



PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE "A"

INTERIM REPORT

ON

ACUTE HEALTH SERVICES IN TASMANIA

Members of the Committee

Hon Ruth Forrest MLC (Chair)

Hon Robert Armstrong MLC

Hon Craig Farrell MLC

Hon Mike Gaffney MLC

Hon Sarah Lovell MLC

Hon Rob Valentine MLC

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INTRODUCTION

1. At a meeting of the Legislative Council Government Administration Committee “A” on Thursday 28 June 2017, it was resolved that a Sub-Committee be established to inquire into and report upon the resourcing of Tasmania’s major hospitals to deliver acute health services, including mental health services, to the people of Tasmania, with particular reference to:

- (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.*

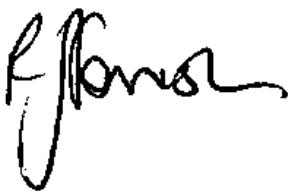
2. The Membership of the Sub-Committee was:

- Hon Rob Valentine MLC (Inquiry Chair);
- Hon Ruth Forrest MLC; and
- Hon Kerry Finch MLC.

3. Thirty-five submissions were received by the Sub-Committee. Public and Private hearings were held in Hobart on Friday 8 September, 9, 10 November 2017, in Burnie on 10 October 2017, and in Launceston on 30 October and 12 December 2017. Twenty-one groups or individuals gave verbal evidence to the Sub-Committee at these hearings.

4. The Sub-Committee conducted site visits at the Royal Hobart Hospital on Thursday 7 September 2017, the Mersey Community Hospital, North West Regional Hospital and North West Private Hospital (maternity services) on Monday 9 October 2017, and the Launceston General Hospital on Monday 30 October 2017.

5. The Sub-Committee Inquiry also established a dedicated web-page at http://www.parliament.tas.gov.au/ctee/Council/GovAdminA_HealthServices.htm.
6. All submissions and transcripts are included on the web-page and these should be read in conjunction with the Sub-Committee Report.
7. The Report provides a summary of the key findings contained in the evidence presented to date during the inquiry process which the Sub-Committee believes is important to be placed on the public record. Other matters which require further investigation will be included in the final report of the Sub-Committee.
8. The Committee reviewed the Report of the Sub-Committee and, on 20 December 2017, resolved to release a final report. The Committee intends that this Report be considered in its entirety as an Interim Report of the Inquiry. It is intended that the Sub-Committee will table a comprehensive and Final Report addressing all terms of reference of the Inquiry in 2018.
9. The Committee resolved that Members of the Sub-Committee be endorsed to speak publicly about the report in their capacity as Members of the Sub-Committee.



Signed this 20th day of December 2017

Hon Ruth Forrest MLC
Committee Chair

APPENDIX A



2017

Parliament of Tasmania

LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE "A"

INTERIM REPORT

ON

ACUTE HEALTH SERVICES IN TASMANIA

Members of the Sub-Committee Inquiry:

Hon Kerry Finch MLC

Hon Ruth Forrest MLC (Committee Chair)

Hon Rob Valentine MLC (Inquiry Chair)

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INTRODUCTION

At a meeting of the Legislative Council Government Administration Committee “A” on Thursday 28 June 2017, it was resolved that a Sub-Committee be established to inquire into and report upon the resourcing of Tasmania’s major hospitals to deliver acute health services, including mental health services, to the people of Tasmania, with particular reference to:

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- (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.*

Thirty-five submissions were received. A combination of public and private hearings were held in Hobart on 8 September, 9, 10 November 2017, in Burnie on 10 October 2017, and in Launceston on 30 October and 12 December 2017. Twenty-one groups or individuals gave verbal evidence at these hearings.

The Sub-Committee also undertook informal site visits at the Royal Hobart Hospital on Thursday 7 September 2017, the Mersey Community Hospital, North West Regional Hospital and North West Private Hospital (maternity services) on Monday 9 October 2017, and the Launceston General Hospital on Monday 30 October 2017.

The Sub-Committee wishes to extend its appreciation to Mr Kyle Lowe, Health Adviser, Office of the Hon Michael Ferguson MP for coordinating the site visits, and to the staff of the Tasmanian Health Service who generously contributed their time and resources during these informal visits.

In particular the Sub-Committee wishes to thank the following staff:

Royal Hobart Hospital

- Susan Gannon, Executive Director of Nursing and Midwifery
- Lorraine Larcombe, Assistant Director of Nursing – Central Coordinator Services

- Trish Allen, Nursing Director – Critical Care, Clinical Support and Investigations
- Tony Bradley, Nurse Unit Management – Emergency Department
- Brian Doyle, Staff Specialist, Department of Emergency Medicine
- Duncan McKenzie, Pharmacy Site Manager - South
- Deb Solomon, Nurse Unit Management, Department of Psychiatry
- Kim Barnes, Safewards Project Officer, Statewide and Mental Health Services
- Michael Pervan, Secretary, Department of Health and Human Services
- Cheryl Carr, Deputy Project Director, RHH Development

Mersey Community Hospital

- Fiona Young, Acting Executive Director of Operations, North/North West
- Julie Duff, Co-Director of Nursing
- Amanda Compton, Co-Director of Nursing and Midwifery
- Lynn Sims, Nurse Unit Manager, Department of Emergency Medicine

North West Regional Hospital

- Fiona Young, Acting Executive Director of Operations, North/North West
- Robert Pegram, Executive Director of Medical Services
- Karen Linegar, Executive Director of Nursing and Midwifery
- Hayley Elmer, Co-Director of Nursing – Medical and Surgical
- Amanda Compton, Co-Director of Nursing and Midwifery
- Veronica Zupan, Nursing Director, Northwest Private Hospital

Launceston General Hospital

- Eric Daniels, Executive Director of Operations - North/Northwest
- Helen Bryan, Executive Director of Nursing – North
- Jane Doorman, Nurse Unit Manager, Mental Health
- Lorinda Upton Greer, Nursing Director Acute Care Services, Medicine North
- Rob Suthers – Nurse Unit Manager – Ward 4D LGH
- Scott Rigby – Nurse Unit Manager – Department of Emergency LGH
- Cassandra Sampson, Nursing Director – Surgical and Perioperative Services LGH
- Janette Tonks – Nursing Director – Women’s and Children’s Services LGH
- Michael Sherring – Nurse Unit Manager Paediatric Services LGH
- Scott Beswick, Office of the Hon Michael Ferguson MP

Many consumers of public health services provided evidence. The Sub-Committee acknowledges and thanks these witnesses for their very personal contributions which have contributed to understanding the challenges for Tasmanians accessing our health services.

The Hansard transcripts of the hearings (where evidence has been made publicly available) are available to access via the Inquiry webpage at http://www.parliament.tas.gov.au/ctee/Council/GovAdminA_HealthServices.htm. The Hansard transcripts and the submissions should be read in conjunction with this Interim Report.

This Report provides a summary of the key findings contained in the evidence presented to date during the inquiry process, which the Sub-Committee believes is important to be placed on the public record. Other matters which require further investigation will be included in the final report of the Sub-Committee.

This Report includes consideration of the written submissions and the verbal evidence provided during the public hearings, as well as other information gathered during the course of the Inquiry, notably during the hospital visits.

It is intended that a comprehensive and Final Report addressing all terms of reference of the Inquiry will be tabled in 2018.

A handwritten signature in black ink, appearing to be 'Rob Valentine', written in a cursive style.

Hon Rob Valentine MLC
Inquiry Chair
20 December 2017

ABBREVIATIONS

ANMF	Australian Nursing and Midwifery Federation
AT	Ambulance Tasmania
BN	Bachelor of Nursing
CEO	Chief Executive Officer
CIN	Clinical Initiatives Nurse
FACEM	Fellow of the Academy of Emergency Management
HACSU	Health and Community Services Union
LGH	Launceston General Hospital
MSA	Medical Staff Association
MCH	Mersey Community Hospital
NWRH	North West Regional Hospital
NWPH	North West Private Hospital
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RHH	Royal Hobart Hospital
THS	Tasmanian Health Service

RECOMMENDATION

The Sub-Committee recommends all parties fully consider the key findings contained in this Interim Report and work collaboratively to propose, refine and implement solutions to the challenges and problems identified within the Tasmanian Health Service and the State's major hospitals.

KEY FINDING 1

A NUMBER OF KEY STAKEHOLDERS RAISED CONCERNS REGARDING THE LEADERSHIP STRUCTURE AND COMMUNICATION WITHIN THE TASMANIAN HEALTH SERVICE (THS).

KEY STAKEHOLDERS IDENTIFIED THE LOSS OF LOCAL ADMINISTRATIVE AND CLINICAL LEADERSHIP AND A LACK OF LOCAL DECISION MAKING CAPACITY AS NEGATIVELY IMPACTING ON PATIENT CARE, STAFF MORALE AND EFFICIENT SERVICE DELIVERY.

The Sub-Committee believes it is important to publish the following summary of concerns raised during the Inquiry in light of the consistent evidence received supporting Key Finding 1 and the subsequent report released by the Minister on 16 December 2017 titled *New Beds Implementation Plan Summary*.¹

Consistent evidence was provided supporting the establishment of the Tasmanian Health Service as proposed in the *One State, One Health System, Better Outcomes* White Paper, *Delivering Safe and Sustainable Clinical Service*.² However, evidence received indicated the implementation has not delivered an effective and efficient service delivery model.

The Australasian College for Emergency Medicine (ACEM) submission stated:

*ACEM considers that a lack of leadership within the THS Executive and poor governance structures across the sector have contributed to these challenges. The issues... have repeatedly been brought to the attention of hospital management and the THS Executive. ACEM Members report that their concerns, as specialist staff working within acute health care and as staff within RHH and LGH, are regularly ignored, dismissed or not acted on. This is resulting in adverse outcomes for patients on a daily basis.*³

Dr Simon Judkins, speaking on behalf of the ACEM, raised concerns regarding the lack of leadership at a senior executive level within the THS:

Emergency physicians undertake a complex variety of tasks and care, given the nature of emergency departments' presentations. To excel in their roles, these doctors require support from the leadership body that is strategic in

¹

http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0011/266528/NBIT_Summary_December_2017.pdf accessed 17 December 2017

² <http://www.onehealthsystem.tas.gov.au/wp-content/uploads/2015/07/OHS-White-Paper-Final-Release-vf4-Press.pdf> accessed 14 December 2017

³ ACEM, *Submission*, p. 3.

its planning and utilises their clinical expertise in developing responses to issues as they arise.

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

Clinical expertise is not being respected. In fact, the current leadership, which is a term I use loosely, seems more interested in centring the message to control damage. Clinicians have been told not to make submissions in this forum despite their grave concerns for patient safety. There are many examples of clinicians raising their concerns regarding the safety of patients only to be dismissed. It reminds me of many of the issues highlighted in well-known public health hospital failings of governments such as the Mid Staffordshire Trust in the UK and the Garling report in NSW. Clinicians know when things go wrong. To dismiss their concerns is a failure of leadership.⁴

Dr Stuart Day, AMA Tasmanian President, expressed concerns about the governance of the THS:

THS, as we are aware, came into existence in July 2015 with the aim of bringing the four acute hospitals working together to deliver safe and high quality care that avoids the costly duplication or inefficient services.

The AMA supported this change from what was then a competing hospital system under the previous structure. Two and half years later, unfortunately, we have not realised the vision. We have a THS which has a structure that is ideologically driven, top heavy and multi-layered. It runs a process that has responsibility matrices that are chopped up, confused and ineffectual. This results in futile cycles and delays on time-critical issues. We have an executive culture that is toxic and dysfunctional.⁵

According to a private witness, there is currently a lack of executive capacity in the Tasmanian Health Service with no clear chain of command and a lack of effective leadership. Evidence was provided indicating the statewide clinical director model is not currently working.⁶

The Australian Nursing and Midwifery Federation (ANMF) submission highlighted the lack of leadership and good governance:

⁴ Dr Judkins, *Transcript of Evidence*, 8 September 2017, p. 12

⁵ Dr Stuart Day, *Transcript of Evidence*, 12 December 2017, p. 25.

⁶ Private Witness, *Transcript of Evidence*.

The most significant impact has been the development of a highly centralised and politicised system which appears to lack leadership responsibility on the ground. The restructure has seen permanent executive services removed from all major THS settings and acting positions. This resulted in the development of a large gap between 'on ground' staff and executive able to make decisions. Removal of CEO's from each hospital to a single CEO responsible for the entire system has left senior hospital staff with little leadership support. Decision making appears to have been made without clear understanding of the on-ground issues for each site. The governing council have not addressed the significant risks and the safety concerns being raised by senior nursing and medical staff within the THS.

This issue could not be more clearly displayed than in the unfolding of the RHH redevelopment process. Lack of direct management by senior hospital executive has seen minimal meaningful engagement with senior medical and nursing staff to review projected impacts of the redevelopment process. No clear modelling was made available to senior staff. The lack of strategic planning is the direct result of a loss in bed numbers and the crisis management situation. ANMF was a member of the Professional Reference Group who wrote to the Premier at the conclusion advising of a number of unmitigated risks. Unfortunately many of these have eventuated e.g. risk of the loss of bed flex capacity resulting in extra bed block. Many senior nursing staff across the four hospitals report feeling unclear on the exact decision making structure, delegation and accountability at executive level. Constant reshuffling and backfilling of senior positions has added to the confusion.⁷

Dr Frank Nicklason, Chair Medical Staff Association (MSA), RHH commented:

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.⁸

...

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.⁹

⁷ ANMF Submission, p. 6

⁸ Dr Frank Nicklason, *Transcript of Evidence*, 10 November 2017, p. 24

⁹ *Ibid.*, p.22.

Dr Nicklason initiated a survey for the Medical Staff Association (MSA) of 160 senior doctors, of whom 81 responded. The survey was initiated on 25 August 2017 to ascertain their experience of working at the Royal Hobart Hospital. The following survey responses provide a snapshot of the feedback provided regarding performance of the THS executive:

"My unit is amazing- excellent nurses and allied health staffing and morale despite poor management over the years from both the unit manager and the hospital and THS executive. I would not be satisfied if it weren't for the amazing professionals I get to work with."

"Not well supported by executive staff. Unrealistic demands and pressure applied to discharge unwell patients when the ED is full."

"I experience excellent support from my fellow clinicians and the multidisciplinary teams with whom I work. However, clinical and organisational leadership within my service is not informed, nor supportive, of my area of work. Leadership at this higher level fails to prioritise the needs of patients and families; does not support clinical governance; perpetuates a service culture of alienation; inhibits clinical innovation; and is unresponsive to even very severe service difficulties and critical events".

"I enjoy my job and feel well-supported by the clinical staff I work alongside. Limited support provided by unit and none from THS executive. It would also be nice to be paid for all the hours I work."

"Working at the 'shop front' of our organisation I feel completely disengaged with the hospital executive and department. I am expected to practise evidence based medicine but the department practises something else. There are always plans in place but they do not appear to be associated with clinical picture. I do not feel valued at all by the organisation. It seems to me that executive positions are filled with people who spend 12-18 months in a position making changes that achieve little, cost a fortune and last a short time before moving on. They come with prejudicial ideas and lack of respect for how much is achieved with so little."

"THS - both the structure and the individuals within it are the most dysfunctional management I have ever witnessed either here or interstate over a 20 year specialist career. They seem, both collectively and individually, absolutely incapable of grasping the issues we face and potential solutions. Even just RECOGNISING the problems (without trying to blame individuals), even if unable to fix them, would be a good start."

"Management have not engaged effectively or in a respectful or thoughtful manner, have milked our resources to plug other gaps, demonstrating poor understanding of the importance of our area to public health and health expenditure and poor governance."

"There is poor leadership and an inefficient system."

"The unit support is excellent. THS executive support is unhelpful and ineffectual at best, antagonistic, vindictive and dismissive at best, particularly since the move to a State-wide structure and gutting of local governance."

"THS Executive support is non-existent. Very well supported by own department."

"Unit support is excellent. THS executive support has been absent, misguided or malicious over the past 18 months. Recent changes to senior management at RHH have produced an improvement."

"I am well supported within my unit by senior doctors. I feel there is a disconnect between admin/human resources/rostering staff and those working at ground level. There is a lot of dissatisfaction around junior doctors' dealings with said staff that has impacted their learning opportunities and experience in general at the Royal."

"My role as a head of department is extremely poorly supported by THS executive. They dismiss serious clinical concerns and fail to advocate for appropriate resources. We have to work to achieve safe patient care despite the State-wide executive."¹⁰

Dr Stuart Day, AMA Tasmanian President, expressed concerns about the governance of the THS:

The AMA believes that Tasmanians deserve access to a well-performing public health system that supports our hospitals in delivering high quality health services with a minimal level of bureaucracy. The AMA believes that the THS as a central bureaucracy that has been developed over the past two and a half years by its CEO and its governing council is of a seriously flawed design. It is top heavy and urgently needs to be cut back to size with staff and resources re-focused back to the state's major hospitals. The AMA is for good governance in health, a positive management culture and removal of unnecessary bureaucracy. We believe that current bureaucracy is diverting resources from our hospitals and thus patient care.¹¹

Dr Day continued with some suggested solutions:

There remain good committed staff within the health system. One, we need to acknowledge the current failings in the structure, the process and the culture of the THS and recognise that there is no quick media fix to this and general reform and engagement is urgently required. This will need to be driven from the highest levels. We believe we should consider that the DHHS secretary take on THS CEO's statutory roles. This would allow reform and restructure of the governing council and they could be held accountable for managing the THS executive and consequential service outcomes. We could also reform the THS executive structure making it smaller in size with its

¹⁰ MSA, *Submission*, 2017, pp. 2-4.

¹¹ Dr Stuart Day, *Transcript of Evidence*, 12 December 2017, pp. 25-6.

focus on high-level strategic planning, monitoring of performance, policy and organisational compliance of what are the hospital regional level operational structures.

We need to continue, in our view, to build hospital and regional level capacity, accountability with devolved operational authority to plan and deliver services within the over-arching framework set by the THS and the DHS (sic). We need to ensure that THS staffing decisions and the decision-making about the staffing is devolved and managed where it is most effective: at the hospital and regional level. We need to build a positive culture in the THS executive by leveraging off the strong, positive hospital regional cultures that do exist rather than creating conflict through the recent failed attempts to eradicate them.¹²

...

We need executive leaders, administrators, good quality administrators doing the day-to-day running. My view - and the view of the medical profession - is that clinicians are best being clinicians and having some sort of management function. As soon as you detach yourself to just management, you lose track of what is actually going on on the ground.

We need professional administrators as well that are good at running the corporate governance, but you need that plugged in locally. Then you have now got three heads, like we had, coordinate that - the three heads of the hospital - but the THS structure would coordinate them and leverage that knowledge in delivering its strategic goals.¹³

Dr Richard Benjamin, Psychiatrist and AMA representative highlighted the lack of leadership and communication between the THS executive and local hospital staff regarding the proposed acute mental health observation unit:

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.

...

¹² Dr Stuart Day, *Transcript of Evidence*, 12 December 2017, pp. 26-7.

¹³ *Ibid.*, p. 30.

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.¹⁴

Dr Day noted the recent review undertaken by Deloitte into the efficiencies and function of the THS Executive:

The AMA believes that the THS CEO and the THS governing council should be held to account for presiding over a toxic and failed senior management system that is diverting resources from our hospitals. The AMA is aware that Deloitte was recently commissioned by government to undertake an urgent external review into the effectiveness and function of the THS executive. It is understood that the Deloitte report has identified serious deficiencies in the function of the THS executive and that these warrant urgent attention. We support the public release of this report, but as a minimum this sub-committee should have access to that report.¹⁵

Dr Fiona Wagg, a child and adolescent psychiatrist stated:

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.¹⁶

Dr Simon Judkins, President of the ACEM Board, stated:

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

¹⁴ Dr Richard Benjamin, *Transcript of Evidence*, 10 November 2017, p. 30

¹⁵ Dr Stuart Day, *Transcript of Evidence*, 12 December 2017, pp. 26.

¹⁶ Dr Fiona Wagg, *Transcript of Evidence*, 10 November 2017, p. 16

Trying to develop links with the executive staff to discuss issues around patient care is very difficult.

There was an example of one of the directors telling us that for 18 months she did not know who she was supposed to report to. There was no firm reporting structure. When there was (sic) issues at the frontline, there was nobody she could go to to report her concerns.¹⁷

When commenting on the need for local decision making capacity, Dr Judkins stated:

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

The information we have received is that certainly there has to be that conversation about hospital strategy and how we are going to manage the increase in demand and the flow. It just has not happened.¹⁸

Concerns raised by the representative groups and clinicians above were also reflected in private evidence from other staff members working within the health system.

According to Mr Mervin Reed, a past Deputy Secretary of DHHS, the current structure is not workable:

We have no single clinical direction... We have no single person responsible for a hospital, and we have no single person in DHHS that has a grasp of all the reins on this and is able to balance out the needs.¹⁹

...

The Tasmanian Health Service was a good idea but at the end of the day it has not worked and the board is irrelevant. You would be better off with CEOs and local community boards in the hospitals.²⁰

In response to concerns raised about the function of the THS executive, Minister for Health, Hon Michael Ferguson MP, at a public hearing on 12 December 2017, stated:

The Government has recognised there have been challenges with local governance. It is fair for me to say to you that since this committee

¹⁷ Dr Simon Judkins, *Transcript of Evidence*, op. Cit., p. 13

¹⁸ Dr Simon Judkins, *Transcript of Evidence*, 8 September 2017, p. 24

¹⁹ Mervin Reed, *Transcript of Evidence*, 1 December 2017, p. 25.

²⁰ *Ibid.*, pp. 31-2.

commenced its work, the Government has moved on this. One of the stakeholder organisations, the AMA Tasmania, called for local governance to be more formally instituted at the local level. I believe other medical staff associations have had the same sort of feedback. We have listened to that feedback and while it is still a work in progress, we are already seeing that being rolled out.

I would not share your view - if it was a view - that it is not working. I would say it is working on the basis we have seen some stunning turning around of some of the waiting times but we can always improve.

I do not disagree that it is a concern if an organisation like AMA Tasmania makes a statement like that. I am not going to speak for the AMA but my understanding is they have expressed a want of confidence in the chief executive officer, just as they did the previous chief executive officer. We need to be recognising that where there have been legitimate and worthy calls for a continual refinement to the way governance works, we are open and willing to do that.²¹

In relation to the review being undertaken by Deloitte, Minister Ferguson stated:

I am happy to inform the committee that this work has included interviews and surveys of leaders and managers across the health system, not just in THS, to gather individual perspectives on how they're working as a health system to achieve strategic objectives. This has been undertaken in part with support from Deloitte. It has presented interview and survey results, but it has not prepared a report.

I know you will be interested and I am happy to tell you that I have received a briefing by way of a presentation from Deloitte very recently as part of a Cabinet subcommittee meeting. Noting that this work does relate to a Cabinet process, there are longstanding conventions in place. I am aware of your interest; I am aware of the public interest. While I stand by my statements on this matter to those who would prefer to believe otherwise that there is no report, I have asked the new bed implementation team to prepare a summary for public release, including progress on the opening of the 120 additional beds and treatment recliners, as well as key findings from the work undertaken by Deloitte.²²

On 16 December 2017, Minister Ferguson released a Report titled *New Beds Implementation Plan Summary*, stating in the media release:

The work of Deloitte also looked at leadership, the clarity of roles and authority, direction and focus, governance and service planning.

²¹ Hon Michael Ferguson MP, *Transcript of Evidence*, 12 December 2017, p. 54.

²² *Ibid.*, p. 61.

Pleasingly, there was very strong support for the statewide One Health System strategy introduced by the Government.

However the survey and interviews showed that the THS Executive is not yet operating effectively, with a need to improve communication, consultation, process, culture, accountability and relationships.

There is a clear need to clarify roles and responsibilities in the THS, so that all members of the organisation understand and work effectively within management structures at the local and statewide levels.

The Government is considering the feedback provided through the survey which we initiated in order to continue our efforts to improve Tasmania's public health system.

The report is available online²³

The report noted:

The feedback provided through the interviews and survey responses indicates:

- *There is strong support for the 'One THS' Strategy.*
- *There is a need to clarify roles and responsibilities across the THS, so that all members of the organisation understand structures at the local and statewide level, and to ensure there is clear accountability for decision making at each level.*
- *The THS Executive is not currently seen to be operating effectively, with a need to improve:*
 - *Communication – particularly with clinical leaders to improve relationships, and also to the broader organisation to impart the THS vision and strategy;*
 - *Consultation - both internally within the Executive, and externally on proposed change and reforms.*
 - *Process - core processes fundamental to the successful and sustained performance of an Executive, in the form of an established approach to problem solving, decision making and a culture of collaboration, are not seen to be operating effectively.*
 - *Culture – to ensure that the THS Executive can perform their duties collaboratively and cohesively as a team.*
 - *Accountability – roles and responsibilities within the Executive are unclear and members need clarity on their individual and collective responsibility.*

²³ http://www.premier.tas.gov.au/releases/new_beds_update accessed 17 December 2017

- *Relationships – the THS Executive need to build foundational elements of trust, conflict resolution and a collective responsibility for leadership.*
- *The perceived lack of unity of the THS Executive appears to be impacting the broader organisation, with the potential to undermine the effectiveness of the leadership group.*
- *Improvements need to be made to collect and analyse operational performance data and make this widely available so that robust decision making can occur to improve patient outcomes.*
- *Governance structures, processes and management protocols are not always clear, or universally understood, or where they do exist, are perceived to be not adhered to. ²⁴*

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http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0011/266528/NBIT_Summary_December_2017.pdf
accessed 17 December 2017

KEY FINDING 2

ACCESS BLOCK AND OVERCROWDED EMERGENCY DEPARTMENTS IS INCREASING THE RISK OF ADVERSE PATIENT OUTCOMES

ANMF noted the impact of access block on patient outcomes in their submission:

Bed Block occurs when patients needing care have to remain in emergency departments for eight hours or longer because ward beds are unavailable. A literature review undertaken for the Australasian College of Emergency Medicine found that waiting times over 8 hours increased a patient's relative risk of death by between 20% and 30%. The research showed that bed block in Australia accounted for at least 1,500 avoidable deaths in 2003. Bed block in Tasmania it is occurring at almost twice the national average. This implies, conservatively, that 70 to 80 people may die avoidably each year in Tasmania as a direct result of the bed shortage. Bed block is accentuated in Tasmania because there are limited options, as might occur in Melbourne or Sydney, to transfer patients between hospitals.

Bed Block occurs in all four Tasmanian acute care hospitals however the Royal Hobart and Launceston General Hospitals are the worst affected. For the first two months of 2017 the number of patients who spent more than 24 hours in the RHH emergency department was 132 compared to 35 for the same period in 2016. There has been several days when all treatment spaces in the emergency department are occupied by patients needing admission, but for whom no beds are available. The percentage of ambulances unable to offload a patient in 30 minutes in 2017 thus far is 13% compared to 4% in 2016. Having ambulances waiting to unload patients reduces emergency response times. ANMF members from Emergency Department at the RHH have outlined their daily lived experience in appendix A provided as part of this submission.

Much of the bed block at the RHH is related to a physical decrease in the number of available beds which, in a small part, can be contributed to the RHH redevelopment. However historical bed data collected by ANMF since 2010 shows the number of beds has failed to increase to reflect long term increases in demand for acute services. The reality is that, since 2010, the number of beds available at the RHH have dropped significantly despite an increase in demand. Much of this reduction has occurred in surgical and mental health beds. The reduction in any number of beds, regardless of the department reduces capacity for flexibility during peak flow. Previously surgical beds were historically changed to medical beds during periods of demand, such as flu season. At this time elective surgery could still continue with only minor disturbances. However there is virtually no flexibility

available in the current system.²⁵

Further noted in the ANMF submission:

The pressure experienced by the ED staff impacts upon those patients in the waiting room of the RHH ED. The ED staff are acutely aware of the impacts upon the AT [Ambulance Tasmania] of ramping and the need to facilitate their release back to the community.

They also need to also balance this need against those acutely unwell patients in the waiting room. This can mean that there are numerous unwell patients in the waiting room with little or no observation or interventions, despite the best efforts of the triage and CIN (Clinical Initiatives Nurse). The CIN nurse is often called away to deal with patients requiring resuscitation as we have only 2 allocated nursing staff for a four bed resuscitation area whose patients often require 1:1 care. This means, particularly on a night shift, that the 1 triage nurse is expected to triage all the patients arriving to the ED, and monitor and provide interventions for 20-30+ patients waiting in the waiting room. This is an unreasonable expectation and is physically impossible for one person to achieve. Once again our patients are put at increased risk because of flow-on effects of access block.

...

We have had multiple clinical incidents occurring because patients have had to face excessive wait times, instead of receiving appropriate and timely management and treatment. This has directly resulted in many patients becoming more unwell, requiring more intensive and invasive treatments and management, and requiring longer inpatient admissions.²⁶

Dr Richard Benjamin noted access block as a factor in adverse outcomes for mental health patients:

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

²⁵ ANMF, *Submission*, pp.11- 12

²⁶ *Ibid.*, pp. 42-43

*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.*²⁷

²⁷ De Richard Benjamin, *Transcript of Evidence*, 10 November 2017, pp. 45-46

KEY FINDING 3

SIGNIFICANT COSTS ASSOCIATED WITH STAFF OVERTIME AND THE ENGAGEMENT OF LOCUMS CONTINUES TO PUT PRESSURE ON THE STATE HEALTH BUDGET

In the Health and Community Services Union (HACSU) submission, a de-identified HACSU nurse member described the impact of double shifts and overtime:

When I started nursing I'm (sic) 2012 I enjoyed my first year as a graduate nurse. After my first year I worked on a few wards on short contracts to gain more experience in different areas but at the end of 2013 I was exhausted from the increased workload, the shift work (late than (sic) early shifts are ridiculous) and stress! I would go to work extremely tired and just run all day to keep up! The acuity of the patients has gone up, as soon as someone gets a little better they are sent home or to a rehab bed straight away now which means that you are always caring for the most sick patients all the time! It's absolutely draining, plus the paperwork has skyrocketed which means you spend a lot of time doing paperwork and less time caring for your patients.

I thought about leaving nursing, 2 years in and I was so over it! I was always tired, I was always getting sick because I was always stresses and working shift work didn't help! I was fed up feeling obligated to work extra, work overtime, I never had a regular roster so I had no life outside of work. I was done so I went to casual! I've been casual for nearly 4 years now, there's no way I will take a contract on a ward now that I have seen the other side! I'm less sick, less stressed, don't feel obligated to work overtime, I can choose which shifts I work so I don't work nights anymore because I was never any good on nights (I couldn't sleep during the day) but if you want a contract you have to work them! I have a lot more balance in my life now.

I can't see myself in nursing in 5 years time if the system doesn't have a massive change, I also worry that when all the older nurses retire the skills wouldn't have been handed down to younger nurses.²⁸

According to Mr Mervin Reed, a past Deputy Secretary of DHHS, there is an immediate need to employ more nurses:

We have been told before. I have listened to people tell committees of this parliament, 'we have a lot of these nurses coming out of the university nursing school and we do not have any positions for them'. We have an

²⁸ HACSU, *Submission*, 2017, p. 3.

older nursing workforce - Ms Forrest is well aware of this - and a lot of these people are going to retire. We need to have a whole bunch of new nurses employed now, not in two years time. You need 250 nurses now to at least provide basic services in the hospitals to allow some of the existing nurses to go on holiday.

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

...

They come home after two and half weeks of relentless shifts with no breaks and they are so tired they just fall asleep. They do not see their kids, do not hug their husband, and they end up having a mental health day or two. This is what we are doing to our health sector by non-employment of the proper levels of people. It is a logistical problem. If we do not employ the people it is going nowhere.²⁹

In relation to the use of locum services to fill the gaps in staffing, Mr Reed continued:

They have already budgeted for the money. In your case you have already heard they are spending \$35 million here in locums. If you employed the people fully you would be about \$22 million a year in salaries and on costs, so there would be a saving. I think I can count that much. The real key to it is the nursing staff. If you do not have the nursing staff at the appropriate levels in the hospital you are not going to be able to provide the services to anybody.³⁰

Minister Ferguson provided the nursing overtime costs by region for 2016-17:

THS North West	\$1.3m
THS North	\$3.2m
THS South	\$3.6m

²⁹ Mervin Reed, *Transcript of Evidence*, 1 December 2017, p. 26.

³⁰ *Ibid.*

Minister Ferguson provided a breakdown of the number and cost of locums by hospital and specialty 2016-17:

Locum Expenditure	2016-17 Total
THS Health Professions	99,894
Royal Hobart Hospital	
Acute Medical	237,065
Cancer, Chronic Disease & Sub-Acute Care	98,037
Critical Care, Clinical Support & Investigations	72,341
Surgical & Perioperative Services	334,752
Women's & Children's Services	334,257
Other	-
	1,076,453
Launceston General Hospital	
Acute Medical*	4,129,465
Cancer, Chronic Disease & Sub-Acute Care	1,417,548
Critical Care, Clinical Support & Investigations	170,981
Surgical & Perioperative Services	1,067,090
Women's & Children's Services	213,582
Other	-
	6,998,666
Mersey Community Hospital	
Acute Medical	1,904,836
Critical Care, Clinical Support & Investigations	2,979,404
Surgical & Perioperative Services	945,383
Women's & Children's Services	1,765,094
Other	-
	7,594,718
North West Regional Hospital	
Hospital Operations - NWRH	-
Acute Medical	1,270,000
Cancer, Chronic Disease & Sub-Acute Care	-
Critical Care, Clinical Support & Investigations	1,981,579
Surgical & Perioperative Services	1,832,890
Women's & Children's Services	2,168,448
Other	-
	7,252,917
Mental Health Services	
Adult Mental Health Services	4,826,898
Alcohol and Drug Services	188,045
Child and Adolescent Mental Health Services	340,965
Correctional Health Services	-
Forensic Mental Health	-
Older Persons Mental Health Services	401,321
	5,757,229
Statewide Primary and Community Care Services	
Primary Health Services	-
TOTAL	28,779,878

KEY FINDING 4

THE DELIVERY OF MATERNITY SERVICES IN THE NORTHWEST OF TASMANIA IS FRAGMENTED

According to the ANMF submission, the North West Integrated Maternity Service implementation occurred in December 2016:

At that time birthing services were relocated from the Mersey Community Hospital to the North West Private Hospital via a service level agreement between the Tasmanian Health Service and the North West Private Hospital. At the time the Minister indicated that this decision was made to improve the continuity and quality of care for pregnant women in the North West of the State.

However, it has become apparent that the reverse of this is true. Women are receiving disjointed maternity care, lack of continuity of care pre and post birth and increasing induction and caesarean rates. Midwives, who are no longer able to participate in deliveries, are losing their skills (which potentially impacts upon their right to remain a registered midwife) meaning that these skills are likely to be lost to the service.³¹

The ANMF submission provides background and information relating to birthing services in the North West:

The North West Integrated Maternity Service is a public inpatient and birthing service delivered by the North West Private Hospital in Burnie and antenatal and postnatal care delivered by the Tasmanian Health Service at the Mersey Community Hospital, the North West Regional Hospital in Burnie and at a number of other rural sites via outreach services. The service was an initiative of the Government's One Health System reforms aimed at putting the health and safety of North West mothers and babies at the forefront of decisions.

Unfortunately the service appears to be failing the women on the NW Coast. ANMF members are struggling with a service delivery model that is under staffed, under resourced and under governed. Specifically members are concerned about:

- a. The increased rates of caesarean sections on the NW coast, a key indicator on the performance of a service.*
- b. The service is not aligning with National Safety and Quality Standards,*

³¹ ANMF, *Submission*, p. 11.

- c. No evaluation of the service has occurred since the service re-structure and implementation*
- d. The service does not align with best practice standards by not meeting the needs of patients, having a decreased in rather than increase or maintenance of continuity of care*
- e. Policy and procedures are out of date and do not reflect the service reconfiguration;*
- f. There is a total of 5.61 FTE vacant across the service;*
- g. Management positions are incorrectly classified, NUM's work across multiple sites up to 40km's apart;*
- h. There is no dedicated administration or HR support across the service.*
- i. Overtime and working short is increasing;*
- j. Student trainees are not able to be witnessed birthing as the public Midwives have no access at the North West Private Hospital. Similarly there is a deskilling of current Public Sector Midwives as they are unable to participate in birthing.*
- k. Facilities at the North West Ante-natal clinic do not provide for confidential consultations, the work space is too small to carry out safe consultations, women are required to walk down the corridor and use the public Hudson Café toilets to collect intimate swabs and urine samples*

Strategically, despite the reconfigured service being implemented over 6 months ago, no evaluation or ongoing review of the service efficacy has been undertaken and several grievances have now been raised.³²

Since this evidence was provided, the Minister has informed the Sub-Committee that a review has been undertaken:

Mr FERGUSON - I take that on board and at this present time there is an evaluation that is occurring.

Ms FORREST - When do you expect that to be completed?

Mr FERGUSON - I do not imagine it will be far away. It is a very open process that has involved local managers, local staff -

Ms FORREST - Who is doing it?

Mr FERGUSON - I can provide you that advice, but some recognised experienced experts in this area who have been locally and nationally sourced.

Ms FORREST - Will this be publicly targeted?

Mr FERGUSON - It will be publicly shared with the unions and the community. Forgive me for repeating this point: we are about patient safety and patient quality - the safety of the experience and the quality of the service. While the service has been in place now for just over one year,

³² *Ibid*, p. 35.

*we always believe that we can continuously improve any lessons from the evaluation we would want to see implemented in the most feasible way.*³³

The Sub-Committee visited the four major hospitals in the state in addition to the North West Private Hospital, particularly to understand the model of delivery of intra-partum care and the unique nature of this service in the North West. There are no labour and birth care services provided at the North West Regional Hospital.

Private witnesses provided evidence indicating the current state of maternity services on the North West coast is fragmented and confusing. There is a lack of continuity of care for women and there are limitations on the midwives' ability to work across their full scope of practice. Women receive antenatal care through the THS, transfer to the North West Private Hospital for birthing services, and then receive some post-natal care from the THS. Both the THS and North West Private Hospitals have differing policies and protocols.³⁴

The Sub-Committee heard there is a lack of cooperation between THS and North West Private Hospital-employed midwives as a result of the current structure. This needs to be addressed for an optimal integrated service to be provided.

In summary, the Sub-Committee heard that the construction of a planned and purpose built facility in the North West would assist women of the North West region access a quality and safe birthing experience.

³³ Hon Michael Ferguson MP, *Transcript of Evidence*, 12 December 2017, p. 71.

³⁴ Private Witnesses, *Transcript of Evidence*.

KEY FINDING 5

THE REDEVELOPMENT OF THE ROYAL HOBART HOSPITAL CREATED ADDITIONAL OPERATIONAL CHALLENGES, INCLUDING DECANTING OF IN-PATIENTS, DEALING WITH THE IMPACT OF THE 2017 FLU SEASON AND ADEQUACY OF THE CURRENT AND FUTURE IN-PATIENT MENTAL HEALTH FACILITIES

Concerns regarding the Royal Hobart Hospital redevelopment were raised by a number of witnesses. Dr Frank Nicklason noted frustrations he and other senior clinicians experienced when seeking to engage the Minister for Health, Hon Michael Ferguson MP, regarding concerns related to the RHH redevelopment.

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.³⁵

A number of witnesses raised concern regarding access to and the adequacy of the acute inpatient mental health services at the RHH.

Dr Milford McArthur stated:

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

³⁵ Dr Frank Nicklason, *Transcript of Evidence*, 10 November 2017, p. 25

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. ³⁶

Professor Fiona Judd from the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and Dr Fiona Wagg, a child and adolescent psychiatrist also commented on the proposed acute mental health unit at the RHH:

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.*

...

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.*

³⁶ Dr Milford McArthur, *Transcript of Evidence*, 10 November 2017 p.2.

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

Ms FORREST - ... 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.

...
*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.*³⁷

Mr Ben Moloney, Project Director, Royal Hobart Hospital Redevelopment, addressed concerns that design of the mental health facilities at the Royal Hobart Hospital is not contemporary, there is insufficient access to outdoor areas and the internal design is not best practice in comparison with other state-of-the-art and best practice facilities around the world:

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

*That is correct. We face many challenges in the fact that we are on a CBD site and we are operating within a footprint. We fully acknowledge that. We believe that the design that we have achieved is utilising that space as best as it can be utilised. Often when stakeholders talk about best practice and things like that, they are perhaps making reference to other sites that do not have the same constraints that we have at the Royal Hobart Hospital.*³⁸

³⁷ Professor Fiona Judd and Dr Fiona Wagg, *Transcript of Evidence*, 10 November 2017 p.13

³⁸ Mr Ben Moloney, *Transcript of Evidence*, 1 December 2017, p. 6.

Dr McArthur noted:

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.³⁹

It is acknowledged the redevelopment of the Royal Hobart Hospital and the severe 2017 flu season has placed significant strain on the delivery of acute health services in Tasmania.

According to the ANMF submission:

Redevelopment of a hospital on site is predictably a challenging task. ANMF commend the tireless effort of the RHH workforce to maintain safe and quality care to the best the circumstances allow. However, many ANMF members report feeling frustrated, daily, by an obvious lack of clear forward planning to account for increased demand and change of services associated with the RHH redevelopment.⁴⁰

The Sub-Committee supports the implementation of a set of mitigation measures to proactively deal with the 2018 flu season, particularly in relation to managing staff overtime, addressing patient flow challenges, bed block and the use of locums.

³⁹ Dr Milford McArthur, *Transcript of Evidence*. 10 November 2017, p. 14

⁴⁰ ANMF, *Submission*, p. 21.

KEY FINDING 6

ACCESS TO TIMELY ACUTE AND COMMUNITY MENTAL HEALTH CARE IS INCONSISTENT, LACKING FUNCTIONALITY AND RESULTING IN INADEQUATE CARE OF PATIENTS WITH MENTAL ILLNESS

The Sub-Committee visited the acute mental health care units located at the three public hospitals as part of the informal hospital site visits and were made aware of an urgent need for an upgrade to the facilities at the Northside Clinic at LGH and Spencer Clinic at NWRH.

According to the Tasmanian Government submission, public mental health services are currently provided across Tasmania through the THS. Services include:

24 hour acute care units located at three public hospitals (RHH, LGH and NWRH);

24 hour older persons acute unit located in the south providing services to people across the state (Roy Fagan Centre).⁴¹

The ANMF submission expressed concern at the current configuration of mental health inpatient services across Tasmania, the difficulties in retaining qualified staff, and the delays in receiving treatment:

Mental health care in Tasmania is an area of major concern for ANMF members. Acute mental health care is a highly specialised and challenging area of nursing. Nationally nurses working within mental health care have one of the oldest age profiles of any area, with significant numbers of highly qualified staff likely to leave the workforce in the next few years. There are presently real problems in attracting and retaining qualified mental health nurses in specialist mental health services.

The situation for patients with mental health problems needing to access acute services in Tasmania is troubling. Every day, mental health patients at the RHH, LGH and NWRH experience prolonged delays in receiving specialised treatment or awaiting inpatient beds. Premature discharge is common and can have fatal consequences. ANMF members report that patients who have attempted suicide regularly chose not to wait for specialist treatment after facing considerable (sometimes 24 to 48 hours) delays in the ED.

⁴¹ Tasmanian Government, *Submission*, September 2017, p. 42.

Unfortunately, under these circumstances there are also higher rates of violence and injury, increased staff sickness, significant difficulties with morale, and serious problems in recruiting and retaining staff at all levels.

Nursing and medical staff in conjunction with the ANMF have been appealing for increased resources, including more available beds for Tasmanian mental health services for at least 2 years. As Public Health data revealed in 2016 the number of individuals experiencing mental health concerns has increased in Tasmania. Bed availability and service delivery forecasting should always match epidemiological data. Health supply should be ready to meet health demand. Instead, in Tasmania, the reverse has occurred, with a steady decline in services despite evidence that need was increasing.

...

ANMF has called for a Zero Tolerance to Violence against nurses. De-escalation training has not been standardised across the State and is often not offered to many high risk areas. There needs to be more trained security staff after hours. Busy, stressed staff, also have insufficient time to try to calm down patients who are agitated – particularly when they are in general (rather than psychiatric) beds.⁴²

Dr McArthur, Chair of the Tasmanian branch of the RANZCP also expressed concerns with the delivery of mental health services across the State:

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 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

⁴² ANMF, *Submission*, pp. 18-9.

highly trained psychiatrists on the ground to deliver best-practice medicine.⁴³

North West Regional Hospital Mental Health Services

The ANMF submission contained the following comments:

Increasing reports of mental health patients presenting to the Mersey Community Hospital and the North West Regional Hospital in conjunction with drug and alcohol co-morbidities is creating unsafe working conditions for nurses and other patients. The Mersey Community and the North West Regional Hospitals need Psychiatric Emergency Nurses to assist with implementing appropriate management plans for these types of patients.

Clinical Liaison nurses are desperately needed to assist inpatient areas with ongoing management when psychiatric patients leave the emergency department. Recent reports from nursing staff that managing patients with mental health illnesses and drug addiction is particularly difficult and there have even been instances where nurses have had to monitor and prevent illicit drug use and drug dealing from patients rooms. Clearly this is inappropriate and completely outside the scope of nursing practice.⁴⁴

Launceston General Hospital Mental Health Services

The ANMF submission also contained the following observations:

Reports this week, from ANMF members in the LGH, indicated that the Mental Health Crisis Assessment Team (CATT) servicing Northern Tasmanian recently had no consultant psychiatrist support for two weeks. In the past CATT staff have had a training psychiatrist available part time.. Patients with mental illness accessing support at the LGH, or through the northern CAT Team, are now receiving second rate mental health care. This is increasing the risk of suicide and other complications for people in the community and within the acute care setting.

The absence of mental health liaison nurses also impacts on the escalation of violence on general wards with patients with dementia and those affected by ice, commonly assaulting nurses. As one nurse commented "it has become normalised" to experience violence.⁴⁵

Royal Hobart Hospital Mental Health Services

Dr Benjamin commented on the impacts of bed blockage on access to timely and appropriate care for patients with mental illness presenting to the RHH:

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

⁴³ Dr Milford McArthur, *Transcript of Evidence*, 10 November 2017, p. 2.

⁴⁴ ANMF, *Submission*, pp. 18-9.

⁴⁵ ANMF, *Submission*, pp. 18-9.

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.⁴⁶

Witnesses advised that timely access to mental health care is crucial both in the acute hospital setting and within the community.

In evidence, Dr Milford McArthur, Staff Specialist Psychiatrist RHH and current Chair of the RANCP, Tasmania branch stated:

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.

...

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.

...

We note and regret that there has been some disconnect and miscommunication between management and senior clinicians.⁴⁷

Dr Richard Benjamin, Psychiatrist and AMA representative, provided evidence related to the number of acute inpatient mental health beds that are needed at the RHH:

...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.

⁴⁶ Dr Richard Benjamin, *Transcript of Evidence*, 10 November 2017, p. 29

⁴⁷ Dr Milford McArthur, *Transcript of Evidence*, 10 November 2017, pp. 1-2

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.⁴⁸

Dr Benjamin expressed frustration as clinicians believed their advice was not sought regarding challenges for addressing access to appropriate mental health care:

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.⁴⁹

⁴⁸ Dr Richard Benjamin, *Transcript of Evidence*, 10 November 2017, p. 29

⁴⁹ Dr Richard Benjamin, *Transcript of Evidence*, 10 November 2017, p. 30

It is noted this plan was scrapped by Minister Ferguson on 9 December 2017, only days before the unit was due to open.

After further consultations with staff at the RHH and major stakeholders, the Government has decided to use the newly refurbished multi-purpose unit for extra beds for general medical and surgical patients rather than the proposed Mental Health Observation Unit.

...

We will continue to work with all stakeholders and the Chief Psychiatrist to explore all options to address acute care needs of mental health patients.⁵⁰

Access to appropriate Acute Mental Health Services

Dr Benjamin noted a number of positive aspects related to psychiatry and mental health services in Tasmania:

... 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.⁵¹

⁵⁰ http://www.premier.tas.gov.au/releases/government_listens_on_mental_health_observation_unit
accessed 16 December 2017

⁵¹ Dr Richard Benjamin, *Transcript of Evidence*, 10 November 2017, p.31

Dr Fiona Wagg, a child and adolescent psychiatrist working for Child and Adolescent Mental Health Services commented on care provided at the RHH:

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.⁵²

Dr Wagg, highlighted the lack of services to young people with mental illness in the north of the state:

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.⁵³*

Dr Wagg further commented on the challenges facing young people with mental illness accessing timely and appropriate care:

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

⁵² Dr Fiona Wagg, *Transcript of Evidence*, 10 November 2017, pp. 10-11

⁵³ Dr Fiona Wagg, *Transcript of Evidence*, 10 November 2017, p 10

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.⁵⁴

Ms Connie Digolis, CEO Mental Health Council noted the need for improvement in discharge planning and transition processes for patients exiting acute mental health care and transitioning to community based care. She stated:

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.⁵⁵

According to the ANMF submission, the Government's accommodation plans for the acutely mentally ill patient as part of the RHH redevelopment remains unsatisfactory:

This is true of both the temporary and the future facility. Both have insufficient beds, are too small and lack appropriate facilities for patients and staff.

⁵⁴ *Ibid.*, p. 15

⁵⁵ Ms Connie Digolis, *Transcript of Evidence*, 10 November 2017, p. 65

Research supports contemporary mental health facilities being situated on the ground floor of any setting, with access to therapeutic (and secure) green spaces. However, both the current temporary and future permanent, mental health facilities are on the second and third floors of the RHH, with little access to the outdoors. Patients wish (sic) to go outside may need to be escorted: the risk of absconding is high. These escorts also need staff.

National Institute of Health and Welfare (NIHW) data recommends 24.3 mental health beds per 100 000 people in a catchment area of persons aged between 18 and 65. That figure provides a minimum of 39 mental health beds in Hobart. There are currently 32 mental health beds in the RHH. On top of these recommendations it is necessary to adjust for other issues such as age demographic, poverty and other factors. The real needed bed capacity is likely to be much higher when adjusted for these demographics.

This failure in service delivery was highlighted two weeks ago when the Royal Hobart Hospital accreditation by The Royal Australian and New Zealand College of Psychiatrists was frozen. The impact of this will be felt heavily by patients. The loss of accreditation means medical staff training in psychiatric care will no longer be available to the RHH.

Because of this patients will wait longer to be seen in the Emergency Department as they are usually assessed by the psychiatric registrars. Patients, already admitted to the wards will wait longer for treatment services. The pressure on nursing staff will increase, particularly in assisting with mental health events and hospital wide code black procedures. In an area with low nursing recruitment and retention the impact on existing mental health nursing staff will be great.⁵⁶

⁵⁶ ANMF, *Submission*, pp. 17-8

KEY FINDING 7

CHILD AND ADOLESCENT INPATIENT MENTAL HEALTH SERVICES ARE LACKING IN TASMANIA, RESULTING IN SUB-OPTIMAL CARE FOR YOUNG PEOPLE EXPERIENCING SIGNIFICANT MENTAL ILLNESS

Evidence was received highlighting the inadequacy of acute mental health services for children and young people throughout Tasmania. Dr Fiona Wagg, a child and adolescent psychiatrist working in Child and Adolescent Mental Health Services stated:

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.⁵⁷

⁵⁷ Dr Fiona Wagg, *Transcript of Evidence*, 10 November 2017 pp. 4-5.

KEY FINDING 8

TASMANIA DOES NOT HAVE A STATEWIDE PERINATAL AND INFANT MENTAL HEALTH SERVICE RESULTING IN SUB-OPTIMAL CARE FOR VULNERABLE CHILDREN AND WOMEN EXPERIENCING POSTNATAL DEPRESSION AND POSTPARTUM PSYCHOSIS

Dr Fiona Wagg, identified a lack of perinatal and infant mental health services throughout Tasmania.

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.⁵⁸

When asked about postnatal mental health care, particularly for women from the north of the state, noting there is only one Mother and Baby Unit bed available to public patients located at St Helens Private Hospital in Hobart, Professor Fiona Judd and Dr Wagg responded:

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.⁵⁹*

Dr Wagg described a proposal for perinatal and infant mental health services to be developed across the state to the Government:

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.⁶⁰

⁵⁸ Dr Fiona Wagg, *Transcript of Evidence*, 10 November 2017, p. 5

⁵⁹ Professor Fiona Judd and Dr Fiona Wagg, *Transcript of Evidence*, 10 November 2017, p. 7

⁶⁰ Dr Fiona Wagg, *Transcript of Evidence*, *op. Cit.*, p. 8

Dr Richard Benjamin agreed:

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.⁶¹

⁶¹ Dr Richard Benjamin, *Transcript of Evidence*, 10 November 2017, p. 45