with your disability it is not easy to get around and that makes it even harder. The fact that you have come in to present to us is really appreciated.

Ms WILKINSON - It is so important and there are a couple of fairly simple things that could be done now like painting the walls and putting up pictures - that is reasonably simple to me. The other thing that is harder but at least if you start somewhere with that training of staff that they understand what some of the issues are. My experience is that people often do not understand it until you actually get them to do some exercises. You can do really simple things like put on a blindfold and say to somebody, 'now go and make a bed'. Or do something they do everyday, now do that task. What do you notice were the differences and how do you feel about it? Those are the things that are really important.

CHAIR - Thank you, Robin.

Ms WILKINSON - Hopefully the inquiry goes well.

CHAIR - I remind you again about parliamentary privilege, everything you have said to us has parliamentary privilege but not outside the door.

Ms WILKINSON - Yes. Thank you very much.

THE WITNESS WITHDREW.