2019 (No. 11)

PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL
GOVERNMENT ADMINISTRATION COMMITTEE "A"

REPORT

ON

ACUTE HEALTH SERVICES IN TASMANIA

Members of the Committee

Hon Ruth Forrest MLC (Chair)
Hon Kerry Finch MLC
Hon Meg Webb MLC
Hon Mike Gaffney MLC
Hon Sarah Lovell MLC
Hon Rob Valentine MLC

TABLE OF CONTENTS

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. An Interim Report was tabled in the Legislative Council on 20 December 2017.

4. Following the presentation of the Interim Report, Parliament was prorogued on 28 January 2018. A new Government was formed on 1 May 2018. Subsequent to the formation of the new Government, the Sub-Committee invited all witnesses to provide updates to their previous submissions.

5. A second Interim report of the Sub-Committee was presented on 16 November 2018. This report included the majority of evidence received by the Committee but was not able to be considered as the final report of the Committee due to a range of information not having been received at the time of reporting.

6. A Special Report of the Committee was presented on 21 February 2019 to report specific issues with the production of documents during the inquiry.
7. The Committee received the final responses from the Minister for Health on 17 December 2018 and 12 April 2019 and proceeded to prepare its final report for presentation.

Signed this 13 day of June 2019

Hon Ruth Forrest MLC, Committee Chair

APPENDIX A

2019

Parliament of Tasmania

LEGISLATIVE COUNCIL
GOVERNMENT ADMINISTRATION COMMITTEE "A"

FINAL REPORT

ON

ACUTE HEALTH SERVICES IN TASMANIA

Members of the Sub-Committee Inquiry:

Hon Kerry Finch MLC

Hon Ruth Forrest MLC

Hon Rob Valentine MLC (Chair)

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This is the final report of the Government Administration Committee 'A' Sub-Committee (the Committee) Inquiry into Acute Health Services in Tasmania.

It is recommended the Interim Report No. 1 & 2, all Hansard transcripts, published submissions and other Inquiry material be read in conjunction with this report to obtain a complete understanding of the Inquiry's findings and recommendations. These documents can be found on the Committee's webpage http://www.parliament.tas.gov.au/ctee/Council/GovAdminA_HealthServices.htm .

This Report has been prepared in two parts. Part one deals with information received from the Minister following the publication of the Interim Report No.2 and considers the following information –

- The transcript of evidence from the 16 November 2018 hearing with the Minister for Health; and
- The responses to outstanding questions contained in correspondence of 17 December 2018 and 12 April 2019.

Part two provides the Committee's final findings and recommendations based upon all of the evidence received

At the time of the release of the Interim Report No.2, a final hearing on 16 November 2018 had only just been held, the majority of which was in-camera at the Minister for Health's request. At the conclusion of the hearing, the Committee noted the majority of the evidence was of a non-confidential nature and requested the Minister review the transcript with a view to the evidence being made public. On 12 April 2019 the Minister consented to the public release of his final evidence.

With the necessity for the Committee to fully consider the evidence from the hearing with the Minister, along with the need to fully explore a number of questions with him, it was resolved to release a Interim Report No.2 containing the majority of evidence received and as a consequence, delay the completion of the Inquiry until outstanding information had been received and considered.

The Committee made the reluctant decision to produce Interim Report No.2 based on the unanimous view that, as with the initial Interim Report, the timely release of evidence was in the public interest.

The Committee subsequently received a final written response to questions from the Minister by correspondence of 12 April 2019 and proceeded to the completion of the final report.

The Committee continued to request a copy of a KPMG Report relevant to this Inquiry. The requested release of the KPMG Report to the Committee was protracted and frustrating to the work of the Inquiry. As Chair of the Committee, my account of the Minister's undertakings regarding the release of the report is contained in an email sent to the Committee Secretary on the day of my telephone conversation with the Minister and is an account that I firmly stand by (**Appendix A**).

The Minister by contrast indicated a very different recollection in his correspondence of 12 April 2019.

The issue of the production of documents to future committees will be the subject of further consideration by a Select Committee of the Legislative Council.

Throughout this inquiry, the Committee and the Government have held differing views on a number of the challenges being faced within the Tasmanian health system. These differences have arisen during discussion at public hearings and in correspondence. However, the Committee is of the view that all interested stakeholders share a primary interest in ensuring the best possible sustainable health services are delivered to the people of Tasmania.

All stakeholders, including political, consumer and health care professionals must work constructively together to address the barriers to optimal acute health care provision identified during the course of the Inquiry. This is one of the most important clarifying issues the Committee has taken from the inquiry and is the focus of committee recommendations made in this and earlier Reports.

The Committee strongly recommends a non-partisan approach be taken to address the financial, cultural and structural issues facing Tasmanian acute health service delivery. This approach must engage key stakeholders, public policy makers, consumer groups and health care professionals, to cooperatively develop a long-term strategic framework that transcends the 4 year election cycle.

A full assessment and review of the efficacy of current governance and clinical leadership arrangements also needs to be undertaken prior to any further structural change being made, to avoid change fatigue.

The Committee also recommends that Government provide more timely, open and transparent reporting of clinical outcomes, in addition to clinical output reporting currently provided. It is vital the Government provides timely and transparent reporting of the financial performance of the acute health sector to ensure early identification and response to emerging and actual challenges.

Immediately prior to the finalisation of this Report the Auditor-General released his report *Performance of Tasmania's four major hospitals in the delivery of Emergency Department services*[1] The above report supports many of the findings and recommendations made by the Committee in Interim Reports 1 and 2 and identifies similar challenges to those presented in evidence received during this Inquiry. The recommendations of the Auditor-General and the Committee's full Inquiry should inform any attempt to resolve those challenges.

The Committee remains optimistic that this inquiry has been a productive mechanism to bring a range of diverse ideas, concepts, concerns and observations together that are very worthy of consideration by the Government. Members of the Committee will continue to encourage constructive engagement between key stakeholders and the Government into the future.

The Committee calls on all political parties and key stakeholders in Tasmania, including those from the non-government sector, to work constructively together to enable the State to attract, retain, support and develop our acute health care professionals, health care facilities and services to deliver the best possible health outcomes for the people of Tasmania. Tasmanians deserve no less.

Hon Rob Valentine MLC
Inquiry Chair
13 June 2019

[1] https://www.audit.tas.gov.au/publication/performance-tasmanias-four-major-hospitals-delivery-emergency-department-services/ accessed 1 June 2019.

Terms of Reference

The Committee's Terms of Reference were 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.

KEY FINDINGS

The key findings made by the Committee throughout this document have been identified from the remaining evidence received since the publication of Interim Report No.2. These findings are also included in sections of this Report relating to the relevant evidence.

The findings of this Final Report should be read in conjunction with all previous findings and recommendations made in the Committee's Interim Reports No. 1 & 2.

The Committee found that:

1. The Minister has acknowledged the ongoing concerns expressed by clinicians regarding the design of the acute psychiatric ward in K Block as part of the Royal Hobart Hospital redevelopment and has established a Southern Reference Group, which in turn informs the Clinical Planning Task Force which is responsible for the Master Plan.

2. The Government has acted and filled the Clinical Director position at the Royal Hobart Hospital and the position of State-wide Clinical Director of

Mental Health Services since the Australian Medical Association (AMA) submission of 15 August 2017 was presented to the Committee and further evidence was taken on this issue.

3. Further evidence is required to determine whether the new local hospital governance approach has improved local clinical decision making and governance.

4. The Government acknowledges there is a higher statistical risk for patients in Tasmanian acute care hospitals which is partly due to the demographic of the population and this does not necessarily translate directly to a higher avoidable mortality rate in Tasmania.

5. Private hospitals operate on a licensing system that does not guarantee they will provide advanced warning to the Tasmanian Health Service (THS), prior to their emergency department going on bypass.

6. As public hospitals are providers of last resort, any occasion when a private hospital emergency department goes on bypass results in demands on public hospital emergency departments increasing.

7. Collaboration with private hospitals in Hobart is taking place with the aim of reducing pressure on the emergency department at the Royal Hobart Hospital.

8. The refusal of the Minister to provide the Committee with a copy of the KPMG report has hampered independent scrutiny of the demand factors impacting on the health budget and has limited its capacity to fully report against the Inquiry's Terms of Reference.

9. The Government considers the cessation of the federally funded Tasmanian Health Assistance Package for community-level services, delivered through Primary Health Tasmania, directly impacted on and increased demand for services provided in public hospital emergency departments.

10. Presentations to Emergency Departments have increased by 8% from 2014-15 levels, to 2017-18, resulting in a further 12,400 people presenting to the emergency departments and an extra 11,300 individuals being admitted to a ward during that period.

11. Tasmania's growing and ageing population and increases in the incidence of chronic disease have contributed to the increase in presentations at public emergency departments.

12. The cohort of individuals presenting to Emergency departments reveals inconsistent patterns, as the cohort changes from week to week.

13. A Community Rapid Response Service (ComRRS) trial, together with an ambulance secondary triage service, is being conducted by Government, seeking to reduce demand on public hospital emergency departments.

14. Deeper data analysis is being undertaken to discover alternate appropriate pathways for mental health patients to access the services they need without needing to present to the emergency departments.

15. The Minister for Health and Secretary of the Department of Health claim the opening of the new K Block at the Royal Hobart Hospital will provide more beds than currently exist, additional beds in other parts of the hospital and will create capacity in excess of demand for approximately ten years.

16. The opening of the new K Block at the Royal Hobart Hospital is expected to address a number of demand related pressures, including for state-wide services that are only offered at the Royal Hobart Hospital.

17. Contracted services, including radiology and pathology, are operating well across the State.

18. The provision of some specialised drugs has been an issue on occasion, due to the State's smaller size as a purchaser.

19. Queensland health services have assisted with the supply of drugs during international shortages.

20. The construction program involving the Royal Hobart Hospital is considered the biggest challenge by the Government.

21. In the last two years waiting times and waiting lists continue to grow and other access KPI measures have deteriorated.

22. The establishment of an Academic Medical Centre, along the lines of the UK and USA models, is not being pursued for legislative and funding reasons.

RECOMMENDATIONS

The Committee recommends that:

1. The Government, through a non-partisan approach, engage all other parliamentary parties, key stakeholders, public policy makers, consumer groups and health care professionals, in the cooperative development of a long-term strategic framework that transcends the 4 year election cycle.

2. Full assessment and review of the efficacy of current governance and clinical leadership arrangements be undertaken prior to any further structural change.

3. More timely, open and transparent outcomes-focused public reporting of episodes of care, funding and financial performance regarding the acute health sector be undertaken.

INTRODUCTION

As previously reported, at a meeting of the Legislative Council Government Administration Committee "A" on Thursday 28 June 2017, it was resolved that a Sub-Committee (the 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.

Thirty-five submissions were received. A combination of public and private hearings were held in Hobart on 8 September, 9 and 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 Committee also undertook informal site visits at the Royal Hobart Hospital on Thursday 7 September 2017, the Mersey Community Hospital, the North West Regional Hospital and the North West Private Hospital (maternity services) on Monday 9 October 2017, and the Launceston General Hospital on Monday 30 October 2017.

A First Interim Report was tabled in the Legislative Council on 20 December 2017.

Following the presentation of the Interim Report, Parliament was prorogued on 28 January 2018. A new Government was formed on 1 May 2018. Subsequent to the formation of the new Government, the Committee was re-established on Thursday 12 July 2018. All witnesses were invited to provide updates to their previous submissions and the Committee called for new submissions in Tasmania's three daily newspapers. An additional six days of public hearings were held in Hobart on 14, 21, and 28 September, on 22 and 24 October 2018

and the final hearing on 16 November 2018. Nine witnesses (individuals or organisations) gave evidence to the Committee at these hearings.

Interim Report No.2 was tabled in the Legislative Council on 20 November 2018 and included the substantial evidence of the inquiry, including 70 findings and 8 recommendations.

The Hansard transcripts of the hearings (where evidence has been made publicly available) can be accessed via the Inquiry webpage at the following link http://www.parliament.tas.gov.au/ctee/Council/GovAdminA_HealthServices.htm. The transcripts, submissions received and the two interim reports should be read in conjunction with this Final Report.

The Committee wishes to again acknowledge the time and effort concerned individuals and organisations throughout the community have expended in preparing their submissions and providing verbal evidence.

Although there has been a range of challenges with the value and timeliness of information provided by the Government to the Inquiry in response to questions, the Committee also wishes to acknowledge the assistance of the Minister for Health, the Tasmanian Health Service and the Department of Health and Human Services throughout the inquiry.

The Committee commends the Minister for appearing before the Committee at multiple hearings when requested to do so.

The Committee also acknowledges and thanks the Parliamentary Research Service and Parliamentary Staff for their dedication and commitment to the research and administrative needs of the Inquiry.

PART 1: FINAL EVIDENCE - MINISTER FOR HEALTH

The following deals with information received from the Minister following the publication of the Interim Report No.2 and considers the following –

- The transcript of evidence from the 16 November 2018 hearing with the Minister for Health; and
- The responses to outstanding questions contained in correspondence of 17 December 2018 and 12 April 2019.

Hearing of 16 November 2018

The Minister had initially requested that parts of the evidence from his final appearance before the Committee be received as in-camera or confidential evidence. At the conclusion of the hearing the Committee requested the Minister review the transcript and consider which aspects he believed should remain confidential. This was confirmed in writing to the Minister on 28 November 2018 and included the full transcript. The Minister consented in writing on 12 April 2019 stating '*I have reviewed the transcript and am content for this to be made available on the public record in entirety and included in sub-committee considerations and the final report*'. The Committee acknowledges the cooperation of the Minister in relation to this decision in the interest of transparency.

The questions put to the Minister at the beginning of the hearing in public session were related to a number of matters that were discussed at the previous hearing with the Minister but limited time had prevented a full exploration of these important matters.

K Block and the Acute Psychiatric Care Unit

The Minister was questioned regarding options for the use of K Block as it relates to the Acute Psychiatric Care Unit (ASCU) and his response indicated he was open minded regarding the ACSU in the context of the development of the master plan.

> ***Ms FORREST*** *- There has been constant criticism of the design of the acute psych ward in K Block. I accept there are differing views on this, but there appeared to be an openness from you to consider a new facility on the corner of Campbell and Collins streets. What is your view on that?*
>
> ***Mr FERGUSON*** *- I do not have a view on that. I am open-minded and have encouraged the master plan - and so has the secretary - that is being developed and I can countenance those ideas.*
>
> *That is not something I support or do not support in terms of a notional new building on a corner but we want the master plan to be robust, well*

informed and done by experts. We have engaged experts to lead that work or to provide the expert advice into the group under the Clinical Planning Taskforce chaired by the Chief Medical Officer. Thank you for acknowledging that while there has been published criticism of the acute psych inpatient unit, there are mixed views and increasingly an acknowledgment that it is a far superior service to the one we have now or had before in B Block.

***Ms FORREST** - Thank you.*

***Mr FERGUSON** - Does that answer the question? There is an understanding that future longer term redevelopment on the site needs to be informed by a master plan and needs to have special -*

***Ms FORREST** - There will be input available for those genuinely concerned members of the AMA in the design?*

***Mr FERGUSON** - Absolutely. A specific southern reference group has been appointed to provide engagement to the Clinical Planning Taskforce.*[2]

FINDING

1. The Minister has acknowledged the ongoing concerns expressed by clinicians regarding the design of the acute psychiatric ward in K Block as part of the Royal Hobart Hospital redevelopment and has established a Southern Reference Group, which in turn informs the Clinical Planning Task Force which is responsible for the Master Plan.

On-Site Clinical Directors

The Minister was further questioned about the Australian Medical Association (AMA) concern that there needed to be on-site Clinical Directors for patients within acute mental health services.

***CHAIR** – (quoting the AMA*[3]*) Acute mental health units manage many patients at high risk, and are inherently highly stressful environments, with many and varied needs. The acute mental health system at the RHH has gradually lost resources, and a loss of the on-site dedicated-to acute-inpatients Clinical Director has been particularly important in this context. As such, it is the firm view of the AMA that all three acute mental health inpatient units in Tasmania should have their own on-site, dedicated Clinical Directors. These Clinical Directors should play oversight,*

[2] Transcript of Evidence, 16 November 2018, M Ferguson, p. 4-5
[3] Australian Medical Association, 2017, *Submission #8, p. 10.*

governance, leadership, resource allocation, strategic, and advocacy roles. They should also provide leave backfill, therefore assisting in the provision of a critical mass for staffing.
Do you have a comment on that?

Mr FERGUSON - *Again, I would throw to the secretary's expertise, but I would support any idea that we have strong clinical leadership in all our disciplines. That is a given from my point of view, and is something we have been strengthening through our local hospital governance approach, which was introduced in the last 12 months but especially in the context of the new legislation that commenced on 1 July. I know there have been workforce changes in mental health and the secretary would be well equipped to provide you further detail on that.*

Mr PERVAN *- Thank you, minister, and thank you, Chair. Before I answer, may I ask what the date of the AMA submission was? That might influence my understanding of the question.*

CHAIR *- It was last year. It was submission number eight.*

Mr PERVAN *- Since that time, Dr Lennie Woo has been appointed to fill the position of clinical director at the Royal and Dr Ben Elijah fills the position of statewide clinical director. That was all consistent with the structures that the minister mandated. Dr Woo and Dr Elijah are also working in close collaboration with the chief psychiatrist, Dr Aaron Groves, on the Mental Health Integration Taskforce, which complements the work the minister was talking about earlier around the Clinical Planning Taskforce in that the Mental Health Integration Taskforce also focuses on community and allied services - the whole model of care, the whole spectrum.*[4]

The Minister stated that in his view there is strong clinical leadership in all disciplines. He also claimed that the local hospital governance approach, which was introduced in the previous 12 months including legislative reform that commenced on 1 July 2018, will improve local clinical decision making and support the provision of the full spectrum of care for patients with mental health challenges.

FINDINGS

2. The Government have acted and filled the Clinical Director position at the Royal Hobart Hospital and the position of State-wide Clinical Director of Mental Health Services since the AMA submission of 15 August 2017 was presented to the Committee and further evidence was taken on this issue.

[4] Op.Cit. p. 6-7

3. Further evidence is required to determine whether the new local hospital governance approach has improved local clinical decision making and governance.

Avoidable Mortality

The Minister was asked about the position of the Grattan Institute's Health Policy Director Dr Stephen Duckett regarding avoidable mortality.

> ***CHAIR*** *- A question on Dr Duckett's observations on avoidable mortality. Is the Government aware of his observations when he says -*
> *It is not necessarily about what happens in hospitals but about the general health of Tasmanians. If you compare Hobart with Melbourne and take into account the age distribution, the avoidable mortality rate is much higher in Hobart than Melbourne with 295 per 100 000 in Melbourne versus 381 in Hobart.*
> *Do you have any comment?*
>
> ***Mr FERGUSON*** *- I am not expert in those demographic and statistical models, but I appreciate you have highlighted, Chair, that the Duckett comments were not an attempt to say this is about the treatment you get in the health system, but a whole-of-population model. If you would like to address that question to the secretary, he will be far better placed than me to speak to that.*
>
> ***Mr PERVAN*** *- Thank you, minister and Chair. Yes, Professor Duckett's observations are interesting. It is a very controversial report, with the Australian Commission on Safety and Quality in Healthcare raising some concerns at some deductions he drew, based on the data available. Notwithstanding that caveat, I think we can all agree due to the age demographic and, more importantly, the morbidity of the Tasmanian population, particularly as it applies to patients with multiple chronic condition, that there is a higher risk, but it is a statistical risk. That puts a challenge on the system to better manage those people as they enter and exit the system and to work closer with general practice and primary care to maintain the health of those people once they are returned into the community.*
> *As the minister said and as, Chair, you pointed out previously, it is a valid statistical observation to say there is a higher level of risk with our population because of its morbidity, but that is just an issue that the health system needs to manage.*[5]

[5] Op.Cit. p. 5

FINDING

4. The Government acknowledges there is a higher statistical risk for patients in Tasmanian acute care hospitals which is partly due to the demographic of the population and this does not necessarily translate directly to a higher avoidable mortality rate in Tasmania.

Private Hospital Emergency Department Bypasses

The Minister was questioned on the issue of private hospital bypass practices at Calvary and Hobart Private Hospitals as it relates to the provision of emergency services at the Royal Hobart Hospital.

> ***Mr FINCH*** *- Minister, there was quite a bit of publicity about the Calvary bypass in the ED department. Can I ask you about the indication of that impact - how you felt about that and what the possibilities might be for closer collaboration into the future?*
>
> ***Mr FERGUSON*** *- That is an important issue. You have zeroed right in on a particular pressure point we have experienced. It has been around for a while but more so we have experienced the impact of that in the last two years. You mentioned Calvary. The Hobart Private Hospital also went on bypass at the same time, about a month ago - maybe six weeks ago. I am speaking rhetorically - it is a choice an independent private hospital operator can make, but it is not a choice we cannot make. As a public hospital provider, we never closed our doors and so the Royal Hobart Hospital experienced significant demand peaks as a direct result, not of its internal pressures, but because of the two privates going on bypass. You asked me how I felt about that. That was something I felt very concerned and even angry about because it was in my mind something we need to have better controls and support over, and it draws the mind back immediately to how our public hospital system needs to be able to collaborate with the private system. While respecting each other's different sectoral responsibilities, we need to be able to rely on them to keep their doors open.*
>
> *I, and our department, spoke to the operators and one of the key issues identified, or at least highlighted, by those operators was their ability to continue when they are experiencing workforce shortfall.*
>
> *That is something we have to manage, so we invite them to manage as well through their recruitment strategies. We have our private hospitals, therefore a reason to support them, particularly with their co-location.*
>
> *We want to see that as a benefit to the public hospital system. The real challenge I have laid out to the private hospitals is to ensure they have done everything within their power to make sure they stay open. Those emergency departments need to cater to the percentage of people who are either privately insured or who have the capacity to pay.*

Mr FINCH *- To that end, do you feel the collaboration will improve, be stronger, be enhanced in the future?*

Mr FERGUSON *- I will ask the secretary to speak about both the collaboration with Calvary and Health Scope, the owner of the Hobart Private Hospital. I can speak immediately regarding the Government's approach to looking at the long-term future role of Hobart Private onsite with the Royal.*

We are looking to Healthscope for a greater level of collaboration and a shared plan for the services delivered, so it is not only two hospitals on the one city block, but it is genuinely two hospitals symbiotically working together and helping maximise the ability of patients to get access to health.[6]

Mr Pervan was also questioned concerning the ongoing challenge of the Private Hospitals in Southern Tasmania going on bypass.

CHAIR *- Secretary, I do not want to take too long over this question. With respect to services like Calvary were providing and now may not be because they go into bypass or whatever, are there any contractual obligations they have in the system to provide certain levels of service?*

Mr PERVAN *- There are, in the conditions of the licences we now issue, which are far more robust documents than they used to be. By way of an aside, until five years ago the licence for a private hospital in Tasmania consisted of a handwritten name in a ledger book. I still have the licence book in my office that goes back to 1901. They are now given a very thorough document that specifies the services they are licensed to provide, as well as particular reporting requirements, such that if, for any reason, they are unable to maintain a licensed service, they have to notify me immediately. We will seek reasons for that. Most often it is because of workforce shortages. We will discuss the time they have before they have to reinstate that service and what our expectations are of them getting that back up and running.*

One of the challenges they have is that the emergency departments, so-called, at Calvary in Lenah Valley and Hobart Private are largely staffed by locum medical officers. When they lose the locum, they lose the service.
There isn't a contract in place as such; there is that licence and, ultimately, if they are unable to sustain that service, I can have that service deleted from their licence. That has revenue consequences from private health insurers for those hospitals.

CHAIR *- Are they bound to give you a heads-up days before that this is their intention?*

[6] Op.Cit. p. 6-7

Mr PERVAN *- No, they are not. Under the licence and under the legislation they are only required to tell me when the service is lifted. We have, through collegial relationships, managed to get a better relationship with Calvary. We had a very good relationship there until there were some recent staff changes, and we are just rebuilding those bridges with new staff who have come in. We are getting into a much more interactive environment.*

We are also just starting a conversation around transfers of medical patients and surgical patients who are coming down to the Royal and who are taking up space in the ED. The staff at the Royal raised their concern that they were seeing increasing numbers of transfers from the private sector. Once again, that goes to workforce issues in the private sector and their not being confident they can hold those patients. Transferring them in the interests of the patient is just adding to the pressure that is on the public system.[7]

FINDINGS

5. Private hospitals operate on a licensing system that does not guarantee they will provide advanced warning to the Tasmanian Health Service (THS), prior to their emergency department going on bypass.

6. As public hospitals are providers of last resort, any occasion when a private hospital emergency department goes on bypass results in demands on public hospital emergency departments increasing.

7. Collaboration with private hospitals in Hobart is taking place with the aim of reducing pressure on the emergency department at the Royal Hobart Hospital.

Release of the KPMG Report

The Minister was questioned by the Committee concerning his decision not to release the KPMG Report or to provide a confidential briefing on its contents. Instead, the Minister had offered an in-camera briefing in relation to the health budget. Prior to concluding the in-camera hearing on 16 November 2018, the Committee requested the Minister review the transcript of his in-camera evidence with a view to his complete evidence being on the public record. This was confirmed in writing by the Committee on 28 November 2018. The Minister confirmed in writing on 12 April 2019 his consent for the evidence to be made public.

The Minister provided a statement regarding his decision not to release the report to the Committee. His statement should be read in full for completeness,

[7] Op.Cit. p. 9-10

however, the Committee notes that the Minister appeared concerned about the relevance of the data contained in the report, given its age.

> ***Mr FERGUSON*** *…… In short, we are in a situation where the report you are seeking was written in the context of budget numbers that go back a number of years. They are historical, not current, and since the report was commissioned and provided to government, three key things have occurred: first, an election; second, significant health spending commitments that build into baseline funding, not special one-off initiatives; and third, the budget itself. The entire landscape is quite different to the years running up to 2015-16 countenanced in the KPMG report that was commissioned.* [8]

The Minister also provided further advice on his reasons for not releasing the report.

> ***Ms FORREST*** *- Minister, you mentioned the KPMG report earlier. I am interested what detail that provided that really is sensitive. I am not asking you for the actual detail, I am asking what the barrier is to us seeing that. I know it is historical, but the history reflects how reached where we are and can inform the future.*
>
> ***Mr FERGUSON*** *- Can I indicate that I found myself, as a science teacher, not the best reader of that document. It is highly technical and provides advice to the department on the cost pressures, which we have often talked about in terms of demand, and it deals with the contributors to price increases, if I can put it in those terms. It is to allow government, the Health department, to understand the push factors in cost increases in Health. Some of the public commentary by some has tried to put a different colour on what that report is attempting to provide advice on.*
>
> ***Ms FORREST*** *- Isn't it important for all of us to understand what those push factors are?*
>
> ***Mr FERGUSON*** *- It absolutely is for Government, for sure.*
>
> ***Ms FORREST*** *- Isn't there an interest for the whole of the Parliament to understand what they are?*
>
> ***Mr FERGUSON*** *- I understand the point but it is advice to government to help it frame its budget preparations. That is why I am so limited in what I am prepared to say about it, not because I am embarrassed by it when I read it or anything like that. It is not of that nature. Would the secretary like to say something further?*
>
> ***Mr PERVAN*** *- Minister, I think you have covered it quite well. It is a technical paper. It is not so much the information Ms Forrest is seeking*

[8] Op.Cit. p.8

around the reasons for those push factors, those cost increase factors. It is a highly academic piece that goes to exploring this concept that has been in the public domain for many years, of health indexation and querying whether health indexation is different to every other sort of indexation. I would say it is not a very high-quality report, it certainly isn't very informative and it doesn't provide, in that context, anything more interesting in the public domain than what the minister has already alluded to. The big push factor is simply activity. It is more complex patients and more of them coming through the front door; it is not due to drugs and it is not the cost of labour or workforce. There is nothing special or magical in there that would explain why our costs are going up.

There are other parts of the report we are not able to share, which have informed past budget submissions and the one we are about to put to the minister for next year's budget. There is some sensitive financial information in there that we are quite protective of but, in terms of those other factors, there is nothing that we haven't provided today that is superior and more current to the material that is in that KPMG report.[9]

FINDING

8. The refusal of the Minister to provide the Committee with a copy of the KPMG report has hampered independent scrutiny of the demand factors impacting on the health budget and has limited its capacity to fully report against the Inquiry's Terms of Reference.

Increasing Emergency Department Presentations

The Minister and Secretary of the Department of Health, Mr Michael Pervan, were further questioned regarding the ongoing issue of increasing presentations to emergency departments within the public system.

Mr Pervan advised the Committee of the impact on the emergency departments following the expiry of the Tasmania Health Assistance Package.

***Mr PERVAN** - I am just trying to frame my comments so they are useful for the committee. I think in addition to the significant increase in demand and the complexity of the demand we are seeing, it is also worth pointing out that the dynamic nature of the system is such that relatively small changes outside our hospital system have profound effects on us.*

Moments ago, you were talking about what happens when the Emergency Department at Hobart Private closes. It is always good to bear in mind that is not what we would consider a tertiary-level emergency department. They do not have a full suite of emergency specialists, equipment and resources, so they tend to deal with the lower acuity cases that come through. Even then, when

[9] Op.Cit. p.18

that small capacity goes, there is a measurable and significant impact on our ED. In respect to the relevance even of that on our budget movements, that is an issue.

In the background to that, we saw the Tasmanian Health Assistance package funding expire. It had been channelled through Primary Health Tasmania for a whole range of community-level services. A lot of those services were around care coordination and the management of people with complex and chronic conditions. As those services wound up because it was fixed-term funding, those patients also started joining the queue to the ED.[10]

Further questioning revealed the current level of demand in public hospital emergency departments and the apparent reasons for the increase:

Mr FINCH *- Minister or Mr Pervan, in respect of those numbers you are talking about - that we didn't have the flu season, we had a milder effect, but there were still the numbers maintained of people using the ED - is there anything revealing there about those numbers that might give some guidance to where things are increasing and where work might be put into assuaging that growth or development of areas of concern?*

Mr FERGUSON *- I will speak in general terms, Mr Finch. First, the numbers are up and the secretary will hopefully have those numbers at his fingertips. I can tell you that increased service levels to the end of 2017-18 include 12 400 more people being seen in emergency departments, so that is an increase of 8 per cent since 2014-15.*

Ms FORREST *- Across the state?*

Mr FERGUSON *- Yes. I think we discussed this at Estimates as well. When we were looking at performance output information, it wasn't just an increase in the number of people presenting, it is also an increase in the number of people at the acuity, which the secretary touched on there, requiring an admission. I remember sharing with the committee then that what was remarkable about that was that it was not just those who needed to be admitted who were - and that has increased by 11 300 people since 2014-15 - and that was not just the number who needed a bed, but the number who got a bed. That is a testament to the effort there.*
The proportion of presentations resulting in admission increased from 26 per cent to 31 per cent since 2014-15. That on its own would be challenging enough but couple that with the increased absolute number of presentations and that is a lot of extra work for staff and it is a lot of extra beds that have been provided. While that has occurred, we have needed to be able to meet that demand by opening those beds all of which will be supported far better when we have got the new building in place when it is completed and

[10] Op.Cit. p.9

commissioned to allow us to grow into spaces and flex at periods of high demand.

***Mr FINCH** - What was of interest to me, Minister, was in fact the reasons for people being in the ED departments and whether there was something revealing there about the reasons. Why there was not so much the increase in numbers but the maintenance of numbers and something that could be worked on -*

***Ms FORREST** - Other than flu.*

***Mr FINCH** - other than flu in the preventative health care sector.*

***Mr FERGUSON** - The Secretary would be well equipped to respond additionally here but I would put it down to a number of factors. First of all, our population is ageing, we are getting an older population each year. As that occurs it would only stand to reason that we could see a higher level of presentation and a higher proportion of needing admission. That second reason is that we have a bigger population as well in Tasmania so we are seeing population growth. Then of course the third and compelling factor is the increase in chronic disease and that is a message about our whole community health and it is why we need preventative and primary health initiatives that drive down the demand for acute health services in the first place. I think that we all agree on that.*
In my mind, those three factors help explain why we are seeing the more or less natural population requiring and feeling the need to present at emergency departments.
There is a fourth that I am not expert in but I will mention and that is the ability of people to access primary care, GP care, support in their home community has to be factored in as well. I am not suggesting it is the full explanation but I am saying it is a small factor, that if somebody could be getting support from their GP but they are unable to access that for whatever reason whether it is opening hours or the cost of that service naturally that does have an impact on the number of presentations at an emergency department. It would be only one of the number of factors.

...

***Mr PERVAN** - Thank you minister. In addition to the Minister's comments I would throw a few other things in there. We have mined that data as you would expect trying to identify a segment or cohort of people presenting to the EDs that we could divert off into alternative services. What has been both challenging and interesting is that the growth or the stand out cohorts tend to change week to week. Last week it was surgical patients at the Royal, the week before that it was mental health patients, but it is not mental health patients every week. What we have done is spent a lot of time and, with Government support, got some initiatives in place to try to pull people out of that ED queue and back into the community through the community rapid response service, or ComRRS. We are in the process of*

getting the ambulance secondary triage service up which is intended entirely to divert people away from that ambulance trip to hospital into safe alternatives as well as going through the data far deeper to see if even with the mental health patients that are coming into the ED there is a faster pathway that we can put in place such that they go from presentation straight to the service they need as opposed to coming into the ED being assessed and going through all of that kind of process. In order to cope with the demands that the minister has been talking about we are needing to re-engineer the front end of our system rather than just making it bigger because as we have seen when we make it bigger that just seems to increase the demand in front of it.

Going to Mr Finch's original question, there is not a specific group that we can isolate, but we are working on diversionary or alternative services so that people who do attend do get treatment and they do get care but in the most appropriate place for them which is also the safest.[11]

Mr Pervan provided evidence regarding data mining activities to better understand and identify opportunities to divert some patient cohorts away from emergency departments:

***Mr PERVAN** - ... We have mined that data as you would expect trying to identify a segment or cohort of people presenting to the EDs that we could divert off into alternative services. What has been both challenging and interesting is that the growth or the stand out cohorts tend to change week to week. Last week it was surgical patients at the Royal, the week before that it was mental health patients, but it is not mental health patients every week.*[12]

FINDINGS

9. The Government considers the cessation of the federally funded Tasmanian Health Assistance Package for community-level services, delivered through Primary Health Tasmania, directly impacted on and increased demand for services provided in public hospital emergency departments.

10. Presentations to Emergency Departments have increased by 8% from 2014-15 levels, to 2017-18, resulting in a further 12,400 people presenting to the emergency departments and an extra 11,300 individuals being admitted to a ward during that period.

11. Tasmania's growing and ageing population and increases in the incidence of chronic disease have contributed to the increase in presentations at public emergency departments.

[11] Op.Cit. p.11-12
[12] Ibid

12. The cohort of individuals presenting to Emergency departments reveals inconsistent patterns, as the cohort changes from week to week.

Community Rapid Response

Associated with programs to divert presentations at public hospital emergency departments is the Community Rapid Response program. The Minister confirmed that following a trial in Launceston, a decision had been made to roll the program out to the other regions in Tasmania.

> ***Mr FERGUSON -*** *What we have done is spent a lot of time and, with Government support, got some initiatives in place to try to pull people out of that ED queue and back into the community through the community rapid response service, or ComRRS. We are in the process of getting the ambulance secondary triage service up which is intended entirely to divert people away from that ambulance trip to hospital into safe alternatives as well as going through the data far deeper to see if even with the mental health patients that are coming into the ED there is a faster pathway that we can put in place such that they go from presentation straight to the service they need as opposed to coming into the ED being assessed and going through all of that kind of process. In order to cope with the demands that the minister has been talking about we are needing to re-engineer the front end of our system rather than just making it bigger because as we have seen when we make it bigger that just seems to increase the demand in front of it.* [13]

The Minister further added:

> ***Mr FERGUSON - ...*** *the secretary mentioned the Community Rapid Response Service, and I will undertake to provide the committee with some information on that. It was trialled in Launceston as a replacement to the Hospital in the Home model - we have stood that back up. The central figure in the referral pathway is still the family doctor - the GP - and then the THS service that attends the patient at their home. It has seen 1600 referrals in two years and has visited 16 000 occasions of service and so on evaluation we have declared this a success and at the election we promised to roll this out in the south and the north-west over coming months.*
>
> ***CHAIR*** *- That is roughly two cases a day.*
>
> ***Mr FERGUSON*** *- I believe the rate was around about 500 referrals a year, but you can have up to four visits a day. It depends on the length of care. It has been a diversion from hospital but also is in many cases better care for the patient. It allows them to continue their daily routines going to work and study.* [14]

[13] Ibid
[14] Op.Cit. p.12

FINDINGS

13. A Community Rapid Response Service (ComRRS) trial, together with an ambulance secondary triage service, is being conducted by Government seeking to reduce demand on public hospital emergency departments.

14. Deeper data analysis is being undertaken to discover alternate appropriate pathways for mental health patients to access the services they need without needing to present to the emergency departments.

Demand Modelling

Another issue in relation to public hospital presentations was the importance of demand modelling and the question of what work was being done by the Department in relation to this issue.

> ***Ms FORREST*** *- Minister, following up with this general conversation because the demand pressure is the DEM, obviously, but hospital overcrowding generally creates the problem of backlog. What modelling has been done on demand leading up to where we are now and modelling for the future?*
>
> ***Mr FERGUSON*** *- In fact the department has been working on this.*
>
> ***Mr PERVAN*** *- We are at a very interesting point in the modelling on demand right across the board - not just acute bed demand - and it indicates that once K Block is opened, it will give us the acute capacity we have needed for a while. This is the reason we are building K Block in the first place and it will address a lot of the challenges and issues we see every day across the state, especially for the statewide services only offered at Royal Hobart. The more interesting part is the work we now need to do around subacute primary and community, to make sure the demand at that level is met with strategies within the resources we have because not every pathway into the system leads to an acute bed admission.*
>
> *There are multiple reports going back over 20 years on one of the issues Tasmania has been challenged by for a very long time, an absence of subacute capacity. We have been greatly assisted with the expansion of the repat. in the last year and the 22 beds there. That has given us a measurable and noticeable difference on subacute demand in the south. We need to look at subacute services and particularly subacute services in the home. Rehabilitation and palliative care in the home - those sorts of services across the north and north-west so we are keeping those acute resources - the high-cost, high-complexity resources - for acute patients. That will also help us manage demand far more efficiently.*
>
> ***Ms FORREST -*** *On that point, minister, the secretary mentioned that once the K Block opens - and you have mentioned this yourself - it is expected to meet the current demand. We know population is likely to increase. We are not going to see any change in patient acuity and complexity in the short term,*

because that creates much greater investment in preventative health. What modelling has been done beyond that?

***Mr FERGUSON** - Thank you. Secretary, I will ask you in a moment to touch on the work of the Clinical Planning Taskforce. In short, the new redeveloped Royal K Block is going to provide in excess of 250 bed capacity theatres, birthing suites and the like. It is a modern building and, in many cases, will allow the breathing space the site has not had for many years. Services moving into the building will leave behind wards and areas that while not as contemporary as the new structure, nonetheless provide that ability to flex. That is about providing the supply.*

***Ms FORREST** - So you are saying the existing buildings now will meet the additional demand beyond what the K Block would meet under current demand levels?*

***Mr FERGUSON** - The new K Block tower will provide more bed stock than is currently provided for even in the services that will move in. There are growth spaces. There are more beds.*

….

***Mr FERGUSON** - In addition, the areas that will move into K Block being vacated suddenly become available for bed growth. We have committed in our budget, in our $757 million policy package which speaks directly to opening more beds, to not only building more structure, but even opening more beds in areas that will require some refurbishment but nonetheless the capacity will be there to staff them.*

***Ms FORREST** - What does the modelling show on this? I was concerned when the secretary said that the new K Block will deal with the current demand, which all of us would reasonably expect is not going to get less and it is not going to stay the same. It is going to get greater, so what does the modelling show in that regard?*

***Mr FERGUSON** - I will ask the secretary to speak about demand projections and prediction. The work of the Clinical Planning Taskforce is material there.*

In my comments I am trying to explain that the redeveloped RHH, obviously a beautiful expansive building -

***Ms FORREST** - Yes, I am interested in what the modelling shows, Minister.*

***Mr FERGUSON** - It will allow us to refurbish the older areas not in K Block and allow us to open 200 -*

***Ms FORREST** - I am interested in what the modelling shows in terms of demand. That is my question.*

Mr FERGUSON *- The demand question I would like the secretary to take up. We have a special taskforce.*

Mr PERVAN.- *Thank you Minister. I will deal with this very quickly. The modelling shows that it will actually have excess acute bed capacity for about 10 years.*[15]

FINDINGS

15. The Minister for Health and Secretary of the Department of Health, claim the opening of the new K Block at the Royal Hobart Hospital will provide more beds than currently exist, additional beds in other parts of the hospital and will create capacity in excess of demand for approximately ten years.

16. The opening of the new K Block at the Royal Hobart Hospital is expected to address a number of demand related pressures, including for state-wide services that are only offered at the Royal Hobart Hospital.

Supply Contracts

The Committee questioned the Minister on the issue of third party supply contracts and whether they were causing any challenges in terms of delays in the contracted services being provided.

CHAIR *- … Does any third party service or goods provision the state uses create any slowing of service provision overall? Whether it is getting consumables, pathology, laboratory services or other services that you rely on in the acute health services system to be able to do your work and that is creating a bit of a bottleneck. Can you comment on that at all? I would be interested to hear.*

…

It is whether or not third party services have helped you to do your work in the hospitals that are slowing down your work because you cannot, for instance, get pathology results quickly enough in one of the hospitals or other services that might be provided.

Mr FERGUSON

…

I can think of one only and that is when the prison has experienced a lockdown, sometimes there has been an interruption to the supply of linen. That is the only one and it is not a good example because it doesn't happen very often.

[15] Op.Cit. p.13-14

CHAIR *- Well, it is a government service. It is not your area; it is an external area.*

Ms FORREST *- Different department.*

Mr FERGUSON *- Secretary, I think you are shaking your head. I am not aware of any particularly. We have pretty robust contracts in place these days. I am not sure if there is anything further to add.*

Mr PERVAN - *Yes, minister, I agree with that. In terms of the pathology services provided in the north-west by Sonic, the imaging radiology service that I-MED provides to the LGH, all the feedback we get is those contracts are performing really well. All our supply contracts are performing quite well.*

The only challenge, which has nothing to do with the organisations or providers, has been that we have had a few moments over the last three to four years where there has been a shortage of particular drugs. Being such a small purchaser, we have had problems obtaining drugs, particularly very specialised antibiotics and drugs like that. We would send a thank you to our colleagues in Queensland who have always come to our aid and enabled us to purchase some of their stock.

We have also entered into a more strategic monitoring relationship with a few of the other states through the Australian Health Ministers' Advisory Council, such that when there are international shortages of those drugs, we are buying appropriately and then sharing that stock across Australia.

CHAIR *- It is almost like a group purchasing arrangement?*

Mr PERVAN *- Almost.*[16]

FINDINGS

17. Contracted services, including radiology and pathology, are operating well across the State.

18. The provision of some specialised drugs has at times been an issue, due to the State's smaller size as a purchaser.

19. Queensland health services have assisted with the supply of drugs during international shortages.

[16] Op.Cit. 14-15

Budgetary Pressures and Waiting Lists

The Minister was questioned regarding budgetary pressures and changes to the current waiting lists.

Ms FORREST *- Minister, at the outset you mentioned budgetary pressures. We are aware that the Health budget consumes a large percentage of the state Budget, do you want to comment further and on the role of Treasury in screwing the screws down? I am sure they do.*

Mr FERGUSON *- It is the law that agencies have to manage their finances in accordance with the Budget, isn't it?*

Ms FORREST *- Yes, it is.*

Mr FERGUSON *- It is not only Treasury, it is the law. Heads of agency, like Mr Pervan, have a serious responsibility to make sure the public dollar is being used appropriately and we are meeting budgets. You are right, you have pointed out that we would all need a very long memory to find a year where the public health system in Tasmania came in with an expenditure that met its predicted, allowed-for budget from the budget for the financial year. That has been the case recently. As a Government we have always been willing to make the additional funds available before the end of the financial year so the THS is able to come in on a balanced budget. We've always done that. We must also be prudent with the spending of money and make sure the public is getting excellent value for that.*

Ms FORREST *- I understand all of that. There seem to be problems within our hospital system, patients aren't getting seen in a timely manner, either with elective surgery or with access through the Department of Emergency Medicine, particularly when they need admission, which is the key bottleneck. You are repeatedly having to request for additional funding and/or supplementary appropriation. We saw both this year but not very much in the RAFs. Is there undue pressure to deliver what you need to within the budget you have?*

Mr FERGUSON *- I was recently asked a different question and I will tell you how I answered it. I was asked what our biggest challenge is in the health system. My answer wasn't that my biggest pressure is the finances and in how Treasury supports us. The biggest challenge is the constraint on physical capacity that we have, which doesn't explain the demand but they do explain why we're not always able to bring our supply to meet that demand. Our biggest challenge is the construction program we are under. Until it's finished and we are able to commission and build those new services, we are having to provide today's demand with yesterday's hospitals. You commented on elective surgery numbers; while the additions are up, we have managed to get the waiting times significantly down. Were it the case that finances were our biggest pressure I would not have been able to get the extra $20 million in the Budget this year, which I did.*

Our biggest challenge is not a financial one. From a patient's point of view, another $100, another $1000 or another $1 million wouldn't be the answer to the question of why they're waiting too long in an ED. The reason is because the beds are all full while we're building more beds.[17]

The Minister was questioned concerning the ongoing issue of waiting lists and how the numbers had tracked since his Government was elected to office.

Mr FERGUSON *- We're still catching up on the long wait list we inherited from the Labor Party. We had 10 one-year patients, as you know, and we're down to two. We've reduced the longest-wait patients by 80 per cent but that is not the compelling story. The compelling story is of the number of people who are being treated within the recommended time. I am pleased to tell you and reinforce with the committee that we started with just over 50 per cent of patients being treated in clinically recommended time frames, whether it was a category 1 at 30 days, category 2 at 90 or category 3 for one year. We have increased that from 50 to, I think, 74 per cent on a state average, taking in the whole picture. That means a lot more people getting their surgery but it also means that our performance has been consistently improving over the life of this Government -*

Ms FORREST *- What date applies to the figures you are referring to now?*

Mr FERGUSON *- The end of June 2018.*
We had a five in front of our waiting list at one point and it has increased in line with additional referrals and additions to the list. The waiting list size should always be part of the public narrative but the more important narrative is the waiting time. How long does a person wait? The data on that shows consistently improving performance and the improvement has been better than any other state and territory, I am advised.

Ms FORREST *- You are saying that the waiting list has gone below 5000 –*

Mr FERGUSON *- At one point the size, the magnitude of the waiting list, was below 6000.*

Ms FORREST *- It is not now, it has gone back up again. I am clarifying what you are saying.*

Mr FERGUSON *- When I said it like that, yes.*

Ms FORREST *- On your dashboard at the moment it is just short of 8000.*

[17] Op.Cit. p.15-16

***Mr FERGUSON** - Yes.*[18]

FINDINGS

20. The construction program involving the Royal Hobart Hospital is considered the biggest challenge by the Government.

21. In the last two years waiting times and waiting lists continue to grow and other access KPI measures have deteriorated.

The Academic Medical Centre Proposal

The Minister was questioned regarding the proposal from former Royal Hobart Hospital Emergency Department Physician Dr Bryan Walpole, that an academic medical centre be established. Dr Walpole had expressed the opinion the establishment of a centre of this type would attract a range of specialists due to the combination of practice, research and education. The Minister indicated that further consideration of the idea had not been considered although the Department of Health was continuing to work with the University of Tasmania with the intention of achieving similar outcomes.

Mr Pervan indicated that a joint commonwealth funding bid between the University, Department and Tasmanian Health Service for a centre of rural health, specialising in rural and regional health issues was being progressed. In relation to Dr Walpole's specific proposal, Mr Pervan advised the Committee that

> ***Mr Pervan** - ... An academic medical centre - and I do know Dr Walpole quite well - is a concept from the United States and the United Kingdom which actually involves the university running the health service. There are all sorts of complexities implied by that, particularly around Commonwealth Health funding, which is why you will see some academic health science centres and things otherwise named around Australia with a very strong university and teaching presence in them, but you will not find that pure model of universities running public hospitals here because there are legislative and funding reasons that would get in the way.*[19]

[18] Op.Cit. p.16-17
[19] Ibid

FINDING

22. The establishment of an Academic Medical Centre, along the lines of the UK and USA models, is not being pursued for legislative and funding reasons.

Part 2: Ministerial Responses to Questions on Notice

Questions were taken on notice by the Minister following his appearances before the Committee on 12 December 2017, 22 October 2018 and 16 November 2018. Copies of the letter to the Minister from the Committee are attached at **Appendix B.**

Responses from the Minister were received on 19 December 2017 and 17 December 2018.

A preliminary response to questions on notice received on 19 December 2017 were included in this correspondence, a copy of which is attached to this report at **Appendix C**.

The questions taken on notice from these hearings related to the following matters:

- Details of Deloitte Assessment including the Terms of Reference;
- Confirmation of the discharge process from acute health services;
- Confirmation that the tender for the 4K Project at the Launceston General Hospital included 7 additional beds;
- Detail regarding the status of the review of North West Maternity Services, who was undertaking the review and, if completed, a copy of the report;
- Request for Minister's response to solutions proposed by the Australian Nursing and Midwifery Federation (Tasmania);
- Further detail regarding collaboration and engagement with the private health sector related to Term of Reference 4;
- An update on the progress of Telemedicine between the North West Regional Hospital and the Victorian Stroke Medicine Program;

The questions and response should be read in full for completeness, however a summary of the key points is as follows:

<u>Deloitte terms of reference and assessment</u>

- At the time of writing, the Minister indicated that Deloitte had not provided a report to Government rather Consultants had presented a verbal report of survey and interview results to a Cabinet Sub-Committee
- The Minister instructed the 'New Beds Implementation Team' to summarise the contents of the oral briefing into a summary for public release (this is included in **Appendix C**);
- The Minister advised that the Deloitte Assessment, including the terms of reference, were presented to a Cabinet Subcommittee and therefore

considered by the Minister as being Cabinet-in-confidence and as a result would not be released to the Committee.

Confirmation of the discharge process from acute health services

In response to questions regarding the patient discharge processes across the State, the Minister provided the following responses:

- The discharge process can vary dependent upon a range of factors including the hospital, patient condition and ward;
    - The North West Regional Hospital has twice daily bed management meetings and weekly multi-disciplinary discharge planning meetings;
    - The Royal Hobart Hospital has medical rounds of inpatient wards with all patients prior to 10.30 am, followed by multi-disciplinary ward meetings. Further discharge meetings also take place;
    - The Launceston General Hospital conducts 'rapid rounding' in the morning on medical wards. Care teams and senior decision makers are included in these rounds;
- The THS is undertaking further work to streamline processes for patient discharge;
- The review of discharge practices is ongoing.

4K Project at the Launceston General Hospital (LGH)

Confirmation was sought regarding the promised additional seven beds for acute paediatric mental health beds at the LGH as part of the ward 4K project. The Minister provided the following advice:

- Capital funding for the full fit-out was released on Saturday 16 December 2017;
- The tender includes six paediatric mental health beds and the option to fit out a further seven beds (subject to the bids being within the available funding);
- If the bids are above the available funding, additional funding will be considered in future budget processes, including consideration of the operational costs for the beds.

North West Integrated Maternity Services (NWIMS)

The Minister indicated the review of NWIMS has been completed. Despite the Committees clear request for a full copy of the report if it had been completed, the Minister only provided a copy of the recommendations made in response to a further request for the full report. The recommendations can be found in **Appendix E**.

In response to questions regarding the NWIMS, the Minister:

- informed the Committee that the review of the NWIMS was conducted by Dr Rupert Sherwood (Head of Gynaecology, Western Health), Ms Patrice Hickey (Former President of the Victorian branch of the Australian College of Midwives) and Ms Lesley Arnott (consumer representative);
- indicated the review was to include significant consultation with key stakeholders confirmed that the review was completed in late 2017 and the recommendations from the review were provided to the ANMF;
- indicated that the model was designed to overcome various challenges arising from the delivery of services across two sites;
- indicated the reviewers provided feedback on the strengths of the service model and provided a series of recommendations to further develop safety and sustainability of the model; and
- stated the report provided validation to the Tasmanian Health Service and North West Private to continue to develop and grow what can be a leading regional/rural maternity service.

Prior to the conclusion of the inquiry, the Committee completed a reconciliation of all questions asked of the Minister that were taken on notice at previous hearings. The Committee subsequently wrote to the Minister on 12 February 2019 to request a response to the outstanding questions – **Appendix D**.

The outstanding questions were previously set out in correspondence of 30 October 2018.

A response from the Minister was provided on 12 April 2019 – **Appendix E**. The questions and response should be read in full for completeness however a summary of the key points is as follows -

Tasmanian Government Actions – Australian Nursing and Midwifery Federation (Tasmania)

- The Minister did not address the specific proposals on the basis that it formed part of a log of claims from the ANMF as part of the current wage negotiations;
- The Minister did not agree with the ANMF proposal that the Statewide Executive Director of Nursing and Midwifery be appointed to the Tasmanian Health Service Executive on the basis that such issues are already represented on the Executive by the Chief Operating Officer. Instead, the Minister indicated that he was in the process of establishing a principal advisory committee (the subcommittee) and that this would meet on a rotational basis across the regions; and

- The Minister indicated that consideration was being given to the minutes of meetings being made available to regional executive committees for developing business rules.

Further comments on the Committee's Term of Reference (4)

The Minister was asked to address Term of Reference 4 related to collaboration and engagement with private health care providers. The Minister provided a list of the collaborations between the Tasmanian Health Service and the private sector. This is included in **Appendix E**.

Telemedicine at North West Regional Hospital

The Minister was asked to provide an update on discussions to link telemedicine between the North West Regional Hospital and the Victorian Stroke Medicine Program.

- The Minister confirmed that approval had been granted by the THS Executive for telemedicine to assist patients who experience a stroke to be implemented at the Launceston General and the North West Regional Hospitals and that a clinical lead had been appointed for the project.

Request for Further Information from 12 February 2019

In relation to the Committee's request for additional information on *Question on Notice 4* arising from the Minister's appearance before the Committee in October 2018, the Minister referred the Committee to his previous responses and attachment 1 (third-party services) to his response of 12 April 2019 (included in **Appendix E)**.

Appendix A:

Rob Valentine

From:	Rob Valentine
Sent:	Friday, 7 December 2018 12:07
To:	Jenny Mannering
Cc:	Ruth Forrest; Kerry Finch
Subject:	Extension to deadline for Ministerial response

Hi Jenny, the Minister rang today to discuss the release, in camera, of the KPMG report and has said he will provide it under those circumstances and as such I have asked that his commitment to that end be provided in writing.

The Minister said he would need until COB Wednesday 12 December next, to provide his response to our request, to which I have agreed.

He also requested to know our next meeting date which I said was yet to be confirmed.

Kind Regards,

Rob Valentine
Independent Member for Hobart
Legislative Council
Parliament of Tasmania

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Electorate Office, Parliament House

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Appendix B:

Parliament of Tasmania, Hobart, TAS, 7000
www.parliament.tas.gov.au

Sessional Committee
GOVERNMENT ADMINISTRATION 'A' SUB COMMITTEE

Tel: 03 6212 2249
Fax: 03 6212 2345
Email: jenny.mannering@parliament.tas.gov.au

4 December 2017

Hon Michael Ferguson MP
Minister for Health

Email: michael.ferguson@parliament.tas.gov.au

Dear Minister

Acute Health Services in Tasmania Inquiry

Further to confirmation of your attendance at the Acute Health Services in Tasmania Inquiry public hearing on 12 December 2017 at 3.00pm, I provide the following advice of information of particular interest to the Committee:

- The cost of nursing overtime by hospital and by speciality;
- The number and cost of locums broken down by hospital and by speciality;
- The rate of turn-over of specialist and non-specialist medical Staff by hospital and speciality; and
- The number and nature of critical incidence reports in four major hospitals and the processes utilised when assessing.

The Committee's questioning will not be limited to these matters.

Yours sincerely

Hon Rob Valentine MLC
Inquiry Chair

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Parliament of Tasmania, Hobart, TAS, 7000
www.parliament.tas.gov.au

Sessional Committee
GOVERNMENT ADMINISTRATION 'A'

Tel: 03 6212 2249
Email: jenny.mannering@parliament.tas.gov.au

29 October 2018

The Hon Michael Ferguson, MP
Minister for Health
Email: michael.ferguson@parliament.tas.gov.au

Dear Minister

Sub-Committee - Acute Health Services in Tasmania Inquiry

I refer to your appearance before the Sub-Committee on Acute Health Services in Tasmania on 22 October 2018.

I confirm that you undertook to provide the following information on notice:

1. Provide information regarding nurse practitioners in relation to how many nurse practitioners there currently are; future projections for how many nurse practitioners there will be; and in what areas.
2. Provide a copy of the Summary from the Deloitte Report
3. Provide a list of the current positions you are seeking medical recruitment for. Also, provide information regarding nursing specialty areas and where the challenges are.
4. Provide further information regarding closure of operating theatres in relation to maintenance etc.

The Sub-Committee would be pleased to receive this information by email to the Secretary, Ms Jenny Mannering by close of business Friday, 2 November 2018.

The Sub-Committee looks forward to receiving the requested information.

Yours sincerely

Hon Rob Valentine MLC
Inquiry Chair

Parliament of Tasmania, Hobart, TAS, 7000
www.parliament.tas.gov.au

Sessional Committee
GOVERNMENT ADMINISTRATION 'A'

Tel: 03 6212 2249
Email: jenny.mannering@parliament.tas.gov.au

28 November 2018

The Hon Michael Ferguson, MP
Minister for Health
Level 5, Salamanca Building
4 Salamanca Place
HOBART

Dear Minister

Sub-Committee - Acute Health Services in Tasmania Inquiry

Thank you for your appearance before the Sub-Committee on Acute Health Services in Tasmania on 16 November 2018. Thank you for confirming your willingness to address further questions of the Sub-Committee in writing due to time constraints on 16 November.

In particular, the Sub-Committee would appreciate your comments on the following:

1. Mr Martyn Goddard's addendum to his 2017 submission to the Inquiry (Submission #10, October 2018 *An analysis of the adequacy of public hospital services in Tasmania*) and Dr Stephen Duckett's transcript of evidence to the Inquiry on 24 October 2018 with regard to their assessment of health spending.

2. Dr Stephen Duckett's statements regarding rising avoidable mortality, particularly as he claims Tasmania is the only jurisdiction where it is rising.

3. Do you have any additional comments to make in relation to on-site clinical directors.

4. What services are currently being provided through collaboration with the private sector? What services are working well, and what areas could be better utilised.

5. A number of concerns were raised by the Neurological Alliance Tasmania regarding access to neurological services across the state. The Sub-Committee would appreciate your feedback regarding these issues raised.

6. In their 2017 submission, the Stroke Foundation commented on a number of issues and raised the concept of a 'hyper-acute stroke pathway' as a more coordinated approach to stroke management. Does the Minister consider the concept of a hyper-acute stroke pathway to be of value and, if so, wish to provide any comment as to its implementation or otherwise in Tasmania?

7. In their 2017 submission the Stroke Foundation identified that the lack of a stroke unit in the North West is resulting in inequitable access to time-critical stroke treatments and, consequently resulting in increased morbidity and mortality. Can the Minister please provide:
    a. An update on discussions regarding the possible implementation of the North West Regional Hospital linking in with the Victorian stroke Tele-medicine service?
    b. Any other moves to improve access to vital stroke services in the North West and other more regional areas?

8. The Heart Foundation submission raises the proposal for a State-wide Cardiac Services Plan, which it has now been raising for some years. Does the Minister consider the concept has merit for implementation?

9. The President of Huntington's Tasmania informed the Sub-Committee of the challenges people with Huntington's Disease suffer both in accessing community based care and acute health care as the disease progresses. Does the Minister have any comment regarding the need for that multidisciplinary clinic with a specialist neurological nurse?

The Sub-Committee would be pleased to receive this information by email to the Secretary, Ms Jenny Mannering **by close of business Wednesday 19 December 2018**. The Sub-Committee also notes there remains a number of questions on notice that require a response from you as per letters from the Sub-Committee to you dated 29 and 30 October 2018.

Please also be advised that the evidence received on 16 November 2018 was not able to be included in the Interim Report No. 2 of the Sub-Committee due to the finalisation of that report on 16 November to enable timely tabling and debate of that Report in the Council, and to allow you the opportunity to review the transcript of evidence as requested. As such, that evidence will be considered for inclusion of the final report of the Sub-Committee in early 2019.

Please find attached the in-camera transcript of the hearing held on 16 November 2018. It would be appreciated if you could indicate if there is any evidence contained in the transcript that you wish to remain in camera, to enable the Sub-Committee to report on this important information.

Yours sincerely

Hon Rob Valentine MLC
Inquiry Chair

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Appendix C:

Minister for Health
Minister for Information Technology and Innovation
Leader of Government Business in the House of Assembly

Tasmanian Government

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Ph: (03) 6777 1032
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Hon Rob Valentine MLC
Chair
Legislative Council Government Administration Subcommittee A – Inquiry into Acute Health

Dear Chair,

Thank you for your letter of 14 December 2017, requesting further information following my appearance at your hearing on 12 December 2017.

Before I address your specific areas of interest, I would like to make a few points.

I find it very concerning to hear both yourself as the Chair and Ruth Forrest as Deputy Chair make public statements speculating that I may have misled the Committee. I attended in good faith and answered all questions accurately and honestly.

Given the politically charged debate around the delivery of health care in Tasmania, and the high level of media interest in this topic with a State election due in a few months, it concerns me that the Committee's work is being drawn into a political argument and process.

With regard to the existence of a Deloitte report, I 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.*

This is clear and simple – there was no report from Deloitte to the Government last Monday, nor is there a report now – it is yet to be provided. However, what did occur was the consultants from the Deloitte verbally presented survey and interview results to a Cabinet Subcommittee on Monday, 11 December 2017, which I attended by telephone.

I was further surprised to hear you as Chair claim it was unexpected that the Government had released the New Beds Implementation Team Summary last Saturday (Attachment 1) – especially as I told the committee this is what I intended to do:

> *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.*

It is clear that my evidence on this matter was accurate, and I provided your subcommittee with full explanations in good faith.

The fact was, and is, that Deloitte has not yet provided a written report the government – rather, they have briefed the Cabinet subcommittee. I subsequently requested the New Beds Implementation Team to summarise the information presented into a written summary for public release – exactly as I told your Committee I would.

I note your request for details of the Deloitte Assessment including the Terms of Reference. As I have previously stated, this material is Cabinet in confidence.

As you would be aware, the precedent of maintaining Cabinet confidentiality is well established, and important in ensuring that Government can receive frank and fearless advice.

Any limitation on this freedom would severely undermine the performance by Government of its executive duties. I attach the letter from Lara Giddings MP, to the Legislative Council Government Administration Committee 'A' in relation to cost reduction strategies of the Department of Health and Human Services, which details this important principle.

I also note a public suggestion in the media from yourself as Chair that Government should release individual survey responses. When the survey was sent to staff, it was made clear that Deloitte would keep individual responses confidential:

> *All answers captured by the survey will be kept strictly confidential. Results will only be reported on as summaries of the survey results, with no way of identifying any individual respondents. To provide a further level of confidentiality, data will not be reported below a sample size of five people. In addition, the THS cannot request the raw data from Deloitte.*

With regard to your other questions, I can provide the following additional information.

Confirmation of the discharge process from acute health services

The precise discharge process can vary depending on which of the major hospitals a patient is at, the sort of condition a patient is recovering from and which ward the patient is discharged from.

With respect to the North West Regional Hospital, there are twice-daily Bed Management Meetings where representatives of all wards attend and discuss the day's anticipated discharges, as well as existing acute inpatients whose care may be suitable for transfer to sub-acute beds or facilities. Multi-disciplinary Discharge Planning Meetings also occur weekly and a review of all current patients discharge needs occurs, with referrals among the team as necessary.

At the Royal Hobart Hospital, medical rounds occur on medical inpatient wards with all medical patients including outlier medical patients reviewed prior to 1030 before commencement of multidisciplinary ward meetings on Ward 2J and Assessment and Planning Unit (APU). Further multidisciplinary meetings are conducted, with discussion of the discharge plan for each patient, and Cardiology ward rounds led by consultants occur daily.

The Department of Medicine at the LGH commenced "rapid rounding" in 2016, which "Rapid rounding" occurs in the morning on medical wards and includes the care team and senior decision makers, led by a senior nurse with a consultant present.

The THS has been working to implement a more streamlined, systematic process for patient discharge, in line with Patients First initiatives, feedback from GPs and recommendations arising from regular reviews and audits of discharge summary processes.

Review of discharge summary practices is ongoing, with education and training available for junior doctors regarding discharge summaries.

Confirmation that the tender for 4k project included 7 additional beds

The Government has made capital funding available for the full fit-out of twenty-nine (29) beds, with the tender released on Saturday, 16 December 2017 including all six Paediatric Mental Health beds.

I am advised that the request for tender provides the option to submit an expression of interest to fit out a further seven beds.

If bids are received that provide for all beds, including the seven, within the funding envelope provided – we will do the work immediately.

If a bid cannot be accommodated within budget, funding that component will be considered in future budget processes, alongside operational cost of those beds, with a further tender not be required.

Who is undertaking review for obstetric services for north-west of Tasmania

I am advised that Dr Rupert Sherwood (Head of Gynaecology, Western Health), Ms Patrice Hickey (former President of the Victorian branch of the Australian College of Midwives) and Ms Lesley Arnott (consumer representative) are conducting the review. The review will include significant consultation with key stakeholders.

Please consider this letter a public submission to your Inquiry.

Yours sincerely

Michael Ferguson MP
Minister for Health

19 December 2017

Attachment 1

New Beds Implementation Team

Summary

December 2017

1. Purpose

On 6 June 2017, the Government announced the establishment of a New Beds Implementation Team (NBIT) to ensure timely opening of the new beds and ensure people get the care they need sooner at the Royal Hobart Hospital (RHH).

The NBIT had responsibility for monitoring and reporting on the opening of 127 beds (including treatment recliners) across Tasmania, with a particular focus needed to ensure the timely opening of new beds in southern Tasmania.

As part of this work, Deloitte undertook a review of leadership and direction within the THS.

This review has been recently presented to a Cabinet Subcommittee. The work of the NBIT is Cabinet in Confidence, however, this summary has been prepared to provide a public update.

1.1 Visitations

The NBIT conducted site visits and spoke to staff at all major hospitals, along with the New Norfolk District Hospital, the RHH Repatriation Hospital, the Roy Fagan Centre, Tolosa Street Respite and Rehabilitation Centre, and the John L Grove Rehabilitation Centre. This opportunity was used to understand processes that may hinder or slow the opening of beds, as well as to identify opportunities to address or resolve issues.

1.2 Advisory Groups

A Reference Group includes representation from the Australian Medical Association, Australian Nursing and Midwifery Federation and Ambulance Tasmania. The Reference Group has met a number of times to discuss the progress of bed implementation and recruitment.

As an immediate action stemming from the site visits undertaken, a Recruitment Action Group (RAG) was established. The RAG has met and is undertaking a review to identify blockers to recruitment related to bed initiatives. The RAG is continuing to advise on solutions to mitigate these blockers.

THS staff have indicated that administrative processes are not a blocker to recruitment, rather that suitably qualified staff are not available to fill vacancies in some specialist areas. However, administrative processes are being reviewed to determine where efficiencies can be made. The RAG has made contact with the Reference Group to ensure that it is fully informed about recruitment issues.

2. Bed Implementation Progress

The NBIT noted solid progress with the delivery of the new beds. As at 14 December 2017, all beds are now open, with the exception of the 16 beds and treatment recliners at the Royal Hobart Hospital (RHH), 6 beds at the Tolosa Street Mental Health Facility and 22 beds at the Repatriation campus are on track for completion by mid 2018 as originally scheduled.

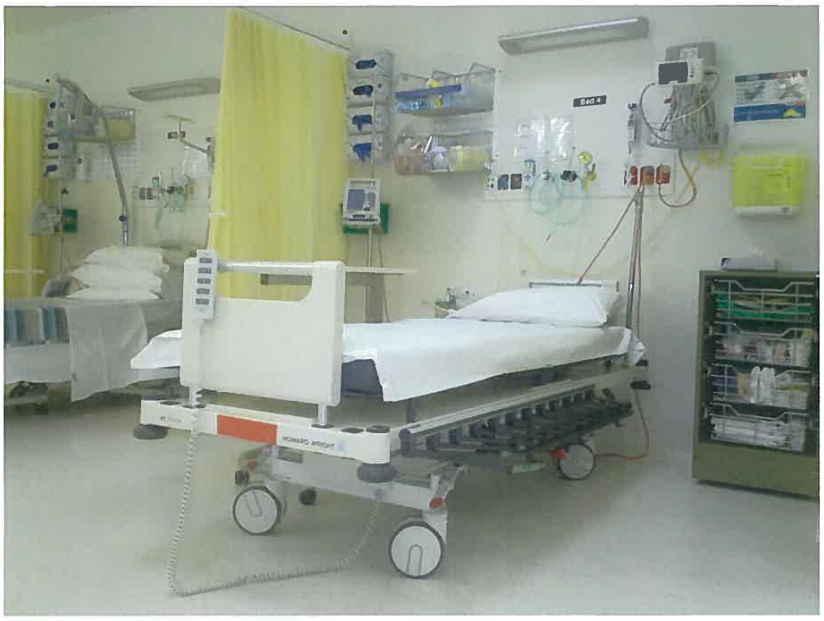
OPEN NOW	Beds	Treatment Recliners	Total
ICU Beds at RHH	2		2
RHH Access and Flow Ward*	5	4	9
Hobart Private Hospital (HPH)	8		8
New Norfolk District Hospital	7		7
Roy Fagan Centre – Jasmine Unit	10		10
LGH 4D at the LGH	19		19
John L Grove Rehabilitation Centre	20		20
ED short stay beds at NWRH	4		4
Surgical beds at NWRH	4		4
Total	**79**	**4**	**83**
OPENING IN NEXT TWO MONTHS	**Beds**	**Treatment Recliners**	**Total**
Tolosa Street Mental Health Facility	6		6
RHH ED Expansion	5	3	8
RHH Multi-purpose Ward	5	3	8
Total	**16**	**6**	**22**
OPENING MID 2018	**Beds**	**Treatment Recliners**	**Total**
Hobart Repatriation Hospital	22		22
Total	**22**		**22**

*Previously known as the Winter Ward

Image One: Patient Flow and Access Ward at the RHH

Image Two: Patient Flow and Access Ward at the RHH

Image 3: Emergency Department Short Stay Beds at the North West Regional Hospital



3. Leadership and Direction Review

The Beds Team undertook to give further consideration to issues in the THS including:

- leadership and clarity on roles and authority;
- direction and focus;
- governance; and
- service planning.

Deloitte was commissioned to undertake a review of the leadership, direction and focus. Deloitte undertook 36 interviews with senior professionals in the health system, including THS Executive members, Governing Council members, THS Clinical Directors, DHHS members and two external stakeholders.

Deloitte also deployed a survey to 317 senior leaders across the THS, with a 46 per cent response rate (145).

3.1 Key Themes

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.
    - 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.


Tasmanian
Government

Appendix D:

Parliament of Tasmania, Hobart, TAS, 7000
www.parliament.tas.gov.au

Sessional Committee
GOVERNMENT ADMINISTRATION 'A'

Tel: 03 6212 2250
Email: stuart.wright@parliament.tas.gov.au

12 February 2019

The Hon Michael Ferguson MP
Minister for Health
Email: michael.ferguson@parliament.tas.gov.au

Dear Minister

Sub-Committee - Acute Health Services in Tasmania Inquiry

At its meeting on Friday 8 February 2019, the Sub-Committee inquiring into Acute Health Services in Tasmania resolved to write to you advising of outstanding responses to written requests which the Sub-Committee is yet to receive.

Please find attached the following copies of correspondence where responses are yet to be received —

1. Letter dated 30 October 2018 requesting answers to questions on notice; and
2. Letter dated 28 November 2018 attaching the in-camera transcript of evidence for your review as agreed at the hearing.

The Sub-Committee further resolved to seek additional information to the answer provided in your correspondence dated 17 December 2018 to the following question —

Question on Notice 4: What services are currently being provided through collaboration with the private sector? What services are working well, what areas could be better utilized.

Answer:

The THS purchases services from the private sector as required. These services range from archival document storage through to clinical services such as elective surgery, pathology, and medical imaging. I am advised that all services purchased from the private sector meet current requirements.

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It would be appreciated if further clarification could be provided i.e. a list of each service by region, further detail regarding the effectiveness of these services and an outline of the current requirements these services are required to meet, as per your response. Please also provide detail of deliverables for each of the contracted private services noted in the previous question.

The Sub-Committee would be pleased to receive this information by email to the Secretary, Mr Stuart Wright **by close of business Friday, 1 March 2019.**

The Sub-Committee looks forward to receiving this additional information.

Yours sincerely

Hon Rob Valentine MLC
Inquiry Chair

Enc.
1. Copy of letter dated 30 October 2018 to the Minister for Health
2. Copy of letter dated 28 November 2018 to the Minister for Health
   In-camera Transcript 16 November 2018

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Parliament of Tasmania, Hobart, TAS, 7000
www.parliament.tas.gov.au

Sessional Committee
GOVERNMENT ADMINISTRATION 'A'

COPY

Tel: 03 6212 2249
Email: jenny.mannering@parliament.tas.gov.au

30 October 2018

The Hon Michael Ferguson, MP
Minister for Health
Email: michael.ferguson@parliament.tas.gov.au

Dear Minister

Sub-Committee - Acute Health Services in Tasmania Inquiry

I refer to your appearance before the Sub-Committee on Acute Health Services in Tasmania on 22 October 2018. Thank you for agreeing to respond to any outstanding questions of the Sub-Committee in writing. The Committee resolved, to receive responses to the following questions —

Please provide a response to the following proposed solutions suggested by the ANMF —

Tasmanian Government Actions
The Tasmanian Government needs to immediately increase the health budget to allow for the immediate implementation of the following —

1. Funding of identified nursing and midwifery staff positions according to the current agreed benchmarking process;
2. Fund all available additional in-patient beds to enable permanent staffing and retention of nursing and midwifery staff;
3. Provide funding to implement identified solutions to support the nursing and midwifery workforce while dealing with bed block, overcrowded emergency departments and caring for patients in emergency department waiting rooms across the State;
4. Fund solutions to address the recruitment challenges to reduce consistent overtime and double shifts being worked by fatigued nurses, midwives and Assistants in Nursing; and
5. Fund the immediate development and implementation of stage 2 of the RHH redevelopment.

Tasmanian Health Service Governance Solutions

As the new *Tasmanian Health Service Act* and new Executive structure was designed to allow for the return of local decision making and improve the clinical outcomes for patients and staff, ANMF suggest the following —

1. That a Statewide Executive Director of Nursing and Midwifery is appointed to the THS Executive to enable nursing, midwifery and clinically specific advice to be considered during all decision-making processes;
2. That the THS Executive increase their presence within each of the health regions and improve transparency around communication, consultation and decisions making; and
3. Make available to all THS management the Executive meeting agenda and outcomes in a transparent and timely way following Executive meetings.

Terms of Reference 4

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

- Please provide further details in relation to term of reference 4, and specifically please provide details regarding any contracts with private providers in relation to the delivery of acute health services.

Telemedicine

- Please provide an update on the status of discussions to link telemedicine between the North West Regional Hospital and the Victorian Stroke Medicine Program.

Evaluation of the NWIMS

- Has the evaluation of the NWIMS referred to by you in evidence to the Committee on 12 December 2017, been completed, and if so, please provide a copy of the report to the Committee.

Central Queensland Hospital and Health Service

- Please find attached further detail in relation to the Central Queensland Hospital and Health Service regarding waiting time improvements in general surgery, orthopaedics, urology, general medicine and gynaecology areas as mentioned by the Sub-Committee during the public hearing on 22 October 2018 for your reference.

The Sub-Committee would be pleased to receive this information by email to the Secretary, Ms Jenny Mannering by close of business Monday 5 November 2018.

The Sub-Committee looks forward to receiving the additional information.

Yours sincerely

Hon Rob Valentine MLC
Inquiry Chair

Enc. *Lean Implementation Program at Central Queensland Hospital and Health Service*

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Parliament of Tasmania, Hobart, TAS, 7000
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Sessional Committee
GOVERNMENT ADMINISTRATION 'A'

Tel: 03 6212 2249
Email: jenny.mannering@parliament.tas.gov.au

28 November 2018

COPY

The Hon Michael Ferguson, MP
Minister for Health
Level 5, Salamanca Building
4 Salamanca Place
HOBART

Dear Minister

Sub-Committee - Acute Health Services in Tasmania Inquiry

Thank you for your appearance before the Sub-Committee on Acute Health Services in Tasmania on 16 November 2018. Thank you for confirming your willingness to address further questions of the Sub-Committee in writing due to time constraints on 16 November.

In particular, the Sub-Committee would appreciate your comments on the following:

1. Mr Martyn Goddard's addendum to his 2017 submission to the Inquiry (Submission #10, October 2018 *An analysis of the adequacy of public hospital services in Tasmania*) and Dr Stephen Duckett's transcript of evidence to the Inquiry on 24 October 2018 with regard to their assessment of health spending.

2. Dr Stephen Duckett's statements regarding rising avoidable mortality, particularly as he claims Tasmania is the only jurisdiction where it is rising.

3. Do you have any additional comments to make in relation to on-site clinical directors.

4. What services are currently being provided through collaboration with the private sector? What services are working well, and what areas could be better utilised.

5. A number of concerns were raised by the Neurological Alliance Tasmania regarding access to neurological services across the state. The Sub-Committee would appreciate your feedback regarding these issues raised.

6. In their 2017 submission, the Stroke Foundation commented on a number of issues and raised the concept of a 'hyper-acute stroke pathway' as a more coordinated approach to stroke management. Does the Minister consider the concept of a hyper-acute stroke pathway to be of value and, if so, wish to provide any comment as to its implementation or otherwise in Tasmania?

7. In their 2017 submission the Stroke Foundation identified that the lack of a stroke unit in the North West is resulting in inequitable access to time-critical stroke treatments and, consequently resulting in increased morbidity and mortality. Can the Minister please provide:
    a. An update on discussions regarding the possible implementation of the North West Regional Hospital linking in with the Victorian stroke Tele-medicine service?
    b. Any other moves to improve access to vital stroke services in the North West and other more regional areas?

8. The Heart Foundation submission raises the proposal for a State-wide Cardiac Services Plan, which it has now been raising for some years. Does the Minister consider the concept has merit for implementation?

9. The President of Huntington's Tasmania informed the Sub-Committee of the challenges people with Huntington's Disease suffer both in accessing community based care and acute health care as the disease progresses. Does the Minister have any comment regarding the need for that multidisciplinary clinic with a specialist neurological nurse?

The Sub-Committee would be pleased to receive this information by email to the Secretary, Ms Jenny Mannering **by close of business Wednesday 19 December 2018.** The Sub-Committee also notes there remains a number of questions on notice that require a response from you as per letters from the Sub-Committee to you dated 29 and 30 October 2018.

Please also be advised that the evidence received on 16 November 2018 was not able to be included in the Interim Report No. 2 of the Sub-Committee due to the finalisation of that report on 16 November to enable timely tabling and debate of that Report in the Council, and to allow you the opportunity to review the transcript of evidence as requested. As such, that evidence will be considered for inclusion of the final report of the Sub-Committee in early 2019.

Please find attached the in-camera transcript of the hearing held on 16 November 2018. It would be appreciated if you could indicate if there is any evidence contained in the transcript that you wish to remain in camera, to enable the Sub-Committee to report on this important information.

Yours sincerely

Hon Rob Valentine MLC
Inquiry Chair

Appendix E:

Minister for Health
Minister for Police, Fire and Emergency Management
Minister for Science and Technology
Leader of the House

Tasmanian Government

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GPO Box 123, HOBART TAS 7001
Phone: (03) 6165 7701; Email: Michael.Ferguson@dpac.tas.gov.au

12 APR 2019

Our Ref: WITS 109253 / TRIM MIN18/27056

Hon Rob Valentine MLC
Inquiry Chair
Sub-Committee – Acute Health Services in Tasmania Inquiry
Sessional Committee – Government Administration 'A'

Email: stuart.wright@parliament.tas.gov.au

Dear Mr Valentine

Please find detailed in this letter the information requested by your committee in your letter of 12 February 2019 relating to your correspondence from 30 October and 28 November 2018.

Questions on Notice from 30 October 2018

I note these questions arise from my 22 October appearance before your sub-committee and relate to proposals presented to your sub-committee from the Australian Nursing and Midwifery Federation (Tasmania).

***Tasmanian Government Actions**: The Tasmanian Government needs to immediately increase the health budget to allow for the immediate implementation of the following:-*

1. *Funding of identified nursing and midwifery staff positions according to the current agreed benchmarking process;*
2. *Fund all available additional in-patient beds to enable permanent staffing and retention of nursing and midwifery staff;*
3. *Provide funding to implement solutions to support the nursing and midwifery workforce while dealing with bed block, overcrowded emergency departments and caring for patients in emergency department waiting rooms across the State;*
4. *Fund solutions to address the recruitment challenges to reduce consistent overtime and double shifts being works by fatigued nurses, midwives and Assistants in Nursing; and*
5. *Fund the immediate development and implementation of stage 2 of the RHH redevelopment.*

The majority of these matters form the basis of the log of claims from the Australian Nursing and Midwifery Federation (Tasmania) in the current wage negotiations. Given these negotiations are ongoing it is inappropriate for me to provide a response to these matters at this time.

***Tasmania Health Service Governance Solutions:** As the new* Tasmanian Health Service Act [2018] *and new Executive structure was designed to allow for the return of local decision making and improve the clinical outcomes for patients and staff, ANMF suggest the following:-*

1. *That a Statewide Executive Director of Nursing and Midwifery is appointed to the THS Executive to enable nursing, midwifery and clinically specific advice to be considered during all decision-making processes;*
2. *That the THS Executive increase their presence within each of the health regions and improve transparency around communication, consultation and decisions making; and*
3. *Make available to all THS management the Executive meeting agenda and outcomes in a transparent and timely way following Executive meetings.*

I note your comments relating to nursing and midwifery representation on the Tasmanian Health Service (THS) Executive. The clinical leads, including nursing and midwifery, within the THS report directly to the Chief Operating Officer who is responsible for representing the specific views of all clinical areas on the THS Executive.

Further to this, the THS Executive is in the process of establishing an Operational Executive Subcommittee as its principal advisory committee.

It is proposed that these meetings rotate through the regions on a monthly basis to ensure that there is improved transparency around communication, consultancy and decision making.

Consideration is being given to making the minutes of this meeting available to regional executive committees in developing its business rules.

Terms of Reference 4: *"The level of engagement with the private sector in the delivery of acute health services." Please provide further details in relation to term of reference 4, and specifically please provide details regarding any contracts with private providers in relation to the delivery of acute health services.*

The Tasmanian Health Service (THS) collaborates with the private sector to purchase services for the direct benefit of a patient or client.

A list of these services is provided at Attachment 1.

Telemedicine: *Please provide an update on the status of discussions to link telemedicine between the North West Regional Hospital and the Victorian Stroke Medicine Program.*

Approval has been granted by the THS Executive for Victorian Stroke Telemedicine to be implemented at Launceston General Hospital and the North West Regional Hospital.

A Clinical Lead for the Project, Dr Matt Lee-Archer, has been appointed. IT requirements are currently being reviewed and a project plan being developed.

Evaluation of the North-West Integrated Midwifery Services (NWIMS): *Has the evaluation of the NWIMS referred to by [sic] you in evidence to the Committee on 12 December 2017, been completed, and if so, please provide a copy of the report to the Committee.*

The North West Integrated Maternity Services Review was completed late last year and the recommendations arising from that review were provided to the ANMF. I provide a copy of the recommendations at Attachment 2.

By way of background and summary, the review was undertaken in 2017, just 13 months after the commencement of the new integrated service. The reviewers have provided feedback on the strengths of the service model and a series of recommendations directed to further development of safety and sustainability.

The model has been designed to overcome the fragmentation and safety challenges of delivering services across two sites. The decision to consolidate birthing and inpatient services has created capacity to deliver a safe service for current and future demand in the region and enabled integration with the broader state-wide maternity services model.

Importantly, you will note the report highlights the support and satisfaction of women in the North West; the women interviewed were complimentary of the care provided within the new service and generally supportive of the care options available to them.

Overall, the report validates that the Tasmanian Health Service and the North West Private Hospital are ideally placed to grow and develop the integrated model to become a leading regional/rural maternity service.

Request for Further Information from 12 February 2019

I note that your request for additional information regarding my response to ***Question on Notice 4*** arising from my 22 October appearance before your sub-committee is substantially a reiteration of your request for further details regarding Term of Reference 4.

This information is provided earlier in this letter and detailed in Attachment 1.

I also take this opportunity to acknowledge the Special Report tabled by your Sub-Committee last week, dated 21 February 2019, and dispute the findings made.

The finding that the Government has not provided a valid claim for not providing a copy of the KPMG report, in camera or otherwise, is without basis and simply dismisses the two reasons I have consistently cited. The second finding is simply an expanded claim of the first finding and neither findings substantiate the basis of the claims that my reasoning is both invalid and incorrect.

I note the chair's recollection of our conversation on 7 December and place on the record that my recollection differs. I do not recall providing such an assurance and my written response on 17 December is consistent with the Government's long-standing position on this matter. I have not changed my position at any stage in relation to the multiple requests from your Sub-Committee for the report, despite my openness to give consideration and seek advice.

I trust the information provided in this letter addresses your outstanding questions and sufficiently informs your deliberations as you consider your final report.

The State Government will provide a response to your final report after it is completed.

Yours sincerely

Michael Ferguson MP
Minister for Health

Encl: Attachment 1: Private Sector Services
Attachment 2: NWIMS Report recommendations

REGION	Service	Who	Where	Deliverables	Current Requirements	Effectiveness
North	Transition Care Program providing residential beds	Regis Aged Care PL	Launceston	Transition from acute inpatient services to short-term accommodation	Transition Care Program providing residential beds	Reduction of average length of stay to inpatient services and supports patient flow.
	Sleep Medicine	Calvary Health Care Tasmania	Launceston	Diagnostic methodology to determine sleep disorders such as sleep apnoea.	Respiratory Physician referred	Assists with hospital avoidance.
	Haematology Services	QML Pathology	Launceston	Provision of Haematology medical services	Provide a Haematologist working in pathology doing laboratory based haematology services and clinical haematology services for Oncology cancers and haematological disorders. Non cancer haematology is an increasing part of the service provided by the W C Holman Clinic.	The contract provides clinical and on-call services as part of the ongoing clinical roster and makes oncall less arduous.
	Ophthalmology	Eye Hospital	Launceston	The Eye Hospital is contracted to do all public patient Ophthalmology procedures. All procedures are performed at their premises utilising their facilities and equipment.	Covers all Public Patient Elective Eye Surgery requirements. The contract covers all category levels: Category 1,2,3 plus Emergency Cases. Cost is based on the NEP – pricing NWAU amount.	Provision of service for which the LGH is not equipped to provide.
	Palliative Care	Calvary Health Care Tasmania	Launceston	Inpatient palliative care services for public patients within a contemporary and multidisciplinary model of care. A suitable clinical governance framework and premises that enable the delivery of care in accordance with the principles of palliative care.	A suitable clinical governance framework and premises that enable the delivery of care in accordance with the principles of palliative care. Provision of various reports within the contract stipulated timeframes. Clinical and Contract Management Committees, consisting of representatives from THS and Calvary, to be established and implemented with meetings held as per the frequency stipulated in the contract.	Provides 4 beds with near 100% occupancy for public patients,
	Provision of Medical Services	Ochre Health PL	North Rural Region	The provision of continuous medical service coverage, emergency medical care and inpatient care services for hospital patients, residential aged care services initiated by THS for aged care residents and limited scope radiography services where applicable.	Medical practitioners are to be available 24 hours per day, 7 days per week and must attend the THS hospital within the specified response times as and when required. Admission, transfer and discharge of THS Hospital patients and undertaking of daily ward rounds. Provision of various reports. Achievement of Key Performance Indicators.	Allow for medical practitioners to be based in these rural and remote areas and assists in providing a sustainable model for private general practices in these locations.
	Rural Community Inpatient Beds	Toosey	Longford	Provides inpatient beds in Longford as part of a broader contracted service model.	Two rural community inpatient beds for uncomplicated acute problems requiring observation, non-complex palliative care, supported rehabilitation or convalescence. General practitioners decide admissions on a clinical basis. Beds are to be used for short term accommodation provided to patients of an uncomplicated nature that cannot be provided by the community based health services but would fail admission to a tertiary institution such as the LGH.	Provide community inpatient beds - 24 hours per day, 7 days per week in accordance with the specified standards, legislative and other contractual requirements. Provision of data, including patient activity, within the specified timeframes.

	Catering Services	May Shaw Health Centre	Various locations across Northern Tasmania	Catering service across THS North Eastern Soldiers Memorial Hospital and May Shaw's aged care services at Scottsdale.	Centre-based day care services, including transport and meals, on the days and times as specified in the contract for eligible clients. Reports on output activities quarterly through the HACC Minimum Data Set. All daily meals and other theme days in accordance with dietary requirements. Catering services to comply with relevant food safety and preparation legislation and standards.	Breakfast, morning tea, lunch, afternoon tea, evening meal, supper, beverages and other theme days in accordance with dietary requirements. Catering services to comply with relevant food safety and preparation legislation and standards.
	Radiology	Regional Imaging Tasmania	Launceston	Radiologist services	Reporting of medical imaging examinations and special Medical Imaging procedures	LGH is unable to attract critical mass of radiologists for in-house service.
	Nuclear Medicine	Regional Imaging Tasmania	Launceston	Nuclear Medicine services	Provide all aspects of this service to public patients in NT and NW	Provides all staff and all equipment.
	Obstetric Imaging	Women's Imaging	Hobart	Tertiary obstetric scans and reports	Specialised mammography imaging service provided on the day of surgery.	Provides tertiary obstetric scans not otherwise available in Launceston.
	Urology biopsy and kidney stone removal services	Alexus Services PL	Launceston	Specialist urology procedure used to treat kidney stones	Provides a service on an as and when required basis. Provides LGH the following procedures at the agreed cost per procedure price: Lithotripsy, Transperineal, MRI Fusion, TRUS Biopsy, TRUS Bx Service	Provides a service utilising specialised equipment that avoids need for LGH to purchase and maintain that equipment. Assists with maintenance and reduction of waiting lists.
North West	Maternity Services	HealthCare	Burnie	Delivery of inpatient care including antenatal care and assessment, assistance with childbirth, postnatal inpatient care and postnatal readmissions for management of breastfeeding and neonatal or maternal complications to public patients in North West Tasmania.	Compliance with the three levels of KPIs specified in the terms of the maternity services contract.	Enables the provision of inpatient maternity services and limited outpatient maternity services (including birthing services) for North West Tasmania.
	Pathology diagnostics	Consultant Pathology Services PL	Burnie and Latrobe	Comprehensive on site pathology services to inpatients and outpatients of NWRH and MCH and remote pathology support for West Coast District Hospital, Smithton District Hospital and King Island Hospital and Community Health Centre.	Compliance with pathology sector KPIs as defined within Australian Council on Health Care Standards (or its legislative replacement), and to maintain all necessary approvals, accreditations, equipment and laboratories in good repair and conditions in accordance with required standards in agreed turnaround timeframes.	Enables the provision of on site services at the NWRH and MCH, supporting patient flow and timely service delivery.
	Radiology and Imaging	Regional Imaging	Burnie and Latrobe	All radiological needs of THS NW with regard to inpatients, outpatients and emergency patients including general x-ray, MRI, mammography, bone densitometry, ultrasound and CT Scanning. Includes provision of all staff, equipment and consumables necessary to provide the service.	Minimum service standards KPIs are specified terms in the Imaging contract	Enables the provision of on site services at the NWRH and MCH, supporting patient flow and timely service delivery.
	Rural Medical Services	Ochre Health PL	NW Rural Region	Continuous medical service coverage in rural areas including emergency care for rural hospital patients, inpatient care for rural hospital patients, rural residential aged care services initiated by referral from THS, limited scope radiography services for rural hospital patients, specialised medical personnel at Strahan.	Rural medical services provided with due care and skill in compliance with legislative requirements, to maintain all necessary accreditations, approvals, credentials and registrations required by AHPRA or other equivalent agency or college, and in accordance with THS Policies and Procedures. Service standards KPIs are specified terms in the rural medical services contract.	Allow for medical practitioners to be based in these rural and remote areas and assists in providing a sustainable model for private general practices in these locations.

	Ophthalmology	Dr Michael Haybittel	Latrobe	Acute and elective ophthalmology services for public and private patients.	Performance indicators are specified terms of the ophthalmology contract. For elective services - observance of a ratio of two public list patients to one private list patient. For acute services - provision of consultative advice for patients presenting to MCH at all times of any given day.	Pre and post-operative assessments and care as well as surgical procedures are available to NW patients.
South	Lithotripsy	Alexus Services PL	Hobart	Specialist urology procedure used to treat kidney stones	Provides a service on an as and when required basis.	Provides a service utilising specialised equipment that avoids need for RHH to purchase and maintain that equipment. Assists with maintenance and reduction of waiting lists.
	Outsourced Elective surgery	Hobart Day surgery	Hobart	Outsourced Opthalmology	900 patients per annum	Supports delivery of elective surgery volumes.
	Pathology services	Hobart Pathology	Hobart	Pathology services for elective surgery outsourced to southern Tasmanian health facilities.	200 patients per annum	Supports delivery of elective surgery volumes.
	Specialised patient monitoring	Neurophysiology Services Australia	Hobart	Provision of Intra-Operative NeuroMonitoring (IONM) Services	120 cases per annum	Helps prevent post-operative neurologic compromise for patients.
	Tasmania Lymphoedema Garment Scheme (TLGS)	Chris Dale-Lenah Valley; Heather Gouldthorpe-Nth Hobart	Hobart	Private Therapists supply of compression garments to patients via the TLGS.	For DHS Pensioner Concession Card and DHS Health Care Card holders.	Compression garments aid in managing lymphoedema.
	Teleradiology Service	Everlight Radiology	Hobart	Out of Hours reporting on medical imaging investigations: CT, General X-Ray, Ultrasound, MRI.	Provide reporting on medical imaging investigations Monday to Sunday 23:00 to 07:00. Urgent cases reported within 1 hour for single anatomical regions and 1.5 hours for multi anatomical regions.	Timely reporting times, enhancing the patients' journey after hours and improving hospital flow/bed access, particularly for emergency department patients.
	Breast Localisation (hookwire) Services	Women's Imaging and Regional Imaging	Hobart	'Hookwire' localisation service provided on the day of surgery as requested by the responsible surgeon.	Imaging required on day of surgery. RHH does not have the specialised mammography equipment required for this imaging service.	Patients having breast cancer surgery are able to have lesions localised to assist in accurate surgical outcomes.
	Sleep Medicine Service	Hobart Sleep Disorder-Dr Mestitz PL	Hobart	Provision of outpatient clinics, specialised chronic ventilation/respiratory failure clinics, full diagnostic service inclusive of overnight polysomnograms, MWT, MSLTs and ambulatory studies, implementation of CPAP and other assisted ventilation for sleep disordered breathing.	180 sleep studies/year, with 100% of overnight sleep study results transferred to THS within 4 weeks, and 100% of patients details provided monthly including current, valid health card details and referring doctor.	Meets 20 per cent of clinical demand.
	Wig Services	Not just Bras; The Hair Gallery-Hobart; Various Online providers	Hobart	Provision of subsidised wigs to eligible patients.	Patients with hair loss due to alopecia or cancer treatment must be health care card or pension concession eligible. Patients pay "out of pocket" cost up front. Service providers then claim reimbursement from THS for wig subsidy. For online purchases, the patient pays the entire amount "up front", and claims the reimbursement from THS directly.	Assist patients to maintain self-image and self confidence.

	Patient Sitters	Community Based Support	Multiple health facilities	Provision of Patient Sitters as required	South region requirements is on average 64 FTE of which this supplier provides 6-8 per annum.	Supports appropriate care to patients and avoids nursing or clinical support staff having to be diverted to these tasks.
	Post-operative beds	Hobart private Hospital	Hobart	Bed and nursing care for RHH post-op patients	Provision of 8-10 beds depending on demand.	Supplements bed footprint of the RHH and enables delivery of elective surgery volumes.
	Outsourced Elective Surgery	Melbourne Private Hospital	Melbourne	Neurosurgery for complex patients not able to be undertaken at RHH	2-3 cases per annum	Highly complex neurosurgery patients receive surgery that is not able to be undertaken in Tasmania.
	Obstetric Imaging	Womens Imaging	Hobart	Specialised pregnancy ultrasound scanning of tertiary referred women.	As and when required due to capacity, demand and/or clinical need	Service used to ensure a quicker turn-around time for tertiary referred patients
	Genetic Testing	Victorian Clinical Genetic Services	Victoria	Cytogenetic testing	As and when required due to capacity, demand and/or clinical need	Clinical service which RHH is unable to provide
	Fertility Testing	Fertility Tas	Hobart	Semen analysis	As and when required due to capacity, demand and/or clinical need	Clinical service which RHH is unable to provide
	IVF Services	Tas IVF	Hobart	Semen analysis/Semen freeze	As and when required due to capacity, demand and/or clinical need	Clinical service which RHH is unable to provide
	Gait Analysis	Royal Children's Hospital	Melbourne	Gait Analysis	As and when required due to capacity, demand and/or clinical need	Clinical service which RHH is unable to provide
	Paediatric Orthopaedic Service	Abhay Khot	Hobart	Specialised paediatric orthopaedic surgeon clinic	2-3 per annum	Clinical service which RHH is unable to provide
Statewide	Interpreter Service	All About Languages; All Graduates; amigos Translate; Ezispeak; Oncall Language Services; TIS National; Victorian Deaf Society; Language Loop; Wesley Mission Australia	Statewide	Interpreter services to enable access to health services 24/7. Preference is given to NAATI accredited professional interpreters.	Service providers must adhere to contractual obligations in delivery of services to non-English speaking or hearing impaired patients.	Improved efficiency and consistency in bookings, data management and finance processes.
	Pathology Services	Number of specialist hospitals and pathology service providers in Vic, NSW and SA	Vic, NSW, SA	Diagnostic results.	There are a number of reference labs to which the THS refers specimens for a number of different tests, either for results confirmation or for expensive tests that are not regularly performed in Tasmania. All service providors must be accredited.	Provides access to diagnostic services that would not otherwise be available.
	Non-Emergency Patient Transport (NEPT)	Ambulance Private Pty Ltd Morton Group Medical Services St John Ambulance Medical Edge Australia Royal Flying Doctors Australia	Statewide	Non-emergency patient transport (NEPT) is for patients who require basic clinical care and observation during transport, but do not have a time critical condition.	Compliance with conditions under section 35F of the *Ambulance Service Act 1982*.	Supplements Ambulance Tasmania service when AT not able to provide NEPT.

Recommendations

Governance

Recommendation 1:
The Maternity Service Contract Management Committee continue to utilise regular reviews of the THS/Healthcare Burnie Pty Ltd contract to guide the delivery of best care to maternity patients, using a systematic review of each of the Schedules 1-9. Adherence to which should ensure that the standards of care set out there deliver an excellent and safe maternity service.

Staffing

Recommendation 2:
Review full time equivalent staffing (FTE) in the Midwifery Group Practice (MGP) service over the next two years to ensure that staffing meets the agreed service model.

Recommendation 3:

3.1 A Clinical Midwifery Educator should be employed at NWPH to support the midwifery staff transition and up-skill where required. This would also address support and clinical facilitation for midwifery students.

3.2 Attendance of midwives at the hospital-based Perinatal Morbidity and Mortality meetings should be actively supported and attendance recorded and reviewed at the time of staff annual performance appraisal.

Recommendation 4:

4.1 That the Clinical Governance committee examines the 2017 RANZCOG re-accreditation report and develop a detailed response and action plan.

4.2 While this response (to a RANZCOG training re-accreditation report) would usually rest with the Training Supervisors and the Director of Obstetrics and Gynaecology, the Review Team recommends a collaborative response would serve to;

- Acknowledge to all leaders and staff the strengths identified by the re-accreditation team.
- Highlight to both THS and NWPH leadership those areas identified as needing improvement.
- Maximise the opportunities to address those deficiencies in the time available prior to RANZCOG review.

Service Model

Recommendation 5:
Provide leadership and governance to enhance integration of the maternity service across sites and improve culture across the sites and midwifery workforce. This role should also have responsibility for development of a strategic plan to guide the service.

Recommendation 6:

6.1 Provide mobile computing devices to MGP midwives to support their practice.

6.2 Implement education of MGP midwives to enable them to perform well baby discharge checks.

Recommendation 7:

7.1 The Maternity Service identifies three levels of care (to replace the current five levels identified by the reviewers), with referral between models according to the National Midwifery Guidelines.

- Level 1 – NORMAL risk (low risk) – suitable for midwifery care – MGP or THS Antenatal Clinic (ANC) midwifery care
- Level 2 – HIGHER risk – complex care requiring both medical and midwifery care
- Level 3 – TERTIARY care required – referral to Royal Hobart Hospital (RHH) (with the likelihood that some care will be provided by the specialists at NW site)

This recommendation will require some discussion at various committees, and might be varied to suit local factors not apparent to the reviewers at a one-day review of the service.

Supporting Infrastructure

Recommendation 8:

Improve the antenatal care space at the North West Regional Hospital.

8.1 The current addition of clerical and office space in the medical centre is supported and was nearing completion at the time of the visit.

8.2 Conversion of part of the current Visitor Units, adjacent to the hospital to a dedicated ANC for midwifery consultations.

8.3 Maintaining the current ANC area as a dedicated medical consultation clinic for higher risk and complex care antenatal patients, with space allocated to consulting, ultrasound and clinical examination.

Recommendation 9:

9.1 Improve and enhance IT capability and capacity. This should include pursuing an ICT solution that permits direct uploading of the THS Obstetrix antenatal record that includes any intrapartum and postnatal plans to the NWRH Digital Medical Record (InfoMedix).

This recommendation is a priority, with the lack of integration of antenatal and inpatient records being highlighted as a significant ongoing risk to best care delivery.

Quality and Safety

Recommendation 10:

10.1 The THS collaborates to develop a statewide evidence-based set of Maternity Clinical Practice Guidelines (CPG'S) to improve consistent, safe, and contemporary clinical practice with a seamless interface between all referring maternity services across the

State. This would address the overwhelming feedback from the midwifery staff related to inconsistent obstetric advice related to maternity care, especially from junior medical staff.

Recommendation 11:

11.1 The antenatal record of all admissions to Birth Suite should be reviewed by the admitting midwife and or medical officer. Relevant items, including management plans, should be noted and become part of the intra-partum care plan.

11.2 The admitting midwife should annotate the NWPH clinical notes to confirm time, date and name that the antenatal record has been reviewed.
Compliance with item (11.2) above should be audited after three months.

11.3 Any systems barriers that impede this should be addressed as a priority, significant risk to be mitigated.

Recommendation 12:

12.1 The Women's Healthcare Australasia (WHA) Benchmarking report should be regularly reviewed and discussed in a multidisciplinary setting. Reviewing one to two indicators at each Perinatal and Maternal Mortality and Morbidity (PNMM&M) meeting and setting actions such as audit/case reviews is a valuable quality activity for a Maternity Service.

Cultural, behavioural and communication issues

Recommendation 13:

13.1 The Maternity Service should review complaints and develop action plans to improve communication and enhance patient experience.

13.2 The Maternity Unit should ensure a comprehensive 'on-boarding' package specifically aimed at short-term medical staff appointments, junior resident medical officer (JMRO) rotations and locum consultants.