LEGISLATIVE COUNCIL

BUDGET AND FINANCE COMMITTEE

Plaza Room, Parliament House, Adelaide

Monday, 14 December 2015 at 10:30am

BY AUTHORITY OF THE LEGISLATIVE COUNCIL

WITNESSES

MEMBERS:

Hon. R.I. Lucas MLC (Chairperson)
Hon. J.A. Darley MLC
Hon. G.A. Kandelaars MLC
Hon. A.L. McLachlan MLC
Hon. T.T. Ngo MLC
Hon. S.G. Wade MLC

WITNESSES:

FLETCHER, JANICE, President, Australian Medical Association (SA)

WALSH, DAVID, Council Chair, Australian Medical Association (SA)

HOOPER, JOE, Chief Executive Officer, Australian Medical Association (SA)

6535 The CHAIRPERSON: Welcome to the meeting. The Legislative Council has given the authority for this committee to hold public meetings. The transcript of your evidence today will be forwarded to you for your examination for any clerical corrections. Should you wish at any time to present confidential evidence to the committee, please indicate and the committee will consider your request. Parliamentary privilege is accorded to all evidence presented to the committee. However, witnesses should be aware that that privilege does not extend to statements made outside of this meeting. All persons, including members of the media, are reminded that the same rules apply as in the reporting of parliament.

In welcoming you formally to the committee meeting this morning, can I introduce to you the members of the committee firstly who are with us this morning. On my right are Tung Ngo and Gerry Kandelaars, and the members of the committee on my left are Andrew McLachlan and John Darley. Stephen Wade has joined us as a non-participating member of the committee, but it means he can ask questions as well.

Thank you for your attendance today. Mr Hooper has been here before, but I think this might be the debut performance for the other two of you. It is a very friendly and informal committee. We have allocated approximately 40 minutes for your evidence this morning. We would invite you in the first instance, for the benefit of Hansard, to introduce yourselves formally and your title or position and your colleagues and their titles and positions. We then invite you to make a brief opening statement to the committee if you wish, and then we will open it up for questions.

Dr FLETCHER: Thank you. I am Dr Janice Fletcher. I am the President of the AMA (South Australia), and I am a visiting medical specialist to the Royal Adelaide Hospital. On my right is Dr David Walsh, who is the Chair of Council for the AMA (South Australia) and a visiting surgeon to The Queen Elizabeth Hospital. On my left, is Mr Joe Hooper, the CEO of the AMA (South Australia).

6536 The CHAIRPERSON: Thank you. Do you want to make an opening statement to the committee?

Dr FLETCHER: Yes, thank you for the opportunity.

6537 The CHAIRPERSON: Please proceed.

Dr FLETCHER: The new Royal Adelaide Hospital presents a once-in-a-lifetime opportunity: it is a huge investment and an immense project. Confusion and uncertainty threaten the success of this project. It comes at a time in which there are other big changes in our health system: Transforming Health, under which the new Royal Adelaide has a central role, EPAS and other new IT systems, and changes as part of the move to a single-service multiple site at local health networks. Notably, these are most advanced at the Central Adelaide Local Health Network.

The new Royal Adelaide Hospital presents a new physical environment and new models of care as well as unprecedented reliance on IT systems, having been designed as a paperless system. Engagement, communication and effective consultation with the health workforce will be vital for success. Also, sufficient training in the use of new systems. Time is short.

Less than a year out from the opening, there remains significant uncertainty as details are still being worked out. We find this very concerning. Our members are so concerned, we asked SA Health to provide an update for the December edition of our publication, medicSA, that goes out to all doctors in the state.

The AMA (South Australia) would like to highlight a few key areas of interest. The first is the process surrounding the actual move to the new hospital, the ramp-down at the existing Royal Adelaide, and the ramp-up at the new Royal Adelaide. We are particularly concerned about what this will mean for our other hospitals and for the people who need services in this time. What will happen with elective surgery in the second half of the year? What will be impacts on our major hospitals in the north and south? How will people needing services know where to go?

We are also concerned about emergency department presentations and outpatient services at the new Royal Adelaide. Experience interstate suggests we should expect a degree of ED tourism in the first few weeks, as people come to take a look. At the new Royal Children's in Melbourne, we know that people came to see the meerkats in the outpatient department. We also understand the model of waiting to be seen in outpatients is so different that our doctors expect significant confusion from the patients.

Another area that needs to be got right is the role and capacity of ambulance services. The consolidation of complex services at the new Royal Adelaide, for example, stroke and people needing a cardiac catheter, is reliant on fast interhospital transfers. This will require a change in attitude from the ambulance service about transfers between hospitals. At present, these are considered a lower priority because the patient is already receiving care in a hospital setting, but they won't be getting the right care if they are not in the right place in the first place.

There is still no detail on the actual clinical services that will be at the new Royal Adelaide, what will be at The Queen Elizabeth Hospital, and what, if any, services won't be provided at all in the public sector. An essential component of clinical service delivery is the workforce needed to deliver the services and maintain training, as well as service delivery.

Our members are also concerned about what will be in place outside the walls of both the old and new Royal Adelaide to support reduced length of stay. New models of care will not necessarily stop bed block.

We have heard significant concern from the doctors at the Royal Adelaide about the lack of planning for clinical research in the new hospital. We have been informed that there will be capacity for at least some clinical research and are awaiting the report of Professor John Beltrame in the hope that there will be a plan for all research to be accommodated somewhere within the Central Adelaide Local Health Network. Our concern is not to know every detail but to know that the right plans are being put in place and shared, and have been constructed with the appropriate input from those who are, and who will be, delivering services.

This is more than the opening of a new hospital: it is new geography, new IT systems and a new way of working, or model of care. There is a need to mitigate the risks by clinician engagement and meticulous planning, including informing patients on how they will interact in this new world. Thank you.

6538 The CHAIRPERSON: Thank you for that. In your presentation you indicated words to the effect that there is still no detail about the clinical services that will be provided at the NRAH and other hospitals and what services might not be provided in the public sector at all. Given that this is an issue that the AMA and SASMOA have raised now for the last two years—and I guess one can be mindful that earlier it was more understandable, the reason being that there was still time to resolve these issues—can you provide more detail on what it is you have been seeking, what sorts of services might not be provided at the NRAH, or indeed not provided in the public sector at all, and finally what you are being told as to when you will get answers to the sorts questions that you are putting?

Dr FLETCHER: We have been asking for the nitty-gritty detail. Will there be ophthalmology services? Will there be dermatology services?

6539 The CHAIRPERSON: When you say that, do you mean at all or just certain—

Dr FLETCHER: At all, or at the new Royal Adelaide. There was an initial statement that said that everything that was in the current Royal Adelaide Hospital would be in the new Royal Adelaide Hospital, but since then the changes that have been happening across the Central Adelaide Local Health Network have meant that some services have moved from the current Royal Adelaide to The Queen Elizabeth. So I am unsure personally, and I believe the AMA is unsure, about the impacts of two things happening at the same time: we have a new hospital, and we have a new model of care that says, 'Actually, some things are going to be best done at The Queen Elizabeth and some things need to be done in the state's big tertiary hospital.'

However, we have not seen is it written down on a plan, that says, 'Outpatients; we'll see these orthopaedic outpatients, we'll see these patients with respiratory diseases.' Will there be a sleep unit or won't there be a sleep unit? Will there be elective surgery for straightforward things or will they all go to The Queen Elizabeth?

So one of the issues that we have is that there are two changes at the same time—if you exclude Transforming Health—meaning that maybe it is not yet quite bedded down. We are worried that not having these things bedded down less than one year from the opening date of the new Royal Adelaide Hospital does not add to comfort for the medical staff who will be delivering the services.

6540 The CHAIRPERSON: Can we be clear, though, that at the time the commitment was made, some years ago now, that all existing services at the Royal Adelaide would be replicated at the new Royal Adelaide Hospital. Is it clear that that is not going to be the case?

Dr FLETCHER: It is not clear that it is not going to be the case, but it is not clear that it is going to be the case.

6541 The CHAIRPERSON: Are there some services that you know have already been transferred to The QEH or to other hospitals and that are clearly not going to be provided at the new Royal Adelaide Hospital?

Dr FLETCHER: I might get Dr Walsh to answer that question, because there are some services that have been transferred already.

Dr WALSH: Effectively, the transfers that have occurred involve vascular surgery, where the vast majority of complex operating has been moved from The Queen Elizabeth to the RAH campus. With gynaecology and breast endocrine surgery the reverse has occurred, where services have come to The Queen Elizabeth Hospital campus.

Likewise, in that zone in which I work there is uncertainty as to what would be the higher acuity support, things like ICU, things like the respiratory services that are required, things like the diabetes, the renal unit. There is a concept that there is low acuity surgery, and I think that that doesn't necessarily mean the description of the operation.

The complexity and the acuity of surgery relates to the coexisting illnesses of patients, and so just to say that you are going to move day surgery or short 23-hour stay surgery for relatively straightforward procedures is fine, but we are dealing with a health system that is ageing, becoming more involved in comorbidities and, in fact, it becomes the patients that add the acuity. That's the concern—how will this balance be struck and when will we see the detail of how that plan will be delivered across the central Adelaide health network so that the new RAH and The Queen Elizabeth work in concert.

6542 The CHAIRPERSON: You've raised a series of questions about ophthalmology, a whole variety of services. When are you now being told, 'We don't have all the answers yet, but we will get them to you by' when?

Dr FLETCHER: We have not been told a time line. We have recently requested a meeting with the person who is in charge of the new Royal Adelaide Hospital project, with an attempt to—

6543 The CHAIRPERSON: Is that Mr Nielsen? Who's that?

Dr FLETCHER: Mr Nielsen's replacement.

6544 The CHAIRPERSON: Who is Mr Nielsen? Does anyone know?

Dr FLETCHER: It's Graeme McKenzie.

6545 The CHAIRPERSON: So, you're seeking a meeting with him, and have you got a meeting?

Dr FLETCHER: We've sought a meeting. We've only requested it recently, and we're anticipating the early new year.

6546 The CHAIRPERSON: But if he's new to the system, is he going to be in a position to give you answers to the questions you've been pursuing for a while?

Dr FLETCHER: He's relatively new to the system. I understand he was appointed in June and took up his appointment in around September, so we're hoping.

6547 The Hon. S.G. WADE: Picking up on the Chairman's point, the Chairman was particularly focusing on whole services lost from the NRAH. In the limited information that has been provided to this point, I wonder whether there are any disciplines where the AMA is concerned that the capacity that's been provided for the discipline in the new RAH is less than the capacity provided in the current RAH and what they might be.

Dr FLETCHER: It's really difficult to answer that question in the absence of detail. The one area where we have been informed there will be less capacity is in the outpatient services. I understand there is a project looking at outpatient services, and we are hopeful that the outcome of that project will be clarity around what outpatient services will be at the new RAH.

6548 The Hon. S.G. WADE: The AMA put out a discussion paper in October on the new RAH, and that was one of the three themes you picked up on, the outpatient reform. By way of a preliminary question, has there been any response from SA Health or the government to the October paper?

Dr FLETCHER: There has been a response from Todd McEwan, who is the chief operating officer of The Central Adelaide Local Health Network, and he has undertaken to engage with the clinicians, and we understand that this is happening.

6549 The Hon. S.G. WADE: On that point of clinical engagement, you make some strong statements ('you' being the AMA) about engagement. On page 15, you state:

> Clinicians feel disenfranchised at disengaged that consultation has not been perceived as genuine, and having put up proposals that have not been heard.

In another part it states:

> …there has been significant concern that the input and feedback of clinicians have not been sufficiently integrated into the process…

We are basically eight years into a nine-year project, and the minister tells us that it is almost ready open some of the buildings, so the capacity for clinical impact on the design has certainly passed. I wonder, first of all: how did we get into this situation, where we are told that the clinician engagement is important and the AMA is telling us that clinicians feel disenfranchised?

Dr FLETCHER: It's a really good question and it's not one I can readily answer. The problems, I guess, stemmed from there being some changes in personnel along the life of the project. This has been a long time coming as any major project is.

The initial thoughts I think were that this is such a big change that clinicians would delve down into the detail and not be able to see the big picture. That was the philosophy, I understand. And then the way things were designed to work were so different from anything that is currently here in South Australia, a paperless hospital, a paperless outpatients department—a new way of doing business in an environment, where a number of senior clinicians have been at the Royal Adelaide Hospital for 50 years, up to 50 years. So I guess that is the explanation. I must say that Mr McEwen, when I went to a meeting about the presentation of the document, to which you

refer by the Medical Staff Society, he was listening and he was saying, 'Yes, we are working on this, we are working on this.' But we haven't seen the detail.

6550 The Hon. S.G. WADE: You mentioned the Medical Staff Society, and you have said that the AMA itself does not need to know all the details, but this paper, as I understand it, was also written in conjunction with the Royal Adelaide Medical Staff Society. So it is the clinicians on the ground who are feeling disengaged.

Dr FLETCHER: Yes.

6551 The Hon. S.G. WADE: The people who are actually going to deliver the task. In the paper you say that the AMA says that the outpatient activity will be reduced by 100,000 weighted occasions of service, new RAH compared with old RAH. What sort of magnitude is that?

Dr FLETCHER: It depends on how they count it, and that is an issue. There was talk that that represented 91 clinics, but I am not sure how that number was generated and that number came from the Medical Staff Society.

6552 The Hon. S.G. WADE: The paper also says that the move to the new RAH is predicated on a reduction of the average lengths of stay from 6.7 days to 5.6. That was in the functional brief, which presumably is five or six years ago. Transforming Health is also assuming a reduction in length of stay. Is that cumulative? Have we got the NRAH reduction length of stay plus the Transforming Health reduction length of stay?

Dr FLETCHER: I can't answer that question. I would assume there would be the same reduction in length of stay, but I cannot confirm that.

6553 The Hon. S.G. WADE: On page 6 in relation to outpatients it says that there should be an innovative treatment unit at the new RAH. Now, I gather, from what the report says, that there is something of that nature at the current RAH. Could you just clarify whether that exists?

Dr FLETCHER: At the current Royal Adelaide there are two places that could be described as innovative treatment units. One is in the PARC, so that is the anaesthesia stuff, and there is the C-Max Clinical Trials Unit. The concern from the clinicians at the Royal Adelaide is that there will be no place in the new Royal Adelaide for clinical research where patients potentially get very sick, because they are given a drug in a clinical trial or something that has the potential to make them very sick and need resuscitation. That concern has been conveyed very strongly. We understand there is support for an innovative therapies unit. We have not seen the detail.

6554 The Hon. S.G. WADE: My understanding from the paper is that, above and beyond that, the AMA is concerned that for, shall we say, the less risky clinical research the blue space alongside a ward is not sufficient to support clinical research, that the clinical research which is integral to Royal Adelaide, as a teaching hospital, may not be able to be done at the new RAH?

Dr FLETCHER: We understand that is the concern. There are a couple of problems. One is that the clinical trials have big paperwork demands that go with them. So that paperwork is frequently audited, and must be available. And if you have a paperless system there is not necessarily the record storage that is required for clinical research protocols. Some patients will have their actual cancer treatment, for example, provided through a clinical trial protocol, because that is the way you get access to the up-to-date treatment. But until we get clarity about what clinical research is in and out of the new Royal Adelaide, I guess we do not know. Our understanding is that the report into clinical research at the Royal Adelaide and therefore going forward to the new Royal Adelaide from Professor John Beltrame will be available early in the new year.

6555 The CHAIRPERSON: I just want to come back to the issue of capacity of the hospital. The AMA previously on two occasions, and others, have raised issues as to whether the 700 beds were sufficient. The AMA is on the record as raising doubts and concerns about that. The answers have always been, and you have referred in response to the question of the Hon. Stephen Wade, that we are going to reduce the length of stay from 6.7 to 5.6 or whatever it is.

The AMA previously have raised questions about whether there will be sufficient step-down facilities and rehabilitation to allow that, and other questions about whether this new model of care, as it has been referred to, and this very significant change is going to be achievable. I would be interested in your response as we sit here now, sort of entering the last year. Is there sufficient

step-down? Is there sufficient rehab? Are you convinced that this new model of care will deliver the reduction in length of stay?

Dr FLETCHER: We understand there has been some work already to reduce the length of stay in areas like orthopaedics at the current Royal Adelaide. We know that there has been a reconfiguration of rehabilitation beds across the state as part of Transforming Health. We do not yet know whether they will be sufficient, and that is a concern. We also know that the Fiona Stanley Hospital in Western Australia was supposed to replace the Royal Perth and did not end up doing so.

We have raised our concerns with SA Health. They say there are more beds than are currently available at the Royal Adelaide, and that is true. We do not know how many beds will be commissioned in the beginning. The other thing that SA Health have said to us is that they are moving more patients to the north to receive care closer to their home and so therefore the demand on the Royal Adelaide Hospital would be expected to be reduced because of that. We have not seen the modelling and we have not seen the data.

6556 The CHAIRPERSON: If I can come back to the question, then: is the AMA at this stage reserving judgement or unconvinced or does not agree? What is the best description you think of this fundamental assumption that we can reduce, through a new model of care, 6.7 down to 5.6, to in essence say that the number of beds proposed at the NRAH is going to be sufficient?

Dr FLETCHER: I think probably reserving judgement is the fairest assessment until we actually see the evidence.

6557 The CHAIRPERSON: Can I also ask you to take on notice—we don't have enough time today—the AMA back in 2011 indicated in a submission and I think also in evidence to this committee that there were 720 overnight beds at the existing RAH. You have talked about the comparison with the number of beds that are at the RAH now—that is, the 700 is greater than that—but I am interested in what was existing when it was first promised. I don't seek a response now, but if you wouldn't mind taking on notice and going back to your previous evidence and submissions. You certainly indicated, back four years ago now, that there were 720 overnight beds at that stage at the RAH, even though now the number might be less than 700 because things have closed down or whatever it might happen to be.

Dr FLETCHER: The only other point is—I wonder whether Dr Walsh would like to comment—over the last five years there has been a move to increasing same-day surgery as a change in practice, and that is one of the reasons I think why they have a much larger capacity at the new Royal Adelaide. Dr Walsh might wish to comment.

Dr WALSH: I think one of the big changes in trends in surgery has been the move to day surgery and 23-hour surgery. I guess one of the concerns is that a lot of that fat has gone already, and the idea that there is significant extra length of stay that can be reduced because of the patient—because we are now getting to the group of patients who, as I said before, are simply not well enough to go home or have day surgery, even though their procedure might be a relatively minor one. We would really like to see the modelling that shows that that excess capacity or that ability to reduce length of stay really exists with the patients who are in the system, rather than just a theoretical number.

6558 The Hon. S.G. WADE: If I could link that comment back to the comment you made before about, if you like, the risk that significantly relates to the patient and what other issues they might have, I think you were adverting to the need for what I might call the non-supersite hospitals to have access to high levels of care, high dependency units or intensive care units. Of those three non-supersites—Modbury, Queen Elizabeth and Noarlunga—do you expect that they will have HDUs or ICUs?

Dr WALSH: I think that is one of the things that is unclear. Within CALHN, I am led to believe that there is to be reductions in The Queen Elizabeth ICU and HDU sites. Modbury is uncertain; its role and its linkages with the Lyell McEwin are still being developed. One of the issues about high-acuity beds is that the presence of those beds on site allows a throughput of surgery even for the patients that are not going there, because you have the safety net existing within that corridor, within that hospital, to deal with someone.

The modelling shows, for example, that in elective surgery only about 5 per cent of patients need an ICU bed but, in fact, many elective operations within our health system go ahead only because there is an HDU/ICU bed available should the need arise. So, if those services are not well distributed across the state, surgical units at various hospitals will be extremely hamstrung as to what they can do safely on their sites.

6559 The Hon. S.G. WADE: In that respect, perhaps the capacity for the non-core sites to take workloads is being overestimated because we're not allowing for, if you like, the people who come with a risk and, therefore, a surgeon would say, 'I'm sorry, I'm not willing to do your surgery at QEH, you'll have to go to RAH.' So, capacity will shift back to the RAH. But also, isn't it a risk for the patients who have a complication within surgery which wouldn't be foreseeable?

Dr WALSH: That's a very real concern to surgeons, particularly the concept that at certain sites there have been discussions about whether there would be access to return to theatre 24 hours a day, and things like that, which really concern us greatly. Relying upon the ability to transfer a patient to another institution when they become unwell we consider to be a risk.

6560 The Hon. S.G. WADE: I was wondering if I could go back to the president's opening comments about, if you like, the multiple factors. We've got, as I understand it, the new Royal Adelaide Hospital opening next November; we've got significant building operations in a number of hospitals, e.g. QEH, FMC and so on, at the same time that these hospitals are meant to be taking the load as part of the ramp-down; we've got EPAS being rolled out—I understand it is now going to be rolled out at The QEH before it's rolled out at the NRAH, so we've got another change challenge; and we've got the single-service changes. Do you think we're getting to the position where SA Health is expecting too much change in one year?

Dr FLETCHER: I think it's a very big ask.

6561 The Hon. S.G. WADE: Are we at the point where one of these projects, in your view, needs to be postponed so that we can actually make the rest of the changes safely?

Dr FLETCHER: I honestly don't know the answer to that question. The projects have become so intertwined that it's probably hard to separate some of them out. For example, Transforming Health and the single-service multiple site, there are joint factors that impact on them.

EPAS, in my view, is one of the essential bases on which the current hospital was designed, so the paperless hospital was designed with the expectation that we would have an IT system for medical records and for everything else that enabled the paperless hospital to function. Anything that slows the introduction of EPAS complicates the success of the new way of doing things at the new Royal Adelaide Hospital. I think it's a very good question, but it's one that I don't believe I can answer.

6562 The Hon. S.G. WADE: In terms of services, when Transforming Health was announced we knew that the specialist eye hospital was going to be built at Modbury. We now know that it won't be. You made a comment about it not being clear what ophthalmology services would be available at the NRAH, so is the AMA aware of an alternative site for the specialist eye hospital that was going to be at Modbury?

Dr FLETCHER: The short answer is no. We have been told that trauma eye services will be available at the new Royal Adelaide but we have not been told any other details about ophthalmology.

6563 The Hon. S.G. WADE: The Macular Disease Foundation suggests that the McEwin Building at the old Royal Adelaide Hospital site would make an ideal site for a specialist eye Hospital—admittedly this was earlier in the year. Do you think we need to be looking at options like that?

Dr FLETCHER: We need to be looking at options, but I think I would wait to see what the proposal actually looks like, when it is available.

6564 The CHAIRPERSON: We are talking about a range of services here. I was just going back through the evidence from Dr Montanaro last year, and she was indicating then that you were questioning, as an organisation, the assumptions behind this whole move. They were going to be

checked to see whether they were valid, and Mr Nielsen was going to get back to the AMA. I am assuming that 12 months later those questions still remain unanswered.

What is the final date by which these decisions just have to be clear if the hospital is going to eventually open in November? All these decisions you are talking about, you still haven't been advised. I guess there are two issues: they know and they are not telling you or, more likely, they still have not decided. When is the date beyond which you just cannot go any further, when you say, 'These decisions just have to be taken for a whole range of issues about accreditation and those sorts of things'? When is the date beyond which you cannot go for these sorts of decisions to be known to clinicians and others?

Dr FLETCHER: My personal opinion?

6565 The CHAIRPERSON: Yes.

Dr FLETCHER: If you do not know what is happening six months out it would be implausible that you would successfully open a new facility.

6566 The CHAIRPERSON: Can I ask you about the issues of accreditation? The AMA has previously given evidence about very long lead times with the colleges. I know that you do not represent the colleges but you are obviously aware—I suspect with other hats on—what some of the colleges might think. Are those issues being resolved in terms of accreditation to consult and operate at the new Royal Adelaide?

Dr FLETCHER: We understand that there is no current major concern about accreditation of training for most of the colleges. I cannot speak for all.

6567 The Hon. S.G. WADE: I appreciate that this does not really refer to accreditation, but in the AMA's October paper it says that in relation to medical training and workforce, there is an urgent need for clear and robust medical workforce planning across SA for all levels of training, that there is uncertainty about training job numbers and potential losses of training places in multiple subspecialties and at multiple sites and potential issues with accreditation, given the time frames involved with changes to services.

Later on it talks about there being concern about funded SA training places perhaps being lost. So whilst you have already addressed accreditation, could you address the other concerns that the AMA has in relation to medical training and workforce?

Dr FLETCHER: Unfortunately I cannot. In the absence of knowing what services are where and the workforce plans that underpin them, the AMA is unable to make a sensible comment.

6568 The CHAIRPERSON: You have given us a couple of examples of services that you know possibly or probably will not be at the new Royal Adelaide Hospital, and you have raise questions about ophthalmology. Dr Walsh raised issues in relation to—

Dr WALSH: Physical surgery for gynaecology and breast endocrine surgery.

6569 The CHAIRPERSON: Okay. Are there any other areas where there are questions or where you are aware there might be the possibility that services that were previously provided at the Royal Adelaide might not be provided at the new Royal Adelaide?

Dr FLETCHER: I have had no specific other concerns brought to my attention.

6570 The CHAIRPERSON: You raised dermatology, was it?

Dr FLETCHER: There is uncertainty, but I have had no specific concerns raised.

6571 The Hon. S.G. WADE: On page 15 of the AMA's discussion paper, it states:

RAH clinicians in key training leadership roles have taken positive steps to compile data on risks of the move to the new RAH. This data needs to be carefully considered and heeded and appropriate action undertaken.

What sort of data is that and what is being done with it?

Dr FLETCHER: We are referring to the number of patients seen and the diagnoses and the issues that are raised going to the new system with all the uncertainties that we have spoken about, with EPAS being in or out, the transport of patients. As I alluded to in my opening statement,

one of the things is that if you are changing the model of care—so that if you are having a stroke you go to one of the hospitals with a stroke unit and you get a quick scan and you get the right treatment if you've got a clot to thin your blood so that your clot gets dissolved—that is predicated by being able to move the patient very quickly by the person who sees them if they come to another hospital being able to recognise, treat under protocol and get that patient moved quickly.

So, it's the underlying assumptions including the transport of patients that need to be very rapid to make sure that patients are actually getting the best possible care.

6572 The Hon. J.A. DARLEY: Having regard to what I would consider the pathetic performance of the new EPAS, has there been any discussion with the AMA as to whether they intend to run EPAS parallel with a paper system for a period of time?

Dr FLETCHER: In our most recent meeting with the minister, he indicated that, yes, that would be happening: there would be parts of the system that would be electronic, and that refers to the administration, and there would be paper medical records in the beginning.

6573 The CHAIRPERSON: My final question is on surge capacity. The AMA previously raised questions about the capacity of the design of the new Royal Adelaide Hospital to cope with the inevitable need for surge capacity. This design has been fixed. What is the AMA's position?

Dr FLETCHER: Until we know how many beds are going to be commissioned, we don't know whether there is surge capacity within the current configuration. So, if it was that not all the beds were commissioned because they were not required, then certainly opening the beds that had not been commissioned instantly creates surge capacity. There has been discussion in the past about the recovery unit being able to be partially utilised for a pandemic, should the need arise, because, as we previously submitted, if there is a pandemic then you stop routine surgery anyway, but until we know the details it's hard to be specific.

6574 The CHAIRPERSON: What is your latest understanding about the number of beds that might not be commissioned when the hospital starts? What have you been told from SA Health?

Dr FLETCHER: We've not been told a number.

6575 The CHAIRPERSON: The issue has been canvassed that a number of beds might not be commissioned.

Dr WALSH: Well, I think the concern is that there seems to be a number of procedural suites and beds that are not going to be commissioned, but they have been mentioned in passing. The question really remains that we are yet to see the detail about that, and I think that again, less than 12 months out, we need to see exactly what we are opening because that has implications for the question of the ramp down and the ramp up, how are we going to start doing these services, and those sorts of things I think we really need to start to see where these plans need to be. Undoubtedly, they will need to be considered and allowed for and planned for, and there is nothing on the table at the moment.

6576 The CHAIRPERSON: Dr Walsh, when people are mentioning things to you in passing, are they talking about 10 or 20 beds, or up to 50? Is there a number?

Dr WALSH: There is, but—

6577 The CHAIRPERSON: What is the range that is being talked about in passing? I know that this is not official, but—

Dr WALSH: Well, because the procedural suites now include operating theatres as well as encompassing endoscopy rooms and many things that would not just be operating theatres, any reduction significantly changes the profile of the hospital because this is where all the procedural work is going to be done, from small to major. My concern is that the initial modelling and expectation was that all those procedural rooms would be needed, so even if there is a reduction of a small number then that affects some of the presumptions.

6578 The CHAIRPERSON: Thank you very much for your attendance at the committee today. I am sure the committee could have continued for quite some time, but we do have other stakeholders who want to present a view. So we thank you for your cooperation with the committee this morning. Thank you.

THE WITNESSES WITHDREW

WITNESSES:

POPE, DAVID, President, South Australian Salaried Medical Officers Association (SASMOA)

EVANS, MICHELE, Senior Industrial Officer, South Australian Salaried Medical Officers Association (SASMOA)

6579 The CHAIRPERSON: Welcome to the meeting. The Legislative Council has given the authority for this committee to hold public meetings. The transcript of your evidence today will be forwarded to you for your examination for any clerical corrections. Should you wish at any time to present confidential evidence to the committee, please indicate and the committee will consider your request. Parliamentary privilege is accorded to all evidence presented to the committee. However, witnesses should be aware that that privilege does not extend to statements made outside of this meeting. All persons, including members of the media, are reminded that the same rules apply as in the reporting of parliament.

Can I introduce to you the members of the committee who are with us today. On my right are Tung Ngo and Gerry Kandelaars, and the members of the committee on my left are Andrew McLachlan and John Darley, and Stephen Wade has joined us for this hearing.

Can I ask you, Dr Pope, for the benefit of *Hansard,* to introduce yourself formally in your position, and your colleague and her position, and we invite you to then make an opening statement to the committee if you wish, and then we will proceed to questions. So, thank you.

Dr POPE: I am Dr David Pope , the President of the South Australian Salaried Medical Officers Association, and with me is Michele Evans, who is Senior Industrial Officer with the association.

6580 The CHAIRPERSON: Do you wish to make an opening statement, Dr Pope?

Dr POPE: I will, if I may. Since 2009 SASMOA has closely followed and sought to be closely engaged with the new Royal Adelaide project. To this end, senior industrial staff and council office bearers have attended all opportunities that SA Health and the Central Adelaide Local Health Network have offered for engagement with industrial bodies.

In addition, to try and improve engagement the association has sought to inform itself about the type and nature of tasks and processes needed to successfully transition a large tertiary hospital to a new site with new technology and new models of care.

Primarily, the new RAH Industrial Liaison Forum, the ILF, has been conducted monthly for many years now, and has been the mechanism used by SA Health and the Central Adelaide LHN to communicate with industrial bodies, including SASMOA, and these meetings are still continuing.

Right from the very beginning members were widely reporting that it appeared that decisions were being made that would greatly disrupt the work of doctors in assessing and treating patients at the new Royal Adelaide Hospital, and that the responsible doctors were excluded from being involved in discussions, seemingly before decisions were made.

Further, there was no clear consultative process available to make submissions about various decisions. The association understands that for a long time discussions about clinical care processes in the new Royal Adelaide Hospital were only happening between some three to four individuals and these individuals were reportedly required do keep these discussions confidential. This led to great frustration amongst the majority of our members working at the Royal Adelaide Hospital.

Consequently, serious concerns by the association about the lack of proper discussions with and engagement of specialist doctors charged with the assessment and clinical management of patients are longstanding and they continue now. Many medical staff across the Central Adelaide LHN find themselves uninformed and disempowered about the move to the new Royal Adelaide Hospital and how that will affect them, their clinical service delivery and the patients that rely on their service.

The association has persistently put these concerns to senior SA Health management and to the Minister for Health only to have them dismissed with denials about their being a lack of discussion, engagement or consultation.

Further, from what the association could determine, there did not appear to be effective governance, structures or processes in place to even allow robust decision-making with consultation to occur. Indeed, the only mechanism SASMOA could find to address the concerns of members about their exclusion from the new Royal Adelaide Hospital project was appeals to the Minister for Health and/or senior managers in Health and within the new Royal Adelaide Hospital project office. When these appeals delivered no reasonable outcome, there was nowhere else to go.

The clear lack of clinical input at the early stages of the new RAH project makes the association question what risk assessments have been done and their accuracy. Effective, well-established governance of a large project like the new Royal Adelaide Hospital is clearly essential, yet it is only in the past few months that the association has been informed of the recent creation of a governance structure within the Central Adelaide LHN that does appear to be clearly documented with responsibilities and lines of reporting laid out.

There has also been an enormous flux of leadership in the project, and in Central Adelaide LHN over the years, and this is still continuing. The combination of this constant leadership change with many years of unclear governance and decision-making processes causes the association great concern about the chances of a safe and effective transition to the new Royal Adelaide Hospital for patients. This will cause our members, who are the doctors directly providing care to patients, great distress if they encounter and have to try to mitigate widespread system-based failures of care.

The accountabilities for significant problems with the transition to the new Royal Adelaide Hospital are very problematic for the reasons I have just outlined. Indeed, the association has formed the view that the people of South Australia, through the elected representatives to parliament, are not able to hold the government to account on the new Royal Adelaide Hospital because of a history of what appears to be a project that has had lack of proper governance and reporting structures, along with senior leaders of the new Royal Adelaide Hospital project regularly resigning their positions.

While it does seem very late to be establishing what appear to be effective governance structures now, this is better than continuing not to have them. However, it is noteworthy and concerning that the persons appointed to the positions also have Central Adelaide LHN operational management positions and may not have the time necessary to make a successful transition to the new RAH possible.

The new RAH project is significantly complicated by major infrastructure changes and the timing of these at the Modbury Hospital, The Queen Elizabeth Hospital and Flinders Medical Centre, which are occurring under the Transforming Health program. These changes seem to bring about planned significant reductions in high-volume acute services, especially in their space capacity, at these sites over 2016 and onwards. At the same time, the move to the new Royal Adelaide Hospital requires a ramp-down of activity at the Royal Adelaide, including a reduction in in-patient numbers by around 40 per cent to what we understand a number to be approximately 250 patients, down from about 660.

The net effect of this is a progressive and substantial reduction in specialist acute care space capacity across South Australia. This reduced capacity appears to be maximal towards the end of 2016 and into 2017, which corresponds to the move to the new Royal Adelaide Hospital, and is likely of a magnitude that the people of South Australia could expect to have enormous and dangerous problems in being able to access acute care specialist medical services when they need them, for want of an appropriate space allowing care. In addition, there are specialist medical service interdependencies that are not accounted for in the Transforming Health infrastructure changes, and these have service-disruptive effects that spread far and wide.

It is now becoming evident that, at the Royal Adelaide, there are currently over 300 outpatient clinics conducted in over 60 locations across the campus. The association understands from information provided by Central Adelaide LHN that there is insufficient space to accommodate all this activity in the new Royal Adelaide Hospital, yet no information is available and

no open discussions are being held as to what will continue in the new Royal Adelaide Hospital, what clinics need to be decommissioned and what clinics will move elsewhere and, if so, where. There is no account of the interdependencies of inpatient and outpatient medical staffing, with it being common for specialist hospital medical staff to be providing a ward service to inpatients via multidisciplinary teams and conducting outpatients at the same time.

Concern about the clinical failure services by our members is becoming widespread and is unprecedented. All of this is building a picture of what is arguably best described as a train wreck for the health system in South Australia expected in about 12 months' time and corresponds to the currently planned move to the new Royal Adelaide Hospital. Foreseeing a train wreck that will cause immense damage to the delivery of health care and then threaten the ongoing health and welfare of South Australians, the association, with its members, is anxious to do everything it can to try and avoid this event.

To this end, we feel we need to focus attention to the issues that I have outlined, as well as a very long list of other issues which are not resolved due to a lack of open and transparent discussion with medical staff and no formal process of consultation being undertaken over decisions needing to occur. These include, but are not limited to:

1. Why there is a lack of operational detail in discussions at the new RAH industrial liaison forum. My understanding is there is a series of high-level model of care type presentations given to the industrial liaison forum which ignore workforce and clinical service issues to cover the infrastructure and corporate matters. I have to say I have lost track of the number of times I have heard about the benefits of natural light, noise reduction and themed way finding, but nothing about the numbers of staff needed to make the new Royal Adelaide Hospital services actually work.

2. What is being done to address the lack of confidence in the EPAS system to deliver a usable and efficient electronic medical record system especially as a new RAH is designed and built around the system?

3. House storage, use and provision of existing paper and electronic medical records to clinicians will occur when doctors are seeing patients to enable uninterrupted medical care during and after the new RAH transition.

4. What the automated pharmacy system, including the automated dispensing cabinet, operational rules will be and how this prescribing and dispensing will be tested for safety and how training will be done for all the medical staff in the use of this system.

5. What the impacts of the governance and leadership of the single-service multiple site model services across the Royal Adelaide, new Royal Adelaide and TQEH, given that this is still being sorted out.

6. How facilities for medical staff, many of whom work very long shifts or are recalled and required to be in the hospital for prolonged periods, will be made available.

7. How staff training and working at the new RAH is to occur at a service-by-service level, as well as for rotating medical staff who change services frequently.

8. How will concerns about the lack of appropriate spaces in outpatient areas for conditions of patients needing to attend outpatients be addressed. There seems to be a lack of suitable seating being available, and this is expected to be a big problem for many patients, especially those with impaired mobility who can't be expected to go wandering around the hospital with a little buzzer waiting to be called to their appointment. That has been tried at other sites and it's absolutely terrible for a lot of patients.

9. How clinical service and medical staffing interdependencies will be accurately mapped and so be able to be taken into account into all the necessary clinical service plans required for the new Royal Adelaide Hospital.

6581 The CHAIRPERSON: Dr Pope, I presume those questions have been put to SA Health representatives in one form or another?

Dr POPE: We continue to raise concerns and make representations on those matters. We have persistently raised these matters in the industrial liaison forum for the new RAH, and we hope that it brings about a change in approach, but every time we turn up to a meeting there is yet another high-level PowerPoint presentation on some model, some bit of the architecture, or some model of care.

6582 The CHAIRPERSON: This committee has continuing oversight of the project, so can we leave you to take questions on notice that should you in the new year receive answers to some or all of those questions, and you might not agree with the answers, but if you do, can you take on notice to correspond with the committee and provide whatever responses you get from the SA Health representatives to your questions?

Dr POPE: Certainly.

6583 The CHAIRPERSON: Can I turn to the earlier part of your statement, this is the transition period, you raised the issue of dangerous problems in terms of, obviously, health care for patients. For the benefit of the committee, can you just give us an example of the type of thing you are talking about in terms of patient care?

What is it that clinicians like yourself and others are concerned about in terms of potential dangers to patients?

Dr POPE: It has to do with not being able to deliver care because the system around the staff, including the availability of staff themselves, just won't be there. So, to deliver any sort of health care anywhere you've got to have space, you've got to have staff, you've got to have a system, and right now we're not seeing in the new Royal Adelaide Hospital that we are going to reliably have those things.

The other thing I would draw people's attention to is the enormous interdependency. There is no practice of health care, especially acute services, that is entirely independent. You can't pick it up and move it somewhere else and just expect it to work. It's highly dependent on a whole range of clinical and infrastructure interdependencies; any one of those things being missing—it doesn't matter what it is—and the whole system fails to deliver the care that is necessary. It's a highly complex system. To bring it down to a spreadsheet level, where you move components around and think that is going to work, is completely fanciful.

6584 The CHAIRPERSON: Is your submission to this committee that the input of clinicians to those who are managing the transition would better manage the dangers for patients? Is it your frustration that you and your colleagues' views and concerns are not being heard? Given that you are going to have to transfer patients from the existing hospital to the new hospital at some time and in some fashion, is it your concern as an organisation that you are not being listened to as to how you might do that most safely?

Dr POPE: Certainly, that's true, but it goes down to having the managerial people in SA Health and the Central Adelaide LHN actually understanding what all the components necessary to deliver a service are. Doctors would be quite content to leave the management side to managers while they get on being doctors so long as the managers have a clear understanding of what is required, what decisions have to be made when and that it's all mapped out so that it's all clear to people.

6585 The CHAIRPERSON: I am assuming from that that you are saying that some managers who are there at the moment don't. How do you suggest to the committee that we better manage the transition to minimise any potential dangers for patients? Clearly, at this stage it's perhaps too late to be changing managers, but again I put the question to you: are you suggesting that more clinicians should be involved in advising the managers or providing advice, what are you suggesting that the managers should just listen to the advice they have already had in relation to how to manage safely the transition?

Dr POPE: Essentially, the way I would put it is that there is an enormous amount of work that needs to be done to develop proper operational service plans for the moves for each of the services. There is a large amount of work to be done to map the interdependencies to map of all those things—so, one service plan feeds into another which feeds into another. We can't see any evidence of that work being done.

Right now, there's a whole lot of governance and managerial work that you would expect to be all done and dusted at this point in a project like this, that the interdependencies are all mapped out, that it's all understood by all and sundry, that the necessary decisions are known and they are taken in a timely way. The concern is that we just see no evidence of that sort of management occurring.

Unfortunately, what that means is that it is always the medical staff in front of the patients, at the end of the day; if the system is collapsing around them, if they can't deliver those services, then somehow they have to try to mitigate the dangers to those patients. They've got no idea how they are going to do it and it's going to be extremely stressful. I have to say that they are rather angry that they would even be put in that position.

I think there's a huge amount of work that needs to be done to allow a safe move to occur. Without that work being done, we don't even know where we currently sit with so many issues. It's impossible to work out the timing and the staging of how that move is going to occur safely.

6586 The Hon. S.G. WADE: In relation to the point you made about clinical engagement being limited to three or four individuals, did you mean three or four individuals across the whole RAH or three or four individuals per department?

Dr POPE: No, that's across the entire Royal Adelaide Hospital. There would be one extra person brought in for various discussions, but again those individuals would be sworn to confidentiality and secrecy. There was a core group of three to four individuals who pretty much made all the early decision-making as the project was being put together and put out to tender.

6587 The Hon. S.G. WADE: Has that clinical engagement broadened as the project has gone on?

Dr POPE: It's starting to broaden now, as you would expect, but not in a way that allows all the issues to be sorted out so that there is a clearly outlined plan for the move to the new Royal Adelaide Hospital.

6588 The Hon. S.G. WADE: You talked about the flux in leadership in the project. Has there been a central leader or two who carry the corporate knowledge, or are we a rolling cycle of people not bringing the lessons from the past?

Dr POPE: It's a rolling cycle of people, I have to say. I think I'm the longest serving member of the industrial liaison forum; every other month, there's a new chair. The senior responsible officer of the whole project is perpetually changing, and you can see that they are trying to learn and understand what is going on, and they often bring a completely different perspective to how things should be done. So, it's a rolling feast that is going nowhere.

6589 The Hon. S.G. WADE: Considering that we have a very mobile society, do you think that the flux in leadership is above and beyond normal turnover; if so, why do you think that's the case?

Dr POPE: I think it is above and beyond normal turnover. The reasons for that, you can only speculate, but I personally would speculate that it is because they soon realise the difficulties and the problems that exist with this project and they don't want to be the person left holding a failed project.

6590 The Hon. T.T. NGO: I must declare a bit of conflict because Dr Pope and I used to work very closely together when I was adviser to the minister for health. You mentioned that there is a change of leadership in the central local health network. I believe that there is a new CEO for—

Dr POPE: That's right.

6591 The Hon. T.T. NGO: How has the leadership gone with her?

Dr POPE: It's very early days, and the relationship at this point is fine. I think she is starting to get her head around some of the complexities and the lack of work that is being done in trying to manage this project. I think her view of the engagement of medical staff is a correct one. She has articulated that quite clearly in recent times. Who knows how the relationship will progress, but right now it's a good one.

6592 The Hon. T.T. NGO: You mentioned that a lot of work needs to be done in terms of the internal services and how you link in stuff with that. What are your views on how much work needs to be done and how long would take to do that sort of work?

Dr POPE: Well, the visibility of what work has been done and what work hasn't been done isn't there. Unfortunately, I'm not in a position to really comment on that, but somebody should be in a position to comment on that. There has to be someone who has the overall visibility of where things are at, where the holes are and what needs to be done to get to the end point.

6593 The Hon. T.T. NGO: I know that when I was adviser I often rang you up and personally asked for your advice. Are there people or doctors in the RAH you believe might be able to help with that sort of work?

Dr POPE: Not with this type of problem. I think what this requires is a very skilled manager who has had experience in managing project of this size, because it is an enormous project to move a large tertiary hospital. I think that would be outside the skill set of pretty much all the doctors in this state and maybe doctors in general. You would need a specialised, highly skilled manager to be able to do it.

6594 The Hon. S.G. WADE: Dr Pope, you suggested that you thought the health system was heading for a train wreck. Do you think there is any way of avoiding that? You mentioned about the fact that a number of projects are being pursued at the same time—for example, Transforming Health, EPAS, CALHN and single service. Could we perhaps avoid the train wreck by postponing one of those?

Dr POPE: I would hope so. We have to avoid the train wreck. The damage that would be caused to the populous is enormous, so it has to be avoided. I think we have to do everything we can to try to avoid that, and that would necessarily mean pausing or suspending a number of projects. There are too many things going on right now with these interdependencies not understood. So, it is going to come as a complete surprise when various services fall over because of changes being made at the QEH, because they are moving parts of Hampstead into QEH.

The messages that we are getting back from some members are very extraordinary and you would not expect them just off the bat. So there is a domino effect, consequences, which are quite unpredictable and we need to take a pause and work out exactly where everything lies so that we can then have an understanding to successfully transition to the new Royal Adelaide Hospital.

6595 The Hon. S.G. WADE: Last year the minister said that we had to have EPAS available on day one at the new RAH, because the new RAH was designed for EPAS. Since then that process has been staged, and the general perception, and certainly my perception, is that the minister was responding significantly to concerns of the ANMF, SASMOA and the AMA that they were not willing for their members to turn up on day one of a new hospital with a new IT system. Is that your understanding of that situation?

Dr POPE: That has certainly been the position of our association and other unions as well. What we have seen of EPAS at Noarlunga and Port Augusta has been an unmitigated disaster—there is no other way to describe it. It has been something which kills efficiencies. We are in an environment where funding is short so we are trying to squeeze the system for as much productivity as we can possibly get and yet we are introducing a computer system which right now substantially reduces those efficiencies.

6596 The Hon. S.G. WADE: Considering the concerns of your association, and those of the AMA which we have already heard about, do you think that health professionals may decide to take action, industrial or other, to try and protect the safety of their patients?

Dr POPE: Well, doctors will do whatever they can think of, essentially, to protect the safety of their patients. As a doctor it is too distressing to do otherwise. You have to work out what that will be and exactly what that will be will be up to various groups to decide at the time.

6597 The Hon. S.G. WADE: Correct me if I am misquoting you, but I think you mentioned that there was planned reduction in services at other sites towards the end of 2016, which would presumably mean an increase in elective surgery waiting times. My understanding from the AMA discussion paper is that there is a planned reduction in outpatient services at the new RAH, and so therefore, if you like, there will be fewer people getting on to the list. So do you think that towards the

end of 2016 and the beginning of 2017 South Australian patients will be suffering a double whammy: they won't have access to the outpatients to get on the list and when they do get on the list they will have to wait even longer?

Dr POPE: Absolutely. What is occurring in outpatients especially is very concerning, and we would argue is completely unethical in that patients are being sent letters demanding a response within a certain time, and if they don't provide a response then they're removed from the list. So you have very vulnerable people, who have been referred for valid medical reasons, who are being removed from outpatient waiting lists, for whatever reason, who are not in a position to really defend themselves. And that is being done without the hospital specialists being in the loop about that decision making. So, there is an enormous problem with the duty of care that doctors, and the public health system more generally, have to patients being completely undermined by a clerical process to remove people off a waiting list for outpatients.

6598 The Hon. S.G. WADE: So there is that list cleansing occurring—

6599 The CHAIRPERSON: Who is doing the list cleansing, the clinicians or—

Dr POPE: The clerical staff acting under instructions from senior health managers.

6600 The CHAIRPERSON: Senior health managers, but not the clinician in charge of the patient's care?

Dr POPE: No. It is being done with the clinicians outside of that loop. So there is a triggering mechanism. If somebody has been on the list for three months or six months then a clerical officer will generate a letter, which then gets posted out, the patient is supposed to respond to that letter in a certain way, and if they don't then they are removed from the list, and the clinicians are none the wiser. There is a letter that goes to the GP to inform this as a process which has occurred. They are not asked really for their input into that situation. So that connection between the GP and the hospital specialist has been completely undermined and broken. It is unethical and I have enormous problems with it.

6601 The CHAIRPERSON: So, if someone is taken off the list and eventually the GP or the clinician says, 'Hey, this is serious. They didn't understand the letter,' or whatever it is, that patient then just has to go back onto a new waiting list. Is that the case?

Dr POPE: Yes, they have to go back to their GP and begin the whole process again.

6602 The Hon. S.G. WADE: That is a new process, do you think? If so, when do you think it started?

Dr POPE: It is certainly a new process. It is something that has been talked about for some time. We pointed out these issues very strongly on multiple occasions and, interestingly, they accept what we say, that it is a failure of duty of care and that it is unethical.

6603 The CHAIRPERSON: When did these letters start getting sent to patients?

Dr POPE: It varies from LHN. Central Adelaide has just started in earnest to send these letters out, and I have to say, they go out with a clerical officer designation but no name and no signature, so you can't even track back any accountabilities. It is appalling.

6604 The Hon. S.G. WADE: Are you aware of any other changes? For example, my understanding from a constituent is that they were told, after being on the list for a year, that to stay on the list they had to go back to their GP and seek a fresh referral. Have you heard of cases of that?

Dr POPE: Yes, that is certainly one of the processes which SA Health has put in process, such that that waiting is suspended pending a review by the GP.

6605 The Hon. S.G. WADE: So, again, going back to the previous example, is that dictated by clinical need, or do you think that is an attempt to suppress the list?

Dr POPE: It's certainly not clinical need, because it's triggered by time. It is simply how long somebody has been waiting on the list. There is no thought going to the clinical needs of that patient. You can't say, 'We've had a look at this particular case and, because of X, Y and Z, they no longer need this appointment.' That process would be perfectly alright, but something that is triggered automatically by the passage of time and done in the way that it's done is unethical.

6606 The Hon. G.A. KANDELAARS: In that discussion, you suggested that the managers you have spoken to actually agree with you in terms of the ethics of that process. Name them.

Dr POPE: Name them? Well, the project officer I am fairly reluctant to name for two reasons: (1) I don't feel comfortable naming them; and (2) right at this second I can't remember her name, but I will. We can certainly provide that to the committee. The people we have dealt with have taken these issues on board and it puts things on hold for a period of time, and then all of a sudden it resurfaces through the LHNs. But I know—

6607 The Hon. G.A. KANDELAARS: Take the question on notice.

Dr POPE: I shall.

6608 The Hon. S.G. WADE: If I could clarify a comment I think you made in your opening statement: you were suggesting that when the new RAH opens you thought the inpatient capacity might be 250 beds below its potential operating capacity.

Dr POPE: No, the 250 number comes from the ramp-down requirements. SA Health understands, from what they have told us, that they need to get the existing Royal Adelaide Hospital to about 250 inpatients or below to effect a move.

6609 The Hon. S.G. WADE: Have they indicated to you, once the transition period is finished, what level of capacity they expect to be operating the new RAH at?

Dr POPE: Not in a comprehensive sense, although we have been told that various services won't have all their beds opened and commissioned. For example, the intensive care unit at the new Royal Adelaide Hospital has a number of beds (I think 12) which are unfunded and won't be able to open.

6610 The CHAIRPERSON: You indicated in your opening statement that there were some 300 clinics at the existing Royal Adelaide in 60 locations, I think. Do you have a concern that some or a number of those clinics will not be able to be replicated at the new Royal Adelaide Hospital?

Dr POPE: We have been told words to that effect.

6611 The CHAIRPERSON: But you don't know which ones, obviously. That's the issue that you are raising.

Dr POPE: Precisely.

6612 The CHAIRPERSON: Have you been given a time frame as to when you will know which clinics won't be able to transfer from the existing Royal Adelaide to the new Royal Adelaide?

Dr POPE: No. There have been no timelines mapped out for any of this, including that issue.

6613 The CHAIRPERSON: Have the managers of the project given a commitment that all the clinics will be replicated, if not at the new Royal Adelaide, at some other location but they just don't know which one yet, or is there some doubt that some clinics might not be able to continue at all?

Dr POPE: We have been told that a substantial volume of outpatients will be decommissioned because it is unfunded.

6614 The CHAIRPERSON: Which means what? That some of those clinics will not be able to continue in any location?

Dr POPE: That's right. So, either the entire clinic is dispensed with or the volumes going through multiple clinics are substantially reduced.

6615 The CHAIRPERSON: For those of us who are the uninitiated, clearly, I guess you are not in a position to know which ones might be in that case, but what are the sorts of clinics that you are talking about here—not that they might be the ones that, I hasten to say, might be decommissioned?

Dr POPE: These are clinics across all the specialities. So, every medical speciality you can imagine will be running an outpatient clinic, essentially, so they can get people home and

out of hospitals faster and then follow them up in clinics to a large extent. There is also a large volume of referrals into the system from general practitioners to allow the patients to be seen by a specialist to arrive at a diagnosis.

6616 The CHAIRPERSON: It's everything: it's cancer—

Dr POPE: It's everything.

6617 The CHAIRPERSON: —it's orthopaedics, it's ophthalmology; it's everything.

Dr POPE: Correct.

6618 The CHAIRPERSON: You have given evidence earlier that the existing services at the Royal Adelaide would all be replicated at the new Royal Adelaide. Has SASMOA a view that that's no longer going to be the case? Have you accepted that that's the case, that there will be some services at the existing Royal Adelaide that clearly won't be provided at the new Royal Adelaide?

Dr POPE: I wouldn't say that we've accepted that, and we haven't had open and frank discussions. That's been one of the problems: that nobody really knows where things are at in the decision-making processes about what will be where, and what size, and what the footprints will be. It's extraordinary, this level of important details that are unknown at this point to the association, to our members, and I would speculate that it's not known by SA Health or the managerial people either.

6619 The CHAIRPERSON: We are running out of time, but one question: one of the key issues which we've discussed with you and others before has been the number of beds at the new Royal Adelaide, and a key part of that is the assumption that we can reduce, through new models of care, the average length of stay from 6.7 to 5.6 days, or numbers of that magnitude, and that means step-down facilities—rehab, all those other sorts of things. Are you confident from what you know that the new models of care will be able to achieve that significant reduction in the average length of stay?

Dr POPE: Not confident at all. In fact, I would expect it to go the other way because of the problems I have outlined with there being no substantive planning, no interdependency mapping. You can't drive a system as efficiently as possible if you've got no understanding of how it's all put together and how it works.

6620 The Hon. S.G. WADE: If I could just refer you back to a comment that SASMOA made in its submission to the government on the Transforming Health proposal, and I'm raising it here not in the context of Transforming Health but in the context of the interface between QEH and the new Royal Adelaide Hospital in terms of emergency departments. SASMOA said that:

> SASMOA members are of the view that the current proposals regarding changes to the emergency departments will only lead to unsafe workloads, further overcrowding, significant delays to patient care and an increase in adverse outcomes for patients.

Considering the year has transpired eight or nine months since then, have those concerns been addressed?

Dr POPE: Not at all. In fact, our concerns are growing rather than declining. We are hearing more and more from members across the system which go to exactly those points.

6621 The Hon. S.G. WADE: That relates to the capacity. For example, the new RAH ED capacity hasn't been increased post Transforming Health. Is it a capacity issue?

Dr POPE: It's absolutely a capacity issue, and the large effect of Transforming Health is to funnel everything to the central site that will necessarily create an overload for that site very quickly to the point where it won't have the capacity to be able to deal with it. The other thing I would say about the models of care is that there is no staffing to go with the models of care, so there's a push to have more senior doctor involvement early on in the process, but the recruitment and employment of those senior doctors necessary to drive it to the levels that are required isn't there.

6622 The Hon. S.G. WADE: That last comment is across disciplines, it's not just ED?

Dr POPE: It's across disciplines, that's right.

6623 The CHAIRPERSON: Does that last comment apply to the quick-look triage model that has been talked about?

Dr POPE: It does, yes.

6624 The CHAIRPERSON: Dr Pope, thank you very much for your cooperation with the committee. The committee secretary will be in touch with you in relation to transcript and any questions that you have taken on notice, so thank you very much for your time this morning.

THE WITNESSES WITHDREW

21 December 2015

Mr Guy Dickson
Secretary of the Committee
Legislative Council
Parliament House
ADELAIDE SA 5000

Dear Mr Dickson

Thank you for your letter dated 14th December regarding the Budget and Finance Committee and the attached transcript.

I advise the following;

1. There is one grammatical error on page 954 at paragraph 6584 where my word "at" after "mapped" should be "out".

2. The answer to the question on notice on page 958 at paragraph 6606 is Lyn Dean.

Thank you for the opportunity to review the document.

Regards

President, SASMOA

SA Salaried Medical Officers Association
ABN: 60 932 342 397

Australian Salaried Medical Officers Federation (SA Branch)
ABN: 23 172 174 608

1st Floor, 161 Ward Street
(PO Box 64)
North Adelaide
South Australia 5006

Telephone: (08) 8267 5151
Fax: (08) 8267 1891
Email: sasmoa@sasmoa.com
Website: sasmoa.com

WITNESSES:

BONNER, ROB, Director, Operations and Strategy, Australian Nursing and Midwifery Federation (SA Branch)

HURLEY, JENNY, Manager, Professional Programs, Australian Nursing and Midwifery Federation (SA Branch)

6625 The CHAIRPERSON: To go through the formalities, firstly, welcome to the meeting. The Legislative Council has given the authority for this committee to hold public meetings, and a transcript of your evidence today will be forwarded to you for your examination for any clerical corrections.

Should you wish at any time to present confidential evidence to the committee, please indicate and the committee will consider your request. Parliamentary privilege is accorded to all evidence presented to the committee. However, witnesses should be aware that privilege does not extend to statements made outside of this meeting. All persons, including members of the media, are reminded the same rules apply as in the reporting of parliament.

I can introduce you to the members of the committee who are with us at the moment: Tung Ngo, who is not with us, but he shall return—I think you know Tung; Gerry Kandelaars, and on my left, the members of the committee are Andrew McLachlan and John Darley, and Stephen Wade has joined us for the hearing.

For the benefit of Hansard, would you mind at the outset introducing yourself formally and your title, your colleague and her title, and then I invite you to make an opening statement should you wish, and then we will proceed to questions. So, thank you for your attendance at the committee today.

Mr BONNER: Thank you, Mr Chairman, my name is Rob Bonner and I am the Director of Operations and Strategy with the Australian Nursing and Midwifery Federation in South Australia. My colleague is Ms Jennifer Hurley, who is the Manager, Professional Programs, with the ANMF(SA).

We are not contemplating making an opening statement, given the previous submissions and statements that we have made. The only substantial thing I think that has occurred since the last time we were before you is the delay in opening of the new hospital due to the delay in completion of the building program. The delay in the building program we can't comment on, but the delay in the transfer of the hospital following the practical completion of the building is one that our organisation have lobbied the minister to achieve given that the alternative was to move the hospital during peak winter season, and that would not be in the interests of safe and effective patient care. So, in terms of the final date of the planned transfer, that is something that our organisation is comfortable with in all of the circumstances.

6626 The CHAIRPERSON: Mr Bonner, I think you were there towards the end of the evidence that SASMOA were giving raising issues in relation to the challenges, or I think they used the stronger words: dangers for patients in terms of managing the transition from one hospital to the other. From your organisation's viewpoint, we give you the opportunity to make a comment as to how the planning, in terms of safety of patients, is going from your viewpoint and what issues, if any, you think might need to be addressed to ensure, to the greatest extent possible, the safety of patients is ensured.

Mr BONNER: I think that the thing to be said is we are still 10 or 11 months out from the actual date of physical transfer of patients. So, to some extent, some of the issues have still got to be worked through and necessarily so in our particular view. The second thing we would say is this is not something that's unique or novel to the development of the new RAH. The opening of the Fiona Stanley in Western Australia necessitated three different sites, moving patients to the new hospital there, and the Gold Coast University Hospital site was a relocation. There are plenty of other examples overseas where hospitals have been decommissioned and moved to new locations, so we should be learning from them.

The critical issue that is yet to become clear is what the ramp-down and ramp-up strategy looks like a head of the new hospital opening. That can't really be locked away now until we have an absolutely locked in date for building completion and transfer because there is an interrelationship between the practical handover of the building from the builders to government, the testing of that building to meet the requirements of the service, which in our understanding takes most of the three months worth of overlap and, secondly, that then needs to accompany the wind back in the inactivity of the existing hospital, matched with a capacity in other sites that is planned to be available to take up some of the emergency and elective loads.

You can't do that during peak activity, as we've said, because they are all going at basically 100 per cent full from September/October anyway. That's going to have to kick in around the end of October/beginning of November next year. We're still about 12 months away from that being put into place. That being said, we are expecting from some of the reports that we've had over the last week or two some practical information about the site by February/March next year, which would still give us six months to work through the fine detail.

6627 The Hon. S.G. WADE: I certainly agree with you, Mr Bonner, that there is good practice overseas and in Australia, but isn't the unique situation here how much we are trying to do at once? We've got EPAS, Transforming Health, single service and the NRAH all at the one time. Do you think that that is manageable for the health workforce?

Mr BONNER: We're not having EPAS at the same time, with respect. The EPAS implementation program for the new Royal Adelaide is yet to be announced. My understanding is that it's going to the steering committee for EPAS this week for planning around when it will be implemented at the Royal Adelaide Hospital. Given the delays in the building completion, there is even still conversation about whether or not EPAS will be introduced at the existing site using mobile equipment so that staff can become familiar with it in the lead-up to transition to the new Royal Adelaide, rather than switching it on at the time for it moving.

The worst possible scenario and it waits to day one, we will need some sort of system in place that will manage where patients are located, where they are contactable, managing of diets and those sorts of things. We have agreed—and so have most other people, in my understanding—that that should be available, the functionality of EPAS, on day one but that it should not be used for clinical data recording and they should maintain the existing paper-based systems for a month or two after transition to the new Royal Adelaide so that people are not overwhelmed by becoming familiar with a new environment.

The only option will be that they use the new pharmacology ordering and management system on day one so that they get those sorts of building blocks in place and then EPAS becomes enlivened a short period of time later.

6628 The Hon. S.G. WADE: In relation to that comment, I wasn't just meaning the change challenge for the NRAH but the change challenge for the system. My understanding is that The QEH is starting to get EPAS rolled out now. The QEH has to cope with the building that starts in January—

Mr BONNER: That's not right. The Queen Elizabeth Hospital, there is planning going on for the use of EPAS at The Queen Elizabeth, but again there has not been a definite decision to roll out EPAS at The Queen Liz. Indeed, our organisation and others are agitating that it should be because of the flow of patients that is expected between the new RAH and The Queen Liz and therefore it's in the interests of more effective and safer patient care to have the continuity and clinical documentation available at the earliest possible opportunity, particularly given the changes in location of some of the services—intensive care and high dependency services that are probably at this stage looking like moving from The Queen Elizabeth site to the new Royal Adelaide campus when it opens—that they be on common systems for clinical information.

6629 The Hon. S.G. WADE: So, the answer to my original question is that the ANMF's view is that all the project's scheduled for the next year are manageable.

Mr BONNER: Time will tell. It's our view that you can list a range of projects that make it look as though the system is overwhelmed by project work or you can look at the interrelationship between some of the programs and recognise that what is currently described as a new Royal Adelaide project enters the commissioning that particular campus around models of care;

at Flinders Medical Centre it's being called a Transforming Health initiative because they are looking at the issue of models of care and length of stay under that heading.

So, the new Royal Adelaide commissioning is in effect a subset of the issues under Transforming Health. The clinical information system is a co-dependency for the effective ongoing management of the system under Transforming Health, so it is wrong to say that these projects exist in splendid isolation. They are part of an overall strategy that provides for the future disposition, management and leadership of the system as a whole.

6630 The Hon. T.T. NGO: I have a quick question about EPAS. It is a testament to your members when I was an adviser to the minister that they tend to be willing to learn new technologies pretty quickly. With the introduction of EPAS in Noarlunga and a few other hospitals, how has that been going? I do not know what has been going on there.

Mr BONNER: It has had its speed bumps, to say the very least. The system over the last 10 to 12 months has been through a significant rebuild and upgrade as a result of the initial rollout at Noarlunga, Repat and Port Augusta where there were very significant issues in terms of the way the system operated. There are hardware issues associated with its rollout that are still extremely problematic. We are certainly of the view that the hardware that was installed as part of a patient entertainment system that was designed to operate EPAS is not up to standard for that purpose and will need to be replaced or supplemented over time. The feedback that has—

6631 The CHAIRPERSON: Has the government agreed with that view?

Mr BONNER: No, that is our position.

6632 The CHAIRPERSON: That is your position.

Mr BONNER: I think there is recognition from most of the people involved in the project that that continues to be the feedback from the staff in the wards and areas that are current users, and certainly the explosion in the use of mobile work stations in all of the existing sites I think lends credence to the view that they are necessary in lieu of the original hardware that was there. In relation to the upgrade, the jury is still out in terms of how that positions EPAS for the future. The most recent evaluation that was attempted was about two or three months ago.

Ms HURLEY: Three months.

Mr BONNER: Three months ago at the existing three sites. The response rate to the survey that we and the department jointly issued was so low that it is not possible to make concluded views about it, but the feedback was ambivalent about the system in terms of the way it was operating as opposed to the initial survey work that we did that was overwhelmingly negative. I guess the good news is that people are now ambivalent about the service at the very least. The conclusion would be that if things were still as bad as they were back when we did the original survey, the response rate would have been higher than it was this time around. Our detection is that things have improved on the ground but the survey work is not there to justify us saying that to you in evidence.

6633 The Hon. G.A. KANDELAARS: On the issue of hardware, I know last time you talked about mobile stations being moved around. Are they doing substantial work in terms of determining what input devices they are going to use, whether it is tablets or iPads?

Mr BONNER: There has been a lot of work looking at the technology for the future, partly as a result of clinician requests so that people can use their own PDAs or phone devices to access the material from wherever they are. A lot of work is going into that space. It should not be taken from my evidence that there is not good work going on, but there is no plan yet for what the hardware will look like when it is ultimately rolled out in other places.

6634 The Hon. G.A. KANDELAARS: What are they doing in terms of getting staff used to working in an environment where things are delivered electronically rather than in paper? You have a substantial mix of age profiles at RAH, for instance, even in the nursing profession. Some of those will adapt quickly and others less so.

Mr BONNER: Nurses have run since 1991-92 at the Royal Adelaide until January last year with a paperless system. It is only because the platform that supported the previous

ExcelCare system was no longer supported by the vendors that it had to be turned off. It had become increasingly unreliable over the last year or so before it was turned off, so that was a decision we supported, but the return to paper is not one that nurses feel comfortable with. The vast majority of our members are used to paperless systems and support the return to that kind of technology provided. It is appropriate to their needs and the clients' needs. That doesn't seem to vary much with age.

6635 The CHAIRPERSON: Final question on this, and then Stephen on a new topic, but the existing entertainment consoles which were going to be the hardware basis for the whole system, is it your understanding that they would continue solely as entertainment consoles or are they going to be scrapped as well?

Mr BONNER: I think they are still being used for the entertainment suite.

6636 The CHAIRPERSON: They are suitable for that at least.

Mr BONNER: Yes, they seem to be, and that's not what our members complained about. It was particularly the keyboards, in terms of their height, adjustability and the way they responded to their tapping—the bouncing and damaging their shoulders and arms.

6637 The Hon. S.G. WADE: The lack of the movie capacity might make it more accessible for your members.

Mr BONNER: It might end the competition.

6638 The Hon. S.G. WADE: I was hoping to go back to the discussion we were having last time about the impact of single-bed rooms. You mentioned last time that there was work being done at Lyell McEwin, Berri and Whyalla. I just wondered if there were any updates as to the impact of single rooms on nursing care?

Mr BONNER: There has not been any significant evaluation of single rooms in those three sites in this jurisdiction, but there has been a report published which I can refer the committee to called 'Health services and delivery research', volume 3, issue 3, February 2015, which was a publication of the NHS in evaluating the impact of single-room accommodation in the United Kingdom at the Pembury hospital, which I think I have talked to the committee about previously, at Maidstone.

That report, which is a substantial one, has been issued. I think it is in keeping with some of the evidence that we have given previously, that is, that there was a great deal of support for single-room accommodation from the patients. In excess of 70 per cent of patients felt more satisfied in a single-room environment. The vast majority of nurses involved thought that it was not particularly satisfactory as an exclusive mode of care in the environment and felt that there were workload and other patient care issues arising from it. Staffing levels under that model went up reasonably significantly, but it needs to be remembered that it went up from a very low base by Australian standards.

6639 The Hon. S.G. WADE: I have had a look at that report, and my understanding, if I remember it correctly, is that nursing costs will increase by about 3.5, which is comparable with what you suggested in your last evidence, but that building and maintenance costs would also increase by about 3.5. I was hoping to pick up another UK report similarly trying to unpack the experience of single beds, not diametrically opposed, but I just wanted to highlight some issues coming out of it. This one was by researchers at Kings College London and was published by the National Institute for Health Research, but unlike Pembury hospital, it was focused on Maidstone. You did mention—

Mr BONNER: It's the same hospital.

6640 The Hon. S.G. WADE: It's the same hospital, is it? I think it is a different report, though. I might be wrong on that. If I could highlight three issues coming out of that, one of the suggestions was that staff were concerned that, in making the transition to single rooms, they were being required to make rapid changes to their work practices in order to monitor and access patients in single rooms and they felt ill prepared. In the context of the NRAH transition, is there work being done to help nursing teams adjust their models of care?

Mr BONNER: There is some; there is a simulation model room that's available. Some of the areas, like the renal unit at the existing Royal Adelaide, have been modelling how they would deliver care in the new environment because they're largely single-room accommodation

where they are; and there are plans to implement. Vascular surgery, for example, currently is trialling the direct admission of patients to that area to replicate the impact of that kind of change in model of care in the existing environment.

It's not the whole hospital adopting a particular mode, but it's different parts of the organisation. The emergency department has already simulated different aspects of the emergency design of the new hospital to reflect some of those experiences, and that gets fed back into the models of care for those areas and they are adapted. It's not as though the models of care are fixed; they are fluid and responsive to the experience.

6641 The Hon. S.G. WADE: My understanding of the report shows that one of the short-term impacts was an increase in falls.

Mr BONNER: Yes.

6642 The Hon. S.G. WADE: But that reduced over time.

Mr BONNER: Yes.

6643 The Hon. S.G. WADE: Presumably, one of the responses could be bed sensors for when people leave their beds. Is there discussion on, shall we say, equipment responses to the challenges?

Mr BONNER: It should be said that that's not unique to either Pembury or what we would expect to see at the new RAH. There was a significant increase in falls at Trondheim, in St Olavs Hospital in Norway and in some of the other single-room accommodation, so there does seem to be an issue associated with falls risk. We are starting to work through some of the issues associated with those sort of features, particularly in rooms that are for the use of people with dementia or some sort of cognitive dysfunction where they might be requiring some supervision and oversight.

6644 The CHAIRPERSON: Just on this issue, when you were last with this, the Hon. Mr Kandelaars asked a very separate question: 'Do you expect better health outcomes as a result of a move to single rooms?' Your response then, 12 months ago, was, 'I think the jury is out on that.'

Mr BONNER: It's still out.

6645 The CHAIRPERSON: I was going to ask you, is it still out or is it coming in?

Mr BONNER: If you look at the Pembury report, there was some ambivalent data. There were some improvements in some areas, but there were other areas where they didn't experience the kind of improvement that they had hoped for. Hospital-acquired infections, for example, was one that I think has been touted from the origins of the single-room experience that would benefit from single rooms; that didn't materialise.

6646 The CHAIRPERSON: So, research indicates why? From a clinical viewpoint, what—

Mr BONNER: That it's still necessary they wash their hands when they go into the room, whether it's a shared room or a single room, and that seems to be the single biggest issue affecting hospital-acquired infections.

6647 The CHAIRPERSON: One of the other associations did raise the issue in emergency departments or outpatient areas as well, so you've got this constant flow of staff through all of these areas as being another issue that would mitigate against the goal of infection control.

Mr BONNER: That being said, there is evidence around about people performing better in some areas than others, and some occupational groups performing better than others in terms of infection-control practice. So, I think it's behavioural rather than structural, and it's how do we deal with that. Certainly, in the UK, there seems to be a level of enforcement and encouragement of behaviour that leaves us behind the performance mark that we need to pick up the game on.

6648 The CHAIRPERSON: Can I ask a question which I put to the other two associations. One of the critical issues with this whole debate about the NRAH is the number of beds, and one of the critical assumptions is the reduction in the average length of stay from 6.7 days down to 5.6 days, and that hinges on changed models of care and a variety of issues like that. As an association, are

you confident that significant change can be achieved by our system? That is, reducing the average length of stay from 6.7 down to 5.6?

Mr BONNER: You would have to ask why it wasn't possible here when the targets have all been achieved in other jurisdictions and overseas. I mean, what intrinsically makes us less able to reach those performance benchmarks in South Australia and in metropolitan Adelaide when they can do it in Sydney, they can do it in Melbourne, and they can do it overseas? What is the barrier?

6649 The CHAIRPERSON: You have just explained in infection control, that perhaps, for whatever reason, we have not been able to achieve, to meet, those standards—

Mr BONNER: But I am saying it is a performance issue, rather than an intrinsic barrier. So it is about how do we manage our system better so that we get the performance, whether it is infection control, or whether it is length of stay reduction, in a way that is sustainable. And certainly there are issues where, in terms of things like nurse-led discharge, we are still dragging our feet behind the rest of the world and behind interstate. So, resistance to allowing nurses the capacity to discharge patients when they are fit and clinically ready is one that continues to be opposed on the ground, and yet there is no good reason for it, and we can show that it works, and works oversees and works locally to reduce length stay.

We still have evidence, over the last 12 months, where hospitals have been in overload, where senior clinicians have gone in on the weekend to see who can be safely discharged to home because the hospital is in complete meltdown. They go in and they discharge 30 or 40 patients who otherwise would have waited until Monday morning for discharge. That is not good for the patients. It is certainly not good for the system, which is paying hundreds of dollars a day for that person to be in a bed where they didn't need to be, and it sure as hell isn't good for the person waiting in ED for the bed that can't be vacated.

So they are the sorts of structural practices that we could implement relatively easily, and get a significant improvement in length of stay. Again, issues like the performance rate we have in the use of day-only elective surgery in South Australia versus the Alfred and other places interstate. There is no good reason why we are sitting at 40-odd per cent, and they are sitting at 50 or 60 or 70 per cent—best practice.

6650 The Hon. G.A. KANDELAARS: Mr Bonner, I do not know if you were here when Dr Pope described the transition to the new RAH as the train wreck ready to happen. I don't detect the same view from yourself. What is your comment?

Mr BONNER: I wouldn't use that term. I think that there is still a lot of work to do. But as I said at the opening when the Chair asked questions, it is our view that clearly there is a level of planning work that still needs to occur and is planned to take place over the next three or four months, as we get closer to the practical plans for movement of patients. And, as I said in response to questions from Mr Wade, I think it is wrong to say, and misleading to say I think, that there are silos in Transforming Health, EPAS, and the new RAH, and that it is sort of a scheme that is necessarily going to lead to collapse of the system. I think that just overplays the hand somewhat.

6651 The Hon. G.A. KANDELAARS: So what is your association's view about the level of consultation that is currently taking place?

Mr BONNER: I think that the problem with the consultation program at the present time is the lack of concrete outcomes from it. I think that people are looking for and need a level of certainty about what is going to happen to them and to their service over the next 12 months, two years, three years, and whether you talk about the new RAH, or Repat Hospital, that is the sort of stuff that people are looking for.

The problem is that there aren't all of those answers squared away at this time for someone to deliver to you. So you can consult as much as you like, but until you can tell me what is going to happen to my service, my job, my population of patients, my mortgage in terms of my income, then, frankly, the consultation process ain't going to be seen for much on the way through. But there is, I think, a genuine engagement in that conversation, it is just where we are at in the planning cycle that doesn't allow for that to take the necessary formal shape that it needs to take.

6652 The Hon. G.A. KANDELAARS: And how have you found the IR/HR responses?

Mr BONNER: Lacking.

6653 The Hon. G.A. KANDELAARS: And in what way?

Mr BONNER: I think that the system is not particularly agile in terms of operationalising the plans that government and the department as a whole might have for it. I think that the way that the system is trying to manage the industrial issues is to try and get agreement to a set of principles in the absence of detailed plans for the future, and we as a organisation have said, 'Well, we are not buying a pig in a poke. Tell us what your concrete plans are for this group and then we will enter into a discussion about how our members respond to that.' That of itself is necessarily taking us to a more evolutionary approach for the industrial response to some of these issues, and that is certainly something we are building in to our plans for bargaining next year.

6654 The Hon. S.G. WADE: The ANMF has said that it continues to oppose the closure of any beds until there is evidence of a reduction of demand within the system. Inevitably, as we start building, in January 2016 there will be closures and the opening and closing of different parts. Does the ANMF have a benchmark in mind—how many beds statewide? I'm just wondering what the closure of any bed means.

Mr BONNER: Well, what we mean by it is the commissioned beds that, as you say, vary according to time of year. For example, you couldn't criticise anyone for closing beds that are used only in every hospital for the peak winter season each year and then winding back to the commissioned level. Our understanding of the beds on the opening of the new RAH is that they will be held at current commissioned levels broadly.

6655 The Hon. S.G. WADE: Presumably, there will be a ramping up as part of the transition itself but then, once we get to the end of that, which I think is meant to be 74 days, or something like that, you would expect it would be the same as the current level.

Mr BONNER: Correct—and that needs to be taken in the context of the reshuffle that is going on at the same time between the existing Royal Adelaide, the existing QEH and the new Royal Adelaide and Queen Liz after it opens. Some bits will come up the road from Woodville and go to the new RAH and bits of the existing Royal Adelaide function will go down to it Woodville; bits of Hampstead will transition to Woodville over the next period as well. So, we're not talking about location of beds here; we're talking about overall bed stock.

Certainly, we are resolutely opposed to any reduction in beds. We have a number of beds that are available for every hospital in the metropolitan area by time of year for the last three years, and we will be monitoring those closely.

6656 The CHAIRPERSON: You have those, do you?

Mr BONNER: We have those; we get them every quarter from every hospital, along with staffing data. So, we can match the staffing, which is required under our enterprise agreement, with the activity.

6657 The CHAIRPERSON: Is that something you are in a position to provide to the committee—the historical records? I think the committee would be interested.

Mr BONNER: Yes, it's not secret data.

6658 The CHAIRPERSON: Could you take that on notice and provide the historical records; in terms of this committee monitoring the ongoing progress, that would be useful information.

Mr BONNER: And that gives you some degree of surgical and other specialties next to the ward area as well.

6659 The CHAIRPERSON: An issue that was raised with other groups the original commitment that existing services at the Royal Adelaide would continue at the new Royal Adelaide Hospital. Does your association accept that the decisions have already been taken that some of those existing services won't continue at the new Royal Adelaide? They might be at The QEH or other locations.

Mr BONNER: Some services are in the process as we speak of being actively moved from the Royal Adelaide to the Lyell McEwin Hospital over the next six months. In

Transforming Health, we've got the recommendation to restructure the cardiothoracic service structure between Flinders and the new RAH , so there will be bits of specialisation going in both directions. It is inevitable, under that overall plan for the system, that some of the disposition of services at the existing Royal Adelaide will not end up in the new Royal Adelaide. That being said—

6660 The CHAIRPERSON: Which particular services are you aware of at the moment that used to be provided at the existing Royal Adelaide which will definitely not be provided—they have already gone to the Lyell McEwin or The QEH—and decisions have been taken?

Mr BONNER: At this stage, the only bits that are going to the Lyell McEwin are all fractions of services as opposed to whole services, but there is still some discussion going on about what belongs ultimately at The Queen Elizabeth versus what belongs at the new RAH. Similarly, the conversation about what is going south to Flinders in particular in relation to cardiothoracic is still an open question.

6661 The CHAIRPERSON: I think we took evidence concerning some gynaecological services; had already been headed to TQEH in relation to some—was it dermatology?

6662 The Hon. S.G. WADE: I thought it was renal.

Mr BONNER: Renal is not going to The Queen Elizabeth. Renal is certainly a major service staying within the new Royal Adelaide footprint. Again, we have been given—it is not a secret document, I am happy to share it with the committee—the plan for bed disposition for the new Royal Adelaide by specialty area. It has already been mapped out for all the clinical areas.

6663 The CHAIRPERSON: If you can take that on notice and provide it to the committee.

Mr BONNER: I am happy to provide that to you.

6664 The Hon. S.G. WADE: I appreciate we are running out time, but going back to the UK research, one of the other issues I think it raised was, and to quote a media report, 'Most staff preferred a mix of accommodation,' that they liked to have access to shared wards for some clients. I was wondering—my understanding is there is no capacity for shared rooms at NRAH—do you think that's a problem, that nurses should have access to more than single-room facilities?

Mr BONNER: I think that's what the research says. The new Royal Adelaide is what it is and there is no capacity to join up rooms into shared capacity. It is not an issue we have contemplated. We are certainly exploring with the department, with CALHN and with university colleagues the need to replicate the Pembury research at the new Royal Adelaide and we have an in-principle agreement to do so.

In our view, that will give us the answers we need to the question down the track, but as you have already found from your own reading, the Pembury research is really the first piece of solid research that has been done anywhere in the world. It was published only about six or seven months ago, so I think it is up to all of us who are involved in this process to continue that piece of work and learn from this and other projects.

6665 The Hon. S.G. WADE: There was a strong preference amongst young people for single rooms as well, and even they apparently liked the idea of shared spaces. Is it your understanding that there are shared spaces in the NRAH?

Mr BONNER: Yes, there are, but the experience again from St Olav's and Pembury was that those shared facilities are not used heavily unless there is a particular purpose or requirement for them to be used. At St Olavs, what they have done is stop serving breakfast in patients' rooms so that people have to go to a common dining room and mingle with one another. You can make those sorts of rules, but if you just bung in a patient lounge and people have the option of sitting in their room and watching telly with their visitors, guess where they are going to be. You end up with those shared facilities that are not heavily utilised, and that is part of the tension between providing shared facilities and single-room design.

6666 The Hon. S.G. WADE: The staffing ratios that will need to operate for the new RAH, have they been settled yet?

Mr BONNER: No, and that is something we will be negotiating in the first quarter to six months of next year.

6667 The CHAIRPERSON: Is that part of your next EB, I assume?

Mr BONNER: No, we have started negotiations ahead of the next EB about how the existing arrangements will be carried forward for the new RAH because we can't all afford to rely on the fact that there will be a conclusion to our enterprise agreement by the time the next—

6668 The CHAIRPERSON: When does the current EB finish?

Mr BONNER: In July.

6669 The CHAIRPERSON: Next year?

Mr BONNER: Correct.

6670 The CHAIRPERSON: You should conclude the negotiations about three years after that, then, based on historical precedent.

Mr BONNER: Our expectation is we will finish them by October, but I don't think anyone would want to be waiting by October for a new staffing arrangement and then begin negotiations for something that is due to open four weeks later. We are using the existing model as the basis for negotiations with nursing directors and the hospital with a view that we can recalibrate that if there are any changes in the form of staffing formulas in the EBA. But best to have that discussion now and recalibrate rather than wait for the final work to be done.

6671 The Hon. T.T. NGO: Are you trying to push to have nurse discharge in the new RAH as well, or is that happening at the moment?

Mr BONNER: It is happening in a very patchy way across the system. We are actively exploring options for nurses to practise to their maximum scope of practice, whether it's at the new RAH or elsewhere in the system as a result of Transforming Health, because that will of itself lead to better coordination, more effective patient management and more efficient patient management than we have at present.

6672 The Hon. G.A. KANDELAARS: Where's the resistance?

Mr BONNER: The people who currently hold the power in those areas would not be secret. It is largely medical colleagues who have been reluctant to share that existing control with our members. That was a complete shock to you and the rest of the committee, I'm sure.

6673 The CHAIRPERSON: Mr Bonner and Ms Hurley, thank you very much for your attendance at the committee today and also thank you very much for your willingness to take some questions on notice and provide some information.

THE WITNESSES WITHDREW

[Answers to questions taken on notice by Australian Nursing and Midwifery Federation SA at the Meeting of the Committee held on Monday 14 December 2015]

New RAH Space Allocation Plan

Directorate Colour Key Code

Medical	Cancer	Renal	Surgical	Subacute	Critical Care	Mental Health	Flexible allocation

<table>
<tr><td></td><td>Level 9G, Wing 2 - Medical</td><td>Level 9G, Wing 1 - Medical</td><td>Level 9F, Wing 2 - Medical</td><td>Level 9F, Wing 1 – Medical</td><td>Level 9E, Wing 2 – Medical</td><td>Level 9E, Wing 1 – Medical</td></tr>
<tr><td></td><td>Level 8G, Wing 2 - Medical</td><td>Level 8G, Wing 1 - Medical (Surgery)</td><td>Level 8F, Wing 2 - Medical</td><td>Level 8F, Wing 1 - Medical</td><td>Level 8E, Wing 2 - Medical</td><td>Level 8E, Wing 1 - Medical</td></tr>
<tr><td rowspan="2">Level 7G, ** Helipad</td><td>Level 7G, Wing 2 - Surgery</td><td rowspan="2">Level 7G, Wing 1 - Surgery</td><td>Level 7F, Wing 2 - Renal</td><td rowspan="2">Level 7F, Wing 1 – Renal</td><td rowspan="2">Level 7E, Wing 2 – Cancer</td><td rowspan="2">Level 7E, Wing 1 – Cancer</td></tr>
<tr><td>Level 7G, Wing 2 - Surgery</td><td>Level 7F, Wing 2 Surgery</td></tr>
<tr><td>Level 6G, Wing 3 - Surgery (Medical)</td><td>Level 6G, Wing 2 - Surgery</td><td>Level 6G, Wing 1 - Surgery</td><td>Level 6F, Wing 2 – Surgery</td><td>Level 6F, Wing 1 – Surgery</td><td>Level 6E, Wing 2 - Cancer (Surgery)</td><td>Level 6E, Wing 1 - Cancer</td></tr>
<tr><td>Level 5G, Wing 3 - Surgery</td><td>Level 5G, Wing 2 – Neuro-trauma Rehab</td><td rowspan="2">Level 5G, Wing 1 - Surgery</td><td rowspan="2">Level 5F, Wing 2 - Surgery</td><td rowspan="2">Level 5F, Wing 1 - Surgery</td><td rowspan="2">Level 5E, Wing 2 - Surgery</td><td rowspan="2">Level 5E, Wing 1 - Surgery</td></tr>
<tr><td>Level 5G, Wing 3 - Neuro-trauma Rehab</td><td>Level 5G, Wing 2 - Surgery</td></tr>
<tr><td>Level 4G, Wing 3 - Critical Care</td><td>Level 4G, Wing 2 - Critical Care</td><td>Level 4G, Wing 1 - Critical Care</td><td>Level 4G, Wing 4 Critical Care (Medical)</td><td>Level 4F, Wing 1 - Medical</td><td>Level 4E, Wing 2 - Medical</td><td>Level 4E, Wing 1 - Medical</td></tr>
<tr><td colspan="7">Outpatients / Concourse / Admin / Commercial</td></tr>
<tr><td rowspan="2">Level 2G Wing 3 - Mental Health</td><td colspan="3">Acute Assess Unit</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Level 2G, Wing 1 - Surgery</td><td>Level 2F, Wing 1 - Medical</td><td>Level 2F, Wing 1</td></tr>
</table>

IN CONFIDENCE - PROVIDED TO THE BUDGET AND FINANCE COMMITTEE AS REQUESTED 14 DECEMBER 2015

Metropolitan and Regional South Australian Public Sector Hospitals 2013/14 - 2015/16 Overnight Occupied Beds Data Summary

Local Network	Site	2013/14	2014/15	2015/16
Central Adelaide Local Health Network	Royal Adelaide Hospital	611	610	623
	The Queen Elizabeth Hospital	239	250	209
	Hampstead Rehabilitation Centre	100	98	112
	St Margaret's Rehabilitation Centre	34	34	27
	Mental Health	103	103	99
	CALHN Total Beds	**1087**	**1094**	**1071**
Northern Adelaide Local Health Network	Lyell McEwin Hospital	176	176	179
	Modbury Hospital	59	59	66
	Mental Health	181	181	171
	NALHN Total Beds	**416**	**416**	**415**
Southern Adelaide Local Health Netowrk	Flinders Medical Centre	358	367	384
	Noarlunga Hospital	68	52	57
	Repatriation General Hospital	208	221	226
	SALHN Total Beds	**634**	**640**	**668**
Womens & Children's Local Health Network	Womens & Children's Hospital	178	176	184
	WCHN Total Beds	**178**	**176**	**184**
Country Health SA	Port Pirie Hospital	36	38	36
	Port Augusta Hospital	35	35	36
	Whyalla Hospital	44	47	53
	Mount Gambier Hospital	61	65	74
	CHSA LHN	176	185	199
	Grand Total Overnight Occupied Beds	**2491**	**2511**	**2537**

Notes

Data Excludes: Emergency Department Short Stay and Psychiatric Emergency Short Stay Wards, Country small and minimum staffed hospitals
Noarlunga Hospital: 2013/14 Vs 2014/15 and 2015/16 OBD Variance: Surgical Service Model Change - Collins Ward from overnight multi-day stay to 23-hour surgical short stay

Reported Prepared 4 January 2016
Data: CALHN, SALHN, NALHN, CHSA LHN and WCHN N/MHPPD Reports provided to the ANMF (SA Branch)

Metropolitan and Regional South Australian Public Sector Hospitals 2013/14 - 2015/16 Overnight Occupied Beds Data Summary

Local Network	2013/14	2014/15	2015/16
CALHN Total Beds	**1087**	**1094**	**1071**
NALHN Total Beds	**416**	**416**	**415**
SALHN Total Beds	**634**	**640**	**668**
WCHN Total Beds	178	176	184
CHSA LHN Total Beds	176	185	199
Grand Total	**2491**	**2511**	**2537**

Notes

Data Excludes: Emergency Department Short Stay and Psychiatric Emergency Short Stay Wards, Country small and minimum staffed hospitals

Noarlunga Hospital: 2013/14 Vs 2014/15 and 2015/16 OBD Variance: Surgical Service Model Change - Collins Ward from overnight multi-day stay to 23-hour surgical short stay

Reported Prepared 4 January 2016
Data: CALHN, SALHN, NALHN, CHSA LHN and WCHN N/MHPPD Reports provided to the ANMF (SA Branch)