2018 (No. 19)

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 Josh Willie MLC
Hon Mike Gaffney MLC
Hon Sarah Lovell MLC
Hon Rob Valentine MLC

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INTRODUCTION

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

    (1) Current and projected state demand for acute health services;

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

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

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

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

    (6) Any other matters incidental thereto.

2. The Membership of the Sub-Committee was:

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

3. Thirty-five submissions were received by the Sub-Committee. Public and private hearings were held in Hobart on Friday 8 September, 9, 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 to the Sub-Committee at these hearings.

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

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

6. 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, and 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 and on 22 and 24 October 2018. Nine individuals or organisations gave evidence to the Sub-Committee at these hearings.

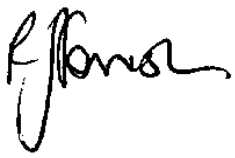
7. A further hearing was held in Launceston and Hobart via video-link on Friday 16 November 2018, and the evidence received from this hearing will be considered for inclusion in the Final Report. The Sub-Committee signed off on the second Interim Report on the 16 November 2018.

8. The Sub-Committee Inquiry also established a dedicated web-page at http://www.parliament.tas.gov.au/ctee/Council/GovAdminA_HealthServices.htm. All public submissions and transcripts are published on the web-page and these should be read in conjunction with the first and second interim reports of the Sub-Committee.

9. These reports respond to the broad range of evidence received during the inquiry process to date.

10. The Committee reviewed the second Interim Report of the Sub-Committee noting that further information has been requested from the Minister and had not yet been received. The Committee accepts the information sought is relevant information necessary to enable a Final Report to be prepared.

11. The Committee resolved that Members of the Sub-Committee be endorsed to speak publicly about the report in their capacity as Members of the Sub-Committee.



Signed this 20 day of November 2018

Hon Ruth Forrest MLC, Committee Chair

APPENDIX A

2018

Parliament of Tasmania

LEGISLATIVE COUNCIL
GOVERNMENT ADMINISTRATION COMMITTEE "A"

INTERIM REPORT No. 2

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)

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EXECUTIVE SUMMARY

The Tasmanian Health Service is facing increasing demand for acute health services and is currently unable to efficiently or effectively meet this demand.

Hospital overcrowding has become the norm. This is evidenced through constant access/bed block, ambulance ramping, high in-patient occupancy and delays to discharge, that all contribute to increased rates of morbidity and mortality.

Hospital overcrowding must be considered a patient safety and quality of care matter, and managed accordingly.

The physical constraints of the Launceston General Hospital and the Royal Hobart Hospital, particularly during its redevelopment, contribute to this challenge.

Historic underfunding of acute health services, particularly in the areas of Admitted Patient Services and Emergency Department Services, need to be addressed to avoid the regular need to 'top-up' health budgets to meet funding shortfalls.

Staff morale across many areas of acute health services is very low, with staff experiencing significant levels of stress.

Tasmanian patients are waiting too long to access necessary elective surgery, waiting beyond nationally agreed guidelines.

Many patients are spending unacceptably long periods of time in the Emergency Departments awaiting medical care and possible subsequent admission. Regular and frequent ambulance ramping is resulting in patients receiving care in areas that are unsafe, inadequately equipped and lack privacy.

Many patients with acute mental illness requiring admission are waiting extended periods of time in the Emergency Departments. This is an inappropriate and non-therapeutic environment for these patients.

This Report contains a summary of evidence provided to the Sub-Committee in 2017, prior to the prorogation of Parliament and subsequent election on 3 March 2018, and the information received since the re-establishment of the Sub-Committee on 12 July this year.

There are many areas of concern across the broader acute health sector and details are contained within this Report. Increased investment in, and attention to, primary health care remains critical to providing improved patient experiences and outcomes as well as to reduce demand on the acute health sector.

The Sub-Committee hoped to prepare a final report but has been unable to do so prior to the end of this Parliamentary year. Information including a copy of the KPMG consultancy report commissioned by the THS, that is important for and relevant to the work of the Sub-Committee, is yet to be provided by the Minister for Health. A final report will be prepared and tabled as soon as possible after this information is received.

The Sub-Committee has determined the production of this further Interim Report is necessary to ensure the Parliament is provided with information that is relevant at the time of publishing.

The Sub-Committee acknowledges the Government's actions in addressing the genuine concerns raised by senior clinicians regarding poor governance across the THS, by bringing in the *Tasmanian Health Service Act 2018* as a priority upon their return to government.

The Sub-Committee strongly recommends the Government consider and respond to the recommendations contained within this report that reflect the large body and quality of evidence received to date.

Hon Rob Valentine MLC
Inquiry Chair
16 November 2018

KEY FINDINGS

The Sub-Committee makes the following key findings:

Term of Reference 1: Current and projected state demand for acute health services

1. Demand for acute health services, including the Emergency Department, is exacerbated by higher levels of acuity, bed/access block (particularly in medical and acute mental health wards) and patients requiring longer hospital stays.

2. All of Tasmania's main hospitals fall below the clinically recommended guidelines for elective surgery and the performance of similar hospitals around the country.

3. Tasmania's demographic status, in particular its high levels of poor health literacy and adverse measures for the social determinants of health, increase demand for acute health services.

4. Patients with disability or acute mental illness are high users of acute physical health care. They are vulnerable and experience higher rates of morbidity and mortality in the health system.

5. Emergency departments are not well equipped to provide high quality care for acutely unwell mental health patients.

6. There is increasing demand for adolescent mental health services.

7. There is a high demand for perinatal mental health assessment and care throughout Tasmania.

8. Bed block in acute mental health care has been exacerbated by a reduction in bed numbers.

9. Workforce development in caring for patients with a disability is needed.

10. Neurological conditions account for one in five Emergency Department hospital admissions.

11. Robust data collection and transparent reporting is needed to fully understand demand trends and growth to accurately inform short and long term planning in all areas of acute health services.

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

1. Ambulance ramping, over-crowded emergency departments, high inpatient occupancy rates and bed/access block, particularly in medical and acute mental health wards, is resulting in delays in access to care, poor patient flow and delays to discharge.

2. Tasmanian acute care hospitals have among the highest rates of access block in the nation with the LGH being the worst performing hospital of 29 large regional hospitals.

3. Acute mental health bed access block is a significant problem for emergency departments around Tasmania.

4. Emergency departments do not provide a therapeutic environment for patients with acute mental illness awaiting admission.

5. An increase in the complexity of individual patients presenting to emergency departments adds to the challenge of meeting NEAT targets and contributes to access block and prolonged length of stay.

6. Tasmanian patients are waiting unacceptably long periods of time for necessary elective surgery.

7. Admitted patients are experiencing delays in discharge while waiting for non-acute care. Pharmacy, pathology, radiology and allied health care are some services not routinely provided outside usual working hours.

8. Good governance and effective leadership in executive management and clinical decision making is essential to manage demand across the Tasmanian Health Service.

9. Repeated reorganisation of acute health services has created ongoing disruption, negatively impacting on staff retention, higher rates of staff stress and turnover, change fatigue, loss of corporate knowledge and inefficient use of scarce financial and human resources.

10. In other jurisdictions efficiency models, such as the LEAN methodology, have resulted in improved performance across a range of measures of service delivery and patient outcomes.

11. Models of care within areas such as emergency departments have modernised and changed over recent years, however medical inpatient models of care have not changed significantly for many years.

12. Collaborative long-term workforce and infrastructure planning for all areas of health service delivery is essential, including a 'whole of hospital' approach to address overcrowding.

13. Chronic hospital overcrowding is causing health care professionals to experience significant workplace stress.

14. Senior staff have felt they have not been listened to by the Minister and senior bureaucrats, have not been adequately supported and have felt unable to propose initiatives and solutions to address local issues and to manage demand.

15. Underinvestment in the health workforce is resulting in the higher use of locum medical staff, agency nursing staff and high levels of overtime.

16. The loss and threatened loss of specialist accreditation at major Tasmanian hospitals is having a detrimental impact on recruitment and retention of specialist medical staff, and the quality of service delivery.

17. Nurse Practitioners play an important role in acute health care.

18. Investment in primary health is needed to reduce demand for acute health services.

19. Infrastructure constraints in major hospitals, particularly the RHH during the period of re-construction, inadequate bed numbers and specialist staff availability are negatively impacting on the delivery of acute health services.

20. Concern remains regarding the design and capacity of the new acute mental health unit in K Block of the RHH redevelopment.

21. Following the release of the Sub-Committee's first Interim Report, the Government has identified alternate models of care aimed at addressing mental health access block to provide greater access to acute mental health care.

Term of Reference 3: The adequacy and efficacy of current state and commonwealth funding arrangements

1. Current funding arrangements for acute, primary and mental health care, remain fragmented and duplicative, creating a barrier to improving system efficiency, simplicity and the achievement of patient-centred healthcare.

2. Chronic under funding of health through the annual budget appropriation is evident from the Department of Health and Human Services Annual Reports and annual budget papers.

3. The health budget has been 'topped up' each year by way of Supplementary Appropriation and/or Requests for Additional Funding (RAF's) to meet the budget shortfall.

4. The Tasmanian Government has historically spent less per capita on health than the national average until the 2015-16 financial year.

5. Since 2015-16, the Tasmanian Government spent in excess of the national average per capita on health.

6. Tasmania currently spends less per capita on health than Western Australia, Queensland and Northern Territory.

7. Commonwealth underfunding is negatively impacting on the resourcing of mental health and primary/preventative health care.

8. Adequate funding of primary/preventative health care remains crucial to reducing demand on acute health care facilities.

Term of Reference 4: The level of engagement with the private sector in the delivery of acute heath services

1. Australia provides a universal access approach to acute health care and is the provider of first and last resort.

2. Collaboration and cooperation between the State public hospital system and the private sector occurs on a limited basis. Strategic collaboration could assist in managing demand within public acute health care.

3. Improvements to cross-sector collaboration between the private mental health workforce and public mental health services could reduce the burden and increase the capacity in public acute mental health services.

Term of Reference 5: The impact, extent of and factors contributing to adverse patient outcomes in the delivery of acute health services

1. Access block and hospital overcrowding is a patient safety issue. More effective strategies are needed to address safety and quality of services.

2. Ambulance ramping and access block impacting on Emergency Departments is resulting in avoidable adverse patient outcomes and an increased risk of unexpected death.

3. Ambulance ramping is reducing capacity to provide timely emergency ambulance services within the community, risking further adverse patient outcomes.

4. Ambulance ramping has resulted in patients receiving treatment in areas of the hospitals that are inappropriate and inadequately resourced, compromising patient safety and privacy.

5. A Grattan Institute report shows avoidable mortality rates in Tasmania are increasing and Tasmania is the only jurisdiction where this is the case.

6. Research has shown an association between hospital overcrowding and Emergency Department access block and increased patient mortality.

7. An ageing demographic and increase in patient complexity and multi-morbidities have added to the risk of hospital overcrowding and adverse patient outcomes.

8. Poor bed capacity planning, particularly at the RHH and LGH, has contributed to access block and hospital overcrowding, increasing the risk to patient safety.

9. Emergency Departments are not appropriate or suitable for the care of acutely unwell mental health patients, many of whom are experiencing excessively long waiting times to be admitted.

10. Despite the intention to reduce restrictive practices through the *Mental Health Act 2013,* more Tasmanian mental health patients continue to be subject to restrictive practices.

11. An inquest held in 2015 into the deaths by suicide of six teenagers, identified a serious lack of acute mental health services for adolescents.

12. A Coroner's report described a direct link between access block to acute mental health beds and the death of a patient.

13. A paucity of community based adolescent mental health services, particularly in the North and North West, is increasing the risk of adverse outcomes for young people with mental health challenges.

14. A lack of comprehensive community-based mental health services is impacting negatively on patient care, recruitment and retention of psychiatrists and admission to acute mental health wards.

15. The loss of specialist accreditation in Tasmanian hospitals is negatively impacting training, recruitment and retention of specialist medical staff.

16. Safer Care Victoria is a newly established healthcare quality and safety improvement agency that may provide solutions to healthcare quality and safety issues facing Tasmania's health service.

17. The cost of complications that occur within the public hospital system across Australia is significant.

18. Patient outcomes can be improved through greater access to adequately resourced tele-medicine for a range of conditions, particularly acute stroke care in the North West.

19. State-wide co-ordination and planning may benefit patients with a range of illnesses including cardio-vascular and neurological disease.

20. Concerns raised in the first Interim Report regarding the fragmented nature of the North West Integrated Maternity Service remain. A review of the service commissioned in 2017 is yet to be reported on.

21. Morale among midwives in the North West Integrated Maternity Service is low as the current operational model negatively impacts on their ability to work across their full scope of practice.

Term of Reference 6: Any other matters incidental thereto

1. The Office of the Health Complaints Commissioner Tasmania (OHCCT) is under resourced.

2. The OHCCT has experienced a reduction in staffing since 2007, an increase in workload and an ongoing backlog of health complaints.

3. The recent increase to the workload of the OHHCT resulting from the passage of *the Health Complaints Amendment (Code of Conduct) Act 2018* has not been supported with additional resourcing.

4. The OHCCT will need at least two additional FTE staff to undertake the statutory role of the Office.

5. There is no one point of contact for patients wishing to make a complaint regarding access to or receipt of a health care service.

6. Greater collaboration between the Tasmanian Health Service and health academic centres, including UTAS and medical research centres in the state, could assist with attraction and retention of specialist medical staff.

RECOMMENDATIONS

The Sub-Committee recommends:

1. Hospital overcrowding and access block be recognised and treated as a patient safety issue.

2. The Government investigate efficiency models used in other jurisdictions (e.g. a LEAN methodology, Safer Care Victoria) which have resulted in improvements to timely access to acute health care, elective surgery, improved patient flow and a reduction in adverse patient outcomes.

    2.1 The Government engage the expertise required to consider, assess and implement an appropriate efficiency model to address these challenges and patient safety.

3. The Government continue to engage with key representative groups to:

    3.1 Fully understand workforce planning and development needs;

    3.2 Identify opportunities to better utilise nurse practitioners and medical staff such as rural generalists;

    3.3 Ensure effective administrative and clinical governance models are implemented and maintained;

    3.4 Identify service delivery and care models that will improve employee engagement and morale; and

    3.5 Improve patient experience, safety and outcomes.

4. The underlying budget shortfall be addressed to avoid the need for significant funding top-ups.

5. The Government continue to lobby the Australian Government for greater investment in all areas of preventative health.

6. The Government continue to work with the Australian Government to ensure there is adequate investment in mental health services within the community, in step-up and step-down facilities and in acute mental health services.

7. The Government continue to critically review mental health patient access and care models for patients requiring acute mental health care.

8. The Government adequately resource the Office of the Health Complaints Commissioner.

ABBREVIATIONS

ACEM	Australasian College of Emergency Medicine
AHPRA	Australian Health Practitioners Regulation Agency
AIHW	Australian Institute of Health and Welfare
ANMF	Australian Nursing and Midwifery Federation
AMA	Australian Medical Association
AMC	Academic Medical Centre
AT	Ambulance Tasmania
BIAT	Brain Injury Association of Tasmania
BN	Bachelor of Nursing
CAMHS	Child and Adolescent Mental Health Services
CAT	Crisis Assessment Team
CEO	Chief Executive Officer
CENA	College of Emergency Nursing
CGC	Commonwealth Grants Commission
CIN	Clinical Initiatives Nurse
CQ	Central Queensland
CQHHS	Central Queensland Hospital and Health Service
DHHS	Department of Health and Human Services
EAP	Employee Assistance Program
ECR	Endovascular Clot Retrieval
ED	Emergency Department
EIRS	Early Intervention Referral Service
FACEM	Fellow of the Australasian College of Emergency Medicine

GP	General Practitioner
HACSU	Health and Community Services Union
HITH	Hospital in the Home
HRC	Healthcare Reform Consulting
HSI	Health Service Innovations Unit
ICU	Intensive Care Unit
LGH	Launceston General Hospital
LOS	Length of Stay
MCH	Mersey Community Hospital
MHCT	Mental Health Council of Tasmania
MSA	Medical Staff Association
NAT	Neurological Alliance of Tasmania
NEAT	National Emergency Access Targets
NGO	Non-Government Organisations
NUM	Nurse Unit Manager
NWIMS	North-West Integrated Maternity Service
NWRH	North West Regional Hospital
NWPH	North West Private Hospital
OHCCT	Office of the Health Complaints Commission Tasmania
PEN	Psychiatric Emergency Nurse
PICAHMS	Perinatal, Infant, Child and Adolescent Mental Health Services
PICU	Psychiatric Intensive Care Unit
PIMHS	Perinatal and Infant Mental Health Services
QVMU	Queen Victoria Maternity Unit

RACS	Royal Australasian College of Surgeons
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RDAT	Rural Doctors Association of Tasmania
RHH	Royal Hobart Hospital
RPH	Royal Perth Hospital
SCV	Safer Care Victoria
TCCN	Tasmanian Cardiac Clinical Network
THO	Tasmanian Health Organisation
THS	Tasmanian Health Service
UTAS	University of Tasmania
VMO	Visiting Medical Officer

INTRODUCTION

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

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

An 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 Sub-Committee invited all witnesses to provide updates to their previous submissions, and called for new submissions in Tasmania's three daily newspapers. An additional five days of public hearings were held in Hobart on 14, 21, and 28 September and on 22 and 24 October 2018. Nine individuals or organisations gave evidence to the Sub-Committee at these hearings.

This Report provides a summary of the evidence received to date and includes consideration of the written submissions and the verbal evidence provided during the public hearings.

The Sub-Committee's first Interim Report should be read in conjunction with this Report. The Government has responded to the Interim Report, and this response is attached as Appendix A.

The Sub-Committee acknowledges the time and effort concerned individuals and organisations throughout the community have expended in preparing their submissions and providing verbal evidence. This has served to highlight the significant problems and issues Tasmanians are experiencing in seeking to access acute health services. These personal accounts helped to focus the work of the Sub-Committee.

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

The Sub-Committee acknowledges and thanks all who provided submissions and attended hearings, the Parliamentary Research Service and Parliamentary Staff.

TERM OF REFERENCE 1

CURRENT AND PROJECTED STATE DEMAND FOR ACUTE HEALTH SERVICES

Tasmania has significant challenges addressing current and projected demand for acute health services.

According to the Australian Medical Association (AMA) submission:

> *Of the Australian states, Tasmania has the oldest, sickest and poorest population with poorer health literacy and adverse metrics for social determinant (sic) of health.*
>
> *Notwithstanding the successful implementation of future community based preventative health strategies, the demand on both primary health services in the community and acute public hospitals will remain above national average and continue to rise over the coming decade. The impact on acute hospital demand arising from entrenched socioeconomic and health literacy disadvantage in the outer suburbs of Hobart and Launceston has to date received scant attention in hospital demand planning. This is particularly relevant when considering these areas are the key drivers of acute and emergency services, often relating to demand arising from vulnerable patient groups such as the frail elderly.*
>
> *The relatively small and decentralised nature of Tasmania's population requires careful planning of acute and subacute public hospital services. Development of staff expertise and physical infrastructure based on sustainable, accessible and rationale models of care delivered through centres of hospital excellence is recommended to ensure the Tasmanian population has timely and affordable access to health care. Clear and enforced role delineation for each of Tasmania's public hospitals is essential to prevent unsustainable replication of complex services across geographic sites, [and] inefficient replication that occurs at the expense of the funding required to develop and sustain primary and secondary healthcare services that are needed at multiple sites state-wide.*
>
> *It must be highlighted that acute health services do not exist solely in the hospitals. The vast majority of medical care is delivered by General Practice in the community. The lack of sustainable funding for General Practice has flow on effects for the hospitals. The lack of timely patient access to Specialists and many Specialties in the outpatient setting of our public*

hospitals leaves General Practice to cope until the enviable (sic) crisis arises and requires an acute hospital admission. There is much to gain by Hospitals from investment and integration with General Practice.[1]

Forecasting Demand

According to the Tasmanian Government submission, the factors traditionally regarded as the best predictors of future activity are:

- *Historical trends in activity;*
- *Changes in population (including changes in age structure); and*
- *Changes in technologies and treatments available across the health system.*

However, more recently, demand for acute services has been increasing at a faster rate than these factors would suggest…. It is likely that increased demand for acute services is due to a range of other factors, including:

- *Increased demand for services from patients with multiple morbidities;*
- *The public responding to promotion and social marketing that constantly reinforces the availability of free high quality health care;*
- *Availability or accessibility of General Practitioner services in some areas and/or a lack of General Practitioner services outside regular business hours;*
- *Local and structural challenges in establishing or scaling up home and community based services able to provide more intensive levels of medical, nursing and rehabilitation support to patients which can avoid admission to hospital; and*
- *The increasing out of pocket cost of primary care, resulting in demand shifting to the acute sector*.[2]

Based on historical trends and likely demographic changes, DHHS estimates that demand for admitted and non-admitted services will grow at around three percent per annum over the coming years. This pattern of constant linear growth in demand for acute services is the same as that seen nationally. While the Tasmanian Government will continue to invest in the health system to meet this rising demand, slowing the rate of demand growth is vital to enabling the health system to remain sustainable in the long term and to improve the welfare of Tasmanians.[3]

[1] Australian Medical Association, 2017, *Submission #8* , p. 1.
[2] Tasmanian Government, 2017, *Submission #32*, p. 7.
[3] Ibid. p. 8.

According to Mr Mervin Reed, Chartered Financial Adviser, population growth in Tasmania is non-existent, but the composition of the population by age has undergone change:

> *We like most Western and indeed Asian countries have become older generally, and now Tasmania has the highest by capita component of older Australians per head of population that (sic) anywhere else in Australia.*
>
> *The demand for hospital services is driven largely by this fact.* [4]

Mr Reed claimed the acute medical service demand in Tasmania will increase by 20% over the next 5 years:

> *This increased demand of around 20% over the next 5 years will impact upon the hospitals with increasingly chronic acute presentations, and mean that there will be no elective surgery performed in the two major hospitals being the LGH and the RHH at all, if resources are not increased.*
>
> *In essence the resources needed are some 200 medical surgical beds activated and funded and staffed between the RHH and the LGH. The projected day surgery centre at the MGH[5] (sic) is again achieving some gains with lower level procedures, but the costs may exceed such service costs if they were purchased directly from the private sector.*[6]

The Australian Nursing and Midwifery Federation (ANMF) submission referred to the Tasmanian State of Public Health Report, released in 2013 by the then Population Health Services, and provided insight into the state of Tasmania's health needs*:*

> *The report indicated that, in 2013, Tasmania's health system was not in crisis but clearly warned that demand for treatment and care for chronic conditions would continue to increase fuelled by relatively poor risk factor profiles in Tasmania as well as an ageing population. In 2016 Public Health Services conducted a follow up population health survey that clearly supported the 2013 predictions. Key factors from that survey showed a substantive increase in chronic conditions, particularly diabetes, eye diseases, depression/anxiety and an aging population.*
>
> *The 2016 survey found that, overall, Tasmanians felt more stressed and less healthy in 2016 compared to previous years, with significantly more Tasmanians reporting financial hardship and food insecurity. Socio-economic disadvantage was found to significantly contribute to poor self-*

[4] Mr Mervin Reed, 2017, *Submission #33*, p. 4.
[5] Mersey Community Hospital
[6] Mr Mervin Reed, 2017, *Submission #33*, p. 5.

assessed health, poor dental health, and low health literacy. The proportion of adults with fair or poor health continued to increase and there were more Tasmanians reporting elevated levels of psychological distress in 2016 than in 2009.

Despite a clear, ongoing increasing demand for health services the Tasmanian acute care system has been shrinking relative to demand. The most recent Australian Hospital data statistics indicate that the average available beds in Tasmania's public hospitals increased by as few as 0.8% between 2013–14 and 2014–15 periods. During 2015-2016 Tasmania had on average fewer available hospital beds than other hospitals in Australia. In 2017 bed numbers have begun to fall. Tasmania is now experiencing a crisis in its health system as the previously predicted public health statistics catch up with a heavily underperforming acute health system. [7]

In the Ministerial Statement on Health, dated 16 October 2018, the Minister for Health stated:

It is no secret that demand for acute health services has been growing at a significant rate. Our staff are doing a remarkable job under what at times can be significant pressure. Hospitals all over the country are facing similar challenges in meeting demand that is outstripping the capacity. Indicative of this growth in sheer numbers of patients that now need to be seen during a demand peak.

As the Premier noted two weeks ago, twelve years ago the Royal Hobart Hospital Emergency Department treated, on average, 108 patients per day. In 2018, we now need a hospital that can treat up to 220 patients a day. Between 2016 and now, annual demand on our ED Departments has risen by more than 7,000 patients. But it is not only the number of patients that has grown.

The complexity of patients that our hospitals are seeing has increased, meaning that we have more patients coming through the front door - more patients, needing longer stays and a higher level of care.

In 2017-18, there has been 15 per cent growth in Emergency Department presentations that converted to admissions, and six per cent growth in emergency surgery. This is a significant jump - putting pressure on patient flow and bed turnover.

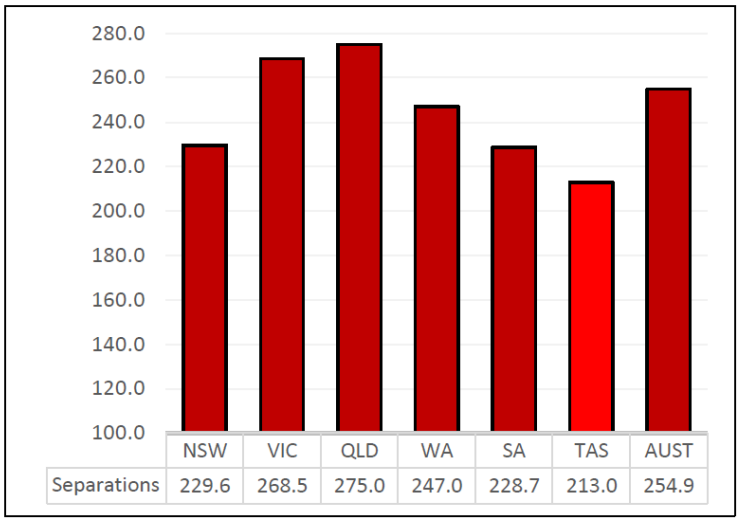
At all of our four major hospitals, but at the Royal Hobart in particular, we are finding more and more that we are attempting to meet today's demand

[7] Australian Nursing and Midwifery Federation, 2017, *Submission #30*, pp. 4-5.

in yesterday's hospital buildings. Last year due to increasing demand from an unprecedented winter flu season we flexed up, recruited more staff and invested an additional $63 million into the system.[8]

Mr Martyn Goddard, Health Policy Analyst, in the addendum to his 2017 submission, claimed that the Tasmanian Health Service was least able to cope with the pressures of the demand being placed on it.[9] Mr Goddard provided the following data which demonstrates the inadequacy of Tasmanian public hospital care:[10]

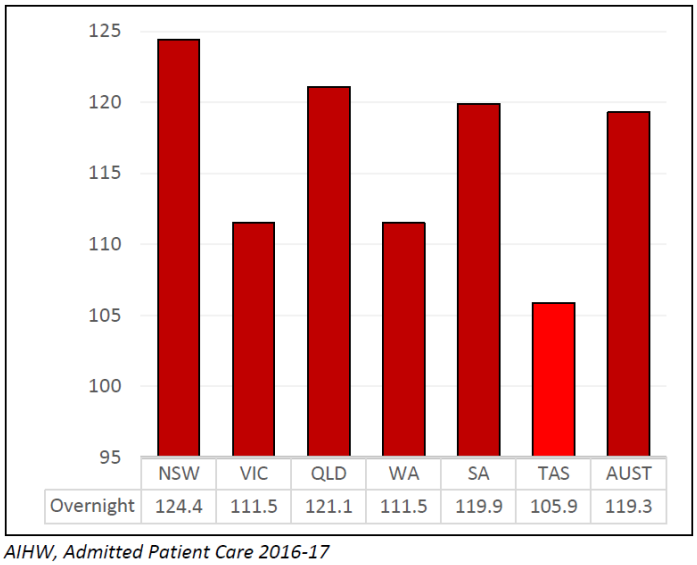
Separations per 1,000 population, public hospitals, 2016-17



	NSW	VIC	QLD	WA	SA	TAS	AUST
Separations	229.6	268.5	275.0	247.0	228.7	213.0	254.9

AIHW, Admitted Patient Care 2016-17

Overnight separations per 1,000 population, public hospitals 2016-17

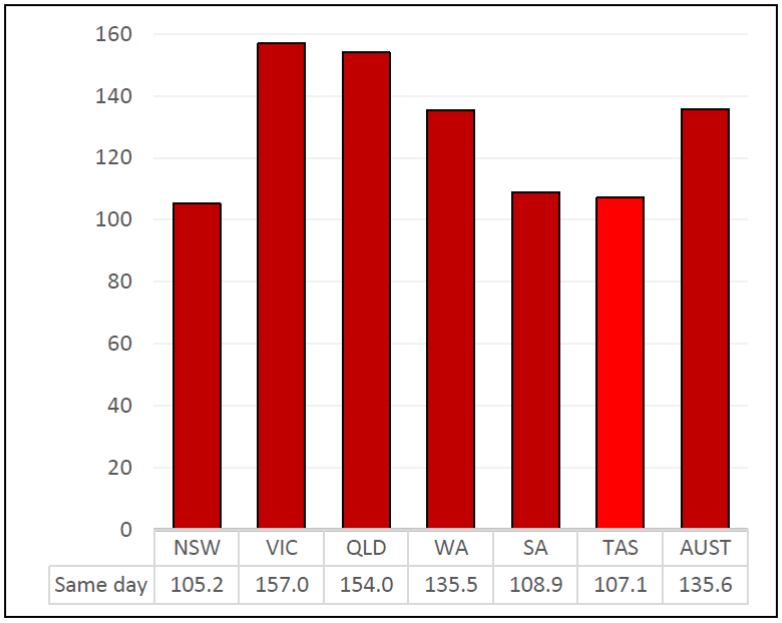


	NSW	VIC	QLD	WA	SA	TAS	AUST
Overnight	124.4	111.5	121.1	111.5	119.9	105.9	119.3

AIHW, Admitted Patient Care 2016-17

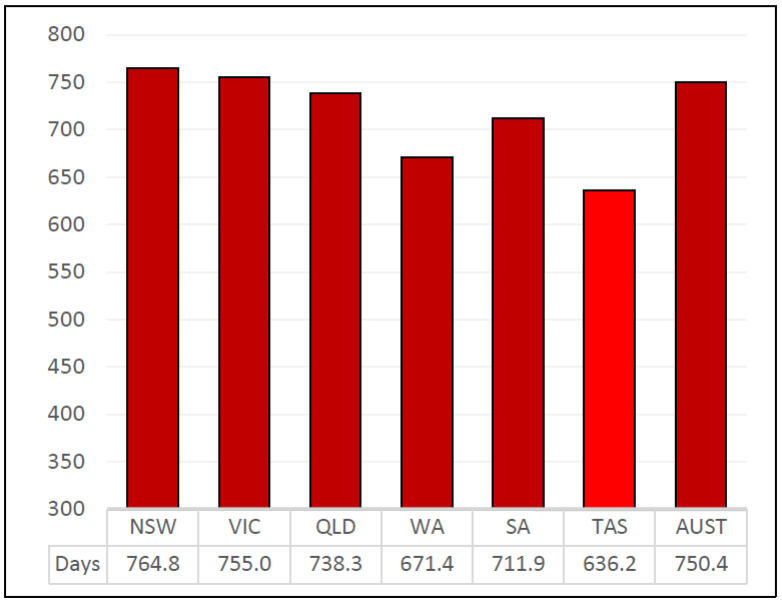
[8] Michael Ferguson, Minister for Health, Ministerial Statement on Health, 16 October 2018, http://www.premier.tas.gov.au/releases/ministerial_statement_on_health
[9] Mr Martyn Goddard, Addendum (2018) to *Submission*, 2017, p. 21.
[10] Ibid, pp. 21-23.

Same-day separations per 1,000 population, public hospitals, 2016-17[8]



AIHW, Admitted Patient Care 2016-17

Patient days per 1,000 population, public hospitals, 2016-17[8]



AIHW, Admitted Patient Care 2016-17

Elective Surgery

The Minister in his 2018 submission claimed a significant improvement had been made regarding elective surgery waiting times:[11]

[11] Tasmanian Government, 2018, *Submission #8*, p. 13.

Figure 1: Elective Surgery Waiting List Improvements[12]

	June 14	June 17	Chg	% Chg
Total Waiting List	8528	5453	-3075	-36%
Over boundary	3658	810	-2848	-78%
Longest Waiting patient	3700	520	-3180	-86%
Average overdue days - all	253	69	-184	-73%
Average overdue days - category 3	491	39	-452	-92%
Total volume of surgeries over 12 months	15376	19135	3759	24%

Source: DHHS Data.

The Department of Health and Human Services HealthStats website provides the following information regarding elective surgery over the last 12 month period indicating significant growth in the number of patients on the waiting list and a fall in the percentage of patients being seen within time:

Figure 2: Number of patients on waiting list/statewide[13]

The number of patients on the elective surgery waiting list who are waiting for a surgical procedure.

Month	All Categories	Category 1	Category 2	Category 3
	No.	No.	No.	No.
Jul 17	5 403	508	1 915	2 980
Aug 17	5 712	543	2 059	3 110
Sep 17	5 934	557	2 115	3 262
Oct 17	6 026	533	2 131	3 362
Nov 17	6 189	526	2 203	3 460
Dec 17	6 366	459	2 324	3 583
Jan 18	6 718	505	2 481	3 732
Feb 18	6 857	506	2 529	3 822
Mar 18	7 087	526	2 658	3 903
Apr 18	7 311	549	2 798	3 964
May 18	7 604	537	2 918	4 149
Jun 18	7 933	574	3 008	4 351

Category 1 - Urgent: patients should be treated within 30 days.

Category 2 - Semi-urgent: patients should be treated within 90 days.

Category 3 - Non-urgent: patients should be treated within 365 days.

About the measure: A person may be included on the waiting list more than once. This occurs when a person is waiting for more than one service included on the waiting list. Each wait is counted as a separate patient.

[12] Tasmanian Government, 2018, *Submission #8*, p. 13.
[13] https://www.healthstats.dhhs.tas.gov.au/healthsystem (accessed 12 November 2018)

Figure 3: Elective Surgery – seen within time[14]

Month	All Categories	Category 1	Category 2	Category 3
	%	%	%	%
Jul 17	76	78	63	93
Aug 17	77	82	64	90
Sep 17	73	75	61	90
Oct 17	72	72	64	86
Nov 17	74	79	62	88
Dec 17	77	77	71	86
Jan 18	72	71	67	87
Feb 18	71	73	59	89
Mar 18	71	77	55	87
Apr 18	69	71	60	80
May 18	70	73	60	78
Jun 18	70	78	52	87

Category 1 - Urgent: patients should be treated within 30 days.

Category 2 - Semi urgent: patients should be treated within 90 days.

Category 3 - Non-urgent: patients should be treated within 365 days.

About the data: Data may vary from that previously published due to data reporting practices.

Figure 4: Elective Surgery – Number of Admissions Statewide[15]

The number of patients who were admitted for surgery from the elective surgery waiting list.

Month	All Categories	Category 1	Category 2	Category 3
	No.	No.	No.	No.
Jul 17	1 637	632	609	396
Aug 17	1 729	664	658	407
Sep 17	1 520	651	543	326
Oct 17	1 564	622	612	330
Nov 17	1 683	636	684	363
Dec 17	1 200	546	416	238
Jan 18	1 174	508	469	197
Feb 18	1 462	564	565	333
Mar 18	1 527	623	573	331
Apr 18	1 258	514	447	297
May 18	1 555	678	546	331
Jun 18	1 269	545	484	240

Category 1 - Urgent: patients should be treated within 30 days.

Category 2 - Semi urgent: patients should be treated within 90 days.

Category 3 - Non-urgent: patients should be treated within 365 days.

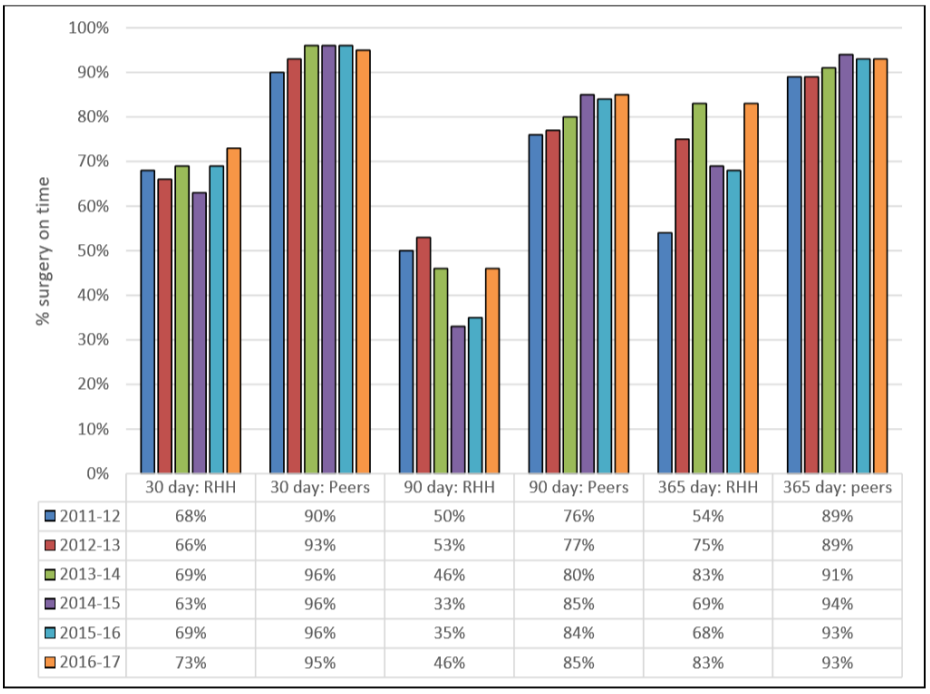
About the data: Data may vary from that previously published due to data reporting practices.

[14] https://www.healthstats.dhhs.tas.gov.au/healthsystem (accessed 12 November 2018)
[15] https://www.healthstats.dhhs.tas.gov.au/healthsystem (accessed 12 November 2018).

According to Martyn Goddard:

> *Elective surgery is defined as any procedure which can be delayed by at least 24 hours. It does not mean that the surgery is optional: elective procedures include correction to life-threatening cardiac conditions, hip replacements, colonoscopies to detect bowel cancer and cataract operations. None of these can be described as optional but if all cannot be done at once, some can wait. But there are limits to the time patients should be made to wait: most are enduring significant discomfort, pain or disability. Many, if delayed for too long, will see their condition worsening, sometimes progressing from elective to emergency.*
>
> *Although the national averages for each of the hospital peer groups vary, all of this state's four main hospitals fall below either (sic) the clinically recommended guidelines and the performance of similar hospitals around the country. The following charts show … the gap between each of those four hospitals and comparable institutions elsewhere over a five-year period.*[16]

Percentages of elective surgery delivered on time: Royal Hobart Hospital and major hospital national peer group, 2011-12 to 2016-17

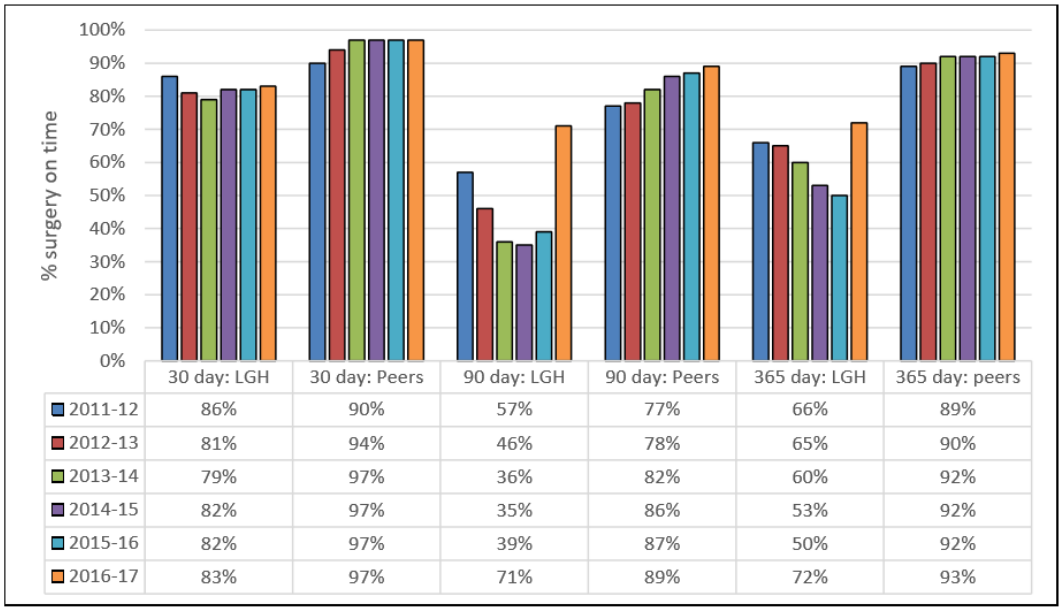


	30 day: RHH	30 day: Peers	90 day: RHH	90 day: Peers	365 day: RHH	365 day: peers
2011-12	68%	90%	50%	76%	54%	89%
2012-13	66%	93%	53%	77%	75%	89%
2013-14	69%	96%	46%	80%	83%	91%
2014-15	63%	96%	33%	85%	69%	94%
2015-16	69%	96%	35%	84%	68%	93%
2016-17	73%	95%	46%	85%	83%	93%

Source: AIHW, myhospitals.gov.au, Elective surgery data.

[16] Mr Martyn Goddard, 2018, Addendum to 2017 Submission #10, p. 34.

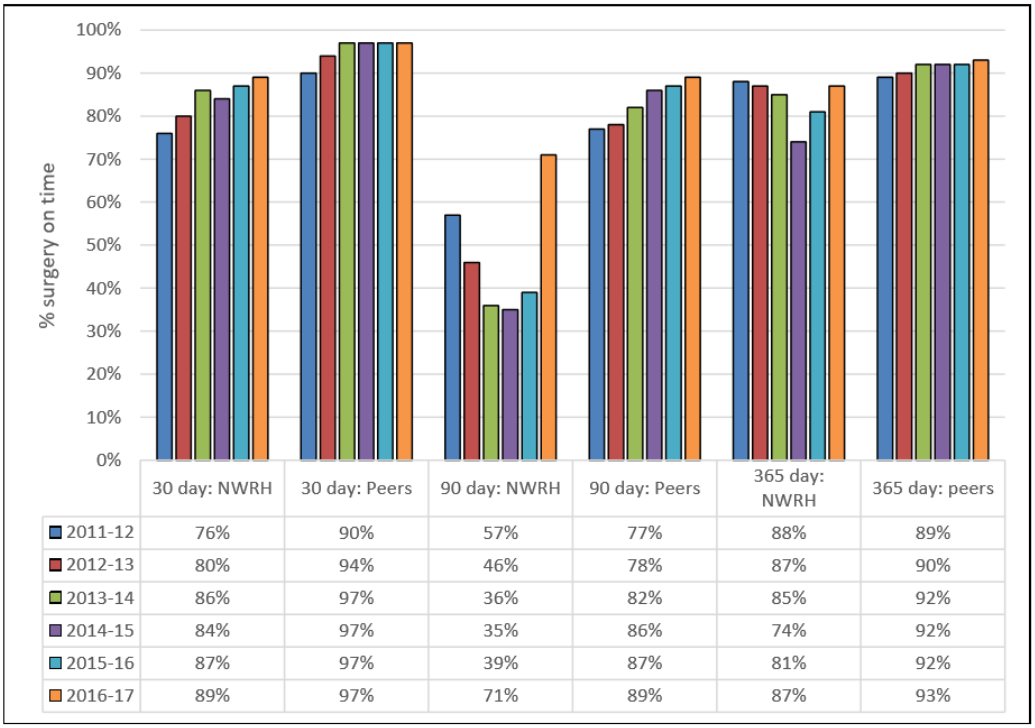
Percentages of elective surgery delivered on time: Launceston General Hospital and large regional hospital national peer group, 2011-12 to 2016-17



	30 day: LGH	30 day: Peers	90 day: LGH	90 day: Peers	365 day: LGH	365 day: peers
2011-12	86%	90%	57%	77%	66%	89%
2012-13	81%	94%	46%	78%	65%	90%
2013-14	79%	97%	36%	82%	60%	92%
2014-15	82%	97%	35%	86%	53%	92%
2015-16	82%	97%	39%	87%	50%	92%
2016-17	83%	97%	71%	89%	72%	93%

Source: AIHW, myhospitals.gov.au, Elective surgery data.

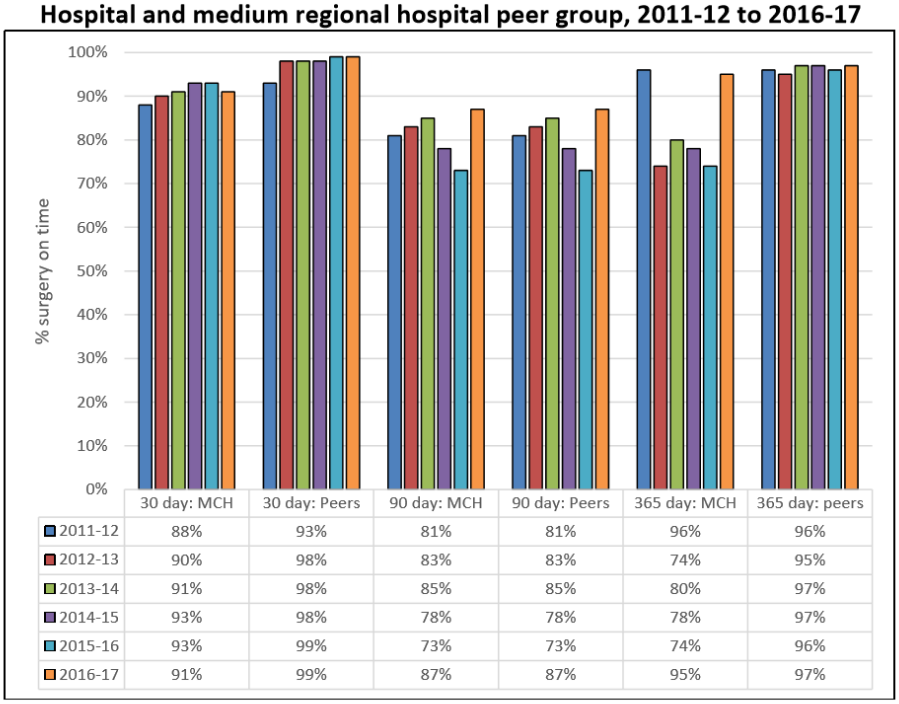
Percentages of elective surgery delivered on time: North-West Regional Hospital and large regional hospital national peers, 2011-12 to 2016-17



	30 day: NWRH	30 day: Peers	90 day: NWRH	90 day: Peers	365 day: NWRH	365 day: peers
2011-12	76%	90%	57%	77%	88%	89%
2012-13	80%	94%	46%	78%	87%	90%
2013-14	86%	97%	36%	82%	85%	92%
2014-15	84%	97%	35%	86%	74%	92%
2015-16	87%	97%	39%	87%	81%	92%
2016-17	89%	97%	71%	89%	87%	93%

Source: AIHW, myhospitals.gov.au, Elective surgery data.

Percentages of elective surgery delivered on time: Mersey Community Hospital and medium regional hospital peer group, 2011-12 to 2016-17



	30 day: MCH	30 day: Peers	90 day: MCH	90 day: Peers	365 day: MCH	365 day: peers
2011-12	88%	93%	81%	81%	96%	96%
2012-13	90%	98%	83%	83%	74%	95%
2013-14	91%	98%	85%	85%	80%	97%
2014-15	93%	98%	78%	78%	78%	97%
2015-16	93%	99%	73%	73%	74%	96%
2016-17	91%	99%	87%	87%	95%	97%

Source: AIHW, myhospitals.gov.au, Elective surgery data.

Demand vs Efficiency

According to the Australasian College of Emergency Medicine (ACEM), consideration should be given not only to the increasing demand for health services, but the efficient utilisation of resources:

> *However, increasing demand for services is not being matched with the increasing supply of services and resources necessary to improve patient outcomes. But it is not just about the increase in supplying resources. It is also about using what resources Tasmanian Health [Service] has better. There is great expertise in your emergency departments, which [is] being under-utilised, not through lack of desire of those skilled clinicians, but by a system and a working environment which is significantly hampered by bed block or the inability to get admitted patients out of the ED wards for ongoing care and subsequent emergency department overcrowding.*
>
> *The dedicated staff who work in EDs are unable to do their job to the best of their abilities due to the dysfunction of many other parts of the hospital system and the failure to recognise where real solutions lie. The situation endangers lives and significantly impacts the sustainability of healthcare workers' careers.*[17]

[17] Dr Simon Judkins, *Transcript of Evidence*, 8 September 2017, p. 12.

…

Putting more beds in is great and recognising investment in infrastructure is a significant investment, but unless you have the systems in place to keep patients moving through to the next point of care, then those beds - you are just going to end up with a bigger car park for a lot more people in line. It really is about engaging people at all levels of the hospital to understand that it might be one extra day for one patient somewhere, or another extra day for another patient there, but all those extra days then build up to decrease the capacity of the system, and then patients wait for the next point of care.[18]

The submission (2018) provided by Minister Ferguson noted the system challenges at the LGH and RHH:

It is no secret that the Tasmanian health system is experiencing a high rate of growth in emergency activity and patient acuity. Indicative of this situation is that over the last financial year there was 15 per cent growth in Emergency Department presentations which converted to admissions, and six per cent growth in emergency surgery. These figures are inclusive of the significant impact resulting from the extraordinary winter flu season during 2017. [19]

Dr Simon Judkins noted that Dr Kate Brockman, Healthcare Reform Consulting (HRC), supported this argument, stating:

She said one of the things she has done with her work is she recognises in any hospital at any time in Australia probably 30 per cent of the capacity is being used by people who do not need to be in hospital, possibly because they are waiting to go somewhere or home or it is a Sunday and there is no ward round.

When I say investments, there needs to be investment in the way we run the hospitals better. There is a whole lot of capacity in the hospital system not being used to its maximum efficiency. There will always be a patient in a bed somewhere who probably does not need to be there.

When you have up to 30 per cent of patients who actually could be in rehab or at home, you have waste of capacity. We can create a lot of capacity by investing in making the inpatient areas, in particular, more effective and

[18] Dr Simon Judkins, *Transcript of Evidence*, 8 September 2017, p. 14.
[19] Minister for Health, 2018, *Submission #8*, p. 3.

efficient. Like doing daily ward rounds, for example. A lot of hospitals only have ward rounds three or four times a week.[20]

When asked during a public hearing whether the Minister for Health and Secretary of DHHS had engaged consultants with experience in patient flow issues and problems, Mr Pervan, Secretary DHHS, responded:

Yes, we have. In fact Kate Brockman has been a visitor to our island many times. The work HSI Tasmania was put in place to do was to support the hospitals doing that analysis and redesign work. There is a lot of it done. One of the challenges is that work requires full engagement of frontline staff - that is the model you use - and a lot of detailed analysis, and while that has been done, it is not moving as fast as the increasing demand coming through the front door.[21]

Demand for Mental Health Services

Dr Richard Benjamin, association representative of the AMA (Tasmania) provided information related to the provision of acute psychiatric beds:

The AMA holds that with respect to acute adult psychiatric beds, this position is out of step with the rest of Australia and with the OECD in general. OECD figures from 2013 reveal the average number of total psychiatric beds across member countries is 68 per 100 000. Australia has only 39 beds per 100 000. Germany has 121, France 89 and the UK 54.

Australian Institute of Health and Welfare figures for 2014-15 demonstrated that the national average of acute psychiatric beds in Australia, beds in general public hospitals like the Royal, sat at 24.2 per 100 000. Before the redevelopment, the Royal had 42 such acute psychiatric beds, or approximately 27 beds per 100 000. The government looked at bed utilisation figures within the Royal over a three-year period, from July 2011 to July 2014, and demonstrated what they referred to in documents as a slight downward trend with respect to occupancy. The government used these statistics to justify cutting 12 beds. Various lobby groups, including the AMA, repeatedly petitioned the government to reverse these planned bed cuts, concerned about eventual bed blocks, but these efforts were largely unsuccessful. The current temporary acute psychiatric unit in the demountable facility only has 32 beds, and K block, the more interim facility, has 33 beds.

[20] Dr Simon Judkins, *Transcript of Evidence*, 8 September 2017, p. 21.
[21] Mr Michael Pervan, *Transcript of Evidence*, 22 October 2018, p. 8.

The government cut the acute psychiatric bed stock gradually over several years, starting in 2013, so that by the time that B block in the old psychiatric wards were demolished and the move was made to the new temporary demountable unit in late 2016, the total number of acute psychiatric beds available at the Royal was only 32. This number of beds equates to only 20.4 beds per 100 000, almost four beds per 100 000 under the national average. Bed block began to occur as beds were cut and by early 2017, the new unit was essentially permanently bed-blocked, as the AMA and other lobby groups had predicted. [22]

The Mental Health Council's submission expressed concern regarding the capacity of Tasmania's acute health services to respond to current levels of demand, particularly in relation to mental health services and the availability of acute psychiatric beds within public hospital settings:

While MHCT is not privy to public hospital admission data, we are advised anecdotally by sources within the Tasmanian Health Service (THS) that since February 2017 emergency departments in all regions of the state have experienced an unprecedented increase in mental health presentations. This increase appears to go beyond the existing upward trend of mental health-related emergency department presentations in Tasmania which had been sitting on a steady increase of 5% per year. Additionally, we understand that the reported escalation of mental health presentations has been accompanied by an increased need for onward admission into inpatient psychiatric beds.

MHCT is firmly of the opinion that solutions must be implemented in each region as a matter of urgency to enable Tasmanian emergency and inpatient units to respond appropriately to patient need. However, we are at pains to emphasise that it is not yet known whether the recent increase in mental health presentations and admissions represents a spike in demand, peak demand within a trend, or ongoing exponential growth.

Until this data becomes available we urge the Tasmanian Government and other key stakeholders to exercise caution in relation to the creation of additional acute care infrastructure that may be unnecessary or inefficient in the longer term. We make this plea based on the body of national and international evidence— borne out time and again by the lived experience of consumers and their families—indicating that an effective mental health system provides acute hospital-based care for those who need it in conjunction with a full range of sub-acute and psychosocial stepped supports delivered in non-hospital settings.

[22] Dr Richard Benjamin, *Transcript of Evidence*, 10 November 2017 p.28.

> *The Tasmanian Government acknowledged this evidence in their 10-year mental health strategy, Rethink Mental Health – Better Mental Health and Wellbeing: A Long-Term Plan for Mental Health in Tasmania 2015-2025, naming up 'shifting the focus from hospital based care to support in the community' as one of ten key directions within the document.*[23]

According to the Perinatal and Infant Child and Adolescent Mental Health Services (PICAMHS) submission, there is a high level of demand for mental health clinicians and mental health beds:

> *This increasing demand is reflected in activity data for inpatient admissions and Emergency Department presentations for under 18 year olds with a mental illness.*[24]

And further…

> *Activity data reflects clinician impression of increasing severity and complexity of mental health presentations in young people. Increasing numbers of young people with mental illness are presenting to emergency departments and requiring inpatient admission across the state. ED presentation rates per <18yo population is similar in each region. In the North West region CAMHS has to cover emergency presentations at two hospitals which presents added challenges for this small team in providing timely and appropriate care.*[25]

According to the PICAMHS Submission, there is also a high level of demand for antenatal assessment and care of pregnant women with mental health problems:

> *The PIMH service at RHH is (sic) referred 13% of all women attending RHH for antenatal care. Those referred present with severe and complex mental health problems including borderline personality disorder, schizophrenia, bipolar disorder, substance dependence, developmental trauma and domestic violence.*[26]

Demand for Neurological Conditions/Services

Neurological Alliance Tasmania (NAT) expressed concern regarding how and what data is collected in relation to the prevalence and needs of people living with neurological conditions, and whether that data is representative of the number of people living with neurological or progressive neuromuscular conditions being admitted to hospital:

[23] Mental Health Council (MHC), 2017, *Submission #17*, p. 2.
[24] Perinatal, Infant, Child and Adolescent Mental Health Service, 2017, *Submission #29*, p. 3.
[25] Perinatal, Infant, Child and Adolescent Mental Health Service, 2017, *Submission #29*, p. 4.
[26] Ibid, p. 5.

For example, if a person with Parkinson's Disease is admitted to hospital for a urinary tract infection (common for people living with Parkinson's) is comorbidity data collected in relation to their Parkinson's? This would then, for example, enable a better understanding of the numbers of people with Parkinson's being admitted, the length of their admission and any adverse outcomes, particularly in relation to medication changes.[27]

According to the NAT submission:

Neurological disorders are common. Neurological disorders account for one in five (5) emergency hospital admissions and one in eight (8) general practice consultations and account for a high proportion of disability in the general population. For a variety of reasons neurological services in Tasmania have lagged behind neurological services in Australia. Future demands on inpatient and outpatient Neurological services in Tasmania are likely to increase.

Neurodegenerative conditions such as Dementia and Parkinson's Disease are driven by an aging population and rising rates of conditions such as Type 2 Diabetes Mellitus with neurological complications which will increase demand for inpatient and outpatient neurology services. Tasmania has the highest prevalence of Parkinson's Disease and Multiple Sclerosis in Australia. The rates of certain neurological conditions such as Epilepsy are likely to remain unchanged.

An increase in therapeutic complexity associated with newer treatment options can also be expected to drive demand for specialist neurology services. These will include both medical treatments and assessment of patients for surgical interventions. Similarly, the neurological side effects and consequences of new therapies used to treat non-neurological disorders (e.g. antineoplastic agents and antipsychotics drugs) will also increase demand for inpatient and outpatient neurology services.

NAT member associations welcome the opportunity to work with the Tasmanian Health Service (THS) to gain a better understanding of the prevalence and needs of people living with the neurological conditions NAT members represent.[28]

People with Disability within the Acute Care Setting

According to Associate Professor Robyn Wallace's submission, demand for acute health services involving hospitalisation by people with disability is high in

[27] Neurological Alliance Tasmania, 2017, *Submission #11*, p.5.
[28] Neurological Alliance Tasmania, 2017, *Submission #11*, p.4.

Tasmania and members of this diverse group are well known to be high users of acute hospital care. This demand is:

> *… not expected to decline, and the successful health outcomes are lower, the rates of adverse medical events higher, and speculated to be more expensive and inefficient compared to the care given to people without disabilities accessing acute health services.*[29]

According to Dr Wallace, there is an opportunity to reduce the requirement for acute health services such as hospitals through the optimal use of outpatient services for such patients:

> *Tasmania has a high number of residents with disability, who are also high users of the acute health systems but with poorer outcomes and they experience increased inefficiency in care.… Identification of stakeholders within disability and mental health sectors and subsequent engagement with them will help in development of reasonable adjustments to generically delivered acute health services.*[30]

Dr Wallace highlighted that people with mental illness and people with intellectual disability are very vulnerable in the Tasmanian heath system:

> *It is not unique to Tasmania; it is well known in Australia and all over the world that people with disabilities are very vulnerable in the health system. They are high users, and they endure higher rates of preventable morbidity and mortality in the hospital setting. They are readmitted more often. They receive a lower quality of health care. It costs more and it is less effective. The good news is that it is treatable and we do not have to reinvent the wheel - a lot of work is being done that we can use to improve this.*
>
> *It is a particular problem in Tasmania because we have the highest rate of disability in Australia. It is not going to improve, it is not expected to decline and we know the gap between physical health outcomes of people with disability and those without is increasing. It is not decreasing.* [31]
>
> *I have looked at the otherwise excellent Rethink Mental Health program of our own government. It does not mention physical health, unfortunately. It is a great guide for acute mental health services, but it is a major deficit, said respectfully, that it doesn't mention physical health. People with mental illness are high users of the physical health hospital. If you have*

[29] Associate Professor Robyn Wallace, 2018, *Submission #1*, p. 1.
[30] Ibid, p. 2.
[31] Associate Professor Robyn Wallace, *Transcript of Evidence*, 14 September 2018, p. 1.

mental illness you are more likely to seek care in a physical health hospital.[32]

Dr Wallace continued:

> *Another important part of our thinking is to do more with what we have. We cannot use the barrier of saying we do not have any money. We have to embrace this and work more with the resources we have, and I think we can. We can improve what we are doing with our current resources and that is vital. Some of the ideas are for implementation of a statewide service, also straddling public and private, where possible.*[33]

According to Dr Wallace, a more proactive linking between psychiatrists and physicians is needed:

> *In the psychiatric ward, we need a proactive approach for physicians to go into the mental health ward and there are barriers. For example, in the wards in internal medicine, people are in pyjamas, in beds and you know they are sick in hospital.*
>
> *In the mental health wards we have to have a swipe card to get in. It seems stark. People are not in their pyjamas. Now they might seem little things to you, but they are all barriers for the physician going into the mental health ward. There are all sorts of things that make it feel different, such as the patient might not be in their bed. We need make it the norm that you go to the psychiatric ward and proactively look at the physical health. How many patients have I had or seen where an acutely unwell patient with mental illness or with a chronic health problem and the physician says, 'Oh, it is psychosomatic, schizophrenia or depression', when in fact they have a serious physical health issue. It is the same with intellectual disability*.[34]

Mr Michael Pervan, Secretary Department of Health and Human Services, recognised the complexities in providing continuity of care to people with disability:

> *The other challenge is that it is not just about the coordination of the care but the collaboration. I think the word you used was 'continuity'. It is making sure that when complex patients come there is a lead clinician who has appropriate experience and skills in dealing with or managing the care of those patients and in coordinating what could be multiple teams. There is no-one in the system who would want to suggest we are not providing*

[32] Ibid, p. 2.
[33] Associate Professor Robyn Wallace, 2018, *Submission #1*, p. 2.
[33] Associate Professor Robyn Wallace, *Transcript of Evidence*, 14 September 2018, p. 2.
[34] Associate Professor Robyn Wallace, *Transcript of Evidence*, 14 September 2018, p. 3.

good care, or that we could not improve the care we are providing for people with disability. It is a question of the capacity of the system to embrace changed practice while they are also dealing with the current demands on the system coming through the front door every day.[35]

Mr Pervan continued:

It is something we will need to consider. Part of the challenge all states have with the introduction of the NDIS is that boundary point where the NDIS starts and where the health system ends. That nexus is where we need to put more effort into outpatient services. It also impacts people in some of our mental health beds who have psychosocial disability, and that point at which we can move them into the community safely and with support as opposed to being in a mental health acute bed. It is something we are already looking at; we are looking at it starting in the mental health area, but we will take it broader than that into intellectual and physical disability as well.[36]

The Minister added:

It is very important that the general workforce develop its expertise and its sensitivity in this area.

…

There is an import here I want to place on the broader workforce being equipped and developed in being able to deal with the range of patients who would be coming in front of them. Nonetheless, I also indicate we would be happy to respond to the notion of whether a specific stream is useful in the public system.[37]

TERM OF REFERENCE 1: CURRENT AND PROJECTED STATE DEMAND FOR ACUTE HEALTH SERVICES

FINDINGS:

1. Demand for acute health services, including the Emergency Department, is exacerbated by higher levels of acuity, bed/access block (particularly in medical and acute mental health wards) and patients requiring longer hospital stays.

2. All of Tasmania's main hospitals fall below the clinically recommended guidelines for elective surgery and the performance of similar hospitals around the country.

[35] Mr Michael Pervan, *Transcript of Evidence*, 22 October 2018, p. 16.
[36] Ibid, p. 16.
[37] Minister Ferguson, *Transcript of Evidence*, 22 October 2018, p. 17.

3. Tasmania's demographic status, in particular its high levels of poor health literacy and adverse measures for the social determinants of health, increase demand for acute health services.

4. Patients with disability or acute mental illness are high users of acute physical health care. They are vulnerable and experience higher rates of morbidity and mortality in the health system.

5. Emergency departments are not well equipped to provide high quality care for acutely unwell mental health patients.

6. There is increasing demand for adolescent mental health services.

7. There is a high demand for perinatal mental health assessment and care throughout Tasmania.

8. Bed block in acute mental health care has been exacerbated by a reduction in bed numbers.

9. Workforce development in caring for patients with disability is needed.

10. Neurological conditions account for one in five Emergency Department hospital admissions.

11. Robust data collection and transparent reporting is needed to fully understand demand trends and growth to accurately inform short and long term planning in all areas of acute health services.

TERM OF REFERENCE 2

FACTORS IMPACTING ON THE CAPACITY OF EACH HOSPITAL TO MEET THE CURRENT AND PROJECTED DEMAND IN THE PROVISION OF ACUTE HEALTH SERVICES

Background

The Tasmanian Government submission (2017) provided some background into the adequacy of Tasmania's health service capacity:

> *Previous studies into the Tasmanian health system have shown that Tasmania appears to have adequate health service capacity. Therefore it is important that focus is given not just to total capacity but also to how it is used – in particular where care could be more efficiently and effectively delivered with the patient at home and seen in primary, community or outpatient settings, or via telehealth.*[38]

The Tasmanian Government submission outlines a variety of reasons why the acute sector sometimes operates above capacity, including:

- Australian Government funding arrangements such as the defunding of preventative health programs;
- Extended freeze of medical rebates for GP visits by the former Australian Labor Government resulting in the public being able to attend public hospital emergency departments for free;
- Workforce issues and supply;
- Long elective surgery waiting lists; and
- Lack of alternatives to hospital treatment.[39]

The Sub-Committee heard a number of specific factors impacting on the capacity of each hospital to meet current and projected demand:

Centralised Tasmanian Health System

The AMA submission identified the centralised THS as a factor impacting on the capacity of each hospital to meet demand:

> *The THS experiment with centralised command and control governance of Tasmania's major hospitals has proven a failure. The opportunity for a rational and role delineated Tasmanian health system that was promised by the Health Green Paper of 2014 has been lost to a poorly considered THS*

[38] Tasmanian Government, 2017, *Submission #32*, p. 16.
[39] Ibid, pp. 19-20.

governance model typified by an overly centralised command and control philosophy. Delayed, yet actively destructive local level hospital governance changes introduced by the THS have disengaged local staff from hospital leadership and management.

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

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

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

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

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

The learnings from the Mid Staffordshire healthcare scandal in the UK, particularly, the findings and recommendations of Robert Francis QC are as relevant to the Tasmanian Health system in 2017. The Francis Inquiry examined the causes for the failings in care at Stafford Hospital run by the Mid Staffordshire NHS Foundation Trust. This report by Francis "identified numerous warning signs which cumulatively, or in some cases singly, could

and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them:

- *A culture focused on doing the system's business – not that of the patients;*
- *An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;*
- *Standards and methods of measuring compliance which did not focus on the effect of a service on patients;*
- *Too great a degree of tolerance of poor standards and of risk to patients;*
- *A failure of communication between the many agencies to share their knowledge of concerns;*
- *Assumptions that monitoring, performance management or intervention was the responsibility of someone else;*
- *A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;*
- *A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation."*[40]

The ANMF submission (2017) supported the view that the model of clinical governance has resulted in a system that lacks governance and leadership, and fails to recognise the risks and concerns of THS staff:

> *During 2015 the Minister for Health implemented a major restructure of the Tasmanian Health Service (THS). This process was known [as] the One State, One Health System, Better Outcomes White Paper. ANMF believes the delay in restructure has impacted greatly on the stability of acute care services.*
>
> *The most significant impact has been the development of a highly centralised and politicised system which appears to lack leadership responsibility on the ground. The restructure has seen permanent executive services removed from all major THS settings and acting positions. This resulted in the development of a large gap between 'on ground' staff and executive able to make decisions. Removal of CEO's from each hospital to a single CEO responsible for the entire system has left senior hospital staff with little leadership support. Decision making appears to have been made without clear understanding of the on-ground issues for each site. The*

[40] Australian Medical Association, Tasmania, 2017, *Submission #8*, pp. 3-4.

governing council have not addressed the significant risks and the safety concerns being raised by senior nursing and medical staff within the THS.[41]

According to Helen Burnet, former Podiatry Manager responsible for Podiatry and Footcare Services to, and directly interfacing with, the RHH and Repatriation General Hospital, the relocation to Launceston of senior executives has created additional challenges:

I believe that this restructure to a statewide system and the way it has been implemented has been not only a very expensive and wasteful exercise (time, travel, petrol, financial cost), but that it had an extremely negative impact on the running of the RHH, the chain of command, roles and responsibilities and clear decision-making for the hospital. I am of the very strong view that without a CEO of the RHH and executive, the RHH was severely weakened as a functioning institution. Over 3000 people working at the RHH and no CEO obviously has ramifications for service care and delivery, with often poor or no decisions that made it difficult to effectively run the hospital.

Importantly, with the senior executives' relocation to Launceston, I found that there was a significant disconnection between staff and the THS executive.[42]

While in the role of Allied Health Director in the Southern Executive, Ms Burnet noted:

… I met with senior clinical managers from another profession I had responsibility for, who provided care at the RHH who were deeply concerned about recent staff cuts to their service which was severely effecting their ability to deliver safe, timely care to their inpatients, and the impact on staffing - burnout, retention of senior and skilled clinicians, being able to supervise students and junior staff, recruitment and sustainability. They requested an increase in staffing which I lobbied for and the clinical position was reinstated. It was evident that this was the first time that these managers had been heard by someone in the position I was covering for. They were very concerned about the cuts to Allied Health Professional staff numbers that had severely compromised their professionalism.

…

It was important that they spoke up at the time, but there is not always the culture to do so in the THS, nor is it necessarily the culture of Allied Health

[41] Australian Nursing and Midwifery Federation, 2017, *Submission #30*, pp. 13-14.
[42] Ms Helen Burnet, *Submission #22*, p. 3.

Professionals to necessarily speak out either. This could improve if there were better connections and less managing up, and instead advocating for staff.[43]

The Sub-Committee notes the first priority of the Tasmanian Government on returning to Parliament after the State Election in 2018 was to introduce and pass the *Tasmanian Health Service Act 2018*.

According to the Minister for Health:

> *The Government undertook significant consultation with key stakeholders in delivering this change, which has now provided a strong foundation for the Tasmanian Health Service [to] continue to grow and to improve the governance of the health system. The Government will continue to work closely with our staff, key health stakeholders and unions, and we of course remain open to new ideas and innovative proposals for improvement. It is vital, however, that the system does not lose sight of the need for well planned and thoroughly consulted strategic direction that delivers over the longer term for Tasmanians.*[44]
>
> *The new arrangements under the Tasmanian Health Service Act 2018 have already strengthened local hospital leadership and ensured greater clarity of roles and authority within the health system, which are in turn providing greater direction and more focus on improved governance and service planning.*[45]

ANMF, in a document titled 'Suggested Solutions by ANMF Members', outlined a number of actions to allow for the return of local decision making and improved clinical outcomes intended by the new Executive structure:

- *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.*
- *That the THS Executive increase their presence within each of the health regions and improve transparency around communication, consultation and decisions making.*
- *Make available to all THS management the Executive meeting agenda and outcomes in a transparent and timely way following Executive meetings.*[46]

Emergency Department Presentations

The AMA noted in their submission that emergency department presentations are increasing in Tasmania:

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[43] Ibid, pp. 4-5.
[44] Response to the Interim Report of the Acute Health Services Inquiry (Minister for Health), 24 August 2018, p. 4.
[45] Ibid, p. 5.
[46] Legislative Council Acute Health Services in Tasmania Inquiry Suggested Solutions by ANMF Members, October 2018, p. 1.

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

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

(a) More physical space (substantially more funded hospital beds, both acute and subacute);

(b) More staffing – both medical, nursing, allied health, cleaning and clerical,

(c) More surge capacity for busy times (only 85% of physical bed space used routinely),

(d) Clear and credible local hospital governance structures that are responsive to local requirements whilst working within a state-wide planning framework,

(e) Stable staffing and effective succession planning and recruitment of both clinical and support staff,

(f) A political environment that provides a consistent approach across terms of government; one where the technical and clinical expertise within the health service is empowered to drive service delivery and innovation without politicisation.

(g) A clear focus on teaching, research and quality improvement as key attributes of an effective public health system,

(h) To accept that its ability to attract and retain staff is limited due to its size, poorer wages and perception of it being a difficult, isolated place to work.

As a result, the health system needs the ability to be responsive to staffing opportunities as they arise – even if this is perceived in the short term as "over recruitment". [47]

According to the ANMF (2017) submission, demand for emergency care cannot currently be met:

In all four major Tasmanian hospitals ANMF members continue to report that demand for emergency care exceeds the physical and other capacities

[47] Australian Medical Association, 2017, *Submission #8*, p. 2.

of the hospital. In many cases, patients are being treated in corridors, waiting rooms and other inappropriate points of care. This results in an increased risk to patient health and safety, along with professional and other risks to staff.[48]

The ANMF (2018) submission noted that this is still an issue:

Since our previous submission there have been changes within the ED, wider RHH and THO. Some of these changes have been positive and there have been some indications that clinicians are being listened to and involved in some of the decision-making processes. However, this does not negate the grave concerns we hold regarding the safety of patients and the fact that the RHH is still unable to manage the capacity demands of day-to-day business. We remain alarmed that adverse patient events are occurring due to the unreasonable workloads being placed on the ED and the ED staff.[49]

Dr Brian Doyle noted bed block and access block are the major issues crippling the health system:

It is not the walking wounded who come in maybe inappropriately. Some of them do. That is not an issue. That is our problem. We treat them and get them out really quickly. The major issue is the sick people who continue to come. Obviously, we cannot tell them [not] to come and we must look after them. I speak just personally as to what goes on at the Royal Hobart Hospital, because I have been working there for the past two-and-a-half years. We have about 27 laydown modern beds in the Emergency Department. At any given point in time, about 24 of them on average are taken up by people who need to be admitted.

The average length of stay for a patient who is being admitted is about 11 hours and has gone up. All the important statistics show the trends are worsening. Every year the Australasian College for Emergency Medicine undertakes a nationwide look at the statistics at how hospitals are faring as far as access block is considered and 24 hour stays, for example. The last survey they did, the Royal Hobart Hospital was the worst in the country as far as 24 hour stays. We had 9 patients in the emergency department. They were in the ED for more than 24 hours. Compare that to Victoria who had one patient in an emergency department for 24 hours.[50]

The performance of Tasmania's four key hospitals was investigated by Ms Kate Brockman, Director Healthcare Reform Consulting (HRC) in 2014, with the

[48] Australian Nursing and Midwifery Federation, 2017, *Submission #30*, pp. 13-14.
[49] Australian Nursing and Midwifery Federation, 2018, *Submission #9*, p. 4.
[50] Dr Bryan Doyle, *Transcript of Evidence*, 14 September 2018, p. 35.

results contained in publicly available reports. It was suggested there is latent capacity in the Tasmanian hospitals:

> *Our findings from these studies indicate that Tasmanian Health had, (at the time of our studies), significant latent capacity in its four key hospitals as evidenced by the follow (sic) key insights (more information available in the redacted reports). In our ED study we identified numerous instances where additional unnecessary time was taken to treat and process patients. This resulted in increased ED LOS and led to over-crowding and ambulance ramping. As an example it took LGH 6 hours and 4 minutes on average to allocate a bed after bed request. Equivalent times were 2:33 for RHH, 1:29 for NWRH, and 4:18 for MCH.*[51]

Ms Brockman outlined in her submission a number of success factors required for improvement in healthcare system productivity, quality and performance:

> *1. Ministerial and executive drive. The Minister for Health and Secretary are key to creating a sense of urgency in the Health system and championing the reform. Their involvement in support of the program should vary between daily and monthly as needed for program success.*
>
> *2. Clear and incremental performance targets. Clear performance targets for key metrics should be set as a final target and due date, as well as monthly incremental targets. The latter provide early insight of an under-achieving site and the opportunity for intervention. Performance targets should be cascaded throughout the hospital. For example, a 210min target for ED length of stay isn't enough, it should be broken down into a) 10 mins triage to enters ED, b) 20 mins enters ED to first seen doctor, c) 90 mins first seen doctor to bed request, d) 30 mins bed request to bed allocated and so on. The intent is to set process targets for the key processes across the hospital that when achieved, assure the overall performance required.*
>
> *3. Robust diagnostic analysis. It is critical that the real root causes of delays or errors are understood. Inaccurate analysis based on perception or past experience can be useful, however in our experience it is not sufficient to accurately identify problem sources, nor provide insights into how to fix issues. Robust diagnostic analysis is also critical to engaging clinical staff to address the issues identified.*
>
> *4. Clinical engagement. Clinical staff must be brought on the journey through their genuine engagement in the process. This includes sharing openly the diagnostic results, providing opportunities to shape the solutions and their implementation, and upskilling in reform processes where*

[51] Ms Kate Brockman, 2017, *Submission #35*, p. 4.

required. Our experience is that the reasons for delay at the operational level are almost always poor process related, and not poorly performing individuals.

5. Hospital executive lead (sic) reform. It is essential that hospital reform efforts be led by that hospitals senior leadership team (top 5-8 individuals). Reform is not an activity that can be outsourced to external consultants, middle management, senior clinicians, junior staff, or an affiliated university. It must be proactively lead (sic) by the hospital's senior leaders and executives.

6. Integrated program of short duration initiatives. Since the challenges in health care productivity are numerous, there can be no one 'big bang' solution. Our experience is that the total solution suite can number more than 25 individual initiatives. However, implementation must come in rapid small batches. Ideally, implementation should be in three month blocks (quarters) involving 3-6 initiatives. One year of reform activities would involve four blocks of improvement initiatives totally (sic) 12-24 individual solutions. This enables rapid learning and doesn't ransom hospital performance to one or two long duration big bang solutions that may not deliver.

7. Improved operational reporting. Healthcare services delivery is complex, with many functional departments involved. Specific metrics that provide real insights when looking across functional silos need to be developed and distributed on daily or weekly timeframes. These are essential to enabling hospital executives to manage day-to-day operations whilst monitoring the performance of improvement initiatives. Our experience is that current operational reporting systems are not fit for purpose.

8. Expert assistance/guidance. Additional support to hospital executives has proven a key enabler of rapid improvement. Whereas an executive that hasn't experienced a high performing hospital can struggle to understand what is required; a proven external change agent who has supported numerous hospitals to achieve rapid improvement can provide immense guidance based on prior experience.

9. Executive accountability. Hospital executives must be held accountable for the delivery of their reform program (3-6 initiatives in 3 month blocks), and the resulting improvement in performance. Our experience is that without the risk of punitive action or job loss, executives can find many other things to focus on. However, when executives are held to account and starting delivering on the reform program, many of the prior concerns that occupied their attention start to fade away.

10. Whole of hospital approach. The genius of the WA and NSW programs is that they adopted a 'whole of hospital approach' – reflecting the complex/interconnect nature of hospitals. Even though the goal was improved ED performance, this was achieved with a focus on 'back of hospital' areas such as patient flow, imaging, visiting consultants, wards, and allied health. The benefit is two-fold; first the ED is engaged in reform knowing the whole hospital is involved and second, these other areas of the hospital need to improve for the ED to improve.

11. Focus on operations – Director of Operations. The complexity and interrelatedness of hospitals means that conventional management lacks the ability to looks (sic) at cross-functional performance as seen by the patient. A Chief Operating Officer or Director of Operations empowered to look at processes across functions and drive improvement is essential to success.[52]

According to Ms Brockman, only four to five of the above eleven key success factors were present with the Tasmanian improvement plan supported by HRC. This is in contrast to Royal Perth Hospital, NSW, and another public tertiary hospital which Ms Brockman worked with, which had ten or more factors present and achieved rapid improvements in NEAT performance.

Lastly, adding additional resources (beds, staff) to the existing system may not deliver the planned performance improvement. Additional resources brings additional management complexity; at some point during the expansion different operational management processes are required. An organisation that is not optimising its current resource allocation is not likely to effectively utilise an increased volume of resources.[53]

By contrast, the Sub-Committee recognises that different methodologies have been adopted in other jurisdictions. For example, the Lean Implementation Program has been used at the Central Queensland Hospital and Health Service (CQHHS).

According to the 2014-15 Annual Report of the CQHHS, the lean methodology is as follows:

Efficiency and the elimination of waste lead to safer and better delivery of health services. This has been demonstrated at many medical facilities across the world but is highlighted by the success at the Virginia Mason Medical Centre in Seattle, USA.

Virginia Mason Medical Centre used the principles of Lean methodology to create a world recognised facility of patient safety and cost effectiveness.

[52] Ms Kate Brockman, 2017, *Submission #35*, p. 6.
[53] Ibid, p. 6.

CQ Health staff began implementing the principles of Lean methodology into the way it delivers health services. Using its First Steps Program, Rona Consulting guided staff through the process of identifying ways to improve processes to deliver safer, streamlined and sustainable services to our patients.

Staff embraced the Lean methodology concept and process and have delivered creative and innovative solutions in the areas they targeted. The Lean theories were put into practice at the Rockhampton Hospital Specialist Outpatient Department and the results speak for themselves:

Specialty	Patients waiting longer than clinically recommended	
	1/07/2014	30/06/2015
General surgery	926	50
Orthopaedic	1147	94
Urology	342	8
General Medicine	204	16
Gynaecology	113	8

The CQ Way is a management and leadership approach that will drive continuous improvement in the services we provide to meet the needs of the patients and the communities we serve. It has four pillars:

- *Those who do the work improve the work. At its heart The CQ Way empowers frontline staff to solve problems, eliminate waste, and reduce variability so we can meet the needs of our patients consistently.*
- *The right process to produce the right result. The CQ Way provides a structured approach to improvement using proven methods to analyse existing process and design and implement new processes while continuously measuring the impact.*
- *The right quality, first time, every time. The CQ Way drives improvement through the relentless pursuit of higher quality and safety, empowering staff to stop and fix problems in a sustainable way.*
- *Place a premium on developing and empowering people. The CQ Way changes the role of management and leadership from command and control to support and trust, to facilitate and create the conditions for frontline staff to understand, improve and implement safer and more reliable ways of providing services.*[54]

[54] Central Queensland Hospital and Health Service (2015) Central Queensland Hospital and Health Service Annual Report 2014-15, Queensland Government, pp. 30-31.

In the 2016 edition of his book – *Lean Hospitals: Improving Quality, Patient Safety and Employee Engagement* – Mark Graban states:

> *Lean has been embraced by hospitals and health systems since the 1990s, especially so in the past 10 years. The Lean approach is powerful, but it is not a quick fix. Lean promotes a new way of thinking and a different organizational culture, requiring change and participation from everybody at all levels. The practical methods and tools used within this broader framework have led to measurably better performance in areas such as patient safety, quality, waiting times, cost and employee morale in healthcare organizations around the world … a "Lean hospital" is one where leaders have a humble, inquisitive mindset and management style that allows for the reinvention of aspects of healthcare delivery and creates a culture of continuous improvement.*[55]

The United Kingdom's National Health Service provides a chart which shows the application of the five Lean principles to healthcare:

Figure 5: Principles of Lean Thinking applied to healthcare[56]

Five principles of lean thinking enhance the quality of healthcare by improving flow in the patient journey and eliminating waste:

1 Specify value → **2** Identify the value stream or patient journey → **3** Make the process and value flow → **4** Let the customer pull → **5** Pursue perfection

Principles	Implications for healthcare
1 Specify value This can only be defined by the customer. Value is any activity which improves the patient's health, well being and experience.	In healthcare we need to identify and agree what value we provide to customers. Anything that improves patient care and experience is adding value, anything else is waste, eg: • less waiting and delay • better outcomes • fewer adverse incidents We also need to identify who our customers are. An obvious customer is the patient, however, other customers do exist and need to be considered.
2 Identify the value stream or patient journey This is the core set of actions required to deliver value for patients.	It covers the whole patient journey from start to finish. Identifying which steps add value and improve quality for the patient.
3 Make the process and value flow Align healthcare processes to facilitate the smooth flow of patients and information.	For a patient this means: • avoiding queuing and batching • avoiding multiple referrals • removal of all obstacles which prevent the quickest safest practical flow of care
4 Let the customer pull The customer should begin to pull products or services as needed. We should deliver care on demand, with the resources needed for it.	We need to create pull in the patient journey. Every step in the patient journey needs to pull people, skills, materials and information towards it, one at a time, when needed. This means responding to demand, rather than handing off patients and pushing them from one department or ward to another. For example: A ward phoning for the next patient rather than waiting for the request.
5 Pursue perfection Develop and amend processes continuously in pursuit of the ideal.	For the patient this means completing their care and treatment • with the best outcome • with no mistakes • on time • without delay To achieve this we need consistent and reliable processes

[55] M. Graban (2016) Lean Hospitals: Improving Quality, Patient Safety, and Employee Engagement, Third Edition, CRC Press, Boca Raton, p.1.
[56] N. Westwood et al. (2007) Going Lean in the NHS, NHS Institute for Innovation and Improvement & University of Warwick, NHS website, p. 4.

Access/Bed Block and Ambulance Ramping

Bed block has been identified as a factor impacting on the capacity of each hospital to meet current and projected demand.

According to the ANMF (2017) submission:

> *Bed Block occurs in all four Tasmanian acute care hospitals however the Royal Hobart and Launceston General Hospitals are the worst affected. For the first two months of 2017 the number of patients who spent more than 24 hours in the RHH emergency department was 132 compared to 35 for the same period in 2016. There has been several days when all treatment spaces in the emergency department are occupied by patients needing admission, but for whom no beds are available.*
>
> *Much of the bed block at the RHH is related to a physical decrease in the number of available beds which, in a small part, can be contributed to the RHH redevelopment. However historical bed data collected by ANMF since 2010 shows the number of beds has failed to increase to reflect long term increases in demand for acute services. The reality is that, since 2010, the number of beds available at the RHH have dropped significantly despite an increase in demand. Much of this reduction has occurred in surgical and mental health beds. The reduction in any number of beds, regardless of the department reduces capacity for flexibility during peak flow. Previously surgical beds were historically changed to medical beds during periods of demand, such as flu season. At this time elective surgery could still continue with only minor disturbances. However there is virtually no flexibility available in the current system.*[57]

In relation to bed block at the LGH, Mr Andrew Brakey, ANMF stated:

> *It is documented clearly on the Tasmanian Health Service risk register that the LGH bed block is an extreme risk. However, lack of funding in the system and budget constraints in the service are hamstringing the THS in dealing with it. This is an emergency department where, through no fault of the staff working to their full capacity to care for the members of the public presenting to the department for treatment, waiting times are the worst in the country.*
>
> *… a specific example of where the LGH budget and best practice has been overridden because of the budget: Ward 4K has four beds available to be opened, which are benchmarked for staffing but no recruitment processes have yet been undertaken because of budgetary constraints. The ICU has*

[57] Australian Nursing and Midwifery Federation, 2017, *Submission #30*, pp. 13-14.

beds available at the LGH. However, if they opened those beds, they would need to employ extra medical professionals and so, because of budget constraints, those beds have not been opened. [58]

Mr Scott Rigby, Nurse Unit Manager at the LGH, appearing on behalf of ANMF, reiterated that bed block is a systemic issue:

When we talk about bed block, bed block is a whole-of-hospital and whole-of-system issue. Sometimes we focus too much on a hospital-based service delivery when it should be the whole organisation and a health service. That includes primary health as well. [59]

However*:*

As much as we should be looking for efficiencies within the system - ANMF completely agrees that - what we should be looking at is releasing that pressure now and then looking at the efficiencies and deciding what the bed numbers need to be like down the road.[60]

The ACEM submission considered the issue of bed block. As part of its commitment to improving patient outcomes, ACEM has undertaken regular engagement with members since 2008 to analyse data on the prevalence of access block across Australian and New Zealand emergency departments.[61] In July of this year, ACEM issued the latest figures across all jurisdictions, including Tasmania:

The data is clear – patients in Tasmanian emergency departments are more likely to be impacted by, or experience, access block. Where access block occurs, ACEM considers it is indicative of a whole-of-hospital problem that is underpinned by systemic inefficiencies, such as a lack of inpatient resources (particularly beds and staff). A measure of this systemic inefficiency is patients spending eight hours or more waiting in the emergency department, which is highest across Tasmanian, Northern Territory and Australian Capital Territory jurisdictions. Tasmanian patients are also more likely to experience waits longer than 24 hours in emergency departments compared to other Australian jurisdictions.[62]

ACEM considers that access block and overcrowding in hospital emergency departments remain significantly unaddressed in Tasmania. This recent data, and anecdotes provided by Members at the Faculty's annual meeting

[58] Mr Andrew Brakey, *Transcript of Evidence*, 28 September 218, p. 19.
[59] Mr Scott Rigby, *Transcript of Evidence*, 28 September 2018, p. 23.
[60] Ibid, p. 31.
[61] Australasian College of Emergency Medicine , 2018, *Submission #10*, p. 1.
[62] Australasian College for Emergency Medicine, 2018. Access Block Point Prevalence Survey Summary 2018-1. Melbourne, Australia.

and scientific conference in August this year, highlights that patients remain at high risk of adverse care outcomes. It is ACEM's view that the situation in emergency departments in Tasmania is deteriorating rather than improving.[63]

The ANMF, in a document provided to the Sub-Committee titled '*Suggested Solutions by ANMF Members*', recognised that the problems of bed block, ED overcrowding and regular level 4 escalations do not have immediate solutions. The ANMF outlined measures to improve patient flow and the safety of nursing staff and patients, at both the RHH and LGH:

The Royal Hobart Hospital and Emergency Department Solutions

- *Additional nursing staff to assist with triage and to monitor those patients who have been triaged and are waiting in the ED waiting room.*
- *Additional Psychiatric Emergency Nurses (PENs) to allow for two on each early shift, one on a late shift and one on a night duty to assist with mental health patient care and treatment as they have one of the longest stays in the ED.*
- *Increase Crisis Assessment Team (CAT) and Community Adolescent Mental Health (CAMHS) nursing staff to assist in acute mental health concerns more easily in the community and hopefully prevent the need for presentation to the ED.*
- *Increase the use of private mental health beds such as those at Hobart Clinic to prevent unsafe length of stays at the RHH ED.*
- *Increase the number of permanent nurses and midwives in the RHH pool to ensure patient flow is not impacted due to unsafe staffing.*
- *Increase baseline nursing and midwifery staff numbers to allow for continued safe staffing on wards and units as well to facilitate timely transfer from ED while allowing for escort of patients to x-ray, picking patients up from day procedure areas or theatre or transferring patients to an alternate ward or unit.*
- *Implement Nurse led discharge criteria to allow nursing staff to discharge patients when the criteria are met, to enable a timely discharge that is not hindered by delays in medical staff approvals.*
- *Increase medical staff numbers, particularly after hours when medical staff may be delayed arranging for or discharging patients due to workloads or attending MET or Code Blue calls (which are a regular occurrence).*
- *Increase pathology and radiology services to 24/7 to prevent diagnostic testing from hindering discharge.*

[63] Australasian College of Emergency Medicine, 2018, *Submission #10*, p. 1.

- *Increase allied health staff numbers to prevent allied health assessments preventing timely discharge of patients from in-patient areas.*
- *Increase cleaning staff to allow for timely cleaning of discharge beds as well as attending to terminal cleans that are required according to infection control policies.*
- *Slow down or cancel elective surgeries during level 4 escalation.*
- *Increase in opening hours for the current transit facility from 7am to 11 pm, 7 days a week.*[64]

The Launceston General Hospital and Emergency Department Solutions

- *Funding and permanently staffing all 29 beds on Ward 4D which are immediately available.*
- *Funding and permanently staffing 4 additional beds on Ward 4K which are immediately available.*
- *Funding and permanently staffing 4 additional ICU beds and the required additional ICU medical team.*
- *Funding permanent psychiatric emergency nurses (PENs) on all shifts in the LGH ED.*
- *Fund additional allied health staff numbers to assist with allied health assessments in ED and on wards to facilitate timely transfer and discharge.*
- *Immediately increase permanent nursing staff in the ED to the actual average worked this year to assist with triage, triage assist area (where ambulances are ramped) and caring for patients who have been triaged and are waiting in the ED waiting room.*
- *Implement a level 4 of the LGH escalation policy to assist with better hospital wide coordination at times of maximum ED capacity, ramping and overcrowding.*
- *Fund and immediately commence the establishment of the new antenatal clinic space (below Ward 4K extension) to allow for renovation of the existing antenatal clinic area which would then facilitate additional ward in-patient beds.*
- *Fund permanently an additional medical outreach team after hours to enable better patient flow and timely discharge from the Emergency medical unit and in-patient beds.*
- *Increase nursing staff in the discharge lounge to allow for 24/7 use to enable better patient flow to discharge and free up in-patient's beds more readily.*

[64] Legislative Council Acute Health Services in Tasmania Inquiry Suggested Solutions by ANMF Members, October 2018, p. 2.

- *Permanently implement additional patient support officers in the LGH ED to prevent violence and aggression and to ensure staff and patient safety.*
- *Increase cleaning staff to allow for timely cleaning of discharge beds as well as attending to terminal cleans that are required according to infection control policies.*
- *Increase baseline nursing and midwifery staff to allow for continued safe staffing on wards and units to facilitate timely transfer from ED while allowing for escort of patients to x-ray, picking patients up from day procedure areas or theatre or transferring patients to an alternate ward or unit.*
- *Increase pathology and radiology services to 24/7 to prevent diagnostic testing from hindering discharge.*
- *Increase Crisis Assessment Team (CAT) and Community Adolescent Mental Health (CAMHS) nursing staff to assist in acute mental health concerns more easily in the community and hopefully prevent the need for presentation to the ED.*[65]

In relation to Ward 4K, Minister Ferguson noted that it is a paediatric ward:

> *The other thing talked about is opening more beds on 4K. That is of course a children's ward. While we hear that repeatedly put about as, 'Why won't the Government open more beds on 4K?', I think that you as a nurse would understand why that is not the solution for a busy ED.*
>
> *…*
>
> *In 4K, if extra support is required, it is provided, but there are just serious issues around opening up bed capacity in 4K as a solution. We need to exercise caution around it. We are building a new children's ward at the LGH which will for the first time ever specifically have beds for paediatric mental health or adolescent mental health, which is less than one year away from not just practically completed but also from when it is opened.*[66]

The AMA (2017) submission stated:

> *Bed block has been particularly severe throughout 2017. The 32 acute psychiatric beds are not only almost full, but there are almost always psychiatric patients requiring acute beds waiting in the Emergency Department (ED); these are designated, admitted psychiatric patients".*

[65] Legislative Council Acute Health Services in Tasmania Inquiry Suggested Solutions by ANMF Members, October 2018, p. 3.
[66] Minister Ferguson, *Transcript of Evidence*, 22 October 2018, p. 19.

Official figures regarding these patients are not published, and are not available to the AMA, however, it is widely recognized that there are often four to six such patients waiting in the ED, and, on occasion, more, sometimes eight, and these patients might wait up to 48 or 72 hours, or occasionally more for a bed.

It should be noted that the ED is a particularly unhelpful environment for those suffering with mental illness (counter-therapeutic). It is small, noisy, and bed based. Patients suffering with mental illness, however, are most frequently, ambulant. They need early access to specialist treatment in both a safe and appropriate environment, with therapeutic space and spaces, including outdoor spaces, and with appropriate professional therapeutic input and time.[67]

Bed block also has significant negative impacts on patients waiting for mental health care and staff caring for all patients. The AMA submission noted:

It is difficult to accurately convey how distressing and unsafe bed block is for patients, and it is just as difficult to convey how distressing this is for staff, who are simply no longer able to secure timely, safe and reasonable mental health care for their patients, care that has been generally available in Hobart for decades.[68]

Minister Ferguson noted in relation to the flow of the RHH ED:

Our biggest challenge is the physical environment. That is the biggest bottleneck on being able to provide the patient flow that we want. We want to reduce the time people are waiting in an emergency department or in an emergency department waiting room, and the best way we can do that is by opening more beds. We have opened 120. It has been very successful but we want to open more. The way to do that - and it is budgeted for - is to get the buildings completed so that we can commission them and start to use them.

…

The answer to the Royal's pressure, which we are all aware of, is more beds. That is the answer. We need to be able to open more medical beds on wards so that the ED, having done its job perfectly well, can allow its patients to be admitted in a timely way to a medical ward, not the ED. The expansion is part of future opportunity for the ED to work even better than it currently does, but we're working with what we have at the moment.[69]

[67] Australian Medical Association, 2017, *Submission* #8, p. 4.
[68] Ibid, p. 6.
[69] Minister Ferguson, *Transcript of Evidence*, 22 October 2018, p. 6.

The submission (2018) provided by Minister Ferguson noted the system challenges at the LGH and RHH:

> *The Government is determined to back our frontline health professionals and to support them to provide the best possible care, which is why in addition to longer term initiatives the Government is also in the process of providing more immediate support for the LGH and RHH emergency departments.*
>
> *The recent $1.5 million package for the RHH and LGH developed by the Secretary of the Department of Health is specifically designed to improve patient flow and bed management, and to put downward pressure on closely related challenges such as ramping and bed block.*
>
> *…*
>
> *In addition to this package and in response to specific acute demand challenges at the LGH, the Government has also delivered five more permanently funded beds on Ward 4D, implemented a new transit lounge to better manage patient flow, and is in the process of recruiting new nursing assistants.* [70]

The Tasmanian Government (2017) submission recognized that access block and ambulance ramping are significant long-term issues within the THS.[71]

Minister Ferguson recognized that ambulance ramping remains an issue:

> *Our efforts are around opening additional beds in hospitals, ensuring that, to answer Ms Forrest's questions, we have the efficient use of our beds to maximise patient flow. We also recognise that even absent a discussion on bed pressure, ambulance call-outs are up as well so that indicates that demand is also up. We are supporting Ambulance Tasmania with that. The Government has never ever said that ramping has been fixed. I know that has been said but it has never been said. The Government has never claimed victory on it but we do want to put down the pressure on ramping and that is our goal here.* [72]

According to Mr Neil Kirby, CEO Ambulance Tasmania:

> *Obviously ramping is an issue for us. It is particularly an issue for our staff. I would be remiss not to commend our paramedic staff who do the work in ensuring patient care is maintained when we have periods of ramping. It is*

[70] Minister for Health, 2018, *Submission #8*, p. 3.
[71] Minister for Health, 2017, *Submission #27*, p. 12.
[72] Minister Ferguson, *Transcript of Evidence*, 22 October 2018, pp. 23-4.

our paramedics who are with the patients while they wait to be seen at the hospital. I would like to commend the work that is done and the stress that it puts on our paramedic staff. It puts a stress on us as a service and we have strategies in place to manage that. To answer your question in terms of whether it is increasing, the figures are produced in the regular reporting through THS.

We know there are seasonal factors around ramping. In the winter months when there are a lot more people going to the hospital, you tend to see ramping occur. This time of the year we would expect it to probably be more than normal. It can be periodic. We can go several days or weeks without a big ramping issue and then the stars align and we have a period where the hospital is very busy, where we are very busy, and we can have an acute period occur very quickly.[73]

According to the ACEM (2018) submission, access block can be reduced:

Through a combination of increased resources, realistic targets properly implemented and improved hospital management. Specifically: Ministerial notification of access block exceeding 24 hours has been effective in Victoria in reducing very long waits in emergency departments. ACEM's most recent Access Block Survey found that patients were waiting for 24 hours or longer in every state and territory. It is noteworthy that the exception is Victoria, where hospital CEOs must alert the Health Minister when a patient's length of stay in the emergency department exceeds 24 hours.

ACEM recommends that the Tasmanian government, through the Tasmanian Health Service, implement a system of ministerial notification for access block exceeding 24 hours.[74]

In relation to ministerial notification of access block exceeding 24 hours, Dr Judkins noted that the system may not be effective in Tasmania:

When it was introduced in Victoria, it was becoming more of a problem so we wanted to try to ration it back to where we were historically. I think you are so far past that, you need to do a lot of work in the system to get to a point it is manageable. Then you introduce those alerts, such as I want to know every time the system fails. I think reporting them on a daily basis almost becomes pointless because you know it is happening anyway. I think you need to address the problem first and then maintain it at that level of performance.

[73] Mr Neil Kirby, *Transcript of Evidence*, 22 October 2018, p. 24.
[74] Australasian College of Emergency Medicine, 2018, *Submission #10*, p. 2.

…

The minister would need to sit down with the CEOs, the directors of the hospital, and say, let's start working on reducing the number of 24-hour stays. Once we have plan in place to fix it, we will put the reporting lines in place. If it started now, it becomes ineffective. You need to put the plans in place as to how you are going to address the 24-hour stays. Now, put the rule in place but you also want a report because you want to see reports on how it is improving. There needs to be agreement. We need to get a plan on how we get that 24-hour number down to zero and then we start the reporting so we know there is progress being made.[75]

Martyn Goddard's submission reiterated the need to address bed block at the RHH:

In 2016-17 bed block at the RHH was the third-worst of all 30 major hospitals in its national peer group; the LGH was worst among the 29 major regional hospitals; time waited at the NWRH was 21st longest of 29 large regional hospitals; and at the MCH was 17th longest of 21 medium regional hospitals. Overall, the LGH had the worst bed block of any of the 287 public hospitals in Australia with emergency departments. And only eight had a worse result than the RHH. Staff at both hospitals attest that the situation has continued to deteriorate in the past year. [76]

Interaction with Primary Health

Dr Stephen Duckett, Director of the health program at the Grattan Institute, an independent public policy think tank, commented on the need for greater investment in primary health to assist in reducing demand on the acute health services:

… we have done three reports on primary care over the last few years. The most recent one is called Mapping Primary Care. Basically what we're arguing is that the primary care system isn't doing enough and the Commonwealth and states should be working together much more closely on trying to improve the primary care system throughout Australia.

… there is a single primary health network in Tasmania and the state should be working with that and the Commonwealth to say what are the priorities we need to work together on in Tasmania to reduce the number of people admitted to hospital who do not need to be admitted to hospital - the so

[75] Dr Simon Judkins, *Transcript of Evidence*, 14 September 2018, p. 40.
[76] Mr Martyn Goddard, *Submission* #10, p. 33.

called potentially preventable hospitalisations – and all those sorts of things, working together rather than pointing fingers at each other. [77]

Staffing Related Matters that Impact on the Provision of Acute Health Services

According to the ANMF (2017) submission, the Tasmanian health care system is dependent on the knowledge, skills and capacities of its workforce:

> *Chronic underinvestment in the health workforce and absence of structured workforce planning is placing at risk the current and future provision of high-quality services. Staff numbers in all our major public hospitals have been critically inadequate for some years and the situation has not been addressed. The rate of increase in the numbers of doctors, nurses, allied health professionals and other staff is inconsistent with the increased growth in patient demand.* [78]

There are significant implications of prolonged staff shortages:

> *Staff who are forced by shortages and funding restrictions to take care of many more patients than is clinically appropriate cannot perform at the level of safety, quality and efficiency that the community requires and deserves. A doctor, nurse or paramedic working unduly long and stressful hours, often with repeated double shifts, has compromised cognitive, response and judgment functions. Problems are much more likely to occur and do occur, every day, in our hospitals. For patients, this means a significantly higher risk of complications and, for some, death.*
>
> *A research study on the effects of overtime, equates working double shifts of 17 hours straight to that of a blood alcohol level of 0.05 with peoples response times 50% slower.* [79]

Furthermore, according to Mr Mervin Reed's submission, there is a lack of political understanding of how understaffing impacts on patients when demand exceeds supply on a daily basis, particularly in relation to elective surgery.

> *Each hospital has a finite capacity to provide services but most are understaffed to the extent that full functionality of the operating theatre suites is impossible. For example the RHH has around 14 operating theatres but has only staff to open and use on average about 8 of these theatres.*

[77] Dr Stephen Duckett, *Transcript of Evidence*, 24 October 2018, p. 12.
[78] Australian Nursing and Midwifery Federation, 2017, *Submission* #30, p. 4.
[79] Ibid, p. 5.

The LGH has a similar constraint, and so although a lot of taxpayer funds have gone into the equipment of these hospitals it is the policies of the Minister for Health, and the present Government that see's (sic) them wholly crippled from being able to deliver services to Tasmanian's (sic).

Thus clearly the Government is aware that it is creating misery for a lot of people, indeed over 30,000 are on the waiting list for elective surgery, but yet they are not motivated to actually generate the funding needed to operate the present facilities so that some of this misery can be alleviated.[80]

On the matter of operating theatres at the RHH, Mr Pervan clarified:

As far as I know, they're currently operating out of 12 theatres because they're doing required maintenance and are rotating the closures. The concept or what was put forward that one or more theatres were permanently closed is not the case; they are going around and doing the required maintenance of those theatres. The HEPA filters - the air filtration system - have to be replaced for safety reasons and a number of things have to happen. It is not something you can delay. It used to be that we would close the theatres down, or the majority of them, over the Christmas period and do them then, but we've been maintaining our elective surgery activity for the last couple of years such that this is now required. We can confirm the number of theatres currently opened, but it is because of that rotating temporary closure while we do required maintenance.[81]

Staff Morale

Several witnesses noted the impact of staff stress and morale in the Tasmanian Health Service.

According to Ms Helen Burnet:

Sadly, right now there is by far the lowest level of staff morale I have seen over 23 years in the Tasmanian health service. With people leaving because of dissatisfaction, significant skills and corporate knowledge is lost. There is also fewer people remaining in their chosen professions, because of stressful work environments.[82]

The ANMF (2018) submission noted the pressure placed on nurses at the RHH in a difficult and pressurised work environment:

[80] Mr Mervin Reed, 2017, *Submission #33*, pp. 8-9.
[81] Mr Michael Pervan, *Transcript of Evidence*, 22 October 2018, p. 23.
[82] Ms Helen Burnet, 2017, *Submission #22*, p. 3.

Many of the nurses who perform the triage role are finding the pressures of bed block and the associated lengthy patient waiting times and ramping difficult to manage. The stressors of being unable to treat patients appropriately to due to space and resourcing constraints, is placing undue strain on our caring and resilient staff. There is distress amongst staff when very unwell and often complex care patients (who are often Category 3 patients – and therefore should be seen and treated within minutes) are faced with excessive and lengthy waits in the waiting room.

Patients and their relatives are understandably perturbed and upset when faced with lengthy waits before appropriate treatment spaces and, often treatment, can be provided. This can lead to upsetting and distressing interactions with staff, and occasionally results in negative media stories or editorials/letters to editor etc. These are demoralizing and contribute to an already difficult job, where we feel unable to speak out about the issues of concern due to our employee and State Service Act obligations.

Many colleagues are struggling with the pressures of the ED at present. Anecdotally, some are leaving, reducing work hours and/or working in other areas or roles. These are appropriate ways to individually manage the pressures of the ED environment, and there has been organisational discussion about encouraging resilience supports and, of course, utilizing the EAP (Employee Assistance Program). Whilst these are important measures to combat staff distress they neglect the fact that the staff in ED are already incredibly resilient and capable people. If the current ED situation is overwhelming the resilience capacity of already highly resilient people, then that does not bode well for staff retention and departmental functioning. A particularly pertinent issue considering the concurrent parliamentary inquiry into first responders mental health issues in Australia.[83]

According to Mr Scott Rigby, staff stress is a major issue at the LGH:

We have had such a great core staff group, and they still are, but you can see the pressure and the strain they are under. Fundamentally, that is becoming just as big an issue as the bed block is.

Being ED, you are very strong. Very strong personalities work in an ED. We are proud and humble people, and it is sometimes hard for them to reach out for help but more and more we are seeing that. I am having more and more conversations that illustrate they are struggling, let alone reading what is in the press and what is being said by the ANMF. It is very real, and

[83] Australian Nursing and Midwifery Federation, 2018, *Submission #9*, p. 3.

very real to them. They go into that job for a reason. They go into the job to help that person coming through the door and when they are constantly under pressure and constantly cannot get that person in to give them the treatment they need - it weighs heavily on them.[84]

Mr Tom Millen, representing ANMF and speaking on behalf of the emergency nurses at the LGH ED, reiterated the situation at the LGH:

I am representing the nurses in the Emergency Department at the Launceston General Hospital. My colleagues and I have been under extreme stress for some time. For well over a year now we have seen bed block and ramping becoming an almost daily occurrence with very little reprieve, and it is actually taking a physical and emotional toll on frontline staff.

We are a very resilient workforce and we are a great team. We do our best, but we are being pushed beyond what we should have to deal with on a daily basis.

We have, as a group, decided we needed to plead for help, essentially.[85]

The ANMF 2018 submission stated that the LGH ED has always been a challenging nursing environment, however:

The consistent and unresolved workloads due to bed block have placed significant strain on even the most senior, experienced, and resilient ED nursing staff members.

With no intention of being disrespectful, nursing colleges (sic) have described working in the LGH ED as like working in a "war zone". Yet all the calls for proactive management of the bed block situation appear to have gone unanswered by senior Tasmanian Health Service management. This situation has contributed to staff feeling undervalued and forgotten about.

Recently, after staff were seriously assaulted in the ED, it took over 24 hours before any management acknowledgement was made directly to the staff, which further highlighted the feelings of isolation. Staff feel that, despite the untenable working environment, there is no help or relief coming as it appears that the Department of Health and The Minister for Health just expect us to carry on as we always have done.[86]

[84] Mr Scott Rigby, *Transcript of Evidence*, 28 September 2018, p. 21.
[85] Mr Tom Millen, *Transcript of Evidence*, 14 September 2018, p. 23.
[86] Australian Nursing and Midwifery Federation, 2018, *Submission #9*, p. 7.

The high level of staff stress places patients at a high level of risk. According to Dr Judkins from the ACEM:

> *From my work in the coalface working in the emergency department, it is incredibly stressful and draining for all the staff involved. It is recognised operating this level of mismatch between resources and demand really puts patients care at a high level of risk, where no doubt it impacts patients' length of stay once they make it into hospital. We have no doubt it increases the amount of misdiagnosis, medical errors, increasing morbidity and mortality, so it is a situation we have to find a remedy for.*[87]

The ANMF submission requested the Sub-Committee make a recommendation the Tasmanian Health Service be appropriately funded in order to open and safely staff all available beds in the LGH in order to address the staffing issue caused by bed block at the ED. [88]

The College of Emergency Nursing (CENA) 2018 submission also noted the issues of staff attraction and retention:

> *[CENA] membership feel current workplace demand is overwhelming staff, causing reduction in current staff FTE, affecting staff retention with senior staff leaving to work in other workplaces, and making recruitment difficult to attract senior staff into the ED environment. This is a concern in all Tasmanian hospitals.*[89]

The ANMF (2018) submission highlighted that the impacts on staff morale also contributes to issues in staff recruitment and retention.

> *There is concern from our medical colleagues too that the current situation is affecting staff recruitment. Once coveted RHH ED registrar positions, are now struggling to attract applicants. This, in turn, has implications for accreditation. The situation where multiple department accreditations (LGH ED, RHH psychiatry etc.) have been revoked provides a stark background to the seriousness of this warning. The once protected registrar teaching time has, this year, been cancelled on occasions due to the Level 4 escalations. With the renovations in ED, there has been a reduction in seminar/office areas available for nursing and medical education.*
>
> *Medical colleagues have also expressed concern that there are fewer senior staff and this means decreased levels of support and safety mechanisms for junior staff whilst also increasing risk of adverse events for patients. There have been occasions where senior medical staff/Heads of Department are so*

[87] Dr Simon Judkins, *Transcript of Evidence*, 14 September 2018.
[88] Australian Nursing and Midwifery Federation, 2018, *Submission #9*, p. 8.
[89] College of Emergency Nursing Australasia, 2018, *Submission #6*, p. 7.

distressed at the inability to provide appropriate patient care, that they have been reduced to tears. It should be noted that 'appropriate' care is not 'excellent' or 'exceptional' it is now reduced to 'adequate' care i.e. sufficient only to ensure the safety of the patient.[90]

Dr Chris Wareing, Psychiatrist, speaking in the context of the North West psychiatric services, stated that retention of staff and the absence of competitive salaries is a significant barrier to the delivery of health services in Tasmania:

The barriers there have been what I have said they have been. One has been a pay barrier in that they are not paying at a competitive basis, something that has been acknowledged by other people besides me.[91]

Dr Wareing highlighted the toxic management culture in the North West that contributed to difficulties in retaining staff in Burnie:

The second issue is the toxic management issues and the history of management relationships with psychiatrists in which psychiatrists have been put under general managers, which has not been a good idea. That has been a problem. If you ring the recruitment agents they will tell you quite openly - they talk about Burnie as a toxic environment where they don't like sending people to, and in which recruitment is very difficult.[92]

According to the ANMF (2017) submission, issues with the retention of staff has resulted in the reliance of the acute sector on overtime and double shifts to fill staffing gaps:

For many years the acute sector has relied on nurses working overtime and double shifts to plug gaps in rostering caused by problems with recruitment, retention or restricted hiring of nursing staff. Like all of Australia, Tasmania's demand for nurses significantly exceeds supply. Forecast projections indicate shortfalls across Australia of approximately 85,000 nurses by 2025. Tasmania needs to start to focus on providing opportunities for our graduates before they find work, and permanently settle, in other states and territories.

The lack of a state or local workforce plan has resulted in shortages particularly in specialty units. These include intensive care, emergency neonatal intensive care, mental health, midwifery, paediatrics and operating theatre units…

[90] Australian Nursing and Midwifery Federation, 2018, *Submission #9*, pp. 3-4.
[91] Dr Chris Wareing, *Transcript of Evidence*, 10 October 2017, p. 8.
[92] Dr Chris Wareing, *Transcript of Evidence*, 10 October 2017, p. 9

> *The NUM's are frustrated they cannot employ more nurses because of bureaucratic processes. Recruitment to a vacant funded position requires nine levels of endorsement, including sign off of the selection report by the North/Northwest CEO. These processes take considerable time: often months. While trying to recruit, NUM's have roster shortages that must be filled – usually by overtime and double shifts. This reflects poor system management and puts patients and nurses' safety at risk. It also increases the cost of health care.*[93]

The Interim Report of the Sub-Committee further details the issues of staff overtime and reliance on temporary staff. The ACEM (2018) submission identified existing and projected gaps in emergency department resourcing, and in particular, staffing modelling and staffing levels, and their 2017 submission outlined the recommended Guidelines on constructing and retaining a senior emergency medicine workforce for emergency departments: [94]

> *ACEM considers that utilising this modelling in Tasmania's emergency departments will greatly improve patient outcomes by more efficiently managing patient admission and patient flow processes through both hospitals. Concurrent to this, ACEM also recommends employing permanent salaried staff to better address gaps in staffing numbers, rather than relying on Visiting Medical Officers and their equivalents, as a policy solution.* [95]

According to Dr Judkins, improvements could be made to the model of care:

> *We haven't really changed the model of care, of how we run our inpatient units, for a long time. When you think about how you get a patient through the system, it is about having people with the capacity to make decisions in a timely manner available to make those decisions. We still run on a system that has the most junior staff doing most of the work and waiting for their bosses to come in and make decisions.*[96]
>
> *One of things we really need to ask is: do we need to move away from an inpatient specialist system that relies on VMOs to a system where we have more full-time specialists, or at least specialists with substantive commitment to the hospital, to really invest in effective and efficient care of patients? If we only have senior decision-makers in the place for a couple of hours every now and then, you can see why patients are sitting and waiting.*
>
> *…*

[93] Australian Nursing and Midwifery Federation, 2017, S*ubmission #30*, p. 7.
[94] Australasian College for Emergency Medicine. Background paper – Guidelines on constructing and retaining a senior emergency medicine workforce (G23). Melbourne: ACEM 2015
[95] Australasian College of Emergency Medicine, 2018, *Submission #10*, p. 3.
[96] Dr Simon Judkins, *Transcript of Evidence*, 14 September 2018, p. 38.

One of the things we can do to ensure we are minimising risks for patients is having people who are experienced at the coalface as much of the day and of the week as we can. I don't think we can move away from that. We have to recognise that is a part of the solution. It is still not getting the mental health patient out of the emergency department under five days. We have to ensure we invest in proper senior staff and FACEMs who can multi-task, who can absorb risk and who can make those decisions. [97]

Rural Generalists

Dr Eve Merfield, president of the Rural Doctors Association of Tasmania (RDAT), noted that Rural Generalists are a resource for some of the issues growing in the acute health sector.

According to Dr Merfield:

A rural generalist is a doctor working in a rural context with an expanded skill set such that they work in primary care as well as inpatient services and have an advanced skill in a particular area. They work in groups such that those skills meet the demands of their local community. Traditionally this has been well set up in Queensland and some other states, and in those states it tends to be a focus on the procedural skills, such as GP obstetricians, anaesthetists, surgeons et cetera.

In Tasmania it may be the community needs in rural areas are more towards having people with advanced skills in mental health, palliative care, aged care, addiction medicine and pain management, and those advanced skills may be more appropriate. That is something communities look at on a local basis.

The rural generalist pathway is something that is being set up nationally. There is a national rural health commissioner, Professor Paul Worley, who has visited Tasmania on a number of occasions to try to get this happening here. Initially there was some state funding and a director of Rural Pathways was appointed. That state funding has run out.

A director of Rural Pathways was appointed and is still in a position but funding is becoming an issue as the state funding has run out and they are looking for funding from other sources. Mr Ferguson has stated his support for rural generalism but we need a bit more than verbal support.[98]

[97] Ibid, p. 46.
[98] Dr Eve Merfield, *Transcript of Evidence*, 21 September 2018, pp. 19-20.

Dr Merfield provided information on how rural generalists can be used to assist as a workforce solution for the Mersey Community Hospital, particularly in areas where locums are currently used such as the emergency department:

> *A rural generalist can be working in primary care as well as working in a number of roles in the hospital. As I said, the idea is that they work in teams with different specialties. All rural generalists have emergency medicine skills. That is part of rural generalist training, so that they can work in different areas of the hospital. If it is busy in emergency, they can go and help in emergency on top of the rostered staff. If it is not so busy, they can go and work in another area. The idea is that it is important to have quality care and they would be working in teams, perhaps with visiting specialists from the north-west region or elsewhere, who would maintain ongoing education, training, quality assurance activities and so on to make sure quality care is maintained.*
>
> *Locums are very high cost. There are issues with lack of continuity of care and some of the extreme costs, which would be decreased by having rural generalists.*[99]

And further:

> *They [locums] might be there for a couple of weeks and then they are gone whereas with a stable workforce, it is much improved. There is also the issue around ongoing education and training, locums do not tend to be involved with education and training of junior doctors. Your next generation of doctors, if they are exposed to rural generalism and can see that and get trained in that becomes self-perpetuating.*[100]

At present there is not a Rural Generalist pathway in Tasmania:

> *The director of Rural Pathways has been working on trying to set up a rural generalist training pathway because there is quite a bit involved in it. It would take three to five years for the first ones to start getting turned out because they have to be adequately trained. We are talking about the right doctor with the right skills in the right place. You cannot just have anybody doing it. It does take a bit to set up. We have secured some training places and there are currently four junior doctors who have embarked on rural generalist training, but at the moment there is not a set end point because the industrial agreements for how a rural generalist will be employed are*

[99] Ibid, p. 20.
[100] Dr Eve Merfield, *Transcript of Evidence*, 21 September 2018, pp. 24.

not in place yet. They have started but they do not know what their end point in terms of where they are going to be in full employment.[101]

Nurse Practitioner Service

Mr Tony Bradley, CENA, noted that the Nurse Practitioner Service can be utilised in the Emergency Department to increase flow and reduce access block.

According to Mr Bradley:

> *They work through most of the 4s and 5s. There is the odd cat. 3 and 2 that they will see if they meet certain conditions and they work within their scope. They are still overseen by a doctor and then you have the nurse practitioner… They can order tests, order X-rays, make the diagnosis, discharge the patient… Prescribe as well.*[102]

Mr Michael Jacques, CENA, further clarified the scope of Nurse Practitioners:

> *Everyone's scope is slightly different. I am not going to administer anaesthetics to put someone to sleep for a procedure. Within my scope, there are set things you can prescribe and it is quite an exhaustive list because you need to have a good cross spread.*[103]

The Nursing Practitioner system is currently not flourishing and there are currently no nursing practitioner courses in Tasmania.

According to Mr Bradley:

> *UTAS does not offer a nurse practitioner course. They offer a postgraduate certificate of emergency nursing and a graduate diploma of emergency nursing which leads on to a masters of nursing.*
>
> *…*
>
> *We need a more clinically approached postgraduate certificate so that people come out with resus skills and are right to work in resuscitation from having a postgraduate certificate. Certainly a lot of other hospitals do not let a nurse work in resuscitation unless they have a postgraduate certificate. We cannot afford that; we train our own. A lot of people have done the postgraduate certificate but do not work in resuscitation. I think we need to have some of the services set up and make the end goal of a nurse practitioner an option.*

[101] Ibid, p. 21.
[102] Mr Tony Bradley, *Transcript of Evidence*, 21 September 2018, p. 10.
[103] Mr Michael Jacques, *Transcript of Evidence*, 21 September 2018, p. 10.

That means having nurse practitioner candidate positions created alongside a nurse practitioner course of some sort. [104]

When speaking about nurse practitioners, Mr Bradley said:

> *… it takes quite a while to get here, but there are quite a lot of people who could probably take that step. It is now a common thing in other hospitals to have nurse practitioners. The RHH has two FTEs of nurse practitioners in the emergency department, but more would be great to deal with the workload.*[105]

Loss of Specialist Accreditations

According to Helen Burnet's submission, the loss of psychiatric training at the Royal Hobart Hospital is detrimental to its reputation:

> *The recent withdrawal of psychiatry training at the Royal Hobart Hospital is an absolute blow and should be reversed immediately. The reputation of the RHH is damaged and this could have flow-on effects to other disciplines, professions and would be very damaging if the status of the Medical School and the RHH as a training hospital was brought into question.*[106]

The Minister for Health, in his submission expressed a commitment to continue to:

> *… work with Royal Australia (sic) and New Zealand College of Psychiatry, to resolve concerns around training and accreditation. There is no doubt this is a disappointing situation that the Government and the THS are taking very seriously, but services at the RHH mental health unit will continue to operate as normal while we work cooperatively on solutions, including working hard to recruit more psychiatric doctors and nurses.*[107]

In its 2018 submission, the Royal Australasian College of Surgeons (Tasmanian Regional Committee) expressed concern in relation to the loss of accredited training positions in the ED at the LGH:

> *RACS and its specialty training boards can only approve training positions in centres that maintain high standards of care, adequate clinical exposure for training, and support for Trainees and trainers within the context of a structured program of education. In order for training positions to remain*

[104] Mr Tony Bradley, *Transcript of Evidence*, 21 September 2018, pp. 9-10.
[105] Ibid, p. 9.
[106] Ms Helen Burnet, 2017, *Submission #22*, p. 2.
[107] Minister for Health, 2017, *Submission #27*, p. 15.

accredited Trainees must have exposure to an appropriate case mix, and demonstrate their ability to adequately perform a wide range of procedures.

Due to the lack of emergency procedures being performed at LGH, accredited training positions have been lost. While this has obvious immediate impacts on the quality of service, the Committee also has significant concerns about the long-term ramifications this will have on the future of Tasmania's surgical workforce.

Experience tells us that surgeons are much more likely to work in hospitals where they have previously trained. Consequently, the lack of opportunities at LGH will force many local Trainees to seek opportunities elsewhere in Australia and New Zealand, and in many cases they will never return to work in Tasmania. Additionally, the loss of Trainees who travel to Tasmania specifically to undertake training rotations at LGH, hinders the ability of future recruitment efforts and creates the potential for workforce shortages.

Tasmania – as a smaller state – must ensure that the number of training positions in surgery are maintained or increased to meet pressure created by an aged population. While the issues facing LGH are complex, there is a requirement for a strong commitment from the state governments to work with LGH to ensure that it is reaccredited, and to provide ongoing funding for additional training posts in the future.[108]

The Sub-Committee also notes the near loss of accreditation by the Australian and New Zealand College of Anesthetists at the NWRH.

According to Dr Stuart Day, CEO of the Australian Medical Association:

The North West anaesthesia has been on the agenda since the beginning of the year, so well over 11 months now. There were some signs that things were pretty precarious, to the point where finally the college came early because there wasn't any action. It is just a shame that the actions that occurred in the last couple of weeks in the north-west coast had been asked for 11 months and could have been supplied through an orderly mechanism. Why that does not get a response through the correction processes and requires the college to threaten to pull everything is really unsettling for us.[109]

[108] Royal Australasian College of Surgeons, Tasmanian Regional Committee, 2018 *Submission #2*, p. 1.
[109] Dr Stuart Day, *Transcript of Evidence*, 12 December 2017, p. 36.

Areas of Acute Health Services with Specific Issues

While many areas of acute services delivery are experiencing particular demand, the Sub-Committee received evidence relating to the following service areas.

Mental Health Services

The AMA expressed concern regarding the capacity and design of the new acute psychiatric inpatient unit and its ability to meet the contemporary care standards:

> *… psychiatric units, wherever possible, go on the ground floor. They go on the ground floor for an obvious safety reason and for more economic access to outdoor spaces. If you read any of the guidelines for the development of psychiatric units, you will see that they repeat over and over again that outdoor spaces are not luxury spaces, they are a primary part of the psychiatric unit.*
>
> *… The way you design a psychiatric unit is very different to the way you design a medical and surgical unit. Medical and surgical patients are generally deemed to be bed-based patients. Psychiatric patients are not generally deemed to be bed-based patients. This is important when you are talking about mental health observations units and the emergency department.*
>
> *… If you looked at the old PICU, it was 750 square metres. It was a bit underground, but it was large. It had a large area you could circumnavigate, and outside of the nurse's station there was a dining area, a TV and socialisation area, which opened out onto an outdoor area. All of those spaces were together so you had a sense of space… as well as making sure the outdoor area and the indoor socialisation and recreational areas are all together so it also feels large. None of the units incorporate any of those designs.*
>
> *… The J and the K block designs are both smaller. They do not have modern designs so that they feel spacious. They are industrial in look rather than domestic in feel, and they do not incorporate many of the modern contemporary designs that you would read about or see in some other places. They have added some outdoor units after lobbying by the AMA, the ANMF and the college. They have added some quasi-outdoor areas to both J and K block but they are very small. They are very different to being able to walk out into a garden.*
>
> *… The larger the space you have, the less you will need to use medication, the less overcrowding you will have and the fewer incidents you will have. There will be direct correlation between the size of the unit and those incidents.*[110]

[110] Dr Richard Benjamin, *Transcript of Evidence*, 10 November 2017, pp35-36.

The AMA recommended a long term commitment to build 'stage two of the master plan' as supported by the Taskforce:

> *"The Taskforce agreed that the preferred location for mental health inpatients would be in a ground floor design but this could only be incorporated in a subsequent stage of the Master plan. On this basis, the Taskforce noted that the opportunities to progress the Master plan should be explored so as to provide the most appropriate level of contemporary care to mental health inpatients". ... "... but this can only be incorporated in to future currently unfunded stages of the Master plan".... "the Master plan for Stage three, much better designed, mental health facility on the corner of Campbell and Collins St is still very much desired and something we will continue to pursue funding for."* [111]

The Minister for Health noted that there is some room for movement in relation to the design or structure of the K block:

> *Mr FERGUSON - Additionally during the election campaign while we are committed to the tower and delivering it on time and on budget as promised, we also have committed to a master plan of the whole site. As part of that master planning process we've given an undertaking that mental health will be considered during that process.*
>
> *Ms FORREST - There is room for some change in that, is that what you are saying in this master plan?*
>
> *Mr FERGUSON - There is room and it will be considered.*
>
> *CHAIR - One of those problems was that it wasn't ground floor. Is that still an issue with some of the clinicians?*
>
> *Mr FERGUSON - It depends who you ask, to be honest with you. I want to be delicate about this but there is definitely a diversity of opinion. Many staff are really looking forward and hoping to move into K Block knowing it is far superior to the current facilities, and I quote the Chief Psych in that regard.*[112]

The Mental Health Council of Tasmania's submission stated there are two primary factors influencing the capacity of Tasmanian hospitals to meet the current demand in the provision of mental health services.

[111] Australian Medical Association, 2017, *Submission #8*, p. 9.
[112] Minister Ferguson, *Transcript of Evidence*, 22 October 2018, p. 34.

These are:

> *… an existing service system that lacks 'step-up step-down' treatment options for mental health consumers; and under-resourcing of the sub-acute structured supports that do exist.*[113]

According to the Mental Health Council of Tasmania (MHCT), a stepped model of care is a feature of all contemporary mental health service design which will ensure people get the right clinical service at the right level and at the right time, linked to other non-health supports as required:

> *Tasmania's Rethink strategy aligns itself with this principle, stating that its "goal is to reorientate the Tasmanian mental health system to increase community support and reduce the reliance on acute, hospital based mental health services".*
>
> *Rethink is a ten-year strategy which means we can expect to see the evolution of a Tasmanian stepped care model in the near future, but it won't appear instantaneously. If we scrutinise the system at the current moment we see a number of new interventions in 'step down' care—one example is Anglicare's Early Intervention Referral Service (EIRS) which provides intensive psychosocial support following hospital presentations after a suicide attempt—but very little yet in the way of 'step up' supports. It is arguably too early to assess the systemic benefits of any nascent initiatives in this space. What this means is that a Tasmanian experiencing mental ill-health who is not already connected to the service system has essentially two presentation options: primary care (GPs) or acute care (emergency departments). There are no self-referring support options available between these two extremes.*[114]

In relation to the under-resourcing of existing sub-acute community and clinical supports:

> *At MHCT we field phone calls on a weekly basis from individuals within the community whose family members experiencing mental ill-health have presented to a GP and been referred onward to specialist care, only to find that there is a three-month waiting period for an appointment with a private psychiatrist. For an individual in the escalating stages of a mental health crisis this is woefully inadequate and there is every likelihood this person will present to an emergency department in a state of distress and desperation before three months has elapsed.*

[113] Mental Health Council of Tasmania, 2017, *Submission #17*, p. 3.
[114] Ibid, p. 3.

What this also means is that individuals who are experiencing worsening symptoms of mental ill-health may present to hospital because there are no other options, only to be triaged and told that they are not sufficiently unwell to be treated. This is not only a deeply unsatisfactory care outcome for the individual but adds significantly to the burden of emergency department presentations.[115]

The ACEM (2018) submission outlined the problem of mental health access block:

Mental health access block is also a significant problem for emergency departments in Tasmania. Recent research published by ACEM found that across Australia, mental health presentations comprise only 4% of patient presentations to emergency departments but they comprise approximately 28% of patients waiting longer than eight hours for an inpatient bed.

Many patients in Tasmania wait for days in the emergency department, which are not designed or resourced to provide mental health care. Emergency departments are full of physical hazards for people at risk of harm or self-harm. The lack of certainty about how long people might have to wait for a bed or a transfer, and the stimulation from noise and lights of the emergency department environment, is harmful for people experiencing mental health crisis and behavioural disturbance. The risks of violence, sedation or patients leaving without being treated also escalates the longer a patient waits.

These circumstances combine to undermine rather than support their recovery while also placing additional demands on already stretched emergency departments.

ACEM recommends that Tasmania commits to a planned investment in acute and community mental health services.[116]

The Minister for Health outlined a number of mental health initiatives in the Ministerial Statement on Health dated 16 October 2018:

Today, I can announce that the Government has reworked our Plan and will now deliver an accelerated mental health beds commitment. We will be taking immediate action to recruit and open 12 new Mental Health in the Home beds in Hobart - in response to increasing demand on the Emergency Department, and in response to increasing pressure on the acute mental health inpatient unit at the RHH.

[115] Mental Health Council, 2017, *Submission #17*, p. 3.
[116] Australasian College of Emergency Medicine, 2018, *Submission #10*, p. 2.

> *Hospital in the Home, or "HITH", is an innovative model utilised throughout the country, through which patients receive hospital level care whilst being accommodated in their own home. Evidence shows that this approach provides the same quality of care as traditional, hospital-based care for medically stable patients, and has superior outcomes in some cases…. Noting current demand at the Emergency Department of the RHH, a staff member of the HITH would be expected to attend the Emergency Department each morning to identify those patients who would be more appropriately treated by the HITH team.*[117]

In response to the challenging Mistral Place proposal:

> *The Government will construct a brand new 12-bed dedicated mental health facility as St Johns Park in New Town, to assist with the management of demand for mental health services, to increase patient flow and deliver more access to mental health care. This is a bigger, better facility than our initially proposed Mistral Place expansion, delivering two more beds and a better environment for clients.*[118]

And in addition:

> *Tasmania's first ever child and adolescent mental health facilities are now less than 12 months away – due to open in Launceston in September next year, after the first stage of the 4K redevelopment is completed.*
>
> *These beds will service young Tasmanians across the North and the North West, providing high levels [of] care closer to home for these young people and their families – a huge step forward for our system. The new adolescent unit at the Royal Hobart Hospital will follow within six months after, providing more specialist child and adolescent mental health facilities for vulnerable Tasmanians, along with the new mental health unit as part of the redevelopment, subject of course to consultation through the Clinical Planning Taskforce.*
>
> *Then later, in 2020, the Peacock Centre will provide 15 more beds, before the 12-bed St John's Park facility at New Town is completed in 2021. All up - this means that within just three years there will be the 27 more mental health beds available in our system, plus the child and adolescent mental health facilities delivering capacity we have never had before in our State.*[119]

These initiatives were proposed after the release of the Sub-Committee's Interim Report, which focused heavily on mental health.

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[117] Michael Ferguson, Minister for Health, Ministerial Statement on Health, 16 October 2018, http://www.premier.tas.gov.au/releases/ministerial_statement_on_health
[118] *Ibid*.
[119] *Ibid*.

In their 2017 Submission, the AMA identified the need for dedicated clinical directors in each acute mental health unit across the State:

> ***6. <u>Need for on-site clinical directors</u>***
>
> *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 unit at the RHH has gradually lost resources, and the 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, governance, leadership, resource allocation, strategic and advocacy roles. They should also provide leave backfill, therefore assisting with the provision of a critical mass for staffing.*[120]

TERM OF REFERENCE 2: FACTORS IMPACTING ON THE CAPACITY OF EACH HOSPITAL TO MEET THE CURRENT AND PROJECTED DEMAND IN THE PROVISION OF ACUTE HEALTH SERVICES

FINDINGS:

1. Ambulance ramping, over-crowded emergency departments, high inpatient occupancy rates and bed/access block, particularly in medical and acute mental health wards, is resulting in delays in access to care, poor patient flow and delays to discharge.

2. Tasmanian acute care hospitals have among the highest rates of access block in the nation with the LGH being the worst performing hospital of 29 large regional hospitals.

3. Acute mental health bed access block is a significant problem for emergency departments around Tasmania.

4. Emergency departments do not provide a therapeutic environment for patients with acute mental illness awaiting admission.

5. An increase in the complexity of individual patients presenting to emergency departments adds to the challenge of meeting NEAT targets and contributes to access block and prolonged length of stay.

6. Tasmanian patients are waiting unacceptably long periods of time for necessary elective surgery.

[120] Australian Medical Association, 2017, *Submission #8*, p. 10.

7. Admitted patients are experiencing delays in discharge waiting for non-acute care. Pharmacy, pathology, radiology and allied health care are some services not routinely provided outside usual working hours.

8. Good governance and effective leadership in executive management and clinical decision making is essential to manage demand across the Tasmanian Health Service.

9. Repeated reorganisation of acute health services has created ongoing disruption, negatively impacting on staff retention, higher rates of staff stress and turnover, change fatigue, loss of corporate knowledge and inefficient use of scarce financial and human resources.

10. In other jurisdictions efficiency models, such as the LEAN methodology, have resulted in improved performance across a range of measures of service delivery and patient outcomes.

11. Models of care within areas such as emergency departments have modernised and changed over recent years, however medical inpatient models of care have not changed significantly for many years.

12. Collaborative long-term workforce and infrastructure planning for all areas of health service delivery is essential, including a 'whole of hospital' approach to address overcrowding.

13. Chronic hospital overcrowding is causing health care professionals to experience significant workplace stress.

14. Senior staff have felt they have not been listened to by the Minister and senior bureaucrats, have not been adequately supported and have felt unable to propose initiatives and solutions to address local issues and to manage demand.

15. Underinvestment in the health workforce is resulting in the higher use of locum medical staff, agency nursing staff and high levels of overtime.

16. The loss and threatened loss of specialist accreditation at major Tasmanian hospitals is having a detrimental impact on recruitment and retention of specialist medical staff, and the quality of service delivery.

17. Nurse Practitioners play an important role in acute health care.

18. Investment in primary health is needed to reduce demand for acute health services.

19. Infrastructure constraints in major hospitals, particularly the RHH during the period of re-construction, inadequate bed numbers and specialist staff availability are negatively impacting on the delivery of acute health services.

20. Concern remains regarding the design and capacity of the new acute mental health unit in K Block of the RHH redevelopment.

21. Following the release of the Sub-Committee's first Interim Report, the Government has identified alternate models of care aimed at addressing mental health access block to provide greater access to acute mental health care.

TERM OF REFERENCE 3

THE ADEQUACY AND EFFICACY OF CURRENT STATE AND COMMONWEALTH FUNDING ARRANGEMENTS

According to the Tasmanian Government submission, healthcare funding arrangements in Australia are complex and rely on multiple funding sources and methods:

> *The ways that governments pay for healthcare services impact directly on the appropriateness, timeliness and accessibility of healthcare and the health outcomes of individuals. The complexity of Australia's funding arrangements is recognised as a barrier to improving system efficiency, simplicity and achieving patient-centred healthcare.*
>
> *Current funding arrangements are fragmented and duplicative, impacting on patients, providers and funders, and jeopardising the sustainability of the broader healthcare system. Policies and programs are often designed in isolation from one another, even though patients access services across boundaries and between programs.*
>
> *…*
>
> *In an effort to address these deficiencies, future reforms to the national health financing framework and current funding arrangements are under consideration at a national level. These reforms include:*
>
> - *The incorporation of value based measures into funding models, building on existing programs such as pricing for safety and quality to include clinical outcomes and patient reported experience and outcomes;*
> - *The expanded use of bundled payments (where a single price is determined to cover a full package of care over a defined period of time, spanning multiple events and settings of care); and*
> - *Blended funding at a provider level, allowing multiple sources of funding for primary care, allied health, specialist care, acute care and restorative aged care to be pooled by individual providers to provide 'wrap around' care for patients and communities.*[121]

According to the AMA submission, health funding will always be a difficult issue:

[121] Tasmanian Government, 2017, *Submission #32*, pp. 21-22.

> *The AMA accepts that there will never be unlimited funding and rationing will in some form will be required. However, it is essential the funding that is provided for health is spent in in (sic) health. Tasmania gets a GST allocation recognising its oldest and sickest population. This should be reflected in the health spend in our state. Similarly, activity based funding and block funding grants need to deliver funds to the health services that are treating the patients, not be unreasonably diverted; the funding should follow the patient journey.*[122]

The ANMF submission noted the difficulties in gaining a clear picture of health funding:

> *Gathering a clear and accurate picture of the funding provided by State Government to the acute care sector is not always easy as costs and data are often skewed by what is presumably a deliberately confusing budget reporting.* [123]

Mr Martyn Goddard, Independent Health Policy Analyst, claimed Tasmania's pubic hospital system is underfunded and underperforming:

> *The submission quantifies the lack of funding and resources by showing the poor performance of Tasmania in providing capacity for our hospitals to do their job. It also shows that in order to provide a level of care comparable to other states, this state would need an extra 300 beds by the end of the next parliamentary term.*
>
> *Although this document uses national averages as its main benchmark, public hospitals throughout the nation are inadequately resourced; Tasmania's are worse than the average. The inadequacy of the nation's hospitals are principally a result of Commonwealth under-funding; the relative inadequacy of Tasmania's, compared with the others, is the responsibility of the state government.*[124]

According to Mr Goddard, both the State and Commonwealth need to share responsibility for the state of Australia's public hospitals:

> *The Commonwealth is the only level of government capable of raising enough money to make the system work as it should, yet it consistently refuses to do so. It is well known that unless Commonwealth funding increases dramatically and fairly soon, health costs will overwhelm all state and territory budgets. On the other hand, the states also have a case to answer.*

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[122] Australian Medical Association, Tasmania, 2017, *Submission #8*, p.2.
[123] Australian Nursing and Midwifery Federation (Tas. Branch), 2017, *Submission #30*, p. 26.
[124] Mr Martyn Goddard, 2017, *Submission #10*, p. 2.

Some jurisdictions – most notably the ACT – are seriously inefficient in their use of money, staff and resources. Queensland and Western Australia are also less efficient than their peers; Tasmania, South Australia and New South Wales are around the average; Victoria is more efficient. But although cost-efficiency has generally improved in recent years, it has often largely (particularly in Tasmania) been as a result of making doctors and nurses work harder, by largely eliminating spare capacity (with implications for safety and the ability to handle peaks) and – as this paper will show – by diverting money away from hospitals into other political priorities.[125]

According to Mr Goddard:

Data from the Australian Institute of Health and Welfare isolate the various sources of per capita health funding by source. The amount of money each state and territory puts of its own money into the day-to-day running of health and hospitals varies greatly. Over a decade, Victoria and Tasmania are consistently at the bottom; the two territories are at the top.

Table 1: Per capita state/local government recurrent health expenditure and national state/territory average, current prices, 2005-06 to 2014-15[126]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Average
2005-06	1 101	978	1 021	1 103	1 179	**975**	1 611	2 304	**1 079**
2006-07	1 157	1 046	1 237	1 265	1 276	**1 126**	1 692	2 493	**1 187**
2007-08	1 181	1 035	1 399	1 380	1 464	**1 216**	1 785	2 641	**1 255**
2008-09	1 192	1 070	1 544	1 489	1 618	**1 211**	2 040	2 955	**1 355**
2009-10	1 271	1 185	1 789	1 561	1 810	**1 283**	2 330	2 908	**1 511**
2010-11	1 317	1 266	1 826	1 828	1 858	**1 710**	2 556	3 722	**1 554**
2011-12	1 397	1 295	2 040	2 214	2 048	**1 648**	2 873	4 489	**1 698**
2012-13	1 528	1 276	2 037	2 157	1 986	**1 275**	2 852	4 456	**1 717**
2013-14	1 565	1 408	2 023	2 165	2 157	**1 389**	2 645	4 049	**1 766**
2014-15	1 590	1 431	2 016	2 152	2 069	**1 442**	2 751	4 470	**1 777**

Source: AIHW, Health Expenditure Australia

The most recent information available from the Australian Institute of Health and Welfare (AIHW) in the following figure and tables show an increase in per capita spending by Tasmania from 2015/16:[127]

[125] Mr Martyn Goddard, 2017, *Submission #10*, p. 2.
[126] *AIHW, Health Expenditure Australia* in Martyn Goddard, 2017, *Submission #10*, p. 2.
[127] https://www.aihw.gov.au/getmedia/e8d37b7d-2b52-4662-a85f-01eb176f6844/aihw-hwe-74.pdf.aspx?inline=true p22. Accessed 8 November 2018;
https://www.aihw.gov.au/getmedia/e8d37b7d-2b52-4662-a85f-01eb176f6844/aihw-hwe-74.pdf.aspx?inline=true p23. Accessed 8 November 2018.

(a) Based on annual estimated resident population. See Appendix C for more details.

(b) The ACT per person figures are not calculated as they include large expenditures for NSW residents; therefore, the ACT population is not an appropriate denominator.

(c) Australian average includes the ACT.

Source: Table 2.11.

Figure 2.11: Average recurrent health expenditure per person[(a)], current prices, for each state and territory[(b)] and Australia[(c)], 2016–17

Table 2.11: Average recurrent health expenditure per person[(a)], current prices, for each state and territory[(b)], all sources of funds, 2006–07 to 2016–17 ($)

Year	NSW	Vic	Qld	WA	SA	Tas	NT	Australia[(c)]
2006–07	4,367	4,311	4,222	4,297	4,408	4,102	5,410	4,337
2007–08	4,652	4,571	4,581	4,690	4,889	4,627	6,000	4,664
2008–09	4,982	4,942	4,977	5,023	5,289	4,971	6,581	5,027
2009–10	5,206	5,289	5,334	5,179	5,590	5,149	6,587	5,302
2010–11	5,470	5,620	5,560	5,518	5,903	5,573	7,364	5,599
2011–12	5,777	5,849	5,945	5,780	6,271	5,858	8,548	5,913
2012–13	5,977	5,884	6,099	5,963	6,298	5,914	8,211	6,035
2013–14	6,196	6,046	6,318	6,235	6,599	6,194	8,161	6,248
2014–15	6,354	6,204	6,502	6,634	6,674	6,409	8,186	6,433
2015–16	6,543	6,378	6,897	6,916	6,930	6,758	8,930	6,685
2016–17	6,678	6,581	7,151	7,259	6,979	7,000	9,827	6,891
				Percentage variation from the national average (%)				
2006–07	0.7	–0.6	–2.6	–0.9	1.6	–5.4	24.7	. .
2007–08	–0.3	–2.0	–1.8	0.5	4.8	–0.8	28.6	. .
2008–09	–0.9	–1.7	–1.0	–0.1	5.2	–1.1	30.9	. .
2009–10	–1.8	–0.3	0.6	–2.3	5.4	–2.9	24.2	. .
2010–11	–2.3	0.4	–0.7	–1.4	5.4	–0.5	31.5	. .
2011–12	–2.3	–1.1	0.5	–2.2	6.1	–0.9	44.6	. .
2012–13	–1.0	–2.5	1.1	–1.2	4.4	–2.0	36.1	. .
2013–14	–0.8	–3.2	1.1	–0.2	5.6	–0.9	30.6	. .
2014–15	–1.2	–3.6	1.1	3.1	3.7	–0.4	27.3	. .
2015–16	–2.1	–4.6	3.2	3.5	3.7	1.1	33.6	. .
2016–17	–3.1	–4.5	3.8	5.3	1.3	1.6	42.6	. .

(a) Based on annual estimated resident population. See Appendix C for more details.

(b) The ACT per person figures are not calculated, as they include large expenditures for NSW residents; therefore, the ACT population is not an appropriate denominator.

(c) Australian average includes the ACT.

Sources: AIHW health expenditure database; ABS 2018a.

Table 2.12: Average recurrent health expenditure per person[(a)], constant prices[(b)], for each state and territory[(c)], all sources of funds, 2006–07 to 2016–17 ($)

Year	NSW	Vic	Qld	WA	SA	Tas	NT	Australia[(d)]
2006–07	5,245	5,144	5,205	5,354	5,396	4,945	6,825	5,261
2007–08	5,461	5,358	5,513	5,683	5,831	5,466	7,393	5,533
2008–09	5,716	5,629	5,812	5,868	6,117	5,708	7,795	5,797
2009–10	5,827	5,893	6,033	5,873	6,293	5,741	7,566	5,954
2010–11	6,080	6,197	6,214	6,207	6,592	6,182	8,397	6,230
2011–12	6,305	6,366	6,525	6,341	6,882	6,384	9,527	6,465
2012–13	6,364	6,269	6,526	6,360	6,738	6,298	8,954	6,438
2013–14	6,476	6,316	6,613	6,493	6,915	6,494	8,653	6,533
2014–15	6,522	6,370	6,682	6,786	6,860	6,590	8,530	6,605
2015–16	6,623	6,463	6,996	6,964	7,019	6,846	9,124	6,770
2016–17	6,678	6,581	7,151	7,259	6,979	7,000	9,827	6,891

(a) Based on annual estimated resident population. See Appendix C for more details.

(b) Constant price health expenditure is expressed in terms of 2016–17 prices. See Appendix C for more details.

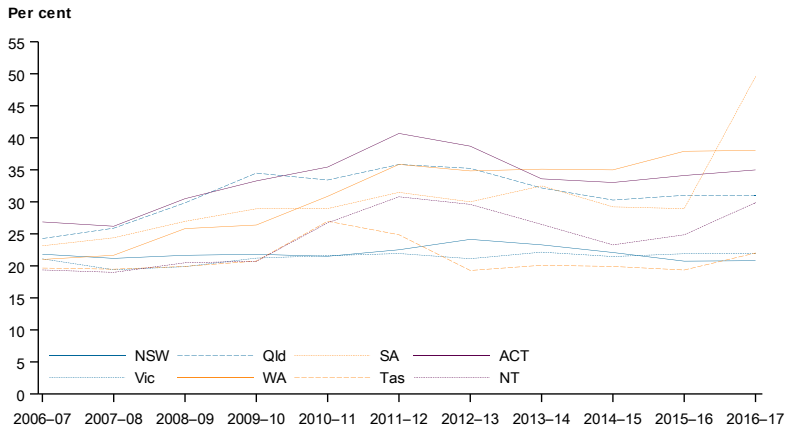
(c) The ACT per person averages are not calculated, as they include large expenditures for NSW residents; therefore, the ACT population is not an appropriate denominator.

(d) Australian average includes the ACT.

Sources: AIHW health expenditure database; ABS 2018a.

According to AIHW data, Tasmania had the lowest ratio of health expenditure to tax revenue of all states and territories from 2012/13 to 2016/17:

Figure 6: The ratio of health expenditure to tax revenue, by state and territory governments, current process, 2006-7 to 2016-17[128]



	Ratio of health expenditure to tax revenue (%)							
	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
2006–07	21.8	21.1	24.3	21	23.1	19.7	26.9	19.4
2007–08	21.2	19.4	25.9	21.7	24.4	19.5	26.2	19
2008–09	21.6	19.9	29.8	25.8	27	19.9	30.5	20.5
2009–10	21.8	21.2	34.5	26.4	28.9	20.7	33.3	20.7
2010–11	21.5	21.6	33.4	30.9	28.9	27	35.4	26.7
2011–12	22.5	21.9	35.8	35.8	31.5	24.9	40.7	30.8
2012–13	24.1	21.1	35.2	34.8	30	19.3	38.7	29.6
2013–14	23.3	22.1	32.2	35.1	32.5	20.1	33.6	26.5
2014–15	22.1	21.5	30.3	35	29.2	19.9	33	23.3
2015–16	20.7	21.9	31	37.9	28.9	19.4	34.1	24.9
2016–17	20.8	22	31	38	49.6	22	35	29.9

[128] Australian Institute of Health and Welfare (AIHW) health expenditure database; ABS 2018f.

The following table, compiled from data contained within various THS Annual Reports and Tasmanian Budget Papers, provides a summary of budget vs actual spending since 2014/15, showing actual expenditure is significantly higher than budget over a number of years:[129]

Expense by Output	**2018**	**2018**	**2017**	**2017**	**2016**	**2016**	**2015(a)**	**2015(a)**
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
1.1 Admitted Services	819,545	902,335	772,698	835,206	760,331	788,755	650,396	*719,539*
1.3 Emergency Department Services	119,583	150,817	115,194	138,317	122, 114	123,535	118,093	*126,507*

(a) Please note the Tasmanian Health Service (THS) commenced on 1 July 2015. Prior to this there were three regionally based Tasmanian Health Organisations (THOs) being THO-North, THO-North West and THO-South. The 2015 figure is a proxy figure as it consolidates the data for the three THOs.

The Minister for Health acknowledged additional funding had been required to meet budget shortfalls:

> *Mr FERGUSON - … The health system in the last financial year cost more than was originally budgeted for, but the Government provided the additional budget.*
>
> *Ms FORREST - It has every year. That is my point, minister.*
>
> *Mr FERGUSON - I understand the point. Since we last sat down together, in our last Budget in May the Government put an extra $465 million in over the next four years. That is structural funding. I am confident in saying that if it is not every single dollar, the vast majority of that is recurrent funding, so it does sit as structural funding and, if you like, baseline funding for the health system. We know it is very busy; no-one is denying that.*
>
> *Ms FORREST - We know, minister, from sitting across the table in budget Estimates that this year's budget is still less than the actual expenditure from last year, in spite of the extra funding you are putting in for this year's budget. So are you sitting here telling me we are not going to see a blowout again this year because you put in extra? It is still less than what was paid last year.*

[129] Tasmanian Health Service, Annual Report - various years & Tasmanian Budget Papers No 2 - various years.

Mr FERGUSON - I have already said publicly on a number of occasions that we expect this year will be no different in that we will be providing extra support.

Ms FORREST - Why don't we budget for that and actually increase the capacity of the system?

Mr FERGUSON - That is exactly what we are doing, Ms Forrest. I have just told you that we have placed an extra $465 million in the May budget.[130]

Funding and Bed Numbers

Mr Goddard continued his analysis by outlining the link between adequate health funding and the number of beds provided in public hospitals, having regard to the different needs in each jurisdiction:

Because of Tasmania's older, poorer and sicker population, the Commonwealth Grants Commission calculates the state needs 1.091 times as much to be spent on admitted patient care as the nation as a whole, and uses this needs-based weighting to deliver commensurately more GST money to the state. If we apply this weighting to bed numbers, it means Tasmania in 2015-16 would have needed about 130 more beds than it had to be able to deliver a national-standard of care to its population. [131]

[130] Minister Ferguson, *Transcript of Evidence*, 22 October 2018, p. 5.
[131] *Australian Institute of Health and Welfare (AIHW), Australian Hospital Statistics (Hospital Resources 2014-15); ABS, Australian Demographic Statistics; Commonwealth Grants Commission, 2015 Review*

Table 23: Average available public hospital bed numbers by state and territory and numbers needed for equal allocation by population share, 2015-16[132]

Table 23: Average available public hospital bed numbers by state and territory and numbers needed for equal allocation by population share, 2015-16

	NSW	Vic	Qld	WA	SA	Tas[h]	ACT	NT	Aust
Beds per 1,000 pop[a]	2.78	2.41	2.51	2.16	2.82	2.54	2.83	2.72	2.56
Population ('000) [b]	7 627	6 033	4 784	2 544	1 702	515	397	245	23 851
Current bed numbers[c]	21 203	14 540	12 008	5 495	4 800	1 308	1 124	666	
Beds needed for nat av[d]	19 525	15 444	12 247	6 513	4 357	1 318	1 016	627	
Beds +/- nat average[e]	-1 678	+904	+239	+1 018	-443	+10	-108	-39	
CGC weighting[f]	1.009	0.972	0.990	0.998	1.038	1.091	0.907	1.292	1.000
Beds for weighted average[g]	19 701	15 012	12 125	6 500	4 523	1 438	922	810	
Beds +/- for weighted average	+1 502	+472	-122	-13	-277	+130	-292	+144	

(a) The average number of available beds per 1,000 population in each jurisdiction.
(b) Population at June 2015.
(c) Current bed numbers, based on AIHW estimate of the number of beds per 1,000 population. This may vary from
(d) The number of beds which each jurisdiction would have if the national average applied across the country.
(e) The number of beds in each jurisdiction above or below the national population-adjusted average.
(f) Commonwealth Grants Commission relative weighting for admitted care, reflecting disparate needs of each population.
(g) The number of beds each jurisdiction would require if the national population-adjusted average also reflected CGC weightings: this is a measure of the bed numbers required in each jurisdiction in order to provide an equal standard of care across the nation.
(h) The AIHW notes that in 2014-15 Tasmania reclassified a number of mental-health aged care and same-day beds. This change increased the reported number of beds in the state by 103 but did not involve actual new beds. In its calculations of the number of beds per 1,000 population (on which this table is based) the Institute adjusted for this change to produce figures which are more comparable across the country.
Sources: AIHW, Australian Hospital Statistics (Hospital Resources 2014-15); ABS, Australian Demographic Statistics; Commonwealth Grants Commission, 2015 Review.

These figures are out of date as soon as they are compiled. Particularly, they do not take into account the needs of hospital systems into the future.[133]

The following table provided by Mr Goddard shows the likely need for additional beds in Tasmanian public hospitals over the period from 2015-16 to the end of the next state parliamentary term in 2021-22.[134]

Table 24: Beds needed in Tasmanian public hospitals to achieve and maintain the 2015-16 national average, 2015-16 to 2021-22

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
% increase yoy	-	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
Beds needed	1 438	1 484	1 531	1 580	1 631	1 683	1 737
Beds increase yoy		46	47	49	51	52	54

Sources: AIHW, Australian Hospital Statistics (Hospital Resources 2014-15); ABS Australian Demographic Statistics; Commonwealth Grants Commission, 2015 Review.

Using the five-year average annual increase in patient days (3.2%) we can see that the number of beds to supply that demand will increase substantially over the period. By the end of the next parliamentary term, Tasmania's need for beds will increase by about 299 above what it ought to have had in 2015-16. Because the state needed an extra 130 beds in 2015-16, it means that 429 beds above the 2015-16 figure would need to be

[132] *Australian Institute of Health and Welfare (AIHW), Australian Hospital Statistics (Hospital Resources 2014-15); ABS, Australian Demographic Statistics; Commonwealth Grants Commission, 2015 Review*
[133] Mr Martyn Goddard, 2017, *Submission #10*, p. 18.
[134] Ibid.

delivered if Tasmanians are by that time to receive the same level of care as other Australians.[135]

The addendum provided by Mr Goddard in 2018 to his 2017 submission provided updated information:

This table shows how the number of staffed and available beds has failed to keep pace with increasing demand. While the caseload increased by 24.87% over the five years, the numbers of beds increased by only 9.76%. Over the period, an extra 281 beds would have had to be provided to keep up with demand. Another way of looking at this is that now, in 2018, the state system would require about an extra 350 fully staffed beds to get back to the capacity levels it had in 2011, before the budget squeezes of both governments began.

Bed numbers versus caseload in Tasmanian public hospitals, 2011-12 to 2016-17

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Cumulative
Separations	99,632	106,358	114,033	119,506	122,604	124,412	
% increase		6.75%	7.22%	4.80%	2.59%	1.47%	**24.87%**
Beds	1,188	1,188	1,187	1,299	1,314	1,304	
% increase		0.00%	-0.08%	9.44%	1.15%	-0.76%	**9.76%**
Shortfall (n)		-80	-86	-62	-34	-19	**-281**

Source: AIHW, Admitted patient care 2016-17; Hospital resources 2016-17.

This increasing shortage of resources has had three main effects: an increasing inability to treat people in need of hospital care, as we have seen; increasing pressures on staff, with serious consequences for staff welfare and the capacity to recruit; and on the safety and quality of care.[136]

Dr Stephen Duckett commented on the Commonwealth allocation of health funding through the GST distribution as assessed by the Commonwealth Grants Commission (CGC):

My position is that I wouldn't overly rely on the Grants Commission data to say that this is money Tasmania is getting that could go into the health sector but is not going into the health sector. Whatever the cause is, the result is that Tasmanians are waiting longer than patients in other states.

However, there is a caveat I put on this and it is why I am being a bit equivocal: we also know that Tasmanian hospitals are more expensive than hospitals in other states, so there is some inefficiency at play in Tasmania, certainly in the larger hospitals.

[135] Mr Martyn Goddard, 2017, *Submission #10*, p. 18.
[136] Mr Martyn Goddard, 2018, Addendum to 2017 *Submission* #10, p. 26.

...

The comparison I am talking about is comparing the patients - that is, the cost per weighted patient. After taking into account the case mix of the patients, Tasmanian hospitals are 10 to 20 per cent - and I have some recent figures in front of me, the Tasmanian cost per weighted patient is over $5100 compared to $4700 in Victoria and $5000 in New South Wales. Even compared to New South Wales, it is $100 per patient more expensive in Tasmania than in New South Wales; this is after taking into account the type of patient. This adds up when you are talking about a lot of patients.[137]

When questioned on this matter and claims made by Mr Martyn Goddard in his submissions to the Sub-Committee, Dr Duckett confirmed that the Tasmanian Government spends less per capita on health than other states:

CHAIR - While you say you wouldn't take the Commonwealth Grants Commission data as the be-all and end-all, or the way it has been used, do you agree with the basic principles being used by Mr Goddard? He says that first it redistributes money between states so that all the jurisdictions that have different capacities to raise money themselves have an equal per capita amount to spend on services. Despite this, we have seen that the Tasmanian Government spends much less than the average on health.

Dr DUCKETT - Yes, I agree with that statement.

CHAIR - The second stage looks at the relative health needs of each population. In this stage, Tasmania currently receives about $260 million a year, redistributed from other states which have lower levels of need. If the state Government actually spent this money on health, per capita expenditure would be much higher than the national average, but it is much lower.

Dr DUCKETT - My concern is that I do not really trust the Grants Commission estimates of what the disabilities or needs are. If you accept that, if you believe the Grants Commission has it perfectly right, Mr Goddard's assessment is also perfectly right.

CHAIR - That does assist. I appreciate that comment in the sense of the underlying data that is being used is your question rather than the way Mr Goddard has used it.

[137] Dr Stephen Duckett, *Transcript of Evidence*, 24 October 2018, pp. 8-9.

Dr DUCKETT - He said the Grants Commission is an independent arbiter and this is what they have said, and he got that right.[138]

And further:

CHAIR - Page 14 of Mr Goddard's submission or addendum, the one he provided in October, refers to public hospital expenditure by funding source. Would you have any reason to doubt those figures?

Dr DUCKETT - No, not at all.

CHAIR – He [Mr Goddard] makes the statement - Over the three years to 2016-17, the Tasmanian Government spent $123.5 million less than the national population adjusted average on its public hospitals. He suggests - This is far more damaging than it seems at first sight. A great deal of Commonwealth funding is forgone. You should also remember that the Tasmanian population needs much more health care than the national average. All levels of funding should therefore be much higher than the average and not, as is the case, lower.

Dr DUCKETT - He would be right there. It is because of the age distribution. Because the Tasmanian population is older on average, you would expect a bit more hospital funding.[139]

Mental Health Funding

According to the MHCT, State and Commonwealth funding arrangements within the mental health sector are inefficient:

While the State Government is solely responsible for the provision of mainstream public health services (i.e. hospitals), both levels of government channel funds into a range of non-clinical mental health supports without the benefit of any overarching strategy or collective arrangement in relation to system design, implementation or outcomes.

This lack of coordination is acknowledged unilaterally, within the Commonwealth Government's review of mental health services, the State Government's mental health plan, and now within the Fifth National Mental Health and Suicide Prevention Plan. MHCT wholeheartedly welcomes this inter-governmental commitment to the development of an integrated and coordinated mental health system, and urges all agencies responsible for the

[138] Dr Stephen Duckett, *Transcript of Evidence*, 24 October 2018, p. 9.
[139] Ibid, p. 12.

delivery of funding into existing services to work collaboratively and pragmatically to ensure that current inefficiencies in service design and delivery—evidenced in fragmentation, service gaps and duplication—are eliminated going forward.

Tasmania's state-owned Rethink strategy goes so far as to identify "blended funding initiatives" as an example of the kind of formal linkages that are "most effective" in supporting system integration. Until our current funding channels are streamlined in this way MHCT expects a continuation of the piecemeal approach to system design, with stepped-care 'solutions' patched into current healthcare structures but no true continuum of care for mental health patients. Additionally, without a whole-of-system approach to mental health infrastructure, there is no entity responsible for the oversight of system trends or outcomes, meaning there is very little scrutiny or insight into the factors contributing to scenarios like the one we are witnessing in Tasmanian emergency departments at present.[140]

The MHCT submission, noted, however, that funding inefficiencies do not necessarily correlate to funding inadequacies:

MHCT's member organisations tell us consistently that Tasmania's state funding arrangements are not insufficient in terms of monetary spend but rather misapplied in terms of emphasis, with acute end hospital care still absorbing a high percentage of funds at the expense of essential upstream community and psychosocial supports.[141]

The Perinatal and Infant, Child and Adolescent Mental Health Services (PICAHMS) submission outlined a number of inadequacies and inefficiencies in the current state and Commonwealth funding arrangements that impact on delivery of care:

Short term commonwealth contracts for NGOs. Most often commonwealth funding is for three year projects. Start-up delays are common, often related to difficulties in staff recruitment. CAMHS and PIMHS frequently have the experience of forming working relationships with NGOs delivering a particular service, only to have that service lose funding just at the point young people are beginning to access the service.

Failure of NGOs to work with state services in developing their service pathways and models of care. Also such collaboration is not specified in commonwealth contracts with NGOs. For NGOs to efficiently and effectively deliver the support the Commonwealth is funding, collaboration with state health and other services is crucial.

[140] Mental Health Council of Tasmania, 2017, *Submission*, #17 p. 4.
[141] Ibid.

Lack of work force with specialist expertise in perinatal, infant, child and adolescent care in Tasmania. Working with infants, children adolescents and families is a specific field of expertise requiring specific developmental understandings; and skill sets in working with complex systems. CAMHS and PIMHS have difficulty recruiting appropriately trained staff to their services and frequently have to train those they recruit as there are very limited opportunities for such experience in Tasmania.[142]

TERM OF REFERENCE 3: THE ADEQUACY AND EFFICACY OF CURRENT STATE AND COMMONWEALTH FUNDING ARRANGEMENTS

FINDINGS:

1. Current funding arrangements for acute, primary and mental health care, remain fragmented and duplicative creating a barrier to improving system efficiency, simplicity and the achievement of patient-centred healthcare.

2. Chronic under funding of health through the annual budget appropriation is evident from the Department of Health and Human Services Annual Reports and annual budget papers.

3. The health budget has been 'topped up' each year by way of Supplementary Appropriation and/or Requests for Additional Funding (RAF's) to meet the budget shortfall.

4. The Tasmanian Government has historically spent less per capita on health than the national average until the 2015-16 financial year.

5. Since 2015-16, the Tasmanian Government spent in excess of the national average per capita on health.

6. Tasmania currently spends less per capita on health than Western Australia, Queensland and Northern Territory.

7. Commonwealth underfunding is negatively impacting on the resourcing of mental health and primary/preventative health care.

8. Adequate funding of primary/preventative health care remains crucial to reducing demand on acute health care facilities.

[142] Perinatal and Infant Child and Adolescent Mental Health Services, 2017, *Submission*, pp. 16-17.

TERM OF REFERENCE 4

THE LEVEL OF ENGAGEMENT WITH THE PRIVATE SECTOR IN THE DELIVERY OF ACUTE HEALTH SERVICES

According to the AMA submission:

> *Public-private sector co-operation is possible and does occur in Tasmania, but service limitations exist in the private hospital sector due to inherent scales of efficiency for complex and tertiary services. It should be noted that Private Hospitals are "for profit" not "for loss", which results in public hospitals needing to be the provider of first and last resort when private sector market failure for the provision of acute services occurs.*
>
> *Many aspects of acute medical care are loss making – but can be supplemented by profitable areas (often elective procedural services) provided by a private hospital. With many Tasmanian patients having multiple major health comorbidities and likely to stay longer in hospital, there are limits of what Tasmanian Private Hospitals can offer, particularly in relation to acute emergency care.*
>
> *Private Hospitals have a significant investment in knowing the money side of their business. This is often not replicated within the public sector when negotiating contracts. For example, the contracting of elective surgery to the private sector over the last few years resulted in cherry picking of patients and significant organisational workload (read cost) to the public hospital system that was never compensated for. It also left the Public system to deal with the complex long-wait patients with a reduced budgetary allocation. A much more compelling case exists for consistently investing in public hospital service capacity the money currently being diverted into the private sector. Greater investment in public hospital capability will be an investment legacy for the efficient and sustainable future of public health care for all Tasmanians.*
>
> *This does not rule out partnerships with private sector providers. These would need to be planned and part of a comprehensive service for the Tasmanian population.* [143]

[143] Australian Medical Association, Tasmania, 2017, *Submission #8*, pp. 2-3.

According to Mr Mervin Reed, engagement with the private health sector is inadequate:

> *The public sector in Tasmania rarely gives any thought to the delivery of Health Services by the private sector and essentially only when the Hospitals are in crisis does the private sector get a phone call.*
>
> *A constant refrain is that the Hobart Private Hospital gutted beds out of the RHH is a lie, as the Government of the day took the opportunity to not replace the bed space leased to the private sector that spent tens of millions on refurbishing the run down Queen Alexandria (sic) Hospital building on the RHH campus.*
>
> *Thus there have been only recently tentative arrangements made with the private sector to take up the load for elective surgery, as the THS has attempted to spend the last of the Federal funds for elective surgery improvement by engaging the private sector. Too little and too late!.*
>
> *One of the prime reasons that we have large elective surgery lists is that no private sector surgical services are sought, quite the contrary.*
>
> *Perhaps the committee can explore this but it is a THS Board failure with no leadership at all in this area.* [144]

According to the PICAMHS submission, there is very limited capacity in CAMHS and PIMHS to work with the private sector:

> *No private hospital admits young people with mental illness below the age of 18 in Tasmania; and there is an extremely limited number of private practitioners with the specialist qualifications and required to provide care to this group of patients.*
>
> *PIMHS does collaborate with the Mother and Baby Unit at St Helen's Hospital in Hobart, where there is one publicly funded bed for maternal mental illness requiring admission. However, this unit cannot cater for the most severely unwell new mother's as it cannot accommodate those with Borderline Personality Disorder, nor those requiring involuntary care for major mental illness such as schizophrenia, bipolar disorder or severe depression. PIMHS also attempts to collaborate with private psychiatrists and psychologists who might offer outpatient support to vulnerable pregnant women or new mothers. However, timely access to care is crucial and often private practitioners have waiting lists; also the majority of PIMH clients cannot afford to pay for care.*

[144] Mr Mervin Reed, *Submission #33*, 2017, pp. 9-10.

CAMHS does collaborate with private child psychiatrists, private psychologists, private paediatricians and general practitioners delivering care to young people with mental illness. However, there is extremely limited access to private child and adolescent psychiatry anywhere in the state. Where a young person receiving care for (sic) a private practitioner presents to hospital for acute care, CAMHS conducts their own assessment and liaises with private practitioners, either referring back to private care with diagnostic and management advice, or taking over care if necessary. A large number of young people presenting at Emergency Departments in distress are referred by general practitioners and private psychologists. In some instances it is evident these private practitioners lack risk assessment and safety planning knowledge and skills. Further training of this private workforce in this area of care may alleviate pressure on Emergency Departments. [145]

The Royal Australian and New Zealand College of Psychiatrists (Tasmania Branch) noted in their submission the challenges related to cross-sector collaboration between public and private mental health care providers:

Given the under-resourced public mental health sector, the Tasmania Branch supports utilising the expertise of Tasmania's private psychiatric workforce to enhance mental health outcomes. However, the private psychiatric sector also has insufficient bed numbers and workforce to manage their current referral rate, both for inpatients and outpatients, thus would be unable to significantly improve public sector capacity.

Improvements can be made by promoting cross-sector collaboration, ensuring early referral from GPs and encouraging private psychiatrists to contribute to public psychiatric services on a sessional basis. Restoring Visiting Medical Officer (VMO) positions would also help in smoothing patient transition between public and private services. Another option could be conjoint psychiatric appointments to facilitate cooperation between the two sectors.

Similarly, the Tasmania Branch believes that ensuring continuity of services and communication between psychiatrists, GPs and psychologists will improve the delivery and integration of mental health services and, in turn, enhance outcomes for Tasmanians with a mental illness.[146]

[145] Perinatal, Infant, Child and Adolescent Mental Health Service, 2017, *Submission #29*, p. 18.
[146] Royal Australian and New Zealand College of Psychiatrists, 2018, *Submission*, p. 7.

According to the ANMF submission, the purchase of private beds for the use of public patients has been utilised with limited success:

> *As a result of the current bed crisis in the South of Tasmania, ANMF understand the THS is currently purchasing 8-10 beds in the private hospital exclusively for the use of public patients. The beds are staffed by Hobart Private Hospital Staff with some medical back up from the RHH. It is expected that these beds will be utilised for simple elective surgery cases and simple medical patients. But it has been reported by ANMF members that these beds are underutilised as not all elective surgery patients are suitable, many acute medical admissions are unsuitable and upon occasion HPH does not have enough staff to open the purchased beds. In particular our members have told us of an example that Orthopaedic patients are not allowed to be admitted to HPH Annex beds simply due to Surgeon preference.*[147]

In the north of the State, the Office of the Coordinator-General is working on a proposal to co-locate the Calvary Private Hospital and LGH:

> *The Government is also continuing to appropriately progress the $100 million Calvary private hospital co-location proposal through the unsolicited bids process. This process is being handled by the Office of the Coordinator-General and has progressed to the second stage, with the Assessment Panel and Calvary working together to finalise the appropriate location within the health precinct to ensure it meets the needs of both parties and future plans.*[148]

The Sub-Committee has written to the Minister for Health seeking further information regarding engagement with the private sector in the delivery of acute health services, however as of 16 November 2018, no response has been received.

TERM OF REFERENCE 4: THE LEVEL OF ENGAGEMENT WITH THE PRIVATE SECTOR IN THE DELIVERY OF ACUTE HEALTH SERVICES

FINDINGS:

1. Australia provides a universal access approach to acute health care and is the provider of first and last resort.

[147] Australian Nursing and Midwifery Federation (Tas. Branch), 2017, *Submission #30*, pp. 27-29.
[148] Minister for Health, 2018, *Submission #8*, p. 3.

2. Collaboration and cooperation between the State public hospital system and the private sector occurs on a limited basis. Strategic collaboration could assist in managing demand within public acute health care.

3. Improvements to cross-sector collaboration between the private mental health workforce and public mental health services could reduce the burden and increase the capacity in public acute mental health services.

TERM OF REFERENCE 5

THE IMPACT, EXTENT OF AND FACTORS CONTRIBUTING TO ADVERSE PATIENT OUTCOMES IN THE DELIVERY OF ACUTE HEALTH SERVICES

The cost of complications related to delivery of health care

Evidence demonstrates a range of factors contributing to adverse patient outcomes, including hospital overcrowding, timely access to related health services and appropriate acute mental health care. Furthermore, the associated financial and human costs are significant.

Dr Stephen Duckett stated:

> *We estimated, right across Australia, the cost of complications, which we estimated to be about $12.6 billion a year from public hospitals and another billion or so from private hospitals. Not all of that is able to be saved. Even if you got the complication rate down for the best 10 per cent of hospitals in the country, you are still going to have a high rate of complications. What we estimated was that across the country you could save $1.5 billion a year if you could get the complication rate down to the level you see in the best 10 per cent of hospitals. I have no reason to believe that Tasmania isn't the same as all of the other states on this. Whatever Tasmania's proportion of the population is, that will be my estimate of the savings for Tasmania.*[149]

Dr Duckett referred to a Report released by the Grattan Institute that notes avoidable mortality rates in Tasmania are increasing, the only jurisdiction where this is the case.[150]

Dr Duckett stated:

> *It is not necessarily about what happens in hospitals but about the general health of Tasmanians. If you compare Hobart with Melbourne, for example, 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. There is obviously something happening where either the Tasmanian Government isn't investing enough in prevention or the*

[149] Dr Stephen Duckett, *Transcript of Evidence*, 24 October 2018, p. 5

[150] https://grattan.edu.au/wp-content/uploads/2018/10/911-State-Orange-Book-2018.pdf, accessed 5 November 2018).

primary care system isn't working. There is something happening down there where Tasmanians are dying when they shouldn't be.[151]

The following data from the State Orange Book 2018: Policy priorities for states and territories, released by the Grattan Institute on 28 October 2018 provides the following:[152]

Figure 7: Avoidable mortality has similar patterns across Australia with higher rates outside metro areas

State	Year	Capital city	Rest of state
NSW	2011	334.6	398.3
NSW	2016	297.4	373.5
Vic	2011	327	391.3
Vic	2016	295	358.5
Qld	2011	367.2	378.4
Qld	2016	326.9	338.8
SA	2011	345.9	380.7
SA	2016	314	340.6
WA	2011	319	394.7
WA	2016	316.3	394.7
Tas	2011	371.7	409.7
Tas	2016	381.5	411.7
NT	2011	426.4	644.1
NT	2016	412.2	617.1
ACT	2011	310.8	
ACT	2016	269.2	
Australia	2011	336.5	393.6
Australia	2016	305.9	364

[151] Dr Stephen Duckett, *Transcript of Evidence*, 24 October 2018, p. 11

[152] https://grattan.edu.au/wp-content/uploads/2018/10/911-State-Orange-Book-2018-Chart-Data.xlsx (accessed 13/11/2018).

The State Scorecard for health, produced by the Grattan Institute in the State Orange Book 2018 – Policy priorities for states and territories, provides the following detail[153]:

Figure 8: State Scorecard for Health

	Avoidable mortality rate in capital city areas, 2016		Avoidable mortality rate outside capital city areas, 2016		Average cost per weighted patient treated, 2015–16		Median waiting time, elective procedures, 2016–17	
	Rate/ 100,000	Change in past 5 years (%)	Rate/ 100,000	Change in past 5 years (%)	$	Change in past 5 years (%)	Days	Change in past 4 years (%)
NSW	297.4	-11.1	373.5	-6.2	5,060	3.2	54	10
VIC	295.0	-9.8	358.5	-8.4	4,707	4.4	30	-17
QLD	326.9	-11	338.8	-10.5	5,086	-4.4	32	19
WA	316.3	-0.8	394.7	0.0	6,355	27.2	34	13
SA	314.0	-9.2	340.6	-10.5	5,737	18.2	39	15
TAS	381.5	2.6	411.7	0.5	5,157	-12.8	45	18
ACT	269.2	-13.4			6,347	17.5	46	-27
NT	412.2	-3.3	617.1	-4.2	6,698	18.7	28	-28
AUS	305.9	-9.1	364	-7.5	5,199	5.7	38	6

Note: See Appendix A for notes and sources.

Dr Duckett suggested the Government should be less focused on the amount of funding being allocated for health care and focus on the patient experience:

> *I try to avoid focusing on how much you are spending; I would rather focus on what the experience of the patient is. The experience of the patient is that they are waiting far too long and they are sicker than they ought to be. Then what I say is, 'This is what we can actually see. I don't actually care whether you think you are putting in enough money or you are not putting in enough money. The outcomes are not good enough for Tasmanians and it is your job to fix it.'*[154]

[153] Grattan Institute, State Scorecard for Health, https://grattan.edu.au/report/state-orange-book-2018 (accessed 15 November 2018).
[154] Dr Stephen Duckett, *Transcript of Evidence*, 24 October 2018, p. 13

Impact of Hospital Overcrowding

Research over recent years clearly shows the adverse impact of hospital overcrowding.

A study undertaken in Western Australia by Sprivulis *et al* in 2006, titled: *The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments,* examined whether high hospital occupancy and ED access block was associated with increased patient mortality.

> *Our study showed that hospital and ED overcrowding is associated with a 30% relative increase in mortality by Day 2 and Day 7 for patients requiring admission via the ED to an inpatient bed. This increase in mortality appears to be independent of patient age, season, diagnosis or urgency. The estimate of 120 deaths per annum associated with overcrowding in metropolitan Perth hospitals suggests that overcrowding should be regarded as a patient safety issue rather than simply an issue of hospital workflow. The finding of increased mortality associated with overcrowding is consistent with the known effects of overcrowding on emergency hospital admissions. Hospital occupancy above 90% has been demonstrated in our study to be closely associated with ED access block and is associated with an increased duration of ED stay. The duration of stay in the ED was longer for patients who experienced overcrowded conditions and died. The positive relationship between overcrowding and mortality is not explained by seasonal or admission selection confounding.*[155]

The study offered some suggestions to address overcrowding:

> *Hospital overcrowding is a complex phenomenon. The prevalence of overcrowding may rise in health services in developed economies as age-related demand for hospital services grows over the next 10–15 years. In addition, economic incentives tend to favour high occupancy. Solutions may include the realignment of incentives that favour high levels of hospital occupancy at the expense of emergency access. Other solutions may include strategies that reduce waste, misuse and overuse of health services, and improved chronic disease management to reduce hospital bed demand. In addition, better matching of bed supply with predictable emergency demand and optimisation of hospital inpatient flow are required.* [156]

[155] Sprivulis, P.C., Da Silva, J., Jacobs, I.G., Frazer, A.R.L., & Jelinek, G.A. 2006. 'The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments', MJA, 184: 208-12 pp. 211-212.

[156] Ibid.

In research conducted in Canada, by McCusker *et al* in 2014, titled *Increases in Emergency Department Occupancy Are Associated With Adverse 30-day Outcomes*, similar outcomes were described:

> *First, we found that ED bed crowding is associated with two 30-day adverse outcomes: mortality and admission at the first return visit. We cannot discount reverse causality for these results; it is possible that there is an increase in more severely ill patients in the ED during periods of increased crowding (i.e., residual confounding by severity of illness). Regardless of the explanation, there are clearly significant threats to patient safety during periods of increased crowding. Return visits without admission, sometimes termed outpatient ED visits, actually decreased following periods of increased bed crowding. Possibly, the long wait times that accompany increased ED occupancy discourage less severely ill patients from returning to the ED.*
>
> *Second, our findings on the changes in admission rates during periods of increased ED bed crowding suggest a threshold level of crowding above which the increased patient caseload cannot be admitted. This supports our conceptual model and suggests that above this threshold, higher risk patients are discharged from the ED. ED crowding with acutely ill, often elderly, and multimorbid patients puts a strain on ED resources, particularly when there is a build-up of patients awaiting transfer to the inpatient wards. The pressure to discharge patients during periods of crowding may lead to the discharge of more vulnerable patients who might otherwise be admitted, in part due to lack of time and capacity to assess each patient's situation. This phenomenon may lead, in turn, to return ED visits for the same problems that may have worsened, resulting in the need to admit these patients at their return visits and excess mortality.*[157]

Research has shown that hospital overcrowding is actually inefficient: it is associated with increased length of hospital stay, thus potentially reducing throughput. The number of adverse events has also been shown to increase with worsening access block.

Research has shown a strong association between access block and mortality rate.

According to an editorial in the Medical Journal of Australia by Peter A Cameron, Head of Pre-hospital and Emergency Trauma Group, Epidemiology and

[157] McCusker, J., Vadeboncoeur, A., Levesque, J.F., Ciampi, A., & Belzile, E., 2014. 'Increases in emergency department occupancy are associated with adverse 30-day outcomes', Acad Emerg Med, 21: 1092-100 p. 1098.

Preventive Medicine at Monash University Central and Eastern Clinical School, Alfred Hospital in Prahran Victoria:

> *Two articles in this issue of the Journal have put pressure on efforts to solve this problem. Sprivulis and colleagues (page 208) and Richardson (page 213), using different methods and different populations, have shown a strong association between access block and mortality rate. Their findings now make access block a patient safety issue for which all health care workers and the community must be responsible. It is incumbent on governments and administrators to prevent overcrowding by improving management of the health care system and, where necessary, providing increased resources.*
>
> *…*
>
> *What Sprivulis et al and Richardson have shown is that there is an association between overcrowding and mortality, not that overcrowding causes mortality. It is possible (but unlikely) that an influx of sick, elderly patients at high risk of death may actually cause overcrowding, thus resulting in the apparent association. Without a controlled intervention study, it is not possible to conclude that reducing overcrowding would reduce mortality. There are good reasons for assuming a causal relationship: known effects of overcrowding include delays in patient management, poor hospital processes, poor infection control, patients not being placed on the appropriate ward, and so forth. Given that it is logical that there is a causal relationship and that there is no known increased risk to patients under conditions of normal hospital bed occupancy, it is unacceptable to continue to allow hospital overcrowding to occur.*[158]

Mr Cameron suggested:

> *An overcrowded hospital should now be regarded as an unsafe hospital. Health care workers should not have to provide services in an environment that potentially jeopardises patient safety.*[159]

[158] Cameron PA. Hospital overcrowding: a threat to patient safety? Med J Aust 2006;184:203–4.
[159] *Ibid*

Mr Cameron suggests two broad strategies for managing access block resulting from hospital overcrowding — reducing hospital demand and optimising hospital bed capacity:

> ***Reduce hospital demand***
> *Diversion/substitution: The major focus of this strategy has been to divert patients to community services and provide more services in the community that traditionally occur in hospital (eg, hospital outreach programs, hospital in the home, and improved after-hours general practice services).*
>
> *Reducing expectations: Reducing community expectations of what a public hospital system can provide is a politically sensitive strategy that has not been systematically addressed. Access block cannot be controlled without some limits being placed on the provision of services. Demand for health care is elastic and potentially unlimited, especially in an essentially free health care system. There must be public debate about what is essential versus what is desirable, and how much the community is willing to pay.*
>
> *Prevention: There is potential to reduce demand by disease prevention strategies, and improved management of patients with chronic ill health.*
>
> ***Optimise hospital bed capacity***
> • *Improved processes: There has been an enormous effort by health care workers to increase capacity by improved efficiency of health care delivery. Many initiatives with quick returns have already been implemented. Further significant improvements will need major investments in infrastructure, especially information technology. Workforce reform is necessary to increase the flexibility of the workforce and the capacity of the health care system. There is presently a shortage of virtually every type of skilled worker in the health care sector.*
>
> • *Balancing elective and emergency workload: Contrary to popular opinion, the emergency workload is highly predictable across metropolitan areas. Elective treatment must be tailored to match the capacity allowed by predicted emergency work.*
>
> • *Better discharge: Moving patients quickly from acute hospitals to more appropriate facilities increases hospital bed availability. Access to rehabilitation, residential aged care and community outreach programs is an essential component of an efficient and well managed health system. Addressing physical, social and psychological issues through care coordination in the emergency department and after hospital discharge can also help reduce hospital length of stay and readmission.*

> • *Increased bed numbers: It is important to note that access block does not correlate well with the absolute number of hospital beds. Increasing the number of hospital beds temporarily alleviates access block, but does not solve the problem — the beds quickly fill and the problem recurs. Nevertheless, governments must fund an adequate number of beds to provide the health care that the community demands.*[160]

Mr Cameron further suggested in his editorial comment that:

> *Government and communities must decide whether they want a well managed, adequately resourced health care system where demand is matched to available resources or to take their chances with the present system.*[161]

Retrospective stratified cohort analysis of an existing dataset of patients who presented to the Canberra Hospital ED and were admitted to hospital in the calendar years 2002–2004 found:

> *Patients presenting during times of increased ED occupancy were reasonably similar to those presenting at other times, but had significantly higher short-term in-hospital mortality. This important finding demands further investigation through research at other sites, prospective studies, and consideration of all deaths after ED attendance, rather than only those occurring in hospital. Subgroup analysis suggests that both the acuity of presenting illness and hospital treatment performance contribute, but the study methods did not enable identification of the causes of excess mortality. The magnitude of the association is around 13 excess in-hospital deaths annually, similar to the number of people killed on the roads in the ACT. If replicated in other studies, this association represents a significant public health issue.*[162]

Mr Martyn Goddard also noted the adverse impact of hospital overcrowding:

> *Bed block has serious health consequences. Research in Australia and elsewhere has shown that patients affected by bed block have a 30% increased risk of death. Studies at a hospital in Canberra and three hospitals in Perth yielded an estimate that bed block caused 8 deaths a year for every 100,000 population: the researchers described this estimate as conservative. Applied directly to Tasmania, this would mean just over 40 avoidable deaths a year. But as bed block in Tasmania is twice (RHH) or three times (LGH) as bad as in those hospitals in Canberra and Perth; and as*

[160] Cameron PA. Hospital overcrowding: a threat to patient safety? Med J Aust 2006;184:203–4.
[161] Ibid.
[162] Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust 2006; 184:213–6.

the risk of death increased with length of stay in an ED, a more realistic conclusion would be that in excess of 80 people die avoidably in Tasmanian hospitals because of emergency department bed block. [163]

According to the AMA submission:

> *Hospitals are by nature dangerous places. Every intervention has risks and patients in hospitals are the sickest in the community and thus are at high risk. To minimise this risk, our public hospitals need the infrastructure, bed capacity, number and quality of staffing to deliver good care. Our public hospitals also need the organisational governance required to keep them running safely and effectively, to identify and respond to risks as they arise. Clearly, poor bed capacity planning has occurred at the RHH and this has resulted in serious Emergency Department overcrowding due to a lack of beds in the acute and subacute wards. This outcome was entirely predictable and both the THS Executive, THS Governing Council and Ministry were provided consistent warnings as to the consequences of inadequate capacity planning during the RHH Redevelopment. A failure to listen and respond to clinicians and other RHH staff over the past two years regarding the impending demand and capacity mismatch reflects a serious failure of effective THS governance arrangements and does not speak of the THS being a patient focused organisation.*
>
> *Public Hospitals have a major role in training the future medical, nursing and allied health workforces. This training attracts the best and the brightest at both the Doctor in Training level but also at the Specialist level. The tight budgets, increases in demand and poor governance has come at the expense of the training functions of our hospitals. Many of the accredited training programs have been lost, significantly downgraded or placed under tighter review. This has resulted in the decreased ability to recruit doctors at all stages in their careers – from Interns to Specialists. This in our view has made our hospitals risker (sic) places for patients – because of the lack of access to Specialists and senior Doctors in Training. Unfortunately, the impact of the generational loss of doctors from Tasmania has yet to be felt.*[164]

The AMA provided further evidence regarding adverse outcomes:

> *Patients of all craft groups requiring admission to an acute hospital who are subject to bed block suffer with increased mortality rates – patients with severe mental illnesses are no exception, and at least one death has been directly related to bed block involving acute psychiatric beds. However, the*

[163] Mr Martyn Goddard, *Submission* #10, p. 33.
[164] Australian Medical Association (Tasmania), 2017, *Submission #8*, p. 3.

situation is more complex as bed block involving acute psychiatric beds affects the ED more broadly, with mentally ill patients occupying beds that are also required by medical and surgical patients.

Patients with mental illnesses also suffer increased morbidity when subject to bed block. They may avoid presenting themselves to hospital, they may become worse during extended waiting periods, they may not be appropriately assessed in the ED, they may not be admitted to hospital when admission is necessary, they may become unnecessarily subject to the Mental Health Act, or to episodes of seclusion, they may receive sedative medication, they may not receive the appropriate medication, and they may have such adverse experiences that they avoid future necessary assessment and treatment.

A number of patients have also left the waiting room whilst mentally unwell and some of these have been arrested, for crimes committed as a result of mental illness.[165]

The College of Emergency Nursing (CENA) addressed ED overcrowding in their submission and position statement.

Their submission noted:

The impact of ED crowding and overcrowding is well documented to have significant consequences on patient outcomes and public safety.

a. Increased time to treatment, such as:
i. Poorer outcomes for patients with chest pain (Pines et al., 2009)
ii. Time to analgesia for pain resulting in decreased patient comfort (Derlet and Richards 2000; Bond et al. 2007 (Mills et al., 2009)).
iii. Antibiotic for infection such as pneumonia leading to increased recovery time and potential sepsis (Sikka et al. 2010).

b. ED crowding increases risks to morbidity and mortality, this is well supported across Australia and internationally (Sprivulis et al. 2006; Richardson 2006; McCusker et al. 2014; Derlet and Richards 2000; Zhou et al. 2012).

c. Crowded assessment and treatment areas result in compromise in patient privacy and confidentiality (Gilligan et al. 2007)

[165] Australian Medical Association (Tasmania), 2017, *Submission* #8, pp. 4-5.

d. Overcrowding – bed block, surge capacity, unsafe patient to staff ratios, unsafe number of patients in ED for work area is compromising care and effecting outcomes.

e. Feedback mechanism for adverse events is limited.[166]

The CENA *Position Statement on Emergency Department Overcrowding and Access Block* states:

Access block significantly contributes to overcrowding in the ED and reflects a systemic lack of capacity within the health system rather than inappropriate patient presentations to the ED. When the ED becomes overcrowded, physical capacity and safe staffing resources are exceeded, impeding the functionality of the ED and delaying care. This is distressing for patients and has a substantial impact on staff workload. Exposure to access block has been associated with significantly longer length of stay and increased morbidity and mortality. Access block also adversely impacts on staff by increasing work-related stress and reducing job satisfaction. This can influence workforce sustainability.[167]

…

1. Emergency Departments must have escalation processes in place to address overcrowding, access block, and surges in presentation. This needs to be in conjunction with a whole of hospital response.

2. Agreements must be in place between the receiving institution and ambulance service to ensure safe patient care with shared responsibility in the event of ramping. This includes but is not limited to:

- *Safe monitoring and senior medical review of all patients on the 'ramp'*
- *Commencement of assessment and basic investigations by emergency staff*
- *Ongoing surveillance for deterioration of ramped patients and escalation of care as appropriate*
- *A safe environment for the patient and staff to transit in.*

3. Strategies must be in place to address specific patient groups that contribute to department overcrowding as a result of requiring complex

[166] College of Emergency Nursing Australasia, *Submission* #6, 2018, pp. 5-6.
[167] Ibid, p. 11.

assessment. For example, the elderly, patients with mental health illness and those requiring isolation.

4. Strategies that incorporate a whole of hospital response in the presence of access block and ambulance ramping, must be established to expedite the timely transfer of existing inpatients awaiting admission and restore operational safety.

5. Processes for the assessment, ongoing review and escalation of patients who have arrived to the ED via means other than an ambulance must also be in place.[168]

Ambulance ramping has been identified as a factor contributing to adverse patient outcomes.

According to the ANMF 2018 submission, the ramping situation at the RHH has worsened significantly since ANMF provided their original submission in 2017, and it is a cause of concern:

We, and our colleagues, are concerned that there has been an increase in interventions carried out on ramped patients, due to the inability to accommodate these patients in an appropriate treatment area for their needs. There has been an increase in procedures performed in inappropriate areas due to the severe limitations on available treatment areas. We are concerned that this is placing both medical and nursing clinicians in evermore risky and error-prone situations whilst trying to care for significantly unwell people. The risk to patients is increased because these spaces are often not suitable (from an available equipment perspective) and are very difficult to work in if resuscitation is required.

There has also been a noted increase in tensions between Ambulance Tasmania (AT) and the ED. Some clinicians have commented that the working relationship between our two organisations is the worst seen in over a decade. Whilst this is unfortunate, it can hardly come as a surprise that morale between colleagues is decreasing when neither party is able to perform the duties required in a timely fashion. Each side is frustrated because there is no evidence of any apparent solutions in the near future.[169]

According to Mr Neil Kirby, CEO Ambulance Tasmania:

We are building up those strategies so that when we have a period of high demand, be it by ramping or any other factor that causes high demand, my

[168] College of Emergency Nursing Australasia, *Submission* #6, 2018, p.12.
[169] Australian Nursing and Midwifery Federation, 2018 *Submission #9*, pp. 2-3.

goal is to increase the availability of ambulances to the community. I do not want to see them parked on the ramp; I do not want to see them busy on non-urgent cases. If we can manage all those things, we can ensure our ambulances are going to the right cases.

As the minister indicated, if there is an indication for that on response times, we show we have been doing that in Tasmania and improving our response to acute cases that we can do. It is about getting that focus on what else we can do for the patient.

On the specifics of ramping, I default to the secretary for the 'in-hospital' strategies used to assist us with ramping, but we as the ambulance service work closely with the hospital department. There are a number of places where we meet formally with the hospital through committees to work out a strategy of best managing the situation when we have ramping and we have internal ambulance processes in place to assist with that as well.[170]

Ambulance ramping is also a regular occurrence at the LGH ED, and according to the ANMF 2018 submission, it is increasing in frequency and volume:

This means that there is whole category of patients who are not receiving care in a timely way, nor in an appropriate environment. As previously discussed this has resulted in less than satisfactory care outcomes for some of these patients and clearly places strain on ambulance officers who are also under pressure to off-load their patients.

The LGH ED is not equipped to have ambulance trolleys ramped in the ED itself. It has a very small designated area for one trolley next to the ED waiting room assessment bay. However, this area is consistently full of ambulance trolleys due to ongoing ramping which results in an overcrowded waiting bay area which not only compromises patient care, it also compromises the work health and safety of all ED Staff and ambulance officers working in the space.[171]

Mr Michael Pervan described the new transit lounge at the LGH:

We have also opened a transit lounge in the LGH. There is one at the Royal. It has been moved around a few times during the works but it is still there. … It is a transit lounge in transit. That transit lounge is exactly as Ms Forrest described it - somewhere where patients who are ready for discharge can go while they are awaiting their medication to be dispensed or some diagnostic

[170] Neil Kirby, *Transcript of Evidence*, 22 October 2018, p. 25.
[171] Australian Nursing and Midwifery Federation, 2018 *Submission #9*, p. 7.

reports to take back to their GP. We are doing all these things. In fact recently in terms of patient flow, I went to a meeting of the statewide Surgical Services Committee in Campbell Town where the orthopods at the Royal were proposing a musculoskeletal pathway that would see patients assessed by a physio and others on their way to seeing a surgeon.[172]

Adequacy of Mental Health Services impacting on patient outcomes

According to the RANZCP submission, there are inadequate mental health services for the community in the North, North West and Southern regions of Tasmania:

> *There is a critical shortage of permanent psychiatrists in the North and North-West with the workforce made up, when they can be employed, with expensive locum psychiatrists. In the South of the state, the critical issues are: acute bed numbers, the lack of planning for contemporary inpatient unit and problems training psychiatrists who will need to work in the health service for the decades to come.*[173]

In relation to the matter of mental health beds, which is particularly acute in the South, the RANZCP submission stated:

> *In the years leading up to the redevelopment of the Royal Hobart Hospital, the mental health ward was reduced from 42 beds to 32 and then moved more recently to a temporary ward in J-Block. The Tasmania branch, together with other professional bodies such as the Australian Medical Association and Australian Nursing Federation, has previously raised concerns to both the Tasmanian Health Service and the Government regarding the reduced bed capacity of both the temporary ward and the new mental health unit in K-Block and advocated for the number of beds to be reinstated to 42.*
>
> *The many problems identified in the current temporary ward, including significant health and safety issues as well as lack of space, will remain in the new ward unless plans are revised. It is the Tasmania Branch's view that the design of the new facility does not meet modern standards as it is too crowded and lacks open space*
>
> *As a consequence of the reduction in bed numbers, patients needing admission to an acute mental health unit have been held for up to several days in the emergency department as there were no acute mental health*

[172] Mr Michael Pervan, *Transcript of Evidence*, 22 October 2018, p.12.
[173] Royal Australian and New Zealand College of Psychiatrists, 2017, *Submission #14*, p. 2.

beds available for them. This is not aligned with best practice for contemporary psychiatric care.[174]

In relation to problems training psychiatrists in the South, the RANZCP submission stated:

> *…the design does not support the education of clinicians, in particular trainee psychiatrists, as there is a lack of office space for trainees on the ward and no training room to provide the Formal Education Course – a requirement for RANZCP training.*
>
> *The RANZCP bi-national Committee for Training is currently reviewing conditions for trainees at the Royal Hobart Hospital. The Tasmania Branch Training Committee has grave concerns about the effect on trainee psychiatrists of ongoing bed shortages at the hospital and is concerned not only for the trainees' physical and mental health but also for the future of psychiatric training in Tasmania. Trainees are at risk of burnout from managing acutely unwell patients in the emergency department as well as working in chaotic acute wards, with insufficient time to complete mandatory Mental Health Act and discharge paperwork. The Tasmanian Branch Training Committee concerns have been confirmed by the Committee for Training, and as a result, effective 17 August 2017, trainee positions in the acute inpatient units will no longer be accredited and no trainees will be placed in these wards. This has potentially devastating consequences for patient care and for psychiatry training in Tasmania.*[175]

In relation to the training problems in the North:

> *There are major problems in the North. There were six training positions in Launceston until 2014 when it was reduced to two due to lack of supervisors and other issues such as frequent on call, burnout etc. Unfortunately the position has worsened as four consultant psychiatrists have left the hospital. There is no permanent consultant psychiatrist for the 20-bed acute unit and as such there can be no trainees placed in that unit. A recent RANZCP site visit to Launceston General Hospital identified that there are insufficient psychiatrists to provide consistency of training and this will most likely result in no training occurring in Launceston once current trainees have completed their training… until there is active recruitment of permanent staff.*[176]

[174] Royal Australian and New Zealand College of Psychiatrists, 2017, *Submission #14*, p. 3.
[175] Ibid, pp. 4-5.
[176] Ibid.

In the North-West, "*the lack of appropriately qualified supervisors has meant that there have been no trainees at that site for 3 years."*[177] According to the RANZCP submission, there is a critical shortage of permanent psychiatrists in the North, North-West and Southern regions of Tasmania leading to poor continuity of patient care.[178]

According to the MHCT there are clear adverse outcomes in the context of public emergency departments and psychiatric units that are stretched by heightened rates of demand:

> *One obvious factor is that emergency departments, of all possible settings within a hospital, are perhaps the least conducive to emotional wellbeing. Particular factors here include incessant intense stimuli—artificial light, repetitive noises, continual human and mechanical interruptions—as well as the stress of being surrounded by other critically unwell patients.*
>
> *MHCT has heard anecdotally that individuals presenting to the Royal Hobart Hospital (RHH) emergency department have recently had waits of upwards of 24 hours before a bed has become available in the Department of Psychiatry for onward admission. For an individual experiencing a mental health crisis this extended period in treatment 'limbo'—whether within the emergency department or another temporary care setting—can be intolerable, and consumers talk of reaching a point where they feel they have no option but to threaten harm to themselves or others in order to expedite care.*
>
> *We should also note that the nature of temporary care settings means they do not necessarily contain the safety and harm-reduction features that are requirements within contemporary inpatient psychiatric units. One obvious and potentially devastating example is access to hanging points.*[179]

And further in relation to the matter of harm minimisation, MHCT stated:

> *We also recognise that mental health patients who experience longer inpatient stays are at greater risk of exposure to restrictive practices through means of seclusion and restraint. Data from the Australian Institute of Health and Welfare shows that overall in Australia rates of seclusion and restraint in public sector acute mental health hospital services are reducing. Yet compared with other states, Tasmania's rates of seclusion incidents in 2015-2016 were second only to those of the Northern Territory, and our rates of physical restraint incidents in the same period were higher than all states except the Northern Territory and Victoria.*

[177] Royal Australian and New Zealand College of Psychiatrists, 2017, *Submission #14*, p. 4.
[178] Ibid.
[179] Mental Health Council of Tasmania, 2017, *Submission #17*, pp. 5-6.

MHCT acknowledges that Tasmania's Mental Health Act 2013, which commenced in February 2014, will encourage progress towards a reduction in these rates, and yet it remains true that mental health patients in Tasmanian acute care settings are still subject to restrictive practices that are now universally recognised as detrimental to recovery. In 2015 the National Mental Health Commission declared that:

> *There is a lack of evidence internationally to support seclusion and restraint in mental health services. There is strong agreement that it is a human rights issue, that it has no therapeutic value, that it has resulted in emotional and physical harm, and that it can be a sign of a system under stress.*[180]

In relation to child and adolescent mental health, the PICAMHS submission stated:

Significant adverse outcomes for infants and young people related to acute health service provision have been identified in two separate coroner inquests. The inquest into the suicides of six teenagers in the south of the state in 2015 identified "a serious gap in Tasmanian mental health services for adolescents"; and the need for early intervention services to assist traumatised children. The coroner recommended "a comprehensive early intervention service for children aged up to three years, to identify children at high risk of suffering mental health issues in the future," noting the recognised trajectory from early childhood neglect and abuse, to childhood emotional and conduct problems, to teenage mental illness and suicidality. In 2017 the inquest into the death of an infant from the north west of the state due to paternal abuse noted that no intervention to ensure the safety of the child had occurred despite multiple notifications to child safety services of risk, including one even before the child was born. The coroner noted of Child Safety Services:

> *"entrenched systemic and cultural deficiencies in the context of inadequate resourcing. The evidence strongly indicates …inexperience and turnover of workers, inadequate staff numbers and lack of training were constant issues preventing effective responses to the notifications."*

There is no Perinatal and Infant Mental Health Service in the north or north-west of the state. At RHH, where a PIMH operates, this service plays an essential role in identification of infants at risk; in antenatally and postnatally developing plans in collaboration with other services including Child Safety Services, to intervene therapeutically and to mitigate this risk;

[180] Mental Health Council of Tasmania, 2017, *Submission #17*, pp. 5-6.

and in educating and supporting other services involved with the vulnerable infant and family.[181]

The PICAMHS submission continued:

> *More generally adverse outcomes relate to morbidity rather than mortality with inadequate treatment or delayed treatment related to insufficient CAMHS staff resources and/or inappropriate or inadequate inpatient facilities.*
>
> *Factors contributing to these adverse patient outcomes include:*
>
> *1) Lack of hospital CAMHS teams at LGH and in CAMHS north- west.*
>
> *2) Lack of appropriate facilities and trained staff for inpatient care, especially where a young person must be accommodated on an adult psychiatric ward. There is currently no budget for staffing Adolescent Units planned in the redevelopment of RHH and LGH.*
>
> *3) Lack of community team resources to offer frequency and intensity of support, and earlier intervention to prevent presentation to acute health services: CAMHS Community teams are currently staffed at 50-60% of national benchmarks and considerably under resourced compared to CAMHS in other Australian states.*
>
> *4) Lack of Perinatal and Infant Mental Health Services at LGH and NWRH; and lack of sufficient resources in PIMH south and state wide to deliver effective early identification and intervention to prevent immediate infant risk; and trajectory to lifelong mental illness.*[182]

Access to Cardiovascular Services and treatment

According to the Stroke Tasmania submission, a more coordinated approach to stroke management is required throughout Tasmania:

> *There is currently no formalised ambulance transfer protocols for stroke patients in Tasmania. It is vital that these are established to increase the number of people accessing time critical stroke treatments.*
>
> *The pre-hospital stroke triage protocol developed by the John hunter Hospital in NSW has been successfully adopted for use in other hospitals to help alert and prepare a stroke team and improve "door to needle" times. The "in the field" stroke screening tool used by ambulance staff is estimated*

[181] Perinatal, Infant, Child and Adolescent Mental Health Services, 2017, *Submission #29*, pp. 18-19.
[182] Ibid, pp. 19-23.

to boost thrombolysis rates from the typical 3% to around 50% of patients with ischaemic stroke.

Prehospital Stroke Pathway:
> Stroke patients are identified by paramedics using an internationally recognised and validated tool - Face, Arm, Speech, Time (FAST).
> Once identified as a FAST positive patient within three (3) hours of symptom onset, the patient is transported to the closest Acute Stroke Treatment Centre offering access to thrombolysis and Stroke Unit Care.
> Ambulance control will notify the receiving hospital of the incoming patient and provide an Estimate Time of Arrival (ETA).
> The Hospital will notify the Stroke team (hospital specific) and upon arrival the patient will receive rapid early medical assessment including brain imaging, neurology review and early decision on definitive treatment (thrombolysis).[183]

The Stroke Foundation submission also identified the lack of a stroke unit in the North West is resulting in inequitable access to time-critical stroke treatments:

In Tasmania the Royal Hobart Hospital and the Launceston General Hospital are equipped to treat patients with thrombolysis. The Royal Hobart Hospital also provides limited access to ECR, a highly specialised procedure which requires senior multidisciplinary clinician involvement and intensive post procedure monitoring.

To increase access to these highly effective treatments in regional areas, Victoria has successfully trialled a stroke tele-medicine service which links regional hospitals to senior neurologists via videoconferencing technology. This service provides support 24 hours, seven days a week, to assess and treat acute stroke patients.

As a result of this link and regardless of their location, patients are receiving clot busting thrombolysis in their regional hospital. Tele-medicine provides appropriate clinical supervision to recognise and treat stroke which improves patient outcomes. This service [is] a simple way to increase equity of access to acute stroke treatment and avoid unnecessary patient transfers. It provides an opportunity to up skill doctors in regional hospitals and recognise those patients who should be transferred for clot-retrieval.

The introduction and ongoing investment into a tele-medicine stroke service for Tasmania would facilitate a direct link for local doctors to highly skilled

[183] Stroke Tasmania, 2017, *Submission #12*, pp. 1-2.

neurologists. It will reduce the impact of stroke on acute services in Hobart by treating patients at their local hospital. Preliminary discussions are underway to link the North West Regional Hospital into the Victorian Stroke Tele-medicine programme.[184]

And further…

There is overwhelming evidence that stroke unit care significantly reduces death and disability after stroke compared with conventional care in general wards for all people with stroke. There is also evidence that stroke unit care has reduced mortality through prevention and treatment of complications, especially infections and immobility-related complications.[185]

According to the Heart Foundation submission, there is currently no statewide coordination of, or monitoring of, the cardiac services provided in Tasmania:

This is key to ensuring that systems are in place to ensure each site is delivering optimal care, and to prevent adverse patient outcomes. In our Statewide Cardiac Services Plan, we highlight that delays in receiving time-critical treatment can be fatal, but if not fatal, can cause irreversible damage to the heart, which can lead to ongoing poor health and readmissions. Our Statewide Cardiac Services Plan provides numerous recommendations in order to minimise delays in treatment.[186]

Multi-morbidity

According to the Tasmanian Government submission, patients with multi-morbidity have higher rates of healthcare utilisation and are at a greater risk of complications and mortality:

The increased risk of complications, mortality and cost to the health system for patients with multimorbidities is evident in Tasmania's acute admitted data. The data show that grossly multimorbid patients (those identified as having six or more chronic conditions) have more than twice as many hospital episodes as other patients, stay in hospital for longer, and are more likely to experience hospital acquired complications.

…

[184] Stroke Tasmania, 2017, *Submission #12*, pp. 2-3.
[185] Ibid, p. 3.
[186] Heart Foundation, 2017, *Submission #23*, p.4.

The increase in patients with multimorbidities presents a challenge for health care systems which… are largely designed and funded for single conditions. [187]

North West Integrated Maternity Service

The Sub-Committee considered the matter of the North West Integrated Maternity Service in detail in its Interim Report.

The ANMF noted in its 2018 submission that the North West Integrated Maternity Service remains a service that does not provide the level of service or continuity of service that it was intended to, and a number of concerns remain for ANMF members:

Service Delivery

• The crossing over of women from the public (for ante-natal and post-natal care) and private system (for birthing services) is difficult to navigate for women and midwives. It appears that no one seems to be in charge and taking responsibility for the continuity between these services and ensuring accountability.
• Sharing of documentation is a major issue. There are many delays with accessing inpatient and outpatient documents from the North West Private Hospital (NWPH). The NWPH often do not document on the only shared database (obstetrix) and this impacts on the ability to provide informed and timely care the next time the patient presents to Tasmanian Health Services.
• There are currently issues relating to access for unplanned assessments. This started with removal of the Resident Medical Officer roster to [the] antenatal clinic at Mersey at the beginning of August. The role had been in place since the NWIMS inception and loss of the position has impacted upon assessments for women of the area.
• Communication is extremely poor throughout the service – particularly between medical staff, North West Private Hospital to the Tasmanian Health Service.
• There is poor communication and inclusion in process development of services outside of NWIMS, i.e. LGH/QVMU who provide birthing services to women of this area also.
• There is poor understanding across obstetric and maternity services in the State of what care is, and can be, provided by THS NWIMS services due to poor communication and consultation when the service was first developed and implemented.

[187] Tasmanian Government, 2017, *Submission #32*, p. 37.

• There is still poor development of policy and guidelines to guide practice for midwives and medical staff across the NWIMS regarding service delivery models and associated requirements for safe and quality care.
• Facilities at the North West Ante-natal Clinic still do not provide for confidential consultations (conversations can be overheard), the work space is too small to carry out safe consultations, women are required to walk down the corridor and use the public Hudson Café toilets to collect intimate swabs and urine samples.
• Members held back on proposed industrial action in November 2017 when it was agreed that an evaluation of the entire NWIMS would be carried out. To date no report has been provided following that service review and members have not even been provided with interim feedback.

Patient Effects

• Patients get the 'run around' between services due to poor communication and poor understanding of service provision changes. For example, a patient can ring Mersey ante-natal clinic for advice, be directed to the NWPH for assessment, arrive at the NWPH (having travelled from Devonport), only to be told they are "too busy" referring the patient to the NWRH Clinic for assessment.
• Access to services is inequitable across the region in terms of care closest to home particularly with altered assessment clinic (Pregnancy Assessment Clinic) at Mersey.
• There will always be women who just present for assessment no matter what they are told, there is risk involved in this because midwives are being undermined and prevented from using clinical skills to determine course of action with the proposed removal of assessments at the Mersey.

Staffing Effects

• Reduced midwives in outreach areas puts greater pressure on those staff working in Rural Health Outreach Funding as well as on NWIMS THS staff and services.
• The NWIMS service is short staffed and consistently relies on agency midwives to keep staff at an appropriate level.
• Staff morale is very low. Staff are felling [sic] unheard, unconsidered and generally fed up. There are only two casual staff in the pool and both have limited availability to allow for leave relief both planned and unplanned.
• There is limited opportunity for staff to access training due to inadequate staffing levels.
• Birthrate plus© (the maternity staffing model that is under development) has had many limitations for data collection and we are now embarking on

a process of further data collection which will better reflect the work performed, especially in Extended Care Midwifery with intention for review of this in 2019.[188]

The ANMF recognise the hard work of members and provide a number of potential solutions to improve service quality:

- *Immediately release the North West Integrated Maternity Service review findings and implement the recommendations.*
- *Ensure that there is a Senior Midwife representative from the Tasmanian Health Service appointed to the contract committee which oversees and monitors the contract between the Tasmanian Health Service and the North West Private Hospital.*
- *Permanently increase the baseline midwifery staffing levels and allocate the required amount of relief factor which … has never been appropriately allocated to allow for leave coverage and reduction in clinics being cancelled due to unavailable midwives.*
- *Implement an agreement for NWIMS midwives to work across the Tasmanian Health Service and the North West Private Hospital and/or the Launceston General Hospital without the need for two employment contracts to enable access to skill maintenance in birthing and the use of the entire scope of midwifery practice to aid in retention and recruitment.*
- *Immediately fund and commence planning for re-integration of birthing services back into the Tasmanian Health Service at the North West Regional Hospital.* [189]

The Sub-Committee requested an update from the Minister regarding the review of the NWIMS and requested a copy of the report in its letter of 29 October 2018. As of 16 November 2018, no response has been received.

Improving quality and safety in health care

Dr Duckett was appointed by the Secretary of the Victorian Department of Health to undertake a public inquiry and to report into quality and safety of health care in Victoria. He took leave from the Grattan Institute to undertake this review.

The report titled *Targeting Zero*, recommended the creation of the organisation that is now Safer Care Victoria and the creation of another organisation now called the Victorian Agency for Health Information.

[188] Australian Nursing and Midwifery Federation, 2018, *Submission #9*, pp. 9-10.
[189] Legislative Council Acute Health Services in Tasmania Inquiry Suggested Solutions by ANMF Members, October 2018, p. 4.

The inquiry was established because:

> *... there was a series of potentially preventable deaths at a hospital on the outskirts of Melbourne and part of the problem was the culture within the Victorian Health department, which wasn't focused efficiently on safety and quality of care. With Safer Care Victoria we were trying to raise the profile of quality and safety but the department was more or less obsessed with finance only and, in my and the review's view, the quality and safety issues were not being addressed appropriately.*
>
> *Similarly with the Victorian Agency for Health Information, the quality and safety issues weren't being addressed appropriately and the government wasn't putting information into the public domain. I am very much of the view that we should share information with the public; I see this as part of democratic accountability. The public, which is after all paying for all this, ought to know what the costs per patient are, what the complication rates are between hospitals and so on. We wanted to improve the transparency of the health system in Victoria, which is why we went in that direction.*[190]

Dr Stephen Duckett, informed the Sub-Committee of the importance of undertaking audits of the coding of activity and patient outcomes. He suggested accountability and transparency related to this data is necessary:

> *The audits by and large show that the mistakes hospitals make on the upside of it are offset by the mistakes they make on the downside. No-one is ever perfect in all this. That being said, my view is we should try to change the processes so that a lot of that coding is done independently of the hospitals to avoid any pressure and any incentive a hospital has to play with that coding.*
>
> *When you are looking at the complications and the quality, we have to take into account the fact some hospitals have a more complex set of patients than any other hospital. If you don't, you are getting false results. Because we have information about the age of the patient and how many other diagnoses the patient has, we can take that information into account in working out a complication rate. When we have been comparing hospitals, we talk about the hospitals' excess risk, by which we mean that once you have taken all those things into account, is it riskier to go to hospital A than to hospital B, everything else being taken into account? We are able to do that. There are standardised ways of doing that now and you can get packages that help you do it more easily.*

[190] Dr Stephen Duckett, *Transcript of Evidence*, p. 2

...

The evidence from the United States is that patients don't use this information. The hospitals get embarrassed when the information is published and it drives the hospitals to change their performance more than it drives patients to change where they go. In Tasmania, which has three or four hospitals big enough to use for this comparative information - and in very small hospitals it is much harder to do - it is worthwhile publishing this information, if only to see whether the hospitals are improving over time. You should be able to see that and you can compare Tasmania, with some limitation, to other states. You can compare yourselves over time and you can compare yourselves within Tasmania.[191]

Victorian Government Response to Adverse Outcomes - Safer Care Victoria (SCV)

The ACEM submission made reference to Safer Care Victoria (SCV) as an excellent example of a Government response to a systemic crisis that had adverse patient outcomes.[192] Dr Simon Judkins stated:

Addressing the issues facing Tasmania's acute health services requires support from all sides of government. Improving the system will require culture change, strategic planning and clinical engagement, strong leadership, accountability and transparency.

Insights can be drawn from the Victorian Government's response to the Bacchus Marsh inquiries, with the government accepting the recommendations to create Safer Care Victoria.[193]

Safer Care Victoria is a healthcare quality and safety improvement agency within the Department of Health and Human Services. SCV was established under section 11 of the *Public Administration Act 2004* (Vic) and began operation on 1 January 2017.[194]

A key point of SCV is that it engages with patients, clinicians and health services to monitor standards and drive the improvement of healthcare.[195] SCV is headed by a CEO who is an eminent clinician.[196]

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[191] Dr Stephen Duckett, *Transcript of Evidence*, pp. 3-4
[192] Australasian College of Emergency Medicine, 2017, *Submission #24*, p. 2.
[193] Dr Simon Judkins, *Transcript of Evidence*, 8 September 2017, p. 13.
[194] *Safer Care Victoria Strategic Plan 2017-2020*, pp. 1, 3.
[195] Department of Health and Human Services (2017) 'Safer Care Victoria – Publications', Safer Care Victoria website, State Government of Victoria.
[196] Department of Health and Human Services (2017) 'Safer Care Victoria – About Safer Care Victoria', Safer Care Victoria website, State Government of Victoria.

The Victorian Minister for Health's Statement of Expectations for Safer Care Victoria includes the following Statement of Functions:

> **Statement of Functions**
>
> The functions of Safer Care Victoria are to:
>
> 1. Support all public and private health services to prioritise and improve safety and quality for patients.
> 2. Strengthen clinical governance, lead clinician engagement and drive quality improvement programs and processes implemented in health services.
> 3. Provide independent advice and support to public and private health services to respond and address serious quality and safety concerns.
> 4. Review public and private health services and health service performance, in conjunction with the department, in order to investigate and improve safety and quality for patients.
> 5. Lead Victoria's contribution to the development of national accreditation and other clinical care standards by the Australian Commission on Safety and Quality in Health Care.
> 6. Undertake research and coordinate the provision of evidence-based research and guidelines throughout the sector.
> 7. Coordinate the efforts of clinical networks to:
>   (a) Reduce clinical variation and issue best-practice guidelines
>   (b) Report annually on improvement strategies
>   (c) Ensure improvement activities are coordinated.
> 8. Reduce avoidable harm by:
>   (a) Sharing trends and learnings from significant harm incident reports
>   (b) Respond to and anticipate health system issues relating to patient safety
>   (c) Coordinate system responses to specify safety events.
> 9. Provide advice to the Minister and Secretary on any issues arising out of its functions.[197]

The Victorian Department of Health and Human Services 2016-17 Annual Report noted some of the actions undertaken and the outcomes of the SCV:

> ## Safer Care Victoria
> Safer Care Victoria (SCV) is the state's peak authority for quality and safety improvement in healthcare.
>
> Established in January 2017, SCV oversees and supports health services to provide outstanding health care to all Victorians.
>
> In 2016–17, SCV worked with consumers, clinicians, health service executives and boards to prioritise support for health services, meeting their needs, and improvement of services. Reflecting those needs, SCV has established five priority areas:
>
> **Partnering with consumers, families and carers**
>
> Safer Care Victoria has supported health services to resolve patient concerns, and worked to ensure consumers are increasingly embedded in healthcare delivery structures. SCV had led the Victorian response to ensure women with adverse outcomes following mesh surgery have access to the care they need.

[197] J. Hennessy, Minister for Health (2017) 'Statement of Expectations for Safer Care Victoria' reproduced in Safer Care Victoria (2017) *Safer Care Victoria Strategic Plan 2017-2020*, State Government of Victoria, pp. 2-3.

Partnering with clinicians
Safer Care Victoria revitalised its clinical networks so that they are better enabled to meet the changing needs of consumers and health services. The new Victorian Clinical Council was launched to utilise the expertise of lead clinicians and consumers from across Victoria to improve system design, policy and implementation. A key focus of the June meeting of the Victorian Clinical Council was how to improve the safety of the health workforce.

Leadership and culture
Safer Care Victoria, in conjunction with its innovation and improvement arm, Better Care Victoria, ran leadership development programs for emerging and existing leaders to support cultures of continuous improvement and learning. It also partnered with other agencies to bolster the number of rural chief medical officers. A new Clinical Governance Framework was launched and released. This resource will be the basis for governance training for boards, executives and clinicians.

Review and response
Safer Care Victoria has strengthened the response to critical incidents and began work to restructure the adverse events reporting and response system. The agency supported several internal health service reviews of serious incidents.

System improvement and innovation
Safer Care Victoria, through Better Care Victoria, continued to lead on the testing and implementation of innovation. Work was also undertaken with the sector to identify a number of targeted objectives for future work.[198]

According to Ann Maree Keenan, Deputy CEO/Chief Nurse, SCV:

> *Safer Care Victoria is structured into four priorities: partnering with consumers, partnering with clinicians, stewardship support, system improvement, leadership and innovation. I am now going to provide you with some examples of the work undertaken by Safer Care Victoria to date since we opened our doors for business at the beginning of this year.*
>
> *We are supporting health services partners with consumers and sharing examples where health services excel at hearing the patient's voice….We've also employed a consumer within Safer Care Victoria and have established a Family and Consumer Council to keep us accountable.*
>
> *We recognise the need to develop the leaders of our health services and to equip them with knowledge and skills for quality and safety improvements. A significant piece of work being undertaken in partnership with the Department of Health and Human Services is aimed at empowering boards and increasing the focus on quality and safety, which Nicole has already mentioned. This has included updating the Victorian clinical governance framework, seeking to have clinicians appointed to boards to balance board composition; and to develop the ability of board members through education and training.*

[198] Department of Health and Human Services (2017) *Annual Report 2016-17*, State Government of Victoria, pp. 25-26.

We have also established a Leadership on the Front Line Program for clinical managers and an Executive Leadership Program for health executives.

Quality and safety is now a standing item at the quarterly hospital performance meetings held between the Department of Health, the hospital CEOs and senior executives.[199]

Nicole Brady, Director Strategy and Implementation, SCV continued:

We have found people at the front line have been hungry for leadership in quality and safety from the central agency. They have been very welcoming of any support we have been able to give them. Having a strong customer focus and orientation in the way we go about doing our business has also been another early learning in terms of the high acceptance, and people are pleased at that type of approach in how we can support them to do their work. That has been very well accepted. We have done quite a lot of ongoing sector engagement. We had the IHI, the Institute for Healthcare Improvement, in Victoria in November, just a couple of weeks ago, and we had more than 500 people over two days come from across Victoria to listen to them. They are international leaders in quality and safety in healthcare. The appetite and the willingness for people to come and engage, listen and learn was enormous. The sector is very keen to do better and to be supportive to do that. [200]

According to Ms Keenan, there is a culture of willingness:

What we have tried to do is elevate the quality and safety agenda, as in the example I gave about us attending the performance meetings, so that is a discussion. The CEOs attend the performance meetings. That is about elevating what is happening with their services in terms of quality and safety. We are in our early phases of that. We have only started to do that for the first quarter of the 2017-18 financial year. That is a work in progress.

Then you asked about reporting of sentinel events. What we have found is that services are starting to contact us and are asking for advice about whether we think that an event is a sentinel event. That is a positive. From my understanding, that had not really occurred prior to our establishment. [201]

[199] Ms Ann Maree Keenan, *Transcript of Evidence*, 12 December 2017, pp. 4-5.
[200] Ms Nicole Brady, *Transcript of Evidence*, 12 December 2017, p.6.
[201] Ms Ann Maree Keenan, *Transcript of Evidence*, 12 December 2017, p. 7.

TERM OF REFERENCE 5: THE IMPACT, EXTENT OF AND FACTORS CONTRIBUTING TO ADVERSE PATIENT OUTCOMES IN THE DELIVERY OF ACUTE HEALTH SERVICES

FINDINGS:

1. Access block and hospital overcrowding is a patient safety issue. More effective strategies are needed to address safety and quality of services.

2. Ambulance ramping and access block impacting on Emergency Departments is resulting in avoidable adverse patient outcomes and an increased risk of unexpected death.

3. Ambulance ramping is reducing capacity to provide timely emergency ambulance services within the community, risking further adverse patient outcomes.

4. Ambulance ramping has resulted in patients receiving treatment in areas of the hospitals that are inappropriate and inadequately resourced, compromising patient safety and privacy.

5. A Grattan Institute report shows avoidable mortality rates in Tasmania are increasing and Tasmania is the only jurisdiction where this is the case.

6. Research has shown an association between hospital overcrowding and Emergency Department access block and increased patient mortality.

7. An ageing demographic and increase in patient complexity and multi-morbidities have added to the risk of hospital overcrowding and adverse patient outcomes.

8. Poor bed capacity planning, particularly at the RHH and LGH, has contributed to access block and hospital overcrowding, increasing the risk to patient safety.

9. Emergency Departments are not appropriate or suitable for the care of acutely unwell mental health patients, many of whom are experiencing excessively long waiting times to be admitted.

10. Despite the intention to reduce restrictive practices through the *Mental Health Act 2013,* more Tasmanian mental health patients continue to be subject to restrictive practices.

11. An inquest held in 2015 into the deaths by suicide of six teenagers, identified a serious lack of acute mental health services for adolescents.

12. A Coroner's report described a direct link between access block to acute mental health beds and the death of a patient.

13. A paucity of community based adolescent mental health services, particularly in the North and North West, is increasing the risk of adverse outcomes for young people with mental health challenges.

14. A lack of comprehensive community-based mental health services is impacting negatively on patient care, recruitment and retention of psychiatrists and admission to acute mental health wards.

15. The loss of specialist accreditation in Tasmanian hospitals is negatively impacting training, recruitment and retention of specialist medical staff.

16. Safer Care Victoria is a newly established healthcare quality and safety improvement agency that may provide solutions to healthcare quality and safety issues facing Tasmania's health service.

17. The cost of complications that occur within the public hospital system across Australia is significant.

18. Patient outcomes can be improved through greater access to adequately resourced tele-medicine for a range of conditions, particularly acute stroke care in the North West.

19. State-wide co-ordination and planning may benefit patients with a range of illnesses including cardio-vascular and neurological disease.

20. Concerns raised in the first Interim Report regarding the fragmented nature of the North West Integrated Maternity Service remain. A review of the service commissioned in 2017 is yet to be reported on.

21. Morale among midwives in the North West Integrated Maternity Service is low as the current operational model negatively impacts on their ability to work across their full scope of practice.

TERM OF REFERENCE 6

ANY OTHER MATTERS INCIDENTAL THERETO

Health Complaints Process and Resourcing of the Office of the Ombudsman and Health Complaints Commissioner Tasmania

It was brought to the attention of the Sub-Committee that the Office of the Health Complaints Commissioner Tasmania (OHCCT) is under-resourced. There is concern this may be contributing to adverse patient outcomes.

The Sub-Committee invited the Commissioner, Mr Richard Connock and the Health Complaints Commission Principal Officer Philippa Whyte to provide verbal evidence in order to better understand:

- the trends in complaints to the OHCCT including any indication of underlying problems in the health service;
- the adequacy or otherwise of the funding and resourcing of the OHCCT; timelines and timeframes for dealing with complaints; and
- trends in the nature and complexity of complaints.

According to Mr Connock, health complaints have increased over the last 10 years:

> *There has been a steady increase in complaints over time, and over the same period the number of people we have to deal with it has decreased for various reasons. In 2007 our establishment was 6 FTEs, now it is down to 4.2 FTEs.*

And further:

> *We get a steady number of complaints and we are able to deal with the complaints we are getting in the sense that we are closing about as many complaints as we receive in a reporting year, but we have an historical backlog.*[202]

Ms Whyte clarified the nature of the backlog:

> *This year it was a carry-forward of 150 and we were not able to close nearly as many complaints as we received.*[203]

[202] Mr Richard Connock, *Transcript of Evidence*, 28 September 2018, p. 3.
[203] Ms Philippa Whyte, *Transcript of Evidence*, 28 September 2018, p. 3.

When questioned about the additional workload related to codes of conduct for unregistered practitioners Mr Connock stated:

> *We are horrified*
>
> *…*
>
> *I have been in contact with my counterparts interstate. New South Wales, South Australia and Queensland already have codes. I have been speaking to them about the impact on their offices of that. I have been to see the Secretary of the Department of Health and Human Services, and I have been to see the Attorney-General. They are aware this is potentially a difficulty. We do not know how big it is going to be down here; that is the problem.*[204]

Ms Whyte added:

> *There is no question we are going to have to bring a lot more rigour to the investigation based on the fact it has the potential to impact on someone's employment*[205]

Mr Connock noted that resourcing issues at the OHCCT are likely to impact on the ability of the Office to undertake assessments in relation to unregistered practitioners:

> *We can issue prohibition orders, we can deprive people of their livelihood, so it is a fairly significant thing.*
>
> …
>
> *It has to be done properly. What I am told by people in other states is that you need people with legal qualifications because you are actually prosecuting a case. It is not like an administrative investigation, which we do in Health, Ombudsman or Energy; you are more prosecutorial. You need someone who knows what they are doing and who knows how to draft an order and how to justify an order.*[206]

The OHCCT currently lacks staff with experience to deal with such matters:

> *We have a couple of legally qualified people but they are not used to doing that sort of work. It is a different approach.*[207]

[204] Mr Richard Connock, *Transcript of Evidence*, 28 September 2018, p. 5
[205] Ms Philippa Whyte, *Transcript of Evidence*, 28 September 2018, p. 6.
[206] Mr Richard Connock, *Transcript of Evidence*, 28 September 2018, p. 6
[207] Ibid.

Mr Connock commented on reductions in staffing levels of the Office since 2007 when the Office had 6 FTEs but now has 4.2:

> *If we go back to the six FTEs, we were productive. Reports were getting done; things were being conciliated in a timely manner.*
> *…*
> *We had the Global Financial Crisis and various other factors that meant a significant cut in funding across the board, but Health [Complaints Commission] has been affected by a loss of effectively nearly two FTEs.*[208]

Ms Whyte noted;

> *The complaints have gone from just under 200 to over 350.*[209]

The Sub-Committee heard evidence regarding the shortcomings of the health complaints process in Tasmania.

According to a private witness, in Tasmania there is not a single point of complaint management for customers, patients or clients who have an issue with the healthcare system. A complaint may be made to a hospital, to Australian Health Practitioners Regulation Agency (AHPRA), to a Health Complaints Commissioner or in writing to the Coroner. In Victoria, by comparison, all complaints go through the Office of the Health Complaints Commissioner where the complaint is managed and directed to the appropriate agency.

Academic Medical Centre

Dr Bryan Walpole, Emergency Physician, in his submission, suggested Tasmania needs an Academic Medical Centre (AMC), also referred to by Dr Walpole as an AHC:

> *There is an important, immediate need for all Tasmanian patients to receive better, safer and more efficient care from highly competent health professionals using existing knowledge and resources. This responsibility needs to be shared between health administrators, front line health professionals, and academic teachers and researchers. We need a new learning institution.*
>
> *The success of AHCs to promote quality learning health systems requires structural alignment and functional integration of research, education, and clinical service delivery. Accountability for each of these three elements, which are currently held by three different agencies UTAS, Menzies (and*

[208] Mr Richard Connock, *Transcript of Evidence*, 28 September 2018, p. 7.
[209] Ms Phillipa Whyte, *Transcript of Evidence*, 28 September 2018, p.7.

Clifford Craig), DHHS/THO, need to be brought together under one integrated learning health framework. This will not be easy. It requires both bottom up leadership by local and academic and clinical leaders and top-down leadership from government departments, statutory bodies and health service administrations. Trust is currently missing here as past attempts have failed, leaving only an MOU in place, with no power only influence.[210]

Dr Walpole stated:

There is ample evidence that your best guarantee of quality and safety in health is to have an active and vibrant research sector working alongside. You have researchers, who basically sit in the university; teachers, who overlap between the university and the health institution; the clinicians; and alongside them are the administrators. They are the four arms of health care.

Here in Tasmania you have eight institutions. The Royal Hobart Hospital; Launceston General Hospital; the two hospitals on the north-west coast; Clifford Craig in Launceston; and the Menzies Research Centre here. There are three clinical schools - Hobart Clinical School, Launceston and on the north-west coast - and there are nursing, pharmacy and now parameds, which is quite a big faculty. None of them is integrated into clinical care so no synergy whereby the researchers who do some clinical work, the clinicians who do some research and all of them teach the students, so a continuum. In Tasmania it does not happen. When you work for the Health department, which I did for 30 years, the predominant word is budget. When you go and work with the university, the predominant word is quality. Health in Australia is driven by numbers.

What does our minister go on about? He goes on about waiting times in the emergency department - waiting lists and the throughput in the operating theatres. Which one of those has quality built into it? None of them. I do not blame them. The people who hold the purse want a number. They are outputs; they are not outcomes.[211]

[210] Dr Bryan Walpole, 2017, *Submission #2*, pp. 1-2.
[211] Dr Bryan Walpole, *Transcript of Evidence*, 8 September 2017, p. 2.

Dr Walpole provided an example of an American cardiac surgeon who could not be attracted to Tasmania due to the inability to pursue an academic/clinical position:

> *He expected, in getting a professor of surgery job, that there would be some clinical work. He is a cardiac surgeon, for goodness' sake. He expected a day-and-a-half of clinical work, and it just was not there.*
>
> *…*
>
> *If we want to attract world-class people to this institution, what do we have to offer them? We do not have a bucket of money to offer them. What do people want? They want some research, some teaching, they want some clinical work and they want it all wrapped up so they are not getting something like Peter Stanton tells me - he used to get some salary from the university, some salary from the hospital, some salary from his time up in the north-west, and a bit of private practice. He had four bags of money involved.*[212]

Mandatory Mental Health Placement in University of Tasmania (UTAS) Undergraduate Nursing Degree

The Sub-Committee was informed, during the informal hospital site visits, that the mandatory mental health placement had been removed from the University of Tasmania's undergraduate nursing degree. The Sub-Committee wrote to the University of Tasmania on 2 November 2017 seeking an explanation for this decision.

On 30 November 2017, the Sub-Committee received correspondence from the Acting Vice-Chancellor Professor Mike Calford responding to the Sub-Committee's query:

> *Let me first clarify that mental health placement experience has not been removed from the BN [Bachelor of Nursing Course]. Rather, over recent years, staff who manage the BN have strengthened mental health content and experience within the program.*
>
> *The nationally accredited BN is undertaken either over six semesters in two calendar years or three academic years and incorporates mandatory 880 hours of Professional Experience Placement (PEP). The hours are weighted towards the ends of the course to enable students to consolidate knowledge and skills and their application in practice. The BN course accredited in*

[212] Dr Bryan Walpole, *Transcript of Evidence*, 8 September 2017, p. 7.

2015 incorporates a contemporary approach which includes mental health perspectives integrated across the entire nursing curriculum with the addition of one targeted Mental Health unit.

The course draws on the concepts of recovery with emphasis on resilience and control over problems and life. Students are also prepared for assisting a person with mental disorders using internationally recognised disorder classifications (Manual of Mental Disorders DSM-5) and International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). Students also develop practical skills relating to the Mental State Examination, basic therapeutic skills and communication strategies in simulated environments. A range of placements offer students mental health and illness experience across all year levels of the course. This approach supports the reciprocal partnership with mental health facilities to develop nursing students' capabilities in mental health and illness.

The School of Health Sciences values stakeholder engagement and advice through a number of formal and informal processes to ensure all of our courses including the BN align with directions of the profession, industry, research and discipline.[213]

Clinical design of the surgical unit at the Launceston General Hospital enhances patient Flow and Efficient Delivery of Surgical Services

According to the Tasmanian Government submission:

The LGH was constructed in 1980 with the aid of Commonwealth funding for regional areas. Since that time, there has been a continuing expansion and consolidation of health services in the immediate precinct which included the Allambie, John L Grove, Anne O'Byrne and Viewpoint Facilities.

In recent years substantial investment has been undertaken in refurbishing and expanding the LGH to accommodate growing demand for health services. This has included the expansion of the ED, the construction of an Acute Medical Day procedures unit, a Short Stay Surgical Unit, the expansion of the Intensive Care Unit and surgical wards, the refurbishment and extension of the Specialist Clinics and redevelopment of the Allied Clinics. In addition, nine surgical theatres have been built or upgraded in recent years.[214]

[213] Letter from Professor Mike Calford, Acting Vice-Chancellor University of Tasmania to Hon Rob Valentine MLC, Inquiry Chair, dated 30 November 2017.
[214] Tasmanian Government, 2017, *Submission #32*, p.17.

The Sub-Committee visited the refurbished surgical ward as part of the informal hospital visits in 2017, and recognises the exemplary clinical design work undertaken in maximising patient flow-through, and enhanced efficiencies in the operation of the surgical unit.

Provision of Cardiac Services

The Heart Foundation submission expressed concern about the impact of the transition from three THOs to a single THS on the provision of cardiac services in Tasmania:

> *There is no mechanism for the planning, budgeting, delivery and monitoring of cardiac services statewide in Tasmania. Instead, planning and budgeting at each site appears to be done based on historical and specialist desires, rather than in a coordinated approach that puts the patient first – regardless of where they live. This is the premise of our argument around the need for a Statewide Cardiac Services Plan. In our Statewide Cardiac Services Plan, we have recommended that a formalised statewide governance structure be put in place (we have called it the Tasmanian Cardiac Clinical Network (TCCN)); with the role of the TCCN being to support decision making, streamline accountability and ensure decisions impacting cardiac services are taken at the state-wide level. Appointing a Statewide Clinical Director for Cardiac Services would support this, with the TCCN providing advice on the development of statewide models of care that would include local and regional protocols and pathways to facilitate and streamline care. A Statewide Clinical Director for Cardiac Services, in consultation with the sites, should also be responsible for allocating budgets to each site for the services deemed required at those sites.*[215]

According to the Heart Foundation submission:

> *The proposed TCCN should also liaise with the DHHS regarding the cardiac-related services being commissioned from the DHHS (external to the THS) to ensure that it is more fully informed of the full health system services provided statewide, and is more informed of where gaps continue to exist. Accurate data also needs to be collected and readily accessible regarding patients who are transferred interstate for procedures that could be undertaken in Tasmania. This would ensure those costs incurred are not borne by the THS, and that the THS can maintain the level and standard of services that are appropriate and required for Tasmania.*[216]

[215] Heart Foundation, 2017, *Submission* #23 p. 3.
[216] Ibid, p. 4.

According to the Heart Foundation:

> *…significant improvements could be made to the heart health of Tasmanians if the Statewide Cardiac Services Plan was adopted by the Tasmanian Government and implemented across the health system*.[217]

In the Heart Foundation's updated 2018 submission, it was noted that:

> *We are still not aware of any mechanism for centrally planning, budgeting, delivering and monitoring cardiac services statewide in Tasmania.* [218]

The Heart Foundation's Tasmanian Statewide Cardiac Services Plan 2018 -2022 is attached to the Heart Foundation's submission and can be accessed via the Sub-Committees website.

Neurological Services

The Neurological Alliance Tasmania (NAT) submission stressed the importance of access to timely and effective services:

> *Hospitals are not intended to make a journey for a sick person a harder one than it already is. People with life-limiting conditions should not have to wait months for a diagnosis, or be denied treatments because they can't be monitored. Leaving a neurology appointment following a life changing diagnosis with only medications, no follow-up plan, and little else in hand is like leaving an emergency department with a band-aid for a severed finger.*[219]

According to the NAT submission, the rate of emergency admissions and readmissions for an existing long term neurological condition is an indicator of poor quality health or community care services or poorly integrated health and community care. There are many factors at play:

> <u>*Early intervention*</u>
>
> *Early intervention is a feature of best practice for people living with neurological or progressive neuromuscular conditions. There is currently a dangerous and unacceptable delay in people being even able to obtain a diagnosis. Motor Neurone Disease (MND) for example, usually progresses rapidly and when there is no access to, or a lengthy wait time for, a neurologist in the North and North West, people are not receiving a diagnosis unless they have been able to access a neurology service in Hobart*

[217] Heart Foundation, 2017 *Submission #23*, p. 5.
[218] Heart Foundation, 2018 *Submission #4*, covering letter, p. 2.
[219] Neurological Alliance Tasmania, 2017, *Submission* #11, p. 9.

or Melbourne. The Patient Assistance Travel Scheme relies on the capacity of people to travel. However, many people with Huntington's Disease and Multiple Sclerosis for example, are too unwell to travel to either Hobart or Melbourne.

Multidisciplinary team approach to care

People represented by NAT live longer with better quality of life when they are supported by a coordinated specialised multidisciplinary team approach to care… They can work in the community, hospital, clinic, residential and other care settings. Each discipline-specific team member enriches the knowledge base of the team as a whole and the composition of the team can change over time to reflect changes in the person's needs.

Preventable admissions through more effective person centred care plans

Individual care is often poorly coordinated, with few people with neuromuscular conditions having a personal care plan… Every person with a neurological condition should be offered a personal care plan, covering both health and community care. The evidence suggests that this is best done by a single professional, for example a specialist nurse or care coordinator.[220]

Ms Pam Cummings, 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.

Because of the degenerative nature of Huntington's and because it's a long span of time, it's around 15 years that these people are going to need health services... Because of their degeneration they still need to see a neurologist on a regular basis. Most of our people on the north-west haven't seen a neurologist for two years since Andrew Churchard stopped coming from Melbourne with the TasReach Program that was running at that time. What we need to establish is a multidisciplinary clinic, which I've seen in other states and works very well.

…

Most of our people, unfortunately, don't like to wait or can't wait and they certainly can't travel. For most of our people their condition is so poor they couldn't travel from Devonport to Launceston. We really need to have that service available.[221]

[220] Neurological Alliance Tasmania, 2017, *Submission #11*, p. 5.
[221] Ms Pam Cummings, *Transcript of Evidence*, 9 November 2017, p. 7.

Ms Cummings further noted:

> *There are no services in the hospital and most of the staff in the hospital, including the medical staff, know nothing or very little about Huntington's.*
>
> *…*
>
> *If we had that multidisciplinary clinic with a specialist neurological nurse. … in the clinic she could liaise with GPs at the end of the clinic. … I believe it's just started up again, the TasReach people coming from Melbourne, which is not a very good service. They come once every two or three months. Sometimes they only see a handful of people and then they go back to Melbourne. It really is not a practical service.*
>
> …
>
> *We are desperately in need, absolutely.*[222]

Ms Deborah Byrne, Executive Officer, Neurological Alliance Tasmania, added:

> *To clarify, we understand the terms of reference is around looking at the hospital, but our position is that I don't think you can look at the acute health care system without thinking about it. … We're saying you would have less burden on the acute health sector or the acute care, the hospitals, if we can keep people out of hospitals. Our premise is around preventable admissions and our solutions for those preventable admissions is having better services in the community, showing those services could be in the community and would get better outcomes for people. It would be more cost-effective because we know that when people have to go to hospital unnecessarily, their outcomes are worse. The main premise of our submission was around preventable admissions.*[223]

In their submission, NAT put forward the following recommendations to improve access to neurological services across the State:

- *A well-resourced (financially and human) State-wide service hub of neurological excellence based in Hobart, with knowledge in and working across a broad range of neurological conditions*

[222] Ms Pam Cummings, *Transcript of Evidence*, 9 November 2017, pp. 7-8.
[223] Ms Deborah Byrne, *Transcript of Evidence*, 9 November 2017, p. 8

- *Regular neurology clinics in regional areas with neurologists with relevant allied health and nursing staff fully supported to travel to these clinics*

- *Where people can travel to Hobart for neurological appointments, they are supported to do so with minimal red tape, and on the understanding that additional time, accommodation, and/or family support may be needed to maximise the outcomes of those appointments*

- *Community neurological nurses/coordinators be located in regional health centres to provided (sic) ongoing clinical support*

- *Three full-time community liaison officers (CLOs) to work from the three major hospitals, to liaise with the community neurological nurses/coordinators and bridge the gap between the acute care and community (Hospital CLO Final Evaluation Report, BIAT).*[224]

TERM OF REFERENCE 6: ANY OTHER MATTERS INCIDENTAL THERETO

FINDINGS:

1. The Office of the Health Complaints Commissioner Tasmania (OHCCT) is under resourced.

2. The OHCCT has experienced a reduction in staffing since 2007, an increase in workload and an ongoing backlog of health complaints.

3. The recent increase to the workload of the OHHCT resulting from the passage of *the Health Complaints Amendment (Code of Conduct) Act 2018* has not been supported with additional resourcing.

4. The OHCCT will need at least two additional FTE staff to undertake the statutory role of the Office.

5. There is no one point of contact for patients wishing to make a complaint regarding access to or receipt of a health care service.

6. Greater collaboration between the Tasmanian Health Service and health academic centres, including UTAS and medical research centres in the state, could assist with attraction and retention of specialist medical staff.

[224] Neurological Alliance Tasmania, 2017, *Submission* #11, pp. 7-8.

Appendix A: Minister for Health response to the Sub-Committee's Interim Report No. 1

Attachment #1 - Response to Interim Report Key Findings

The Government provided a public response to the Interim Report issued by the Inquiry on 21 December 2017. The below responses have been updated to reflect the current context and commitments being delivered as part of the 2018-19 Budget.

Key Finding #1

The Government has listened and taken action to strengthen local hospital decision-making.

On 17 December 2017, the Government announced that a re-elected Hodgman Liberal Government would introduce legislation to restructure the Tasmanian Health Service (THS) so that the THS would report direct to the Secretary of the Department of Health and Human Services (now the Department of Health).

With the passing of the *Tasmanian Health Service Act 2018* and the new arrangements coming into effect on 1 July 2018, the next stage of empowering and strengthening local leadership is being progressed. As part of this process, the Tasmanian Health Service is working to implement new operational structures as outlined in the document released by the Secretary of the Department of Health, in consultation with staff and key stakeholders.

Key Finding #2

The Government is committed to building a better health system, but there is no doubt that access block is regrettably a long-term issue for Tasmania.

The 2012 Legislative Council Inquiry into Labor's $500 million health budget cut found that "Ward closures have increased the incidence of bed blockages within the major hospitals" and that "Patient outcomes have been adversely affected by the strategy".

The Government acknowledges that there is growing pressure from increasing demand and is taken action to respond.

Over the last four years the Government has opened more than 120 additional beds and treatment recliners, and increased frontline staffing by more than 600 FTE from March 2014 to March 2018 - including more than 375 FTE nurses and almost 90 FTE doctors.

The Government has now taken further action to provide immediate support – opening five more permanent beds on Ward 4D to take the total permanent beds on the ward to 24, providing $1.5 million to recruit nurses and improve patient flow at the RHH and LGH emergency departments, and opening a brand new transit lounge at the LGH.

Over the next six years, the Government will roll out our $757 million plan, of which key components are completing the Royal Hobart Hospital Redevelopment and opening almost 300 new hospital beds which will greatly assist with bed access.

The facts are that if former Governments had not mismanaged the RHH Redevelopment, bed capacity would be available to help Tasmanians today.

Key Finding #3

This is a long-term issue that the THS is working to address through a number of strategies. It is important to note that, as a Government, we have been willing to fund locums to ensure patients have access to needed services.

With certainty provided to the Mersey, and new services coming, it is becoming easier to recruit permanent medical staff, and we are already seeing some improvements with more permanent specialists taking up appointments.

Likewise in Burnie, there have been appointments to paediatric positions, obstetrics and gynaecology as a result of the new birthing service, and in other areas.

The Government has had recent success in recruiting to long-term vacancies experiencing national shortages, including two FTE permanent endocrinologists at the LGH for the first time ever, as well as in Psychiatry, Palliative Care and Oncology.

The THS will continue to work on recruiting to other key specialist positions in the North, including an additional Neurologist (to ensure the specialty can function as a unit), and in the Emergency Department. Once achieved, these recruitments will all help to bring down locum costs.

Key Finding #4

The former model of care for North West birthing put mothers and babies at risk. It was not supported by doctors, failed to provide ICU and paediatric care cover for mothers and babies at Latrobe and suffered from a permanent contract with the private hospital that had bound the government in perpetuity.

The establishment of an integrated North-West maternity service was based on best the clinical advice from specialists, and is first and foremost about improving the safety of North-West mothers and babies. This required an additional $3 million investment by the Hodgman Government to ensure the service was appropriately resourced.

The reason clinicians called for the new model was to deal with unacceptable risks to patient safety in the region and the reliance on locums.

The consolidation of birthing services has allowed strengthening of the Obstetrics and Gynaecology medical workforce with a complement of permanent consultants recruited. Previously, with the service split over the two (2) sites the North West were unable to recruit to the service, resulting in long term locum requirements. There have been more than 1600 births since the service commenced.

We have received exceptional support from health experts and clinicians for these changes, which are part of the universally endorsed White Paper.

The Government is undertaking a review of the new birthing services in the North-West, which demonstrates our commitment to constantly improving patient care.

I welcome comments from the ANMF that progress was being made in relation to a number of the issues they have raised and ANMF members have made a concerted effort to work with the THS to achieve a positive resolution. This includes a better staffing model, and provision of additional space for antenatal clinics.

The new antenatal clinic at the Mersey Community Hospital, funded by the Tasmanian Government at a cost of $1.6 million, has been operational for some months now, and the Government has provided $2.2 million to construct a new antenatal clinic at the NWRH in the 2018-19 Budget, in line with the commitment made during the 2018 State Election.

Key Finding #5

Building a new hospital in a working hospital was never going to be easy, and the Government has worked to address challenges throughout this process.

The decant plan and 54-bed temporary building was far preferable to the former Labor Government's unsafe and unsupported (by clinicians) decant plan of sending sick patients to community health facilities away from the city, including mental health patients.

There can be no doubt that last year Tasmania did see a severe flu season, but the Government commends the nurses, doctors, allied health and other hospital staff who did a fantastic job ensuring patients received the care they need.

The Government has now opened the new 22-bed ward at the Repatriation Hospital, which is providing much-needed support and improved patient flow at the RHH.

The Royal Hobart Hospital Redevelopment remains on track for practical completion in mid-2019, after which the Government has allocated $28.1 million to undertake refurbishments as part of the process to open 250 new hospital beds.

The Government has provided funding for 25 new mental health beds as part of the 2018-19 Budget, once the construction of the facilities is completed, and within two years Tasmania will have access to fully funded inpatient child and adolescent mental health facilities in both the North and the South for the first time.

The Government is progressing significant planning work for the future of the RHH and southern health services, as part of the site masterplanning work, the Clinical Planning Taskforce, and the Mental Health Integration Taskforce.

The facts are that if Labor had not mismanaged the RHH Redevelopment, bed capacity would be available to help Tasmanians today.

Key Finding #6

We will continue to work hard to improve mental health care in Tasmania, in line with the long term direction outlined in the Rethink Mental Health Plan that enjoys the overwhelming support of clinicians, stakeholders and political parties.

Over the last four years the Hodgman Liberal Government has delivered more than $25 million of additional funding for facilities and community-based mental health services, including six more beds at Tolosa and over $11 million for individual packages of care to reduce pressure on acute services.

The Government is now focused on rolling out our six year, $95 million plan to improve mental health care in Tasmania, to ensure that Tasmanians are able to access the care and support they need in the right place and at the right time.

Key initiatives under the plan include 25 new mental health beds, more community-based support, specialist inpatient child and adolescent mental health facilities for the very first time and suicide prevention support for rural and regional communities.

The Mental Health Integration Taskforce is well progressed on work to make recommendations for mental health services to provide more seamless care. The Taskforce features key mental health stakeholders such as Mental Health Services staff, the Mental Health Council of Tasmania and consumers.

Key Finding #7

Regrettably, the sub-committee failed to acknowledge that the Government is currently building these facilities, with Ward 4K especially well progressed.

There has never been dedicated child and adolescent inpatient mental health facilities in Tasmania, but the Government recognised the growing need and within the next two years the following facilities will be coming online – fully funded and strongly supported:

- The redevelopment of the Royal Hobart Hospital includes a 16-bed adolescent unit in K-Block, which is on track for completion in 2019.
- The upgrade of the Children's Ward 4K at the LGH will also include specialist facilities for child and adolescents with mental health issues.

The Government has also increased funding for the Child and Adolescent Mental Health Service (CAMHS), which enabled CAMHS to hire much-needed additional staff and provide more care.

Key Finding #8

The Government strongly supports services for new mothers and babies and will continue to do so.

There can be no doubt the Government has a strong commitment to providing better services for mothers and babies, having established the integrated North West maternity service at Burnie which offers many benefits to expectant mothers, including better access to specialised services such as paediatrics, an expansion of antenatal and postnatal care, greater levels of midwife led outreach and home visits after the birth.

Appendix B: Submissions Received (2017)

1	CONFIDENTIAL
2	Dr Bryan Walpole
3	Alan Churchill
4	Peter Schulze
5	Dave and Sally Wimbridge
6	Lyn Cleaver
7	Northern Suburbs Health Committee Inc.
8	AMA
9	CONFIDENTIAL
10	Martyn Goddard
11	Neurological Alliance Tasmania
12	Stroke Foundation
13	CONFIDENTIAL
14	RANZCP
15	Tasmanian Patient Health Group
16	HACSU
17	Mental Health Council
18	CONFIDENTIAL
19	Robin Wilkinson
20	CONFIDENTIAL
21	CONFIDENTIAL
22	Helen Burnet
23	Heart Foundation
24	Australasian College of Emergency Medicine
25	MSA
26	Dr Chris Wareing
27	Minister for Health
28	Royal Australasian College of Surgeons
29	PICAHMS
30	ANMF
31	CONFIDENTIAL
32	Tasmanian Government
33	Mervin Reed
34	Karalyn Hingston
35	Kate Brockman

Appendix C: Submissions Received (2018)

1	Clinical Associate Professor Robyn Wallace
2	RANZCP (updated)
3	CONFIDENTIAL (updated)
4	Heart Foundation (updated)
5	CONFIDENTIAL (updated
6	College of Emergency Nursing Australasia (Tas Branch)
7	Royal Australasian College of Surgeons
8	Tasmanian Government
9	ANMF (updated)
10	Australasian College for Emergency Medicine (updated)
11	Rural Doctors Association of Tasmania