AMA
TASMANIA
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Appendix

AMA Submission Legislative Council Enquiry into Acute Health Services in Tasmania.

Requested headings:
(1) Current and projected state demand for acute health services;
(2) Factors impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health services;
(3) The adequacy and efficacy of current state and commonwealth funding arrangements;
(4) The level of engagement with the private sector in the delivery of acute health services;
(5) The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services; and
(6) Any other matters incidental thereto."

1) Current and projected state demand for acute health services.

There have been numerous reports into the current and projected demand for acute health services in Tasmania. The AMA recommends that as a starting point the Committee review prior reports. In addition, it should be noted that of the Australian states, Tasmania has the oldest, sickest and poorest population with poorer health literacy and adverse metrics for social determinant of health.

Notwithstanding the successful implementation of future community based preventative health strategies, the demand on both primary health services in the community and acute public hospitals will remain above national average and continue to rise over the coming decade. The impact on acute hospital demand arising from entrenched socioeconomic and health literacy disadvantage in the outer suburbs of Hobart and Launceston has to date received scant attention in hospital demand planning. This is particularly relevant when considering these areas are the key drivers of acute and emergency services, often relating to demand arising from vulnerable patient groups such as the frail elderly.

The relatively small and decentralised nature of Tasmania's population requires careful planning of acute and subacute public hospital services. Development of staff expertise and physical infrastructure based on sustainable, accessible and rationale models of care delivered through centres of hospital excellence is recommended to ensure the Tasmanian population has timely and affordable access to health care. Clear and enforced role delineation for each of Tasmania's public hospitals is essential to prevent unsustainable replication of complex services across geographic sites, inefficient replication that occurs at the expense of the funding required to develop and sustain primary and secondary healthcare services that are needed at multiple sites state-wide.

It must be highlighted that acute health services do not exist solely in the hospitals. The vast majority of medical care is delivered by General Practice in the community. The lack of sustainable funding for General Practice has flow on effects for the hospitals. The lack of timely patient access to Specialists and many Specialties in the outpatient setting of our public hospitals leaves General Practice to cope until the enviable crisis arises and requires an acute hospital admission. There is much to gain by Hospitals from investment and integration with General Practice.

2) Factors impacting on the capacity of each hospital to meet the current and projected demand in the provision of acute health services.

Emergency Department presentations as well as elective admission demand are increasing in Tasmania. Emergency Department demand growth is particularly strong in Southern Tasmania with the Royal Hobart Hospital experiencing a consistent 4% rise in demand year-on-year for almost a decade. This demand is reflected in both the requirement for adequately resourced Emergency Departments in Tasmania, but also adequately provisioned acute and subacute inpatient bed stock, as over one third of all patients presenting to an Emergency Department require inpatient hospitalisation. For example, this equates to a bed growth requirement of approximately six more acute beds required year-on-year, every year at RHH alone.

For Tasmania's hospitals to meet this growth in demand they need:

a. More physical space (substantially more funded hospital beds, both acute and subacute),
b. More staffing – both medical, nursing, allied health, cleaning and clerical,
c. More surge capacity for busy times (only 85% of physical bed space used routinely),
d. Clear and credible local hospital governance structures that are responsive to local requirements whilst working within a state-wide planning framework,
e. Stable staffing and effective succession planning and recruitment of both clinical and support staff,
f. A political environment that provides a consistent approach across terms of government; one where the technical and clinical expertise within the health service is empowered to drive service delivery and innovation without politicisation,
g. A clear focus on teaching, research and quality improvement as key attributes of an effective public health system,
h. To accept that its ability to attract and retain staff is limited due to its size, poorer wages and perception of it being a difficult, isolated place to work. As a result, the health system needs the ability to be responsive to staffing opportunities as they arise – even if this is perceived in the short term as "over recruitment".

3) The adequacy and efficacy of current state and commonwealth funding arrangements.

Heath funding will always be a difficult issue. The AMA accepts that there will never be unlimited funding and rationing will in some form will be required. However, it is essential the funding that is provided for health is spent in in health. Tasmania gets a GST allocation recognising its oldest and sickest population. This should be reflected in the health spend in our state. Similarly, activity based funding and block funding grants need to deliver funds to the health services that are treating the patients, not be unreasonably diverted; the funding should follow the patient journey.

4) The level of engagement with the private sector in the delivery of acute health services.

Public-private sector co-operation is possible and does occur in Tasmania, but service limitations exist in the private hospital sector due to inherent scales of efficiency for complex and tertiary services. It should be noted that Private Hospitals are "for profit" not "for loss", which results in public hospitals needing to be the provider of first and last resort when private sector market failure for the provision of acute services occurs.

Many aspects of acute medical care are loss making – but can be supplemented by profitable areas (often elective procedural services) provided by a private hospital. With many Tasmanian patients having

multiple major health comorbidities and likely to stay longer in hospital, there are limits of what Tasmanian Private Hospitals can offer, particularly in relation to acute emergency care.

Private Hospitals have a significant investment in knowing the money side of their business. This is often not replicated within the public sector when negotiating contracts. For example, the contracting of elective surgery to the private sector over the last few years resulted in cherry picking of patients and significant organisational workload (read cost) to the public hospital system that was never compensated for. It also left the Public system to deal with the complex long-wait patients with a reduced budgetary allocation. A much more compelling case exists for consistently investing in public hospital service capacity the money currently being diverted into the private sector. Greater investment in public hospital capability will be an investment legacy for the efficient and sustainable future of public health care for all Tasmanians.

This does not rule out partnerships with private sector providers. These would need to be planned and part of a comprehensive service for the Tasmanian population.

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

Hospitals are by nature dangerous places. Every intervention has risks and patients in hospitals are the sickest in the community and thus are at high risk. To minimise this risk, our public hospitals need the infrastructure, bed capacity, number and quality of staffing to deliver good care. Our public hospitals also need the organisational governance required to keep them running safely and effectively, to identify and respond to risks as they arise. Clearly, poor bed capacity planning has occurred at the RHH and this has resulted in serious Emergency Department overcrowding due to a lack of beds in the acute and subacute wards. This outcome was entirely predictable and both the THS Executive, THS Governing Council and Ministry were provided consistent warnings as to the consequences of inadequate capacity planning during the RHH Redevelopment. A failure to listen and respond to clinicians and other RHH staff over the past two years regarding the impending demand and capacity mismatch reflects a serious failure of effective THS governance arrangements and does not speak of the THS being a patient focused organisation.

Public Hospitals have a major role in training the future medical, nursing and allied health workforces. This training attracts the best and the brightest at both the Doctor in Training level but also at the Specialist level. The tight budgets, increases in demand and poor governance has come at the expense of the training functions of our hospitals. Many of the accredited training programs have been lost, significantly downgraded or placed under tighter review. This has resulted in the decreased ability to recruit doctors at all stages in their careers – from Interns to Specialists. This in our view has made our hospitals risker places for patients – because of the lack of access to Specialists and senior Doctors in Training. Unfortunately, the impact of the generational loss of doctors from Tasmania has yet to be felt.

Any other matters incidental thereto.

The THS experiment with centralised command and control governance of Tasmania's major hospitals has proven a failure. The opportunity for a rational and role delineated Tasmanian health system that was promised by the Health Green Paper of 2014 has been lost to a poorly considered THS governance model typified by an overly centralised command and control philosophy. Delayed, yet actively destructive local level hospital governance changes introduced by the THS have disengaged local staff from hospital leadership and management.

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After two years of existence, the THS has produced a patchwork of outcomes, a significant number of which are adverse due to inadequate local governance authority being delegated to staff within Tasmania's major hospitals. This is typified by:

- ailing clinical services,
- major capacity and demand mismatch at THS hospitals,
- serious deficiencies in planning around key projects such as the decant bed requirements associated with the RHH Redevelopment,
- increased patients at risk through hospital and ED overcrowding (particular at the RHH),
- a culture of apparent distrust between senior THS management and hospital staff.

Competent and authorised local hospital executive management and clinical governance is now urgently needed at our hospitals. This means devolving to the State's major hospitals the executive authority and resourcing that is required for planning and delivering functions that the THS Executive have unsuccessfully attempted to centralise:

- day to day operational governance of hospitals,
- key elements of hospital strategy and planning and project management,
- key elements of clinical leadership and corporate leadership,
- key elements of teaching, training and clinical succession planning,
- key elements of Human Resource management.

Regional hospital management and clinical leadership now needs to be reinvigorated so that staff in our hospitals can locally plan and proactively manage the key elements required for safe and effective clinical service delivery in their facilities.

The learnings from the Mid Staffordshire healthcare scandal in the UK, particularly, the findings and recommendations of Robert Francis QC are as relevant to the Tasmanian Health system in 2017. The Francis Inquiry examined the causes for the failings in care at Stafford Hospital run by the Mid Staffordshire NHS Foundation Trust. This report by Francis "identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation."

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Reference:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

The other submissions in respect to mental health give a detailed insight to some of the broad comments we make above. Sadly, these examples exist are not isolated to one area.

In conclusion AMA Tasmania thanks the Legislative Council members for the opportunity to make this submission to the enquiry.

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