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INQUIRY INTO THE CAPACITY OF TASMANIA'S MAIN HOSPITALS TO IMPROVE PATIENT OUTCOMES

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide an in-confidence submission to the Tasmanian Government Subcommittee inquiry into the capacity of Tasmania's main hospitals to improve patient outcomes in acute care (the Inquiry). It is in the public interest to have a high quality and responsive health system. Achieving this outcome is of vital importance to each patient's health care experience and to the quality of life for the individual, their family and the broader community.

ACEM is the not-for-profit organisation responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. As the peak professional organisation for emergency medicine in Australasia, ACEM has a vital interest in improving the quality of training and clinical supervision of its Members, while ensuring the highest standards of emergency medical care are provided for all patients.

ACEM believes that the Inquiry provides an avenue to identify the challenges facing Tasmania's main hospitals[1]. The Terms of Reference (ToRs) are broad in scope and provide ACEM with the opportunity to provide expert commentary and data. However, ACEM calls on the Tasmanian Government to engage with the Inquiry findings in a bipartisan spirit. Improving patient outcomes should underpin and drive the efforts of all sides of Government and of the acute health care system.

ACEM considers that ED staff face increasing workplace demand pressures from:

- An increasing number of patients presenting to Tasmanian EDs. (1)
- Unproductive political discourse over hospital resources for the ongoing care needs of patients. (2)
- Governance structures and leadership practices that have led to a reactive blame culture, detracting from a focus on improving patient outcomes. (3)

ACEM believes that State and Commonwealth Governments must provide more support to address these demand pressures. ACEM believes that the leadership of Royal Hobart Hospital (RHH) and Launceston General Hospital (LGH), and in particular the Executive of Tasmanian Health Services (THS), must take action to address the systemic problems at all of Tasmania's hospitals and across the broader health care sector.

ACEM is willing to work with Governments, hospital leadership and the THS Executive to develop the necessary response and actions to improve patient outcomes, and looks forward to working with the Committee in anticipated next steps of this Inquiry.

ACEM appreciates the opportunity to provide our in-confidence submission to the Committee.

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[1] Tasmania's main hospitals are considered to be: Royal Hobart Hospital; Launceston General Hospital; North West Regional Hospital; and the Mersey Community Hospital. For the purpose of this submission, Royal Hobart Hospital and Launceston General Hospital form the majority of examples used.

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The systemic and cultural issues impacting on the ability of Tasmania's acute health care services are not new. The impact on ED staff has reached a critical point – our Members clinical expertise is being ignored. There is ample evidence that poor patient outcomes result when staff morale is low and the executive leadership does not value clinical engagement. (4, 5, 6) Ultimately, this continues to increase the risk to patient health outcomes. This risk is unacceptable.

ACEM makes the following observations:

The Tasmanian acute health care service is in systemic crisis. The RHH and LGH in particular face persistent ambulance ramping, a lack of available beds and low staff morale. They are under-staffed and under-resourced. This is resulting in consistent ED overcrowding and access block, with patients being assessed in corridors, chairs and in side-rooms.

ACEM considers that access block[2] is the most significant issue facing EDs in Australasia as it negatively affects the provision of safe, timely and quality medical care to patients. (7) Access block is a key indicator of systemic crisis, with an average of 7.7 patients per emergency department across Australia waiting for inpatient beds on any given day. (8) Anecdotal evidence from ACEM Members highlights that access block is a persistent problem at RHH and LGH in particular. It directly contributes to increased risk to patient adverse care outcomes and provides unacceptable clinical risks to staff. Access block also directly contributes to ambulance ramping[3] and this delays the ability of staff to assess patient needs and provide efficient medical care. (9) ACEM Members have highlighted that ramping is also an *"everyday occurrence"*, with ambulance crews often waiting in excess of six hours[4] to respond to 000 calls as they are unable to offload patients into the ED. Media reports regularly draws public attention to this issue at RHH. (10, 11, 12)

ACEM also considers that time-based targets for patients in EDs is a useful indicator of the capability of health care systems, providing an insight into hospital patient flow issues and the patient's experience of acute care. (13) In 2015-16, 66% of presentations at Tasmania's major hospital EDs were seen on time, with 62% of patients seen within four hours at RHH. (14) Royal Hobart Hospital has been below the average since 2013-14, and is moving further away from improving standards, when compared to other major hospitals across Australia. (15) At Launceston General Hospital, 61% of patients departed the ED within four hours in 2015-16. (16) When compared to other large regional hospitals across Australia, LGH has been below the average since 2011-12, with the largest gap (11%) seen in 2014-15 and 2015-16. (17) For all major hospitals with EDs in Tasmania in 2017, the percentage of patients who departed the ED within four hours decreased from 69% in April 2016 to 63% in March 2017. (18) However, for RHH and LGH, this has fallen further to 59% in March 2017. (18) The current wait times for patients in Tasmanian EDs is unacceptable.

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[2] Access block is defined by ACEM as "the situation where patients who have been admitted and need a hospital bed are delayed from leaving the Emergency Department because of lack of inpatient bed capacity".

[3] The situation where ambulance officers and/or paramedics are unable to complete transfer of clinical care of their patient to a hospital ED, within a clinically appropriate timeframe, specifically due to a lack of an available appropriate clinical space.

[4] Public data not available.

Efforts by Governments to fund major capital works in both hospitals has not improved patient outcomes. ACEM contends that the current level of funding, and in particular, how that money is allocated, does not go far enough to address clinical concerns as well as the increasing demand for services. This is subsequently impacting hospital staff in their ability to meet community demand, with the resources available.

In response to increasing demand and projected trends, ACEM acknowledges that Governments have funded major capital works at both hospitals and has committed funds to address health care system needs (19, 20). However, the decision to undertake a re-build at RHH rather than on a new site directly contributes to the difficulty Members face in providing specialist emergency medicine care. For example, THS reported that the RHH ED had 59,504 presentations in 2015-16 – a 6% increase on the previous year. (21) Unless there is investment in creating capacity in the inpatient arena, the situation in acute care will not improve.

Demand for services will only continue to increase. Tasmania's population growth from 2006 to 2021 is predicted to be primarily driven by people aged 60+. This will have a direct impact on demand for health services as *"...older people have greater needs for health services....their needs are more likely to relate to chronic diseases"*. (22, p 13) This impact is being felt in EDs now. Between 2007 and 2011, ED presentations in Australia increased by 13%. The largest increase in demand was evident in the 65-84 age group (16%) and in the 85+ age group (26%). This increase in demand for ED services was larger than the population growth experienced over the same period. (23)

General community demand for ED services is also increasing. Between 2011-12 and 2015-16, demand for EDs in Australia continued to rise each year (3.7% on average) to a total of almost 7.5 million ED presentations in 2015-16. Increasing demand for services is also evident in Tasmania, where 153,541 ED presentations were reported in 2015-16 – an increase of 2.3% from 2014-15. (1)

Members have provided examples of the demand pressures they face:

"...it is 9am on a Tuesday morning and of the 40 patients in the ED, 26 are admitted inpatients. This is a marker for disaster."

"Today, when I look at the tracking screen, I see that we have had a psych patient wait 120hrs for a bed. Two days ago, we had seven psych patients waiting for beds – a couple of them for three days."

"A few days ago, we were powerless to stop a lady dying in our main cubicle area because we could not get her to resus to give the care needed to prevent deterioration. We recently had a young lady with a ruptured ectopic pregnancy in the hallway getting resuscitated. A person seizing in the waiting room was left there because there was nowhere else to put them."

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

Healthcare systems require sound governance processes in order to minimise the risk of adverse patient outcomes. Monitoring and reporting on the quality outcomes of care provided to patients is an essential component within the ED and within the broader hospital system. It is also essential that

the actions undertaken by responsible authorities uphold the overall aims of patient safety and quality care. A case where these were lacking was in Djerriwarrh Health Services[5], where a cluster of perinatal deaths had occurred in 2013 and 2014. Following review by the Australian Commission on Safety and Quality in Health Care (ACSQHC) into the governance arrangements and response by governing organisations, an additional review was commissioned. It found that the processes in place to ensure patient safety and quality health care outcomes were lacking, and required comprehensive reform across the entire health care system in order to protect patients from adverse outcomes. (24) ACEM considers that this review has similarities with the experiences raised by Members. ACEM notes that there have been similar themes in other inquiries, the most prominent being the Mid Staffordshire inquiry in the United Kingdom, which required comprehensive system reform by Government following extensive independent review. (6, 25, 26, 27)

Members have provided anecdotal evidence that the THS Executive are absent to staff, and lack ownership of the strategic direction, responsibility and accountability that comes with their positions. Members have highlighted poor executive reporting mechanisms when they seek to raise concerns about the quality of care in the ED and safety of patients. For example, when staff seek to raise an issue with hospital management/THS Executive they are initially met with no response. When a response is provided, it either denies that the issue requires action, 'points the finger' at ED staff as causing the issue, or introduces new processes that do not address the issues.

The Mid Staffordshire inquiry noted that:

> *"The trust's board and senior leaders did not develop an open, learning culture, inform themselves sufficiently about the quality of care, or appear willing to challenge themselves in the light of adverse information."* (p 10-11, 25)

There are significant parallels to the current Tasmanian situation. It should be noted that in Mid-Staffordshire, this issue led to a large number of patient deaths and adverse outcomes.

Members have provided examples of their experiences:

"There is a lot of rhetoric but very little meaningful action."

"The leadership of the THS appears disengaged from the acute sector..."

"There appears to be a major resistance to truly recognise access block and issues around flow as a whole of system problem...see it instead as an ED problem."

ACEM notes that the Coroner's report into the death of Anne Maree Woulleman-Jarvis considered that the time taken by the hospital Executive to respond to staff concerns over staffing levels was a contributing factor to her death. (28) ACEM also notes that the THS Executive leadership has been identified as a risk to patient health outcomes by other professional organisations, including the Tasmanian branches of the Australian Medical Association (AMA), the Australian Nursing and Midwifery Association (ANMF), the Royal Hobart Hospital Medical Staff Association, the Royal College of General Practitioners and the Health and Community Services Union. (3, 29) The AMA has previously declared it has no-confidence in THS senior management and the Royal Australian and New Zealand College of Psychiatrists (RANZCP) has recently withdrawn accreditation of training posts at RHH. (30, 31, 32)

[5] Located in Bacchus Marsh, Victoria

ACEM is responsible for training doctors for recognition as specialist emergency medicine physicians. This training occurs primarily within hospitals that have been accredited by the College as being able to provide the necessary teaching, learning and experience necessary for trainees to train towards Fellowship of the College in a safe environment that provides appropriate training. These hospitals are required to meet specified standards and requirements to ensure minimum acceptable levels of training are provided at a site (e.g. RHH or LGH) so that the provision of emergency medicine care is at the standard and quality expected by patients. ACEM considers that the action by the RANZCP is significant as the College also takes *"...most seriously the issue of health and safety of our patients and trainees."* (31) The outcomes of this development between RANZCP and THS are of interest to ACEM and we will continue to monitor future developments.

Staff morale is suffering and is impacting on their wellbeing and patient care. The repeated inaction by Tasmania's acute health care leadership in considering staff advice is having a negative impact on ACEM Members' morale and well-being. Staff continue to raise their concerns about the current environment of acute health care, including the indicators of system crisis (access block, ED overcrowding, ambulance ramping), increasing demand to use EDs, and the actions undertaken to address these (for example, the RHH re-development).

ACEM members report:

"Every shift in the RHH ED is overcrowded and plagued by access block. This impacts on our ability to function effectively as emergency specialists and provide safe and quality patient care. I cannot emphasise enough the negative impact this is having upon staff morale and mental health."

"Medical staff feel poorly valued and not 'heard' by senior management."

"Morale is low, staff feel undervalued and there is too much political knee-jerk response when an issue becomes a headline."

"Staff at all levels are tired. If every nurse in the THS refused to do any overtime or double shifts, the system would crash in less than 12 hours."

"We are not able to provide satisfactory care to our patients."

ACEM research supports this feedback. Tasmanian Members have reported the highest prevalence (58.7%) of instances of discrimination, bullying, sexual harassment and harassment by a professional colleague across all States in Australia. (33) Across all EDs in Australasia, Members and EM trainees reported that ED overcrowding, access block and patient expectations are key work stressors impacting on their ability to do their job. Employer responses to assist staff manage these stressors have been insufficient (including lacking any response at all), with staff tending to undertake their own stress reduction methods. (34)

Anecdotal evidence from Members also highlights that the number of staff taking sick leave has greatly increased and that the process of taking leave entitlements has been made difficult by the Executive body. Members have reported that the low level of staff morale is contributing to the challenge of retaining staff, for example at LGH. (35) Hospitals face staff turnover and recruitment challenges due to the reputation of the current system outside of the State, the increasing demands required of staff to undertake their role and from the inaction from the THS Executive to address staff concerns. Such difficulties will only exacerbate the existing significant workforce issues, and ultimately continue to impact the quality of care provided to patients.

ACEM draws the attention of the Committee to Members' feedback that their input as clinical specialists is not being considered by hospital management and the THS Executive. This has occurred when staff seek to provide their clinical expertise to assist in developing options that address the challenges facing RHH and LGH, for example on budget and financial planning. There have been multiple attempts across medical personnel, colleges and institutions to direct the attention of THS Executives towards actions that seeks to implement strategic planning with clinical input to improve patient outcomes. ACEM considers that the expertise Members bring to their workplace is valuable and must be considered as part of the planning and development phases undertaken by hospital management and the THS Executive. The response to date has been lacking, particularly given THS was established to improve patient outcomes in Tasmania. ACEM considers that cultural change within the THS Executive is needed in order to address the increasing demands on the sector.

ACEM makes the following recommendations to the Committee

ACEM recommends that the Committee seeks additional data in considering the systemic factors (including those listed above) influencing patient outcomes in Tasmania's acute health care system. Data comparing Tasmania against national averages and comparable hospitals[6] that would assist the Council includes:

- ED deaths
- Adverse events and SAC1
- Access block
- Available ED capacity at 8am each morning
- Did Not Waits
- >24hr ED lengths of stay (including patients identified as requiring specific mental health in-patient care)
- Performance against National Emergency Access Targets (NEAT)
- Staff leave (including sick leave; annual leave; and the ability to take leave)
- Staff shift structures (number of double shifts; instances of overtime)
- The number of Visiting Medical Officers engaged
- Written correspondence between staff and the THS Executive in working to address staff concerns.

ACEM also recommends that other reports into the state of EDs would assist the Council, including the 2012 Monaghan Report[7] and the 2016 Sullivan, Staib et al report into NEAT and the 4-hour rule. (35)

ACEM further recommends that a formal mechanism for clinical engagement[8] with front-line staff is a necessary outcome of this Inquiry. It is clear that existing processes are not working as intended, with Members' reporting that the THS Executive are absent from the clinical environment, are not responsive to staff concerns and introduce processes that have not considered specialist clinical input. 'Safer Care Victoria' is an excellent example of a Government response to a systemic crisis that had adverse patient outcomes. The Victorian Government accepted recommendations to provide an avenue for clinicians and researchers to influence the outcomes of patient safety and health care. This avenue was the establishment of Safer Care Victoria. (37) ACEM acknowledges that this is a new

[6] If this data is not available within the AIHW, HealthStats or equivalent this should be sourced from hospitals, health organisations (for example, THS, the Department of Health) and staff directly.

[7] Unable to source this Report but consider it an important indicator of historic acute health care pressures.

[8] *"Clinician engagement is about the methods, extent and effectiveness of clinician involvement in the design, planning, decision making and evaluation of activities that impact the Victorian healthcare system."* (reference 25)

initiative and recommends that the Committee considers the approach undertaken by the Victorian Government, and engages with Safer Care Victoria directly.

For noting by the Committee

Members have reported that they have repeatedly sought advice and direction on how they can participate in this review as a member of staff within RHH and LGH, or as a member of staff within the broader context of THS. ACEM is disappointed to have received feedback from Members that they have been verbally directed by hospital management not to provide personal responses to the Committee that would include "*...information that has come to you as a result of your occupation...*". ACEM considers that the Inquiry needs to be shaped by submissions that are honest, accurate and constructive. ACEM believes that improving patient outcomes requires the input of front-line staff.

ACEM is willing to work with the Committee to clarify any claim made in this in-confidence submission.

Thank you for the opportunity to provide feedback to this Inquiry. Should you require clarification or further information, please do not hesitate to contact the ACEM Policy Officer Lee Moskwa on (03) 9320 0444 or via email at lee.moskwa@acem.org.au.

Yours sincerely,

Dr Simon Judkins
President Elect
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Dr Yusuf Nagree
Chair
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