THE LEGISLATIVE COUNCIL SESSIONAL COMMITTEE GOVERNMENT ADMINISTRATION A MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, ON FRIDAY 10 NOVEMBER 2017

ACUTE HEALTH SERVICES IN TASMANIA

Dr MILFORD McARTHUR, **Dr FIONA WAGG** AND **Professor FIONA JUDD**, RANZCP, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Mr Valentine) - Welcome, all. This is a Legislative Council committee so it is not a committee that has been set up by the Government as such. The Legislative Council is the House of review and has the opportunity to set up committees to look into various aspects of government operations, and that is what is happening in this case. I noticed in your submission that you may have been under the impression that the Government had set up this inquiry and I wanted to make sure that was very clear.

All evidence taken is protected by parliamentary privilege. I remind you that any comments you make outside the hearing may not be afforded that privilege. Today we would ask you to first make an opening statement if you wish - it can be short or long; up to you - and then we will take the opportunity to ask questions after that.

Dr McARTHUR - I would like to read a brief statement and then hand over to my colleagues, who will also make brief statements before any questions. My name is Milford McArthur. I have worked in various roles for state public mental health services, mainly at the Royal Hobart Hospital for the past 28 years and most recently as a staff specialist psychiatrist. Currently I am chair of the Tasmanian branch of the RANZCP.

We believe our college has a duty to advocate for our patients and to deliver high-quality clinical and management services through its fellows and registrars to the people of Tasmania. We think we have an important role in advocacy; for example, advocating for best-practice service provision, which we believe is the thrust of this hearing, or advocating as we do with the coroner for preventative health measures such as the construction of a safety barrier on the Tasman Bridge, which we are now working towards.

As you all know from the media and various other sources, mental health services are currently in a difficult situation regarding the delivery of treatment for patients. Specifically, this involves the admission and treatment of patients and is due to a series of problems. These include long waiting times for patients to be seen by specialist mental health services in the community and difficulty in getting patients with acute psychiatric conditions into inpatient care, largely due to bed block.

Over the last few years senior management decisions were made against the advice of the RANZCP and others, including the AMA and the ANMF, the nursing body, and we think the impact of the decisions made then have now been shown to be very severe. We have attempted to chronicle these events in our submission, and I understand more detail will be gone into in the submission from the AMA later today.

Due to the impact of these earlier decisions, we have to consider what is best for the health authorities to do now for the people of Tasmania, as we think some of these earlier decisions are no longer easily reversible.

We note and regret that there has been some disconnect and miscommunication between management and senior clinicians. We strongly advocate for the retention of locally trained psychiatrists where possible and the recruitment of appropriately trained psychiatrists to the north-west, the north and in southern regions to fill any gaps in service that are currently often filled by very expensive locum services. As part of that issue we would like to see continued work towards the return of college-accredited registrar training, where it is currently absent. This ensures highly trained psychiatrists on the ground to deliver best-practice medicine.

As to the Royal Hobart Hospital, we have to manage the J block with all its problems as best we can, but we need to continue to make rectifying adjustments to improve patient care. In the short-term, as we have to continue in the J block with its limited space and amenity, we need to increase medical resources, both clinical and administrative, for the J block. We have to work to ensure that college training accreditation is regained as soon as possible for the inpatient unit. We have to increase the capacity to manage acute and sub-acute patients, some of whom may need to be outside the undersized and cramped J block, and we have to develop a well-staffed and placed short-stay or observation unit. That is in the short term.

In the medium term, in the K block, when the new hospital is completed, regrettably we feel the situation will not be much improved, as there is only one more bed and the amenity and the space remain poor. We advocate that some areas in the current J block should be retained as psychiatric wards after the K block opens. Potential for use in the old J block facility might include a step-down unit or short-stay unit, mother and baby unit, or child and adolescent unit to supplement the K block wards. This would go some way to address the current service deficits.

All this should be a temporary measure until we think the final goal is realised, which is stage 2 of the master plan. This is what we are really hoping for in the long term. The stage 2 master plan is a modern, built-for-purpose - unlike both K and J blocks - contemporary psychiatric unit on site that was in the original plans, if you look at the diagrams. It should be a tertiary statewide teaching psychiatric hospital, and this could serve the needs for Tasmania for the life of the hospital, which I presume would be 30 or 40 years, because we do not think K will. We also advocate that contemporary medical practice includes both a child and adolescent psychiatric unit and a mother and baby unit, so that is specifically addressing the terms of reference. We are concerned that the situation for the treatment of severely ill psychiatric patients will remain below best practice for the people of Tasmania until stage 2 of the master plan is built and adequately staffed.

Prof. JUDD - I am going to focus more on the training aspects that have been touched on by Dr McArthur. The RANZCP is responsible for accrediting training programs in psychiatry and in Tasmania the activities required to do that are delegated to the Tasmanian branch training committee which is a subcommittee of the bi-national colleges committee for training.

We feel that a robust local training program is key to attracting high-quality medical staff at registrar level, but importantly also it is a key strategy in longer-term workforce development. I think it is well established now that if you think about rural practice - and I think we do have to think about Tasmania as rural practice - doctors who practice in rural areas are more likely to be those who have either lived and/or trained in a rural area. It is not a sensible strategy to bring in

people from the mainland, who tend not to stay and go away again. We need to train high-quality people here for a strong workforce into the future.

The key criteria for accreditation of training include adequate support and supervision by consultant psychiatrists; clinical care needs to be delivered in a manner consistent with contemporary practice and be evidence based; there needs to be a safe work environment; access to formal education activities; and appropriate breadth of clinical experience at a training post. As you have heard, the posts within the inpatient unit of the Department of Psychiatry were disaccredited in August of this year because they did not meet some of those criteria.

We have been particularly fortunate in Tasmania to have substantial federal funding to support psychiatry training. We have 10, or 45 per cent, of our registrar positions funded through the various federal initiatives such as the specialist training program, the training for all specialist doctors for Tasmania and the integrated rural training program posts. Those funds have also included the capacity to provide grants to trainees to access education which would otherwise not be available. This has been fantastic but it is not guaranteed to be long term. It is on a funding cycle and we do not know whether that will be continued.

If we lost those positions that would be half of our training program gone really, because unfortunately over the past several years there have been no new state-funded training posts. We have been very heartened by a commitment to fund some new posts in the near future, partly in response to the difficulties with the disaccreditation of the Department of Psychiatry.

Ms FORREST - From the federal government or the state?

Prof. JUDD - State. We are constantly looking for more federal ones, so next time the ARTP comes up we will apply again, but this is state, which is fantastic.

At various times Burnie, Launceston and Hobart have all been accredited training sites, but currently Burnie is not; there have been no trainees there for three years. In Launceston we have only one trainee and that person will finish at the end of January, and certainly the site is keen to have more trainees but there will need to be some work done to achieve that. As a branch training committee, we are very supportive of that. We have 21 trainees in Hobart, which is fantastic, but as we have both mentioned before, we have lost three training positions currently in the inpatient unit because they did not meet required standards.

It is important to say that despite the problems which have appeared in the media, our training program has been very successful. We have had seven of our trainees this year sit college exams at various stages of their training and all of them have been successful. That is far in excess of the general college results, so that has been really heartening and fantastic for morale obviously.

CHAIR - You mentioned that three were lost because they did not come up to standard. You are talking about the site not coming up to standard.

Prof. JUDD - Correct.

CHAIR - You are not talking about the people.

Prof. JUDD - No, definitely not the people.

CHAIR - I just wanted to clarify that for the record.

Prof. JUDD - No criticism at all of the people, quite the reverse.

In summary, we feel that a high-quality psychiatry training program and accredited training positions, ideally at Burnie, Launceston and Hobart, are critical to the quality of mental health services in Tasmania's major hospitals both now and in the longer term. Thank you.

Dr WAGG - I am Dr Fiona Wagg. I am a child and adolescent psychiatrist of over 20 years experience and I have been in Tassie for the last 15 years as part of the Child and Adolescent Mental Health Services, or CAMHS, as I will refer to it from now on. I am speaking from my position at the faculty of Child and Adolescent Psychiatry.

It is important to say that in preparing the submission I spoke with my CAMHS colleagues across the state, including paediatricians, perinatal mental health services and also child and safety services, so it is a view from a broader perspective than just child and adolescent mental health. The role of CAMHS is to provide care to pregnant women and to young people from 0 to 18, and those with the most severe and complex mental health problems are the ones that get direct care from us. We also provide a lot of support through consultation, liaison, and education and training to the broader maternity and child sector; education, child safety services, child health and parenting services and disability services.

We have a broader role. It is important to say that CAMHS in Tasmania is the most poorly-resourced CAMHS of any state in Australia. We are slightly above half the national average in terms of our resourcing. It is often not well understood that mental illness occurs at similar rates throughout the lifespan. CAMHS is nationally funded to see the most severe and complex, 2 per cent of mentally ill young people. We are funded to see 1 per cent, but actual estimates of the real level of need of severe and complex mental health problems is 7.3 per cent. We are facing vast amounts of need with very limited resources.

There is a really strong neuroscientific and economic evidence base that interventions early in the lifespan, especially during pregnancy and in the first two years of life, are more clinically effective and much more cost-effective than interventions later in life when illness is established. Wellbeing outcomes are cost savings for health, but also for education, employment, welfare, social security and the justice departments.

There are no dedicated inpatient beds for child and adolescent mental health patients requiring hospitalisation for mental illness in Tasmania. These mentally ill young people, around 400 patients per year across the state, so it is not an insignificant number, must be accommodated either on general paediatric units or adult psychiatric units. Admission to an adult psychiatric unit is inevitably traumatic to young patients and is considered a highest-level risk event in other Australian jurisdictions.

At the LGH, North West Regional Hospital and the Mersey, there are no CAMHS hospital-based teams. We have a small hospital-based team for CAMHS in the Royal Hobart Hospital that was established with funding from paediatric money. At the Royal Hobart Hospital we see 224 inpatients per year and 359 emergency department presentations per year. There is no inpatient or hospital-based team in the north or the north-west. This has to be serviced by in-reach from the community teams, which limits the capacity of those teams despite their very

best efforts to give adequate care to those inpatients and emergency department presentations. It also impacts on their capacity to deliver community-based services because they are having to cancel appointments to come in to do that work.

The majority of young people that we see in emergency departments, and that is about 662 statewide per year, present with suicidality. This is a common problem in young people. Only a small proportion of those have major mental illness such as depression or psychosis that needs them to come into hospital. Over half of them have emerging personality disorders, which is a condition that's related to early childhood experiences of adversity, these kind of trans-generational patterns of trauma that are related to poverty, parental mental illness, substance use and domestic violence that impact on the actual development of the brain and their social and emotional capacities. It becomes hardwired into how their brain works. That leads to mental health problems, depression, personalty disorder and suicidality in later life.

There is a developmental trajectory we see from this kind of trauma and family adversity during pregnancy and infancy that impacts on the brain development, to severe emotional and behavioural conduct problems in primary-age kids, and to personality disorder and suicidality in adolescence. This is the vulnerable cohort of patients that are notified to Child Protection Services as infants, who start falling out of school due to violence in primary years, and as teenagers present with suicidality, to Ashley with criminal justice problems, or as pregnant teenagers.

There are interventions that are effective for this really vulnerable group, and that includes: prenatal and infant mental health services for vulnerable pregnant women and their infants and families; interventions in the primary-age group for these kids who are developing conduct problems and severe emotional problems; for adolescents, services like mobile youth outreach teams, which are like adult CAT teams; CAMHS education day programs, where kids can be maintained in education with a therapeutic input at the same time; and what we call multi-systemic therapy, which is where you provide intensive support to at-risk families, which is much cheaper and more cost-effective than bringing them into out of home care and foster care, which we know is ineffective and highly expensive.

It is important to say that these services do not exist in Tasmania. There is no statewide perinatal and infant mental health service. In the south we have been able to redirect some of our CAMHS resources to establish a small team at the Royal Hobart Hospital. They punch way above their weight. They see 13 per cent of all of the presentations to the antenatal clinic at the Royal Hobart Hospital and that is about 250 patients per year. These are women with very severe and complex problems including schizophrenia, bipolar disorder and severe personality disorder.

There is no perinatal and infant mental health service at the Launceston General Hospital or the North West Regional Hospital. There are no dedicated mother and baby unit beds in Tasmanian public hospitals. Benchmarking suggests we should have two in the south and two in the north. There is access to St Helens Private Hospital, but it does not meet the needs of those most severely ill women who need that.

We currently have no mobile youth outreach services, education day programs or multisystemic therapy options for our suicidal teenagers in Tasmania.

CAMHS community teams are significantly under-resourced in all regions of Tasmania. To say if we could adequately resource our community-based services, we could really significantly

reduce demand on acute hospitals; both emergency department presentations and the need for inpatient admissions. This would be much better for young people, who could be cared for in their homes and in their communities.

My final point is, investing in the mental health care of pregnant women, children, adolescents is addressing really high levels of current distress and severe mental illness and is a preventative intervention in the long-term for health and wellbeing and costs in other sectors.

CHAIR - Thank you. Before we go to questions, if at any time during questioning you feel the information you want to give should be confidential, talk to us about that and we can consider that, continue in camera and people will leave the room. I want to make sure you are aware you do have that capacity if the questions dictate that for you.

To begin, can you build a picture as to the number of psychiatrists we have in the state to meet the total state demand. You compare percentages with the mainland, but how far short are we falling of people on the ground to deliver the services required? I am not looking at the positions in the hospitals, but within the profession.

Dr WAGG - You might answer from your perspective and I can answer from a CAMHS perspective, possibly.

Dr McARTHUR - You have to take each region separately because they are so different in their capacity to attract specialists. In the north-west, best I can tell at the moment, there is only one staff specialist psychiatrist who is about to resign. They will be largely dealing with locum people. The can obtain locum psychiatrists. They are very expensive. The north-west is always having to use locums. As far as I know, I cannot think of any in private practice in the north-west of the state.

Ms FORREST - I guess they rely on Launceston to provide some kind of service.

CHAIR - The demands. We look at Tasmania as being around 3 per cent of the population for the nation. We compare with other states, but is the demand higher per head of population that it is on the mainland?

Dr McARTHUR - We think it is. The evidence is because Tasmania is older, poorer and more of us are on pensions, most of the measures of public health are worse in Tasmania.

Currently, you would probably know our suicide rate, I think it is the only state that is rising, but it has risen recently in the last few years. By all those sorts of measures, Tasmania is poorly off compared to the other states, perhaps with the exception of the Northern Territory, as I understand it.

CHAIR - Is there one age bracket that stands out in terms of the rise in those occurrences?

Dr McARTHUR - I cannot answer that, but I suspect it is Fiona's -

Dr WAGG - From our experience, completed suicide is a rare event. We do have high national rates. One death can influence that rate. It is not so predictable, but in terms of actual presentations of young people coming and saying they feel like killing themselves, we had a 10 per cent increase between 2014 and 2015, a 40 per cent increase between 2015 and 2016, and

we haven't got our data yet for the whole year but it looks like another increase this year. It is a very common presentation and, as I have tried to outline, it is very much related to complex factors.

CHAIR - It is not like ice?

Dr WAGG - No, it is the kind of factors that Milf was citing such as poverty, family violence, those things that are impacting on our young people, and getting in early and providing greater support and intervention at that point in time. It is important to say that it can be seen that intervening then is maybe a preventative intervention, but we are talking about infants at very high levels of risk. We know unfortunately that there have been some very serious cases in Tasmania that are related to exactly these conditions we are talking about.

CHAIR - There were no beds available for mothers and babies. It must be very significant if somebody is living at, say, Strahan. How are they accessing services? Do you have any understanding of that? Do they go through the North West Regional Hospital first and then come through to Hobart? How does that work?

Prof. JUDD - Most of them don't come through to Hobart. The north and the north-west can also access the so-called public bed at St Helens, but mostly people don't want to do that because it's a long way from home and it's very disruptive.

CHAIR - At St Helens Hospital?

Prof. JUDD - Yes, at St Helens Hospital here in Hobart. The short answer to your question is they do not get services. Some get some service through the generic adult mental health team but basically they don't get services. They get far fewer services than the women in Hobart can get, for example, and even in Hobart it's a very small team so we can't provide nearly as much service as we would like to be able.

Dr WAGG - And it's not just beds, it's important to say. Those kinds of perinatal infant mental health services exist in every other part of Australia but not here.

Prof JUDD - Most women who have mental health problems will not actually need inpatient care, but they do need other care and that is not available in the north or north-west and is only available to a limited extent here, which is due to lack of staff.

Ms FORREST - Can I take this point up? I am very sad and I have been sad for many years now, because I have sat on committees for nearly 10 years hearing the same thing. What saddens me even more is that I have been banging on for 12 years about the need for early intervention, particularly for pregnant women, because if we are going to make any difference clearly we need to invest more. It is not just the mental health of the mother and family and children, it is the dental care which reduces the risk of premature low birth-weight babies, and a whole range of other things.

Up in the north-west we are seeing a complete fragmentation of the service. We are seeing unhappy midwives who cannot practice easily across their full scope of practice. We are seeing a lot of women having to have their care fragmented, not all of them. Let's just look at the north-west for now. It is not as bad in Hobart, it is not as bad in Launceston, but clearly there are challenges there too. If we were to try to put in place something that would make a real

difference, not in the next election cycle necessarily, which is part of the problem, but for the long-term health and wellbeing of Tasmanian families and women, children, the whole lot of us.

Prof. JUDD - You should start with that. It is broad, isn't it?

Dr WAGG - I think it is. We have been very fortunate to have Fiona Judd come from the Royal Women's Hospital and introduce a model of mental health input into antenatal care where the patients are seen in the antenatal clinic so they don't have to go to a separate appointment and that becomes an integrated part of their care. The teams very much work together across all of those domains you are talking about, so it's not just mental health, as in 'Do they have schizophrenia?', it's actually, 'Are you experiencing domestic violence? Let's work with the social worker, let's work with child health and parenting services', so it's that comprehensive integration of resources led by someone who can hold levels of risk and assess major mental illness, such as a psychiatrist. This is crucial to that kind of care.

We have put in a business case for perinatal and infant mental health services to be developed across the state. There would a team in the north-west, in the Launceston General Hospital and in the south, but in that it is specialist expertise we would have hub-and-spoke models that we could support through supervision and education and training and possibly site visits for services across the state in their establishment. We would see them delivering a model in a very similar way to that which has been developed in the south where you don't make women go to separate appointments for their complex care, whether it is drug and alcohol, domestic violence or mental illness.

Ms FORREST - It's hard enough to get some of these women there in first place.

Dr WAGG - It's very difficult, Ruth, you know that, but the majority do turn up for antenatal care - not regularly, but they come. If they come we will see them and that give us an opportunity to begin to do things like get pre-birth involvement and get an unborn alert process going, which puts supports in place around the family. That is an excellent model that would really make a big difference.

Ms FORREST - In terms of funding, because everything comes down to money, with some mental health services in the community, not so much hospital based perhaps, there is a cost-shifting problem we have where some are funded by the Commonwealth and some funded by the state. We heard yesterday that patients under the NDIS, for example, once they step inside the hospital that stops, when they would clearly benefit from the engagement of their carer or the person who knows their condition and can manage it into the hospital setting. That is something we need to look at.

In terms of mental health, where there is a crossover here, the services are being provided under the state funding arrangement but there are clearly other services that are needed. If you're going to do a patient-centred approach and wrap the services around the patient or the person, is that a barrier or does it work better in other places?

Dr WAGG - Making it an active part of our care plan in CAMHS and in perinatal and infant mental health, we would get those teams together and work together. It is about an individual service ethos. For complex patients in perinatal and child and adolescent mental health, we would have multiple meetings where we get all the relevant players together, NGOs -

Ms FORREST - How is that currently funded?

Dr WAGG - For CAMHS state services brings their parts and the NGOs come from their part and you try to develop a plan together where the roles of each service is clear. There is no extra funding for doing it. Consultation and liaison take a lot of time and effort and we're not funded to do it. When they look at our data, that is not recognised.

Ms FORREST - What would you recommend to address this in terms of how it could be better funded to make it more accessible?

Dr WAGG - It could be factored into what resources you need in state services to do that work. Some of it isn't going to cost money; it's just about an attitude change that this is something that should be an intrinsic part of your work. People live in families and systems and education and other services are involved. You should meet with them and they get much better care if we all do our bit in a clear way. Part of it is a philosophy change but another part of it is about services not being about, 'You only saw five patients today, what were you doing for the other three hours?' 'Actually, in those three hours I was attending crucial meetings about the welfare of my patients'. 'That is great, well done for doing that', not, 'Well, why are your data looking worse than the north-west?'. It is very hard for general practitioners or private practitioners. It would help if there was a way in which they could be funded to do that work. Private practice work is okay for those people who have an isolated problem, but where the problems extend to the school -

Ms FORREST - That comes back to the Medicare scheduling, doesn't it? That is a federal government matter.

Dr WAGG - It does.

Ms FORREST - If they scheduled longer consults and were paid appropriately for it, that could happen.

Dr WAGG - That's right.

Prof. JUDD - Also, if the schedule would support them to come to a case conference that would be good, because that's one of the most useful things we have, where we bring people together and talk about what we are doing and what they are doing and what we are going to do in the next month, six months, who is involved with the baby, et cetera. Not having a GP, for example, is a big gap because sometimes they can be the most important and consistent person for that particular woman or family.

Dr WAGG - That would be very true in suicidal teenagers as well. We always ring them, but in terms of getting them along to a meeting where we clarify what their role would be and how we work together, they can't afford it.

Mr FINCH - Dr McArthur, you detailed our shortcomings in Tasmania in respect of service people and facilities and psychiatrists and also the issues we have in Tasmania. In a perfect world and best-case scenario, what would the numbers be like on the north-west coast, the north and the south of clinicians and people to deal with our issues in Tasmania?

Dr McARTHUR - I don't know if I can specifically answer that, especially for the north-west or the north. I would be guessing at the exact numbers. I don't know if there is anyone else knows.

Dr WAGG - I know the numbers for CAMHS but I don't know the numbers for the rest.

Prof. JUDD - This is the recommended number per head of population figures, but if you take the north-west for example, the remoteness and some of the other issues, probably mean that you need more than what the college would say is the ideal number. I think the college and all practitioners would readily acknowledge that if you're working in Melbourne, which I used to in the past, there are huge numbers of people in private practice and that has a very beneficial effect for the public system because there are pathways other than just being in the public system. So it's not just numbers, it's where the practitioners are and what other supports are available.

That's the other thing. If you're in a large metropolitan area you've got large numbers of clinical psychologists, for example, who are able to see patients. Again, if we go to the north-west, we've got a dearth up there, even general practitioners, for that matter. We have fewer there than we would have in other places, so it's a cumulative kind of thing. It is the system that we have to look at rather than one group in particular.

Dr McARTHUR - You will see from our submission that you can work out the average Australian numbers, which is 12.7, and you can see how far away we are from that.

CHAIR - And that is without waiting, the extra demand.

Dr McARTHUR - That is without the extra waiting, yes.

Prof. JUDD - The thing we're very aware of is that if we look at psychiatrists across the country, Tasmania has the greatest percentage of older psychiatrists.

Ms FORREST - With all due respect to those at the table!

Prof. JUDD - Exactly. It's a worry, isn't it, because we are going to lose a significant part of our workforce in the next 10 years or so without enough new people coming through. In some ways it might get worse before it gets better, which is a great anxiety for us all.

Dr WAGG - In CAMHS, because we work in multidisciplinary teams of psychologists, social workers and occupational therapists, we are about half of what we should be in all regions of the state.

CHAIR - Given the services that are being provided are there to try to get the best outcome for the patient, do you have any comment on the fact that it seems from the information provided that patients are sitting for long periods of time in emergency departments? Can you just outline the detriment of that, if that is possible?

Dr McARTHUR - The first thing to say is that this hasn't been a longstanding problem. I have been working on and off in DEM since the late 1980s, as a trainee initially and then as a consultant, and it wasn't that often that patients would be kept over night in DEM. It did happen occasionally, but as you know and I have brought the figures with us, almost every day over the

last nearly 12 months it has been the case where there have been up to eight or nine or 10 patients in casualty.

CHAIR - This is at the Royal you're talking about now?

Dr McARTHUR - I am talking specifically about the Royal, yes - overnight and some for a couple of nights. This is new. Various people have given various reasons why this might be, including increased demand, and I am sure that is part of the reason, but there are other reasons and they include the lack of bed numbers. It does slowly correlate with the reduction in bed numbers that occurred over the past few years.

Ms FORREST - Inpatient psychiatric beds? Yes.

Dr McARTHUR - Inpatient psychiatric acute beds, yes. We think that is an important cause. It's probably not the whole cause because there are changes in society and perhaps more ice is used now, as someone mentioned a minute ago. Perhaps there are other reasons as well, but certainly the bed numbers are a crucial feature, and this is a fairly new occurrence. It's not as if we have been struggling with this for a long time. It did occasionally happen but not often and never to this extent we have seen in the last 12 months.

CHAIR - Are more people presenting in the north-west and the north?

Dr McARTHUR - I don't know so much about -

CHAIR - In the same circumstance?

Dr McARTHUR - I have heard that it does occasionally occur in the north but I don't know the situation so much.

Dr WAGG - The comments from my colleagues in the north are that they're suffering more from a lack of staff than a lack of beds, so they have different but still serious issues. Speaking from a child and adolescent mental health perspective, our experience is that our young people who need admission are often having longer stays in the emergency department. We had a suicidal young person there for most of the weekend lying in a bed in hospital. We had a 15-year-old young man with first-episode psychosis who was in an ED bed overnight repeatedly trying to leave. He was terrified, a very awful experience for a young man experiencing his first episode of psychosis. In the past we were able to admit them to the adult ward but in a separable unit, but that doesn't exist any longer.

Ms FORREST - Because of the redevelopment?

Dr WAGG - Because of the way they've designed the temporary unit, and it's not factored in for the redevelopment either. Not having youth beds in any mental health facility is just completely out of line with national and international practice. Unfortunately, the last three young people we've had to admit to the adult ward, and despite them having one-on-one nursing and the best efforts of everybody involved, they have been traumatised in various ways. One young woman was sexually touched, another young man was hit, and with another young man, a very disturbed patient came into his room and he was very frightened. This is not a criticism of the people who are sick, but it's just not appropriate to mix very vulnerable young people with adult patients.

As I say, anywhere else in Australia that would be a level 1 risk event, not only that they were assaulted but they were there at all. I think that has been a change in what our facility availability has meant for the care of young people.

CHAIR - The issue of there not being the youth or adolescent beds has been raised and the response coming back -

Dr WAGG - There is a plan in the redevelopment of the Royal Hobart Hospital to develop specific mental health beds in the adolescent unit at both the Royal Hobart Hospital and the Launceston General Hospital. That is at least five years away in both of those cases, and in the meantime we don't have any safe maintaining spaces on paediatric wards; they're in with a mix of intubated babies and three-year-olds having chemotherapy. It's a very difficult mix. Our nursing staff do a brilliant job, but when you've got a very disturbed young person who's trying to constantly leave and the doors are opening and shutting and there is only one room they can be in, they get stir-crazy. It is very hard to give them a single room so often we are having to admit to adult wards just so they stay in hospital. But that's not safe for them either, so we have nowhere to admit safely at the moment.

It is an issue I have raised and they've had to look at how we might try to modify the facility, but again the issues of how short of beds they are and the fact that you would need to sacrifice a bed in order to create a safe space for a young person has meant it hasn't happened.

CHAIR - There would also be issues with staff training too, wouldn't there, because the staff in those wards simply don't have the expertise perhaps to handle those special cases, if you could put it that way?

Dr WAGG - It is true. CAMHS does provide the care to young people who are admitted to that ward and in general they are nursed by paediatric nurses on the ward rather than adult psychiatric nurses, but it is true to say that it is a context in which you would do things very differently if there was an actual adolescent unit. Unfortunately this young man who was very psychotic had to have the injected medication because he refused to take it orally. That was quite traumatic for everybody again because despite everyone's best efforts it wasn't done in a way that it would have been in a specific facility where staff had specialist training.

Ms FORREST - Following up from that, it's not like this is news to us. When I chaired the Mental Health Act review many years ago it was raised then and we have been asking ever since for a dedicated adolescent mental health unit. It's not like we don't know this is a problem.

Dr McArthur, you talked about the redevelopment of K block at the Royal and the current unsuitability of the J block, which is temporary but it's still a little while before K block is going to be finished and you still have to manage in the meantime. People still need the care. You said about keeping some of the J block potentially as a step-down facility or a child and adolescent unit and mother and baby unit. We had a site visit there a couple of weeks ago where it was made clear to us - and other committee members will correct me if I am wrong - that that is a temporary building that is going to be removed and that is part of the plan. Is that your understanding?

Dr McARTHUR - Yes, for lots of reasons. The hospital is a heritage building and it can't stay there permanently but maybe it could stay there for a year or two longer while something else

happened. I don't know if that is technically possible but it would be one opportunity or possibility if that was possible. Surely that would be possible, you would think.

Ms FORREST - Yes. That is something we can ask about. According to you, the current design and layout of the new K block inpatient psychiatric facility does not have any youth space, or for mother and babies and so on. Can it be included or does it need rethinking? How do we address this? It is not a new problem and it is odd to me that it has not been factored in.

Prof JUDD - When we lost the three registrar positions in the adult acute ward, one of the things that was noticed by the College of Accreditation visitors who came was how unsuitable the layout of the ward is. They were very taken aback to hear that in the new ward that is coming, it is going to be the same.

Ms FORREST - The accreditors?

Prof JUDD - Yes, the accreditors. External experts, really. We have said if it is blatantly unsuitable, how can you possibly do something else that is also blatantly unsuitable. We are told that it cannot be changed but the building is not built. Surely, it can be changed.

Dr WAGG - It is important to say there have been strong representations even in the first development that there should be these facilities but they were completely ignored.

Prof JUDD - That is right. Clinicians had advocated very strongly for this.

Ms FORREST - I understand the AMA will address their minds to this later today; they have put in a submission. What is going to happen if we don't do this, if we do not take the chance while it is here?

Dr WAGG - We will have a white elephant.

Prof JUDD - That is our anxiety. If we don't take the chance, we will never get what we need and the services will continue to be totally inadequate.

Ms FORREST - Will there be risk to the accreditation?

Prof JUDD - There will be, yes.

Ms FORREST - If we are going to train and keep our psychiatrists, which is what you said at the outset, Dr McArthur, we have to provide an environment where the accreditors and the college will be happy.

Prof JUDD - Exactly, yes.

Dr WAGG - Also, patients will be safe.

Prof JUDD - And patients will be safe. Patients and staff, I guess. The accreditors have recommended some changes in the current ward as to interview rooms and things like that because of these issues. We are still waiting for the report to come from them. We anticipate there will be strong concern about the repetition of an unsuitable facility for the patients, primarily, but also for safety of staff who work there.

Mr FINCH - You talked in your submission, Dr McArthur, about decisions made against advice given. Is this what you are talking about or are they more historical occurrences of ignoring advice?

Dr McARTHUR - Yes, both of those. I confine myself mostly to psychiatry because that is what I know best. It was probably ubiquitous, though. The senior psychiatric clinicians were very concerned about the design of the new K block, its lack of open space and a whole lot of things regarding the shape of it, the number of beds; a whole group of things.

We put these submissions to various bodies. There were some minor changes made for which we were pleased and grateful. There was some added space, one or two extra beds were included. We did not think it went far enough, especially when one considers this is the hospital for Tasmania, or the major teaching hospital, for the next 50 years. It is not as if it is a temporary arrangement. This has to last and be capable of growing and developing whatever is needed over the next 50 years, or however long the hospital lasts. There is no capacity in K block to expand at all, sadly.

Mr FINCH - Was that about a budget limitation? Was there a concern about the cost?

Dr McARTHUR - I am not sure of that, but space especially, yes.

Ms FORREST - Some would say, and I am not an expert, contemporary ways of managing acutely ill mental health patients, as well as those who are best cared for in the community, dictate that the design proposed is forward thinking and future thinking and we will, whoever 'we' are, will be providing other services, community-based services and so on. For the majority of people with mental illness, hospital should be the last resort and the last place they should be. What do you say to that? I am hearing in some quarters that it is modern, it is contemporary, and that some of these 'older' psychiatrists and others working in the field are stuck in the past. I am repeating what I am hearing from some quarters.

Dr McARTHUR - I have a couple of things to say. I do not think it is contemporary because it is a lack of open space. That is the big difference between it and modern units built interstate. They have space, and there is no space.

Dr WAGG - And separable areas for vulnerable populations, yes.

CHAIR - Are you talking about outdoor areas as well?

Dr McARTHUR - That sort of thing, space, yes. That is the first thing. You were implying we will not need so many beds - not implying - but you said we may not need so many beds if our community services were terrific. That is true, but our community services are not. They have been going backward. We have to get the community services to a certain level before we can even ask if we need so many inpatient beds.

You need a base inpatient bed number and as the community services get better and better over time, which is not happening because we are going backward, you might be able to rely less on inpatient beds. That is true. We do not have either, that is the trouble. The waiting time for most of the adult community services is a couple of months.

Ms FORREST - What is needed to bring the community - this is an acute health inquiry, but you cannot consider one without the other.

CHAIR - It is impacting, isn't it?

Ms FORREST - Yes. What do we need to do in community mental health to reach a point where this may be a suitable structure?

Dr WAGG - I do not think it will ever be suitable.

Prof JUDD - I do not think this will be a suitable structure. As to what we need, if we compare what we have with what some of the better centres on the mainland have, they have acute beds like this will be. They have a significant number of step up and step down beds, which substantially helps community management. We have very little of any of that.

They have much broader-based community teams, so that they have teams who can provide intensive case management. They have mobile support teams, for example, and they have more extensive CAT teams as well as case management. Our teams do 'everything' and there are not enough of them to do everything.

Dr McARTHUR - They do a wonderful job, but overworked and not enough -

Dr WAGG - That is true, as I have highlighted, in terms of having no inpatient beds, having no stepdown unit, having no CAT team at all, having no education-based therapeutic programs -

Ms FORREST - It is part of the whole -

Dr WAGG - Yes.

Prof JUDD - I think the experience has been similar elsewhere in that, sadly, I have been in psychiatry long enough that we went through a phase where it was thought intensive community management would solve all the problems and we would not need beds. I think we are all very clear now that intensive community management is something that only happens in very small places with very small teams that were very expensive and had very committed clinicians. It has never been a model that could be rolled out across the board. If you do not have that, you still need beds.

Ms FORREST - Is there a model we could look at?

Dr WAGG - Can I make one important point? I think, particularly in our population, a very significant number of young people you would meet have serious medical issues they needed to be in hospital for. We could never care for them in the community. Our young people with anorexia nervosa, we really only admit them if they are on the point of death, basically. From a medical point of view we cannot care for those patients in the community, they need a medical bed. Our young people who are presenting with psychosis: we have a very high rate of identifying neurological or neuropsychiatric problems in that population. They need to be in hospital.

We need our medical colleagues to be assisting us with the care that would ensue across a broad range of disorders. It is important to understand that often it is not an inappropriate intervention, it is absolutely the right intervention. They would not be given the care they need if we cannot admit them.

Ms FORREST - Is there a model somewhere around the country that is doing it well?

Prof JUDD - I am most familiar with Victoria. I am sure there are other places that do it well. For example, the Alfred is a major service in Victoria with lots of the various components, or the service based at Royal Melbourne, the NorthWestern Mental Health program -

Dr WAGG - The child and mental health services in Victoria are probably the best in the country.

CHAIR - Do you see the management model employed here in Tasmania as a major or minor issue in the outcomes we are seeing in terms of delivery of services?

Dr McARTHUR - Let's hope that communication improves between senior clinicians and management because if that doesn't happen, things that have happened that we're currently facing will continue to happen. I mean, there is hope if communication can improve and managers listen to senior clinicians. Obviously it will not do everything senior clinicians want, and they have an overview that a clinician will not necessarily accept that, but even so, three of us here are clinicians and we each spend our lives seeing patients. That is what we do. If the managers don't listen to the doctors and nurses who see the patients, it often causes a lot of trouble and we are now seeing the result of that.

Dr WAGG - I might elaborate a bit on that. I hold a clinical leadership position in CAMHS in some ways, as well as my direct clinical care role. I would like to see very much more engagement and collaboration. We have a highly professional, skilled workforce, not only in psychiatry but in medicine more generally, but also in our other professions, and I think far too many decisions are made and delivered downwards rather than there being engagement and collaboration around what might work best. It is ineffective in terms of actually developing best responses and also in terms of getting on board with change, which needs to happen. Compared to other places I have worked, it is very noticeable that there is not that same degree of engagement in change management and being able to scope a problem and look at what all the potential solutions might be rather than impose a decision without actually looking at what the data suggests might be the best outcome, which is not good practice.

CHAIR - Given the model that exists at the moment with the Tasmanian Health Service and the regional circumstances that exist, is there any one particular aspect of that management that needs to change and listen to the clinicians? Has it become too amorphous? Is it a fact that we still need more on-the-ground management and clinical leadership in each region, even if it is basically administratively managed from one location?

Dr WAGG - In some ways the issues for CAMHS are a little different from other areas but I probably speak best from that perspective. From a child and adolescent mental health perspective, we're very keen to become a statewide service because there are economies of scale we could develop by putting together our expertise across the state that would support the delivery of services in the north-west that don't currently exist. CAMHS teams across the state already have strong clinical leadership within their own small teams, and we want to maintain that. I don't think you ever make a service work by taking that away from the day-to-day running of a service. I think you need the statewide organisation to integrate services and develop economies of scale and best-practice models, rather than reinventing the wheel in each region, which is not sensible.

CHAIR - It should assist the bottom line in any event, which is the real issue that the administration has about keeping within budget.

Dr WAGG - It just delivers better care to patients. It is about sharing that expertise and those models of care that are evidence based where you can, but also making sure that people regionally are supported to identify the solutions that work for them within that kind of model.

Prof. JUDD - That's a really important point because although we talk about statewide, the areas are actually very different and the way in which people need to work in those areas to work effectively are very different. What works in Hobart won't necessarily work in the north-west. We see that all the time in other states, where metropolitan services are run very differently from rural services because of the various needs and opportunities or the gaps that might exist in those various places. Having local input as well as the broad-based stuff is very important.

Dr WAGG - And again, I think Victoria in terms of mental health services has done better than others with hub-and-spoke models.

Mr FINCH - Professor Judd, you mentioned training facilities in Tasmania. Where are we now and where you think we should be - what is that difference? What would be required to get us to where you think we need to be to provide that development for new people to replace the older people?

Prof. JUDD - We need to have training at the three sites. We need to have trainees at Burnie, Launceston and Hobart and effectively with one trainee in Launceston, at the moment we really only have training in Hobart. There needs to be a substantial investment in both those other sites but that will require recruitment of psychiatrists to support those trainees. We spoke with Launceston yesterday and they are actively working very hard to do that, and I know there is an intent to try to do the same for Burnie. If we start retiring at a great pace, we will need to graduate a significant number of trainees each year. At the moment we probably graduate one or two and that rate we certainly can't keep up.

Dr WAGG - We need more than replacements, though, we need to significantly increase our numbers.

Prof. JUDD - Yes, absolutely. There needs to be system-wide changes to support more trainees and more trainees in turn will be what supports our system in the longer term. It is important to say, though, that over the last several years training has moved forward substantially. It was a much smaller program only a few years ago. With those federally funded positions we have expanded dramatically. We have been very fortunate in that and the training committee and the director of training have worked incredibly hard to get that federal money. It has also meant we can provide what is called specialist advanced training for people. For example, we have a child and adolescent psychiatrist who has been home-grown, so to speak, who will shortly finish, and an old-age psychiatrist who is shortly to finish, so as well as our general psychiatrists we are managing to develop some sub-specialty expertise, which is absolutely critical for our services. We can't emphasise enough the importance of investing in that part of the service for both the short and long term.

Mr FINCH - When you talk about the disconnect between management and clinicians, is a request like this falling on deaf ears? Are you being listened to in respect of trying to progress these thoughts?

Dr McARTHUR - There is some evidence that may be changing. Certainly that was the situation some years ago, so I am hoping that will change.

CHAIR - Thank you very much for taking the time to put the submission together which obviously has a lot of information in it and for coming here to talk to us this morning. We really appreciate that.

THE WITNESSES WITHDREW.

Dr FRANK NICKLASON, CHAIRMAN, MEDICAL STAFF ASSOCIATION, ROYAL HOBART HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATON AND WAS EXAMINED.

CHAIR - Thank you for coming, we appreciate it. We thank you for your submission, which is interesting with some of the responses you have received back from doctors. Dr Nicklason, what is your position?

Dr NICKLASON - I am the chairman of the Medical Staff Association at the Royal Hobart Hospital.

CHAIR - All evidence taken at the hearing is protected by parliamentary privilege but any comments you make outside the hearing may not be afforded that privilege. A copy of the information for witnesses has been made available. Have you read that?

Dr NICKLASON - Yes, I have.

CHAIR - The evidence you present is being recorded and a *Hansard* version will be published on the committee website when it becomes available. Should you reach a point during the questioning where you feel you want to make confidential statements, you can alert us to that, we can discuss it and allow you to make an in camera submission, if you wish. Would you like to make an opening statement?

Dr NICKLASON - Thank you for bringing this inquiry together. It is an important thing that has been achieved, just to have the inquiry. Also, thank you for the opportunity to present to it.

One of the things I wanted to briefly say is there has been some very negative press - opinion pieces in the *Mercury*, for instance - about the performance of the Royal Hobart Hospital and I want to give a counterbalancing statement about that.

My experience of working at the Royal is that there is an incredible number of devoted staff who are working in very difficult circumstances, particularly over this last winter where we have had unprecedented pressure on beds. The actions of many have been bordering on heroic. Not only is the Royal Hobart Hospital the secondary hospital for the south of Tasmania, we are also the tertiary hospital. We have a big interest in what is going on in the rest of the state but we are also a major training and teaching hospital. We have had extraordinary success with our trainees over the years but this year, despite all the stress we have had, we have nine out of 10 of our physician trainees passing their clinical exams, all of the trainees in anaesthetics passed and all the paediatric trainees passed. That is an extraordinary performance and gives the lie to any people who are suggesting the Royal Hobart Hospital is somehow populated by people who are slack or don't know what they are doing. It is important the committee understands that.

As to service provision, the Royal Hobart Hospital is a very busy hospital. We have patient flow that is absolutely consistent and often better than interstate hospitals. That is because we have to, because we have an inadequate number of beds. I have listened with interest to the last part of the submission from the psychiatrists. Once again, there are similar themes. One of the themes you have heard is there has been inadequate engagement and attention to sincerely-held

views, opinions and ideas for reform in the hospital to help us deal with the challenges; service, training and teaching related.

Just to amplify that, I am going to give you a specific example of what can happen in that situation. I am going to be referring to a meeting but I am not going to give you the date. It was in September this year -

Ms FORREST - This is an actual meeting, not a scenario?

Dr NICKLASON - This is a meeting that happened with the Minister for Health and a number of senior managers within the Mental Health Service. At that meeting particular individuals, three of them, were named to the minister as a source of difficulties being encountered in the delivery of service at the Royal Hobart Hospital. I was informed about this as the chairman of the Medical Staff Association. A number of statements were made about this in the letter of information.

The first was that representation of it being individuals that were the principal obstruction was considered as completely inaccurate. The person who wrote this said -

> It is considered that ineffective leadership and management of mental health services has resulted in an alienated and demoralised workforce.

Three individuals were 'inaccurately blamed and defamed'. The difficulty is not just getting access and the respect to have your opinions, advice, experiences or suggestions listened to. It is the case that some people, who delivered really important information that could be helpful, have been singled out and treated in that way. That is worthy of noting.

I am a geriatrician. The patient group I am particularly responsible for at the Royal Hobart Hospital, along with patients with mental health problems, are amongst some of the most vulnerable patients that attend the Royal Hobart Hospital. I have given you a submission with respect to the issue of our really poor compliance to the National Emergency Access Targets, which are a nationwide requirement. For those people who require admission to hospital from the emergency department, we should be aiming to have somewhere between 60 per cent and 80 per cent of those patients admitted within four hours.

The reason for that is the emergency department, as you can well imagine, is a high stress place. There are 23 beds, or cubicles, in the emergency department at the Royal Hobart Hospital and there are four resuscitation bays. If you walk into the emergency department at 8 o'clock any morning there is an average of something around 15 to 16 of those cubicles occupied by people who have been admitted, but for whom there is no bed available within the hospital. New patients coming into the emergency department at the Royal Hobart Hospital may have to wait in the waiting room on chairs. They may need to be interviewed on chairs in the emergency department. You can imagine their comfort issues, the difficulties of performing an adequate examination and the privacy issues. This is all clear.

There are also patients who are required to be in monitored areas in the resuscitation bay. The access to those areas, being only four beds, is a difficulty. There have been a number of situations over the winter period, as predicted by senior clinicians at the Royal Hobart Hospital, where every single bed in the emergency department has been occupied by someone who has been there, often many hours, and who has already been admitted but a ward cannot be found.

Unfortunately, the representation of that problem in the media has been difficult. There have been times when people have not told the whole truth and nothing but the truth about that. They have said that our NEAT compliance is something like 60 per cent. That is for all patients who enter the emergency department. Only one-third require admission. The Royal Hobart Hospital's emergency department is very efficient and we are good at getting patients home, sorted out, who do not need admission. It is important to concentrate on those patients who require admission from the emergency department.

Ms FORREST - Frank, are you saying that the NEAT reporting should be broken down into those being discharged, those being admitted and those going elsewhere?

Dr NICKLASON - Absolutely. There is another complication. There is also an emergency medical unit called EMU. The EMU is for patients who may require 24 hours or thereabouts. That data should be differentiated as well. It is really important to differentiate that data. That has not always been done and it has caused some confusion. Sometimes that confusion, unfortunately, has been deliberate.

Why is it so important? I have already said the emergency department is a high stress place. It is uncomfortable, busy, noisy. It is not a great place for people with mental health problems or elderly, frail people with complex medical problems, often with delirium.

We know, from data that comes from the Princess Alexandra Hospital in Brisbane, that if we can achieve better a NEAT compliance for admitted patients, the risk of certain groups of patients dying in hospital goes down. There is a paper that is headed, *Who is less likely to die in association with improved National Emergency Access Target (NEAT) compliance for emergency admissions in a tertiary referral hospital?*, and not surprisingly, it is those older patients with complex medical problems.

The second submission I have made relates to a survey I participated in with my executive colleagues in the Medical Staff Association. You have had a look at that. It was done in August. It was a survey. We had 81 respondents. Overwhelmingly, the respondents were very senior clinicians at the Royal Hobart Hospital and they were saying some things that really reflect that my media presentations and those of other people are very much the mainstream view. It is not just a few people who are dissidents, are looking for trouble and get off on telling bad news. Not at all.

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One of the questions was, 'To what extent do you feel that value is placed on your opinions and suggestions about services, problems at the Royal Hobart Hospital?'. Sixty per cent of those people surveyed said they were either somewhat dissatisfied or very dissatisfied.

Maybe most troubling of all is this question. People were asked to respond to a question about executive decisions impacting on the provision of safe and quality care at the Royal Hobart Hospital. This is one of the statements people could agree or disagree with, out of five statements. There is a real gradation. 'I do not get the sense that safety and quality of patient care is regarded highly when critical executive decisions are made'; 51 per cent of these senior hospital staff had that as the statement most accurately representing their opinion. Thirty-seven per cent agreed with a somewhat watered down version of that. Sometimes and somewhat, rather than a more polarised statement.

With respect to the roll out of the THS process, another thing that is typically misrepresented is that the Royal Hobart Hospital represents a fiefdom, that there are people who are anti-change and who just want to hang on to what they have got; their empire. That is not borne out by the attitudes of people I talk with. I do not know when I last spoke to someone who was not strongly in favour of their being statewide strategic planning and compliance structures that look over the whole of the state. There was very strong support for the THS roll out.

What there is not support for, or what there has been trouble with, is the implementation of the THS roll out. That has been regarded as majorally problematic by around 70 per cent of people. Worse than that, a lot of people, 42 per cent agreed to this statement: 'There have been serious errors in the roll out of the THS project.'. As a result of this - speaking just for the Royal Hobart Hospital here, which is all I am able to speak for - there has been a governance failure at the Royal Hobart Hospital.

When I drill down talking to people about that, they say that resources have been removed from all the hospitals, Launceston General Hospital, North West Regional Hospital, Mersey Community Hospital, Royal Hobart Hospital, to create a centralised bureaucratic and somewhat micromanaging structure that is not delivering the kind of support and help required at each of the local hospitals.

Regarding the redevelopment of the Royal Hobart Hospital, people were asked to give their opinion about how that has been going. Again, there are some troubling responses. Errors of implementation and planning have occurred. When legitimate concerns have been raised by well-informed, well-intentioned frontline workers at the Royal Hobart Hospital, those concerns have not been well addressed; not attended to by people who are in a position to listen and to make changes based on that information. Fifty-three per cent of the respondents agreed with that statement, and 35 per cent agreed with a somewhat watered-down version of that statement.

THS function is regarded as creating disengagement, demoralisation; is highly centralised, micromanaging and bureaucratic. Really importantly, there has been insufficient attention paid to the teaching and training roles at the Royal Hobart Hospital and other hospitals; from personal communication, not from my survey. Staff are regularly feeling stressed. They feel that their health issues related to working in a stressed environment have not been sufficiently addressed.

When asked about the factors that seem to be driving executive decisions, about 85 per cent say that political factors, rather than data and evidence about what would work, are too often a driving factor. They say that financial considerations are a driving factor. I have specific examples if you wish to ask me about those. I think I have gone on long enough, thank you.

Mr FINCH - I have so many questions. If you could clarify for me please, you are talking about coming into the emergency section with there being something like 15 beds or 15 places already occupied and waiting to go into the system. What are the implications of that system of getting people allocated to beds? I wonder whether there might be a shortcoming in the communication within the system, when you have somebody being discharged, then having to clean, prepare the ward bed for the person to move into it? I wonder if that time lag creates some sort of extension of the NEAT time of moving people from the emergency department into a ward bed.

Dr NICKLASON - I am not saying it has never happened. What I am saying is that we had a review done of our emergency department by Staib and Sullivan from the very hospital who

have improved their NEAT compliance a great deal. I know the hospital has taken on board as many of the recommendations they can of that study. It is regarded as a whole-of-hospital problem and that there is a great deal of efficiency in terms of maintaining patient flow. If you take general medicine, which is one of the engine rooms of the hospital, our length of stay is substantially shorter than equivalent hospitals around Australia and New Zealand. I do not feel there is evidence that this is an inefficiency problem across the board. I'm not discounting there may be times when something could have been done better, but I believe that is not the predominant issue.

Mr FINCH - This is a general question about this survey, comprehensive and from the people who you feel matter strongly in developing evidence like this. What will happen with this survey apart from the presentation to us now?

Dr NICKLASON - It does help the staff to feel that at least there is some way of expressing their concerns about the system. It is useful for me as spokesperson for the MSA to know that when I am talking to the media and senior executives in the THS, I am not just talking out of the top of my head, I am representing in a very mainstream way the view of the members of the Medical Staff Association - and might I add, very mainstream. There was plenty of opportunity for people to make their own comments on this survey and some of them were not repeatable in polite company.

People can be assured that I and other people who are representing the problems in the hospital pay very close attention to not wanting to raise concerns in the general community that the hospital is dysfunctional. The hospital works remarkably well, considering. The problem is we do not have enough beds, and that is well demonstrated when you look at per capita beds around Australia.

Mr FINCH - About the survey, doctor, we heard earlier from Dr McArthur that there is a disconnect between management and clinicians. If you want to progress this evidence to management or the minister, would you feel there is a disconnect there that might not be taken on board or received as well as you would like?

Dr NICKLASON - I don't like to make across-the-board statements like that. There has been in the last few months some, if you like, green shoots at the Royal Hobart Hospital. There has been a reconstitution of an executive structure at the Royal, with stream leaders, very good people in those and other executive positions which are very good and I feel very comfortable presenting information to them. I believe that there is really serious dysfunction within the THS. It is not a group of people who are able to get on because of strong personalities and a rather autocratic leadership, in my opinion.

Ms FORREST - Are we talking about the management level?

Dr NICKLASON - Yes, within the THS executive, and that is known because there has been a survey. There has been a review by Deloitte that shows the executive dysfunction. Pressure needs to come on to have the findings of the Deloitte review made publicly available, because we can't have the same situation that occurred when we had a review of the emergency department by Sullivan and Staib which was completed in August last year and didn't see the light of day until some time earlier this year. That must not happen again. This review gives information that tells us what we need to do with respect to governance, safety and quality, and it must be released as quickly as possible.

CHAIR - Is that review only for the Royal Hobart Hospital or is it statewide?

Ms FORREST - It is the THS.

Dr NICKLASON - That's right.

CHAIR - With respect to the survey, you say 64 doctors responded.

Dr NICKLASON - There was a total of 81; that is the latest figure. When I sent that in it may have been 64, so sorry. It is now 81.

CHAIR - How many would it have been sent to?

Dr NICKLASON - Probably about 160 or so.

CHAIR - So it is a 50 per cent response, which is probably not unusual. Is that 160 the total complement of doctors in the Royal Hobart Hospital or is that just your members?

Dr NICKLASON - I targeted senior doctors.

CHAIR - With respect to the management model which you touched on a little, do you have any observations as to the type of model that would be better employed to see acute health services across the state better managed?

Dr NICKLASON - I can just really talk to principles. I have been pretty much a clinician all my time and I'm not the best person to ask that, but the principle is that there definitely needs to be statewide strategic planning structures that audit the compliance to safety and quality of care and credentials et cetera.

Ms FORREST - HR, payroll - that sort of thing?

Dr NICKLASON - Yes, all of those things. We have to get that in Tasmania we are all together and we have to make decisions for the whole of the state. We have to recognise that there are some parts of the state that are very much under-serviced by medical specialists. I work partly in the north-west and partly in Launceston. I originally come from the north-east and now I am here. That statewide overview must never be at the expense of the local structures and the ability to make correct decisions quickly on the ground at the local hospitals. It is very difficult to be tasked with the job of being in a centralised executive structure and responding to things that are happening a distance away.

Mr FINCH - Is there an inadequacy there, do you think, in respect of that ability to be a flexible management operation in the various locations?

Dr NICKLASON - Yes, and that has been one of the key things the various medical staff associations around the state have been concerned about. Probably one of the key failures of the way the rollout has occurred is that it has taken away local decision making from each of the hospitals, not just the Royal.

CHAIR - This is probably not an easy question to answer but how much do you think this is impacting on bed block, for instance, the decisions that are not being able to be made at various points of time that stop patients from being discharged, for instance, and therefore creating that bed pressure?

Dr NICKLASON - I don't think it operates so much at that level. In the paper that Staib and Sullivan produced based on their work at the Princess Alexandra Hospital they identified a number of ways of reducing bed block regarding the ED need compliances, a whole-of-hospital challenge, if you like, and identifying ways that patients who no longer need acute care can be managed in a different site. They identified two things that mean all of the good work the hospital might be doing could be overwhelmed, and there is no surprise what those two things are. One is insufficient beds, and we have insufficient beds and that is known. The other is an overwhelming event, and I'm not saying that we should plan for that; it isn't what we can cope with, it is a sudden inundation if there was some disaster.

CHAIR - Like Port Arthur?

Dr NICKLASON - Yes.

Ms FORREST - Even the flu season would almost count for that this year.

Dr NICKLASON - But that is predictable.

Ms FORREST - That was predictable, yes.

Dr NICKLASON - Yes, it is, and the problem there was that at a time when we knew we were going to get a flu epidemic in the winter, which we always do, we got a bad one, the vaccine probably was not up to scratch and we'd lost flexible bed capacity because there had been miscalculations about the numbers of beds we would need when B block was demolished.

CHAIR - That was hard to forecast, I suppose.

Dr NICKLASON - No, I'm not sure if I have understood it correctly but I will just touch on something. In the weeks before the demolition of B block, probably in November or late October last year, a group of us from the Medical Staff Association had a video meeting with the minister and we asked him to consider what was happening at the Royal because we were at a point where it was really obvious that we had insufficient decanting options. B block was being decanted, but at any time on that block, which was going to be demolished in just a few weeks, there were 40-odd patients that would need to squeeze into 22 beds in the J block demountable structure on Liverpool Street. At the same time, there was an average of somewhere between 12 and 15 admitted patients in the emergency department. This was before the demolition.

It wasn't rocket science. It was clear that we were going to be in a much worse position with the demolition of B block, so we asked the minister to delay the demolition until we could identify adequate decanting sites, which we didn't have at that time. There were things that could have been done that would have eased it a little bit which subsequently got done, but it was a little too late and a little too little.

Ms FORREST - This is a big-picture question, Frank. I know you are a clinician and not an administrator, however I think you could shed some light on this. Say you are now the health

minister, congratulations. Where would you start? What would you do? Would you look at key priorities to addressing the challenges? They are being identified throughout the submissions and the evidence, but where would you start as a clinician in making sure that patients get good outcomes? I wanted to briefly take you to one of our terms of reference.

Dr NICKLASON - I heard what Fiona Wagg said earlier about the modelling of problems and looking at what we have. In order to model properly you need to have people of good heart and experience and knowledge about the system as it is, and that has been a really clear fault that was identified by the previous three witnesses. That is a start. We need to have a look at what evidence we have already and there is a lot of evidence that we are severely under-resourced for acute public hospital beds. That evidence is there. For instance, Martyn Goddard has made a report on that that was released in December last year, to very little response.

Ms FORREST - So it is the resourcing of the beds, not just the beds themselves?

Dr NICKLASON - It's the beds and the resourcing. We're short on beds and we're short on the staff that are required for the beds. We need to take that on board because we know that is causing this symptom which we see in the emergency department, because it is a symptom, it's not the whole problem, that we do not have enough beds. And it is also a symptom that the people who can make the decisions that would rectify this, like the minister - myself - have not recognised or responded to that clear information that is there. It is evidence that has not been listened to or heeded. Unless that changes, we're not going to get anywhere.

Ms FORREST - So to paraphrase your answer, we first need to work together with the people who have the patience, knowledge and experience to understand more fully where the problems are, or do we already know the problems?

Dr NICKLASON - I think we know a lot of the problems and a lot of the solutions. What we don't have is the commitment to the people of Tasmania who are very dependent on the acute public hospital services. In Hobart, that is the northern suburbs. I do one clinic a week in the northern suburbs. When I see patients there they're regularly telling me if they've had a recent hospital admission, which is a group of patients I try to see who were bounced out of hospital very, very quickly, and the sorts of support services available to get them functioning well back in the community are a bit ropey.

Ms FORREST - Can I take you briefly to term of reference (5) -

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

What impact is it having?

Dr NICKLASON - It is huge. It means that there is a reverberation right through the hospital. Patients admitted acutely into general medicine have to be gotten out of hospital within three or four days. Decisions have to be made to get people out before they are really ready in some situations. The capacity to provide restorative rehabilitation care is less than it should be. The stress that then exists in the community is there, trying to provide services for those people. I really hope you are going to be hearing from someone from general practice because my discussion with general practice colleagues is that they are having to look after sicker and sicker people and keep them at home because they know that when people come into hospital they may

get what we call 'bounced' or they may have very brief admission that really doesn't get to the root of the things that are really required.

CHAIR - Are you saying it creates further problems rather than fixing things?

Dr NICKLASON - Yes, it can do, because the hospital at the moment is quite a hostile environment for frail people with complex care needs.

CHAIR - We have run out of time, Frank, but we thank you for taking the time to put in your submission and to come and present. It is always important to hear from the coalface. I am sure we could have another hour dealing with this. It is appreciated.

Dr NICKLASON - Yes. I have to get to work very quickly now so I won't be hanging around. Thank you.

THE WITNESS WITHDREW.

Dr RICHARD BENJAMIN, AND **Dr STUART DAY**, AMA TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to the Government Administration A Subcommittee Inquiry into Acute Health Services in Tasmania. This is a Legislative Council inquiry. It is not an inquiry that the Government put forward. It has been decided that we will do this. As we are taking sworn evidence, we need you to make a statutory declaration. If you could each undertake that and state your position as well being here, please.

Messrs BENJAMIN and DAY - Yes.

CHAIR - Thank you. All evidence taken at the hearing is protected by parliamentary privilege. Any comments you make outside of this hearing may not be protected. You have a copy of the information for witnesses statement. Have you read it?

Messrs BENJAMIN and DAY - Yes.

CHAIR - This session is being recorded by *Hansard* and it will be published on the committee website when it becomes available. We will provide an opportunity for you to make a statement prior to members asking questions. If during the questioning or at any time you feel there are statements you wish to make that you would like to be in camera, you can make us aware of that. We can consider your request and proceed from there.

Dr BENJAMIN - Thank you, Chair, I have a statement. The AMA welcomes this Inquiry into Acute Health Services in Tasmania and is grateful for the opportunity to contribute. The AMA has two major roles: to promote the interests of medical staff; and to promote the healthcare needs of patients and community. In advocating on behalf of its members and the community, the AMA has a role in challenging governments on policy that may harm the interests of patients. It is in this area that the AMA has been most active with respect to the redevelopment of the Royal Hobart Hospital and the provision of acute psychiatric services at that hospital, particularly in relation to the closure of acute psychiatric beds.

Before going into detail with respect to service provision at the Royal Hobart Hospital, it is important to note that Tasmania has some of the worst health and socio-economic indicators in the country. Tasmania has, for example, low levels of education and health literacy; high levels of obesity and chronic illness; and are an older population on average. Unfortunately, Australian Bureau of Statistics results released in September of this year, the data from the year of last year, 2016, revealed that Tasmania now has the second highest suicide rate of any Australian state or territory, at 17 deaths per 100 000 per year, with the Australian average sitting at only 11.7 deaths. Tasmania is the only state or territory to show an upward trend with respect to suicide deaths over the last three years.

These factors taken together suggest that Tasmania needs higher than average levels of expenditure on health and mental health. However, figures show that at the Royal, southern Tasmania now has a very low number of acute psychiatric beds in comparison to national figures. Across the state, Tasmania has the lowest number of public sector adult community mental health workers of any Australian state or territory.

With respect to psychiatry and mental health, the AMA believes over recent years that policy errors have occurred in two important areas. First, the focus on community care at the expense of

acute hospital care with the associated closure of acute psychiatric beds. Second, the centralisation of bureaucracy leading to policy decisions being made out of context, an inability to make decisions at regional levels and the gradual disengagement of clinical staff.

Moving to the issue of acute psychiatric bed closures at the Royal, the Tasmanian Government's submission to this inquiry explicitly stated that one of the key aims of these reforms is to shift the focus of the Tasmanian mental health system from hospital-based care to the community.

The AMA holds that with respect to acute adult psychiatric beds, this position is out of step with the rest of Australia and with the OECD in general. OECD figures from 2013 reveal the average number of total psychiatric beds across member countries is 68 per 100 000. Australia has only 39 beds per 100 000. Germany has 121, France 89 and the UK 54.

Australian Institute of Health and Welfare figures for 2014-15 demonstrated that the national average of acute psychiatric beds in Australia, beds in general public hospitals like the Royal, sat at 24.2 per 100 000. Before the redevelopment, the Royal had 42 such acute psychiatric beds, or approximately 27 beds per 100 000. The government looked at bed utilisation figures within the Royal over a three-year period, from July 2011 to July 2014, and demonstrated what they referred to in documents as a slight downward trend with respect to occupancy. The government used these statistics to justify cutting 12 beds. Various lobby groups, including the AMA, repeatedly petitioned the government to reverse these planned bed cuts, concerned about eventual bed blocks, but these efforts were largely unsuccessful. The current temporary acute psychiatric unit in the demountable facility only has 32 beds, and K block, the more interim facility, has 33 beds.

The government cut the acute psychiatric bed stock gradually over several years, starting in 2013, so that by the time that B block in the old psychiatric wards were demolished and the move was made to the new temporary demountable unit in late 2016, the total number of acute psychiatric beds available at the Royal was only 32. This number of beds equates to only 20.4 beds per 100 000, almost four beds per 100 000 under the national average. Bed block began to occur as beds were cut and by early 2017, the new unit was essentially permanently bed-blocked, as the AMA and other lobby groups had predicted.

The effects of this bed block have been both widespread and dramatic. Acutely ill psychiatric patients with various associated risks are no longer able to access specialist help in a timely way. Some simply leave the Royal and others wait for days in the emergency department. There are now often four to six patients waiting in the emergency department for a bed and on occasion there have been 10 or more.

In addition, on average, the AMA understands that another one to three patients await acute psychiatric beds from medical and surgical beds at the Royal and other patients await beds from the community. Appropriate treatment is frequently delayed, risks are protracted or increased and illnesses are prolonged. For patients who do get into a psychiatric bed, the pressure to discharge is such that they are often sent home prematurely. The coroner has ruled in one case that bed block was the critical factor in a patient's suicide and the AMA fears that more very serious adverse events will occur.

States such as South Australia have cut acute psychiatric beds and watched waiting times in emergency departments increase, but they have already reinstated their beds and seen the waiting times reverse.

Ms FORREST - Over what time period was that, do you know?

Dr BENJAMIN - I have a graph I can pull out and show you with respect to that.

Ms FORREST - That would be helpful later on. That would be good.

Dr BENJAMIN - The bed closures have also severely affected local clinical staff, who are often distressed about the inability to have patients admitted when at need or at risk, or are overworked with a need for very high patient turnover, and morale in this sector of mental health is very low.

The Royal Australian and New Zealand College of Psychiatrists' decision in August of this year to remove the accreditation of training posts at the Royal was thought to be in large part due to the bed cuts, with trainees both mentally and physically exhausted as result of the high workload and working conditions.

The Government has responded to the ongoing crisis with two series of strategies and the most recent change proposal to open a mental health observation unit at the Royal. Although the strategies listed are laudable they do not address the basic problem of insufficient acute psychiatric beds, even though the second document titled 'A Plan to Deliver Improved Patient Flow' states that there has also been a continuing increase in both a demand for service and client complexity over this 10-year period. Strategies include enhanced communication and changing the usage pattern of some non-acute beds but strategists at the AMA do not believe this will significantly assist with bed block.

The most recent strategy to address bed block at the Royal involved the development of a mental health observation unit. The change proposal was received on 5 October 2017, with the unit to open on 30 October. The proposal essentially involved accommodating up to eight psychiatric patients in one room, with little or no amenity. The unit was to be freestanding, and the AMA could not find a precedent for any such unit in Australia. The AMA felt the change proposal was for a unit that would be unsafe, untherapeutic and therefore unfit for purpose, and gave this feedback to government. The AMA is uncertain where the change proposal currently stands.

The development of this unit followed a pattern the AMA has become familiar with over recent years and involves a senior management culture generally reluctant to proactively seek senior clinical advice and a culture that does not readily incorporate clinical feedback. This pattern is evident from the correspondence included in the AMA submission to this inquiry. In the case of the mental health unit, the CEO of the Royal Hobart Hospital, Susan Gannon, had been meeting regularly with both the AMA and the local college of psychiatrists to locate a site that could be renovated to accommodate 10 acute psychiatric patients after they had been admitted to the current temporary demountable unit and could more safely be managed as lower risk. At the same time the CEO had been developing a plan for a five-bed multipurpose short-stay unit that could more safely and appropriately care for a mix of medical, surgical and psychiatric patients.

CHAIR - Is that the EMU you are talking about?

Dr BENJAMIN - No, this is at the side of the transit lounge.

Ms FORREST - They showed us around the back where they were building it the day we were there. I think that is the one.

Dr BENJAMIN - As the AMA understands it, mental health services took the space allocated for the short-stay unit at the Royal for their own mental health observation unit. The background to these types of decisions being made involves a loss of regional authority over psychiatric services at the Royal, with mental health services taking over responsibility approximately six years ago, with work first being carried out at New Town and more recently at a statewide level.

With management off-site, many medical positions were also lost. These included an on-site clinical director, a psychiatrist for the Intensive Care Unit, and a second consultation liaison psychiatrist for the medical and surgical wards. All losses were important, but the loss of the on-site director was particularly important with respect to day-to-day governance issues and advocacy for resources.

These cultural factors were also involved when management decided early in the redevelopment process to decant all acutely unwell patients to the hospital that currently caters for psychiatrically unwell older patients in Lenah Valley, a decision that the AMA successfully opposed. The same factors were at play throughout the period during which the plans for the temporary demountable unit and K block were created. The relevant lobby groups were only able to marginally influence unit bed numbers, unit placement, size and design and, as a result, the AMA believes that both units are or will be substandard. The most obvious issues relate to the seriously insufficient number of beds and the fact that neither units are on the ground floor, so that patients are unable to easily access the outdoors and green space.

Although on the surface it seems obvious that the current crisis in adult psychiatric services is due to the loss of the 10 acute psychiatric beds, the AMA believes that the majority of the current problems could potentially have been averted if management had been more meaningfully engaged with their clinical staff and relevant stakeholder groups, if they had seriously considered thoughtful feedback from a range of stakeholders, and if current trends in psychiatric practice had been carefully studied.

Before finishing the statement with recommendations, it is important to recognise a number of positive aspects regarding psychiatry and mental health in Tasmania. First, there are many very highly trained, very experienced and very caring staff working many different sub-specialties. They are all very keen to contribute. There are also many well-meaning and very experienced managers in the system.

The AMA also believes the Tasmanian Helpline is the only statewide facility in Australia. With the restructure in the south of the state in 2006 to three one-stop adult community mental health-themed shops providing both acute and ongoing community care, the system, from Helpline to adult community team, is more streamlined and efficient than those in other jurisdictions with multiple entry points and multiple community teams required to cover different functions.

The introduction of a psychiatric emergency nurse, or PEN, to the Royal quite some years ago has also been a great advance for emergency psychiatric care, although with bed block the work has become exceedingly difficult. The Tasmanian Psychiatry Training Program also has a

very good reputation across the country, with a very high pass rate for our trainees. It is important to note that no trainee was disadvantaged with the disaccreditation process. All junior registrars at the Royal were relocated and over 20 registrars currently continue in training. The training disaccreditation has also brought local and national attention to the difficulties at the Royal. As a result, two locum psychiatrists were rapidly employed to assist with the care of patients. The process gave more impetus to the need to find a solution to bed block.

With respect to solutions, the AMA asks that the Government, in retrospect, concede that the decision to close 10 acute psychiatric beds at the Royal was not sufficiently evidenced based. This decision has been the most significant contributor to bed block. After all, the number of acute psychiatric beds at the Royal is now well below the national average and the number of patients awaiting beds roughly approximates the number of beds lost and needed back in the system.

The AMA would also like to see recognition that acute psychiatric beds are a basic necessity. These beds cannot be replaced with non-acute beds or any other form of care in the community. Tasmania deserves to have at least the national average number of acute psychiatric beds and the AMA would argue that additional beds are necessary to cater for both increased psychosocial disadvantage and the increasing number of mental health-related presentations to the emergency department every year.

As such, the AMA recommends that the Government urgently identify a site that, with modest renovations, 10 acute psychiatric patients could be admitted to. These patients would have already been admitted to the temporary demountable units at the Royal for safety and assessment reasons, so some compromise over unit fit-out would be acceptable.

The AMA also suggests that consideration be given to keeping the temporary demountable unit open when K block becomes available because of the shortfall of beds in that unit. Another option would involve keeping open any other additional acute space that is renovated in the short term. The AMA also recommends that thought be given to carefully designing a contemporary psychiatric emergency care centre, or PEC, collocated within the emergency department, for low risk patients. Such a unit would need to be built in addition to an extra 10 acute psychiatric beds at the Royal Hobart Hospital, or nearby.

The AMA does not support the current plan for the mental health observation unit. The AMA believes very strongly that all acutely unwell and at-risk patients should be admitted to the purpose-built temporary demountable unit, in the first instance for safety reasons but also because that unit provides some therapeutic space.

Importantly, probably most importantly, the AMA recommends the government immediately set aside funding and begin designing stage two of the master plan for psychiatry at the Royal. This second stage involves a purpose-built, state-of-the-art facility on the corner of Campbell and Collins Streets. The need for such a unit has been acknowledged in multiple official documents because of the limitations of K block. Such a unit would allow for a greater number of beds, a more contemporary design and greater access to the outdoors and green spaces. Such a unit should also include some youth-specific beds and a mother and baby unit, and would accommodate in the order of 50 or more patients. The AMA cannot stress highly enough that need for such a contemporary unit to be built to cater for the needs of those patients in southern Tasmania who require an acute psychiatric admission.

The AMA also believes it is vital for psychiatric services at the Royal to be run by an on-site clinical director, one who can develop strong relationships with senior staff, other craft groups at the Royal and with relevant staffing bodies elsewhere.

More broadly, the AMA would also like to see clinicians at all levels more meaningfully appreciated and engaged by management.

Ms FORREST - I don't like to use the term devil's advocate, but I am going to use that as a way of testing you and your evidence. I appreciate the amount of detail, thank you.

One of the points you raised frequently, throughout the written submission and your verbal contribution today, is the decision of the government to reduce the number of beds, and the design and layout of the new facility in the K block at the Royal. You said you believe the decision to remove beds was not evidence-based. Some have said to me this is the new way; it is a new contemporary design and it meets the needs. We should not be putting people in hospital necessarily; it should be more community-focused, community-based. I want you to reflect on -

Dr BENJAMIN - I do not think there is any malice in any of that in any way. I think there are different paradigms and they are running at different time frames.

Ms FORREST - If you can explore that, I also wanted to ask you specifically for the evidence you can provide to the committee about the appropriate design of a mental health service, not only the inpatient -

Dr BENJAMIN - Do you want me to start with beds first?

Ms FORREST - The whole bit. Even though this is about acute health services, in my mind you cannot separate them.

Dr BENJAMIN - If you can let me be very broad, I will step right back to how people who are in distress are assisted in society.

If you step right back to the very beginning, people who are distressed, in the first instance, are supported by their family and friends. Then they are often supported by their church and sporting clubs. After that, they are usually supported in primary care through general practitioners, private psychologists, private psychiatrists. For people with severe mental illness, they almost inevitably come to the public mental health system and the public mental health system can be split roughly into two different parts. We are talking now about adult care, inpatients and outpatients. We don't talk about outpatients; we talk about community because it is more than just outpatients, it is run by a team. We need inpatient care and we need community care. Community care has become more complex over the last 10 or 20 years with the addition of the community sector organisations who provide psychosocial support in the community.

We have two different paradigms. You will know, because of the advent of anti-psychotics in the 1950s, the deinstitutionalisation process began when we were able to treat people with severe mental illnesses with medication. The huge numbers of beds that were used around the western world gradually diminished over a period of about 50 years. There is a very strong sense across the western world now that, that deinstitutionalisation process has gone far too far.

There is a lot of talk in the international literature now about the number of beds required to manage psychiatric illness. Those numbers of beds across the OECD are extremely relevant. What we don't have in Australia is an agreed benchmark for what is required. We only have averages. The OECD is very important. They feel in England that at 54 beds per 100 000 they have gone way too low. We have 39 in Australia and in Tasmania we have gone under the national average for acute psychiatric beds. Even though that bed number is not an agreed benchmark, it is an inordinately meaningful number.

This is what happened in South Australia when beds were cut. The process takes a long time to unfold and a long time to reverse. In South Australia they cut 40 acute psychiatric beds.

Ms FORREST - In 2011, was it?

Dr BENJAMIN - I am not exactly sure of the dates because this is in South Australia, but you can see the process unfolds over quite a long time. There is a direct relationship between the number of acute psychiatric beds and the wait times in emergency departments.

Ms FORREST - It's over a 10-year period.

Dr BENJAMIN - That has clearly unfolded in the local environment. Those beds in South Australia were reinstituted.

Ms FORREST - Some of the evidence you have referred to, particularly the OECD numbers, do you have references you could provide to the committee? That would be helpful.

Dr BENJAMIN - Yes, and they are all in the submission.

Dr DAY - People seem to become confused when we talk about psychiatric care: it would be sensible to be in the community. Let us talk about pneumonia because people understand pneumonia. You get pneumonia, the majority of people stay at home with their GP giving them some antibiotics. They feel rotten for a week or two and then get better, but you still need the high-end hospital, both the acute medical ward and an ICU, for those tip-of-the-iceberg people who are severely unwell and may die.

Ms FORREST - And people do still die.

Dr DAY - That's right. We have pushed what we can do for somebody's pneumonia to infinite levels. We regularly put people on cardiac bypass for pneumonia.

It is exactly the same in psychiatry and mental health. You have people who are severely unwell and the people coming through the front door are not the people who have a little bit of pneumonia or a little bit of mental health issues. They have all gone, they are in the community and the teams are effective at keeping them out of hospital. The people you are getting through the front door of emergency departments and acute hospitals are severely unwell and are going to need high level care that isn't available anywhere else. This is an important component of the whole care of a community.

Ms FORREST - In the design of the new K block, if you look at the evidence you have around the most patient-centred, effective, outcome-based care in the design of the unit, it should

be a blank canvas, shouldn't it? There is a new building being built, you are building a new inpatient psychiatric facility and you're saying it is not -

Dr BENJAMIN - Unfortunately, it didn't happen that way.

Ms FORREST - I understand that from your evidence. What evidence do you have about how it should be designed? What is the best practice, evidence-based, contemporary design?

Dr BENJAMIN - Moving from the number of beds to how the beds should look, there are a number of important basics. The user group involved in the designs were given a number of parameters that were already set, so they didn't have the start point you were referring to. They didn't have a blank canvas. Should you have a blank canvas, there are a number of things you must do. Setting aside the number of beds that are required, there are certain design features. That is, psychiatric units, wherever possible, go on the ground floor. They go on the ground floor for an obvious safety reason and for more economic access to outdoor spaces. If you read any of the guidelines for the development of psychiatric units, you will see that they repeat over and over again that outdoor spaces are not luxury spaces, they are a primary part of the psychiatric unit. You need to be on the ground floor.

Ms FORREST - Or a rooftop garden?

Dr BENJAMIN - It would need to be designed thoughtfully enough to incorporate the components, given the space that you have.

Ms FORREST - Yes.

CHAIR - And considering the safety issues.

Dr BENJAMIN - And considering the safety issues. Ground floor is important. The way you design a psychiatric unit is very different to the way you design a medical and surgical unit. Medical and surgical patients are generally deemed to be bed-based patients. Psychiatric patients are not generally deemed to be bed-based patients. This is important when you are talking about mental health observations units and the emergency department.

We must make some acknowledgment that the current designs do have some contemporary value to them. They are ligature-free, for example. They meet all the guidelines in that the bedrooms are around the outside of the building so that you have access to natural light. Because of the building envelope, when you do that, you have a limited space. You cannot do all the things that you would normally do with a contemporary design.

The second-last iteration of contemporary mental health unit design was called 'palm and fingers'. The accommodation units would be the fingers and they would look out into natural light, and the fingers of accommodation units would open up into the palm, where there was a range of social, dining, recreational and outdoor spaces that were contiguous so that there was an enormous sense of space.

If you looked at the old PICU, it was 750 square metres. It was a bit underground, but it was large. It had a large area you could circumnavigate, and outside of the nurse's station there was a dining area, a TV and socialisation area, which opened out onto an outdoor area. All of those spaces were together so you had a sense of space as well as space, as well as making sure the

outdoor area and the indoor socialisation and recreational areas are all together so it also feels large. None of the units incorporate any of those designs. We, in lobbying the Government -

Ms FORREST - That is the proposed -

Dr BENJAMIN - No, the current units.

Ms FORREST - The current J block, but also the K block?

Dr BENJAMIN - J block and K block are very similar, really.

Ms FORREST - Yes.

Dr BENJAMIN - They are very similar. Just going backward, the AMA sought the plans from the hospital for the unit we used to have in B block. Unfortunately, they were not able to be located. The AMA estimated the area of the B block psychiatric unit was approximately 4400 square metres. J block is now 2200 square metres. It is half the size of the old block. Even though it was seen to be a bit dingy and dark, it was large, it had internal courtyards and it had access to blue sky.

The J and the K block designs are both smaller. They do not have modern designs so that they feel spacious. They are industrial in look rather than domestic in feel, and they do not incorporate many of the modern contemporary designs that you would read about or see in some other places. They have added some outdoor units after lobbying by the AMA, the ANMF and the college. They have added some quasi-outdoor areas to both J and K block but they are very small. They are very different to being able to walk out into a garden.

Ms FORREST - What impact does the design have on the extended factors contributing to adverse patient outcomes?

Dr BENJAMIN - The larger the space you have, the less you will need to use medication, the less overcrowding you will have and the fewer incidents you will have. There will be direct correlation between the size of the unit and those incidents.

Ms FORREST - Length of stay? Is that affected at all?

Dr BENJAMIN - I am not sure of that question.

Ms FORREST - A patient who is admitted to a psychiatric unit will have varying lengths of stay.

Dr BENJAMIN - They will have varying lengths of stay.

Ms FORREST - If you have the more open space and the more contemporarily designed unit, does that have an impact on their length of stay?

Dr BENJAMIN - I do not know if there is any research on that, but it intuitively makes sense that there would be an inverse relationship between the therapeutic nature of the unit and the length of stay.

Ms FORREST - That is going to affect your bed block issues, because people do not need to stay as long as they recover more quickly. There is no evidence, it is only anecdotal?

Dr BENJAMIN - It is only anecdotal. I did not want the opening statement to take up the entire time so I did not put everything in it. The length of stay and getting out of your own space is also important. The average length of stay in Australia is over 15 days. The average length of stay in the Royal is just over 12 days because of the pressures. The average length of stay in England is 30 days. We do not have enough beds here and we are pushed for time for patients -

Ms FORREST - Do you consider the UK model is evidence-based and best practice?

Dr BENJAMIN - The UK is already starting to think they do not have enough beds. They have more than us and their patients stay in them for longer, and they are already starting to think they have gone down the community path too far - and we have gone further.

CHAIR - Looking at the second page of your submission, you make a statement –

> It is only since management of psychiatric services at the RHH has been outsourced that resources - particularly the acute beds and medical staff - have been lost to the RHH.

Can you explain what you mean by 'outsourced'? Outsourced to whom?

Dr BENJAMIN - Dr Day might be able to chip in here about how hospitals are run because he is more familiar across the craft groups. Psychiatry is always a little bit out of step because most of psychiatry is out of the hospital. If you look at most of the craft groups in the hospital, most of the work they do is in the hospital and most the people who run those businesses have traditionally been in the hospital. That was true for the Department of Psychological Medicine, the Department of Psychiatry, it had numerous names between 1994 when I arrived and about 2011. There was an on-site clinical director and they have a line of authority straight up to the Royal. That person left in about 2011, I am not exactly sure of the dates, but about six years ago mental health was taken over by Mental Health Services, which came from outside. There was no on-site clinical director and the lines of authority went out to Mental Health Services.

Dr DAY - The acute psychiatric wards in all our hospitals were not part of the hospital at all. They were a separate entity even though you could walk down the corridors and see them.

CHAIR - You are saying that the Mental Health Services unit within the department manages it, not within the hospital?

Dr BENJAMIN - Yes.

Ms FORREST - Do you believe you could still have a statewide Mental Health Service if there was a local medical director?

Dr BENJAMIN - Absolutely.

Ms FORREST - We heard evidence this morning from other psychiatrists suggesting they would prefer a statewide model for planning and strategy, et cetera, but there is a need for local clinical leadership. Is that the model?

Dr BENJAMIN - There is also something about ringfencing your funding, so that if you don't have someone advocating for your own area and the funding is not ringfenced, and there is a bigger picture to look at, then there is a danger of losing resources in a particular area.

Ms FORREST - I think all disciplines would say the same.

Dr BENJAMIN - Except that the proof of the pudding is in the eating with respect to this situation, in that the Royal has only lost resources since the management have gone off site.

CHAIR - With regard to the north and north-west, you are the AMA so you come with the state in your purview. Do you have any comments? Acute services within hospitals aren't being provided with beds in the north and north-west, I presume?

Dr BENJAMIN - There aren't -

CHAIR - In the north-west? There are not any beds?

Ms FORREST - Yes, there are beds.

Dr BENJAMIN - Let me explain.

CHAIR - Can you explain?

Dr BENJAMIN - I will explain the best I can. The first caveat I would like to give is that the AMA is a member-based organisation and has almost no members in psychiatry north of Oatlands, so we have very little information.

Mr DAY - The reason we have no members is because we have no psychiatrists north of Oatlands. It is hard to get a member that does not exist -

CHAIR - I suppose you are right there.

Dr BENJAMIN - therefore we get much less information.

If you reasonably think that the north and south of the state are roughly equal in population, the north of the state has 39 acute psychiatric beds and the south of the state now has 32, which is why you are hearing the feedback about bed numbers.

The north of the state has 39 acute psychiatric beds and the south of the state now has 32, which is why you are hearing the feedback about bed numbers. The north of the state has more psychiatric beds acutely than the south of the state so you won't hear so much about bed block from that area, but that is also because there aren't many permanent staff there as part of the furniture to be giving that sort of feedback.

Dr DAY - Richard, how many psychiatrists are there south of Oatlands?

Dr BENJAMIN - A lot more than there are north of Oatlands.

Dr DAY - It is a factor of 10 difference.

Dr BENJAMIN - It is something like that. If you were to have a meeting here that all psychiatrists from the public sector would attend, there would usually be 20 or more people in the room. If you were to have a meeting in the north-west with staff specialists, I'm not sure there would be any people in the room - maybe one.

Dr DAY - There might one and a half, I think.

Dr BENJAMIN - In Launceston, the numbers have gone up and down quite a bit over the last few years. They are down at the moment but are building up again.

One more thing to say about the comparison between the north and the south, the north only has acute psychiatric beds and outpatient care. It doesn't have any of the other resources we have in the south. It has no step-up, step-down beds. It has no long-stay facility. Millbrook Rise, although that is a statewide facility, has no detox unit and no Wilfred Lopes unit or Roy Fagan Centre.

Ms FORREST - I am from the north-west and we rely on the Roy Fagan Centre for psycho-geriatric care.

CHAIR - The one in Lenah Valley?

Ms FORREST - Yes. On that point about the dearth of permanent psychiatric trained specialists and other staff in the north of the state, what has been done regarding workforce planning? I know that some of you, and perhaps not so much you, Richard, but others are getting older. We are all getting older but some of them are probably closer to retirement than you might be, for example, so what has been done in the workforce planning space?

Dr BENJAMIN - I will ask Stuart to make some comments about the market allowances because that may be a contributing factor.

Dr DAY - That is probably a reasonable comment to make. Tasmania doesn't pay the going rate, so it's not sexy in dollar terms to come to Tasmania.

Ms FORREST - For psychiatrists or across the board are we talking?

Dr DAY - Psychiatrists are generally hard to come by and across the industrial landscape across Australia they are at a higher remuneration in order to attract them. We have had significant problems in the industrial sphere with how the Government employs people because most of the psychiatrists are in the community and therefore don't have access to some of the money they pay specialists within the hospitals. Getting some way of paying and compensating for that has been very difficult. Government and its agencies have been tripping over themselves, calling any payments above award illegal. They have been paying them for years but they have decided they are all illegal now. That has been a difficult thing industrially to actually get them on a level paying field to pay the same, so that is a big driver. The other issue is that once you get your numbers down to a low number, the whole thing becomes very unattractive.

Ms FORREST - Unsustainable, yes.

Dr DAY - Yes, just because of that normal interaction. Our Hobart colleagues can have an interaction and 15 people turn up.

Ms FORREST - So the peer support and the back-up for each other is just not there, is that what you're saying?

Dr DAY - That is right, once you are down to a low number. Acute psychiatric services and even community services are a 24/7 problem to cover and I don't know how you split one and a half people 24/7.

Ms FORREST - And give them a meaningful quality of life.

Dr BENJAMIN - Has there not been some move to add an extra allowance for the north-west?

Dr DAY - Yes.

Ms FORREST - Financial incentive?

Dr DAY - Yes.

Ms FORREST - Has the AMA done any modelling on the cost over the last 10 years of employing locums predominantly in the north of the state in psychiatry - as far as I am aware, that is pretty much how it has been run; they have had some psychiatrists up there - compared with paying them a rate that would be commensurate with what mainland psychiatrists get?

Dr DAY - Yes. Locums have a role and the costs on the bottom line may seem expensive, but that is what it costs. Tasmania does not pay particularly much more than anywhere else in Australia for locums.

Ms FORREST - No, but you rely on locums all the time.

Dr DAY - We don't necessarily think a flip from relying on locums to permanent staff will save you a significant amount of money. It will save you some money, but what you gain from your money is a continuity of care and a building of a service because you have people invested locally in the community to want to make things better. With a locum-run service you get a two-week 'thanks for coming' in-and-out service, then you get another two-week in-and-out service.

CHAIR - It's not likely to be the same person?

Dr DAY - It is unlikely. Sometimes you are lucky and get a longer-term person, but their investment is not there and it is going to be, 'I've got a bit of free time so I'm getting on a plane to go home', whereas if you live in Launceston or Burnie that is home.

Ms FORREST - So from the Government's point of view the cost may not be that different overall. The barriers, as you describe them, still appear to be that psychiatrists are not paid as much in Tasmania as they are in other places. Then, when you get down to a very low critical mass of specialists and your peer support and opportunity to have time off is very reduced, as is access to CPD, it must be nearly impossible to get away to do anything. Are these the factors?

Dr DAY - The other big factor is you are essentially crisis managing every day. Having time to chew the fat and plan a better service locally just does not exist because 'The locum's not coming today, how are we going to fix this today?'.

Dr BENJAMIN - I will give you an example of that which is quite incredible. You would think in a small state that many of the services would be roughly the same, but there are inordinate differences between the services and a lot of them are based on historical and geographical anomalies, like the ones we are talking about. In the south of the state we have the same population roughly as the north of the state. In adult community mental health services we have approximately 1100 patients in the south and 500 patients in the north.

Ms FORREST - That are getting treatment.

Dr BENJAMIN - That are getting treatment.

Ms FORREST - There must be a lot out there who are not.

Dr BENJAMIN - That is a very, very big difference.

CHAIR - That's the question, isn't it - how are they going to identify them?

Ms FORREST - They're just managing, or trying to.

Dr BENJAMIN - The systems that are somewhat demedicalised work out different ways of managing that may not always be in the best interests of the patient cohort.

Mr FINCH - Doctors, I want to explore a section of your submission here about management culture and the lack of meaningful consultation. You suggest there is a general reluctance to incorporate senior clinical advice. Tell me about that, and whether you can foresee a change or an improvement in that circumstance that might benefit patients and benefit the system.

Dr BENJAMIN - I don't know how to answer that question. The reason the AMA is here is because the old patterns of having conversations broke down some years ago. The pattern that has developed is repetitive. In the documents you have you will see that the plans for the PAPU and the move of patients to the Roy Fagan Centre about four years ago were signed off on. The process had been agreed internally and then the consultation began. It was only after the consultation that the plan to move all patients to the Roy Fagan Centre was successfully opposed by various lobby groups, so the process doesn't usually unfold in the right order.

The mental health observation unit change proposal is a particularly good example. The change proposal was received on the fifth and the Government wanted to open the new unit on the twentieth and have a consultation period which could not possibly unfold in that period of time.

That process continues. It began with the PAPU, which was a proposal that if B block psychiatry was going to be removed they were going to have a unit much like the mental health observation unit in the same place at the Royal for all new patients, and all other acute patients were going to be transferred to the Roy Fagan Centre, which is out of step with all contemporary practice around Australia, where all acute psychiatric patients are managed in general hospitals. So that process was agreed on to a certain extent and then it went out to consultation and had to be reversed rather than a group of people having a conversation at the beginning about what facilities

were around, what resources were around, and what would be the best mix in coming up with a plan that everyone had some buy-in to and you move forward from that. That process is repeated. As to whether I can see things changing, I don't know the answer to that.

Mr FINCH - You suggest there is insufficient understanding of contemporary public mental health principles and I am just wondering whether you perceive, as the evidence we have heard earlier this morning, that there is a feeling of alienation and demoralisation. Do you get a sense of that as well?

Dr BENJAMIN - Absolutely; the staff in the system are absolutely crying out. The first consultation session was held on 9 October 2017 in the Keith Millingen Lecture Theatre, about 50 staff were there and there was an enormous amount of distress in the room about the change proposal, how quickly it had been put forward and how it didn't really embody any of the things we would want to see for acute psychiatric care.

Mr FINCH - Is this from the minister down, do you think?

Dr BENJAMIN - I couldn't possibly answer that question. These decisions are made in other areas.

CHAIR - With respect to those staff coming together to express what they did, how impacting is it on the staff as opposed to the patients they are trying to deal with to exist in the situation they have at the moment and with the way it is being managed? Are you finding you're getting more people affected physically or mentally as a result of this circumstance they have to live with?

Dr BENJAMIN - Absolutely yes. I don't have any figures about sick leave and workers compensation, but morale is very low and people are very stressed.

CHAIR - And that's from clinicians down?

Dr BENJAMIN - That's across the board. A lot of it relates to the work that has been done over the last number of years about predicting what was going to happen. We all knew very well what would happen, it has exactly unfolded and now we need to reverse the situation by putting the staff back where they were before. The ironical thing is that the new mental health observation unit has a staffing quotient of about the same as an acute psychiatric ward.

Ms FORREST - You also made a comment about adequate resources not going to the community sector either.

Dr BENJAMIN - Yes. We have to be very careful about what we call the community sector. Before I answer that, there was something else about paradigms that I might usefully talk about. There are two paradigms. There is a medical acute psychiatric care paradigm and there is a psychosocial in the community recovery paradigm, and they are overlapping but not the same and are both running in parallel. The community sector rightly wants more resources to in an appropriate modern and civilised way provide support for people in the community, and perhaps the nursing and medical fraternity see more that there is a need for acute psychiatric beds, as Dr Day was echoing a minute ago. Both of those are really important, but what has happened is that the emphasis has been moved to the community at the expense of the hospital to a point where everyone has become so distressed, and this sort of came about because the National

Mental Health Commission announced two years ago that something like $1.5 billion needed to be removed from the acute sector and moved into the community sector. A community sector paradigm for some years has been to encourage the movement of resources from acute to the community psychosocial community sector and it is very hard to know where the right balance is.

Ms FORREST - It seems there needs to be an expansion of both to ensure that patients who need to be cared for in a hospital setting can be and those who are better served outside of a hospital setting can be.

Dr BENJAMIN - Absolutely. I don't think we could possibly have any argument with that. You had a question about the community sector which I did not answer.

Ms FORREST - You made some comment that resourcing was not beefed up either.

Dr BENJAMIN - When you talk about treatment outside of a hospital, there is treatment in primary care, there is treatment in the public community sector and there is treatment in the CSO sector. As we understand it from the 2014-15 AIHW figures, Tasmania has the lowest number of adult community sector workers.

Ms FORREST - Across the board?

Dr BENJAMIN - No, that is general. The numbers are separated out for general, child youth and -

Ms FORREST - I am saying across NGOs and the public -

Dr BENJAMIN - I don't know whether those figures are aggregated but if so, I haven't seen them. The AIHW figures talk about all the money that goes into the public sector.

Ms FORREST - Is that state money we are talking about?

Dr BENJAMIN - It all comes through the state but some of it comes from the feds. The CSO money typically comes from federal money and goes through the state and out to the community sector organisations. There is a table, if you would like to see it, which outlines exactly how much money is spent in each sector.

Ms FORREST - That would be helpful.

Dr BENJAMIN - Which you don't have.

CHAIR - Can we table that?

Dr BENJAMIN - I can't table the top part of it but I can table the rest of it.

Ms FORREST - We can get that from you later then.

CHAIR - You can pass it through by email to Jenny.

Ms FORREST - There was one other point in your submission that says in the context of the upcoming state election the AMA wrote to Mr Ferguson asking him whether the state

Government would acknowledge that bed block had arisen as a consequence of beds being closed, and whether the state Government would make a commitment to reopening acute mental health beds in the short term and allocating more beds to K block and to the creation of a second stage more state-of-the-art acute mental health unit. We have heard some evidence about that this morning from our previous witnesses. You said the letter was sent on 28 June this year, calling for a response by 14 July. You had not had a response at that time. Has the AMA had a response to that letter since?

Dr BENJAMIN - No.

Ms FORREST - Okay, we can take that one up. Maybe they're waiting for a pre-election promise or something. It hasn't been called yet, as far as I know - I'm being facetious, sorry.

CHAIR - My previous question about beds was to do with perinatal and adolescent beds and the north-west not having any there. I am wondering whether you have a comment from your members as to how that is impacting on the services they deliver.

Dr BENJAMIN - My first caveat is that the people who spoke this morning will be far more knowledgeable than me.

CHAIR - That is okay. If you can't add any more that's fine. It is not a problem.

Dr BENJAMIN - I can, but this morning you had advice from a perinatal psychiatrist and a child psychiatrist. There has been in southern Tasmania a private mother and baby unit with access to a public bed.

Ms FORREST - There is only one public bed, as I understand it.

Dr BENJAMIN - The fraction of that has moved into St Helens. It used to be half a bed and I'm not quite sure what it is now. We have had access to a bed but it has been under the limitations of whatever the private system can do, so we're not able to take the people we would like to be able to. I have been here long enough to remember that back in the 1990s we did have a mother and baby room in the public sector and we would certainly like to be able to have access to facilities for mothers and babies. We understand that both the north and the south are going to get specific child and adolescent beds going forward, but we think that-

CHAIR - Only two beds?

Dr BENMJAMIN - I don't know the detail, but we do think there is certainly more need for staffing in those areas and inpatient facilities at both ends of the state.

Dr DAY - My only comment is - and correct me if I am wrong, Richard - that child and adolescent psychiatry is a sub-specialty and, like anything in the north and north-west, you are dealing with smaller numbers, so attracting those sub-specialists when you cannot even attract a general psychiatrist becomes more difficult. Yes, those communities need access to those sorts of beds but whether they are ever realistically going to be staffed with our smaller numbers is a different discussion.

Ms FORREST - In terms of prevention, and I ask you this as you are a clinician, Richard. We heard this morning about the importance of early intervention and early identification, particularly of women at risk when they are pregnant. We know young children are exposed to family violence and a range of other unfortunate experiences, which can have a negative impact

on the child's mental health. There is value of intervening in a pregnancy and providing support to women, before their baby is even born, but is not being delivered. What is your view on the need to invest in that area?

Dr BENJAMIN - In some of those questions I am finding I am in complete agreement with you. The entire zero-to-five age group needs an enormous injection of funding because the amount of resources you can put in there pays huge dividends down the track. That includes perinatal and postnatal. The first three or four years is thought to be the most important part for brain maturation, where the possibility of things going wrong are much larger and the input of resources will create a much greater yield.

Mr FINCH - There are nine recommendations in the submission from the AMA. Are they in order of importance?

Dr BENJAMIN - I would have to see them again.

Mr FINCH - I am curious about the first recommendation. If they are in order of importance, I would like you to talk about the urgent response required for those 10 acute psychiatric beds to be reopened.

Dr DAY - Being acutely psychiatrically unwell, you could imagine being locked in a room like this, in an emergency department for three or four days, is not going to do you any good. If you were locked in a room like this, it would be a luxury because at least there would be some space. You are locked in a room not much bigger than a bed, in a noisy, always lights-on environment. Having access to beds within a hospital that is an appropriate environment, even though it is not ideal, is still more appropriate than the emergency department. It is absolutely essential. I think it is a failure of our system to keep an acute, psychiatrically unwell person in the emergency department any longer than they need to be.

Now, they have to stay in the emergency department for a short period of time. You need to make sure they do not have a medical condition that is causing the problem and some people need a bit of time to work that out. We are talking hours, not days, so it is essential there is a capacity in the system to move people out of the emergency department.

Mr FINCH - Are these in order of importance? Is that a critical factor of your submission?

Dr BENJAMIN - Let me answer that question. The reason I showed serious hesitation in agreeing there was a ranking was that the recommendations involve multiple craft groups and multiple regions of the state and it would be unfair to try and prioritise.

Having said that, the acute psychiatric bed issue is of enormous significance. The coroner made it very clear that at least one death has been due to bed block. The coroner is investigating another death that occurred in the waiting room of the emergency department, where a patient hanged himself. Given that there are two competing paradigms, acute psychiatric care and psychosocial care in the community, it would be inappropriate of the AMA not to emphasise that this is the most dire need: to replace what has been removed in a way that is suitable and safe for patients.

We can acknowledge the mental health observation unit plan from the government is a plan that has been put together to do something to try to help. We think the space is inappropriate and might be used in better ways. Something needs to be done very quickly to respond to the need or

terrible things will happen. Terrible things are already happening. People have been trans-institutionalised. They are being arrested as they are leaving the hospital. They are not getting treatment. Their manic illnesses are going for longer.

The other thing that happens when you first come in to the system is if you see that the system does not work, it does not help with engagement. There are lots of issues with engaging people because the front end of the system is very problematic at the moment. This is an enormous problem.

If I could leave the inquiry with two issues, it would be that we need an urgent response for 10 beds in which people can stay for two weeks. The MHOU may have changed over the last two weeks, I have not been to recent meetings, but the plan was for five beds and three recliners in one room for up to two days. We need 10 beds for people to stay for up to two weeks. That is absolutely urgent.

CHAIR - Would it be off-site from the unit?

Dr BENJAMIN - What would be appropriate would be the best fit for what we have now, that would be something that would have to be worked out with the Government. The Government has something like 300 or 400 facilities around the state. We would presume something could be identified that was suitable enough. That is the first thing.

The second thing is that although there are some positives in J and K block that were not in B block, there are lots of deficiencies, even in comparison to B block. For K block to be a semi-permanent solution would be a very damning testament for this current regime and for the care of psychiatric patients.

Mr FINCH - With the AMA being such an august body in the system, with these nine recommendations you have put here, do you feel that you will have success in wanting to drive the points through to the Minister for Health? Is there an open channel to dialogue with the minister, for him to have an understanding of these nine?

Dr BENJAMIN - I hope so.

Dr DAY - Yes, there is an open channel. He is aware.

CHAIR - Thank you for putting your submission together. You have given us a huge amount of communication material and if we need to look at the finer detail, we can.

Dr DAY - Can I make a comment about that huge volume? It is really a case study. We could have put that together for medicine, surgery or any other. Life is too short to do that too often. Hopefully what you are seeing is an example that we have a system that is not right.

Kerry asked about administration and managers. It is important to note it is hard; it is hard to find a neurologist for northern Tasmania, it is hard to find good medical administrators or system managers. It is a tough job to run a show where the needs will always outstrip the available funding. Unfortunately, we have not managed to attract high quality people that can rise to the challenge the Tasmanian health system is currently delivering and that is a big problem for us.

CHAIR - Thanks very much for taking the time and the effort to put that together. It is appreciated. Just to remind you again that anything you say to the media outside this room is not covered by parliamentary privilege. Thank you for attending.

Messrs BENJAMIN and DAY - Thank you.

THE WITNESSES WITHDREW.

Ms EMILY SHEPHERD, **Ms JENNIFER BROWN**, **Mr JAMES LLOYD**, **Mr ANDREW OSTLER** AND **Ms DEANNA BUTLER**, NURSES, ANMF, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you very much for coming today. We appreciate the time and effort you have gone to put your submission together for a start which has a lot of interesting information in it. All evidence taken at this hearing is protected by parliamentary privilege, so I remind you that any comments you make outside the hearing may not be afforded that same privilege.

Perhaps you could explain how your witnesses will address us today. You were talking about sectioning them up.

Ms SHEPHERD - Thank you very much for the opportunity to come today. I am Emily Shepherd, the secretary of the ANMF Tasmanian branch, representing members here today. With me today I have a number of members and staff. In terms of our submission, which is quite lengthy, we wanted to break it up into relevant themes to make it a little clearer about what aspect of the system and services we are talking about. We would like to commence with a bit of an overview and some examples of those members working within the inpatient setting in acute health services, and once we have completed that aspect we will ask our other members to come and talk about the outpatients setting.

CHAIR - Perhaps each one of you could state your role so that we have it on *Hansard*.

Mr OSTLER - I am an ANMF member and I work on a Tasmanian neurosurgical unit. I will be talking about surgery and surgical waiting lists amongst other things.

Mr LLOYD - I am currently the Tasmanian branch ANMF president and am also an after-hours nurse manager at the Royal Hobart Hospital.

Ms BROWN - I am an ANMF member. I also work for ANMF and I wrote the bulk of the submissions, so I am here to provide anything in relation to that.

Ms BUTLER - I am also an ANMF member and one of the ANUMs at the emergency department at the Royal.

CHAIR - You have an opportunity to make an opening statement to run as you will and should there be any time you feel there is information you want to impart to the committee in confidence you can alert us to that and we will have a discussion about that and proceed from there.

Ms SHEPHERD - Thank you very much. I would like to begin by making an opening statement in addition to our written submission to the committee. We felt it valuable to have as many members here today as possible to be able to provide their lived experiences working within the acute health services system in Tasmania. We also represent the ANMF members, of which we have over 8000 in Tasmania working across all sectors and a number of workplaces including public, private and aged care settings.

Our core business is very much about representing our members industrially and also from a professional nature but we also see our role as advocating for those accessing health care services in Tasmania and that is very much our view here today as well.

We would like to begin by focusing on and providing some examples of what it is like to work within the acute health services currently and some of the challenges we hear from our members on a day-to-day basis working within the acute health sector. I would like to begin with James Lloyd. As mentioned, he is an after-hours nurse manager at the Royal Hobart Hospital and we wanted to provide somewhat of an overview of the strategic concerns we have in relation to the health system.

Certainly it is ANMF's view that one of the serious concerns in relation to health services in Tasmania in the public acute sector is that there does not appear to be a long-term strategic plan. It appears that the service provision and resourcing is very much provided on a reactive instead of a proactive basis and there isn't a strategic plan based on evidence to be able to support both the health service provision and also the resourcing in terms of nurses and midwives into the future. That is a very serious concern of ours and some of the examples James provides today will highlight that.

Mr LLOYD - As I said, my job at the Royal Hobart Hospital is as an after-hours nurse manager and essentially I work outside normal business hours and with another colleague we essentially run the hospital; we're the top people in the hospital. One of our roles is patient flow and essentially being bed managers, so we try to get people into beds from the ED and various sources. That is my main role amongst some other duties.

What I wanted to talk about today, and the example which you guys may very well know, is about November last year when B block was decommissioned, where the new two K blocks are coming up. At that time and especially in the new year, you guys would be aware that we talked a lot about the impacts that was going to have because we did lose bed stock, isolation rooms and negative pressure rooms. In about January, February, March we, with other groups from HACSU, the AMA and the Royal Hobart Hospital Salaried Doctors Association, were doing media and putting submissions out there, talking and saying, 'Okay, you've done this and we've got less beds. There's a crisis happening.'.

What was happening is we were just getting the hand saying, 'No, there's no problem, nothing's happened, it's okay, it's all good', and then the penny dropped about the end of April and suddenly it was, 'Oh my God, there is a crisis'. Then May happened and even though May isn't winter that is essentially when it all starts ramping up. We started seeing in ED - the focus is on ED because that was the main area - as really getting very dangerous. We would have evenings where we would have 70 plus patients in the department. In context, 40 to 45, maybe 50 is a normal evening. When you start getting to 70 plus is when you start getting the ramping. You get ramping in the corridors. It starts to become dangerous. People are sitting out in the waiting room who should be in beds. My colleague, Deanna, can talk about that a little bit more.

We did get a reaction from the Government. It was a reaction that should have started in January. Things did happen but this reaction should have started in January. We went most of winter really not having any extra beds despite the Health minister saying, 'Yes, we do. We have extras in ICU', that were already there, 'We have extras in New Norfolk', that were already there, 'We had the annex beds in Hobart Private', they were already there.

Ms FORREST - The beds or the staffing, were they staff beds or physical beds?

Mr LLOYD - Physical beds. These beds were already in play. The example was the John L Grove at the LGH, that had already been staffed and open for years. There were apparently new beds there. We went most of the winter in crisis, most of the time at level 3. There is level, 1, 2, 3 and there is now a 4. For the first time -

Ms BROWN - Can I add that at that time the Royal Hobart Hospital was already going into, in December of last year, was already going into code yellow. It was already having access problems before B block went down. I attended meetings in my role as organiser for ANMF. I had members highlighting issues with wards on B block that were above capacity. That meant that when B block came down, when B block was emptied, there was no more capacity. We were already over capacity. We were already working at code yellow, then B block came down.

CHAIR - For clarification, when you talked about May, you were talking about May 2016?

Mr LLOYD - No, May this year, 2017.

Ms BROWN - Last year, in 2016, in May, June, July, August, the hospital was running above capacity. There were problems with not enough beds in the hospital. It was known that B block was going to come down. Wards were decommissioned on B block. They had to reopen those decommissioned wards because they were experiencing bed block in the emergency department and they had nowhere to put the patients. Then they eventually had to go ahead with the B block and the decant went ahead. That was before. We raised that issue a couple of times in meetings with senior management. We were basically told, as James said, there was not a problem. That was raised in December. That was on the back of an already very overworked, overstretched hospital system. Then we went on to have the demolition of B block and the real issues in May.

CHAIR - I needed to clarify which May you were talking about.

Mr LLOYD - To clarify some points that Jen made, as an overall thing, usually at Christmas time, Christmas 2016, we close wards and close beds. For the first time ever in my 25-year career at the Royal Hobart we did not close one bed. We had a sustained busy period from just before Christmas until about four weeks ago, it just did not let up.

Ms BROWN - I know at that time I attended meeting after meeting with nurse unit managers who were incredibly stressed. This was before B block went down. There were staff in tears. There were nursing staff concerned about where they were going to put these patients. They were asking, how am I going to staff these wards? What are we going to do? What is going to happen?

I really want to raise this point. It was around December or earlier, an occupational health and safety issue was raised in the emergency department. We probably included some of this in our report, but I would like to note that a report was done. An occupational health and safety officer came down and inspected the emergency department at the Royal in the knowledge that B block was coming down and there was going to be this consistent bed block issue. That report came back saying the emergency department is not meeting occupational health and safety

standards. Staff are already at increased risk of injury because the department is so full. There were problems with blocking access to fire exits.

The report was provided in confidence to ANMF and we raised the report with senior management at the hospital, with the CEO of the health organisation, and we received no response to that report. About a month or two later, after consistent letters from ANMF regarding the safety of our members, we were then given the opportunity for five meetings to discuss the report. However, to this day we understand there are some changes being made to the emergency department, but that is now almost six or seven months after that report was commissioned. We have major concerns for the health and safety of the staff in the emergency department in relation to that report.

Ms FORREST - There must be some concern for patients if you have fire escapes blocked?

Ms SHEPHERD - Absolutely. I might also raise to sum up that information that AMNF have long been concerned, even during the preliminary planning for the demolition and the concern around the reduction in inpatient beds. That has been highlighted from individual member feedback that has been fed back to ANMF. It was highlighted throughout the entire planning process that the rebuild was going to result in a significant reduction in beds and we had serious concerns that would impact on staff and on the provision of appropriate, safe and quality care for patients in being able to access the emergency department, being able to access inpatient beds and not spending onerous amounts of time in the emergency department.

As you would know from our submission, the evidence also suggests that the longer, over eight hours, patients spend in the emergency department there is a significantly increased risk of adverse events. Our concerns were not heeded. As James said, it was not until April this year, when we started to see a significant increase in presentations despite the fact the Royal Hobart Hospital had already been at capacity when we saw a significant influenza season arise and significant numbers of increased admissions due to that, that it was acknowledged the rebuild had reduced the capacity of the Royal Hobart Hospital and the availability of inpatient beds.

We recognise that there has been recognition of that now and there is a significant attempt to increase the amount of available inpatient beds and also inpatient beds off-site from the Royal in terms of trying to alleviate some of those bed block issues. The real concern is that the issues and the concerns were not taken into account and members were not listened to, members who were working within the system at the coal face. No-one was taking those concerns seriously, which is fundamentally the real concern.

Mr OSTLER - Can I add something to that? It even goes back three years when we were looking at the development of the K block. The demolition of the B block was vaguely looked at. Way back then, with a different hospital administration I might add, they were very confident that the beds would be there. When that was demolished they looked at statistics and you would hear quotes at meetings that it was all going to be okay but we knew, the people on the ground knew, it wasn't. An example would be the thought that they could place psychiatric patients up at Roy Fagan and move them off-site. Some of my colleagues in ANS said, no. The government responded to that and added to the demountable to keep those patients at the hospital, but on the other hand they didn't listen to all the worries we had.

Now we have the kneejerk reaction from a new administration saying well, hang on, this is a disaster. Last winter was bad enough. We had B block and we had flexibeds. There were beds unstaffed that we could use and staff and then drop back if it became quiet, but it just didn't. That was last winter and this summer was equally busy, where did the summer go? Summer can be a quieter period and it wasn't, it was just flat out.

Where I work in surgery, we have to keep churning. We have to keep the churn happening because if you don't the waiting lists are blowing out. One of the reasons the waiting lists are now blowing out is we don't have the beds. People are desperately trying to place people - if there is a cupboard, you could put a bed in it at the moment. Staff walk around thinking, where else could we put beds? Someone has already thought about it. The hospital gymnasium was knocked out. They are inappropriate spots, but they are the only spots they have.

In some ways I feel quite sorry for the current administration. It's changing and it's developing as more positions come available, but they are faced with this massive problem that was created three and four years ago through lack of thought and lack of listening.

Ms SHEPHERD - In terms of patient flow and patient safety, one of the things that has really been highlighted in regard to the lack of inpatient beds is about how we care for our patients who require isolation due to things like MRSA or VRE. That is for their quality care, but more importantly for the safe provision of care for other patients around them. What we have also seen at the Royal Hobart Hospital and around the state is a lack of capacity of isolation rooms to put these types of patients into. We have heard instances where patients with MRSA, which can be transmitted through contact with other patients in shared facilities -

CHAIR - MRSA for Hansard is?

Ms SHEPHERD - Methicillin-resistant staphylococcus aureus. VRE is vancomycin-resistant enterococci.

That is then putting other patients at risk due to the lack of isolation beds. Something that we are seeing throughout the state is a lack of isolation beds and how that then impacts on patient flow. Deanna, I might come to you for the emergency department examples.

Ms BUTLER - I agree, it has probably been a lot to do with lack of planning with the redevelopment. I have been in emergency for over 10 years. I have worked in a senior role for six to seven, so I have been part of organising all this flow and I have been right in the firing line. The last three or four years, the winters, we have been seeing more and more demand and not enough space to look after everybody. It seems to be this year with the redevelopment it is almost like the straw that has broken the camel's back. There is just nowhere to go for all these people. Hence, the emergency department has carried the load.

What the difference is, and the impact on the patients I feel I am here to advocate for, the last three or four years we have been doing what we refer to as waiting room medicine. That is where we would be seeing patients in the waiting room on this tiny little side room off triage. You could have 20 patients in the waiting room as well, that you are trying to look after out of this little side room. This winter we have had to look after our Category 2 patients on the ambulance ramp and in the waiting room. That is where it is really bad and really dangerous because that is our core business. That is our emergency work. These are people who need treatment straight away and if

we are delaying treatment they are going to have poorer outcomes, increased lengths of stay, which is not good all round.

An example of that this winter; one busy night they had a Category 2 patient walk into the waiting rooms, self-presented. The patient had an ectopic pregnancy and there was no bed available for the patient to go into. She collapsed in the waiting room and a trolley was needed to be found from all these cramped areas. Staff had to pick somebody off the waiting room floor. This patient had to then be rushed and resuscitated in the ambulance ramping corridor. Again, there would have been other people around. The staff had to run and get equipment and that is very sub-standard for a tertiary emergency department.

CHAIR - Not to mention the privacy, and the information the patient is giving at the time.

Ms FORREST - It is also a life-threatening condition.

Ms BUTLER - A pat on the back to the team because the patient did survive and get to theatre but, again, if we had space and an appropriate area to care for that patient, that next level of stress would have been avoided. That is the difference, being able to have to look after our emergency patients without space -

Ms SHEPHERD - That is happening across the state in all of our emergency departments.

CHAIR - I will invite the others to come forward.

Mr FINCH - I am hearing here, with the warning the ANMF has given and on the signals that came through to management, we have heard the schism between organisations such as yours trying to develop that information flow through to management and through the minister's department to the minister himself. It is not a good flow of communication or relationship at this time. Is that a fair observation? It worries me that a respectable organisation such as the ANMF should be reflecting these frustrations as well as other organisations.

Ms BUTLER - Yes, that is the case. We refer to the warning we made in relation to the lack of capacity with the rebuild. We are seeing the issues in consultation and communication between our organisation, which is representing nurses and midwives. We are working at the coalface with patients. That is where our concerns and our communication arise from, and is the evidence that we provide.

We are again seeing a situation where we find that information, which we put back through change consultation processes, et cetera, is often not taken into account. We find we get a change proposal come through, for instance, for the mental health observation unit, that has been proposed within the emergency department at the Royal Hobart Hospital. All parties and all members agree it is not the most appropriate use for that space and it will not provide quality care for mental health patients in that environment. But there was no initial discussion with key stakeholders like the ANMF, like the AMA, and like our members working within that environment, to seek their input into what would be a meaningful use of that particular space and how that might be used to assist inpatient flow and reducing bed block within the Royal.

These sorts of proposals are happening across the state. We are being consulted late into the process when decisions have already been made and members are unable to have meaningful

input. That is demonstrated in the example we have provided around the rebuild, but that has not changed and in some instances has become even worse.

Ms BROWN - The change in the structure of the THO created a problem as to who to go. For a period of, and it has changed now, but there was a lack of sense of responsibility: who should we take these issues to? Should we really be going to David Alcorn with some of our issues? We are trying to raise issues from the lower levels and they are not getting heard, or they are not getting listened to. We are going up and up, eventually going to the top where it is pushed back down or it is not responded to. You try to raise it with the minister's office, who send it back. Some of these problems have been addressed in some recent changes but some of these relationship issues bubble under the surface in response to that.

Mr OSTLER - I make this point about surgery. Surgery waiting lists are blowing out. Certainly in my area, on neurosurgery, we have just under 100 category ones. We have had to sacrifice beds to the medical division to accommodate ED patients. That sacrifice means that this waiting list is blowing out and it blows out for a number of reasons. GPs are getting very clever about sending patients into clinics. They do all the research first. Those patients have already been vetted. Despite outsourcing, without outsourcing of some of our patients our waiting lists would be blowing out even more quickly.

It is a great concern for some in surgery that we cannot provide the appropriate service. As a neurosurgical nurse looking at the waiting lists, sometimes the patients on that list are at high risk. They at high risk and they need to be seen, but the bed loss to the medical side makes it incredibly difficult. Often it seems to create some tension too between different units. There is competition for those beds.

CHAIR - A very quick question with respect to observations that might be made that say this bed block business is just simply a lack of organisation in one particular area and it is echoing back. There are improvements that can be made to move patients through more quickly up the chain so that the beds are made available. Is there any one particular issue that you see as a really critical thing that could improve the bed block situation that occurs?

Ms SHEPHERD - We do have a number of solutions. When I referred earlier to the strategic plan, ideally our position would be that there would be a strategic plan that was agreed to by all political parties, that was not tied to election cycles, that could enable an evidence-based plan that was adequately funded to allow for infrastructure to be built now. Obviously we need it in all of the areas across the state. We are seeing a 6 per cent annual increase in presentations at the LGH emergency department. Just yesterday, at the LGH we were hearing from theatre that the elective surgery waiting lists are continually overbooked, and for the first time staff in theatre are doing double shifts.

There obviously needs to be more capacity. That needs to be done now. We need to be thinking into the future. We also need to be thinking about -

CHAIR - How far into the future, five years, 10 years?

Ms BROWN - Could I draw your attention - if you are interested - to the Adelaide hospital which redeveloped on site about 15 years ago, and quickly reached capacity and was rebuilt and recently opened in the last two years. That is a very good example.

Ms SHEPHERD - There needs to be a short-term plan immediately. We need to be building capacity immediately, but then we need to be reviewing the evidence. We know service demand is going up. We know we have an ageing population and a huge chronic disease burden. That also means that our nursing and midwifery professions are ageing as well. We absolutely need to have a workforce plan tied to that strategic plan. Even if we build capacity in the short term and the long term, if we are not investing in our nursing and midwifery professions, then there will not be the workforce to support the additional patients within the hospital.

We also need to think about our preventative health care and our hospital avoidance programs and the connection between those to ensure that those accessing acute health care services are accessing them because they have been through all the other avenues of preventative health care, hospital avoidance and are there because they absolutely need to be there, as opposed to that being the only option available to them at the moment.

CHAIR - Okay. Something like a long-term strategic framework with five-year reviews.

Ms SHEPHERD - Milestones, yes.

CHAIR - Without putting words into your mouth, are you talking about something like that?

Ms SHEPHERD - Yes. We would absolutely see that there would need to be a 20-year plan.

CHAIR - Okay, thanks. Perhaps we need to swap the nurses over. Thank you for coming in.

THE WITNESSES WITHDREW.

Ms MONICA WERNER, Mr SCOTT BUTLER AND **Ms JENNA BOWLING,** NURSES, ANMF, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED, AND **Ms EMILY SHEPHERD** AND **Ms JENNIFER BROWN** WERE RECALLED.

CHAIR - For the record now we have staff that are involved in which area?

Ms SHEPHERD - These are all branch councillors that are joining us today and I might let them introduce themselves and the areas in which they work in.

CHAIR - They have to take the statement as well so if we can have each of you make that statement that would be very good.

Ms WERNER - I am an ANMF member and I work in cancer services.

Mr BUTLER - I am an ANMF member and I also work currently in acute rehab, with a background in theatre as well.

Ms BOWLING - I am a registered nurse at Correctional Primary Health.

Ms SHEPHERD - What we thought we might do, just to cover off, we have covered acute in-patient areas come to rehab, then have Jenna talk about the correctional setting and then come to Monica who works in the out-patient setting.

Mr BUTLER - Just in general to go through in rehab and that we get a lot of bed blockages. As a rehab specific unit we obviously have patients to come from surgery, come up have their rehab get them going. We are getting bed blockages because we are filling beds with patients that have nowhere to go. Currently we have one patient just on the ward at this point - well, we have several but this one is waiting for a group home, and they have waited up to four months. Then the family reject the group home and there is nowhere to go, we lose the spot and hence we still have this patient in an acute bed, not a rehab patient, not receiving any goals of rehab.

Patients we know we have waiting down at the main hospital, waiting to come up to rehab from hip replacements that we can get home very quickly if we get them, the evidence is there to show us that if we get someone up and moving quickly and get their rehab started, we can get them home quickly. We also have patients who are waiting. The biggest thing is the delay in modifications and that later on in the community. They have reached their rehab goals, they may need bars in place, things like that. We get stuck with these patients sitting there for two or three months because we cannot get subcontractors, contractors to put any of this stuff in place.

Even sending to another facility, for example, like New Norfolk which is a step down facility for us that could manage a lot of these patients that do not need acute care. It is a department run, but the problem is we need an accepting doctor. They are off using GP clinics which are not departments. We have nurses, we have physiotherapists, we have occupational therapists, a beautiful centre out there - vacant beds, importantly. We cannot send one there unless we get an outside GP that can accept them as a patient. If they do not accept them we can't send them. But the beds are part of us, so we have delays there as well.

In general, we have had patients since I have been up there and they have been over there six months just waiting. Not even rehab patients anymore. This has happened on several occasions. Currently on the ward at the moment, we have probably about five out of the 18 beds that are not rehab candidates. We probably have another five that are just waiting purely on modifications in home environments. They have been sitting there, three or four months, day in day out, using up beds and we also have a long list of patients sitting down there that we could free up, get up, get them into rehab, get them moving and get them back home and we are stuck with a blockage. We cannot move them anywhere and we cannot send them when they have nowhere to go.

We have homeless people. We have to find them housing. If we cannot find them housing at the time they are there as well and that has happened in recent months. We have had that.

Ms SHEPHERD - Certainly from a mental health patient perspective that is quite a significant issue in terms of appropriate accommodation post discharge as well. The linkages between the acute setting and the community setting in terms of community services is not something that is well established and there are not clear processes around that, which makes it very difficult to appropriately discharge and support patients as they move out of the acute health care services.

Mr FINCH - If I am right, Chair, is the rehabilitation area that you work in the main victim of the circumstance or are there other departments in other areas?

Mr BUTLER - Many other departments. That is just an example from the department I am currently in at the moment. That is a direct one I can give reference to with the patients that I am seeing. I am hearing from other members there is bed blockage in other areas even just above us in that which is another ward which is a slow stream ward P3. A lot of them are waiting on nursing home placements and they are using up acute beds and services when they could be in a nursing home or home environment. So that is two wards there.

Other wards around the state are having trouble as well, as Andrew spoke to. The neurosurgical ward is getting patients that are not necessarily surgery patients because there is nowhere else to put them. Some of those patients could be coming towards the step-down wards. I think Oatlands have step-down facilities. They have to be accepted somewhere by GPs a lot of the time, which delays things, because we do not use our own doctors in those environments.

Ms FORREST - You mentioned one of the reasons that some of the patients have been in the rehab ward for three to four months is because they are unable to get modifications done at home. Whose job is it to get that done? Who provides that?

Mr BUTLER - There are two steps to it depending on whether the patient has enough funding of their own. They have to pay for it out of their own pocket if they can provide that. At other times they could be subsided. It is covered by certain outreach programs, so then it goes to a different department that will authorise outside of the hospital because then they become an outpatient. So it becomes an out service, so then it has to be signed off somewhere else.

Ms FORREST - Streamlining this, how do you fix that problem? Surely that could be something that could be fixed easily, in the small world I am thinking of.

Mr BUTLER - I believe it should be fixed very easily. You need modifications done; you get a contractor in and they do the modifications. That is a simple solution but for some reason there seems to be a lot of tape which goes to different departments. We cannot authorise it if it goes to a different area. It is done as an outpatient. It could be Community Rehab that then have to authorise it, and it may be Disability Services that may have to get the funding for it. There is no one direct area you get the funding from, so depending on what stream that person goes into, it could be disability care, it could be community care, it could be a private provider they are dealing with and -

Ms FORREST - I can see a whole new social enterprise out there just to do this.

CHAIR - It relates to item (4).

Ms SHEPHERD - It is the funding coordination that is a real issue. That is getting a lot worse in terms of the funding arrangements with individual NGOs. Then you have federal government funding, you have packages. And then as Scott said, if someone is at home, it comes out of that HACC funding as opposed to the department funding. So it is very difficult and there is a lot of buck-passing going on because of the funding.

Ms FORREST - Plus it is different funding for different areas, cost shifting.

Ms BOWLING - Basically there are a lot of issues in correctional health. We have not had an increase in staff numbers for probably over a decade, yet there has been a 45 per cent increase in the prison population since 2014. In October 2017, there were 600 inmates. At the moment I think there are probably over 700. It is only going to increase with the doing away of suspended sentences, which has increased the workload immensely. We are looking at a population of people who are more unwell than previously. There is a lot more drug use in the community. Ice is a big issue; mental health is another big one. These are very time-consuming issues. They can come into the health system, and turn up at the front door at any time. When the court decides to put someone in prison there is no consideration for numbers. They are doubling up inmates in cells, and we are having to double up inmates in the inpatient area as well. The infirmary is only a five-bed, five-cell ward and it is almost always full. Lately it has almost always been full of people that need to be monitored for numerous -

Ms FORREST - Separate to Wilfred Lopes?

Ms BOWLING - They are separate to Wilfred Lopes. We are not really connected to Wilfred Lopes. People can go there for psych reasons. Even getting access to Wilfred Lopes from Correctional Health seems to be impossible. There are a number of meetings that have to occur and there have been times where they have declined to accept an inmate for unknown reasons. It is very confusing for the nurses and we are never really told why. There are people who need to be at Wilfred Lopes who are not taken on board. They have had their own issues as well in terms of staffing.

CHAIR - What sort of percentage of patients that you are dealing with should be across, in your estimation?

Ms BOWLING - I really would not know. I am not a psychiatric nurse so the bulk of my work is not looking after the psychiatric patients. I know there has been one or two occasions

where patients have been refused admission to Wilfred Lopes who probably should have been. Then they will accept an inmate who is not as unwell as the one that we wanted to send. It does not make any sense.

The infirmary is regularly full. We are looking at acute drug and alcohol withdrawal that requires observation and medicating, threats of self harm and diabetic monitoring. A lot of diabetics come into prison and a change of diet is enough to upset their diabetic management, so they need to be closely monitored. It is not safe for them to be down in the regular cells, but sometimes there is nowhere else to put them. We just have to hope that nothing goes wrong. There are just so many issues.

We did have the case of a quadriplegic being put into prison earlier in the year. That was the example I wanted to talk about. There seemed to be no consideration from the courts about putting this man into prison in terms of the care that he would need. He just turned up. I think that on a higher-up level there may have been some discussion, but for the nursing staff that were on that day he just turned up and there he was. All of the equipment and things that we needed had to be sourced for him. Before he came there was no training provided for the specialised care that he would need. There is a condition called autonomic dysreflexia that can occur in quadriplegics, which is a very serious life-threatening emergency situation. We were all quickly trying to read through journals trying to educate ourselves as best we could about this condition. We had not been given any prior education before he turned up. We are general nurses but a lot of us have not worked with a quadriplegic patient for a long time.

After he had arrived and had been there for a little while there were services provided and education was put in. But it needed to happen before he turned up. The man posed no immediate threat. He was hardly a flight risk. He was not going to hurt anybody. From a nursing point of view it just does not make sense why he needed to be immediately put into prison. We could have had time to organise ourselves, then have him brought into care. We are not to say who should not come into prison, but we need to be prepared if we are having somebody that unwell.

Ms FORREST - It is a justice issue. The Government has made noises about alternative sentencing options, like home detention. In the absence of that - I do not know the circumstances about this particular prisoner - clearly there was a reason why he was sent there. Maybe this highlights that this needs to be bigger than just health, it needs to consider justice.

Ms BOWLING - Yes, that is the depth of the issues we have at correctional health.

Ms FORREST - Are there other examples of that need for greater collaboration across government sectors? Health is big enough on its own, we all know that. You have mental health, you have a whole range of preventative health, but obviously justice forms part of that when you have Wilfred Lopes and other correctional aspects of it. Are there other examples of where collaboration needs to occur, that you are aware of?

Ms BOWLING - Work does need to be done. We could work more closely with TPS. For as long as I have been with the service and long before that, we are known as being the guests within the Tasmanian Prison Service. There is not always a great working relationship. We only get two and a half hours of access to run clinics. Sometimes even that does not happen if there is a staffing issue or an incident occurs, which is understandable. We know that the environment that we are working in can be very difficult. It is just that it does not run as smoothly as it should.

Ms SHEPHERD - In remand in Launceston we have had examples where decisions are made through the corrections department, which affects the clinical outcomes for patients. There is not that understanding of that clinical context that is required for nursing staff.

If I can also quickly touch on a point that Jenna made in relation to staffing which is a very important point that we make today. I have an RTI document I would like to submit to the committee to review, to add to our submission. We have continually had to do Right to Information requests to obtain numbers of vacancies and double shifts that are worked across the Tasmanian Health Service. We are very concerned about the number of existing vacancies, currently 246, to our knowledge. We know there is a working group and a dedicated unit looking at recruitment and retention. We are very concerned, particularly for our speciality areas such as the area Jenna works in, in our theatres, emergency departments and ICUs and midwifery services that there aren't the skilled nurses with the knowledge required to fill those positions. They would need significant orientation and during that time there are still not enough baseline staff.

We then see those onerous amounts of double shifts and overtime by staff having to work because the baseline rosters aren't filled. That then leads to sick leave. There is this perpetual cycle of staff rotating through and having to do double shifts and overtime. Then they get sick and there are more double shifts, and it is just ongoing. We are very concerned.

Mr FINCH - Exacerbated by the flu this year, too.

Ms SHEPHERD - Yes. The double shifts data is on an upward trajectory. Despite other reports that have been made that they have been reduced, the overtime and double shifts combined is a continual upward trajectory. The highest we saw was in March this year at the Royal was more than 300 double shifts, which is an all-time record.

Ms FORREST - In March? That's before the flu season.

Mr FINCH - Is there a figure on overtime? Is it separated from the budget figures for the hospital?

Ms SHEPHERD - All the overtime is in surplus to the baseline staffing establishments, so it is over and above. Our view is very much that instead of paying overtime we should be putting that money back into baseline staffing. We know there are significant numbers of staff within THS on fixed-term contracts who would like permanency. Our view is very much there should be a moratorium on the fixed-term staff and they should be allowed to have permanent positions. That should then establish what the actual vacancy rate is and what is required. We also very much need to be encouraging more graduate nurses into the profession and supporting them with appropriate levels of education and skills facilitators on individual wards and units, particularly in our specialty areas.

CHAIR - If there was an increase in double shifts in March, what would it have been like through the flu season? Did it increase?

Ms SHEPHERD - We don't have the up-to-date figures. Our RTI gives us retrospective data and I have no doubt we will need to do another RTI to get appropriate figures around that. We

know from members there were significant amounts of double shifts and overtime worked during that period.

Ms FORREST - Is that the most recent data you have? Are you able to table that for us?

Ms SHEPHERD - Yes.

Ms WERNER - I work in the outpatient area for cancer services and our service delivery means we try to keep our patients as outpatients and to be able to deliver their cancer care within the outpatient area. It was a purpose-built unit, probably about four years ago, and we have now outgrown it. We have waiting lists for patients to commence their cancer treatment and we also have waiting lists for patients who are mid-treatment, waiting to continue to access their treatment.

Just yesterday, before I left work, there were eight patients waiting to continue on schedule for their treatments for two days, 22 and 23 November. Evidence says any delays to their schedule treatments will affect their survivorship, and there's proof with that. We are open seven days a week - 7.30 a.m. to 5.30 p.m. Monday to Friday, and on Saturday and Sunday it is 7.30 a.m. to 3.30 p.m. - to provide care and supported treatments. It is not only chemotherapy. We also do procedures, harvest stem cells, re-infuse stem cells, which is in effect a transplant. We also do bone marrow biopsies and other procedures on the unit.

We don't get any sick leave cover because it is a specialised area. There are no nurses with the skills, and despite recruitment drives we still have vacancies. The other day we had five nurses off sick. We had a full unit and some complex, complicated and risky procedures that needed to be completed. We managed. I have very grave concerns for my professional safety for my nursing colleagues as well as grave concerns for the safety of my patients. We are just getting through this by the skin of our teeth.

The other part of access as an acute service for these patients is that we spend considerable time in educating them to recognise signs of when they become unwell. We provide them with a 24-hour phone number to contact. It is a triage phone number so there is either a cancer nurse or there is an oncologist after hours that they speak with, they tell them their story and the oncologist or the cancer nurse talks them through what steps they need to take.

These people are immuno-compromised, which means they are at very high risk of becoming septic, going into septic shock if they are not managed correctly, and then going to ICU or worse. Patients that are ringing up are being told at the other end of the phone, despite having a temperature and all these quite significant symptoms they are telling their clinicians, that they should not go into ED because it is full: 'ED is full …', particularly during the winter time when you have a waiting room full of flu viruses, ' … and it is safer for you to stay at home'. These people will crash and burn very, very quickly and we have lost patients.

There is one example when one young mother called the number overnight. She was told to stay home. She presented the next morning to our outpatient unit. She was reviewed on the unit. She had an ADDS - Adult Deterioration Detection System - score of 6, which means when you take vital observations there is a number score and the higher the score the more unwell they are. If they get an 8 that is a medical emergency. She was on an upward move. We still did not admit her that day. She was very lucky, but she very easily could not have been and we were very

concerned for her safety. There were no beds for this woman who really should have been an inpatient.

To further compound the flow of our patients, we spoke before about MRSA and VRE patients, as of yesterday we have a patient who is probably the first one in the hospital to have a super bug CPE - carbapenemase-producing enterobacteriaceae. I have some information here. Carbapenem is the antibiotic that is the top of the ladder. This bacteria is resistant, so any patient who has this CPE, and particularly in our cohort of patients who are extremely vulnerable to picking up anything, we cannot treat them and their outlook is very, very grim. From an infection control point of view they need a dedicated room and a dedicated bathroom. We need to protect our other patients from contracting this bug and it is really becoming a public health concern.

CHAIR - How is it contracted? Is it by touch, through the air?

Ms WERNER - It is contact. It is not airborne. It is contact and particularly gut, so they do need to have a dedicated bathroom and they do need to have trained cleaners to clean the area. The bathroom needs to be cleaned after every use, not once a day or at the end of the day.

CHAIR - They are specialist cleaners?

Ms WERNER - They are infection control cleaners. Yesterday we had an in-service from a senior infection control nurse; this is all new information for me as well. She said she doesn't have enough cleaners on her staff and we really need to be looking at training up more.

Mr FINCH - Are you saying this is the first case of this in Tasmania?

Ms WERNER - She said there was two other cases that she knew of, but this is the first one that has come through our area. It is brand new and we are going to be seeing more of it.

CHAIR - It does not bode well, does it?

Mr FINCH - You say there were eight patients delayed in there.

Ms WERNER - They are not delayed yet. They are on the waiting list. Each day we look at the waiting list because there is movement. If a patient is delayed because they're unwell, we can slot someone into the waiting list. Occasionally, it becomes problematic. You try to squeeze a long appointment into a short appointment. This is a risk because you are trying to do complex cases in a shorter amount of time where they really need to have more time and more skills to be able to do the assessments and to be able to provide the treatment and the care.

Mr FINCH - Is this a circumstance that has developed recently? What is your experience in this department?

Ms WERNER - My experience? I have been working in cancer services for nearly 18 years.

Mr FINCH - At the Royal Hobart Hospital?

Ms WERNER - Yes.

Ms BROWN - Can we add that this is a redeveloped site. It is a new purpose-built area.

Ms WERNER - That we are outgrowing now. It is only four years old, at most. It might not even be four years old now.

Mr FINCH - This has slowly developed to this stage.

Ms WERNER - You can see that the numbers are increasing.

Mr FINCH - What you are giving is a signal, would you call it, that a critical situation is getting worse?

Ms WERNER - It is definitely under pressure. On Saturday I went in after I had finished on Friday. There were two patients I still needed to get in for Monday for who I didn't see any space. I went on Saturday with a clear head because I couldn't do it Friday and I managed to move one patient from Monday on to the weekend and get another patient in an inappropriately small spot. Things obviously run late. There was another person I brought in and tandem booked them. That was the only way. Otherwise, they don't receive their care. There are risks with doing that. Big risks.

CHAIR - We are running overtime, but it has been very important to hear that evidence. It certainly helps us to understand the bigger picture.

Perhaps we can have the other members that presented to come to the table because I want to make sure you all hear what I have to say after this hearing.

Ms FORREST - It is a very comprehensive submission too.

CHAIR - It is, it is a very comprehensive submission and I am sure we have only touched on a third of it. I can see that. We appreciate the fact that you have taken the time and made the effort to put it all together. We appreciate the fact that you have taken the time to come in and talk to us. As I said before, an inquiry is nothing without evidence and you have provided that today.

To remind you, when you walk out of this room, you are not protected by parliamentary privilege if you are talking to the media or anyone else in regard to that, even if you repeat what you have said in here. That is not protected out there. You need to understand that.

Thank you again and very much appreciate it.

THE WITNESSES WITHDREW.

Ms CONNIE DIGOLIS, CHIEF EXECUTIVE OFFICER AND **Ms CAITLIN GRAHAM,** MENTAL HEALTH COUNCIL, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED**.**

CHAIR - Thanks for coming in and providing us with verbal evidence as well as your submission, that is always appreciated. My colleagues, Kerry Finch and Ruth Forrest. We have Stuart Wright and Julie Thompson from the administration side. You will have a sheet in front of you. We need to have you repeat that because it is sworn evidence today. If you could please read that sheet and tell us what your role is, so that we have that for *Hansard*.

For the record, this is a public hearing of the Government Administration A Sub Committee inquiry into the Acute Health Services in Tasmania. It is a Legislative Council inquiry, it is not of the Government's making. All evidence taken at the hearing is protected by parliamentary privilege. You have possibly given evidence before the committee before, so you are probably aware of that. I remind you that any comments you make outside the hearing may not be afforded such privilege. A copy of the information for witnesses has been made available. Have you had a chance to read that?

Ms DIGOLIS - Yes.

CHAIR - The evidence you present is being recorded and a version of it will be published on the committee website when it becomes available. We will give you the opportunity to make opening statements before we ask questions if you wish to do that. During the questions, if you feel that there is something you wish to say to the committee that might be confidential or you would prefer for it to be confidential, you can alert us to that and we will take it from there. Over to you.

Ms DIGOLIS - Thank you. The Mental Health Council of Tasmania is a member based peak body. We represent and promote the interests of community managed mental health services and have a strong commitment to enabling better mental health and wellbeing outcomes for every Tasmanian. We welcome the opportunity to respond to this inquiry into acute health services in Tasmania. The Mental Health Council of Tasmania is advocating for our members and for the needs of people who experience mental health challenges.

Whilst we wish to recognise and acknowledge the important role that acute health services play in mental health care, we also want to highlight that acute mental health care is only one part of a larger overall mental health system.

I would also like to clarify that our findings and recommendations are firmly developed from evidence-based best practice models that are utilised successfully both nationally and internationally. Our recommendations are based on this research of other state and national mental health strategies, including the Fifth National Mental Health and Suicide Prevention Plan and Tasmania's own Rethink Mental Health plan, along with models that we can see are successful in other jurisdictions.

All of these point towards the need for a broader coordinated systematic approach which recognises the importance of, and need for, low to moderate sub-acute support options, acute care when it is needed and structured discharge planning and referral processes that ensure patient flow. This is because successful recovery does not, nor should it, occur in hospitals. There has been an increase in mental health presentations across emergency departments statewide and

currently it appears that emergency departments are the first point of call for many individuals experiencing a mental health challenge or a crisis.

While some of these individuals are presenting with a need for acute care, it appears others are not. This is not to say that care and supports are not required, but more that their needs are not at an acute level and are more suited to low to moderate support and care options that could be provided with sub-acute style facilities and supports. We believe that these non-acute presentations to emergency departments highlight gaps within overall statewide mental health services. There is a clear correlation between the availability of community-based clinical mental health services, early intervention support and service options and the numbers of people who are presenting in emergency departments to receive acute mental health care.

Evidence tells us that for those consumers not in need of acute care, the hospital is not the best environment for recovery. Best practice models for mental health and the key principles of recovery oriented mental health practice emphasise that for people with these lower to moderate care needs, long-term recovery is better achieved outside of hospitals in familiar surroundings. Hospitalisation should only occur when people need intensive help and support to manage their mental health. Ensuring access to acute care for those that need it is essential to our mental health care service and providing a range of step-up, step-down services would alleviate the current pressure placed on our acute mental health services by ensuring a range of individualised supports, both pre and post discharge, are available to those in need of low or sub-acute care and supports.

Both state and national mental health strategies emphasise the importance of developing a stepped model of care that, in the words of the Australian Government, 'Will ensure people get the right clinical service at the right level and at the right time linked to other non-health supports. Tasmania's Rethink strategy also aligns itself with this principle, stating that its goal is to reorientate the Tasmanian Mental Health System to increase community support and reduce the reliance on acute hospital-based mental health services.

While Tasmania does not yet boast a full range of step-up or step-down mental health programs and facilities they do exist and many are successfully delivered in community-based environments. However, through the public health system's failure to implement consistent discharge planning and transition processes, onward referral of patients into these community based services is dependent on the individual clinician's knowledge and understanding of the services. We believe these inconsistent and subjective discharge practices may be a contributing factor to the current inefficiencies that are being experienced in emergency and in-patient units.

For many, hospitals are the first point of call because they have reached a crisis point. However, others simply have nowhere else to turn and this can be prevented for a large number of people through the strengthening of a range of targeted and individualised early intervention services and support options within local Tasmanian communities.

The reinforcement of these community-based services strengthens individuals, communities and the health system overall. Through closing current systematic gaps, establishing new and developing existing community-based mental health care and recovery options consumers will have access to mental health services out of hospitals and within their own communities, which is shown to be the most effective environment to promote and achieve long-term recovery.

In turn when these steps are well established and gaps within the system are reduced, the addition of more care options will allow for early intervention models and preventative health processes outside of the hospital environment in line with the fifth mental health and suicide prevention strategy and rethink.

The development and refinement of this integrated preventative health system would relieve the dependency on acute services through early intervention steps and supports, enabling a state-wide mental health system to function in a way which assists consumers earlier in their journey rather than when they reach a crisis point.

This brings me to our key motivator and something I hope we would all agree on, which is better experiences and better outcomes for Tasmanians.

I would like to introduce you to Lauren. Lauren is a 38 year old who, after the combination of her marriage breaking down, additional stress at work and the pressure of caring for a sick family member, found herself struggling with depression. However, she was not only unsure of why she was feeling this way, she did not recognise the need to seek further support and help. Lauren's family had noticed changes in behaviour, but did not know that these behaviour changes maybe symptomatic of some deeper issues. Lauren approached her GP and described feelings of exhaustion and hopelessness. Her GP referred Lauren to a psychologist. However, with an eight-week waiting period, Lauren was not given options for support in the meantime.

Eventually Lauren did not show up for work one day and her sister, concerned for her wellbeing, visited her home where she found Lauren in a distressed state. Unsure of what to do she made the decision to take Lauren to the emergency department. Lauren was triaged on arrival and was asked to wait in the emergency department. Lauren experienced an extended wait and became increasingly distressed due to the intense nature of the waiting room and the commotion around her. When Lauren was seen by a clinician Lauren's sister expressed concerns that Lauren may harm herself. While the clinician was empathetic to these concerns he found Lauren to not be an immediate risk to her own wellbeing and referred her back to her GP for further interim support until her psychologist appointment.

Due to difficulties getting a GP appointment, Lauren's sister made arrangements to stay with Lauren until her next appointment. However, she was not advised of any options for Lauren should she not be able to make these arrangements. Due to not being equipped to care for Lauren once returning home Lauren's sister became increasingly concerned for Lauren's wellbeing as she became further distressed. Lauren's sister was worried Lauren had become a risk to herself.

As a result of this concern Lauren's sister had no choice but to return to the emergency department with Lauren in a greater state of distress.

In this situation Lauren experienced a number of difficult and stressful events and while she did have supportive individuals around her, due to a lack of resources and options these friends and family members and Lauren herself did not recognise when further help was required and what it looked like.

An alternative ending to Lauren's story, one which did not require multiple trips to the emergency and a decline in her condition prior to receiving treatment, may have been possible if she'd had access to varied treatment options more suitable for her needs. In this alternative ending, had Lauren had access to subacute care options, such as the diversion unit or a respite

centre, she may have been able to have access to clinical care and interventions alongside counsellors in an appropriate environment to assist her in establishing a long-term treatment plan.

Had this option been available it would have allowed her to return home with a fully individualised plan and strategy with referrals and care options to ensure she was fully supported to achieve and maintain her individual long-term recovery goals. Under a system which incorporates the stepped model of care, Lauren may have also been able to avoid multiple trips to the emergency department through better access to early and preventative support options within her community. Lauren's journey may have been changed through the availability of services such as greater community education, providing her family with the tools and knowledge to understand how Lauren's changes in behaviour may require some greater support, service and information directories for family members and GPs to assist with finding timely and appropriate services and supports and stepped care options to provide wraparound supports for Lauren to ensure she is monitored and supported, while working towards her goals and her recovery within familiar environments.

A good model of step-up, step-down provision is the Victorian Adult Prevention and Recovery Care (PARC) service, which provides early intervention for people who are becoming unwell or in the early stages of recovery from an acute psychiatric episode to strengthen and consolidate gains from the in-patient setting. For someone like Lauren the availability of this kind of service could have prevented a trip to emergency, or could have been offered after receiving short-term acute care as a step-down option. These services are short-term residential treatment services located in the community, enabling consumers with severe mental illness to receive both clinical intervention and treatment and active support for their recovery in a safe and supportive setting.

The PARC setting encourages links to consumers' natural supports and their participation in community life. That includes active specialist mental health assessment and treatment, safe time-limited accommodation, relapse prevention and management, recovery-oriented services and the opportunity for consumers to participate in structured programs that aid their recovery.

Lauren's story reflects a common scenario and is by no means intended to simplify or dilute the complexities of mental illness and the challenge in front of us to change her outcome. Mental illness is complex and individualised, which creates great challenges when trying to deliver the right care at the right time in a way that is sustainable and effective. But for people like Lauren, and for all Tasmanians, the Mental Health Council wants a health system that looks beyond the acute beds. We would assert that new acute beds are not a solution, rather a symptom of the systematic failure of our overall preventative and primary health system.

Surely we should be doing everything we can to demonstrate to all Tasmanians that we are doing everything we can to keep people out of hospital. Until we can do that, we would urge caution around building expensive infrastructure that could inhibit better outcomes and goes against what we see other states and countries doing.

In closing, I would like to touch on the questions that the committee posed in this inquiry, and the fact that you focused on current, as well as projected demand for acute health services. Projecting numbers based on our population demographic, say for chronic disease, is something we may be able to get some relative accuracy around. The same approach cannot be taken with mental health. There is no argument that we have been experiencing an unprecedented number of presentations at our emergency departments, though our understanding is that this has actually

been for all health conditions, not just mental health. Strategies to address current demand are warranted and should be escalated.

Our concern, however, is if longer term solutions are based on a projected number that is based on our current mental health system design, then we are at risk of completely overlooking the opportunity to ensure better mental health outcomes for Tasmanians. Good public policy and a successful health system should not focus on how we can help people once they have reached crisis, but rather focus on how we can prevent people from reaching a crisis point at all.

We appeal to the committee, that when considering recommendations to meet projected demand, you consider the impact of service redesign that is focused away from acute care that would thereby alleviate demand. Thank you.

CHAIR - Thank you very much for that, Connie. We will go straight to questions. With respect to your submission on the second page. About the third paragraph from the bottom, you say, 'It is not yet known whether the recent increase in mental health presentations and admissions represents a spike in demand, peak demand within a trend, or ongoing exponential growth'. You alluded to that just then. You say, 'until this data becomes available we urge the Tasmanian Government and other stakeholders to exercise caution in relation to the creation of additional acute care infrastructure that may be unnecessary and inefficient in the longer term'.

That is an interesting statement. One would say that is forward thinking. We have been hearing from parties about the pretty sad state - that is the way it is being described in some instances - of mental health services within our acute setting.

Do you see a way forward in being able to reduce that impact? You talked about diversion units and respite centres. Do you have experience with these particular facilities?

Ms DIGOLIS - We certainly have examples of those in other states. The PARC model I talked about is one of those. We have seen some recent developments locally at the Royal. The THS is starting to look at an observation unit, which is to be able to divert those people who might not require sub-acute care. Ideally, it would be something that isn't co-located in a hospital. We would need the systems in place in the longer term to ensure that people have enough awareness to know that the hospital is not the place to go. One of our broader public challenges is that Tasmanians do not actually think hospital is the place they should be going to.

Educating the general public is one issue for us. We also need to look at what supports could be available outside of that hospital system. While we have people presenting at hospital, if that is the place they are landing, then we do need to look at something that is going to be co-located within that hospital environment. The last thing we want is to be sending them away or on another rabbit chase for another site.

CHAIR - What current respite centres are there in Tassie that you are aware of?

Ms DIGOLIS - For mental health?

CHAIR - Yes.

Ms DIGOLIS - We would have some sub-acute ones in the northern suburbs. We have Tolosa; we have Mistral Place. We have ones within public mental health services and we also have community-delivered services.

We are aware of recent developments with one of our community organisations which is looking at providing accommodation as well. That is looking at shorter-term transitional needs.

CHAIR - What is there is likely to be delivered by you. You are a peak body aren't you, basically? One of your member organisations?

Ms DIGOLIS - Yes. At the moment we still have a mix between more limited community-delivered services, which are still sitting within public mental health services. It is important to work out the balance with where that leads to.

CHAIR - Their funding comes from where?

Ms DIGOLIS - State Government.

CHAIR - Okay, thank you.

Ms FORREST - You raise some really good points on the need for public awareness. A lot of people, particularly on the north-west where I am from, would think if they are having a bit of an anxiety crisis, they have to go to hospital. They don't think there is any other place to go, and there probably isn't. Not easily identified and easily assessable. Certainly in the minds of those who love and care for them.

You talked about the Victorian PARC model. Can you tell us a bit more about that - how it is run and where it is run out of. Is it separate to the public health system or not? I do not know much about that and it would be really helpful to know a bit more about it.

Ms DIGOLIS - It is actually a blend of clinical and community-based services. When I say a blend, it is quite an interesting model. Here in Tasmania we tend to have our clinical services sitting within a hospital or within our public mental health services. Then we have community-based which tends to be more psycho-social supports. There is almost a divide between clinical and non-clinical supports. PARC is a blend of those, so those services are co-located. They have clinical supports and psycho-social supports all being delivered within that same location and they are separate to a hospital.

Ms FORREST - They provide outreach services?

Ms DIGOLIS - They do both, they do residential and outreach.

Ms FORREST - I would be interested in how they actually do that.

The other point you made was for the need for the step-up and step-down models of care. That is what they provide as well?

Ms DIGOLIS -Yes, they fit that model. Someone could be referred to them if you can see that someone might be escalating towards ...

Ms FORREST - To try to prevent acute hospital care?

Ms DIGOLIS - Yes, they provide that intervention and then they take people directly from hospital so they are referred into their services as part of the discharge process. That often includes some short-term accommodation to then support them back into their home.

Ms FORREST - We do not need more acute hospital beds? You were not here earlier today but we heard a number of representations from the psychiatric workforce. I do not think you will disagree that we do need some inpatient beds because some people are sick enough to warrant that.

Ms DIGOLIS -Absolutely.

Ms FORREST - They were saying that over a number of years the number of acute beds has been reduced. The move has obviously been to institutionalise people who had serious psychosis and things like that. There is a view by some that they have gone too far and force it all to the community lately, and we need to come back a little.

The Royal redevelopment has been an interesting challenge for most people, but even with the new facility in K block that is being built, there are fewer beds than they had a few years ago, and only one more than the unit in B block before they knocked it down. They are saying they need more inpatient beds to meet the demand, particularly, I think the comment was, because we don't have step-up, step-down facilities. You need to do both at once. What do you say about that? There is a disconnect there. No-one is denying we need inpatient beds and no-one is denying we need improved mental health care in the community. That can be interpreted a couple of ways but how do we find the balance here?

Ms DIGOLIS - A question we often ask ourselves.

We advocate for more beds, but our question is whether it is acute beds that we require more of or whether it is sub-acute beds. While there is the absence of a coordinated, integrated step-up step-down model for people, then there are big gaps. We are falling into the trap of waiting until people are unwell and hospital is becoming the entry point.

Ms FORREST - Having to leap over the bit that should be there.

Ms DIGOLIS - Yes, because step-up would have more apparent gaps in it than step-down. We can probably find more examples of working systems and services that support people out of hospital than we would find to divert people from needing to present to hospital in the first place.

The number of beds is an interesting one. Clinicians on one side will say 'These are the numbers we use and this is how we have calculated per population', and the Government can say, 'Well, we have our experts and they have used similar calculations and this is how we have come up with our number'. I think it is an argument of which expert you want to say is right or is wrong. That is a very difficult one to determine and we have tried to step further away from that particular debate.

Ms FORREST - That is fine.

Ms DIGOLIS - Inherently, we are really trying to urge that in terms of infrastructure and longer-term cost to the health system, an acute bed is about as expensive as we can get. Our argument is that surely we should demonstrate that we can do everything on either side of hospital and everything that we can to avoid people needing hospital. Then we would have an accurate picture as to what the requirements might be in actual numbers of acute beds.

Ms FORREST - If those step-up care facilities were much more readily available, as well as an increase in the number of step-downs - in many areas of the state there are not adequate step-downs - what impact do you believe that would have on the rate of adverse patient outcomes and poor patient outcomes we see?

Ms DIGOLIS - On one hand we would be looking at a cohort of people that at the moment are needing acute care, which could have possibly been completely avoided because we would have had the right supports and interventions in place for them to not require hospital care.

On the other side of it, we could also look at people's longer-term recovery being more effective. Anecdotally, we have some of the longest hospital stay rates in the country. Part of the argument has been that we do not have anywhere else to refer them to. It is about ensuring that patient flow is being maintained, so we are moving people out when they are no longer at that acute end of their episode. They are being supported and transitioned into care and interventions that will support their recovery, rather than support their condition.

Ms FORREST - Thanks.

Mr FINCH - It is a nice, short assessment of your circumstance, with some nice conclusions. With the work you do with the Mental Health Council, how do you progress your thoughts, your concerns, your evidence to the government of either shade, state or federal government? Do you have regular reporting or contact opportunity to express your observations?

Ms DIGOLIS - We do, with the current Government. Around certain aspects of Rethink, we are a stakeholder in the consultations, the development of some of those initiatives and the overarching implementation of Rethink. What we see lacking in regard to the implementation of Rethink is that overarching strategy as to what the system needs to look like, how we know we have got there.

Mr FINCH - A strategic plan, do you mean?

Ms DIGOLIS - More of a comprehensive implementation plan, so that we can recognise what it is that we are working towards as a system, not just pieces of the system. I can see that is challenging. We have federal government initiatives as well, which also impact on mental health services. There is the need to coordinate across both the state and federal level. We do what we can to work with Primary Health Tasmania and the state government. As we are moving into an election phase, there are more conversations we are having in regard to how we would like to see an integrated mental health system achieved. It is a combination of trying to put the periscope up and say, this is where we believe we need to be, and reminding government this is what we are aiming for. Then it is being down in the trenches with them and ensuring we are part of what is being implemented now.

Mr FINCH - How long have you been in this job, with the Mental Health Council?

Ms DIGOLIS - Two-and-a-half years.

Mr FINCH - Two-and-a-half years, okay. You do not have any experience of working with a different shade of government?

Ms DIGOLIS - No.

Mr FINCH - Okay.

Ms DIGOLIS - Well, not in this role, no.

Mr FINCH - I wondered whether there might have been a comparison you could make as to whether you find your prognostications are included, are accommodated, you have an open dialogue, open communication with the Government, whether it has improved or deteriorated.

Ms DIGOLIS - I would not be comparing apples with apples in that regard. I was previously working with the health sector but in chronic disease, so it was a completely different area. I have to confess that mental health is a lot more complicated. As I said, by having federal government having a very active stake in mental health service delivery within our jurisdiction, I think that does create more challenges.

Mr FINCH - Yes, okay. We have seen the concern presented to us through the inquiry on this area of concern for the Tasmanian community. It seems the Mental Health Council is going to have a strong role to play in the provision of those suggestions and recommendations you might have for the government to take into account as they do that forward planning.

Ms DIGOLIS - We would hope they would have an ear towards our recommendations, yes.

Mr FINCH - Yes.

CHAIR - On a day-to-day basis, how often do your organisations have contact with hospitals, with acute health services as to the needs of a patient or anyone exiting their system?

Ms DIGOLIS - There are arrangements in place with specific organisations. There are programs that have been funded -

CHAIR - Federally funded or state funded?

Ms DIGOLIS - State funded. They are service to service. There are referral systems in place for them to work directly with those organisations. It would really be a matter of asking them what level of referral rate or contact they have with the hospital.

CHAIR - I wondered whether you had any statistics or further information.

Ms DIGOLIS - No. We could get it but it is a little bit more challenging.

CHAIR - No, that is okay.

Mr FINCH - Is there a model - as to the things you have been talking about and presented in here; how things should work in the current environment and climate - in Australia that is the

exemplar we might use, an example as to where we might go? We talk about a plan for the future. Is there an operation in Australia that is doing it as it should be done, to suit contemporary times?

Ms DIGOLIS - I would question that we do in Australia, to be honest. I am basing that on knowing we have some particularly successful models, like the PARC model in Victoria. There is a similar model in country New South Wales, which is slightly different again. Would I say that there is one across an entire region? Probably not. That is reflected in the Fifth National Mental Health and Suicide Prevention Plan, because the recognition is still there that we have not achieved it yet.

There are some very effective international models and some of them are really about that system. Looking at the system re-design, I know I referred to the PARC as being clinical and non-clinical supports being provided together, but you can look at some areas in countries in Europe where they do not have public mental health teams based in their hospitals. Rather, they provide complete outreach services. There are exemplar models where there are virtually no acute services in some areas in Europe because of that model they have adopted.

We are a long way from that, but there are certainly ways that we could achieve something like that fairly quickly; were there the will, the pressure and policy to do so. As I said, it means system re-design.

Mr FINCH - Do we have a Mental Health Council in each of the states?

Ms DIGOLIS - Yes.

Mr FINCH - You would all be able to compare? Do you have an annual gathering?

Ms DIGOLIS - Yes, we have a national alliance. We have Community Mental Health Australia, which is our alliance. So yes, we do meet regularly. Interestingly, we all have slightly different challenges. As you would expect we all have different population demographics as well.

Mr FINCH - Even in Tasmania, as we have heard.

Ms DIGOLIS - Yes, there is that too. We do have different impacts even just around NDIS so where we have different bilateral agreements which is impacting on some of those community-based services as well.

CHAIR - But you are a standalone organisation, you are not affiliated in the sense. You are just simply -

Ms DIGOLIS - No, we are a member of that organisation.

CHAIR - You meet to exchange ideas and -

Mr FINCH - And your funding too is federal? You might have mentioned it before, I'm sorry.

Ms DIGOLIS - Our funding is largely state so from the state government and then we also have membership fees.

Mr FINCH - What is the quantum of your state funding?

Ms DIGOLIS - Overall income, it would be about 85 per cent.

Mr FINCH - But the quantum, the amount? One million dollars, two million?

Ms DIGOLIS - No, we are around five hundred.

Mr FINCH - Five-hundred thousand dollars? Okay. Does that leave you starved for funds? How does it work? I am wondering whether there might be a need for the government to look at whether there is a need for more funding to support the work that you do.

Ms DIGOLIS - The decision for the government would possibly need to be around whether there is an advantage to having an organisation involved in the process of redesign that is actually independent of government, in the sense that we are not directly working with public health services. Our role, from a policy perspective, is actually to be able to look at the system and not necessarily to advocate for individual members and their work, but to actually say if the overall system needs to be designed in this way then this is how we can actually ensure that it is working or that we are moving towards that.

Mr FINCH - So you are positioned to do that at this point? Or does the funding coming mainly from the state government mean that you might be guarded in the work that you do and that you need to be more compliant with the government or are you able to advocate strongly in respect of your constituents?

Ms DIGOLIS -We are not compliant to the government in the sense that we actually advocate for our member's views. So until our members are actually saying that the mental health system is delivering the outcomes for their clients and for the population that they work with then we do not have any room for being compliant. We have to keep pushing forward and advocate for the need that is necessary, the change, sorry that is necessary.

CHAIR - It is interesting in your submission that Tasmania's Rethink Mental Health strategy aligns itself with this principle to ensure people get the right clinical service at the right level at the right time linked to other non-health supports as required. That principle, the Rethink strategy, aligns itself with this principle you say, stating that its goal is to reorientate the Tasmanian Mental Health system to increase community support and reduce the reliance on acute hospital-based mental health services. One would expect that if that is the government's thinking that there would be every reason why they should be wanting to communicate more with you and improve that side of the equation.

Ms DIGOLIS - We certainly have many cases where that actually happens. Touching on Rethink we have just in the last few months gone back out to our members and consumers and carers and talked to them about the reform directions that are in Rethink to ensure that it still has relevance for them. The resounding response from them is yes, they actually do still find all of the priorities of importance in Rethink. No question, there are some frustrations with what they feel is or is not being achieved, or needs to be achieved, and the pace that it is actually happening at, but when it comes to the goals of the 10-year mental health plan they do support it and they want to see it continued.

CHAIR - Are you able to articulate what some of that frustration might be?

Ms DIGOLIS -Yes, absolutely. We have two funding players, the state government and federal government, but we do not have a mechanism that ensures they are coordinating everything under one implementation plan. We are finding we might still have a little bit of tripping over each other when it comes to funding services. We still have duplication of some services and we still have existing gaps that are not being addressed because we do not have that mechanism to take that systematic oversight toward a step model of care and to making sure we have an integrated mental health system.

Ms FORREST - A comment in your submission in the third paragraph -

> Additionally, without a whole-of-system approach to mental health infrastructure, there is no entity responsible for the oversight of system trends or outcomes, which means there is very little scrutiny or insight into the factors contributing to scenarios like the one we are witnessing in Tasmanian emergency departments at present.

I am interested in how you see a system that overcomes that. I had a quick look at PARC (prevention and recovery care) guidelines, which I sent to you all to have a look at.

Ms DIGOLIS - We can provide you with links to any other documents if you are interested.

Ms FORREST - That would be helpful. I looked to governance to see how it operates. It says -

> Adult PARC services are managed by the health service through its area mental health service (AMHS). A distinctive feature of adult PARC services is that the AMHS forms a collaborative operational relationship with a psychiatric disability and rehabilitation support service (PDRSS) to deliver the required services to PARC clients.

It seems that it sits under Victorian Health to some degree but I have not read all of it. You are dealing with a bigger and a more centralised population base in Victoria, which makes some things easier, although it provides its own challenges. It is probably easier to attract special staff to Melbourne than it is to the north-west coast of Tasmania. How do you see this whole-of-government systems approach being managed to achieve this sort of focus the PARC system would have?

Ms DIGOLIS - If we look at it in three parts - as primary, public and community areas of health service delivery - then it is ensuring we are taking a coordinated approach to those three areas of the system working toward that overarching goal, which is that stepped model. We need to be ensuring we have Primary Health Tasmania, and whatever they might be funding in regard to primary care and the services they fund along with the work they do with GPs, complementing how it goes into more of this high level of care, such as the PARC provides. Then it is getting those community services working within that PARC system as well. You could do regional models with something like PARC.

Ms FORREST - There was strong support for a statewide mental health service as to strategic planning and so on, from other witnesses in this space. With a statewide model, you can

pool resources and make strategic decisions for the whole state. We should be able to do that, we are a small state.

Ms DIGOLIS - As I say, the population of Geelong.

Ms FORREST - We are much more spread out than Geelong, but when you look at that, how do you then achieve that locally-based system without going back to pulling it apart? One of our biggest challenges in Tasmania is saying, we are from the north-west, we are from the north, we are from the south; we are not going to talk to each other. A statewide mental health service aims to avoid that. I do not know how big their area mental health services are or how many there are in Victoria, but it seems that there is that degree of -

Ms DIGOLIS - Local implementation?

Ms FORREST - Yes.

Ms DIGOLIS - You would need that to work with the community services. We have a complete variation of who is able to deliver what across different regions of Tasmania. It may be that you would look at regional plans but they are all working under an overarching mental health service plan, and that is where you get back to your statewide service.

What we are also lacking are some of those measures around knowing we have set the outcomes we need to achieve but we also have those targets there. I would also go so far as to suggest we still have not done the benchmarking to identify where the current gaps are in the services and, in addressing them, how they get addressed systematically, rather than saying we are just going to bandaid that or patch in that. It is to say, we are taking a coordinated approach to this full continuum of care and make sure we are aware of where those gaps are and how they can be met.

Ms FORREST - That is work that needs to be done by the statewide planning or strategy?

Ms DIGOLIS - Yes. You would find that for a lot of community-based services, they may come under different names but they provide very similar types of services and programs across the region. You could then look at regional implementation plans.

CHAIR - How many of those services operate statewide? Are they all regional?

Ms DIGOLIS - No, I am going to pull this off the top of my head, but I would say at least half of our members offer statewide services, if not more.

CHAIR - Okay.

Ms DIGOLIS - We do need to look at those thin markets. We need to look at rural and regional supports and the most effective way to provide that.

Ms FORREST - We often see really good ideas and good projects pop up and be funded and there is always the challenge of them being re-funded. Maybe they do away. One of the other problems is if they continue to be funded and they are simply duplicating services. It might be better to be consolidated in a region. I am not saying you would consolidate statewide,

necessarily. Smoking is the same. You have all these programs and if you pooled your resources you might be able to run a more effective campaign, for example.

Ms DIGOLIS - Which has been the conversation we have been having around suicide prevention. We have some very clear funding streams coming in from federal and state government, and priorities around suicide prevention, in this state. We can say there is some really good evidence the state government and Primary Health Tasmania are working very well on doing that together. If it should work anywhere, it should work in Tasmania; being able to consolidate that funding. The policy is consolidated. Federal and state governments have both set exactly the same goals and outcomes for mental health. We have an alignment of policy, we just don't have an alignment of funding initiatives and implementation of the policy.

If it should work anywhere, it should be able to work in Tasmania because we have a manageable size with our jurisdiction and we have less players. We do not have multiple primary health networks that are competing against each other.

CHAIR - Is postnatal and adolescent -

Ms DIGOLIS - Perinatal.

CHAIR - Perinatal, sorry.

Ms FORREST - Postnatal is part of it.

CHAIR - It is, yes. Does that ever come up in conversation with your organisations?

Ms DIGOLIS - Perinatal and adolescent and the lack of -

CHAIR - The lack of acute services for them.

Ms DIGOLIS - Yes. We know there aren't any adolescent mental health beds. I am not entirely sure of what the demand is either. We tend to be talking more with our community-based organisations who are talking about their concerns, not having private consultants or the support services to refer people to. CAMHS is an example of a state-based service, which -

CHAIR - CAMHS being?

Ms DIGOLIS - Children and Adolescent Mental Health Services. We have reports and I am talking to them as well. They triage to take the most extreme and highest intensity cases. They do not have the resources to take any more than that. People who might be middle to high need but not complex end up landing somewhere like headspace. So headspace is now dealing with a demand for higher level needs of care and support that they are struggling to meet, but it is the most urgent one so they start addressing that. Then they do not necessarily have the full capacity to deliver the lower-level care and supports for adolescents because they are delivering the higher end.

It is that ripple effect where the push keeps going further down. We are finding there are people who are not being able to receive the supports and valuable intervention so that they do not become more unwell.

CHAIR - Thanks. We are getting close to time. Is there any other statement you wish to make before we draw it to a close? Everything is fine. Thank you again for coming. I remind you again about the parliamentary privilege. Whatever you say away from this table is not subject to parliamentary privilege. I will just alert you to that. Thank you very much for taking the time, it is really appreciated.

Ms DIGOLIS - Thank you. Good luck with your inquiry. If there is any more information that you would like us to forward to you, please let us know.

CHAIR - Thanks very much, Connie and Catelin.

THE WITNESSES WITHDREW.

Ms GILLIAN MANGAN, HEALTH DIRECTOR, AND Mr GRAEME LYNCH, CEO TASMANIAN DIVISION, HEART FOUNDATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR - For the record, welcome to the Government Administration A Subcommittee Inquiry on Acute Health Services in Tasmania. That is to make sure that you do not think you are in a TasWater hearing or something like that. All evidence taken at the hearing is protected by parliamentary privilege. I remind you that any comments you make outside of the hearing may not be afforded that privilege. There is a copy of the information for witnesses, have you had the chance to read that?

Mr LYNCH - Yes, we have.

CHAIR - That is fine. The evidence you present is being recorded. The *Hansard* version will be published on the committee website when it becomes available. If, during the hearing, you feel that you want to make any confidential statements just please make us aware of that and we can discuss that and go forward from there. First we will ask you to make some opening statements if you wish to do that.

Mr LYNCH - We would like to, to put the context.

CHAIR - So, over to you.

Mr LYNCH - Chair, we would like to thank the subcommittee for the opportunity to present today and give oral support for our written submission of 24 August 2017. First a couple of procedural things. We would like to seek the subcommittee's permission to table an updated version of the annexure to our submission of the state-wide Cardiac Services Plan. It does not have any material changes. It has a foreword and an executive summary that was not ready at the time that we submitted our submission.

CHAIR - You wish that to replace the ...

Mr LYNCH - We wish that to replace, yes. There are no material changes to the content of the state-wide Cardiac Services Plan.

And secondly, on page four of our submission we seek to make an amendment halfway down that submission we want to replace 'the THS' with 'the DHHS'.

CHAIR - So, 'the DHHS is to commission ...'

Mr LYNCH - The role of the DHHS is to commission.

CHAIR - Under the level of engagement with the private sector in the delivery of acute health services.

I am informed it can be done by email, but then we have to table it in the committee to have it submitted.

Mr LYNCH - Could I suggest, Chair, that we make the amendment here and table the amended document.

CHAIR - They do not go in and amend the submission that is on the site. If you could simply email it to us with the attachment so it is a fresh submission. That is an important process for us.

Mr LYNCH - As the committee would be aware the Heart Foundation's submission focuses on cardiac services. It is the Heart Foundation's view that many of the issues that are given cause to this inquiry of the subcommittee would be addressed if plans like the Heart Foundation statewide Cardiac Services Plan were developed and used as a blueprint for the One Health System when it was designed several years ago. We see that as a major gap and it has led to many of the issues that this committee is addressing at the moment.

Also, unfortunately it is our view that the One Health System was developed with a view to looking at the acute sector administered by the Tasmanian Health Service in Tasmania rather than a whole system plan. By contrast, the Healthy Tasmania preventative health strategy is a more holistic approach to health and well being in Tasmania. That strategy had the benefit of recommendations to a joint parliamentary select committee on preventative health. It recognises the need for an integrated joined-up approach across all layers and sectors of the government, private for-purpose sector and the community. Unfortunately, it does not inform or connect to the One Health strategy system plan which was written in the environment of a government-controlled health service silo.

The DHHS, in its role as a commissioner, should have statewide plans, of which the statewide Cardiac Services plan may serve as a blueprint. We would see that as providing a framework for comprehensive need assessments, system design and allocation of resources across the Tasmanian health services, not just the Tasmanian Health Service but across all health services.

This is the view the Heart Foundation has promoted nearly over seven years now, as we point out in the background of the Cardiac Services plan. It is our view, it is conventional and accepted view in health systems, that integration is critical if we are to reduce the ever-increasing stresses and burdens around the world, but particularly in the Tasmanian acute health setting. That is the integration between the primary and acute, secondary patient journeys, including the role of the private sector and the not-for-government organisations, other service providers and the community more broadly.

The main recommendation the Heart Foundation makes to the committee is that the statewide Cardiac Services plan be adopted by the Tasmanian Government and implemented across the health system, and that it could form a blueprint and a way of dealing with other streams within the health system so they are holistically integrated.

The Cardiac Services plan does recognise there are different funding streams and responsibilities in the Tasmanian health system. Implementation of this plan would require joint commissioned approaches - we see commissioning as a very important part in tackling some of our issues in Tasmania - in the DHHS, which is both Commonwealth and state government funded, primary health networks, the MBS and other funding streams, to deal with an integrated, multidisciplinary approach and, as far as possible, care in communities outside the acute system. That is really the main point the Heart Foundation wishes to make to this inquiry.

CHAIR - When did you last speak with the Government about a plan such as this being put in place?

Mr LYNCH - We have been constantly discussing this, which began seven years ago with the secretary at the time. It has been something, as we outlined in the background of our submission, we strongly pursued with the government. In the previous health plan it was an action item in that plan that there should be statewide systems and plans for a range of conditions. About four years ago we realised that was not going to happen within the structure of the DHHS and the three health organisations, as they then were. The board of the Heart Foundation made a conscious decision to enable and resource us in Tasmania to take the evidence from around Australia, apply it to the Tasmanian context and come up with a document like this.

It was our original intention this plan would be endorsed by the government, by the health minister and it would be a joint plan. It has become apparent that if we continue to wait for that to happen we would not be here today.

Ms FORREST - A joint plan being both parties would adopt it?

Mr LYNCH - A joint plan the Heart Foundation and the government would adopt as evidence-based and independently produced, but taking into account stakeholders from across the whole health system and be endorsed in that way. It became apparent to us that that just wasn't going to happen. We are now using it as an advocacy document, if you like, to present and start this discussion about the need about strategic planning for what the health system should like. Glancing at, not having read in full, many of the submissions that have come before this committee already, many of them dive into the detail about what needs to be done without looking at how we coordinate the whole of the health system.

A recent example of that has been some money that became available recently in the cardiac care space. We had all sorts of stakeholders from various hospitals around Tasmania and others come into us asking, will you endorse this funding application? There was no coordination about where that might sit into a whole-of-state Cardiac Services plan. That is the same for many other issues, funding becomes available but there is no obvious place where that fits in and joins up to leverage and produce something that works toward a better system. It is more an ad hoc approach.

CHAIR - In trying to promote this, have you looked at encouraging a tripartisan approach to the delivery of this plan?

Mr LYNCH - Tripartisan in the political sense, do you mean, Chair?

CHAIR - Yes.

Mr LYNCH - We have briefed all sides of politics around this approach. It is something that has been in our advocacy documents for six years. Originally we were seeking support for funding of this. That did not appear as though that would happen. We believed it is that important, and again this inquiry is now at a point where we are looking at, 'what do we do?', and there is an absence of an integrated plan. We have bits of plans, but they are not joined up and they are not connected.

One of the most important things about the acute setting is looking at what happens at the interface of the acute setting. It is important to look at people coming into acute care and going out the other side, how we look after people in communities, how we cannot do a lot of the acute interventions in cardiology or in other disciplines. Cardiology is what we know a bit about, for example, you cannot have catheter labs in every site around Tasmania. You cannot do cardiothoracic surgery everywhere. We need to have those supports built in an integrated way so we can deliver the best care, but then look after people when they return to their communities.

CHAIR - It links with the preventative advice you submitted to us during the preventative health inquiry.

Mr LYNCH - Prevention comes into every aspect of health care. If someone has a heart attack then prevention is a very important part of their rehabilitation. It is secondary prevention. One of the main differences between secondary prevention and primary prevention is the acute event that happens in between. Unfortunately, the way the One Health System has been designed it has not addressed the whole system. It has only addressed the Tasmanian Health Service, which is really the government commissioned hospitals. It ignores all of the other factors that can contribute in this space, which includes the private health system, the not-for-profits and so on, and very much the community.

Ms MANGAN - We would also say the One Health System really only focuses on the acute four hospitals and doesn't look at the capacity of the community health centres or the smaller district hospitals in being able to look after people, keeping them out of the -

Ms FORREST - If you look in the budget papers you will see they are all separate line items. The overall message is clear and I am tempted to say it is a no-brainer.

Mr LYNCH - No, do not say that.

Ms FORREST - Sorry, I will take that back. If you are looking at better, faster access to time-critical care, I will take out 'cardiac', raising community awareness of early warning signs, support rapid access to whatever it is that person needs; you can apply it to stroke, asthma, trauma, almost anything that is an acute, life-threatening event.

Mr LYNCH - Precisely.

Ms FORREST - Has the Heart Foundation had discussion with other key peak bodies to suggest we work on the whole plan? I accept the government's job, but it is not only about us and the Heart Foundation. We are concerned with cardiac care but we are looking at the whole health system. Would that be a more effective approach as to convincing the government?

Mr LYNCH - There is the Australian Chronic Disease Prevention Alliance, the committee is aware of the members of the alliance. We discuss these issues but the prevention alliance is primarily an alliance around prevention, whereas this covers the whole journey and management of particular diseases.

We talk to our colleagues and we work very closely with Primary Health Tasmania, who are really leaders in this integrated approach because they are out in the community looking at the interface. That is why we have couched in our submission that we see this type of an approach could be applied, as you have just pointed out, to all chronic conditions, and could be adapted.

When you get into the acute sector, there are quite different methods of treatment required and different role delineations. Once you are in the acute system it is different, but the interface going in and coming out of the system is the same. Discharge, summaries, communications with GPs and interventions within the acute care system are all exactly the same. A bit of this plan is around how the cardiac services are distributed around the state and how they should be managed. That will be different to cancer treatment and it will be different to some chronic diabetes care and community care and so on.

Ms FORREST - Yes. As you have rightly identified, Graeme, there are services in the preventative space that continue up to the point of a need for an acute admission. Is the different funding stream still creating challenges here? We used to see a lot of cost-shifting going on: if they can push you into the hospital system then the state will pay for this procedure or this investigation or this test. Likewise, if they could push you out of hospital a bit quicker then the Commonwealth funding picks up on your post-operation blood tests and your physiotherapy and whatever else there might be. Is that an issue?

Mr LYNCH - Certainly the multiple funding streams are an issue. They have been the topic of a lot of discussion in Tasmania over the past four or five years. Ideally there would be a single funder. That is something that should continue to be discussed. Under our current federal arrangements and the fiscal arrangements, that is probably not going to happen soon. What we identify is a real opportunity and we have talked to both the Primary Health Networks and the DHHS about this plan. The way to implement all of the things that are in a plan like this is through commissioning.

Commissioning is becoming a new way of purchasing health services from the Tasmanian Government and from the Commonwealth Government. Commissioning is an approach where you look at what the need is, which is the needs assessment base. You look at what the right solution should be and then you commission people through an evaluation process to find who can deliver that. The real opportunity to implement something like this is through a joint commissioning approach, where the DHHS as a commissioner works with Primary Health Tasmania as a commissioner and other sources of Commonwealth funding and joins that into a commissioning bundle.

To have good care for people after an acute intervention, you need coordinated care which is joined-up commission care. The majority of that care is about how to get to appointments, how to adhere to medications. Those things we should be funding in the same way. We should be joining up the funding streams and asking how are going to get the best outcome for these heart patients using this plan? We have money in the state pool that can commission some of this, we have money in the commonwealth pool that can commission this and we commission it with the same outcome and we manage it as an improvement process.

Ms FORREST - You are talking about a patient-centred care approach, Graeme.

Mr LYNCH - It is a patient-centred care approach and it is fascinating-

Ms FORREST - Both in, out and back of various systems.

Mr LYNCH - In the introduction we have acknowledged that this has been prepared with the work of the Heart Foundation around Australia and what we have done in Australia. It has also

relied on our local health advisory committee, which is most of the main players in cardiac services in Tasmania. In those discussions it is very difficult sometimes to break away from a siloed or a location-based approach. Getting the Heart Foundation or other NGOs involved in supporting and writing these plans that are owned outside of government enables you to have an objective evidence-based approach about what is best for the whole system, rather than the political interference that comes when you are looking at bits of the system or when you are looking at entrenched silos in ways of working.

This plan, while it has had the input of many clinicians, such as the cardiac services advisory group when it existed as a DHHS group, brings an impartial evidence-based approach. As we sit with our stakeholders, they might think there is some interest or self-interest, but we have been able to bring them back with exactly what you said was about the patient. We are here to talk about the patient and not about shifting costs.

CHAIR - And the outcome for the patient.

Mr LYNCH - Yes, and the outcomes for the patient.

Mr FINCH - Graeme, do you monitor the progress of the people who suffer heart attacks or have cardiac issues? Do you monitor their progress through the system - callouts, ambulance, emergency department, the way they are treated at the hospital and the after care?

Mr LYNCH - That is a good question. I will pass that to Gillian. The ideal way to manage chronic disease is to have registers of what happens.

Ms MANGAN - That is something you have mentioned here. The data collection that happens around the state does not talk to each other. One hospital's data does not talk to the other. Tas Ambulance data does not talk to ...

CHAIR - Is that for privacy issues?

Ms MANGAN - It is different systems that have been set up.

CHAIR - They are not compatible systems.

Ms MANGAN - Not compatible. Even the inter-hospital systems do not talk to each other. There is some hope, it has been talked about for years, that there will be a single hospital system that will be the same ...

CHAIR - I worked in ICT in Health for 20 years and ...

Ms MANGAN - You were probably trying to put it in place.

Ms FORREST - Single unit health records? I was told recently when I challenged this that they are in place in the public hospitals.

Ms MANGAN - There is a unit record number but that is not necessarily linked to the ambulance data. It does not talk to GP systems, so there is not a capacity to overview that. The Heart Foundation does not have access to that level of data. We would love to, but the way to get around that would be to establish registers.

Mr LYNCH - To track what you are referring to really needs an Australian-wide registry. People move, they have their events in different places. Until we get to - if we get to - a national personal electronic health record - you are correct, there are identifiers for people in the Tasmanian health system but that is limited so that does not cover what happens when they are outside the THS …

CHAIR - Mind you, they trialled the personal electronic health record in Tasmania first.

Mr LYNCH - ... and there continues to be a lot of work around that. It is changing from an opt-in to an opt-out system. That is ideally what we need because data is very powerful in how you manage and design services.

Ms MANGAN - One small example of that. I am in a working group with the THS to try to address ambulance callouts that go to someone who is having a heart attack. Ambulance now has the capacity to do a 12-lead ECG but they cannot transmit it to a cardiologist at the Royal at the moment. We are finally getting to the point that there has been agreement that a phone shot of the ECG is going to be sufficient quality. These are the sorts of things that -

Ms FORREST - Such is the technology of our iPhones these days.

Ms MANGAN - That is exactly right, but there are ECG machines that can actually talk to the hospital system so the cardiologist at the time can go, 'Yes, that is definitely a ...'.

Mr LYNCH - That is eHealth, the ECG transfer. That is one aspect of eHealth. It is just like chatting to people. The deeper question that enables us to plan effectively for a whole of health system is those lifetime records where we can get the whole journey and then we can link the data. We do have a Tasmanian data linkage unit in Tasmania which can take records from the DHHS and link those to population records. We can link them to education; link them to criminal offences. All of that is possible. It is happening. It has been funded through significant Commonwealth funding, but you still need the whole-of-health record to be able to do that very effectively.

Ms MANGAN - That tends to be used for research purposes rather than system planning, at this point.

Mr FINCH - Would the Heart Foundation get across issues that might come out of ambulance ramping, where a person with a heart problem requires urgent treatment and they come in, in the ambulance and then it is blocked or held up or they need to be treated on a ramp. Do you get any feedback on those circumstances? Do you monitor what is going on there?

Mr LYNCH - No, we do not monitor that. We see that as a system problem. The way to address the system problem is through this sort of evidence-based activity in ensuring that these things get implemented rather than as a bandaid. That is the problem at the moment.

I have read through many of the well-informed submissions of people on the ground coming before this subcommittee. Most of them are, 'here is the problem, here is a bandaid solution to fix this or that particular problem', rather than looking at the whole of the system.

We have had, over the last two or three years, cardiologists and cardiothoracic surgeons coming to talk to us about the capacity of the cardiothoracic unit, which has been a hot issue. They have come to me because they are on our committees and I say that I cannot comment on that until I have a document like this that tells me what the evidence is we should have in Tasmania, until we work out where things should be. Now, I can comment on it because we have the evidence, we have been able to link that in with the role delineation work that has been done, which is good work, around the ranking of the THS-controlled hospitals in Tasmania. Then there are the other players with capacity in the private system.

Ms MANGAN - That only does the role delineation at the four major hospitals, not district.

Mr LYNCH - That is what I am saying.

Mr FINCH - I will be interested to see the establishment of the adult cardiac surgery unit in Tasmania. I am curious about this process. We do not have the capacity to deal with people who need surgery in Tasmania and need to travel interstate. That is all done efficaciously, not a problem there. Have you had any reports that it could not be done in Tasmania because there is a fear there could be a circumstance that beds, which might otherwise be allocated to a CHU unit, might not be available because of the shortage?

Mr LYNCH - There is an issue around cardiothoracic surgery in that. To have a cardiothoracic unit in the first place you need a certain population, which is around 500 000 to 550 000 people. We have that, but not for two or three locations in one place. That is centralised here in Hobart. To maintain that service and for a surgeon to keep his skills up to speed and so on there is a certain throughput of operations that need to occur.

To do cardiothoracic surgery you need intensive care beds and you need profusionists, particularly if it is open-heart surgery because the heart is taken into an artificial pump while the surgery operates. There are real blocks if you do not have the throughput, you do not have the number of profusionists and you do not have the intensive care beds to enable that to occur. What has been happening, we have been informed by the cardiothoracic unit, is that surgery is often planned, the intensive care beds are not available and they are delayed. Then what happens is you have cardiologists around Tasmania who have patients who need treatment, who are concerned that if they refer them to the Royal Hobart Hospital their surgery may be delayed. There is an incentive for many of them to send their patients interstate. Once that happens you start to lose the volume that is required to perform the surgery. That is because of the inefficiency and the lack of overall planning of the whole system to deal with those things. It is easy to explain it, as I just have.

The solution is to look at the whole of the system and how we manage that, to ask, what are the real blockers of those activities and what stops us from delivering it? You do have to have a cardiothoracic surgery in Tasmania because it is not just heart attacks they deal with. They also deal with traumas.

Mr FINCH - Is that happening with regularity, Graeme, that these beds are not available because of the fear there might be a delay in the service that needs to be provided, that we have a regularity of people needing to go interstate?

Mr LYNCH - Surgery is regularly cancelled because the intensive care bed for immediate post-surgery care is not available.

Mr FINCH - Is this because they are being picked up by the hospital system to use for other clients?

Mr LYNCH - Of course, yes.

Ms MANGAN - That is outlined on page 37 to 39 in the plan, the issues around cardiothoracic services that we have an understanding of.

Mr FINCH - What are your thoughts about this unit being established in Tasmania? Is there a wish list, a desire for it to be completed, or be considered and established within a certain time?

Mr LYNCH - The unit has been here for 20-odd years. It has been in service for 20-odd years. It was doing - I would have to go back and look at the numbers.

Ms MANGAN - Approximately 400 to 500 cases a year and that has dwindled down over the last number of years. They are often only doing about 300 a year.

Mr FINCH - The 'guidelines' for the establishment of an adult cardiac surgery unit, what is meant by that? An enlargement in the operation?

Ms MANGAN - They are guidelines as to what is required to have a cardiothoracic unit. The reason that is in there is because it is referred to throughout the document, as to what is required for Tasmania. There is one for Tasmania that has been established. As Graeme said, they had their 20th birthday a couple of years ago.

Mr LYNCH - Prior to that, Kerry, those patients primarily went to South Australia or Victoria.

Mr FINCH - The suggestion here is that we should have a better, bigger operation and try to cover these things required as back up for the proper functioning of the CSU?

Mr LYNCH - Absolutely. We should be doing all of the surgery that can be done safely and competently in Tasmania, which is most cardiothoracic surgery. We cannot do heart transplants and really rare things that need to go to places where they have greater throughput and more expertise. There is a lot of capacity to do surgery here in Tasmania with the burden of disease we have that is not being dealt with here in Tasmania, which is going to Melbourne, Sydney or Adelaide.

Mr FINCH - Is there pressure on to have this unit established in the form you suggest and with the recommendations you have made here?

Mr LYNCH - We have talked about it throughout, and in my comments; there are solutions. The DHHS does not just have to commission the health service. It can commission other people and there is a cardiothoracic unit proposed at Calvary, the building is there. They are in the process of enabling that. We speak to that in this plan. Our view in this plan is that is one of the ways of meeting the demand. It is a strong recommendation for a population of our size that it should be a single service. Even though it might be commissioned for the surgery to take place at a different site, it should still be the same team, same perfusionist, same cardiologist, same nursing support, and so on. It is a single service over two sites. People who might be in the

private system might elect to go to the private hospital, but it could also deal with public patients as need dictates. That is a sensible approach to a whole-of-health system, rather than looking at the Tasmanian Health Service, which is commissioned and controlled by the government.

Mr FINCH - How far down the track is this proposition?

Mr LYNCH - As I say, the building is there. Where the negotiations are at the moment we cannot tell you, we do not know, but likely to happen, as we understand it.

Ms MANGAN - As I understand it, it is looking at the new year for it to be in operation at Calvary. It is our understanding that the Royal Hobart Hospital cardiothoracic unit will continue on, but whether there is a decrease in resources because now there is this other site established we are yet to see. Our plan says that we need a certain amount of throughput. It should be considered as a single service if it is split over two sites.

Mr LYNCH - It then gives you the volume. That starts to deal with the issue of referrals interstate. We keep our own, if you like, and look after them here in Tasmania. There is always an issue and it is not just the acute event that is important. It is what happens after the acute event. If you are discharged from a hospital in Melbourne and you come back to Tasmania, which health system looks after you?

Mr FINCH - Or you cannot come back straight away. The airlines will not fly you.

Mr LYNCH - There is that as well. When you come back, you come back into this system. It is that interface in the system. In Tasmania it should be efficient and effective so that we can do the surgery here and we can have the handover through cardiac rehabilitation, whatever form that might be, back into the community, back into general practice care.

Mr FINCH - And that is how the community would prefer it to work, rather than have to travel, moving away from Tassie, to get it done.

Mr LYNCH - Yes, it is the system failure that has led to that situation.

CHAIR - You do not think that at the end of the day the total service becomes more expensive because of the private component, no control over charging?

Ms MANGAN - If the DHHS commissions it, they commission it for the -

CHAIR - They have control over that side of it.

Ms MANGAN - That is right.

Ms FORREST - You spoke about this in your opening comments. I wonder if there is anything else you wanted to say about it, Graeme. You are talking about the fact that it is impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health services. You have said that the transition from three THOs to a single THS was meant to build a system that would provide better access to care and higher quality services. You said you were concerned this promise has not been realised.

Mr LYNCH - Yes.

Ms FORREST - What do you think needs to happen? If you were the health minister and you had the power to put a system in place that did that, what would your priorities be and where would you start?

Mr LYNCH - I would start with the needs of the community, of the Tasmanian health system. I would look at the whole patient journey, as we have described it. I would look at a statewide plan that delivered the outcome you required, then I would implement it. This is the hardest part of this, and this is why it is difficult. The health system is a huge bureaucracy and employs a lot of people. There are industrial relations. You are dealing with clinicians and their bodies. There are a lot of barriers to driving significant change. Often it is thought of in terms of who the current incumbent might be delivering a particular service rather than looking what is the best way to do it.

That is difficult to manage. But if you have a plan that is evidence-based, where you can point and say, 'We do not need to be commissioning these things here. What we do need to be doing is commissioning these things over here'. Then you have the evidence base that enables you to start to drive some of that change. That has been the problem. The reason this plan has never been written in this way is because of the barriers that come up within the bureaucracy to do it. Whereas if you leverage the thinking of the university sector, of the health think tanks and the NGOs that understand, have the evidence and can implement the evidence, then you have a tool that says this is how we should do it.

At the moment if some money becomes available and someone wants to do a particular procedure in Tasmania, that we may have the need for only half a dozen operations a year, but it is the particular interest of a particular clinician, then all of a sudden we can have a whole bucket of money that goes towards implementing that service because it is of an interest. It is not in the interests of all Tasmanians, because we need another perfusionist, or we need to be doing what we do much better. Everybody comes up with innovation and new ideas but we are not doing it right.

I would have these plans that are integrated and that seriously look at how we can move as much of the acute activity, meaning that when people do get sick and we take it out of the acute system and look at the integration with the primary system. It is a planning evidence-based approach.

Ms FORREST - There are two very significant challenges that most governments shy away from addressing because it is not popular. One is telling the clinicians, 'We are only buying this one type of hip. If you want to replace hips, you use this one'. That does not go down very well with a lot of clinicians. There is that engagement with the clinicians. The other is going to the people in the community saying, 'We are not going to provide this service in your local hospital because it is not safe to do so' - they think it is not safe and that the building is going to fall down. I have had lots of discussions about this over the years, as you well know - 'What we will do is provide that service three, four or five hours away'.

We still have a lot of work to do on equity of access in terms of transport and accommodation. The community engagement is a challenge, is it not?

Mr LYNCH - The One Health System was introduced as a health plan for Tasmania, but it wasn't, it was a hospital plan. Consultation is always an issue. What we have experienced in limited application in Tasmania are concepts like citizens' juries and so on. If you have a

document that has the evidence and you talk to people in your electorate and say you are going to provide some information about the safe way of doing things, then people would say clearly we cannot be doing cardiothoracic surgery in Wynyard or Ulverstone because there just is not the number of people there. However, we do need to build that integrated care where we concentrate on how we give that access through transport, through telehealth and by grouping together for that out-of-hospital care.

CHAIR - Post-operative care.

Mr LYNCH - You have 90 percent of it that is not disease specific, such as how do I get to my doctor's appointments? How do I take my medicine? How do I do my physiotherapy? It is common to all these conditions. It is about serious community engagement and there is a move across both the DHHS and the primary health network to look at how we engage much better with consumers to get their informed feedback. If you ask everybody if they want to be able to have their stent put in at Ulverstone, they are going to say yes. Though if you then explain why that is not safe for them physically, not because the building is going to fall on them but because of the competency of the person doing that.

Ms FORREST - There are services, such as chronic pain management, that should be delivered locally. For instance one-off hip replacements. If you go to a place where they do them all the time then you are going to get a better and quicker outcome and response. There are some things that are probably not part of the acute health setting. The initial instance, maybe. Often we find people with chronic pain are put into hospital because there is nowhere else for them to be dealt with, which is probably wrong. We can do a citizens' jury, and it would be an ideal topic for a citizens' jury, but we cannot do it in isolation from the Commonwealth because the Commonwealth funds so much of it.

Mr LYNCH - This is where it comes back to this notion of commissioning that is coming to Australia. We are still learning how to do it - the Primary Health Network and DHHS - but it does provide a framework to look at how we can solve these problems together and commission for the outcomes rather than just buying the hip.

Ms FORREST - Commission for outcomes rather than outputs?

Mr LYNCH - Exactly, so rather than just buying the hip you are buying the overall care, the discharge and the care in the community. As I said earlier, single funding would be ideal because you could just commission for one person. It is a tool that if used appropriately could be very powerful. I think there is a willingness for the government to look at some of these things, or for the system to look at these things because these problems have been around. This is seven years and we have had different governments during that time. It has been a common issue, not an issue that just sits with the present Government. It has been an issue that has existed in Tasmania for the time that I have been involved, which has been eight or nine years now and Gillian the same.

CHAIR - It is often the nature of the beast, isn't it, when it comes to politics. The governments of whichever colour want to be the original thinkers, not the facilitators. What you are presenting here today with regard to this plan is the thinking has been done and we are just simply asking you to play the facilitating role and put that in place. It is not to say that you won't work with the Government to tweak it and to make it better. I presume you are saying that?

Mr LYNCH - This is what it could look like.

Ms MANGAN - We also say that it can be iterative. We have no sets on short-term, long-term, medium-term goals and outlined who we think needs to be at the table to implement those things. There are some things in this plan, since it has been written, that look as if they are starting to happen now anyway.

Ms FORREST - Never give up.

Ms MANGAN -That is right.

CHAIR - What is the time line on this plan? How far forward are you thinking?

Ms MANGAN - We have said that it is a five-year plan.

CHAIR - Five is strategic? The longer-term, broad view -

Mr LYNCH - The example I often give on the health system, in preventative health and the acute health issue; you are here and you want to go to there. There will be opportunities that come along the way. The really good example was the change to LUPA. Out of the blue came an opportunity to put a health objective in LUPA. It was not something we had been advocating for or thinking of, but we wanted to put a health objective into state policy, for example. The opportunity comes along, you grab it and in it goes, but it is on the trajectory.

We would not expect and it would be unreasonable to expect that everything in a plan like this would be implemented in five years. The point is that as you go along and you have to make a decision - a resourcing decision, a system change decision - and you use this as the blueprint. You say, 'If I put that bit in there today, tomorrow there will be an opportunity to put a bit here that will support that, and later we will put a bit in here.'. All of a sudden you have a joined up plan that is going somewhere rather than the approach that we are seeing at the moment, which is all bandaids on issues without that bigger blueprint to drive it forward. It is not the great detail in the plan itself, it is the need for these plans to be developed.

CHAIR - That is right, and it is not only in health, we should be looking at this through the whole-of-government.

Unless there is anything extra you wish to touch on, thank you again for coming along and it is an interesting concept.

THE WITNESS WITHDREW.