The Tasmanian Patient Health Group welcomes the Legislative Council Sessional Committee Government Administrative A Sub-Committee Inquiry into acute care services in Tasmania.

The Tasmanian Patient Health Group was founded in 2017 to give patients a voice in telling how the current crisis in our health system has impacted on them and their family members/carers. Also to highlight the Governments and in particular the current Health Ministers inability to listen to the concerns of medical staff and others warning of the pending situation we now find our public hospitals and the acute health services around the state in.

The Tasmanian Patient Health Group will continue to hold any government to account to provide quality health care to all Tasmanians.

This submission does not address each item in the terms of reference for this inquiry individually but concentrates on number 5 and number 6. We are aware of issues related to numbers 1 to 4 due to our running various health forums and contact with Doctors, Nurses and the unions representing them (HACSU, ANMFU and AMA). We have decided not to embark on addressing these but rather acknowledge we have concerns related to them and their impact on both patients and health professionals alike.

The Tasmanian Patient Health Group has serious concerns regarding the current adequacy of relevant services in terms of quantity, quality, capability and coordination

There is a plethora of evidence to support concerns in relation to the acute care system being under pressure and performance on a number of important indicators, including long waits for A&E, shortages of beds, early discharges, delays in treatment, misdiagnosis, transfer delays to other hospitals, care issues, staff shortages, ambulance ramping and handover time (which has been getting much worse in recent months)

While the focus of attention has been on the pressures felt by A&E services, there is no single cause or solution to this problem. The pressures are caused by issues across the health and care system that prevent the flow of patients through the system and any solutions need to reflect this. These are complex issues that will not be solved just by short-term increases in funding.

To address the problems created by increasing demand on urgent and emergency care we need more strategic approaches that reduce the complexity of the system for patients. All of this requires leadership across a system rather than attempting to fix each individual component . We remain concerned that the fragmentation of commissioning and lack of strategic responsibility will make system-wide change more difficult to implement.

The *One State, One Health System, Better Outcomes* reforms as outlined in the White Paper identified the framework to provide improved health services for all Tasmanians. This means every Tasmanian should have access to high quality, safe and efficient clinical services. The THS was created to bring together three regional health services into one delivery system. The aim is to provide better services for all. The THS IS RESPONSIBLE for delivery of health services to all Tasmanians. This includes ensuring appropriate governance is in place to monitor and evaluate. The THS is also responsible for accountability and addressing issues i.e accountability and care outcomes

When talking or referring to Governance in health it is related to how services are run or governed. There are overarching guiding principles which ensure this occurs. They relate to Transparency, Accountability, Stewardship and Integrity. These are essential to the health system and should be enacted at every juncture of the system. We have also annexured (Aiv) a copy of The Australian Charter of Healthcare Rights. This is a framework set down by the Australian Commission on Safety and Quality in Health Care which lays out the National standards and accreditation in health. Tasmania is part of the national framework. The charter describes the rights of patients and other

people using the Australian health system. These rights are essential to make sure that, wherever and wherever care is provided, it is of high quality and is safe. In light of this the Tasmanian Patient Health Group has serious concerns in light of the stories and issues we will be raising below.

As a group primarily concerned with patient care we will lay out the issues as we have seen them arising and causing affects. In this submission we will include patients' stories and highlight how they link to each named issue. Also we will include some coroners reports as they also relevant to the issues we are raising. Following is a list factors contributing to adverse patient outcomes:

1. DELAY IN DIAGNOSIS/ FAILURE TO DIAGNOSE

Delays can result in adverse outcomes for people, their families and carers as well as cause significant distress to professionals providing care.
Within Appendix Section A coronial reports there are five people who were affected by this. They are v), vi), xvi), xxiii) and xxiv)
Within the Appendix Section there are four patient stories which highlight the problems in this area. They are Appendix B patient stories a), b), f) and g)

2. MISDIAGNOSIS

It is concerning that since the Tasmanian Patient Health Group was formed we have been advised by many patients and relatives of problems with wrong diagnosis of conditions. Also we have had several coronial reports shown to us by relatives of patients who have died as direct result of this. It highlights an extremely serious area within acute care services that needs addressing before more patients are subjected to more pain, lengthy recoveries or at the very worst death
Within Appendix Section A Coronial reports there were seven reports which elated to this issue. They are iii), iv), v), viii), xv), ix) and xx)
Within the Appendix section there are three patient stories which highlight further the problems in this area. They are Appendix B patient stories a), b) and c)

3. FAILURE TO ARRANGE TREATMENT

Again it is concerning that many cases have been neglected within acute care services. Many times tests were not arranged despite symptoms warranting them as seen in coroners reports in particular. Also many were discharged from emergency department without treatment only to go on to GP's and find they had suffered an injury or condition that required urgent treatment
Within Appendix Section A coronial reports there were five people who were affected by this. They were v), vi), x), xi) and xiii)
Within the Appendix section there are six patient stories which highlight issues in this area. They are Appendix B patient stories a), b), d), f), g), h)

4. UNDERTREATED

Due to this many patients are seeing a decline in their health. They are suffering physically, emotionally and financially with many return trips to hospitals, specialists and GP's. In Annexure (Aii) an article by ABC news highlights that patients have been undertreated for so long and it is causing more issues.
Within Appendix Section A coronial reports there were four people who this affected. They are xi), xiv), xv) and xix)
Within the Appendix section there are six patient stories which are highlighting

problems in this area. They are Appendix B patient stories a), b), c), d), f), g)

5. UNDERESTIMATION OF DEGREE OF ILLNESS

As evidenced by the coronial reports people died because there was not enough attention paid to their illness. Other patients are continuing to suffer because their treatment was not started or delayed due to not being sufficiently listened too or judgements made to empty beds due to bed blocks. This causes further issues for patients , delays recovery and can lead to worse conditions including ones which lead to deaths.
Within Appendix Section A coronial reports there were four people affected by this. They are v), xiii), xix) and xx)
Within the Appendix section there are six patient stories which highlight this issue. They are Appendix B patient stories a), b), c), d), f) and g)

6. EARLY DISCHARGE

This is leading to patients having to continually return to the emergency department as they deteriorate and require further assistance. All indicators have pointed to bed blockage being a cause of discharging patients early. This is less than ideal as it can lead to further issues with health and often death results which could have been avoided. The health union have claimed the Launceston General Hospital have discharged patients before it is clinically appropriate in an attempt to combat bed block (The Examiner 20 Aug 2015 "Early discharge concerns" Emily Baker health reporter)
Within Appendix Section A coronial reports there was one person affected. This was xv)
Within the Appendix section there are eight patient stories which have been affected by early discharge. They are Appendix B patient stories a), d), e), f), g), i), n), p)

7. POOR MEDICAL PRACTICES

We have heard many stories highlighting terribly poor medical practices. In particular patient story a) is fraught with multiple examples where he was not afforded safe and proper medical care and consequently suffered many painful procedures. In the Australian charter of healthcare rights it clearly raises safety whereby everyone has a right to safe and high quality care.(Annexure [Aiv]). This is most distressing in light of the stories highlighted below.
Within the Appendix Section A coronial reports there were five people affected by this. They were iii), v), viii), xvi) and xxvi)
Within the Appendix Section there are five patient stories affected by this. They are Appendix B patient stories a), b), d), k) and n)

8. SUPERFICIAL ASSESSMENT IN EMERGENCY DEPARTMENT

This has been raised many times and the finger has been pointed at bed blockage as the main reason for it. Overrun emergency departments with ambulances ramped have seen many patients given substandard assessments or sent home told to see GP.
Within Appendix Section A there were two people affected by this. They were v) and viii)
Within the Appendix section there are three patient stories highlighting issues with this. They are Appendix B patient stories d), f) and g)

9. DROP IN LEVEL OF CARE/NO CONTINUITY OF CARE/FRACTURED CARE

In this area we were told many stories of how patients received less than adequate care and had to return many times over with same issues due to this. It is concerning to see so many different stories but all highlighting major concerns with confusion over care, being shunted all over the place or left without assistance.
Within the Appendix section there are twelve patient stories which highlight how they have been affected by this. They are Appendix B patient stories a), b), c), d), f), g), i), j), n), p), q), r)

10. FOLLOW UP SUPPORT NOT ADEQUATE

The patient stories and the two coronial reports detail major issues with no follow up support. It is evident when reading these that patients are suffering unnecessarily and ultimately paying the price for the neglectful care given to them. The stories speak loudly for themselves
Within Appendix Section A coronial reports there were two people affected. They were v) and xvii)
Within the Appendix section there are nine patient stories detailing how their follow up care wasn't adequate. They are Appendix B patient stories a), b), d), e), f),h), i), o) and q),

11. DELAYS BEFORE SURGICAL REVIEW

This is putting lives at risk and causing much worsening conditions for patients. It has also resulted in deaths which were deemed preventable.
Within Appendix Section A coronial reports there were two people affected. They were viii) and xvi)
Within the Appendix section there is one patient story which highlights issues related to this. It is in Appendix Section B patient story k)

12. FAILURE TO REFER

Due to this many peoples conditions become increasingly worse and consequently more difficult to treat. If referrals are made and followed up it is clear that patients conditions can be treated easier and avoid complicated surgeries and death.
Within Appendix Section A coronial one person, namely xx) was affected
Within the Appendix section there are three patient stories that relate to issues due to failing to refer. They are in Appendix Section B patient stories g),h) and i)

13 MENTAL HEALTH ISSUES

There have been many discussions more recently in the media and at health forums highlighting the issues in this area. It is apparent that in acute care services there are multiple difficulties in attending appropriately to patients and to getting care and follow up. It is an increasing difficult and complex issue but one that needs addressing and care taken.
Within the Appendix section there are two patients who have been adversely affected due to issues of care in mental health area. They are Appendix Section B patient stories e) and i)

14 COMMUNICATION ISSUES

This is a broad area and includes all forms of communication whilst accessing acute care services. Many patients have disclosed lack of communication with their care from the moment they present to emergency departments through to

explanations upon discharge. A lot of cases mentioned they struggled to be kept informed and often were told very little. Perhaps there would be benefit in increasing patient liaison officers to tackle this area
In an article [Annexure (Aii)] by ABC news, Martyn Goddard mentions communication as an issue that needs addressing
Within Appendix Section A coronial reports there were two people who were affected by communication issues. They were v) and xxvi)
Within the Appendix section there are four patients that have issues due to lack of communication. They are Appendix Section B patient stories a), d), i) and k)

15 FAILURE TO RECORD/WRONG INFO RECORDED

This can cause issues in regard to appropriate treatment and as seen in some cases has caused further complications. It also complicates further treatment plans of GP's who are hindered by lack of information being supplied and delays their follow up care. This all impacts on patients safety and well being
Within Appendix Section A coronial reports xxv) was affected by this
Within the Appendix section there are two patients that have highlighted issues with this area. They are Appendix Section B patient stories g) and o)

16 MISUNDERSTANDING/MISINTERPRETATION

This issue has similar repercussions to number 15. It can affect treatment and recovery
Within Appendix Section A coronial reports xxv) was affected.
Within the Appendix section there are two patients who have had issues in this area. They are Appendix Section B patient stories f) and g)

17 INCONSISTENCY OF REPORTS

It was distressing to read these cases as it highlighted the problems within acute care services and the effect it has had on patients losing their lives and grief for family members.
Within Appendix Section A coronial reports there were three people affected. They were v), xxv) and xxvi)

18 FAILURE TO ADMINISTER MEDICATIONS/FAIL TO GIVE ON DISCHARGE

These issues highlight further problems within the system. It can directly affect the life and pain of the patient. It needs to be addressed to perhaps put checks in place to prevent it happening
Within the Appendix section there are two patients who have had this occur. They are Appendix Section B Patient Stories a) and n)

19 DRUG DOSAGES/SAFEGUARDS

This is particularly concerning as it can cause complications or death. The stories below highlight what occurred and in the coronial report it goes into lengthy detail as to what occurred
Within the Appendix section there is one patient who was affected by this and one in the coroners findings. They are Appendix Section B patient stories g) and in Appendix Section A coronial reports xii)

20 USE OF WRONG EQUIPMENT/MEDICATIONS

This highlights issues similar to 19 and can adversely harm patients and cause

death
Within the Appendix section there is one patient who was affected by this and two in the coroners findings. They are Appendix B patient stories g) and in Appendix Section A coronial reports xi) and xvi)

21 INTERPRETATION OF TESTS/LOCUMS UNFAMILIAR WITH EQUIPMENT

This can also adversely impact on patients and lead to further complications and preventable deaths. The coronial reports detail at length how this affects patients.
Within the Appendix Section A there are three people who were affected by this. They are Appendix Section A coronial reports v), xxiii) and xxvi)

22 SHORTCOMINGS IN HOSPITAL MANAGEMENT

An article by ABC news [Annexure (Aii)] speaks about the health system in Tasmania needing better management.
Within the Appendix Section A there are six people who this Affected. They are Appendix Section A coronial reports i), iv), v), vii), xviii) and xxvi)
Within the Appendix Section B there are six patients affected by this. They are Appendix Section B patient stories a), b), d), f), g) and q)

23 DELAY OR FAILURE TO TRANSFER TO ANOTHER HOSPITAL

In the coronial reports it highlights how delays/failure in transferring patients can lead directly to death. In the patient stories it shows clearly adverse effects and more complications and distress when delays occur.
Within the Appendix Section A there are three people who were affected by delays and failures in transferring to another hospital. They are Appendix Section A coronial reports x), xiii) and xx)
Within Appendix Section B there are four patients affected. They are Appendix Section B patient stories a), j), k) and s)

24 LACK OF NEURO PAEDIATRICIAN/NEURO NOT CALLED

In the coronial case it shows issues when a neuro doctor isn't called. It clearly shows many problems which arose due to this not occurring and consequently led to the death of the patient. The patient story in regard to the neuro paediatrician also highlights the grave seriousness of the lack of such and impact.
Within Appendix Section A one person was affected by issues related to neuro. This is v) in Appendix Section A coronial reports
Within Appendix Section B one patient was affected by lack of neuro paediatrician. This is b) in Appendix Section B patient stories

25 SHORTAGE OF BEDS

Efficiency and bed utilisation initiatives have left hospitals running at high levels of occupancy and with little or no capability to respond to fluctuating demand and with no option but to discharge patients or turn them away. This has had a direct impact on patients health and has led to deaths. There has been much information in the media and via speakers at forums in regard to how bed shortages are affecting care. As can be seen by the number of patient stories which have had issues due to this.
Within Appendix Section A two people were affected by this. They were v) and

xxi).
Within Appendix Section B twelve patients have been affected by this. They are a), b), d), e), f), g), j), l), n), o), and p)

26 SHORTAGE OF AMBULANCES/LENGTHY WAITS/RAMPING

Patient care is severely impacted by both shortage of beds and ambulances having to wait with patients outside the emergency departments. Not only does it impact care it also causes wait times for ambulance callouts to rise dramatically. In many instances so many ambulances were tied up ramped outside hospitals that other patients had to wait in excess of two hours for an ambulance to arrive to transport them. Delays like this can cost lives.
Within Appendix Section B there has been six patients affected by this. They are b), g), j), k), m) and s).

27 WAITING LISTS

Many patients who speak to our group are in immense amounts of pain and it is having daily impact on their quality of life and that of their families and carers. Waiting list time frames are still long and patients are struggling and most are going downhill and having to keep returning to emergency departments
Within Appendix Section B there are five patients affected by waiting list times. They are c), d), f), g) and p)

28 STAFF SHORTAGES/DOUBLE SHIFTS

This area has been constantly reported on in the media by the various unions and has a flow on effect to patient care. An article in ABC news by George Burgess and James Dunlevie on 18th May 2017 (annexure document [Ai]) highlights issues where an understaffed hospital was clearly an issue related to the death of a woman. In coronial report v) Appendix Section A page 13 and 14 in particular refer to shortages raised as an issue by Dr Huckerby

It could be said that everyone has been affected by this at some stage but most specifically we have found three patients in particular who have identified it as causing issues. These are in Appendix Section B patient stories b), k) and q)

29 COSTS OF TESTS/TREATMENT/TRAVEL

Many patients have discussed issues surrounding costs of tests and the travel To access them has caused financial stress with some opting to not have the test done due to the costs associated. Often they have long travel between hospitals and this not only causes further issues with their conditions but places burdens on struggling budgets.
Within Appendix Section B patient stories there were three stories which highlighted issues here. They are b), k) and q)

30 PRIVACY/CONFIDENTIALITY

An article in the Mercury newspaper on February 2 2017 [Annexure (Aiii)] clearly states that there are issues with patients being interviewed in waiting rooms. This can have adverse effects on people who do not wish to have their conditions openly discussed in crowded waiting rooms of emergency departments
In Appendix Section B patient stories this was highlighted in q)

In concluding we would like to say please let's respect the living and not let those who have died through negligence not have died in vain and further deaths avoided.
We are their voice
Let us be heard

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APPENDIXES

A) CORONER'S REPORTS

i) Andrea E Baldock
ii) Margaret E Bugg
iii) Wendy Crosswell
iv) Maurice C Nancarrow
v) Anne Maree Woulleman-Jarvis
vi) Robert N Handasyde
vii) Marlene J Harper
viii) James M Smith
ix) Mark A Gordon
x) Jason K Harrison
xi) Jason M Brook
xii) Teressa M Beswick
xiii) Ian P Summerfeldt
xiv) Mary Weir
xv) Nicole C Hingston
xvi) Heather M Bird
xvii) Mr D
xviii) Alexander Pasinski
xix) Mr B
xx) Margaret W Newett
xxi) Mr S
xxii) Paul L Henri
xxiii) Tyler J Broomhall
xxiv) Maureen A Rogers
xxv) Mr P
xxvi) Neville R Hoskinson

B) PATIENTS STORIES

a) Khiam 0412805561
b) Mother of Triplets C/- 0419422076
c) Margaret C/- 0419422076
d) Therasa Barr 0424677778 (also attached is photos)
e) Patient A C/- 0419422076
f) Danielle Sproule 0437715094
g) Rebecca Lyons 0401347254
h) Patient 1 0419422076
i) Kate Leitch kateleitch01@gmail.com
j) Patient B C/-0419422076
k) Patient C C/-0419422076

l) Patient D C/-0419422076
m) Patient E C/-0419422076
n) Charmaine Smigielski 0419422076
o) Elderly grandmother 0419422076
p) James Davidson jamesdavidsonsnr@iinet.net.au
q) Louise 0419422076
r) Sheila Allen sheilaallen1953@hotmail.com
s) Patient F 0419422076

ANNEXURES:

Ai) ABC news "Premier Will Hodgman admits health system 'clearly failed' in death of Anne Woulleman-Jarvis", By George Burgess and James Dunlevie, 18th May 2017

Aii) ABC News "Tasmania's 'broken' health system needs better management, not money, senior doctor says", 29th March 2016

Aiii) The Mercury, "Doctors complain of chronic bed shortage at the Royal Hobart Hospital", Loretta Lohberger, 2nd February 2017

Aiv) The Australian Charter of Healthcare Rights: A guide for healthcare providers. www.safetyandquality.gov.au